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Report of the Special Commission of Inquiry into Child Protection Services in NSW

Executive Summary and Recommendations

The Hon James Wood AO QC

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Executive Summary

The child protection system in New South Wales consists of much more than the Department of Community Services (DoCS). NSW Health through its Area Health Services and The Children's Hospital at Westmead fund and deliver many services for children, young people and their families, including prenatal care, home visiting and counselling, with the aim of preventing or minimising harm. Similarly, the Departments of Education and Training, Juvenile Justice and Ageing, Disability and Home Care, Housing NSW and the NSW Police Force offer programs, funding and services, ranging from breakfast programs, diversionary sentencing options for young people, respite for parents of children with disabilities, and housing and youth support activities.

They also have a role in reporting suspicions of abuse or neglect of children and young people, and within their available resources or facilities, responding. The role of the NSW Police Force in investigating criminal offences directed at children, and in responding to family and domestic violence forms a significant part of the child protection system.

Non-government organisations are also key players in the system and provide universal, secondary and targeted and tertiary services to children, young people and their families aimed at minimising the risk of abuse and neglect as well as supporting those children and young people who have been harmed, some of whom will have been removed from their families and placed in out-of-home-care.

The contemporary challenge facing all child protection systems in Australia, and in particular NSW as the largest, is sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe.

Once children and young people are the subject of reports of being at risk of harm, the challenge is to have adequate skills and tools with which to assess and identify those who need the full attention of the state including removal from their families, and those who can be assisted to remain in their homes with the necessary support being provided. Children and young people who cannot live at home require carers who are financially, emotionally and practically supported by the system, and who have been well matched to them. They also need state assistance to access medical, dental and allied treatment when it is needed.

Importantly, children and young people need to be listened to and participate in decisions which affect them.

A range of complex and often chronic factors characterise many of the families coming into contact with the child protection system such as low income, unemployment, substance abuse, limited social supports, imprisonment,

domestic violence, and mental health issues. Many of these factors are inter-related. The elimination or reduction of each of these factors would significantly lower the number of children and young people reported as being at risk of harm.

DoCS has undergone a period of significant reform since 2002 when it received a substantial injection of funds which took the annual budget in 2007/08 to more than $1.2 billion. While, in 2008, many of those reforms have been implemented or are underway, insufficient time has passed for the benefits to be fully evident.

In 2008, there are a number of challenges both old and new facing DoCS, some of which are unique to it, but many of which are experienced by most child protection systems within Australia.

Reports

a. Reports to DoCS of children and young people suspected to be at risk of harm are increasing annually, although the extent of the increase seems to be slowing and those reports which are made are being assessed as less urgent.

b. A large number of children, young people and families are repeatedly reported, often within short periods, with the result that reports to DoCS are more likely to be about a child or young person already known to it. Thus, in 2006/07 about the top 20 per cent of the children and young people who were frequently reported accounted for more than half the total number of reports.

c. Most reports to DoCS concern domestic violence, psychological abuse, neglect, carer substance abuse, carer mental health and/or sexual abuse. There is little reliable research to guide effective interventions for children and young people who are neglected, although a report of neglect is more likely to receive greater DoCS attention than one concerning domestic violence.

d. A detailed examination of what happened to reports to DoCS in 2007/08 reveals that:

   i. about 13 per cent of the reports were not ‘risk of harm’ reports as defined in the *Children and Young Persons (Care and Protection) Act 1998* and thus, while the family may have needed assistance, they should have been referred to, and met with a suitable response from, an agency other than DoCS

   ii. another 21 per cent of reports were assessed by the Helpline as requiring further assessment, but received none from the Community Services Centre to which they were referred

   iii. 33 per cent received some attention which fell short of a face to face visit

iv. only 13 per cent of reports resulted in a home visit from a DoCS caseworker, as part of a secondary assessment process

v. the remaining reports mainly concerned children and young people who were already being assessed by DoCS.

e. Too many reports are being made to DoCS which do not warrant the exercise of its considerable statutory powers. As a result, much effort and cost is expended in managing these reports, as a result of which the children and young people the subject of them receive little in the way of subsequent assistance, while others who do require attention from DoCS may have their cases closed because of competing demands on the system (that is, insufficient resources).

f. Those who are required to report when they reasonably suspect a child or young person to be at risk of harm, known as mandatory reporters, receive insufficient information from DoCS about its response to their reports. As a result, they keep reporting, often to little effect and it is less likely that they will work in partnership with DoCS to assist the child or young person. If informed that DoCS was not in a position to take up the case, they may well provide more assistance themselves.

Infrastructure

a. DoCS information management technology is not adequately suited for the purpose of supporting workers to assess and intervene in the lives of children and young people, and its complexities and shortcomings continue to be a source of frustration and delay to its staff.

Workforce

a. While, in the main, DoCS has developed sound, comprehensive and evidence based policies and procedures, they are not consistently implemented, with the result that quality practice in each CSC within its several regions remains challenging.

b. Recruiting and retaining a skilled, diverse workforce to provide services in all parts of the State is an issue for DoCS, as it is for all other justice and human services agencies in NSW and for non-government organisations working in the welfare sector.

Availability of services

a. There are not sufficient prevention, early intervention and targeted services provided by state agencies or by the non-government organisations for children and young people at risk and their families.

b. Currently, the capacity in some non-government organisations and Aboriginal organisations is not sufficiently developed to enable them to properly partner DoCS and other state agencies in working towards the safety, welfare and well-being of the children and young people who need assistance.

c. There are barriers to non-government organisations and other state agencies working together in the interests of the safety, welfare and well-being of children and young people. Some can be cured by legislation, such as information exchange, but generally a change in attitude and approach including greater acceptance of working in collaboration, is needed.

d. Aboriginal communities remain over represented in the child protection system and culturally appropriate interventions for Aboriginal children, young people and their families are not widespread in any of the agencies that are expected to work with them.

The legal system

a. Data collection is generally good at DoCS, but in areas such as the Courts, there is an absence of sufficient data of the kind that is required for an understanding, assessment and monitoring of the operation of the child protection system.

b. Too many Children's Court decisions are made by non-specialist Magistrates, the Children's Court does not facilitate alternative dispute resolution as was originally intended and its processes are unduly technical.

c. DoCS does not always present its evidence to the Children's Court in a fair and balanced manner and legal practitioners who appear in the care jurisdiction are not subject to uniform standards or accreditation.

Out-of-home care

a. There are increasing numbers of children and young people in out-of-home care for longer periods of time and with increasingly complex needs at a cost per child which continues to rise.

b. There is a decreasing pool of foster carers.

c. There is a need for a greater number and range of different placement options for children and young people for whom it is not safe to live at home.

d. Children and young people entering, and in, out-of-home care generally do not receive, as a matter of priority, the medical, dental and allied health assessments and treatments they should receive. Neither do they receive the degree of assistance that is needed when leaving care.

Other matters

a. The arrangements by which DoCS is scrutinised by other agencies are complex.

b. There is a duplicative, unduly complex and administratively burdensome funding system.

The principles and goal underpinning the Inquiry's proposed reforms

The key principles which underpin the Inquiry's reforms are as follows. Child protection is the collective responsibility of the whole of government and of the community. Primary responsibility for rearing and supporting children and young people should rest with families and communities, and with government providing support where it is needed, either directly or through the funded non-government sector.

The outcomes sought from the service system should be to ensure children and young people are able to grow up at the very least unharmed by their social, economic and emotional circumstances and are supported to do so by their parents. Where their parents are unable to do this, the state needs to be in a position where it can step in and fill the gap in a humane and responsive way that will preserve the safety of those children and young people.

The participation of children and young people is critical to guiding the delivery of services.

The child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion. They should be delivered by a mixture of the non-government sector and state agencies, with DoCS being a provider of last resort.

DoCS, and where necessary, the NSW Police should remain responsible for interventions mandated under the *Children and Young Persons (Care and Protection) Act 1998*, and for the investigation and prosecution, in a timely and efficient manner of criminal offences committed against children and young people.

All services should be integrated and, where possible, co-located or operated in 'hubs', with outreach capacity.

Early decision making about permanency planning, including restoration to family, results in better outcomes for children and young people, both in immediate terms and for life after care.

All Aboriginal children and young people in out-of-home care should be connected to their family and their community, while addressing their social, emotional and cultural needs.

Greater in-depth assessment of children and young people coming into care through more comprehensive assessment and interventions in the crucial early stages of placements should be part of agency placement and planning processes.

Carers should be provided with timely information about those in their care, their needs, and the type of support they need to flourish in their care, and given

ongoing support by DoCS or by designated agencies in fulfilling their care responsibilities.

Children and young people where possible should be placed with relatives and/or with siblings, and generally should be placed as close as possible to where their family/kinship and support networks are located.

There should be sufficient health and specialist services including dental, psychological, counselling, speech therapy, mental health and drug and alcohol services available to meet the needs of children and young people in out-of-home care.

Foster, kinship and relative carers should be supported in caring for children and young people, including assistance to work with those with challenging behaviours, to improve the stability of placements. This should include access to regular and planned respite care, behavioural management support, and other evidence based specialist services.

Young people should be assisted when leaving care to transition effectively to stable accommodation and to receive further education and/or training and/or employment, so as to maximise their potential for independent living.

Non-government organisations in partnership with other relevant government agencies such as DoCS, NSW Health, the Department of Education and Training and the Department of Ageing Disability and Home Care should deliver out-of-home care services.

The Key Reforms

Amendment of the *Children and Young Persons (Care and Protection) Act 1998* is proposed so as to require that only children and young people who are suspected, on reasonable grounds, to be at risk of significant harm should be reported to DoCS.

Each of the Area Health Services, The Children's Hospital at Westmead, the Department of Education and Training, NSW Police Force, the Department of Ageing Disability and Home Care and the Department of Juvenile Justice should create a Unit which advises staff on whether a report should be made to DoCS and, if the proposed report does not disclose a risk of significant harm, the Unit should assist the child or young person by, among other matters:

a. referring them to a newly created Regional Intake and Referral Service. That service is to be located within a non-government organisation and it will determine the nature of the services required and refer the family to the appropriate non-government organisation or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education

b. referring them to the early intervention program Brighter Futures

c. working with the child or young person, alone or in combination with another appropriate agency or non-government organisation, to address their need for assistance or specialised services.

Reports made to DoCS, which are assessed as being a report that a child or young person is at risk of significant harm should be investigated by DoCS if the matter is urgent or the risk is high or the child is young. Otherwise, if eligible, the family should be referred to Brighter Futures. If not eligible, the family should be referred to a Regional Intake and Referral Service which should be able to link families with the most appropriate local service to meet their needs.

The Regional Intake and Referral Service should be operated and staffed by a non-government organisation with one or more child protection caseworkers, seconded from DoCS, the number of staff will depend on anticipated demand for that region.

Integrated, multi-disciplinary and co-located child and family services should be established in locations of greatest need to deliver services to children, young people and their families.

Non-government organisations and state agencies should be funded to deliver services that should cover the continuum of universal, secondary and tertiary services and should target key developmental stages and transition points in the lives of children and young people. Such services should include:

a. home visiting, preferably by professionals, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs

b. sustained home visiting for at risk families, parent education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance

c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, Physical Abuse and Neglect of Children services, services for 10-17 year olds who display sexually abusive behaviours and allied health services such as speech pathology and mental health services.

Secondary and tertiary services that include intensive, short term, in-home and crisis interventions and that also provide links to other services following intensive support should also be available and able to respond where needed.

In addition, work should be undertaken to extend current programs including, Brighter Futures, family preservation services provided by non-government organisations, free early childhood education before commencing school for low income families, family and domestic violence programs and the Safe Families Program – Orana Far West.

The capacity of non-government organisations, Aboriginal and non-Aboriginal, to staff and deliver these services to children, young people and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed.

DoCS, Area Health Services, The Children's Hospital at Westmead, NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of Education and Training and non-government organisations should use a common assessment framework to identify and respond to the needs of children, young people and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, risk taking adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency should identify their most frequent clients, referred to by DoCS as frequently reported families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant non-government organisations should be provided, together with mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including non-government organisations should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person, and for that to occur, amendment is required in relation to the existing privacy legislation. In addition, enhanced interagency collaboration and acceptance of responsibility for child protection is recommended.

Within three years, case management of families in Brighter Futures should be transferred to Lead Agencies. The responsibility for out-of-home care should similarly be progressively transferred to the non-government sector. The Inquiry supports a revised scheme for voluntary out-of-home care.

A workforce strategy should be established which takes into account the need of non-government organisations to employ additional skilled staff and to accommodate the transition of early intervention and out-of-home care casework to the non-government organisations.

Caseworkers should be employed on a temporary basis, or reassigned from Brighter Futures or out-of-home care work as case management is transferred to the non-government sector, to manage those children and young people who will require DoCS services in relation to statutory intervention.

Other reforms

In relation to reporting, the Inquiry has made recommendations to encourage more and better feedback to mandatory reporters, to provide them with targeted training and access to aggregated data. Its recommendations directed to the NSW Police Force are designed to ensure that victims of domestic violence are better served, and that the system is not overburdened by reports that do not justify DoCS intervention.

The Inquiry has also made recommendations to enhance the information management technology available to DoCS and to ensure consistent, quality casework through supervision and professional development, audits and reviews, clarifying policies and procedures.

Significant amendment of the *Children and Young Persons (Care and Protection) Act 1998* is recommended in relation to the principles which underpin it by giving greater emphasis to the best interests of the child principle, extending the grounds on which a care order may be made, restricting the allocation of parental responsibility by the Children's Court to DoCS, limiting the power of the Children's Court to make contact orders, while confining enhanced powers in the Children's Court in relation to restoration.

In relation to the processes followed by the Children's Court, various recommendations are made designed to simplify the practice and procedure of that Court and to reduce technicality. In addition, the Inquiry urges the greater use of alternative dispute resolution and the development of a code of conduct for all legal representatives practising in the care jurisdiction. The status of the Court should be enhanced by a District Court Judge being appointed as its senior judicial officer.

Building capacity in Aboriginal organisations is a focus of the report, as is the need for the adoption of other methods of reducing Aboriginal representation in the child protection system, and of securing greater participation of Aboriginal agencies in that system.

The review of deaths of children is considered and recommendations are made for a change in the current arrangements, including a reconstitution of the Child Death Review Team to be led by the NSW Ombudsman.

The report concludes with a suggested framework for implementation of the 111 recommendations which have been ranked by degree of priority, and likely cost.

Recommendations

R.1 In the recommendations which follow, the Inquiry has assigned a priority ranking and a cost ranking to each. In relation to priority, the term ‘immediate’ means that the implementation of the recommendation should be substantially commenced within six months, ‘short term’ means that implementation of the recommendation should be substantially commenced within 12 to 18 months and ‘long term’ means that the implementation of the recommendation should be substantially commenced within two to three years.

R.2 In respect of some recommendations, specific timeframes have been allocated.

R.3 Whether the cost of implementing the recommendation is low, medium or high is generally based on information provided by DoCS. As a guide, recommendation 1 is estimated to cost $17.8 million over three years, and is assigned the category of ‘medium’.

R.4 Many of the recommendations are dependant upon or integrated with other recommendations. The recommendations contained in Chapter 10 are integral to the key reforms contained in this report. The timing of the introduction of the following reforms will be affected by amendments to the Care Act in that, generally they should follow those amendments: recommendations 2.1, 6.1, 6.5, 9.2, 9.3, 9.5, 10.1, 10.2, 10.3, 10.4, 10.7 and 17.2.

R.5 If the testing of the Structured Decision Making tools proves effective, there will need to be a revision of many of the policies and procedures currently in place, including a number of those about which recommendations have been made.

	Priority	Cost

Chapter 2 Structure and Reform

Recommendation 2.1 *Immediate* *Medium*

The KiDS Core Redesign Project should be funded and implemented.

Recommendation 2.2 *Immediate* *Medium*

DoCS Information Management and Technology Strategic Plan should be funded and implemented.

Recommendation 2.3 *Immediate* *Low*

The trial of the quality review tools should proceed immediately and the approved tools should be then applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.

Recommendation 2.4 *Immediate* *Low*

The decision consequent upon the SINC Report to relocate the bulk of the Complaints Unit functions to the Helpline and to revise the complaints handling system, should be implemented.

Recommendation 2.5 *Short term* *Low*

Carer Support teams should be responsible for liaising with DoCS foster carers and kinship/relative carers in relation to their complaints and to ensure they have the assistance they require.

Chapter 3 DoCS Workforce Capacity

Recommendation 3.1 *From 1 July 2009* *Low*

From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.

Recommendation 3.2 *Short term* *Medium*

A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.

Recommendation 3.3 *Short term* *Low*

A review of financial delegations should be undertaken.

	Priority	Cost

Chapter 6 Risk of harm reports to DoCS

Recommendation 6.1 *Short term* *Low*

DoCS should revise its case practice procedures to develop clear guidelines for classifying risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.

Recommendation 6.2 *Immediate* *Low*

In relation to *the Children and Young Persons (Care and Protection) Act 1998*:

a. Sections 23, 24 and 25 should be amended to insert 'significant' before the word 'harm' where it first occurs; and s.27 amended to insert 'significant' before the word 'harm' wherever it occurs.

b. Section 23 should be amended to insert as paragraph (g) "the child or young person habitually does not attend school."

c. A provision should be inserted defining that (with the exception of s.23(d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.

d. The penalty provision in s.27 should be deleted.

Recommendation 6.3 *Immediate* *Medium*

Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.

Recommendation 6.4 *Short term* *Low*

DoCS should provide the key agencies employing mandatory reporters, namely NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training with quarterly aggregated data about the reports made by the agency and its staff. These data should be made public.

	Priority	Cost

Recommendation 6.5 *Short term* *Low*

Targeted training strategies for each of the key mandatory reporters, namely the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training in relation to the circumstance in which reports need to be made and in relation to the information required, so as to ensure its relevance and quality, should be developed and implemented by each agency in collaboration.

Recommendation 6.6 *Short term* *Low*

The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children's Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force.

Chapter 7 Early intervention

Recommendation 7.1 *Short term* *Low*

DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.

Chapter 8 Assessment and response

Recommendation 8.1 *Short term* *Medium*

The JIRT Reform Program, as set out in the Implementation Plan should be completed.

Recommendation 8.2 *Long term* *Low*

JIRT should be regularly audited.

Recommendation 8.3 *Immediate* *Low*

Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and DoCS.

Recommendation 8.4 *Short term* *Medium*

NSW Health should provide an appropriately trained workforce to provide

	Priority	Cost

forensic medical services where needed for children and young persons who have suffered sexual assault and physical injury.

Recommendation 8.5 *Long term* *High*

The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.

Chapter 9 Assessment and response: issues arising

Recommendation 9.1 *Short term* *Medium*

DoCS should test the use of Structured Decision Making tools at the Helpline and at CSCs in relation to assessments and interventions including restoration.

Recommendation 9.2 *Short term* *Low*

A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors.

Recommendation 9.3 *Short term* *High*

DoCS should develop a strategy to move to electronic record keeping and abolish the use of paper records.

Recommendation 9.4 *Short term* *Low*

DoCS should revise its case practice procedures to provide Helpline caseworkers with greater guidance as to determining response times for reports of risk of harm.

Recommendation 9.5 *Short term* *Low*

For all caseworkers and casework managers there should be a structured program for ongoing professional development which is incorporated into annual Personal Planning and Review agreements.

Recommendation 9.6 *Short term* *Low*

In addition to individual supervision, there should be a facilitated monthly

	Priority	Cost

group case practice review of selected cases within each CSC and at the Helpline, in which all caseworkers and managers participate and which may include specialists from other agencies, if the cases require it.

Recommendation 9.7 *Long term* *Low*

DoCS should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.

Recommendation 9.8 *Short term* *Medium*

The work of the Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.

Chapter 10 Directions for the way forward

The creation of different pathways

Recommendation 10.1 *Short term* *High*

Members of the community and mandatory reporters who are not those described below, who suspect that a child or young person is at risk of significant harm ("the statutory threshold") should report their concerns to the Helpline. Reports should be as comprehensive as the knowledge and professional or expert experience of the reporter permits.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is at risk of significant harm, which is imminent, should report directly to the Helpline.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency ("the Unit"). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work (see below).

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

	Priority	Cost

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

a. The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.

b. Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

c. A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.

d. The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.

Recommendation 10.2 *Short term* *High*

Reports made to DoCS should be assessed at the Helpline with the use of Structured Decision Making tools (after being tested and applied). If a report is assessed as meeting the statutory threshold, the report should be dealt with in one of the following ways:

a. Families who are assessed by the Helpline as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

b. Where a child or young person is:

   i. assessed as in need of a response within 24 hours, or

   ii. assessed as in need of a response within 72 hours and the risk is assessed as high, or

   iii. under five years and the primary care-giver’s functioning or ability to parent is impaired due to current substance abuse, unmanaged mental illness or intellectual disability, and:

   - the child has high support needs, or
   - the primary reported issue is neglect or actual injury, or
   - the child or a sibling has been previously removed from the family by reason of care and protection concerns

   then such child or young person should be referred to a CSC that will apply the Structured Decision Making tools in assessing,

	Priority	Cost

intervening and, if ultimately found to be appropriate, removing the child or young person from his or her family.

c. Children and young persons who are assessed as in need of a response within 72 hours with a risk assessed as less than high, or as in need of a response within less than 10 days and who do not meet the criteria for Brighter Futures, should be referred to the Regional Intake and Referral Service which should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for such assistance as may be reasonably available and likely to meet the relevant need.

The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkers seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer to the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS Region.

DoCS structure

Recommendation 10.3 *Long term* *Medium*

DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key agencies and each region should contain such number of CSCs (see Chapter 23) as are appropriate for the level of demand within the region.

Service availability

Recommendation 10.4 *Long term* *High*

Services should be integrated, multi-disciplinary and co-located, wherever practicable and child and family services should be established in locations of greatest need, by outreach if necessary.

NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:

a. home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning

	Priority	Cost

programs

b. sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance

c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents aged 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services

d. secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed

e. the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case.

Recommendation 10.5

Short term *High*

a. Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system (DoCS estimates that this should assist an additional 1,200 families).

Long term *High*

b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to services for Aboriginal children and their families (DoCS estimates that this should assist an additional 3,400 families).

Short term *High*

c. The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families (DoCS estimates that this should assist an additional 3,000 families).

Short term *High*

d. The Aboriginal Maternal and Infant Health Strategy should be delivered statewide (funds have been allocated for this service).

Long term *High*

e. Young, first time, isolated mothers with low educational attainment should receive secondary services, particularly sustained home visiting where the focus should be on positive maternal and child outcomes.

	Priority	Cost
	Short term	High
f. One year of free early childhood education before school should be provided to low income families.		
	Short term	High
g. Co-located child and family centres servicing Aboriginal communities, involving health and education services should be developed.		
	Short term	High
h. In relation to domestic violence, the commitment to the Domestic Violence Court Intervention Model, Integrated Case Management, Non-government sector grants, Staying Home Leaving Violence, the Court Assistance Scheme, Indigenous Programs and police equipment should be implemented.		
	Short term	Medium
i. The commitment to establish the Safe Families Program – Orana Far West should be implemented.		
	Short term	
j. The commitment to fund the Preschool Investment and Reform Plan should be implemented.		
	Short term	
k. The implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional 260 child care centres on primary school grounds and other community land in areas where there are service gaps, should be progressed.		

Recommendation 10.6 *Five years* *High*

The capacity of NGOs, Aboriginal and non-Aboriginal, to staff and deliver the services detailed in Recommendations 10.4 and 10.5 a, b, c, e, f and g to children, young persons and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed. The principles underpinning performance based contracting should apply.

Working collaboratively

Recommendation 10.7 *Short term* *High*

DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of

	Priority	Cost

Education and Training and NGOs should use a common assessment framework to identify and respond to the needs of children, young persons and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, high risk adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency, namely DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, Housing NSW, the Department of Juvenile Justice and the Department of Education and Training should identify their high end users, referred to by DoCS as Frequently Reported Families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant NGOs should be provided including the adoption of mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including NGOs should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (see Chapter 24).

A multi-agency systems approach to case review should be established (see Chapter 9).

Workforce needs

Recommendation 10.8 *Short term* *Low*

A workforce strategy should be established which takes into account the needs of NGOs to employ additional staff and to accommodate the progressive transition of early intervention and OOHC (see Chapter 16) casework to the NGOs.

NGOs should receive sufficient funding to develop the infrastructure needed to attract experienced staff, and be assisted in providing uniform training for caseworkers and carers.

Recommendation 10.9 *Short term* *High*

A Unit of one or more positions, depending on the size of the agency, should be created in each Area Health Service, The Children's Hospital at Westmead, the Department of Education and Training, the NSW Police Force, the Department of Ageing, Disability and Home Care and

	Priority	Cost

the Department of Juvenile Justice to receive reports of risk of significant harm from staff of the agency and to take appropriate action for the protection of children and young persons, including reporting to DoCS. In addition, the Unit should ensure communication with other agencies, primarily the human services agencies and relevant NGOs, and provide advice to the Human Services and Justice CEOs Cluster about any problems or emerging trends concerning interagency collaboration.

The Unit in each agency should:

a. report to the agency's CEO or a defined and consistent second tier within the agency
b. use data systems and processes that are common across agencies
c. meet regularly with the positions created in the same agency and with those in other agencies
d. keep relevant data which is then shared across agencies
e. be child protection trained
f. be positively named.

Recommendation 10.10 *Immediate* *High*

Caseworkers should be employed on a temporary basis or re-assigned from Brighter Futures or OOHC work as case management is transferred to the NGO sector, to manage those reports meeting the criteria set out in 10.2 b above until Recommendations 6.2, 10.1 and 10.2 are implemented (DoCS estimates that 300 temporary caseworkers are required).

Brighter Futures

Recommendation 10.11 *Three to five years* *High*

Within three to five years, case management of all families in Brighter Futures should be by Lead Agencies.

Chapter 11 Statutory basis of child protection

Recommendation 11.1 *Immediate* *Low*

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

i. Section 8(a) should be amended to provide as follows:

> that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them.

		Priority	***Cost***

ii. Section 9 should be amended to provide:

> The principles to be applied in the administration of this Act are as follows:
>
> > In all actions and decisions concerning a particular child or young person that are made under this Act the safety, welfare and well-being of the child or young person must be the paramount consideration.

Paragraphs (b) to (g) should then be renumbered commencing with (a).

iii. Section 18 should be amended to insert the words “or a non-government agency in receipt of government funding for the requested services” after “or agency”.

iv. Section 21 should be amended to permit an NGO in receipt of government funding for the requested services to apply on behalf of a child or young person for assistance.

v. Section 28 should be proclaimed.

vi. Section 29(1)(f) should be amended to reflect the changed reporting structure as set out in Chapter 10.

vii. Section 29(1)(f) should be amended to permit the disclosure of the reporter’s details to a law enforcement agency pursuant to the investigation of a serious crime committed upon a child or young person, where that might impact on the child’s safety, welfare or well-being.

viii. Section 71 should be amended so that the grounds are not limited to those enumerated, while still retaining each sub-section.

ix. The Act should be amended to make clear that, other than emergency care and protection orders made under s.46(2) of the Care Act, the Children’s Court can not allocate parental responsibility to a designated agency or a principal thereof.

x. The Act should be amended to limit the power of the Children’s Court to make contact orders to those matters where the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration.

xi. Section 90(3) should be amended to permit the child or young person to make an application pursuant to that section.

xii. Part 3 of Chapter 7 should be repealed.

xiii. Section 58 (1) (a) should be amended to delete “or unwilling.”

xiv. Pursuant to s.82, the Children’s Court should have the power to order that a written report be made to it and, if after receiving that report, it is not satisfied that proper arrangements have been made, it should have the power to re-list the matter with notice to the parties to the original proceedings in order to give any of them an opportunity to make an application pursuant to s.90 or for any other ancillary or incidental order. However, if no party wishes to apply

	Priority	Cost

for an order varying any of the orders made, the matter should be taken no further. In the absence of a moving party, the Children's Court should not be empowered to make orders of its own motion.

In addition, the Children's Court should develop rules concerning timing, notice, confidentiality and procedures to ensure that reports are made to it in a timely fashion, that all parties are provided with a copy of the report and that the process by which a date is set for hearing is also clear.

xv. The Children's Court should have the power to order that expert evidence be provided to it, in the form of reports provided by the Children's Court Clinic or otherwise.

xvi. Relevant amendments should be made to ensure that *Re Rhett* [2008] CLN 1 is followed.

xvii. The Act should be amended to provide that a decision to restore a child or young person to the care of the parents from whom he or she had previously been removed by an order of the Children's Court, in circumstances where the Children's Court had accepted the assessment of the Director-General that there was not a realistic possibility of restoration, must be made by the Children's Court upon application by the person with parental responsibility.

Recommendation 11.2 *Short term* *Low*

There should be a feasibility study into the transfer of the Children's Court Clinic to Justice Health that should also investigate its expansion to provide the services of the kind currently offered by Justice Health in the criminal jurisdiction, as well as an extension of the matters dealt with in the current assessments so as to provide greater assistance in case management decisions.

Recommendation 11.3 *Short term* *Low*

Data in relation to all aspects of proceedings pursuant to the *Children and Young Persons (Care and Protection) Act 1998* should be kept by DoCS and the Children's Court and made public.

Recommendation 11.4 *Immediate* *Low*

DoCS should review its Casework Practice Policy, Taking Action in the Children's Court, to ensure it is consistent with the *Children and Young Persons (Care and Protection) Act 1998,* in particular, the principles set out in ss.9, 10 and 36.

Recommendation 11.5 *Short term* *Low*

DoCS should develop Guidelines for staff in order to ensure adherence

	Priority	Cost

to the Aboriginal and Torres Strait Islander Child and Young Person Placement Principles in s.13 of the *Children and Young Persons (Care and Protection) Act 1998.*

Recommendation 11.6 *Short term* *Low*

Evidence based guidelines for Magistrates should be prepared in relation to orders about contact made under s.86 of the *Children and Young Persons (Care and Protection) Act 1998.*

Chapter 12 Other models of decision making

Recommendation 12.1 *Immediate* *Medium*

Adequate funding should be provided so that alternative dispute resolution is used prior to and in care proceedings in order to give meaning to s.37 of the *Children and Young Persons (Care and Protection) Act 1998*, in relation to:

a. placement plans
b. contact arrangements
c. treatment interventions
d. long term care issues
e. determination of the timing/readiness for returning a child to the home
f. determination of when to discontinue protective supervision
g. the nature and extent of a parent's involvement
h. parent/child conflict
i. lack of, or poor, communication between a worker and parents due to hostility
j. negotiation of length of care and conditions of return
k. foster carer/agency/parent issues.

Recommendation 12.2 *Not applicable* *Medium*

The Nowra Care Circle Pilot should be monitored and evaluated. If successful, consideration should be given to its extension to other parts of the State with significant Aboriginal communities.

Chapter 13 Court Processes in statutory child protection

Recommendation 13.1 *Immediate* *Low*

The *Children's Court Act 1987* should be amended to insert a provision similar to s.27 of the *Local Court Act 2007* and the *Children's Court Rules*

	Priority	Cost

2000 should be reviewed to ensure that the Rules are consistent with the *Children's Court Act 1987* and the Care Act, and any practice directions or notes that are issued after amendment of the Act should similarly accord with the legislation.

Recommendation 13.2 *Immediate* *Low*

There should be no requirement, by way of legislation or practice, that DoCS is to file all material relied upon in care proceedings at the beginning of the proceedings.

Recommendation 13.3 *Immediate* *Low*

Care applications by DoCS under ss.45 and 61 should be made by way of an application filed in the Court supported by a written report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection and any interim orders sought, without any requirement for the filing of any affidavit, unless ordered by the Court in circumstances where establishment is contested. The DoCS file or relevant portion of it should be made available to the parties.

Recommendation 13.4 *Immediate* *Low*

Section 45 of the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require DoCS to apply to the Children's Court no later than 72 hours after the child or young person has been removed or care assumed.

Recommendation 13.5 *Immediate* *Low*

The Children's Court should revise its practices in relation to changing hearing dates and moving proceedings between courts, as well as its listing practices for callovers and mentions.

Recommendation 13.6 *Immediate* *Low*

DoCS caseworkers should be given more specific training and guidance in relation to the nature of care proceedings and in relation to the evidence to be placed before the Court, to ensure its relevance, accuracy and fair balance.

Recommendation 13.7 *Short term* *Low*

Guidelines should be developed for DoCS caseworkers based on the Code of Conduct applicable to the Office of the Director of Public Prosecutions.

	Priority	Cost
Recommendation 13.8	*Short term*	*Low*

A code of conduct should be developed applicable to all legal representatives in care proceedings. Specialist accreditation should be regularly available. Any necessary training or assessment mechanisms should be available on an ongoing or regular basis. A similar regime should also be established for Guardians ad Litem.

Recommendation 13.9	*Immediate*	*Low*

A District Court Judge should be appointed as the senior judicial officer in the Children's Court.

Recommendation 13.10	*Short term*	*Medium*

There should be sufficient specialist Children's Magistrates appointed to permit rural and regional circuits to be held to ensure that the proportion of matters in the care and protection jurisdiction presided over by non-specialist Magistrates is reduced to fewer than 10 per cent.

Recommendation 13.11	*Short term*	*Low*

A trial of a 'docket system' in the Parramatta Children's Court for matters in the care and protection jurisdiction should be undertaken.

Recommendation 13.12	*Immediate*	*Medium*

Registrars of the Children's Court should be legally qualified and alternative dispute resolution trained and sufficient in number to perform alternative dispute resolution and to undertake procedural and consent functions.

Chapter 15 Child protection and the criminal justice system

Recommendation 15.1	*Long term*	*Medium*

An after hours bail placement service should be established by the Department of Juvenile Justice similar to the Victorian Central After Hours and Bail Placement Service, that is available to young people aged between 10 and 18 years, who are at risk of being remanded in custody, or who require bail accommodation; or similar to the Queensland Conditional Bail and Youth Program Accommodation Support Service.

	Priority	Cost

Chapter 16 Out-of-home care

Recommendation 16.1 *Short term* *Medium*

DoCS OOHC/NGO OOHC caseworkers should become involved with children and young persons in OOHC at an earlier stage than final orders and have a responsibility to identify and support the placement of the children or young people, where it has been determined that there is not a realistic possibility of restoration.

Recommendation 16.2 *Three to five years* *High*

Over the next three to five years, there should be a gradual transition in the provision of OOHC for children and young persons as follows:

a. Most children and young persons in OOHC should be supported by one of the two following models:
   i DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. The agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of a child or young person with an authorised carer, and for any decision to remove a child or young person from a carer. DoCS retains the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change Court orders and for providing after care assistance.
   ii DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers) subject to consultation with the Children's Guardian (see Recommendation 16.15).
   iii Children and young persons with significantly complex needs or who are assessed as at high risk of immediate or serious harm or whose case management requires high level collaboration with other government agencies will remain case managed by DoCS.
b. At an early stage, DoCS should progressively commence the transfer of long term kinship/relative carers to NGOs so as to allow the NGOs to carry out any necessary training and to provide ongoing support for these carers.
c. At an early stage, DoCS should progressively reduce its role in the recruitment of foster carers and transfer current long term foster carers to NGOs.

	Priority	Cost
Recommendation 16.3	*Short term*	*Medium*

Within 30 days of entering OOHC, all children and young persons should receive a comprehensive multi-disciplinary health and developmental assessment. For children under the age of five years at the time of entering OOHC, that assessment should be repeated at six monthly intervals. For older children and young persons, assessments should be undertaken annually. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by NSW Health and DoCS.

Recommendation 16.4 *Immediate* *Low*

NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead.

Recommendation 16.5. *Immediate* *Low*

The Department of Education and Training should appoint an OOHC coordinator in each Region.

Recommendation 16.6 *Long term* *High*

The NSW Government has a responsibility to ensure that all children and young persons removed from their parents and placed in its care receive adequate health treatment. Thus, there should be sufficient health services including speech therapy, mental health and dental services available to treat, as a matter of priority, children and young persons in OOHC.

Recommendation 16.7 *Short term (interim strategy)* *High*

The introduction of centralised electronic health records should be a priority for NSW Health. Given that this is likely to take some time, an interim strategy should be developed to examine a comprehensive medical record or a transferable record for children and young persons in OOHC, which should be accessible to those who require it in order to promote or ensure the safety, welfare and well-being of the child or young person.

Recommendation 16.8 *Short term* *Medium*

Within 30 days of entering OOHC, all preschool and school aged children and young persons should have an individual education plan prepared for them which is reviewed annually by the Department of Education and Training and by the responsible caseworker. A mechanism for monitoring, evaluating and reviewing access and achievement of

	Priority	Cost

outcomes should be developed by the Department of Education and Training and DoCS.

Recommendation 16.9 *Long term* *Medium*

Carer allowances should be reviewed periodically by an independent body and should more closely reflect the actual costs to the carer of providing care, according to the varying categories of need.

Recommendation 16.10 *Immediate* *Low*

The Memoranda of Understanding between DoCS and respectively, the Department of Ageing, Disability and Home Care, NSW Health and the Department of Education and Training should be revised to reflect the increasing responsibilities of NGOs for the provision of OOHC.

Recommendation 16.11 *Long term* *Medium*

A common case management framework for children and young people in OOHC across all OOHC providers, should be developed, following a feasibility study on potential models including the Looking After Children system.

Recommendation 16.12 *Long term* *Medium*

Due to the large numbers of Aboriginal children and young persons in OOHC, priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.

Recommendation 16.13 *Short term* *Medium*

There should be sufficient numbers of care options for children and young persons with challenging behaviours that include specialised models of therapeutic foster care.

Recommendation 16.14 *Long term* *High*

DoCS and/or relevant NGOs should receive sufficient funding to service the actual and projected OOHC population to enable an average ratio of one caseworker to 12 children and young persons.

Recommendation 16.15 *Short term* *Low*

DoCS should consult with the Children's Guardian before delegating parental responsibility to any person, except in circumstances where DoCS has shared parental responsibility and is delegating to the person with whom it shares parental responsibility. In the event that a

	Priority	Cost

mechanism for that to occur has not been introduced to the satisfaction of DoCS and the Children's Guardian within 12 months of the publication of this report, the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require that consultation.

Recommendation 16.16 *Immediate* *Medium*

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

i. the proposal set out in the draft Cabinet Minute to introduce a revised scheme for voluntary care should be implemented and the Children's Guardian should receive the additional resources necessary to perform the functions of that office that would apply to those within that scheme
ii. section 183 should be repealed
iii. section 181(1)(d) should be repealed
iv. section 181(1)(a) should be repealed
v. section 186 should be repealed
vi. section 105(3)(b)(iii) should be amended to delete reference to the Children's Guardian and to replace it with the Director-General of DoCS
vii. section 90(3)(b) should be repealed
viii. section 159 should be proclaimed

Chapter 17 Domestic and family violence in child protection

Recommendation 17.1 *Immediate* *Low*

The NSW Police Force should amend its policies in respect of reporting domestic violence incidents to DoCS to align with the requirements of s.23(d) of the *Children and Young Persons (Care and Protection) Act 1998* and should provide the necessary training to its officers to enable them to comply with the amended legislation.

Recommendation 17.2 *Short term* *Low*

DoCS and NSW Police should agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made.

Recommendation 17.3 *Short term* *Medium*

DoCS caseworkers should receive domestic violence specific training, jointly with other relevant agencies and NGO workers.

	Priority	Cost

Chapter 18 Aboriginal over representation in child protection

Recommendation 18.1 *Immediate* *Low*

The NSW Ombudsman should be given authority to audit the implementation of the Aboriginal Child Sexual Assault Taskforce recommendations as described in Recommendation 21 of the Taskforce's report.

Recommendation 18.2

The NSW Government should consider the following:

Short term *Medium*

a. Assisting Aboriginal communities to consider and develop procedures for the reduction of the sale, delivery and use of alcohol to Aboriginal communities.

Short term *Medium*

b. Working with the Commonwealth to income manage Commonwealth and State payments to all families, not only Aboriginal families, in circumstances where serious and persistent child protection concerns are held and there is reliable information available that income is not being spent in the interests of the safety, welfare and well-being of the relevant child or young person.

Short term *Medium*

c. Introducing measures to ensure greater attendance at school, preferably by means other than incarceration, including the provision of transport and of meals.

Immediate *Medium*

d. In smaller and more remote communities, introducing the greater use of night patrols to ensure that children are not wandering the streets at night in circumstances where they might be at risk of assault, or alternatively of involvement in criminal activities.

Short term *Medium*

e. Providing accommodation to Aboriginal children and young people at risk of harm of a boarding nature type where the children are cared for and educated.

Recommendation 18.3 *Short term* *Medium*

The NSW Government should take steps to ensure that the recommendations of the Aboriginal Child Sexual Assault Taskforce

	Priority	Cost

report, and the actions in the Interagency Plan, which relate to provision of direct services to Aboriginal children, young persons, families and perpetrators, are carried into effect within the lifetime of the plan.

Recommendation 18.4 *Short term* *Low*

The NSW Government should work actively with the Commonwealth in securing the delivery, in NSW, of the services identified in the New Directions Policy and in the 2008/09 Commonwealth Budget that were earmarked for the benefit of Aboriginal people.

Chapter 20 Young people, leaving care and homelessness

Recommendation 20.1 *Short term* *Medium*

DoCS should train and appoint to each DoCS Region, specialist caseworkers to assist in the case management of young people.

Recommendation 20.2 *Short term* *Low*

DoCS should fund a training package to assist foster carers and kinship and relative carers in preparing young people for leaving care.

Recommendation 20.3 *Short term* *Low*

DoCS should fund the provision of detailed information to care leavers as to the assistance which is available to them through State and Commonwealth sources after they leave care, and as to the means by which they can access that assistance.

Chapter 21 Children and young persons and parents with a disability

Recommendation 21.1 *Short term* *Medium*

A data management system should be developed in DoCS and the Department of Ageing, Disability and Home Care to identify joint clients.

Recommendation 21.2 *Immediate* *Low*

The Memorandum of Understanding between DoCS and the Department of Ageing, Disability and Home Care should be revised to provide the operational definitions set out in the 2008 Memorandum of Understanding evaluation and to specify the manner in which joint assessment and planning will occur.

	Priority	Cost
Recommendation 21.3	*Short term*	*Low*

Joint training should be carried out for DoCS and Department of Ageing, Disability and Home Care staff, in relation to the care and protection of children and young persons with a disability, and in relation to the individual and mutual responsibilities of the two agencies.

Recommendation 21.4 *Short term* *Low*

The recruitment and training of foster carers who care for children and young persons with a disability in voluntary and statutory OOHC should occur jointly by DoCS and the Department of Ageing, Disability and Home Care.

Recommendation 21.5 *Short term* *Medium*

The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community Services, or for those whose disabilities are such that they are unable to continue to reside in their homes.

Recommendation 21.6 *Long term* *Low*

Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services.

Chapter 22 Disaster recovery

Recommendation 22.1 *Short term* *Medium*

DoCS responsibilities under the *Community Welfare Act 1987* should be transferred to the Department of Premier and Cabinet or to such other government department as is entrusted with the principal responsibilities for planning for and responding to disasters or emergencies, with DoCS staff being available to be called upon to provide, under the coordination and direction of the Department of Premier and Cabinet or of such other department, assistance appropriate to the event.

Recommendation 22.2 *Short term* *Medium*

In the event that DoCS retains responsibility under the *Community*

	Priority	Cost

Welfare Act 1987, it should be resourced sufficiently to adequately perform that role, without frontline child protection caseworkers being deployed.

Recommendation 22.3 *Short term* *Low*

The NSW Government should assign responsibility for distributing drought relief to an agency other than DoCS, and such relief as is provided should not be a cost to the DoCS budget.

Chapter 23 Oversight

Recommendation 23.1 *Immediate* *Low*

The relevant legislation including Part 7A of the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that Team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Recommendation 23.2 *Immediate* *Low*

DoCS should review the death of any child or young person about whom a report was made within three years of that death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.

Recommendation 23.3 *Immediate* *Low*

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* should be amended by:

i. repealing s.35(1)(b) and (c)

ii. replacing the requirement for an annual report, in s.43 with a requirement that a report be made every two years.

Recommendation 23.4 *Short term* *Low*

Information obtained by persons appointed by the Minister as official visitors should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards and s.8 of *Community Services (Complaints, Reviews and Monitoring) Act 1993* and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* should be amended to achieve this outcome.

	Priority	Cost
Recommendation 23.5	*Short term*	*Low*

The class or kind agreement between the NSW Ombudsman and DoCS should be revised to require DoCS to notify only serious allegations of reportable conduct and to impose timeframes within which DoCS will investigate those allegations.

Recommendation 23.6	*Immediate*	*Low*

DoCS should centralise its Allegations Against Employees Unit and receive sufficient funding to enable this restructure, and to resource it to enable it to respond to allegations in a timely fashion.

Recommendation 23.7	*Immediate*	*Low*

DoCS should revise the findings available following an investigation into an allegation against an employee so as to and permit one of the following findings to be made but no other: sustained, not sustained, not reportable conduct. Adequate reasons should be recorded, and kept on file, which should note not only why an allegation was sustained, but also the reasons why an allegation was not reportable or not sustained.

Recommendation 23.8	*Short term*	*Medium*

The *Commission for Children and Young People Act 1998* should be amended to require background checks as follows:

a. in respect of DoCS and other key human service agencies all new appointments to staff positions that work directly or have regular contact with children and young persons (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)

b. any contractors engaged by those agencies to undertake work which involves direct unsupervised contact to children and young persons, and, in the case of DoCS, access to the KiDS system or file records on DoCS clients

c. students working with DoCS officers

d. children's services licensees

e. authorised supervisors of children's services

f. principal officers of designated agencies providing OOHC or adoption agencies

g. adult household members, aged 16 years and above of foster carers, family day carers and licensed home based carers

h. volunteers in high risk groups, namely those having extended unsupervised contact with children and young persons.

	Priority	Cost

Chapter 24 Interagency cooperation

Recommendation 24.1 *Immediate* *Low*

The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons.

Recommendation 24.2 *Immediate* *Low*

Each human services and justice agency CEO should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.3 *Immediate* *Low*

The Director-General, each Deputy Director-General and each Regional Director of DoCS should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.4 *Long term* *Medium*

The boundaries of key human services and justice agencies should be aligned.

Recommendation 24.5 *Short term* *Low*

Cross agency training should be delivered in relation to interagency collaboration and cooperation in delivering services to children and young persons.

Recommendation 24.6 *Immediate* *Low*

The *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person in accordance with the principles set out in Chapter 24. The amendments should provide, that to the extent inconsistent, the provisions of the *Privacy and Personal*

	Priority	Cost

Information Protection Act 1998 and *Health Records and Information Privacy Act 2002* should not apply. Where agencies have Codes of Practice in accordance with privacy legislation their terms should be consistent with this legislative provision and consistent with each other in relation to the discharge of the functions of those agencies in the area of child protection.

Recommendation 24.7 *Short term* *Low*

An improved structure should be established for regular regional meetings between the key human services agencies and NGOs to facilitate collaborative cross agency work, and to be accountable to the Human Services and Justice CEOs Cluster.

Chapter 25 DoCS funded non-government service system

Recommendation 25.1 *Long term* *Medium*

All NSW Government funding to NGOs delivering universal, secondary and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should be reviewed, so as to establish a coordinated system for the allocation of their funded resources that will eliminate unnecessary overlap and provide for the delivery of service where most needed.

SPECIAL COMMISSION OF INQUIRY INTO CHILD PROTECTION SERVICES IN NEW SOUTH WALES

TERMS OF REFERENCE

The New South Wales Governor commissioned the Hon James Wood AO QC to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

- the system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters;
- management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;
- management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;
- recording of essential information and capacity to collate and utilise data about the child protection system to target resources efficiently;
- professional capacity and professional supervision of the casework and allied staff;
- the adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies;
- the adequacy of arrangements for inter-agency cooperation in child protection cases;
- the adequacy of arrangements for children in out of home care; and
- the adequacy of resources in the child protection system.

Report of the Special Commission of Inquiry into Child Protection Services in NSW

Volume 1

The Hon James Wood AO QC

November 2008

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Special Commission of Inquiry
into Child Protection Services in New South Wales

24 November 2008

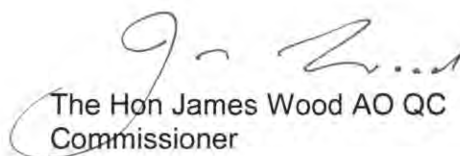
Her Excellency Professor Marie Bashir AC CVO
Governor of the State of New South Wales
Office of the Governor
Macquarie Street
SYDNEY NSW 2000

Your Excellency,

I was appointed by Letters Patent issued under *the Special Commission of Inquiry Act 1983* to conduct an Inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are complete and to report to Your Excellency.

I now present to you the Report of my Inquiry.

Yours sincerely



The Hon James Wood AO QC
Commissioner

Darlinghurst Supreme Court Taylor Square Oxford Street Darlinghurst NSW 2010
Tel (02) 9377 5400 | Freecall 1800 442 819 | Fax (02) 9377 5411
Email cps_inquiry@agd.nsw.gov.au | www.lawlink.nsw.gov.au/cpsinquiry

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Executive Summary

The child protection system in New South Wales consists of much more than the Department of Community Services (DoCS). NSW Health through its Area Health Services and The Children's Hospital at Westmead fund and deliver many services for children, young people and their families, including prenatal care, home visiting and counselling, with the aim of preventing or minimising harm. Similarly, the Departments of Education and Training, Juvenile Justice and Ageing, Disability and Home Care, Housing NSW and the NSW Police Force offer programs, funding and services, ranging from breakfast programs, diversionary sentencing options for young people, respite for parents of children with disabilities, and housing and youth support activities.

They also have a role in reporting suspicions of abuse or neglect of children and young people, and within their available resources or facilities, responding. The role of the NSW Police Force in investigating criminal offences directed at children, and in responding to family and domestic violence forms a significant part of the child protection system.

Non-government organisations are also key players in the system and provide universal, secondary and targeted and tertiary services to children, young people and their families aimed at minimising the risk of abuse and neglect as well as supporting those children and young people who have been harmed, some of whom will have been removed from their families and placed in out-of-home-care.

The contemporary challenge facing all child protection systems in Australia, and in particular NSW as the largest, is sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe.

Once children and young people are the subject of reports of being at risk of harm, the challenge is to have adequate skills and tools with which to assess and identify those who need the full attention of the state including removal from their families, and those who can be assisted to remain in their homes with the necessary support being provided. Children and young people who cannot live at home require carers who are financially, emotionally and practically supported by the system, and who have been well matched to them. They also need state assistance to access medical, dental and allied treatment when it is needed.

Importantly, children and young people need to be listened to and participate in decisions which affect them.

A range of complex and often chronic factors characterise many of the families coming into contact with the child protection system such as low income, unemployment, substance abuse, limited social supports, imprisonment,

domestic violence, and mental health issues. Many of these factors are inter-related. The elimination or reduction of each of these factors would significantly lower the number of children and young people reported as being at risk of harm.

DoCS has undergone a period of significant reform since 2002 when it received a substantial injection of funds which took the annual budget in 2007/08 to more than $1.2 billion. While, in 2008, many of those reforms have been implemented or are underway, insufficient time has passed for the benefits to be fully evident.

In 2008, there are a number of challenges both old and new facing DoCS, some of which are unique to it, but many of which are experienced by most child protection systems within Australia.

Reports

a. Reports to DoCS of children and young people suspected to be at risk of harm are increasing annually, although the extent of the increase seems to be slowing and those reports which are made are being assessed as less urgent.

b. A large number of children, young people and families are repeatedly reported, often within short periods, with the result that reports to DoCS are more likely to be about a child or young person already known to it. Thus, in 2006/07 about the top 20 per cent of the children and young people who were frequently reported accounted for more than half the total number of reports.

c. Most reports to DoCS concern domestic violence, psychological abuse, neglect, carer substance abuse, carer mental health and/or sexual abuse. There is little reliable research to guide effective interventions for children and young people who are neglected, although a report of neglect is more likely to receive greater DoCS attention than one concerning domestic violence.

d. A detailed examination of what happened to reports to DoCS in 2007/08 reveals that:

    i. about 13 per cent of the reports were not ‘risk of harm’ reports as defined in the *Children and Young Persons (Care and Protection) Act 1998* and thus, while the family may have needed assistance, they should have been referred to, and met with a suitable response from, an agency other than DoCS

    ii. another 21 per cent of reports were assessed by the Helpline as requiring further assessment, but received none from the Community Services Centre to which they were referred

    iii. 33 per cent received some attention which fell short of a face to face visit

  iv. only 13 per cent of reports resulted in a home visit from a DoCS caseworker, as part of a secondary assessment process

  v. the remaining reports mainly concerned children and young people who were already being assessed by DoCS.

e. Too many reports are being made to DoCS which do not warrant the exercise of its considerable statutory powers. As a result, much effort and cost is expended in managing these reports, as a result of which the children and young people the subject of them receive little in the way of subsequent assistance, while others who do require attention from DoCS may have their cases closed because of competing demands on the system (that is, insufficient resources).

f. Those who are required to report when they reasonably suspect a child or young person to be at risk of harm, known as mandatory reporters, receive insufficient information from DoCS about its response to their reports. As a result, they keep reporting, often to little effect and it is less likely that they will work in partnership with DoCS to assist the child or young person. If informed that DoCS was not in a position to take up the case, they may well provide more assistance themselves.

Infrastructure

a. DoCS information management technology is not adequately suited for the purpose of supporting workers to assess and intervene in the lives of children and young people, and its complexities and shortcomings continue to be a source of frustration and delay to its staff.

Workforce

a. While, in the main, DoCS has developed sound, comprehensive and evidence based policies and procedures, they are not consistently implemented, with the result that quality practice in each CSC within its several regions remains challenging.

b. Recruiting and retaining a skilled, diverse workforce to provide services in all parts of the State is an issue for DoCS, as it is for all other justice and human services agencies in NSW and for non-government organisations working in the welfare sector.

Availability of services

a. There are not sufficient prevention, early intervention and targeted services provided by state agencies or by the non-government organisations for children and young people at risk and their families.

b. Currently, the capacity in some non-government organisations and Aboriginal organisations is not sufficiently developed to enable them to properly partner DoCS and other state agencies in working towards the safety, welfare and well-being of the children and young people who need assistance.

c. There are barriers to non-government organisations and other state agencies working together in the interests of the safety, welfare and well-being of children and young people. Some can be cured by legislation, such as information exchange, but generally a change in attitude and approach including greater acceptance of working in collaboration, is needed.

d. Aboriginal communities remain over represented in the child protection system and culturally appropriate interventions for Aboriginal children, young people and their families are not widespread in any of the agencies that are expected to work with them.

The legal system

a. Data collection is generally good at DoCS, but in areas such as the Courts, there is an absence of sufficient data of the kind that is required for an understanding, assessment and monitoring of the operation of the child protection system.

b. Too many Children's Court decisions are made by non-specialist Magistrates, the Children's Court does not facilitate alternative dispute resolution as was originally intended and its processes are unduly technical.

c. DoCS does not always present its evidence to the Children's Court in a fair and balanced manner and legal practitioners who appear in the care jurisdiction are not subject to uniform standards or accreditation.

Out-of-home care

a. There are increasing numbers of children and young people in out-of-home care for longer periods of time and with increasingly complex needs at a cost per child which continues to rise.

b. There is a decreasing pool of foster carers.

c. There is a need for a greater number and range of different placement options for children and young people for whom it is not safe to live at home.

d. Children and young people entering, and in, out-of-home care generally do not receive, as a matter of priority, the medical, dental and allied health assessments and treatments they should receive. Neither do they receive the degree of assistance that is needed when leaving care.

Other matters

a. The arrangements by which DoCS is scrutinised by other agencies are complex.

b. There is a duplicative, unduly complex and administratively burdensome funding system.

The principles and goal underpinning the Inquiry's proposed reforms

The key principles which underpin the Inquiry's reforms are as follows. Child protection is the collective responsibility of the whole of government and of the community. Primary responsibility for rearing and supporting children and young people should rest with families and communities, and with government providing support where it is needed, either directly or through the funded non-government sector.

The outcomes sought from the service system should be to ensure children and young people are able to grow up at the very least unharmed by their social, economic and emotional circumstances and are supported to do so by their parents. Where their parents are unable to do this, the state needs to be in a position where it can step in and fill the gap in a humane and responsive way that will preserve the safety of those children and young people.

The participation of children and young people is critical to guiding the delivery of services.

The child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion. They should be delivered by a mixture of the non-government sector and state agencies, with DoCS being a provider of last resort.

DoCS, and where necessary, the NSW Police should remain responsible for interventions mandated under the *Children and Young Persons (Care and Protection) Act 1998*, and for the investigation and prosecution, in a timely and efficient manner of criminal offences committed against children and young people.

All services should be integrated and, where possible, co-located or operated in 'hubs', with outreach capacity.

Early decision making about permanency planning, including restoration to family, results in better outcomes for children and young people, both in immediate terms and for life after care.

All Aboriginal children and young people in out-of-home care should be connected to their family and their community, while addressing their social, emotional and cultural needs.

Greater in-depth assessment of children and young people coming into care through more comprehensive assessment and interventions in the crucial early stages of placements should be part of agency placement and planning processes.

Carers should be provided with timely information about those in their care, their needs, and the type of support they need to flourish in their care, and given

ongoing support by DoCS or by designated agencies in fulfilling their care responsibilities.

Children and young people where possible should be placed with relatives and/or with siblings, and generally should be placed as close as possible to where their family/kinship and support networks are located.

There should be sufficient health and specialist services including dental, psychological, counselling, speech therapy, mental health and drug and alcohol services available to meet the needs of children and young people in out-of-home care.

Foster, kinship and relative carers should be supported in caring for children and young people, including assistance to work with those with challenging behaviours, to improve the stability of placements. This should include access to regular and planned respite care, behavioural management support, and other evidence based specialist services.

Young people should be assisted when leaving care to transition effectively to stable accommodation and to receive further education and/or training and/or employment, so as to maximise their potential for independent living.

Non-government organisations in partnership with other relevant government agencies such as DoCS, NSW Health, the Department of Education and Training and the Department of Ageing Disability and Home Care should deliver out-of-home care services.

The Key Reforms

Amendment of the *Children and Young Persons (Care and Protection) Act 1998* is proposed so as to require that only children and young people who are suspected, on reasonable grounds, to be at risk of significant harm should be reported to DoCS.

Each of the Area Health Services, The Children's Hospital at Westmead, the Department of Education and Training, NSW Police Force, the Department of Ageing Disability and Home Care and the Department of Juvenile Justice should create a Unit which advises staff on whether a report should be made to DoCS and, if the proposed report does not disclose a risk of significant harm, the Unit should assist the child or young person by, among other matters:

a. referring them to a newly created Regional Intake and Referral Service. That service is to be located within a non-government organisation and it will determine the nature of the services required and refer the family to the appropriate non-government organisation or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education

b. referring them to the early intervention program Brighter Futures

c. working with the child or young person, alone or in combination with another appropriate agency or non-government organisation, to address their need for assistance or specialised services.

Reports made to DoCS, which are assessed as being a report that a child or young person is at risk of significant harm should be investigated by DoCS if the matter is urgent or the risk is high or the child is young. Otherwise, if eligible, the family should be referred to Brighter Futures. If not eligible, the family should be referred to a Regional Intake and Referral Service which should be able to link families with the most appropriate local service to meet their needs.

The Regional Intake and Referral Service should be operated and staffed by a non-government organisation with one or more child protection caseworkers, seconded from DoCS, the number of staff will depend on anticipated demand for that region.

Integrated, multi-disciplinary and co-located child and family services should be established in locations of greatest need to deliver services to children, young people and their families.

Non-government organisations and state agencies should be funded to deliver services that should cover the continuum of universal, secondary and tertiary services and should target key developmental stages and transition points in the lives of children and young people. Such services should include:

a. home visiting, preferably by professionals, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs

b. sustained home visiting for at risk families, parent education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance

c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, Physical Abuse and Neglect of Children services, services for 10-17 year olds who display sexually abusive behaviours and allied health services such as speech pathology and mental health services.

Secondary and tertiary services that include intensive, short term, in-home and crisis interventions and that also provide links to other services following intensive support should also be available and able to respond where needed.

In addition, work should be undertaken to extend current programs including, Brighter Futures, family preservation services provided by non-government organisations, free early childhood education before commencing school for low income families, family and domestic violence programs and the Safe Families Program – Orana Far West.

The capacity of non-government organisations, Aboriginal and non-Aboriginal, to staff and deliver these services to children, young people and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed.

DoCS, Area Health Services, The Children's Hospital at Westmead, NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of Education and Training and non-government organisations should use a common assessment framework to identify and respond to the needs of children, young people and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, risk taking adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency should identify their most frequent clients, referred to by DoCS as frequently reported families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant non-government organisations should be provided, together with mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including non-government organisations should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person, and for that to occur, amendment is required in relation to the existing privacy legislation. In addition, enhanced interagency collaboration and acceptance of responsibility for child protection is recommended.

Within three years, case management of families in Brighter Futures should be transferred to Lead Agencies. The responsibility for out-of-home care should similarly be progressively transferred to the non-government sector. The Inquiry supports a revised scheme for voluntary out-of-home care.

A workforce strategy should be established which takes into account the need of non-government organisations to employ additional skilled staff and to accommodate the transition of early intervention and out-of-home care casework to the non-government organisations.

Caseworkers should be employed on a temporary basis, or reassigned from Brighter Futures or out-of-home care work as case management is transferred to the non-government sector, to manage those children and young people who will require DoCS services in relation to statutory intervention.

Other reforms

In relation to reporting, the Inquiry has made recommendations to encourage more and better feedback to mandatory reporters, to provide them with targeted training and access to aggregated data. Its recommendations directed to the NSW Police Force are designed to ensure that victims of domestic violence are better served, and that the system is not overburdened by reports that do not justify DoCS intervention.

The Inquiry has also made recommendations to enhance the information management technology available to DoCS and to ensure consistent, quality casework through supervision and professional development, audits and reviews, clarifying policies and procedures.

Significant amendment of the *Children and Young Persons (Care and Protection) Act 1998* is recommended in relation to the principles which underpin it by giving greater emphasis to the best interests of the child principle, extending the grounds on which a care order may be made, restricting the allocation of parental responsibility by the Children's Court to DoCS, limiting the power of the Children's Court to make contact orders, while confining enhanced powers in the Children's Court in relation to restoration.

In relation to the processes followed by the Children's Court, various recommendations are made designed to simplify the practice and procedure of that Court and to reduce technicality. In addition, the Inquiry urges the greater use of alternative dispute resolution and the development of a code of conduct for all legal representatives practising in the care jurisdiction. The status of the Court should be enhanced by a District Court Judge being appointed as its senior judicial officer.

Building capacity in Aboriginal organisations is a focus of the report, as is the need for the adoption of other methods of reducing Aboriginal representation in the child protection system, and of securing greater participation of Aboriginal agencies in that system.

The review of deaths of children is considered and recommendations are made for a change in the current arrangements, including a reconstitution of the Child Death Review Team to be led by the NSW Ombudsman.

The report concludes with a suggested framework for implementation of the 111 recommendations which have been ranked by degree of priority, and likely cost.

Recommendations

R.1 In the recommendations which follow, the Inquiry has assigned a priority ranking and a cost ranking to each. In relation to priority, the term 'immediate' means that the implementation of the recommendation should be substantially commenced within six months, 'short term' means that implementation of the recommendation should be substantially commenced within 12 to 18 months and 'long term' means that the implementation of the recommendation should be substantially commenced within two to three years.

R.2 In respect of some recommendations, specific timeframes have been allocated.

R.3 Whether the cost of implementing the recommendation is low, medium or high is generally based on information provided by DoCS. As a guide, recommendation 1 is estimated to cost $17.8 million over three years, and is assigned the category of 'medium'.

R.4 Many of the recommendations are dependant upon or integrated with other recommendations. The recommendations contained in Chapter 10 are integral to the key reforms contained in this report. The timing of the introduction of the following reforms will be affected by amendments to the Care Act in that, generally they should follow those amendments: recommendations 2.1, 6.1, 6.5, 9.2, 9.3, 9.5, 10.1, 10.2, 10.3, 10.4, 10.7 and 17.2.

R.5 If the testing of the Structured Decision Making tools proves effective, there will need to be a revision of many of the policies and procedures currently in place, including a number of those about which recommendations have been made.

	Priority	Cost

Chapter 2 Structure and Reform

Recommendation 2.1 *Immediate* *Medium*

The KiDS Core Redesign Project should be funded and implemented.

Recommendation 2.2 *Immediate* *Medium*

DoCS Information Management and Technology Strategic Plan should be funded and implemented.

Recommendation 2.3 *Immediate* *Low*

The trial of the quality review tools should proceed immediately and the approved tools should be then applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.

Recommendation 2.4 *Immediate* *Low*

The decision consequent upon the SINC Report to relocate the bulk of the Complaints Unit functions to the Helpline and to revise the complaints handling system, should be implemented.

Recommendation 2.5 *Short term* *Low*

Carer Support teams should be responsible for liaising with DoCS foster carers and kinship/relative carers in relation to their complaints and to ensure they have the assistance they require.

Chapter 3 DoCS Workforce Capacity

Recommendation 3.1 *From 1 July 2009* *Low*

From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.

Recommendation 3.2 *Short term* *Medium*

A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.

Recommendation 3.3 *Short term* *Low*

A review of financial delegations should be undertaken.

	Priority	Cost

Chapter 6 Risk of harm reports to DoCS

Recommendation 6.1	*Short term*	*Low*

DoCS should revise its case practice procedures to develop clear guidelines for classifying risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.

Recommendation 6.2	*Immediate*	*Low*

In relation to *the Children and Young Persons (Care and Protection) Act 1998*:

a. Sections 23, 24 and 25 should be amended to insert ‘significant’ before the word ‘harm’ where it first occurs; and s.27 amended to insert ‘significant’ before the word ‘harm’ wherever it occurs.

b. Section 23 should be amended to insert as paragraph (g) “the child or young person habitually does not attend school.”

c. A provision should be inserted defining that (with the exception of s.23(d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.

d. The penalty provision in s.27 should be deleted.

Recommendation 6.3	*Immediate*	*Medium*

Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.

Recommendation 6.4	*Short term*	*Low*

DoCS should provide the key agencies employing mandatory reporters, namely NSW Police Force, NSW Health, each Area Health Service, The Children’s Hospital at Westmead and the Department of Education and Training with quarterly aggregated data about the reports made by the agency and its staff. These data should be made public.

	Priority	Cost

Recommendation 6.5 *Short term* *Low*

Targeted training strategies for each of the key mandatory reporters, namely the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training in relation to the circumstance in which reports need to be made and in relation to the information required, so as to ensure its relevance and quality, should be developed and implemented by each agency in collaboration.

Recommendation 6.6 *Short term* *Low*

The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children's Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force.

Chapter 7 Early intervention

Recommendation 7.1 *Short term* *Low*

DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.

Chapter 8 Assessment and response

Recommendation 8.1 *Short term* *Medium*

The JIRT Reform Program, as set out in the Implementation Plan should be completed.

Recommendation 8.2 *Long term* *Low*

JIRT should be regularly audited.

Recommendation 8.3 *Immediate* *Low*

Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and DoCS.

Recommendation 8.4 *Short term* *Medium*

NSW Health should provide an appropriately trained workforce to provide

	Priority	*Cost*

forensic medical services where needed for children and young persons who have suffered sexual assault and physical injury.

Recommendation 8.5 *Long term* *High*

The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.

Chapter 9 Assessment and response: issues arising

Recommendation 9.1 *Short term* *Medium*

DoCS should test the use of Structured Decision Making tools at the Helpline and at CSCs in relation to assessments and interventions including restoration.

Recommendation 9.2 *Short term* *Low*

A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors.

Recommendation 9.3 *Short term* *High*

DoCS should develop a strategy to move to electronic record keeping and abolish the use of paper records.

Recommendation 9.4 *Short term* *Low*

DoCS should revise its case practice procedures to provide Helpline caseworkers with greater guidance as to determining response times for reports of risk of harm.

Recommendation 9.5 *Short term* *Low*

For all caseworkers and casework managers there should be a structured program for ongoing professional development which is incorporated into annual Personal Planning and Review agreements.

Recommendation 9.6 *Short term* *Low*

In addition to individual supervision, there should be a facilitated monthly

	Priority	Cost

group case practice review of selected cases within each CSC and at the Helpline, in which all caseworkers and managers participate and which may include specialists from other agencies, if the cases require it.

Recommendation 9.7 *Long term* *Low*

DoCS should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.

Recommendation 9.8 *Short term* *Medium*

The work of the Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.

Chapter 10 Directions for the way forward

The creation of different pathways

Recommendation 10.1 *Short term* *High*

Members of the community and mandatory reporters who are not those described below, who suspect that a child or young person is at risk of significant harm ("the statutory threshold") should report their concerns to the Helpline. Reports should be as comprehensive as the knowledge and professional or expert experience of the reporter permits.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is at risk of significant harm, which is imminent, should report directly to the Helpline.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency ("the Unit"). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work (see below).

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

	Priority	Cost

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

a. The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.

b. Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

c. A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.

d. The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.

Recommendation 10.2 *Short term* *High*

Reports made to DoCS should be assessed at the Helpline with the use of Structured Decision Making tools (after being tested and applied). If a report is assessed as meeting the statutory threshold, the report should be dealt with in one of the following ways:

a. Families who are assessed by the Helpline as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

b. Where a child or young person is:

   i. assessed as in need of a response within 24 hours, or

   ii. assessed as in need of a response within 72 hours and the risk is assessed as high, or

   iii. under five years and the primary care-giver’s functioning or ability to parent is impaired due to current substance abuse, unmanaged mental illness or intellectual disability, and:

      - the child has high support needs, or
      - the primary reported issue is neglect or actual injury, or
      - the child or a sibling has been previously removed from the family by reason of care and protection concerns

   then such child or young person should be referred to a CSC that will apply the Structured Decision Making tools in assessing,

	Priority	***Cost***

intervening and, if ultimately found to be appropriate, removing the child or young person from his or her family.

c. Children and young persons who are assessed as in need of a response within 72 hours with a risk assessed as less than high, or as in need of a response within less than 10 days and who do not meet the criteria for Brighter Futures, should be referred to the Regional Intake and Referral Service which should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for such assistance as may be reasonably available and likely to meet the relevant need.

The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkers seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer to the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS Region.

DoCS structure

Recommendation 10.3 *Long term* *Medium*

DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key agencies and each region should contain such number of CSCs (see Chapter 23) as are appropriate for the level of demand within the region.

Service availability

Recommendation 10.4 *Long term* *High*

Services should be integrated, multi-disciplinary and co-located, wherever practicable and child and family services should be established in locations of greatest need, by outreach if necessary.

NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:

a. home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning

	Priority	**Cost**

programs

b. sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance

c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents aged 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services

d. secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed

e. the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case.

Recommendation 10.5

Short term *High*

a. Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system (DoCS estimates that this should assist an additional 1,200 families).

Long term *High*

b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to services for Aboriginal children and their families (DoCS estimates that this should assist an additional 3,400 families).

Short term *High*

c. The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families (DoCS estimates that this should assist an additional 3,000 families).

Short term *High*

d. The Aboriginal Maternal and Infant Health Strategy should be delivered statewide (funds have been allocated for this service).

Long term *High*

e. Young, first time, isolated mothers with low educational attainment should receive secondary services, particularly sustained home visiting where the focus should be on positive maternal and child outcomes.

	Priority	*Cost*
	Short term	*High*

f. One year of free early childhood education before school should be provided to low income families.

Short term *High*

g. Co-located child and family centres servicing Aboriginal communities, involving health and education services should be developed.

Short term *High*

h. In relation to domestic violence, the commitment to the Domestic Violence Court Intervention Model, Integrated Case Management, Non-government sector grants, Staying Home Leaving Violence, the Court Assistance Scheme, Indigenous Programs and police equipment should be implemented.

Short term *Medium*

i. The commitment to establish the Safe Families Program – Orana Far West should be implemented.

Short term

j. The commitment to fund the Preschool Investment and Reform Plan should be implemented.

Short term

k. The implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional 260 child care centres on primary school grounds and other community land in areas where there are service gaps, should be progressed.

Recommendation 10.6 *Five years* *High*

The capacity of NGOs, Aboriginal and non-Aboriginal, to staff and deliver the services detailed in Recommendations 10.4 and 10.5 a, b, c, e, f and g to children, young persons and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed. The principles underpinning performance based contracting should apply.

Working collaboratively

Recommendation 10.7 *Short term* *High*

DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of

	Priority	Cost

Education and Training and NGOs should use a common assessment framework to identify and respond to the needs of children, young persons and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, high risk adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency, namely DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, Housing NSW, the Department of Juvenile Justice and the Department of Education and Training should identify their high end users, referred to by DoCS as Frequently Reported Families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant NGOs should be provided including the adoption of mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including NGOs should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (see Chapter 24).

A multi-agency systems approach to case review should be established (see Chapter 9).

Workforce needs

Recommendation 10.8 *Short term* *Low*

A workforce strategy should be established which takes into account the needs of NGOs to employ additional staff and to accommodate the progressive transition of early intervention and OOHC (see Chapter 16) casework to the NGOs.

NGOs should receive sufficient funding to develop the infrastructure needed to attract experienced staff, and be assisted in providing uniform training for caseworkers and carers.

Recommendation 10.9 *Short term* *High*

A Unit of one or more positions, depending on the size of the agency, should be created in each Area Health Service, The Children's Hospital at Westmead, the Department of Education and Training, the NSW Police Force, the Department of Ageing, Disability and Home Care and

	Priority	Cost

the Department of Juvenile Justice to receive reports of risk of significant harm from staff of the agency and to take appropriate action for the protection of children and young persons, including reporting to DoCS. In addition, the Unit should ensure communication with other agencies, primarily the human services agencies and relevant NGOs, and provide advice to the Human Services and Justice CEOs Cluster about any problems or emerging trends concerning interagency collaboration.

The Unit in each agency should:

a. report to the agency's CEO or a defined and consistent second tier within the agency
b. use data systems and processes that are common across agencies
c. meet regularly with the positions created in the same agency and with those in other agencies
d. keep relevant data which is then shared across agencies
e. be child protection trained
f. be positively named.

Recommendation 10.10 *Immediate* *High*

Caseworkers should be employed on a temporary basis or re-assigned from Brighter Futures or OOHC work as case management is transferred to the NGO sector, to manage those reports meeting the criteria set out in 10.2 b above until Recommendations 6.2, 10.1 and 10.2 are implemented (DoCS estimates that 300 temporary caseworkers are required).

Brighter Futures

Recommendation 10.11 *Three to five years* *High*

Within three to five years, case management of all families in Brighter Futures should be by Lead Agencies.

Chapter 11 Statutory basis of child protection

Recommendation 11.1 *Immediate* *Low*

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

i. Section 8(a) should be amended to provide as follows:

> that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them.

Priority ***Cost***

ii. Section 9 should be amended to provide:

> The principles to be applied in the administration of this Act are as follows:
>
> > In all actions and decisions concerning a particular child or young person that are made under this Act the safety, welfare and well-being of the child or young person must be the paramount consideration.

Paragraphs (b) to (g) should then be renumbered commencing with (a).

iii. Section 18 should be amended to insert the words "or a non-government agency in receipt of government funding for the requested services" after "or agency".

iv. Section 21 should be amended to permit an NGO in receipt of government funding for the requested services to apply on behalf of a child or young person for assistance.

v. Section 28 should be proclaimed.

vi. Section 29(1)(f) should be amended to reflect the changed reporting structure as set out in Chapter 10.

vii. Section 29(1)(f) should be amended to permit the disclosure of the reporter's details to a law enforcement agency pursuant to the investigation of a serious crime committed upon a child or young person, where that might impact on the child's safety, welfare or well-being.

viii. Section 71 should be amended so that the grounds are not limited to those enumerated, while still retaining each sub-section.

ix. The Act should be amended to make clear that, other than emergency care and protection orders made under s.46(2) of the Care Act, the Children's Court can not allocate parental responsibility to a designated agency or a principal thereof.

x. The Act should be amended to limit the power of the Children's Court to make contact orders to those matters where the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration.

xi. Section 90(3) should be amended to permit the child or young person to make an application pursuant to that section.

xii. Part 3 of Chapter 7 should be repealed.

xiii. Section 58 (1) (a) should be amended to delete "or unwilling."

xiv. Pursuant to s.82, the Children's Court should have the power to order that a written report be made to it and, if after receiving that report, it is not satisfied that proper arrangements have been made, it should have the power to re-list the matter with notice to the parties to the original proceedings in order to give any of them an opportunity to make an application pursuant to s.90 or for any other ancillary or incidental order. However, if no party wishes to apply

	Priority	Cost

for an order varying any of the orders made, the matter should be taken no further. In the absence of a moving party, the Children's Court should not be empowered to make orders of its own motion.

In addition, the Children's Court should develop rules concerning timing, notice, confidentiality and procedures to ensure that reports are made to it in a timely fashion, that all parties are provided with a copy of the report and that the process by which a date is set for hearing is also clear.

xv. The Children's Court should have the power to order that expert evidence be provided to it, in the form of reports provided by the Children's Court Clinic or otherwise.

xvi. Relevant amendments should be made to ensure that *Re Rhett* [2008] CLN 1 is followed.

xvii. The Act should be amended to provide that a decision to restore a child or young person to the care of the parents from whom he or she had previously been removed by an order of the Children's Court, in circumstances where the Children's Court had accepted the assessment of the Director-General that there was not a realistic possibility of restoration, must be made by the Children's Court upon application by the person with parental responsibility.

Recommendation 11.2 *Short term* *Low*

There should be a feasibility study into the transfer of the Children's Court Clinic to Justice Health that should also investigate its expansion to provide the services of the kind currently offered by Justice Health in the criminal jurisdiction, as well as an extension of the matters dealt with in the current assessments so as to provide greater assistance in case management decisions.

Recommendation 11.3 *Short term* *Low*

Data in relation to all aspects of proceedings pursuant to the *Children and Young Persons (Care and Protection) Act 1998* should be kept by DoCS and the Children's Court and made public.

Recommendation 11.4 *Immediate* *Low*

DoCS should review its Casework Practice Policy, Taking Action in the Children's Court, to ensure it is consistent with the *Children and Young Persons (Care and Protection) Act 1998,* in particular, the principles set out in ss.9, 10 and 36.

Recommendation 11.5 *Short term* *Low*

DoCS should develop Guidelines for staff in order to ensure adherence

	Priority	Cost

to the Aboriginal and Torres Strait Islander Child and Young Person Placement Principles in s.13 of the *Children and Young Persons (Care and Protection) Act 1998.*

Recommendation 11.6 *Short term* *Low*

Evidence based guidelines for Magistrates should be prepared in relation to orders about contact made under s.86 of the *Children and Young Persons (Care and Protection) Act 1998.*

Chapter 12 Other models of decision making

Recommendation 12.1 *Immediate* *Medium*

Adequate funding should be provided so that alternative dispute resolution is used prior to and in care proceedings in order to give meaning to s.37 of the *Children and Young Persons (Care and Protection) Act 1998*, in relation to:

a. placement plans
b. contact arrangements
c. treatment interventions
d. long term care issues
e. determination of the timing/readiness for returning a child to the home
f. determination of when to discontinue protective supervision
g. the nature and extent of a parent's involvement
h. parent/child conflict
i. lack of, or poor, communication between a worker and parents due to hostility
j. negotiation of length of care and conditions of return
k. foster carer/agency/parent issues.

Recommendation 12.2 *Not applicable* *Medium*

The Nowra Care Circle Pilot should be monitored and evaluated. If successful, consideration should be given to its extension to other parts of the State with significant Aboriginal communities.

Chapter 13 Court Processes in statutory child protection

Recommendation 13.1 *Immediate* *Low*

The *Children's Court Act 1987* should be amended to insert a provision similar to s.27 of the *Local Court Act 2007* and the *Children's Court Rules*

	Priority	Cost

2000 should be reviewed to ensure that the Rules are consistent with the *Children's Court Act 1987* and the Care Act, and any practice directions or notes that are issued after amendment of the Act should similarly accord with the legislation.

Recommendation 13.2 *Immediate* *Low*

There should be no requirement, by way of legislation or practice, that DoCS is to file all material relied upon in care proceedings at the beginning of the proceedings.

Recommendation 13.3 *Immediate* *Low*

Care applications by DoCS under ss.45 and 61 should be made by way of an application filed in the Court supported by a written report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection and any interim orders sought, without any requirement for the filing of any affidavit, unless ordered by the Court in circumstances where establishment is contested. The DoCS file or relevant portion of it should be made available to the parties.

Recommendation 13.4 *Immediate* *Low*

Section 45 of the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require DoCS to apply to the Children's Court no later than 72 hours after the child or young person has been removed or care assumed.

Recommendation 13.5 *Immediate* *Low*

The Children's Court should revise its practices in relation to changing hearing dates and moving proceedings between courts, as well as its listing practices for callovers and mentions.

Recommendation 13.6 *Immediate* *Low*

DoCS caseworkers should be given more specific training and guidance in relation to the nature of care proceedings and in relation to the evidence to be placed before the Court, to ensure its relevance, accuracy and fair balance.

Recommendation 13.7 *Short term* *Low*

Guidelines should be developed for DoCS caseworkers based on the Code of Conduct applicable to the Office of the Director of Public Prosecutions.

	Priority	Cost
Recommendation 13.8	*Short term*	*Low*

A code of conduct should be developed applicable to all legal representatives in care proceedings. Specialist accreditation should be regularly available. Any necessary training or assessment mechanisms should be available on an ongoing or regular basis. A similar regime should also be established for Guardians ad Litem.

Recommendation 13.9 *Immediate* *Low*

A District Court Judge should be appointed as the senior judicial officer in the Children's Court.

Recommendation 13.10 *Short term* *Medium*

There should be sufficient specialist Children's Magistrates appointed to permit rural and regional circuits to be held to ensure that the proportion of matters in the care and protection jurisdiction presided over by non-specialist Magistrates is reduced to fewer than 10 per cent.

Recommendation 13.11 *Short term* *Low*

A trial of a 'docket system' in the Parramatta Children's Court for matters in the care and protection jurisdiction should be undertaken.

Recommendation 13.12 *Immediate* *Medium*

Registrars of the Children's Court should be legally qualified and alternative dispute resolution trained and sufficient in number to perform alternative dispute resolution and to undertake procedural and consent functions.

Chapter 15 Child protection and the criminal justice system

Recommendation 15.1 *Long term* *Medium*

An after hours bail placement service should be established by the Department of Juvenile Justice similar to the Victorian Central After Hours and Bail Placement Service, that is available to young people aged between 10 and 18 years, who are at risk of being remanded in custody, or who require bail accommodation; or similar to the Queensland Conditional Bail and Youth Program Accommodation Support Service.

	Priority	Cost

Chapter 16 Out-of-home care

Recommendation 16.1 *Short term* *Medium*

DoCS OOHC/NGO OOHC caseworkers should become involved with children and young persons in OOHC at an earlier stage than final orders and have a responsibility to identify and support the placement of the children or young people, where it has been determined that there is not a realistic possibility of restoration.

Recommendation 16.2 *Three to five years* *High*

Over the next three to five years, there should be a gradual transition in the provision of OOHC for children and young persons as follows:

a. Most children and young persons in OOHC should be supported by one of the two following models:
   - i DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. The agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of a child or young person with an authorised carer, and for any decision to remove a child or young person from a carer. DoCS retains the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change Court orders and for providing after care assistance.
   - ii DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers) subject to consultation with the Children's Guardian (see Recommendation 16.15).
   - iii Children and young persons with significantly complex needs or who are assessed as at high risk of immediate or serious harm or whose case management requires high level collaboration with other government agencies will remain case managed by DoCS.

b. At an early stage, DoCS should progressively commence the transfer of long term kinship/relative carers to NGOs so as to allow the NGOs to carry out any necessary training and to provide ongoing support for these carers.

c. At an early stage, DoCS should progressively reduce its role in the recruitment of foster carers and transfer current long term foster carers to NGOs.

	Priority	Cost
Recommendation 16.3	*Short term*	*Medium*

Within 30 days of entering OOHC, all children and young persons should receive a comprehensive multi-disciplinary health and developmental assessment. For children under the age of five years at the time of entering OOHC, that assessment should be repeated at six monthly intervals. For older children and young persons, assessments should be undertaken annually. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by NSW Health and DoCS.

Recommendation 16.4 *Immediate* *Low*

NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead.

Recommendation 16.5. *Immediate* *Low*

The Department of Education and Training should appoint an OOHC coordinator in each Region.

Recommendation 16.6 *Long term* *High*

The NSW Government has a responsibility to ensure that all children and young persons removed from their parents and placed in its care receive adequate health treatment. Thus, there should be sufficient health services including speech therapy, mental health and dental services available to treat, as a matter of priority, children and young persons in OOHC.

Recommendation 16.7 *Short term (interim strategy)* *High*

The introduction of centralised electronic health records should be a priority for NSW Health. Given that this is likely to take some time, an interim strategy should be developed to examine a comprehensive medical record or a transferable record for children and young persons in OOHC, which should be accessible to those who require it in order to promote or ensure the safety, welfare and well-being of the child or young person.

Recommendation 16.8 *Short term* *Medium*

Within 30 days of entering OOHC, all preschool and school aged children and young persons should have an individual education plan prepared for them which is reviewed annually by the Department of Education and Training and by the responsible caseworker. A mechanism for monitoring, evaluating and reviewing access and achievement of

	Priority	Cost

outcomes should be developed by the Department of Education and Training and DoCS.

Recommendation 16.9 *Long term* *Medium*

Carer allowances should be reviewed periodically by an independent body and should more closely reflect the actual costs to the carer of providing care, according to the varying categories of need.

Recommendation 16.10 *Immediate* *Low*

The Memoranda of Understanding between DoCS and respectively, the Department of Ageing, Disability and Home Care, NSW Health and the Department of Education and Training should be revised to reflect the increasing responsibilities of NGOs for the provision of OOHC.

Recommendation 16.11 *Long term* *Medium*

A common case management framework for children and young people in OOHC across all OOHC providers, should be developed, following a feasibility study on potential models including the Looking After Children system.

Recommendation 16.12 *Long term* *Medium*

Due to the large numbers of Aboriginal children and young persons in OOHC, priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.

Recommendation 16.13 *Short term* *Medium*

There should be sufficient numbers of care options for children and young persons with challenging behaviours that include specialised models of therapeutic foster care.

Recommendation 16.14 *Long term* *High*

DoCS and/or relevant NGOs should receive sufficient funding to service the actual and projected OOHC population to enable an average ratio of one caseworker to 12 children and young persons.

Recommendation 16.15 *Short term* *Low*

DoCS should consult with the Children's Guardian before delegating parental responsibility to any person, except in circumstances where DoCS has shared parental responsibility and is delegating to the person with whom it shares parental responsibility. In the event that a

	Priority	Cost

mechanism for that to occur has not been introduced to the satisfaction of DoCS and the Children's Guardian within 12 months of the publication of this report, the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require that consultation.

Recommendation 16.16 *Immediate* *Medium*

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

i. the proposal set out in the draft Cabinet Minute to introduce a revised scheme for voluntary care should be implemented and the Children's Guardian should receive the additional resources necessary to perform the functions of that office that would apply to those within that scheme
ii. section 183 should be repealed
iii. section 181(1)(d) should be repealed
iv. section 181(1)(a) should be repealed
v. section 186 should be repealed
vi. section 105(3)(b)(iii) should be amended to delete reference to the Children's Guardian and to replace it with the Director-General of DoCS
vii. section 90(3)(b) should be repealed
viii. section 159 should be proclaimed

Chapter 17 Domestic and family violence in child protection

Recommendation 17.1 *Immediate* *Low*

The NSW Police Force should amend its policies in respect of reporting domestic violence incidents to DoCS to align with the requirements of s.23(d) of the *Children and Young Persons (Care and Protection) Act 1998* and should provide the necessary training to its officers to enable them to comply with the amended legislation.

Recommendation 17.2 *Short term* *Low*

DoCS and NSW Police should agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made.

Recommendation 17.3 *Short term* *Medium*

DoCS caseworkers should receive domestic violence specific training, jointly with other relevant agencies and NGO workers.

	Priority	Cost

Chapter 18 Aboriginal over representation in child protection

Recommendation 18.1 *Immediate* *Low*

The NSW Ombudsman should be given authority to audit the implementation of the Aboriginal Child Sexual Assault Taskforce recommendations as described in Recommendation 21 of the Taskforce's report.

Recommendation 18.2

The NSW Government should consider the following:

Short term *Medium*

a. Assisting Aboriginal communities to consider and develop procedures for the reduction of the sale, delivery and use of alcohol to Aboriginal communities.

Short term *Medium*

b. Working with the Commonwealth to income manage Commonwealth and State payments to all families, not only Aboriginal families, in circumstances where serious and persistent child protection concerns are held and there is reliable information available that income is not being spent in the interests of the safety, welfare and well-being of the relevant child or young person.

Short term *Medium*

c. Introducing measures to ensure greater attendance at school, preferably by means other than incarceration, including the provision of transport and of meals.

Immediate *Medium*

d. In smaller and more remote communities, introducing the greater use of night patrols to ensure that children are not wandering the streets at night in circumstances where they might be at risk of assault, or alternatively of involvement in criminal activities.

Short term *Medium*

e. Providing accommodation to Aboriginal children and young people at risk of harm of a boarding nature type where the children are cared for and educated.

Recommendation 18.3 *Short term* *Medium*

The NSW Government should take steps to ensure that the recommendations of the Aboriginal Child Sexual Assault Taskforce

	Priority	Cost

report, and the actions in the Interagency Plan, which relate to provision of direct services to Aboriginal children, young persons, families and perpetrators, are carried into effect within the lifetime of the plan.

Recommendation 18.4 *Short term* *Low*

The NSW Government should work actively with the Commonwealth in securing the delivery, in NSW, of the services identified in the New Directions Policy and in the 2008/09 Commonwealth Budget that were earmarked for the benefit of Aboriginal people.

Chapter 20 Young people, leaving care and homelessness

Recommendation 20.1 *Short term* *Medium*

DoCS should train and appoint to each DoCS Region, specialist caseworkers to assist in the case management of young people.

Recommendation 20.2 *Short term* *Low*

DoCS should fund a training package to assist foster carers and kinship and relative carers in preparing young people for leaving care.

Recommendation 20.3 *Short term* *Low*

DoCS should fund the provision of detailed information to care leavers as to the assistance which is available to them through State and Commonwealth sources after they leave care, and as to the means by which they can access that assistance.

Chapter 21 Children and young persons and parents with a disability

Recommendation 21.1 *Short term* *Medium*

A data management system should be developed in DoCS and the Department of Ageing, Disability and Home Care to identify joint clients.

Recommendation 21.2 *Immediate* *Low*

The Memorandum of Understanding between DoCS and the Department of Ageing, Disability and Home Care should be revised to provide the operational definitions set out in the 2008 Memorandum of Understanding evaluation and to specify the manner in which joint assessment and planning will occur.

	Priority	Cost
Recommendation 21.3	*Short term*	*Low*

Joint training should be carried out for DoCS and Department of Ageing, Disability and Home Care staff, in relation to the care and protection of children and young persons with a disability, and in relation to the individual and mutual responsibilities of the two agencies.

Recommendation 21.4 *Short term* *Low*

The recruitment and training of foster carers who care for children and young persons with a disability in voluntary and statutory OOHC should occur jointly by DoCS and the Department of Ageing, Disability and Home Care.

Recommendation 21.5 *Short term* *Medium*

The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community Services, or for those whose disabilities are such that they are unable to continue to reside in their homes.

Recommendation 21.6 *Long term* *Low*

Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services.

Chapter 22 Disaster recovery

Recommendation 22.1 *Short term* *Medium*

DoCS responsibilities under the *Community Welfare Act 1987* should be transferred to the Department of Premier and Cabinet or to such other government department as is entrusted with the principal responsibilities for planning for and responding to disasters or emergencies, with DoCS staff being available to be called upon to provide, under the coordination and direction of the Department of Premier and Cabinet or of such other department, assistance appropriate to the event.

Recommendation 22.2 *Short term* *Medium*

In the event that DoCS retains responsibility under the *Community*

	Priority	Cost

Welfare Act 1987, it should be resourced sufficiently to adequately perform that role, without frontline child protection caseworkers being deployed.

Recommendation 22.3 *Short term* *Low*

The NSW Government should assign responsibility for distributing drought relief to an agency other than DoCS, and such relief as is provided should not be a cost to the DoCS budget.

Chapter 23 Oversight

Recommendation 23.1 *Immediate* *Low*

The relevant legislation including Part 7A of the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that Team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Recommendation 23.2 *Immediate* *Low*

DoCS should review the death of any child or young person about whom a report was made within three years of that death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.

Recommendation 23.3 *Immediate* *Low*

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* should be amended by:

i. repealing s.35(1)(b) and (c)

ii. replacing the requirement for an annual report, in s.43 with a requirement that a report be made every two years.

Recommendation 23.4 *Short term* *Low*

Information obtained by persons appointed by the Minister as official visitors should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards and s.8 of *Community Services (Complaints, Reviews and Monitoring) Act 1993* and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* should be amended to achieve this outcome.

	Priority	Cost
Recommendation 23.5	*Short term*	*Low*

The class or kind agreement between the NSW Ombudsman and DoCS should be revised to require DoCS to notify only serious allegations of reportable conduct and to impose timeframes within which DoCS will investigate those allegations.

Recommendation 23.6	*Immediate*	*Low*

DoCS should centralise its Allegations Against Employees Unit and receive sufficient funding to enable this restructure, and to resource it to enable it to respond to allegations in a timely fashion.

Recommendation 23.7	*Immediate*	*Low*

DoCS should revise the findings available following an investigation into an allegation against an employee so as to and permit one of the following findings to be made but no other: sustained, not sustained, not reportable conduct. Adequate reasons should be recorded, and kept on file, which should note not only why an allegation was sustained, but also the reasons why an allegation was not reportable or not sustained.

Recommendation 23.8	*Short term*	*Medium*

The *Commission for Children and Young People Act 1998* should be amended to require background checks as follows:

a. in respect of DoCS and other key human service agencies all new appointments to staff positions that work directly or have regular contact with children and young persons (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)

b. any contractors engaged by those agencies to undertake work which involves direct unsupervised contact to children and young persons, and, in the case of DoCS, access to the KiDS system or file records on DoCS clients

c. students working with DoCS officers

d. children's services licensees

e. authorised supervisors of children's services

f. principal officers of designated agencies providing OOHC or adoption agencies

g. adult household members, aged 16 years and above of foster carers, family day carers and licensed home based carers

h. volunteers in high risk groups, namely those having extended unsupervised contact with children and young persons.

	Priority	Cost

Chapter 24 Interagency cooperation

Recommendation 24.1 *Immediate* *Low*

The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons.

Recommendation 24.2 *Immediate* *Low*

Each human services and justice agency CEO should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.3 *Immediate* *Low*

The Director-General, each Deputy Director-General and each Regional Director of DoCS should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.4 *Long term* *Medium*

The boundaries of key human services and justice agencies should be aligned.

Recommendation 24.5 *Short term* *Low*

Cross agency training should be delivered in relation to interagency collaboration and cooperation in delivering services to children and young persons.

Recommendation 24.6 *Immediate* *Low*

The *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person in accordance with the principles set out in Chapter 24. The amendments should provide, that to the extent inconsistent, the provisions of the *Privacy and Personal*

	Priority	Cost

Information Protection Act 1998 and *Health Records and Information Privacy Act 2002* should not apply. Where agencies have Codes of Practice in accordance with privacy legislation their terms should be consistent with this legislative provision and consistent with each other in relation to the discharge of the functions of those agencies in the area of child protection.

Recommendation 24.7 *Short term* *Low*

An improved structure should be established for regular regional meetings between the key human services agencies and NGOs to facilitate collaborative cross agency work, and to be accountable to the Human Services and Justice CEOs Cluster.

Chapter 25 DoCS funded non-government service system

Recommendation 25.1 *Long term* *Medium*

All NSW Government funding to NGOs delivering universal, secondary and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should be reviewed, so as to establish a coordinated system for the allocation of their funded resources that will eliminate unnecessary overlap and provide for the delivery of service where most needed.

Acronyms

Acronyms	*Phrase/meaning*
1987 Act	*Children (Care and Protection) Act 1987*
AAE	Allegations Against Employees
AAS	Area Assistance Scheme
Aboriginal Affairs	Department of Aboriginal Affairs
Aboriginal Placement Principles	Aboriginal Child Placement Principles
ABS	Australian Bureau of Statistics
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACSAT	Aboriginal Child Sexual Assault Taskforce
ACWA	Association of Children's Welfare Agencies
ACYFS	Aboriginal, Child, Youth and Family Strategy
ADR	alternative dispute resolution
ADT	Administrative Decisions Tribunal
AHS	Area Health Service
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMIHS	Aboriginal Maternal and Infant Health Strategy
AODP	Alcohol and Other Drugs Program
Attorney General's	Attorney General's Department
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
CALD	culturally and linguistically diverse
Care Act	*Children and Young Persons (Care and Protection) Act 1998*
CCYP	Commission for Children and Young People
CCYP Act	*Commission for Children and Young People Act 1998*
CCYP Act	*Commission for Children and Young People Act 1998*
CDC	Caseworker Development Course
CDCRU	Child Deaths and Critical Reports Unit (DoCS)
CDRT	Child Death Review Team
CEC	Chief Executives Committee
CEO	Chief Executive Officer
CIW	Corporate Information Warehouse
Clinic	Children's Court Clinic
COAG	Council of Australian Governments
Community Welfare Act	*Community Welfare Act 1987*
Corrective Services	Department of Corrective Services
CRC	Children's Research Center
CS CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993*
CSC	Community Services Centre
CSGP	Community Services Grants Program
CYP	Children and young persons
DADHC	Department of Ageing, Disability and Home Care
Discussion Paper	DoCS Discussion Paper, *Statutory child protection in NSW: issues and options for reform,* October 2006
Displan	NSW State Disaster Plan

Acronyms	Phrase/meaning
District Court	District Court of NSW
DoCS	Department of Community Services
DPP	Office of the Director of Public Prosecutions
Education	Department of Education and Training
EOI	expression of interest
ESD	Enhanced Service Delivery
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
Family Court	Family Court of Australia
Family Law Act	*Family Law Act 1975*
FGC	family group conferencing
FTE	full time equivalent
Health	NSW Health
HNEAHS	Hunter New England Area Health Service
Housing	Housing NSW
HREOC	Human Rights and Equal Opportunity Commission
HRIP Act	*Health Records and Information Privacy Act 2002*
IFBS	Intensive Family Based Services
Interagency Guidelines	*Interagency Guidelines for Child Protection Intervention 2006*
Interagency Plan	Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011
JIRT	Joint Investigation Response Team
JRU	JIRT Referral Unit
Juvenile Justice	Department of Juvenile Justice
KiDS	Key Information and Directory System
LAC	Legal Aid Commission NSW
LAC proposal	Draft Proposal for a Care and Protection Mediation Pilot (Legal Aid NSW)
LAT	Less Adversarial Trial
Law Society	Law Society of NSW
Magellan	Magellan Case Management Model
MOU	Memorandum of Understanding
NCOSS	Council of Social Services of NSW
New Street	New Street Adolescent Service
NGO	non-government organisation
NTER	Northern Territory Emergency Response
OHS	Occupational Health and Safety
Ombudsman	NSW Ombudsman
Ombudsman Act	*Ombudsman Act 1974*
OOHC	out-of-home care
PANOC	Physical Abuse and Neglect of Children
Police	NSW Police Force
PPIP Act	*Privacy and Personal Information Protection Act 1998*
PPR	Personal Planning and Review
Premier and Cabinet	Department of Premier and Cabinet
PSA	Public Service Association
RACP	Royal Australian College of Physicans
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCMG	Regional Coordination Management Group

Acronyms	*Phrase/meaning*
Regulations	*Children and Young Persons (Care and Protection) Regulation 2000*
Rules	*Children's Court Rule 2000*
SAAP	Supported Accommodation Assistance Program
SACS Award	Social and Community Services Award
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment State 2
SCAN	Suspected Child Abuse and Neglect
SCI	Special Commission of Inquiry
SDM	Structured Decision Making
SDRC	State Disaster Recovery Centre
SERM Act	*State Emergency and Rescue Management Act 1989*
SNAICC	Secretariat of National Aboriginal and Islander Child Care
Treasury	NSW Treasury
Triple P	Positive Parenting Program
Usher Review	Review of Substitute Care Services in NSW 1992
Young Offenders Act	*Young Offenders Act 1997*

Part 1 DoCS structure and workforce

1. Introduction

1.1 A boy, aged two years and seven months died on 11 October 2007. His mother was charged in relation to his death on 20 October 2007. A girl, aged seven years, died on 3 November 2007. Her parents were charged in relation to her death on 17 November 2007. Both children and/or their siblings had been the subject of reports of suspected risk of harm to the Department of Community Services (DoCS).

1.2 It was largely in response to the deaths of these two children that, on 14 November 2007, a commission was issued for an Inquiry to determine what changes within the child protection system were required to cope with future levels of demand once the current reforms to that system which had been initiated in 2002 were completed.

1.3 The deaths of these two children have been the subject of comprehensive reviews by the NSW Ombudsman and DoCS. As criminal proceedings have commenced but not yet finalised, the Inquiry will not comment on the two cases.

1.4 However, the Inquiry has had the benefit of reviewing the material gathered from all agencies in relation to their deaths and the findings and lessons from these reviews have informed the considerations and recommendations of the Inquiry.

1.5 For the purpose of the Inquiry, the child protection system is defined to include each department or agency in NSW with responsibilities towards children, young persons and their families. They include DoCS, NSW Health and each Area Health Service and The Children's Hospital at Westmead, the Department of Education and Training, the Department of Ageing, Disability and Home Care, the NSW Police Force, the Department of Juvenile Justice, the Department of Aboriginal Affairs and Housing NSW.

1.6 In addition, those non-government organisations (NGOs) which receive funding from the Government to provide services to children, young persons and their families are also part of the child protection system. Those NGOs extend from agencies in receipt of tens of millions of dollars in funding to small organisations run by volunteer committees.

1.7 Courts and Tribunals are also part of the child protection system, including the Children's Court, the family law courts, the Supreme Court, the District Court, the Administrative Decisions Tribunal and the Coroner's Court.

1.8 Commonwealth agencies which provide funding or services also have responsibilities for children, young persons and their families including the Department of Families, Housing, Community Services and Indigenous Affairs, the Department of Education, Employment and Workplace Relations, and the Department of Health and Ageing. Local Councils also provide services to children, young persons and their families.

1.9 In addition, there are private sector bodies which provide services such as private schools and day care facilities and those involved in the provision of medical and dental services. Finally, the child protection system encompasses the independent, advisory or watchdog agencies which include the NSW Ombudsman, the Children's Guardian, and the Commission for Children and Young People.

1.10 The services to assist children, young persons and their families and to prevent them from entering or escalating within the child protection system range from universally provided services such as prenatal care and quality child care, to more targeted or secondary services such as home visiting and supported playgroups. Tertiary services for those children and young persons who have suffered abuse, include counselling and more intensive services.

1.11 The processes and procedures followed by the Inquiry are set out in detail in the various appendices to this report. However, it is important to note that during the course of the Inquiry, the Inquiry staff travelled extensively in NSW from Boggabilla in the north, to Broken Hill in the west and Wagga Wagga in the south and many small and large towns in between. In addition, the Inquiry held Public Forums at many of those locations, as well as speaking with the staff of the local DoCS community services centres and other local agencies involved in the child protection system.

1.12 In Sydney, the Inquiry held nine Public Forums to canvass the views of those within, and outside the system, including its clients, concerning the discrete topics covered at each Public Forum.

1.13 The Inquiry benefited from the views of many experts in the area, located in Sydney, other parts of Australia and internationally.

1.14 While summons were issued to permit lawful disclosure, generally the Inquiry found that each agency readily cooperated with it and provided all relevant material in a timely fashion. In particular, DoCS provided material sought, volunteered much material and undertook significant analysis of data for the Inquiry.

1.15 As can be seen from the terms of reference, the Inquiry was required to form a view about future levels of demand. It did so with the assistance of data analyses from DoCS. That can be summarised as follows. While demand as measured by reports of children at risk of harm continue to increase, the rate of increase has slowed. Further, a significant number of children the subject of risk of harm reports are already known to the system.

1.16 Unfortunately, however, the number of children and young persons in out-of-home care (OOHC) continues to grow at a significant rate. While reforms to the system generally, and in particular the provision of more and earlier intervention and prevention services should, in the future, reduce the number of children and young persons removed from their home, those children and young persons in

OOHC are staying there longer. The budgetary implications of this are both serious and urgent.

1.17 A range of complex and often chronic factors characterise many of the families coming into contact with the child protection system such as low income or unemployment, substance abuse, limited social supports, domestic violence, mental health issues, social or geographic isolation and burdens of sole parenting. Many of these factors are inter-related and inter-generational, and further exacerbate problems faced by families. They continue to present a significant challenge for some Aboriginal[1] communities, whose needs were the subject of particular attention by the Inquiry.

1.18 It is almost trite to observe that the attention paid to each of these has a direct impact on the number of children, young persons and families coming into contact with the system.

1.19 This report is divided into parts. Part 1, of which this chapter is part, comprises a consideration of the reforms referred to in the terms of reference, DoCS structure and the capacity of its workforce.

1.20 Part 2 considers the early intervention and child protection arms of DoCS. For ease of reference, key child protection research and data have been collected in two chapters and that data and research informs the report as a whole. Part 2 addresses the regime by which reports of risk of harm are made to DoCS and considers the contributions and obligations of mandatory reporters. It also details the early intervention work undertaken by DoCS, other state agencies and NGOs, with particular attention to DoCS Brighter Futures program. The assessment and response work of the Department and others is then detailed. Chapter 10 entitled 'Directions for the way forward' collects the principles underpinning the child protection system. It notes the desirable goals and makes general recommendations for the way forward. Each chapter within this and other Parts contains a description of the aspects of the system under consideration followed by the issues which arise from that consideration and recommendations specific to these issues.

1.21 Part 3 deals with the legal basis of the child protection system including the powers, functions and processes of the Children's Court, and to a lesser extent the family law courts and the relevant appellate and administrative review processes. The interface between child protection and the criminal justice system is also considered in this part.

1.22 Part 4 concerns OOHC and similarly to Chapter 10, collects the principles and goals that should govern OOHC and its goals.

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[1] Throughout this report any reference to 'Aboriginal' should be taken to mean 'Aboriginal and Torres Strait Islander' as defined in s.5 of the *Children and Young Persons (Care and Protection) Act 1998.*

1.23 Part 5 collects a range of specific areas of particular concern including domestic and family violence, Aboriginal communities, adolescence, children and young people with disabilities and disaster recovery.

1.24 Part 6 looks at the roles played and the functions of the other government and non-government agencies which come within the definition of the child protection system as set out above, including the oversight arrangements. It considers the processes by which the non-government sector is funded by DoCS and others to perform or provide services for children, young persons and their families. Specific attention is given to the need for more effective interagency collaboration. Some comment is also made on performance measures.

1.25 Part 7 of the report contains commentary about implementation of its recommendations.

1.26 The recommendations are collected at the beginning of the report.

1.27 Over the 12 months of the Inquiry, more data has become available than that which existed in the early months. In particular, DoCS and other agencies have released their annual reports in recent weeks. Where possible, this report attempts to capture the most recent data available, however, depending upon the topic, the most recent data can vary between 2006/07, April 2007 to March 2008 or the financial year 2007/08. The most recent data available to the Inquiry is used and accordingly, in some areas that data maybe older than in other areas.

1.28 The Inquiry was undertaken on the basis that its focus was to be on achieving system reform, rather than on allocating fault or finding a solution for individual cases where families were dissatisfied with the outcome for their children and for themselves.

1.29 Any different approach would have delayed the delivery of the report by a very considerable period, and would not, in any event, have been consistent with the terms of reference. Notwithstanding, submissions were received from the public and given careful consideration as to whether they identified deficiencies in the system which the report should address. In some instances the stories told have become case studies in the report.

1.30 The Inquiry has been careful to maintain the confidentiality of the families and children whose cases have come to notice, and to observe statutory restrictions on the disclosure of their names and identities. For these reasons, many submissions have not been publicly released. They have, however, provided a useful resource for the Inquiry, and it is grateful for the assistance provided by the very many individuals and agencies that responded to its invitation for submissions.

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Introduction

2.1 The terms of reference require the Inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.

2.2 The Inquiry has interpreted those terms of reference to refer to the Reform Package which was proposed by the then Director-General and subsequently accepted by Cabinet and funded in December 2002. While the Inquiry agrees with the general thrust of the Reform Package, for a variety of reasons some of those reforms are not complete and should not be continued in the manner thought appropriate in 2002. Thus, the Inquiry does not view the terms of reference as constraining it to the acceptance of all the reforms set out in the Reform Package.

2.3 Before considering the 2002 Reform Package and its current status, it is necessary to understand some of the key events which preceded it.

Pre 2002

2.4 During the 1990s there was significant change in the Government's response to the care and protection of children. First, the Community Services Commission was established to, *inter alia*, review, monitor and deal with complaints in relation to the Government's care and protection of children. Secondly, a review was conducted of the *Children (Care and Protection) Act 1987.* Thirdly, a child death review team was created and ultimately placed in the newly created Commission for Children and Young People. Fourthly, many of the recommendations made in the review of the 1987 legislation were reflected in the *Children and Young Persons (Care and Protection) Act 1998*, (the Care Act) including an extension of mandatory reporting. Finally, the Helpline was operational from 2000.

2.5 Then, in 2002 a number of reports critical of DoCS were published.

2.6 In April 2002, the NSW Ombudsman (the Ombudsman) made a special report to Parliament which criticised many areas of DoCS' operations including its response to increased reports of child abuse, authorisation and training of foster carers, record keeping, its client information system and the lack of knowledge of staff about policies and procedures.[2]

2.7 A joint DoCS/Public Service Association working party, commonly known as the Kibble Committee, reported in December 2002 and recommended a significant increase in OOHC caseworkers, to between 150 and 200, and in child

[2] NSW Ombudsman, *DoCS: Critical Issues*, April 2002.

protection caseworkers, to between 700 and 1,000. It also identified various areas to increase efficiency.[3]

2.8 In the same month, the final report on child protection services by the Legislative Council's Standing Committee on Social Issues was published.[4] It recommended a new Department of Child Development to coordinate and fund the programs that promote the development and well-being of children and young persons. It stated that DoCS should not have a direct service delivery role in early intervention and that secondary prevention should be built largely within the non-government sector.

2.9 Its areas of recommendation were broad and included data collection, a better interface between the Department and the court system, creating a core function of research and evaluation, increasing funding in prevention and early intervention and a range of matters in the OOHC system including a recommendation that all children in OOHC should have an identified and designated caseworker.

2.10 Matters such as supervision, procedures, external oversight, information systems, mandatory reporting, secondary risk of harm assessment frameworks and reducing time spent by caseworkers on paperwork and general administrative duties were also addressed.

2.11 It is against this backdrop of consistent criticism that the then Director-General sought the funds and support of the Government to reform significantly the manner in which DoCS carried out child protection work.

2002 Reform Package

2.12 In its 2002 request for funds, DoCS provided a snapshot of the environment in which it then operated.

2.13 There had been a 432 per cent increase in child protection reports in the five years 1996/97 to 2001/02. Of the nearly 160,000 reports in 2001/02, about 92,000 were assessed as requiring investigation. Of those cases DoCS could only allocate 55 per cent of those reports requiring a less than 24 hour response to a caseworker for investigation, 26 per cent of those requiring a less than 72 hour response and 12 per cent of those requiring a less than 10 day response.

2.14 A child protection demand curve was prepared which noted that demand was continuing to rise at 59.3 per cent per annum and that the OOHC increase was steady at 10 per cent per annum, but with increasing costs per child. On these

[3] Joint DoCS/Public Service Association Working Party Report, December 2002.

[4] NSW Legislative Council Standing Committee on Social Issues, *Care and Support: Final Report on Child Protection Services*, December 2002.

trends, estimated figures for 2006 were 384,000 child protection reports and 12,591 children in OOHC.

2.15 Costs per child per annum in OOHC had risen from $15,422 in 1999/2000 to $20,246 in 2001/02. It was stated that the estimated increase in cost of OOHC by 2006/07 would be between $134 million and $194 million just to maintain the status quo.

2.16 It was also reported that there was a DoCS caseworker/client ratio of 1:30 in OOHC as against an international benchmark of 1:12, and a lack of support for, and significant shortage of, foster carers.

2.17 DoCS predicted that over time, the proposed changes would result in a downwards trend in child protection reports and unit costs, a stabilising of OOHC costs and a significant reduction in placement breakdowns which would control further cost increases.

2.18 In December 2002 the Reform Package was announced comprising a $1.2 billion package of recurrent funding over the remainder of that year and the next five years taking the DoCS recurrent budget from $641 million per year to over $1.2 billion per year by 2007/08, together with a capital injection of over $80 million in the same period.

2.19 The following table sets out the reforms proposed in 2002, the progress made as at March 2008 and a brief comment by the Inquiry. Each matter will be the subject of detailed discussion in the report.

Table 2.1 **Progress on implementation of 2002 Reform Package, March 2008.**

REFORM PROPOSED IN 2002	*PROGRESS BY MARCH 2008*	*INQUIRY'S COMMENT*
Establish a new client information system	KiDS approved prior to reform package, operational from October 2003	KiDS needs significant re-design
Create a new records management system	Mostly not commenced	DoCS needs to move to an electronic records system
To deal with the high cumulative cost of workers compensation claims	Achieved	The Helpline needs particular attention
Replacement of the human resources system	Completed	
Creation of a performance management system	Completed	More by way of professional supervision is needed
Create a corporate information warehouse and minimum data set exchange	Completed	Ongoing work required
An economics capacity	Established	Performs essential and quality work
An Aboriginal services unit	Established	Additional Aboriginal recruitment needed

REFORM PROPOSED IN 2002	*PROGRESS BY MARCH 2008*	*INQUIRY'S COMMENT*
An increase in expertise based positions in child protection, early intervention and OOHC	Established	Expertise needed in specific areas, for example mental health, family and domestic violence and young people
Adequately staff the Complaint Handling and External Reviews Unit	Increase in staffing	Location and staffing of the Complaints Unit is currently inadequate for volume of work
A central coordination of what happens in regions	Achieved	More needs to be done to ensure quality and to communicate policy and practice changes
Training	Achieved significant changes in training strategy	Need to integrate research into practice
Changes in corporate support	Achieved	More functions could be transferred to Businesslink
Equivalent to 375 child protection caseworkers were sought at the rate of 75 caseworkers a year between 2003/04 and 2007/08 and 40 casework managers	Achieved, vacancies remain	More needs to be done to divert low risk of harm reports
Additional 30 psychologists to work in Community Services Centres to direct caseworkers support and 3 deputy principal psychologists	Not achieved because of opposition by the union	They should be employed
30 legal officers based in CSCs	Achieved	
To strengthen Joint Investigation Response Teams	Additional positions created	Recent review recommendations need to be implemented
Fund intensive support to Aboriginal families	Achieved	Similar model should be in place for non-Aboriginal children and young persons
Additional 350 caseworkers for early intervention work	350 caseworker positions created, vacancies remain	Universal and secondary or targeted services should be expanded
Increase caseworkers in OOHC by 150, later extended to 300	Largely achieved	Too few caseworkers to support children and young persons in OOHC
Increase the number of foster carers and foster care support systems	Progress made	More needed
Reduce reliance on expensive 'for profit' providers when children first come into care	Significant progress made	The number of 'high needs kids' has increased
Expand the range of service options in the community for children and young persons with challenging behaviours, including professional carers and intensive community based placements	Progress made	Needs to be implemented
Commence funding to increase capacity in the sector particularly in Aboriginal services and identified areas of high demand	Progress made	More needs to be done
Augment Children's Services	Not funded	
A new model of disaster recovery management	Not funded	A new model needed

2.20 As can be seen from the above table, most of the reforms identified in 2002 have been implemented or are well underway. However, more and different reforms now need to be undertaken in these and other areas, each of which will be explored in this report.

2.21 The Inquiry has conducted its examination of the child protection system based on, *inter alia,* the comprehensive data obtained from DoCS, which are set out in Chapter 5. In addition, the Inquiry has identified the obstacles to reform which were encountered over the past five years and considered the likelihood of them persisting in the current environment.

Obstacles encountered and persisting

2.22 Events and situations which prevented or hindered the realisation of all the change sought by the Reform Package, and which are likely to impede any further change include:

a. a continuing increase in reports of risk of harm

b. an inadequate client information system and a reluctance by caseworkers to properly use it

c. the expectation of other agencies that DoCS alone can and should protect children and young persons

d. the Public Service Association's (PSA) slowness to embrace change, particularly in relation to quality audits of Community Services Centres (CSCs)

e. the productivity savings required by the Government of all departments.

2.23 This report will deal with the first three matters, and indicate the Inquiry's views concerning the key area in which there remains union disagreement. The final matter is ultimately a question for the Government.

Conclusion

2.24 The child protection system the subject of the 2002 Reform Package was essentially limited to the work of DoCS. It was a comprehensive and smart package, focusing primarily on early intervention to deal with the volume of reports then made and the OOHC system. It made enormous gains in the face of an increasingly complex client base and spiralling reports. Its full impact will not be realised for some years, in part because the bulk of the funds have only been expended in the last two financial years, and also because of the time needed to embed significant reform.

2.25 The Reform Package did not extend to the other agencies with responsibilities in protecting children, or to a detailed examination of the child protection arm of DoCS, about which little comprehensive data was then available. However, shortly before the commencement of the Inquiry in November 2007, DoCS initiated the Child Protection Major Project, a significant piece of work reviewing

child protection practice, based on data available from statistical analyses undertaken within DoCS.

Child Protection Major Project

2.26 Key benefits from the Child Protection Major Project thus far have included increased data and analysis about child protection reports, including those families who are frequently reported, and the relationship between reports and socio-economic factors. That analysis has also permitted the conclusion that increasing numbers of child protection reports from police are not related to changes in the numbers of police.

2.27 In addition, as part of the project, DoCS reviewed promising child protection programs in other jurisdictions. Its key finding was that all comparable jurisdictions are investing in the development of services earlier in the intervention spectrum, particularly for new mothers and parents generally. The review identified the use of a common assessment framework and alternative ways for dispute resolution, particularly for Aboriginal families, as promising initiatives.

2.28 In relation to mandatory reporting, DoCS has introduced e-reporting with some schools and is considering various communication and other strategies to improve the quality of reporting.

2.29 Finally, DoCS has enhanced screening and assessment processes for drug and alcohol casework assessment and intervention.

2.30 All the work identified by DoCS in late 2007 as desirable, but which has yet to be completed, is supported by the Inquiry and is addressed throughout this Report. It includes:

a. reviewing the work done in CSCs in case planning and management. Unfortunately, this work has been hampered by the response of the PSA with the effect that the audits planned have not yet taken place

b. redesigning DoCS' client information system, and generally improving information and communication technology systems

c. strengthening the non-government system including better alignment of service funding with the needs of the child protection system

d. identifying service gaps

e. introducing a program for legislative reform following from a discussion paper released in October 2006. The Inquiry has considered all proposals put forward prior to and since that discussion paper and this report makes various recommendations both in relation to that program and in relation to additional structural and legislative reform.

DoCS organisational structure and budget

2.31 DoCS is the largest child protection agency in Australia. DoCS operates within the legal framework set by the Care Act, the *Community Welfare Act 1987* and the *Adoption Act 2000*.

2.32 The Department's key responsibilities are:

a. providing assessment and casework services for children and young persons at risk of harm

b. providing funding, accommodation and support services for children and young persons who can no longer live at home

c. funding and regulating children's services such as preschools and day care centres

d. funding and monitoring a range of service providers to deliver family support, early intervention, community development and OOHC services to children, families and communities

e. coordinating recovery services to help people affected by disasters

f. offering community support services to help homeless people and families move to independent living.[5]

2.33 Under the NSW State Plan DoCS has lead agency responsibility for two State Plan priorities:

a. F6: increased proportion of children with skills for life and learning at school entry

b. F7: reduced rates of child abuse and neglect.

2.34 The DoCS budget for 2008/09 is $1.348 billion, which is allocated across community services, prevention and early intervention, statutory child protection and OOHC.

a. Within the community services area, $194.9 million has been identified for services that aim to support and strengthen families and communities. Services funded within this area include community development and capacity building, crisis support services and disaster recovery services.

b. Within the prevention and early intervention area, $263.2 million has been allocated to children's services, and prevention and early intervention services including the Brighter Futures program.

c. $395.2 million has been identified for statutory child protection.

d. $495.2 million has been allocated for services that aim to support children and young persons who are not able to live at home safely.[6]

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[5] DoCS, *Annual Report 2006/07*, p.2.

[6] DoCS, *NSW State Budget 2008/09.*

2.35 In 2007/08, funding to external service providers accounted for 57 per cent of the total DoCS budget. This included 45 per cent ($573.1 million) for services from external agencies, and 12 per cent ($145.8 million) for payments to individuals. Carer payments made up most of this 12 per cent.

2.36 The remaining 43 per cent of the 2007/08 DoCS budget was allocated for internal use. Of this, 29 per cent ($366.7 million) was employee related and a further 14 per cent ($174.6 million) was allocated for operating costs.

2.37 DoCS provides services through its Head Office in Ashfield, Sydney, seven regional offices and 80 CSCs which deliver frontline services. The DoCS Helpline is a 24 hour statewide telephone service to which reports of suspected child abuse or neglect are made. DoCS also operates a statewide Domestic Violence Line which is a toll free 24 hour telephone counselling and referral service.

2.38 DoCS employs more than 4,500 full time and part time staff. The workforce includes caseworkers, psychologists, legal officers, community program officers, researchers, statisticians, economists, children's services advisers, communications professionals, policy analysts, managers and administration staff. Caseworkers comprise almost half of the DoCS workforce. Caseworkers can work in a number of different roles, including:

a. child protection: assessing reports and providing assistance to families to reduce harm or the risk of harm to the child or young person and, if necessary, taking Children's Court action

b. street teams: reducing crime, risk taking and antisocial behaviour by children and young persons in areas such as Redfern, Cabramatta and Kings Cross

c. Joint Investigation Response Teams (JIRTs): working with Police and Health in undertaking the joint investigation of child protection matters where serious physical or sexual assault of children is involved

d. OOHC: supporting children and carers where children are unable to live safely with their birth parents

e. early intervention: assessing strengths and needs of families and working with lower risk families

f. Helpline: taking initial reports from people with concerns about the safety and well-being of a child or young person, and assessing what further actions may be taken

g. Aboriginal Caseworker: consulting and advising on Aboriginal children who are at risk, and on the placements of Aboriginal children and young persons who are in OOHC

h. Multicultural Caseworker: providing services to children from culturally and linguistically diverse families and communities.[7]

2.39 As at June 2007, DoCS was administered through five divisions.

a. Operations Division oversees the delivery of frontline services across NSW, supports the introduction of new policies and develops procedures and implements strategies to improve professional practice. It also delivers statewide specialist services such as the Helpline, adoption services, psychology services, JIRTs and disaster recovery with partner organisations.

b. Communities Division works across the government and non-government sectors to develop coordinated, strategic approaches to issues facing young persons, children and families and to implement community programs locally. These include youth initiatives, services for women experiencing domestic violence and parenting programs. The division is also responsible for reform and regulation of the Children's services sector.

c. Service System Development Division provides the research, business planning, analysis, policy development and program evaluation to underpin DoCS reform agenda and implement funding reform to achieve the best outcomes for children and families. It develops policy initiatives in early intervention, child protection and out-of-home care.

d. Strategy, Communication and Governance Division coordinates issues management and accountability in DoCS, including media and communication, freedom of information, governance, investigation and reviews, strategic policy, complaints management, and corporate and ministerial information.

e. Corporate Services provides administrative, financial and legal services, information and communication technology, funding administration and building management services. There is also a corporate and workforce strategies function which includes Aboriginal and multicultural services, human resources, learning and development, and workforce planning.[8]

2.40 The organisational structure of DoCS is as follows.[9]

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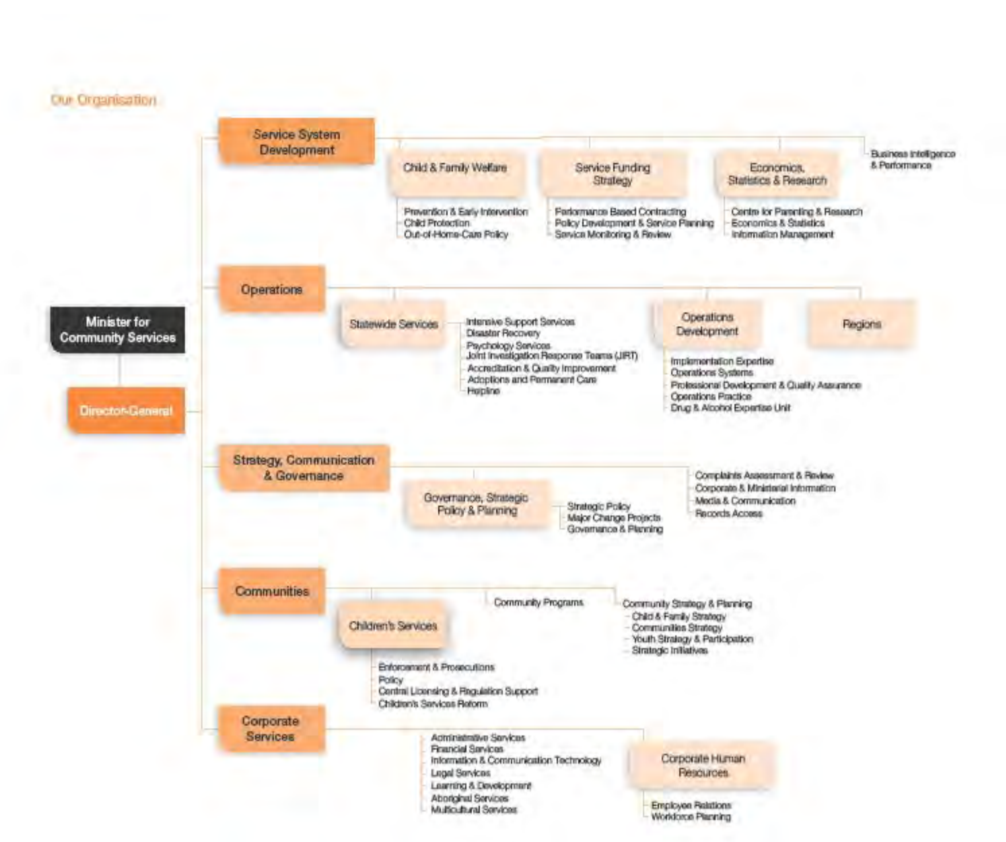
[7] DoCS, *Annual Report 2007/08*, p.7.

[8] ibid., p.8.

[9] Correspondence: DoCS, 17 October 2008.



2.41 Within each of the seven DoCS regions there are two distinct but complementary functions:

a. Casework and case management services to children, young persons and their families in the child protection, OOHC and early intervention programs. These are generally delivered by CSCs.

b. Funding and monitoring of non-government and other agencies to provide services to children and families. This is undertaken by Partnerships and Planning Teams located in each region.

2.42 While most casework services are undertaken by the 80 CSCs located across the State, there are also a number of specialist services operating in the regions. Specialist services include:

a. JIRT

b. OOHC Specialist Teams (including carer recruitment and support)

c. Intensive Family Based Services (Aboriginal specific)

d. Adolescent support teams

e. Domestic violence teams.

2.43 There are 18 Partnerships and Planning Network areas. Directors Partnerships and Planning are responsible for managing and monitoring the DoCS funded services within the region. Teams comprise Children's Services Advisers and Community Program Officers.

2.44 Children's Services Advisers work within a regulatory framework to licence and monitor a range of early childhood services and are responsible for overseeing funding to community based children's services. Children's Services Advisers and Team Leaders will soon report centrally to the Children Services Directorate in Head Office.

2.45 Community Program Officers are responsible for making recommendations on the planning, development and purchasing of external services within the region and the ongoing monitoring and review of services. Community Program Officers are also responsible for the management of service delivery contracts and for the processing of complaints, appeals and prosecutions relating to these services.

Information systems

Key Information and Directory System

2.46 DoCS' current client database, the Key Information and Directory System (KiDS), was designed and approved in July 2002, before the DoCS Reform Package was developed. The system went live on 24 October 2003, replacing the 15 year old DoCS Client Information System.[10]

2.47 KiDS organises client information and records actions undertaken by DoCS staff in the areas of: early intervention; child protection; OOHC; adoptions; service providers (including authorised carers); and financials.

2.48 In order to understand the size and complexity of the data kept, as at 1 February 2008, KiDS held information on 1,484,043 persons. There were also:

a. 1,125,118 case plans

b. 5,202,801 records

c. 2,742,277 attachments (such as affidavits, scanned identity documents for the subject child or letters)

d. 846,595 addresses.

2.49 KiDS was designed to support the Care Act. It is based around reports, records and plans rather than DoCS clients.

2.50 DoCS Connect is a secure online system launched in December 2007 that allows certain external parties to have limited access to KiDS. Currently, this access is available to Brighter Futures Lead Agencies[11] and public schools

[10] DoCS, *Child protection quarterly data, April 2004 to June 2005*, p.1.

[11] DoCS, *Inside Out bimonthly newsletter*, January/February 2008.

participating in a trial of electronic reporting.[12] The DoCS Connect portal is accessed from the home page of the DoCS website.

2.51 Through DoCS Connect, registered users in Brighter Futures Lead Agencies are able to make referrals to DoCS, accept referrals from DoCS, record details relating to the people their organisations are case managing and make requests for services.

2.52 While KiDS is a considerable improvement on the previous client information system, DoCS has acknowledged that there have been a number of challenges to overcome since it went live in 2003:

a. KiDS was designed prior to the policy and practice changes that occurred as part of DoCS' reform process. While modifications have been made to KiDS over the last five years, a more thorough redesign is now required.

b. Data quality is poor, in large part due to the lack of mandatory fields.

c. Caseworkers find the system complex, not intuitive and difficult to navigate. There is limited guidance built into the current design of KiDS.

d. There is a culture of resistance to KiDS within DoCS as recording and documenting are not always seen as a critical component of good casework practice.

e. Case plan processes are problematic and require redesign to replace the current process which involves creating a new plan for each new report. The system often contains multiple open plans on the same person which can result in information about children and families being missed.

f. There is duplication in the system regarding person records. On average 500 duplicate person records are merged each month. This duplication makes it difficult to accurately search for individuals on the system and further exacerbates the multiple open plan problem.

g. The process for capturing and finding legal proceedings and orders is cumbersome.[13]

2.53 DoCS is currently building a support site within KiDS called 'iHelp' which will allow DoCS staff to access policies, procedures and advice on the use of KiDS without having to navigate in and out of different screens. To date, iHelp has been incorporated into the early intervention areas of KiDS.

2.54 The Inquiry was advised by DoCS that the core design of KiDS, coupled with inadequate training on the system has led to the perception by caseworkers that rather than being a tool to support casework practice, KiDS is a burden. The Inquiry understands that the resistance to KiDS is very strong in DoCS. One

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[12] ibid., May/June 2008.

[13] DoCS, *KiDS Core Design Update Project Business Case*, August 2007, p.6; Information provided to Government by DoCS, March 2008.

DoCS worker whose job is to support staff in using KiDS stated "the biggest part of our role is trying to change attitudes."[14]

2.55 To address the ongoing issue of poor data quality in the longer term, DoCS has commenced work on the Corporate Information Major Project. The project aims to achieve "a long term and sustainable improvement to the quality of KiDS information and reduce the current reliance on, and the overheads associated with data remediation activities."[15] DoCS has acknowledged that it would be simplistic to assume that improving KiDS would automatically result in improved data quality.[16]

2.56 DoCS has developed the KiDS Core Redesign Project which is designed to deliver:

a. an improved method of capturing contact information into KiDS from the Helpline and alerting caseworkers of new activity

b. functionality that will prevent the ongoing proliferation of multiple open plans

c. improved operational reports

d. an efficient search facility that will facilitate a quick and accurate location of records for a known individual

e. an improved user interface for KiDS, making increased use of intuitive and of context-sensitive help and workflow guides or tools

f. a facility to allow KiDS users to correct information that has been identified as incorrect or missing, from within the standard KiDS interface

g. increased automation of certain functions to satisfy current business rules, and to simplify the use of KiDS

h. increased validation rules within KiDS to enforce the capture of mandatory information at the appropriate point in the case development to reduce the need for data remediation

i. process maps for identified business functions.[17]

2.57 DoCS advised the Inquiry that since 2006, it had gathered a significant body of knowledge on the interplay between KIDS, policy and business practice and the user. This identified the need for clear policy on roles and responsibilities in relation to data entry, effective training and user support and an acceptance of

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[14] Transcript: Inquiry meeting with DoCS staff, 15 July 2008, p.22.

[15] DoCS, *CIP Steering Committee-project update*, 17 June 2008, p.1.

[16] ibid.

[17] DoCS, *KiDS Core Design Update Project Business Case*, August 2007, p.29.

the importance of KiDS. The proposed redesign of KiDS needs to be seen in the context of a broader reform of DoCS business processes and not solely as an information technology project. In this regard a redesigned KiDS could see defined business processes supporting the use of workflows within the system, facilitating its navigation and allowing caseworkers to concentrate on key information requirements.

2.58 The estimated cost of the KiDS redesign is $17.8 million over three years. DoCS' current information, communications and technology budget does not have funds to support the KiDS Core Redesign Project. Therefore additional funding is required before any major redesign of KiDS can proceed.

2.59 The Inquiry was advised that at the very least, DoCS has the in-house capability to fix defects at the lower end of the scale.

Corporate Information Warehouse

2.60 The Corporate Information Warehouse (CIW) is an integrated and aggregated source of information and data about DoCS core operations and performance that went live in December 2005. It provides online access to corporate and business reporting measures.

2.61 The CIW produces statistical information relating to child protection and OOHC for DoCS annual reports, reports to the Australian Institute of Health and Welfare (AIHW) and to its external partner agencies. The quarterly statistical reports published on the DoCS website are also sourced from the CIW.

2.62 The CIW has the capacity to provide accurate data on functional performance at departmental, regional and business unit level for managers and senior staff in the department. Such data on performance management is essential in order to measure improvements in practice and inform the allocation/reallocation of resources. In 2007/08 a number of corporate indicators (CIW Indicator Dashboards) have been released allowing management decisions to be informed by relevant data.[18]

2.63 The proposed redesign of KiDS will have implications for the CIW. DoCS has advised that this would involve a review of all CIW reports, review and modification to counting rules and redesign and/or modification to existing CIW reports.

Data analysis

2.64 Established in January 2004, DoCS' economic and statistical analysis function sits within the Service System Development Division and underpins DoCS' research and evaluation capacity. Using the CIW, DoCS has the capacity to undertake very detailed and complex statistical analyses on data recorded in

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[18] DoCS, *Annual Report 2007/08*, p.67.

KiDS. Such analyses can improve the Department's understanding of the child protection system and of the factors that contribute to future levels of demand.

2.65 DoCS analyses its data and produces reports which show usage trends in child protection, OOHC services, early intervention, and human resources. These are reported quarterly.

2.66 Data are also used to inform economic modelling and cost benefit analyses associated with new policies and in assessing the efficiency and effectiveness of services.

2.67 The information in the quarterly reports is extensive in so far as it records processes and includes the number of contacts, the number of reports by outcome of initial assessment, and reports by age, gender, Indigenous status, reporter group and primary reported issue. KiDS contains limited data about the types of services provided to children and young persons and families and their effectiveness, and no data about outcomes for children and families. The need for such data is addressed in Chapter 26.

2.68 DoCS has established a Benefit Estimation Database during 2007/08 which is designed to increase awareness of benefits associated with child welfare initiatives and allows economists, researchers and practitioners to identify the wide range of benefits associated with child protection and welfare initiatives and improved use of economic techniques to assess the monetary value of these benefits.[19]

2.69 The database contains summary analyses of international and national child protection and welfare literature containing benefit estimations.

2.70 DoCS has also developed economic models to underpin its major funding reforms in early intervention and OOHC. These models show what resources are required and where to fill gaps in services. A unit costing information service has also been developed. Costing models are used in costing existing and new services for the purposes of service planning and comparison.

DoCS Information Management and Technology Strategic Plan

2.71 DoCS advised the Inquiry that its Information Management and Technology Strategic Plan incorporates the KiDS redesign, refreshing Helpline technology, and various other management systems including the CIW and improving data quality. DoCS has costed it as $34 million. The Inquiry agrees that it is essential for this work to proceed.

[19] ibid.

Research function

DoCS Centre for Parenting and Research

2.72 The Centre for Parenting and Research which commenced in 2003, undertakes research to establish an evidence base to inform decisions about DoCS core businesses. It undertakes literature reviews, program evaluation and primary research. There are a range of internal research projects being undertaken by the centre, as well as external projects that are either being funded or supported by DoCS. Research activity reflects DoCS' four core business areas: prevention and early intervention, child protection, OOHC and community development and capacity building.[20] The research program is extensive and has included:

a. human services and parents with a disability: working cooperatively in the best interest of the child

b. early intervention strategies for children and young persons aged 8-14 years: literature review

c. effective early intervention strategies for children, young persons and families within Indigenous communities

d. parental alcohol misuse and the impact on children: a review of the literature

e. neglect risk factors: severity and chronicity

f. effective strategies and interventions for adolescents in the child protection context: literature review

g. domestic violence: strategies and interventions to support families

h. effective strategies and interventions to support children and young persons living with parents who have a mental health problem: a review of the literature

i. longitudinal study of wards leaving care: four to five years on.

2.73 The centre will soon commence a long term, large scale longitudinal study of children in OOHC.

2.74 An annual evaluation agenda has also been developed which sets out the projects and programs that DoCS will evaluate in the coming year to inform program improvements and results for clients.

Research to Practice

2.75 The Research to Practice Program aims to encourage the active use of research within the Department. Research to Practice Notes present the key

[20] DoCS, *Research Report, 2006/07.*

issues and findings of research reports developed by the Centre for Parenting and Research and other relevant individuals and organisations. Their purpose is to increase knowledge as well as informing staff of practice implications where relevant. Examples of Research to Practice Notes include:

a. Models of service delivery and interventions for children and young persons with high needs

b. Permanency planning and placement stability

c. Mental health of children in OOHC in NSW

d. Attachment: key issues

e. Making decisions about contact.

2.76 Staff are alerted to the availability of Research to Practice Notes via email and the notes are available electronically and in hard copy.

2.77 As part of the Research to Practice Program, the Centre for Parenting and Research coordinates a seminar series for staff with both local and international guest speakers. Examples of seminars held in 2007/08 include Engaging Fathers, Aboriginal Child Health and Welfare and Developmental Implications of Early Trauma. Seminar kits are distributed to CSCs for all staff to access.[21]

Research Network

2.78 A Research Network, made up of regional and Head Office staff, provides advice to the Centre for Parenting and Research in relation to shaping the research agenda and Research to Practice program. Network members also act as research advocates, promoting the availability and active use of research in the field.

Research Advisory Council

2.79 The Research Advisory Council was established in 2003 and comprises 10 academics in the areas of child welfare, paediatrics and child psychology relevant to DoCS. The council meets twice yearly to review DoCS' research agenda, review major research projects and advise on research grants. Members act as reviewers for research papers that are to be published in journals or as occasional papers. The council oversights a substantial volume of funded research carried out by academic institutions, post doctoral scholars and PhD students in areas specified by DoCS.[22]

[21] DoCS, *Annual Report 2007/08*, pp.68-69.

[22] Information provided to Government by DoCS, March 2008.

DoCS Collaborative Research Program

2.80 In addition to developing the capacity for in-house research through the Centre for Parenting and Research, DoCS has collaborated with external research institutions to support research that is relevant to DoCS' needs and help build a culture of research within DoCS and the sector more widely.

2006/09 research agenda

2.81 DoCS has developed a three year research agenda to answer the question: "what interventions and practice approaches lead to the desired results for clients of DoCS and in what contexts or circumstances?"[23]

2.82 For the July 2007 round of the Collaboration Research Program, DoCS' priority for research centred on issues focusing on child protection, that is:

a. How can DoCS better respond differentially to the range/spectrum of child protection reports received - which must be supported by an adequate service system, including NGOs and others?

b. What intervention strategies work to build resilience in those families whose children do not fit early intervention program parameters but who do not require a full statutory response?

c. Half of all reports DoCS receives relate to only 20 per cent of children, many of whom are Aboriginal. What intervention strategies would work with this group to reduce the high level of re-reporting of the same children and their siblings from the same families?[24]

2.83 DoCS also undertakes other occasional research. This includes the *Spotlight on Safety* report which is a study of community knowledge, attitudes and behaviours in relation to child protection and well-being.[25]

2.84 The Inquiry is of the view that the DoCS research strategy is sound, and that the production of Research to Practice Notes is an important way of providing evidence based procedures.

Complaints system

2.85 In 2004, DoCS established a Complaints Unit located in Head Office to improve the way in which the Department responds to client inquiries and complaints.

2.86 It has responsibilities for responding to complaints, tracking and analysing systemic trends, and monitoring complaint handling at the local level, as well as

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[23] DoCS, *Research Report 2006/07*, p.i.

[24] DoCS, *Collaborative Research Program*, June 2007, p.4.

[25] DoCS, *Spotlight on safety: community attitudes to child protection, foster care and parenting,* September 2006.

a responsibility for providing training, specialist advice and assistance to the regions and Head Office. As a result of its tracking and monitoring responsibilities, it has the capacity to identify emerging issues and advise on policy and practice development.

2.87 The Unit has a staff establishment of six positions, all of which are occupied. Previous proposals for an increase in staff numbers, and for the filling of specialist positions (for example, those of Foster Care Liaison Officers) have not been implemented.

2.88 Complaints can be received by regional offices, CSCs or operational units, by the Complaints Unit via the DoCS Complaints Line or via correspondence. The usual course is for DoCS staff to attempt local resolution, but if this is unsuccessful then typically a formal complaint will be made to the Complaints Unit.

2.89 Operational units, regional offices and CSCs are expected to keep a record of complaints that cannot be resolved in the course of day to day business, as well as written complaints, as part of a Local Complaints File. The Inquiry understands that there is no single data system that is capable of capturing and recording all of the complaints that are made, or their outcomes.

2.90 Guidance in dealing with complaints is provided in a draft 2007 document Policies and Procedures for Complaints Handling – Complaints Unit CAAR Branch. An additional set of procedures is available as a Casework Practice[26] document, Trial – Responding to Complaints, which was updated in September 2006, and prepared for the purpose of providing guidance for responding to complaints which are made directly to staff in operational units.

2.91 Other practice documents have been issued dealing with specific areas of complaint, for example, those concerned with privacy issues. The existence of multiple overlapping documents concerned with complaint management does not assist in an easy navigation of the system. Amalgamation and production of a single comprehensive practice guide would be advantageous.

2.92 Between 2004/05 and 2007/08, the number of complaints about DoCS increased by 44.0 per cent.

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[26] Casework Practice is published on the DoCS intranet and contains policies, procedures and resources for casework staff. It was launched in May 2008 and replaced the Business Help site.

Table 2.2 **Number of complaints received by DoCS, 2004/05 to 2007/08**

Year	*Total*
2004/05	1,494
2005/06	1,835
2006/07	2,324
2007/08	2,151

2.93 DoCS Complaints Unit receives and processes other forms of public contact with the Department, including inquiries as to entitlements, suggestions, compliments, and comments, which are not included in the above figures. Historically complaints represent at least two thirds of work done by the Unit.

External reviews of DoCS complaints system

2.94 This system has been the subject of three major reviews:

a. The Clarinda Review in 2006 concluded that gains could be achieved by co-locating the bulk of the Complaint Unit's functions within the Helpline, a change that would see three grade 7/8 positions move to the Helpline and two managers remain at the Head Office to manage investigations, walk-ins and governance functions.

b. The Gerrand Review in 2007 analysed current practices and conducted a process mapping exercise to streamline complaints handling using the Helpline infrastructure, which resulted in the preparation of a new complaints process mapping document. It questioned the entrenched culture within the Complaints Unit that saw its role as one that should involve a critical review of the actions and policies of the Department, with the corollary of regarding itself as the key to departmental success.

c. The SINC Solutions Review, between November 2006 and October 2007, reviewed a random sample of complaints and came up with similar conclusions and recommendations to those of the earlier reviews, involving the adoption of a triage approach that would be facilitated by co-location at the Helpline.

2.95 The SINC Report identified shortcomings in the handling of complaints by the Complaints Unit in relation to the timelines, prioritisation, local resolution referral, record keeping and effective handling of serious issues. It made recommendations to review manuals, train staff, implement the changes recommended in earlier reviews and improve record keeping.

2.96 As a consequence of these Reviews the former Director-General of DoCS, on 20 January 2008, approved the relocation of the bulk of the Complaints Unit functions to the Helpline, together with a revision of the complaints handling system. This has been opposed by the PSA and as a consequence the Director-General's decision has not yet been implemented.

Issues arising

KiDS redesign

2.97 In submissions from DoCS, former and current DoCS employees, and in meetings with the PSA and with DoCS staff across the State, the Inquiry was advised of a range of problems stemming from the use of KiDS. The four major areas of concern can be summarised as follows:

a. KiDS is not user friendly and is difficult to navigate

b. it is difficult to carry out comprehensive child protection history checks on KiDS

c. KiDS is not a tool that supports reflective casework practice

d. caseworkers are required to spend too much time completing tasks on KiDS which restricts the amount of time they can spend on field work.

2.98 As well as being identified as a problem by DoCS staff and the PSA, the Ombudsman also expressed concerns about the difficulties DoCS staff encounter when conducting history checks. Reviews undertaken by the Ombudsman have consistently identified cases where there have been incomplete or inaccurate history checks undertaken, which in turn impacts directly on the quality of judgements made by caseworkers. The Ombudsman reported that:

> *Under the current KiDS system, for a user to apprise themselves of a family's child protection history, they may need to spend hours navigating their way through numerous data fields.*[27]

2.99 A DoCS staff member made a similar point:

> *As far as looking up the history, it's just very time consuming. It's very hard. It's easy to miss the history. You need to go to each screen on each report and have a look at it: each record, each child. It's just very time consuming to do that.*[28]

2.100 If the KiDS Core Redesign Project, discussed earlier, achieves all of its aims, it will go a long way to addressing the major concerns about KiDS raised with the Inquiry. Its value would lie in facilitating quicker and better informed decision making and in potentially improving job satisfaction. Further, it is preferable to the more drastic and disruptive option of scrapping the system and starting all over again. This would involve a massive effort in preserving existing data that may be relevant for future care and protection work.

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[27] Submission: NSW Ombudsman, Assessment and Early Intervention, p.12.

[28] Transcript: Inquiry meeting with CSC staff in Western Region, p.6.

2.101 The Inquiry accordingly supports the proposed changes to KiDS that aim to effect a more user friendly system in which critical information concerning children and families is recorded. A significant change management process will be required to ensure that the new system is embedded as part of casework practice. As such the design will need to integrate processes that caseworkers and their managers follow when managing a case. It will need to be intuitive and be supported by ongoing training and development.

2.102 The Inquiry, as noted in Chapter 9 in this report, recommends a move to one electronic recording system, rather than the current paper file and KiDS records.

2.103 The Inquiry supports a related recommendation made in a recent review of DoCS' existing business processes by the Department of Premier and Cabinet (Premier and Cabinet), that the mapping and documenting of statutory child protection business processes occur. This should enable any duplication and waste to be identified and rectified and should occur as part of the KiDS redesign and prior to its completion.

New technologies

2.104 It was also suggested to the Inquiry that DoCS and other agencies could make better use of emerging information and communication technologies. For example, DoCS workers could use voice activated systems to record notes soon after a home visit which would then become part of the KiDS record.

2.105 Emerging technologies could also assist with case management functions and facilitating linkages between agencies, for example, interagency case conferences, case consultation and planning, transmission of images and data, feedback on assessments, and video link meetings.

2.106 These technologies would be of particular assistance in remote and rural locations as a means of reducing travel times, exchanging information, bringing professionals together to discuss cases and supporting supervision and training.

2.107 Health has made some advances in this area[29] and it may be possible at the interagency level for DoCS to 'piggy back' on the availability of these resources.

Data quality and availability

2.108 Quality and timely data underpins evidence based research, policy and practice. The Inquiry has relied extensively on data supplied by DoCS to undertake its analysis and inform its opinion. Without access to the data reports, research papers and literature reviews the time it would have taken the Inquiry to conduct its work would have been significantly lengthened.

[29] For example, broadband projects to enable clinical outreach projects, videoconferencing for mental health, electronic medical record and picture archiving, see also www.health.nsw.gov.au.

2.109 The Inquiry also notes that it is intended that access to the CIW data be expanded to include a broader group within DoCS. The Inquiry suggests that it would be appropriate to accelerate this expansion as such data can only better inform the work done in the field.

2.110 Researchers and academics consistently state that Australia urgently needs to develop a research base for policy and practice in relation to prevention, early intervention, child protection, OOHC and child and family welfare in order to inform practice.[30] They say that there are a number of important topics that have not been addressed, as well as insufficient and inadequate research and evaluation.[31]

2.111 The establishment of economics, statistics and research function within DoCS is a significant step in this regard. Most of the research and evaluation information is available in a timely way on both the DoCS intranet and on the DoCS website. This represents a significant contribution to the development and dissemination of information and knowledge in this area. It is also important for accountability purposes.

2.112 The Inquiry supports the continued building of the research and analysis capability in DoCS in order to assist in making informed decisions and evidence based improvements to policy, programs and service delivery.

2.113 The Inquiry acknowledges the links DoCS has built with the academic community and further encourages DoCS to build research and evaluation collaborations with its interagency counterparts in order to build momentum and foster exchange.

2.114 Tomision has suggested that a key question for the child protection field is: "how can an evidence based approach be cultivated to better inform practice?"[32] Tomison states that in order for agencies to make the most of research opportunities and to develop evidence based practice, agencies must develop a research culture where research is valued and encouraged across the organisation, staff are trained in the process of evidence based practice and the most is made of information that is currently collected.[33]

2.115 The Inquiry suggests that supporting and expanding the research and evaluation function in DoCS could be developed as a performance indicator to track the extent to which DoCS is developing an evidence based research culture.

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[30] J Cashmore, D Higgins, L Bromfield, and D Scott, "Recent Australian Child Protection and Out-of-Home Care Research, What's been Done and What Needs to be Done?" *Children Australia*, *Vol 31, No.2,* 2006, pp.4-11.

[31] ibid.' "Evaluating Child Abuse Prevention Programs," Resource Sheet, No.5, December 2004, *National Child Protection Clearinghouse*, *Australian Institute of Family Studies*, p.4.

[32] A M Tomison, "Evidence-based practice in child protection: What do we know and how do we better inform practice," Keynote presentation, Association of Children's Welfare Agencies Biennial Conference, undated, p.2.

[33] ibid., pp.7-8.

2.116 The Inquiry is also supportive of a national research agenda which would:

> *…provide a systemic framework to ensure that there is a quality evidence base to inform policy and practice. It would provide guidance to researchers and research funders regarding relative priorities. Routine monitoring and revision of such an agenda would enable accurate assessments of progress and provide professionals within the sector an avenue to ensure that policy and practice needs for evidence are being heard and addressed.*[34]

2.117 The Australian Institute of Family Studies (AIFS) Issues Paper *Developing a road map for research: Identifying the priorities for a national child protection research agenda* noted:

a. For child abuse prevention and child protection there is a need for a draft national research agenda to be developed in consultation with government and non-government sectors and informed by the systematic review of the existing evidence base and identified research priorities both nationally and internationally.

b. For OOHC there is a need to routinely (for example, biennially) update systematic literature reviews of the evidence base, monitor and publish the progress of the research groups established following the OOHC research agenda planning forum, and establish mechanisms for new members to become involved.

c. In order to track the progress of a national research agenda and inform updates to the agenda, audits need to become 'live' accessible databases. There is also a need to ensure there is a national repository of Australian child abuse prevention, child protection and OOHC research. Research agendas need to be consolidated to ensure that there are not gaps at critical transition points. Further, there is a need to review and incorporate research agendas developed by state and territory child protection departments which also commission and conduct research. Finally, any national research agenda itself needs to be accessible, and to be monitored and routinely updated.[35]

2.118 The Inquiry agrees.

The location and role of the Complaints Unit

2.119 The Inquiry was informed that the Complaints Unit is understaffed and in a state of flux. This is attributable to the unresolved issue concerning the move of the bulk of the unit's functions to the Helpline and to the fact that, while a

[34] L Bromfield and F Arney, "Developing a road map for research: Identifying the priorities for a national child protection research agenda, Child Abuse Prevention Issues," *National Child Protection Clearinghouse, Australian Institute of Family Studies, No. 28*, February 2008, p.13.

[35] ibid.

complaints operating framework was prepared and signed off, it has not been implemented in the field.

2.120 The PSA in its submission to the Inquiry has confirmed its opposition to the transfer of any part of the unit's functions to the Helpline. It has also drawn attention to the fact that the unit has continued to be understaffed, with the result that there are delays in speaking to complainants, and an inability to conduct staff training in the field.

2.121 The following arguments were advanced by the PSA against locating functions of the Complaints Unit at the Helpline:

a. there is a lack of experience and knowledge among Helpline staff

b. as a front end operational unit, Helpline staff, including CSC staff who provide back up support to the Helpline at times of high demand, may themselves become the subject of complaints, with a consequent risk of a conflict of interest arising

c. foster carers and clients may view centralisation as a devaluation of the Department's commitment to complaint handling

d. the Helpline is situated at an unadvertised location and is unsuitable for face to face meetings with complainants

e. the potential increase in the staff responding to complaints would threaten the consistency of response, and generate a lack of confidence in the system on the part of foster carers

f. it would involve a shift in the nature of the call centre approach, involving intake without evaluation, to a more complex response, requiring training, that might also influence overall performance targets

g. there would be additional costs in extending the software licence to accommodate new operators as well as in the set up costs involved in a transfer to the Helpline location

h. frequent callers would lose their direct contact with Complaints Unit staff, who would otherwise have been familiar with the issues raised

i. the confidentiality requirements would restrict access by Helpline staff to the complaints database, denying them the capacity to screen out matters already dealt with

j. the need to respond to complaints might divert Helpline staff from higher priority work, or alternatively result in a lower level of priority being given to complainants

k. the level of detail that could be recorded on the database could, on the one hand, lead to a widening of access to confidential issues, or, on the other hand, result in complaints that could have been closed on receipt being transferred to the Complaints Unit and closed there with an increase in complainant frustration.

2.122 The Inquiry is of the view that these issues can be satisfactorily addressed by a change that would transfer portions of the unit's functions to the Helpline and preserve a complaints management function at Head Office.

2.123 Locating complaints officer positions (DoCS suggests three such positions) within the Helpline, with responsibility for triage and allocation of responsibility for management, followed by referral to a Central Complaints Unit or to an operational unit (depending on complexity or seriousness) would fit well within a call centre function which has experience in caller management. This would have the advantage also of diverting the one third of the matters currently received which do not constitute a complaint, to the Community Service Operator at the Helpline. The deployment of specialist complaints officers at the Helpline to respond to complaints would seem to answer the majority of the objections to the proposal.

2.124 Such a reform would preserve the capacity of those located at the Central Complaints Unit to deal with complex and serious complaints and with 'walk-ins' who can be violent or vexatious. It would also provide the Unit with the capacity to provide support and training for complaint management at operational unit level, to identify significant practice issues, to assist in the development of policy in relation to complaint handling, and to report to and liaise with senior management as required, for example, where a complaint may require referral to a higher authority for resolution.

2.125 It is recognised that there would need to be suitable safeguards adopted to ensure the confidentiality of the complaints databases, and some extension or modification of the software system, to allow its use at the Helpline, as well as at the Central Complaints Unit. While some extra cost would be entailed there would not seem to be any insurmountable difficulty in this respect.

2.126 The Inquiry was informed that, because of the limited size of the current Complaints Unit and lack of training or expertise in complaints handling at the regional or CSC level, many complaints were either not addressed or addressed inadequately. This should be capable of being addressed if the Central Complaints Unit at Head Office is tasked with providing training to caseworkers and with acting as a point of reference for advice or support where that is needed by an operational unit.

2.127 Of particular concern has been the volume of complaints in relation to foster carer issues, much of which relates to allowances and expenses. The importance of this was recognised by DoCS in 2005, when consideration was given to the creation of specialised Foster Care Complaint Liaison Officer positions, an initiative that has not, however, been carried into effect.

2.128 In Chapter 16 the Inquiry notes the establishment of Carer Support teams, which could incorporate the function that was to be allocated to the Foster Care Complaint Liaison Officers. The prompt and equitable resolution of concerns on the part of carers, in relation to issues surrounding the payment of allowances and contingencies, or contact difficulties, is fundamental to the preservation of

the goodwill between DoCS and its carers, and recognition of their value to DoCS.

2.129 Also of concern has been the delay in resolving complaints. The SINC Report noted that for 50 per cent of the complaints received by the Complaints Unit, the time taken for resolution was unreasonable. Submissions received by carers and observations made by carers at the Inquiry's Public Forums confirmed the need for concern in this respect.

2.130 The model proposed by DoCS would provide for:

a. 90 per cent of all complaints to be triaged on receipt, prioritised according to complexity or seriousness, and allocated for a response

b. the retention of specialist case officers in the Central Complaints Unit who would be available to focus on the complaints that raise significant policy or procedural issues

c. referral of the remainder of the complaints for local resolution

d. the achievement of a more timely disposal of complaints, so long as it was accompanied by the provision of suitable training for staff at the local level, the development of clear policy guidelines, and the establishment of time standards for the resolution of these matters that are referred out for management by CSCs or other Operational Units.

2.131 One benefit to DoCS arising from the establishment of an improved complaints management structure would be a reduction in the number of complaints that escalate to the point where they attract the attention of the Minister or the Ombudsman, and require DoCS staff to process and respond to inquiries in relation to those matters.

2.132 Perhaps more significantly, a structure that can provide a more timely response should have the additional benefit of improving relationships between DoCS and its carers and clients. The Inquiry agrees with the proposed model.

Location and role of the Allegations Against Employees Unit

2.133 Currently allegations against employees are investigated, for the most part, at CSC or operational unit level, subject to reporting back to the Allegations Against Employees Unit, although more serious allegations remain with that unit. In Chapter 23 we give consideration to whether there should be a restructure to centralise the investigation function in relation to allegations of this kind.

Structure and function of DoCS Head Office

2.134 The Inquiry reviewed the existing structure and functions as detailed in DoCS Head Office organisational structure and makes the following observations.

Policy and planning

2.135 Presently, the Strategic Policy Unit and the Major Projects and Planning Unit sit within the Strategy, Communication and Governance Division. Functions within these units include the oversight and management of Commonwealth/State relations, coordination of DoCS input to, and monitoring the impact of, a range of state whole of government and human services policy projects as well as management of internal major projects that require a high level of project management.

2.136 The Service System Development Division has responsibility for child and welfare policy, service funding, economics, statistics, research and performance of the service system. The division also has responsibility for working with other state and Commonwealth government agencies in the development of policies.

2.137 The strategic policy and planning functions currently located in the Strategy, Communication and Governance Division, appear to more closely align with the functions within the Service System Development Division.

Funding and service planning

2.138 The Communities Division role is to work across both government and non-government sectors to develop coordinated, strategic approaches to issues facing young persons, children and families and to implement local community programs to deal with these issues. These programs include youth initiatives, services for women experiencing family and domestic violence, parenting and family support services and Families NSW.

2.139 The Inquiry believes this is a critical function within DoCS, given the significant amount of funding DoCS provides to other agencies and the need to ensure that services are integrated. There is, however, in the Inquiry's view, room to improve planning, design and funding of the service system currently shared between the Communities Division and Service System Development Division. The Inquiry heard from many agencies that there was a need to develop a more integrated service planning framework and move away from discrete program funding streams to an outcomes based model. These matters are addressed in Chapters 7 and 25.

2.140 The Service System Development Division is presently implementing significant funding reforms, which are supported by the Inquiry. Similar processes should equally apply for services funded by Communities Division. It would seem that this should occur in one area within DoCS.

2.141 There could be improved efficiencies by examining the role of the DoCS Partnerships and Planning teams at the regional level and those of the regional positions within Communities Divisions and considering whether these roles could be better aligned to ensure a more effective integrated planning mechanism at the regional level.

Corporate support services

2.142 At the commencement of the DoCS Reform Package it was proposed that all transaction level functions for corporate services be placed with the shared service supplier, NSW Businesslink and that DoCS would only retain strategic functions and those expertise functions directly involved with core business.

2.143 While this has largely been achieved, there were some aspects of these functions that were retained in DoCS as it assessed that Businesslink did not have the capacity to deliver them at the scale or speed required for DoCS reforms. The retained capacity is currently a mix of expertise and transactional skills. Given that the reform has neared completion and Businesslink is considered by DoCS as a sound provider of corporate services,[36] the Inquiry is of the view that transition to Businesslink would now be timely.

2.144 As there are still significant issues associated with DoCS information technology systems there is some opportunity to examine that which is best provided by Businesslink and that which is necessary to be retained within DoCS. There appears to be a significant cost to DoCS in employing contractors to undertake some of these functions which may be more cost effective through Businesslink.

2.145 There appear to be two divisions (Service System Development and Corporate Services) whose focus is on data collection, management, maintenance and quality. Within Service System Development there are also a range of positions located within regions reporting centrally whose main role is to undertake data remediation and assist casework staff. Within Corporate Services, there is a small unit called the KiDS support team which also provides a statewide support service to field staff. It would again appear that these functions could be integrated within one division. Logically that would appear to be Corporate Services, as it also has a training function.

Quality assurance

2.146 The Inquiry considers that there would be benefit in developing an integrated framework for all quality assurance functions within DoCS. Presently different aspects of quality assurance are either in development or undertaken in different ways by different divisions (Strategy, Communication and Governance, Operations and Service System Development).

2.147 The Inquiry is of the view that key components of an effective quality assurance system include having clear service standards, monitoring mechanisms, evaluations, feedback from service users, complaints mechanisms and routine internal evaluative approaches.

2.148 DoCS has and will need to continue to change its policies and practices as the evidence base grows about what works and does not work. While DoCS

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[36] Information provided to Government by DoCS, March 2008.

presently has a small implementation unit to assist in coordinating and assessing the operational impacts of its reform agenda and any associated staff learning needs, this should be incorporated into a broader quality assurance framework.

2.149 The Inquiry is of the view that there appears to be a need for further focus on change management and understanding barriers to effective implementation in the field. This needs to be undertaken in a systematic manner and feedback provided on performance to regions.

Consideration of a restructure

2.150 The Inquiry has, in the preceding paragraphs noted some provisional views and comments in relation to the Head Office structure. So far as these involve corporate management issues, it lacks the expertise for the informed conclusions that would be required before any recommendations could be offered. However, the Inquiry is of the view that careful consideration should be given to the need for any restructure of the management of the agency along the lines mentioned that would facilitate the reforms that arise out of this report.

Industrial climate

2.151 Both the PSA and DoCS advised the Inquiry that the industrial relations climate has changed over recent times.

2.152 There have been no formal disputes or organisational matters listed in the Industrial Relations Commission since the introduction of the Reform Package in 2002, however the PSA has issued industrial bans or directions to its members on ten occasions. The most significant of those, in terms of their effects on the child protection system, relate to the CSC audits program which is, the improvement plan devised following the death of a child in 2006.

Audits of CSCs

2.153 As part of DoCS' professional development and quality assurance program, DoCS determined to conduct a limited trial of quality review tools in a CSC over a period of about six weeks, requiring approximately 5–7 hours of staff members' time, with the intention of ultimately conducting audits in every CSC over the next few years.

2.154 PSA delegates have issued instructions to members not to participate in the program, and in particular, have blocked a trial of quality review tools. This instruction has effectively halted the audit.

2.155 The Inquiry understands that DoCS has informed staff that they are free not to participate, and the trial would not be used to target the practices of individual staff.

2.156 The PSA assert that the audit methodology is fundamentally flawed due to CSCs being under staffed and staff being unable to comply with many DoCS directions on a daily basis: "They have no choice but to take short cuts when making important casework decisions."[37]

2.157 The PSA contends that "DoCS is not staffed or funded adequately to complete basic casework let alone best practice"[38] and that many DoCS policies and procedures and Casework Practice topics lack consistency with the DoCS internal systems and with relevant legislation. It is concerned that due to volume and difficulties accessing up to date information, DoCS staff are not always aware of changes to policies, procedures, guidelines and protocols.

2.158 The PSA believes that the time DoCS has suggested needed by Caseworkers, Managers Casework and Managers Client Services to complete the work associated with this program is underestimated. It believes that if DoCS takes frontline staff off line to complete the work it may leave children and families unattended and at serious risk.

2.159 The PSA is also concerned that "any such CSC review may reveal the vulnerability of staff working in such an unsupported and crisis driven environment" and has noted that PSA members have expressed concern that "information gained through the review will be used for disciplinary purposes."[39]

2.160 Following a number of meetings, the Inquiry understands that DoCS has agreed to change its proposed audit program. Instead of conducting audits or file reviews, it has agreed to undertake case practice reviews facilitated by Casework Specialists during the usual Thursday morning Practice Solutions sessions.

2.161 The Inquiry is most troubled by this concession made by DoCS. As will be seen in subsequent chapters, particularly in Chapters 9 and 16, there continues to be significant criticism of DoCS casework practices and its relationships with carers, non-government organisations and others. An audit of the kind originally intended would have been a critical first step in improving these practices. What has now been agreed to is little more than the usual supervision.

2.162 While the Inquiry acknowledges the PSA's legitimate concern that aspects of the work carried out by its members may be cast in a critical light following the audit for reasons associated with resources and management, it is firmly of the view that the audits are essential to identify and understand the deficiencies in casework practice and management. Once they are defined, further work can be done to unravel the reasons for, such deficiencies and to remove any residual problems.

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[37] Correspondence: PSA, Letter to Inquiry in response to questions raised at meeting of 19 May 2008.
[38] ibid.
[39] ibid.

2.163 The Ombudsman holds a similar view. Since 2004, his reports of reviewable deaths have identified the need for DoCS to include in its practice improvement strategies a systemic performance audit of each CSC to identify the degree to which practices were improving over time. In his 2006 report the Ombudsman states that the "proposed quality reviews of CSCs are a significant undertaking in relation to enhancing child protection responses within DoCS.[40]

2.164 It may be that the PSA can be given the opportunity to provide an addendum to any audit which is conducted by which it seeks to indicate reasons for any identified shortcomings and is provided with an assurance that the purpose of the audit process is to improve service and not to investigate staff for disciplinary purposes.

2.165 Similarly, and more locally, DoCS developed a plan to improve practices arising from a review following the death of a child in May 2006. The Inquiry understands that the implementation of that plan, which has a component concerning the review of cases dealt with by the two relevant CSCs, has not occurred because of industrial action by the PSA.

2.166 The Inquiry is of the view that DoCS should move quickly to complete the audits, and that the resistance of the PSA is out of step with the general acceptance in contemporary commercial and governmental operations of the need for an audit process.

Consultative processes

2.167 DoCS has formal consultative mechanisms with the PSA including a bi-monthly State Consultative Committee, Regional Joint Consultative Committees, fortnightly meetings at officer level and ad hoc meetings on request.

2.168 The major reforms in DoCS have led to many operational policy and process documents being referred to the PSA for comment. DoCS informs the Inquiry that these comments have been constructive, although the process of consultation has often been extremely detailed and protracted.

2.169 In its submission to the Inquiry, DoCS noted that in the second half of 2007, PSA delegates became increasingly concerned about the rate of change and the impact of rising workloads on their members, and as a result, various bans were instituted, including those relating to file remediation where audits had found errors or omissions, or where carer checks had not been completed.

2.170 In order to address this situation an industrial relations consultant was engaged to advise on a way forward. A meeting was held on 18 February 2008 where the following was agreed:

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[40] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.91.

a. The PSA Industrial Officer would address the process for instructions to members to be authorised by a PSA official, and not just by delegates.

b. DoCS would develop a proposal regarding the types of policies and procedures that do and do not require consultation, and the level and process of consultation required, as the basis for discussion on joint development of a framework for consultation with the PSA.

c. DoCS would adopt the practice of preparing and sending to the PSA a list of policies to be developed and indicate the level of consultation they might require (in line with the framework referred to above) so the PSA can anticipate how to coordinate comments from delegates.

d. In cases where DoCS believed it had made a reasonable proposal and taken appropriate consultation steps but had failed to reach agreement with the delegates, DoCS would write formally to the PSA to give one or two weeks notice of intention to implement.

2.171 In line with these agreements DoCS sent letters to the PSA about a number of key issues on which agreement had not been reached with the delegates and also forwarded a proposed consultation framework for discussion.

2.172 This seems a sensible approach. The Inquiry observes that PSA support for the implementation of this Report and its constructive involvement in the process is critical.

Recommendations

Recommendation 2.1

The KiDS Core Redesign Project should be funded and implemented.

Recommendation 2.2

DoCS Information Management and Technology Strategic Plan should be funded and implemented.

Recommendation 2.3

The trial of the quality review tools should proceed immediately and the approved tools should be then applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.

Recommendation 2.4

The decision consequent upon the SINC Report to relocate the bulk of the Complaints Unit functions to the Helpline and to revise the complaints handling system, should be implemented.

Recommendation 2.5

Carer Support teams should be responsible for liaising with DoCS foster carers and kinship/relative carers in relation to their complaints and to ensure they have the assistance they require.

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DoCS workforce

3.1 There are many factors that impact on the capacity of a workforce to conduct its business, such as funding levels, the number and distribution of positions, demand and caseloads, as well as internal organisational factors such as occupational health and safety, leave, business and administrative processes and systems. This chapter focuses on recruitment processes, staff turnover, retention and professional development and supervision.

Staffing

3.2 DoCS 2002 Reform Package provided an additional $186.2 million from 2003/04 to 2007/08 to increase the frontline support capacity in DoCS. Overall there was an increase of 45.6 per cent in the numbers of DoCS staff between 2001/02 (2,683 staff) and 2006/07 (3,907 staff).[41]

3.3 As part of the Reform Package DoCS established the Enhanced Service Delivery (ESD) project which aimed to improve resources, policies, procedures and systems in each CSC. The implementation of the ESD project in CSCs has involved the creation of extra caseworker positions, the establishment of specialist early intervention casework teams/positions, recruitment and training of new staff, reconfiguration of teams within CSCs, improved support systems and new or refurbished accommodation. As at February 2008, 76 ESD sites were completed.[42]

3.4 As part of the Reform Package, an additional 875 caseworkers were to be recruited over five years from 2003/04 to 2007/08. The 875 new caseworker positions comprise 375 child protection caseworkers, 350 early intervention caseworkers and 150 OOHC caseworkers. By 2005, DoCS determined that the initial allocation of 150 caseworkers for OOHC was insufficient to meet the caseworker-client ratio of 1:16-18 for general foster care case management and 1:5 for high needs children case management. As a result, DoCS funded an additional 150 OOHC caseworker positions from its OOHC budget.

3.5 To determine where all new positions were to be allocated, in early 2004, DoCS developed a resource allocation methodology. Specific factors examined under this model are the number of child protection reports referred to each CSC, the age of the children and young persons who are the subject of the reports and the number of children and young persons in OOHC allocated to each CSC. Regional and rural CSCs receive an extra allocation to compensate for longer travelling times involved in undertaking casework duties.

3.6 The resource allocation methodology is updated annually as new data become available. DoCS has determined that it is best to adjust the allocation of

[41] Figures are for end of year non casual only and include permanent and temporary employees, executive staff and cadets. Figures are rounded.

[42] DoCS, *Result and Services Plan 2008/09.*

caseworkers where there are changes of more than 20 per cent in the number of referred reports and children and young persons in OOHC.[43]

3.7 At May 2008, the total number of funded caseworkers positions including the additional 1,025 was 2,146.

3.8 The Reform Package also included funding for additional supervisory positions[44] (to enable a supervisor to caseworker ratio of 1:6). In June 2003, there were 211 funded Manager Casework positions, which, by June 2008, had risen to 437. Additional administrative support (to a ratio of 1:6) was provided so that by 13 January 2008, there were 453 clerical supports positions (115 new positions) in CSCs.

3.9 At the commencement of the Reform Package, DoCS needed to recruit an estimated 1,225 caseworkers, of which, 1,025 were new positions.

3.10 As at 30 June 2008, DoCS had recruited all but 59 of the 1,025 new caseworkers. By the end of December 2008, DoCS expects to have achieved its recruitment targets and have normal vacancy rates of approximately seven per cent per annum.

3.11 The following list illustrates the impact of the 2002 Reform Package on casework staffing numbers between 2001/02 and the end of 2006/07, bearing in mind that staff numbers have increased further since 30 June 2007:

a. in early intervention the numbers of caseworkers and managers increased from nil to 207

b. in child protection the number of caseworkers and managers rose from 825 to 1,308

c. in JIRT the number of caseworkers and managers rose from 37 to 58

d. in OOHC the number of caseworkers and managers increased from 203 to 395 (general OOHC, intensive support and carer support)

e. the number of specialist positions increased from 65 to 156 (Aboriginal, multicultural, casework, domestic violence).

3.12 DoCS currently has 77 Casework Specialists who provide clinical support and targeted professional development to CSC casework staff and their managers. In 2007, these positions were revised and upgraded[45] and recruitment to the new positions was undertaken in late 2007. Casework Specialists are based in CSCs and mentor and coach caseworkers and their managers, undertake case practice reviews and are available to discuss more complex cases.

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[43] DoCS, *Caseworker Allocation Methodology,* November 2007.

[44] Managers Casework, Manager Client Services, Director Child and Family.

[45] Previously a Grade 7, recruitment has recently been completed for these positions and they are now Grade 9, same level as Manager Casework.

Selection and recruitment process

Processing applications

3.13 Since 2003, changes to the recruitment process have been progressively implemented to allow DoCS to process larger numbers of applications. Changes have included increased advertising through the print and electronic media, the introduction of an online application process and a graduate recruitment strategy targeting final year university students that included a strengthened student placement program.

3.14 Businesslink is the shared corporate services provider to DoCS, Housing NSW (Housing) and the Department of Ageing, Disability and Home Care (DADHC). Businesslink has had responsibility for processing all caseworker applications throughout the DoCS budget reform process.

3.15 In March 2006, DoCS established Assessment Centres for the bulk recruitment of caseworkers. Like the conventional selection panel, DoCS staff participate in Assessment Centre recruitment processes. The methodology is standardised and it provides an integrated eligibility list that allows applicants to be considered for positions across the State. DoCS states that the Assessment Centre methodology provides "accuracy in forecasting job performance, consistency of selection standards and a high level of transparency and fairness."[46]

3.16 Businesslink reviews all applications and short lists those applicants that meet the selection criteria.

The Assessment Centre process

3.17 The Assessment Centre methodology was designed by a firm of organisational psychologists. As a result of qualitative and quantitative research involving DoCS caseworkers and managers, the core caseworker skills were identified.

3.18 Applicants who attend an Assessment Centre undergo a four hour structured assessment process. Specifically, they undertake five activities: a written exercise; a group task; a role play; an interview; and a detailed verbal reasoning test. These activities are observed and considered by a number of assessors who rate each applicant's performance.

3.19 Assessment Centres are located in various metropolitan and regional centres, are operated and managed by Businesslink and are run on a continuous basis according to demand. In addition to the Businesslink officers, eight DoCS assessors and one independent organisational psychologist staff each Assessment Centre. All DoCS assessors are graded at Senior Caseworker,

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[46] Submission: DoCS, Caseworker Recruitment, p.4.

Manager Casework or above and receive specialised assessor training. DoCS has promoted the role of assessor as a professional development opportunity in staff newsletters.

3.20 Recommended candidates are advised that, subject to the outcome of pre-employment screening, their names will be placed on the statewide caseworker eligibility list. Successful candidates are offered appointment to vacancies in their preferred locations as they arise and in order of merit. If there are no current vacancies at their preferred locations, candidates are offered alternative positions in other locations where appropriate.

3.21 Of the 2,308 applications received during 2006/07, 1,172 applicants were invited to attend an Assessment Centre (1,171 of whom attended). Of these applicants, 678 were recommended for appointment and 520 were appointed. DoCS and Businesslink increased the number of Assessment Centre sessions during 2007/08 to cater for a larger number of applicants.

3.22 In 2007/08, DoCS received more than 6,000 applications for caseworker positions, an increase of over 270 per cent from 2006/07.

3.23 For the period 1 July 2007 to 31 March 2008, a total of 6,181 caseworker applications were received. As at 24 June 2008, 2,020 of these applicants progressed to the Assessment Centre stage and of 1,736 who attended an Assessment Centre session, 914 had been recommended for appointment.[47] The total number of permanent appointments for 2007/08 was 644.[48]

3.24 Managers Casework are also recruited through the Assessment Centre process. In 2006/07, DoCS received 214 applications for Manager Casework positions. A total of 57 candidates accepted offers of permanent appointment. For the period 1 July 2007 to 31 March 2008, a total of 294 Manager Casework applications were received. Of these, 152 candidates attended an Assessment Centre session of which 68 were recommended for appointment and placed on the eligibility list. A total of 17 candidates accepted offers for permanent appointment. The other successful candidates on the eligibility list will be considered for permanent appointments as they arise, and for filling short and long term acting arrangements.

3.25 DoCS does not collect data on either the number of applicants who decline positions or the reasons given for turning down an offer of employment. However, in December 2007, DoCS conducted a review of 32 candidates from metropolitan Sydney who did not take up an offer of employment as a caseworker with DoCS. The following reasons were given for declining the offer of employment:

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[47] Not all applications received by 31 March 2008 would have been finalised by 24 June 2008.

[48] DoCS, *Annual Report 2007/08*, p.65.

a. eleven declined the offer because the available position was not in their preferred location

b. seven had obtained other employment

c. six declined the offer because they were seeking only part time work

d. five were unavailable at the time of offer

e. three could not be contacted.

Timeframes

3.26 The selection and recruitment process for caseworkers involves a number of steps, all of which take varying amounts of time to complete. They include conducting referee checks and undertaking pre-employment screening of successful candidates.

3.27 In 2006/07, the average time taken from the receipt of an application to a verbal offer being made to a successful candidate was 146 days. In the three month period from January to March 2008, the average time taken from the receipt of an application to a verbal offer being made to a successful candidate had been reduced to 82 days.

Strategies to recruit caseworkers

3.28 Since 2006/07, DoCS has implemented an advertising campaign to recruit caseworkers. Advertisements appear in a wide range of local, statewide and interstate print media as well as online media. All advertisements direct applicants to the DoCS website for further information.

3.29 In addition to general advertising, DoCS also specifically tailors advertisements to attract caseworkers from different demographic groups, such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, older people, or final year university students. In 2007, DoCS also commenced an advertising campaign targeting caseworker positions for difficult to fill locations, most notably in western and north-western NSW.

3.30 In 2007/08 DoCS introduced an integrated online application system and recruitment database for casework job applicants, reducing waiting times and providing more information on applicants.[49]

Recruitment of graduates

3.31 In October 2004, following agreement with the PSA, a degree level qualification became an essential requirement for all caseworker positions with the exception of Aboriginal caseworker positions. The preferred degrees are those in social work, social science and community welfare, although those with related

[49] ibid., p.73.

degrees (for example, nursing) and with experience in community work can also be accepted.

3.32 DoCS has advised that it has established relationships with over ten universities including all the NSW schools of social work/social welfare and some Queensland and Victorian universities. Relationships with the latter have led to some success in recruiting graduates to border towns.

3.33 Strategies to recruit and retain qualified staff in rural and remote areas also include the creation of a joint DoCS/Charles Sturt University senior position at Wagga/Dubbo that contributes to building workforce capacity in isolated and rural areas. This position is used to: support employment strategies; provide student supervisor training; supervise social work student placements (where the staff do not hold social work qualifications); and support practice improvements and solutions, coaching, consultancy and mentoring. University duties for this position may include direct teaching, research and writing curricula.

3.34 Many degrees relevant to DoCS professional positions require supervised student placements. DoCS has advised that it has actively promoted itself as a provider of student placements. In 2007, DoCS provided work experience placements for 137 students enrolled in courses directly relevant to the role of caseworker.

3.35 DoCS' final year student recruitment strategy targets students in their final semester of study for an undergraduate degree in social work, social science, community welfare or psychology in NSW and interstate universities. For the calendar years 2006 and 2007 there were a total of 220 students recommended for permanent caseworker positions as a result of this recruitment strategy.

3.36 DoCS has also negotiated accreditation for some of its internal courses to allow staff to gain advanced standing in a range of tertiary courses.

3.37 DoCS has advised that it convenes bi-annual meetings with the NSW Combined Universities Field Education Group to address student placement and caseworker recruitment issues.

Recruitment of Aboriginal caseworkers

3.38 As at 30 June 2008, DoCS had the following workers who identified as Aboriginal or Torres Strait Islander: 192 caseworkers (9.0 per cent), which rises to around 20 per cent in Northern and Western Regions; 32 Managers Casework (6.8 per cent); and three Managers Client Services (4.5 per cent). In 2006/07, DoCS had 79 identified Aboriginal positions. However, DoCS has now adopted a strategy of active recruitment of Aboriginal candidates for all caseworker positions rather than for identified positions only.

3.39 Some specific initiatives to improve recruitment and retention of Aboriginal staff in 2006/07 included:[50]

a. mentoring programs for Aboriginal managers and caseworkers

b. CDC Plus, through which new and existing Aboriginal casework staff can gain additional support with business writing, information technology, social welfare theory and communications skills.

c. a program to enrol about 50 Aboriginal casework staff in the Diploma of Community Services

d. the DoCS Aboriginal Cadetship Program, with five cadets enrolled at 30 June 2007, and one graduate of the program gaining permanent employment in DoCS. Three graduates from this program have now been employed by DoCS.

3.40 In addition, DoCS:

a. introduced a twelve month pilot Aboriginal Mentoring for Management program that seeks to develop Aboriginal staff who have the potential to move into management positions

b. organises an annual Aboriginal Staff Conference to allow presentation and discussion of current policies and issues as well as networking amongst Aboriginal staff

c. plans to increase the number of Aboriginal legal officers from nil in 2002/03 to one legal officer and two legal cadets in 2008

d. uses the expertise of the Department's Aboriginal Reference Group which is made up of Aboriginal staff representatives from each regional area, Head Office and the Helpline. The group provides an alternate structure for Aboriginal staff to raise issues of concern and comment on current approaches.

3.41 Applicants who identify and are recognised as Aboriginal are exempted from the requirement that they hold a degree level qualification in recognition of the skills and knowledge they would contribute to DoCS engagement with Aboriginal families. In lieu of a degree qualification, Aboriginal applicants are required to have a minimum of two years of relevant community services related work with Aboriginal communities and be successful at the Assessment Centre, where Aboriginal staff are generally involved in the assessment process.

Recruitment of multicultural caseworkers

3.42 DoCS also recruits multicultural caseworkers with bilingual and cross-cultural skills to provide casework to children and families from culturally and linguistically diverse backgrounds. Sixty-one of the additional caseworker

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[50] DoCS, *Annual Report, 2006/07*, p.81.

positions funded under the Reform Package are designated as specialised Multicultural Caseworker positions.[51]

3.43 Multicultural Caseworkers conduct casework with children and families from their target communities and provide information and advice to their colleagues. Under the Community Language Allowance Scheme the Department has 137 staff with registered language skills (covering 30 languages), an increase from 105 staff in the previous year.[52]

Recruitment strategy for rural and remote NSW

3.44 While the number of applications being received for caseworker positions would indicate that there is a strong interest in working for DoCS as a caseworker, there are some locations within NSW where caseworker positions remain difficult to fill. In 2006/07, while 20 successful applicants accepted appointments as caseworkers in DoCS Western Region, a significant number of new and existing caseworker positions remained vacant. DoCS has advised that in response to its limited success in recruiting to the new caseworker positions in Western Region, coupled with the high vacancy rate for already existing caseworker positions, a specific strategy to recruit casework staff for western NSW has been developed and is being considered by Premier and Cabinet.

3.45 DoCS is undertaking a number of targeted advertising campaigns to fill vacancies in particular towns in Western Region.

3.46 To address serious staff shortages in regional and remote areas of the State in the short term, DoCS has developed an internal short term rural secondment program for experienced metropolitan casework staff, which entitles staff to a travel allowance.[53] In 2007/08, 10 rural short term secondments were organised. DoCS promotes this strategy both as a way to fill short term vacancies and as a professional development experience for caseworkers and managers.[54]

3.47 DoCS is one of the NSW government agencies participating in the Remote Areas Attraction and Retention Pilot announced by the then Premier in October 2006. Seven caseworker positions in the Bourke CSC grouping are part of this Pilot. As at April 2008, five of these positions were filled and a further position was expected to be filled. Under this Pilot some incentives are offered.[55]

3.48 The Inquiry is aware of disquiet because DoCS staff already occupying caseworker positions in similar situations are not eligible for the incentives package given to new caseworkers.

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[51] ibid., p.79.

[52] DoCS, *Annual Report 2007/08*, p.75.

[53] DoCS, *Travel Allowance: Guide for Short Term Rural Secondees*, August 2006.

[54] DoCS, *Annual Report 2007/08*, p.73.

[55] Remote Areas Attraction and Retention Pilot 2006/09, www.dpc.nsw.gov.au.

3.49 As at April 2008, Premier and Cabinet was considering a proposal developed by DoCS that contained incentives more generous than those offered in the Remote Areas Attraction and Retention Pilot, to be offered in nominated locations in western NSW. The proposal is being considered in the context of the broader provision of human services across government agencies.

3.50 As evident by the Remote Areas Attraction and Retention Pilot, the recruitment and retention of skilled Aboriginal and non-Aboriginal staff in the rural and remote parts of the State is an ongoing difficulty for all human service agencies. In an effort to develop a longer term response to this problem and to the shortage of suitable staff housing and office accommodation in these areas, Premier and Cabinet has commenced work on the Human Service Delivery in Rural and Remote Areas Project. The Inquiry has been advised that recommendations under this project are to be brought to Cabinet before the end of 2008 addressing four specific issues: new service delivery models; government employee accommodation; uniform public sector incentives; and education, training and government assistance.

3.51 As a specific example of initiatives being instituted to recruit and retain workers in rural and remote locations, partner agencies in the Safe Families Program in the Orana Far West will undertake joint recruitment, training, induction and orientation of staff in the initial stages of the Program. In addition, to avoid worker burnout and to aid staff retention, the positions will be linked with a range of new and existing forums to provide support networks including local interagency meetings and forums, linking workers with the broader Aboriginal Family Health Worker network and mainstream community health networks.

3.52 DoCS has also recognised that for some locations, particularly in western NSW, an alternative model of service provision may need to be implemented to ensure staff have a supportive working environment. A ‘hub and spoke’ model of service delivery is being considered, where a caseworker may be permanently placed at a remote location, but is attached to a larger hub office for supervision, training and administrative support. Alternatively, a remote office may only be operated by staff from a hub office on a part time basis, such as three days per week.[56]

3.53 This proposal was put to the Aboriginal Reference Group and they were “exceedingly attracted to that as a possible way of dealing with some of the West's problems.”[57]

Other factors impacting the recruitment process

3.54 DoCS has experienced difficulties in finding suitable accommodation in some locations outside Sydney. This has caused delays in the appointment of additional caseworkers in some areas, particularly in Western Region.[58]

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[56] DoCS, *Recruitment Strategies for Western Region of New South Wales*, April 2008, p.3.

[57] Transcript: Inquiry meeting with DoCS senior executives, 30 November 2007, p.82.

3.55 The recruitment of additional manager positions to support the new caseworker positions has also impacted on DoCS' ability to become fully staffed. As outlined previously, this is largely because many manager positions have been filled by experienced caseworkers, which in turn has increased the number of positions that need to be filled.

Staff retention

3.56 The following table provides a breakdown of separation rates for caseworkers and casework managers from 2003/05 to 2006/07.

Table 3.3 **Separation rates for DoCS staff 2003/04 – 2006/07**

Separation Rates	*2003/04*	*2004/05*	*2005/06*	*2006/07*
Caseworker	6.93	9.05	8.22	7.18
All DoCS	7.72	8.75	6.72	6.35
Manager Casework	3.86	5.45	2.5	2.42
All DoCS	7.72	8.75	6.72	6.35

3.57 Data made available to the Inquiry from the Public Sector Workforce Office indicates that for each of the years 2002/03 to 2005/06 the DoCS separation rate of non-casual social welfare professionals (which includes caseworkers and casework managers) was lower than that for the human services sector,[59] the Public Service[60] and the total public sector (social welfare professionals).[61] This suggests that, at least in comparison with the public sector, DoCS has no particular difficulty in retaining social welfare professionals.

3.58 Caseworkers had a higher turnover compared with all DoCS staff in 2004/05 but caseworker separation rates are close to the organisational average in 2006/07. In 2005/06 and 2006/07 Managers Casework had lower separation rates than the departmental average. In addition, the separation rates for caseworkers and managers have declined since 2004/05.

3.59 The highest rates of turnover of caseworkers in 2006/07 were in the Hunter/Central Coast Region (11.6 per cent) and Western Region (10.5 per cent), however these regions had low turnover rates for Managers Casework.

3.60 The average tenure of a caseworker in DoCS in 2001/02 was five years. In 2006/07 the average tenure was four years. The average tenure of a Manager Casework in 2001/02 was ten years. This remained unchanged in 2006/07.

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[58] DoCS, *Recruitment Strategies for Western Region of New South Wales*, April 2008, pp.4-5.

[59] Which includes the Department of Ageing, Disability and Home Care, Department of Community Services, NSW Health (including all Area Health Services), Department of Education and Training, Department of Housing, Department of Aboriginal Affairs.

[60] This includes employees under Chapter 2 of the *Public Sector Employment and Management Act 2002* who are employed in one of the 47 Departments in the Public Service. Teachers, school support staff and fire fighters are not employed under this Act and therefore are not counted as members of the Public Service for the purpose of comparing separation rates.

[61] Total Public Sector figures include non-casual employees from all public sector agencies including State Owned Corporations.

3.61 In 2007/08 DoCS introduced a buddying program aimed at reducing transition time for new staff by actively building on the job skills and confidence.[62]

3.62 DoCS reports that the retention rate for Aboriginal staff is higher than for non-Aboriginal staff.

Caseloads

3.63 Caseloads are defined by DoCS as the number of open plans for children and young persons that a full time equivalent (FTE) direct worker (such as a caseworker) has responsibility for at any point in time or over a stated period. Generally, caseworker activities include implementation of the case plan, conducting assessments, coordination of services and supports and monitoring.[63]

Early intervention

3.64 International research and practice evidence suggests that caseload ratios of 1:15 to 1:20 families are appropriate for the Brighter Futures Early Intervention program. When DoCS Early Intervention Caseworkers are delivering the Parents as Teachers Home Visiting program, it is expected that a lower caseload of around 10-15 families will apply.

3.65 The average caseload for Early Intervention Caseworkers as at April 2008 was 6.84 plans and 15.95 children and young persons in these plans. At the regional level, caseloads based on plans vary between 5.37 in Hunter/Central Coast Region to 8.29 in Northern Region. The number of children and young persons in plans varied from 12.27 in Hunter/Central Coast Region to 20.11 in Western Region. The Inquiry understands that plans equate to families and, on this basis, the caseloads are, relatively, low.

3.66 DoCS informed the Inquiry that it undertook a detailed benchmarking analysis in April 2008 in an effort to increase caseloads in CSCs. At the conclusion of this work as at September 2008, average caseloads were nine cases per caseworker. DoCS also informed the Inquiry there is a time delay in caseload figures until all Early Intervention Caseworker resources have been approved, fully trained, and operational.

Child protection

3.67 Caseloads internationally range according to the type of child protection work being undertaken. For example, screening of reports can range from 69-116 per month. Investigations per worker can range from 10-30 per month.

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[62] DoCS, *Annual Report 2007/08,* p.73.

[63] DoCS, *Technical Report 2, Caseloads in child and family services,* November 2007, p.3.

3.68 Murray reviewed cases of substantiated abuse of children in care in Western Australia and made recommendations for good practice in child protection. Her recommendations of caseload benchmarks of one worker to 15 cases were accepted by the WA Government.[64]

3.69 In Tasmania, it has been recommended that the caseloads in the assessment/case management area have been recommended to be limited to 10 children, or 12 if there is a sibling group or less complex cases.

3.70 As at April 2008, DoCS' child protection caseload based on plans varied from 9.90 in Hunter/Central Coast Region to 16.98 in Western Region. Overall, however, the average of 12.21 plans for Child Protection Caseworkers is generally within, or lower than, the recommended or actual caseloads of agencies in other jurisdictions. The number of children in plans opened during the month varied from 18.56 in Hunter/Central Coast Region to 30.79 in the Western Region, with a state average of 21.58.

3.71 For families that require intensive services, caseloads nationally and internationally are between two and six. The DoCS family preservation/intensive support models are generally within, or lower than the recommended or actual caseloads of similar models.

Out-of-home care

3.72 Caseloads in OOHC vary according to the assessed need of children and young persons. Nationally, caseloads recommended vary from 5-20 children and young persons per worker although in practice they can reach 32. Internationally recommended caseloads range from 8-24 although in practice they can reach 49 children and young persons per worker.

3.73 There is no universally accepted formula for calculating caseload. On average the literature offers support for a caseload of a round 15 OOHC cases per worker. Research evidence broadly identifies a recommended OOHC caseload range of 12-20 for low need cases/children per caseworker and 5-8 for intensive high need children per caseworker at any given time.

3.74 In the USA, research into caseloads for OOHC services has shown that most agencies attempt to adhere to the caseload recommendations of the Council on Accreditation and the Child Welfare League of America. The Council on Accreditation recommends maximum caseloads of 18 children per caseworker dropping to eight children per caseworker for children with higher support needs (therapeutic) at any given time. Comparatively, the Child Welfare League of America recommends a caseload of between 12-15 per caseworker for foster and relative care, depending on needs. Where care is ongoing a caseload of 15-18 children is recommended.

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[64] G Murray, "A Duty of Care to Children and Young People in Western Australia, Report on the Quality Assurance and Review of Substantiated Allegations of Abuse in Care," *National Family Preservation Network,* 2005 cited in DoCS, *Technical Report 2, Caseloads in child and family services,* November 2007, p.6.

3.75 As at April 2008, the overall caseload figure of 11.97 plans per OOHC Caseworker within DoCS is within or lower than the recommended or actual figures for 'general' OOHC clients. Caseloads varied from 8.42 plans per worker in Hunter/Central Coast Region to 14.30 plans per worker in the Metro West Region. The number of children and young persons in plans opened during the month per caseworker varied from 11.79 in the Hunter/Central Coast Region to 18.32 in the Western Region. Chapter 16 contains a detailed discussion on caseloads and allocation rates in OOHC.

3.76 Caseload data provided by DoCS suggests that for all program areas DoCS is within or lower than average benchmarks in other jurisdictions.

Occupational Health and Safety

3.77 On average, DoCS staff take more sick leave than their public service counterparts in the human services sector. The average annual sick leave per employee in the NSW Human Services sector is 5.29, however in DoCS it is 6.75.

3.78 DoCS also faces significant challenges in terms of its occupational health and safety (OHS) performance and the amount of time lost to workers compensation claims. Since 2002 DoCS has significantly improved its OHS performance with the number of workers compensation claims reducing from 8.5 claims per 100 FTE employee in 2003/04 to 5.8 claims per 100 FTE in 2007/08. DoCS has also achieved a reduction of 4.5 per cent in claim costs from 2005/06 to 2006/07.

3.79 However, examination of DoCS data suggests that there are a number of OHS pressure points in the organisation. The highest number of claims originate from the Helpline, that is 16.3 of claims per 100 FTE compared with 5.3 claims per 100 FTE for the whole of DoCS. The most frequent claim types in 2006/07 for the whole of DoCS were body stressing, followed by vehicle accident, mental stress and falls, trips and slips. Whilst claims are largely spread across DoCS Regions, in 2007/08 49 per cent of body stressing claims came from the Helpline.

3.80 The Helpline also has the highest rate of reported incidents.[65] For 2006/07 the departmental average was 14.4 incidents per 100 FTE whereas at the Helpline there were 43.2 reported incidents per 100 FTE.

3.81 The Helpline, therefore, has the highest number of claims per 100 FTE and the highest claim costs per employee and by far the highest number of reported incidents. The number of claims and incidents at the Helpline would have an impact on workforce capacity.

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[65] Incidents are events that had the potential to, or did, cause injury or illness.

3.82 Mental stress accounts for 32 per cent of all reported incidents and 26 per cent of claims in DoCS. The highest proportion of time lost to work is attributable to mental stress claims. Mental stress injuries are psychological injuries. The Inquiry does not know the cause of these injuries, that is, whether they have been sustained as a result of the type or nature of work undertaken or whether they are due to ‘internal issues’ (for example, relationships between staff and supervisors or managers, or amongst staff or workplace culture).

3.83 From 2002/03 to 2006/07 DoCS has had 33 ‘very large’ workers compensation claims.[66] Whilst ‘very large’ claims account for three per cent of the overall number of claims over the past five financial years, they account for 43 per cent of costs over this period. Mental stress claims are the most common, accounting for 64 per cent of all ‘very large’ claims. The occurrence of psychological injury in DoCS would have an impact on workforce capacity and would benefit from specific attention as part of DoCS OHS planning, since the nature of the work is inevitably complex and stressful, and is often required to be performed subject to stringent time pressures, particularly where it involves the urgent removal of children from the parents or carers, or is carried out in the JIRT context.

Professional standards

Qualifications

3.84 The qualifications for caseworkers are set out above (paras 3.31 and 3.41). Managers Casework are not required to have a degree. They are required to have in depth knowledge of contemporary principles, theory and practice in the field of child, young person and family development and protection as evidenced by:

a. possession of a degree in social work, relevant social/behavioural science, welfare or related discipline, and/or

b. evidence of recent exposure to current academic/theoretical thinking through relevant experience and/or attendance at seminars/conferences, participation in professional groups, enrolment in short courses or diploma course

c. capacity to articulate and discuss contemporary theory and practice.

3.85 Qualifications required for other relevant casework staff are as follows:

a. Casework Specialists require a tertiary qualification, as outlined for caseworkers but with at least two years experience in child protection.

b. Directors Practice Standards require a postgraduate degree or equivalent experience in child and family services.

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[66] The threshold for ‘very large’ claims for 2006/07 was $146,000.

3.86 In most other jurisdictions, the equivalent position to a caseworker requires tertiary qualifications, although Victoria accepts diploma level qualifications.[67]

Casework support positions

3.87 As part of the Reform Package funding was also provided to improve professional support to assist caseworkers by way of 30 additional psychologists and 30 legal officers. A further 30 JIRT positions were also created, in addition to four JIRT referral team positions.

3.88 As at June 2007, the additional legal officers and JIRT caseworkers have been recruited and allocated to regions. The number of legal officers has increased from 19 positions in June 2005 to 48 by October 2008. The number of psychologists, however has decreased from 41 positions in 2001/02 to 36 in 2006/07. DoCS states that not all psychologists have been recruited as a result of "PSA opposition (2003-2007) and centralised award negotiations (2007)."[68] The PSA opposition, as understood by the Inquiry, was to the management and supervisory structure under which the additional psychologists would work. That has now been resolved. Twenty-three psychologist positions remain to be created and filled in 2008.

Professional supervision

3.89 Across professional disciplines, supervision is considered central to high standards of professional practice[69] and quality outcomes for clients.[70] High quality, consistent and developmental supervision has been associated with greater worker motivation, productivity and staff retention. It also contributes to the acquisition of essential practice knowledge and skills. Supervisors can help workers to evaluate their performance and to identify and learn from their successes and mistakes.[71]

3.90 The Inquiry requested information from a range of service providers including area health services (for allied health professionals and nurses), DADHC and DoCS in relation to the policies, procedures, models and structures which they have in place for professional and/or clinical supervision of new and experienced staff.

3.91 It was informed that supervision may occur face to face, in group work, peer review, expert panel review, interagency case reviews, case consultation with specialists, within a multi-disciplinary team or discipline specific context, or via

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[67] Victorian Department of Human Services, Child Protection, www.dhs.vic.gov.au, Queensland Department of Child Safety, www.childsafey.qld.gov.au, WA Department for Child Protection, www.community.wa.gov.au.

[68] Information provided to Government by DoCS, March 2008.

[69] For example, Australian Association of Social Workers, *National Practice Standards*, p.1; R Bryant, J Cranney, K McConkey, *The Supervision of Psychologists, A Report to the NSW Psychologists Registration Board,* p.1.

[70] Southern Regional Quality Improvement Centre for Child Protection, *Review of Literature Associated with Social Work Supervision*, p.6.

[71] ibid., pp.5-6.

teleconferencing, online forums or video link up. Supervision may occur weekly, fortnightly or monthly and may vary according to the experience of the supervisee.

3.92 Some services have full time senior clinicians who are responsible for supervision, professional support and ongoing learning and development, case consultation, debriefing and working alongside clinicians in complex cases.[72] In other services the line manager is accountable for all supervision arrangements while in others supervision may be provided by external providers.[73]

3.93 Different agencies and professional associations draw a distinction between professional, administrative or line accountability and clinical supervision.[74] Professional, administrative or line accountability may be defined as day to day supervision, role clarification, work allocation and service planning, record keeping, time management, and working within the goals and values of the service. Clinical supervision, however, is concerned with the quality of clinical decision making, interventions and skills development.[75] Quality supervision comprises an opportunity for the development of skills and competencies, reflective practice and case management review.

3.94 Best practice models build this flexibility into their frameworks, for instance, to enable a practitioner, or team, to access supervision from outside the agency with the required specialist expertise (for example Aboriginal maternal health). This can be particularly valuable in rural and remote areas, or in the case of sole practitioners. Protocols are then in place in terms of meeting the time, cost and logistic requirements of this arrangement. Confidentiality and other possible ethical dilemmas may also need to be anticipated and clarified between the practitioner and the external consultant.

3.95 A number of professional/clinical supervision frameworks share common principles:[76]

a. supervision is mandatory for clinicians

b. the most appropriate supervisor in the first instance is the person who is designated as such in the organisational chart

c. an effective supervisory relationship relies on a mutual feeling of respect and trust between both parties. When this cannot be achieved an alternative supervisor should be offered

d. the supervisee and supervisor should share a common knowledge base

e. when an appropriate supervisor cannot be found from within the agency an external supervisor can be appointed

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[72] For example, Northern Sydney Child Protection Service, Northern Sydney Central Coast Area Health Service.

[73] For example, Sexual Assault Services, Greater Western Area Health Service.

[74] For example, Hunter New England Area Health Service, Sydney South West Area Health Service.

[75] For example, Sydney South West Area Health Service.

[76] For example, Sydney South West Area Health Service.

f. supervisors must be trained and/or be competent in supervision skills

g. where an external supervisor is used, clinical standards need to be discussed up front with the external supervisor, and they should provide reports to the manager on what has been achieved in supervision and, in addition, provide feedback into the performance appraisal system

h. a contract between the supervisor and the supervisee should be written at the commencement of the supervisory relationship outlining the process for supervision

i. supervision logs are used as a method of recording the aims and outcomes of supervision.

3.96 The DoCS approach to professional supervision is based on the following principles:

a. supervision is intrinsically important for quality service delivery and client outcomes

b. supervision policy must be located within a performance management framework

c. supervisors need training, support and ongoing supervision

d. an agency needs an agreed definition of supervision

e. it is undesirable to split the administrative and professional functions of supervision in child protection

f. learning and professional development will only be effective in a functional learning environment.

3.97 Professional supervision within DoCS sits within the broader Personal Planning and Review system process as a specific requirement for field staff.

3.98 The need for enhancing professional supervision skills among frontline staff has been raised in internal and external Child Death Reviews and Ombudsman Reports. Professional supervision has also been supported by the PSA as a key priority for frontline staff.

Personal Planning and Review system

3.99 DoCS introduced a Personal Planning and Review (PPR) process in 2004 with more than 3,150 staff meeting all aspects of the process in 2006/07.[77] PPR involves a six monthly and annual review of performance agreements, which is monitored centrally.

3.100 In an evaluation of the PPR conducted in 2006 the five key findings were as follows:

a. there is an acceptance of PPR

[77] DoCS, *Annual Report 2006/07*, p.80.

b. the commitment, leadership and people management skills of the manager is crucial to the success of PPR

c. there is a perception that PPR is benefiting people's work and continuous improvement

d. DoCS is ready to move from a focus on compliance to a focus on the quality of PPR

e. there is a need to amend and further communicate aspects of the PPR procedures and forms.[78]

3.101 Compliance with PPR processes is part of the performance agreements of Senior Executive Service staff.[79] The evaluation found that 94 per cent of staff had a PPR Agreement in place. However, the evaluation also found that only 78 per cent of staff participated in the six month formal PPR review and only 78 per cent had the annual review meeting with their supervisor.

DoCS professional supervision

3.102 The target group for professional supervision includes Directors Child and Family, Directors Practice Standards, Managers Client Services, Managers Casework, Casework Specialists and Caseworkers. The DoCS policy stipulates that at minimum one hour per month is set aside for professional supervision and should include:

a. debriefing (discussing recent experiences)

b. reflection (considering the impact of interventions)

c. development of skills/knowledge (discussion of recent literature, strategies, alternative approaches)

d. professional development (progress with any development steps agreed as part of the Learning and Career Development Plan)

e. constructive feedback (meaningful feedback on work performance and areas for further development)

f. recording of information (tasks and activities to be used as a reflection tool for the next supervision session)

3.103 During 2005/06, DoCS implemented its Professional Supervision Strategy which is a key element within the broader DoCS Professional Development Framework. The Strategy consists of a training program and monthly practice groups for directors and managers to support transfer of learning to practice. It also sets requirements around the frequency and standard of supervision to support caseworkers in undertaking their duties.

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[78] DoCS, Intranet, *PPR Evaluation Report*, November 2006, p.4.

[79] ibid., p.1.

3.104 A recent review undertaken by DoCS found that Managers Casework attributed at least some positive change to the training program (88 per cent) and the practice groups (82 per cent). The majority of caseworkers reported their current supervision had a helpful to very helpful impact on nearly all casework practice areas, however 45 per cent stated that the use of contemporary research evidence had a lesser impact.

3.105 The assessment by caseworkers of how well their Managers Casework undertook the key function of supervision was not as positive, with only 50.6 per cent agreeing it was done well. 22 per cent of caseworkers were neutral and 27 per cent of responses were negative. Only half of the 480 caseworkers surveyed said they received regular supervision and only 48 per cent said supervision met their needs.

3.106 The review highlighted a number of recurring themes of which some have been raised with the Inquiry. These included:

a. lack of time for supervision due to priorities given to the crisis nature of the work

b. supervision being task based

c. supervision not being modelled from the 'top down' with a specific focus on the Manager, Client Services/Manager, Casework relationship

d. inconsistent attendance by Managers across practice groups with an average of 42 per cent of available staff attending.

3.107 Following this survey, DoCS informed the Inquiry that it would:

a. use experienced managers as mentors to new managers

b. develop experienced managers in the role of practice group facilitators

c. target support for managers requiring further development in their supervision practice, for example, coaching.

3.108 To better measure the effectiveness of professional supervision, DoCS proposes to use the CSC quality reviews discussed in the previous chapter to monitor implementation of supervision practices.

Lines of supervision and supervision ratios

3.109 Line management varies across the State. While there are 80 CSCs, there are not 80 Managers Client Services. In some cases, groupings of smaller CSCs are managed by one Manager Client Services (for example, the Orana Far West Grouping in Western Region). In other cases, a small CSC may be a sub-office of a nearby, larger CSC (for example, Bowral CSC, which comes under the Manager Client Services at Campbelltown). In larger CSCs such as Blacktown CSC there are two Managers Client Services and responsibilities are divided along functional lines.

3.110 Sufficient ratios of supervisors to caseworkers are needed so that supervisors can adequately determine priorities, guide caseworkers, and ensure the quality of services provided.

3.111 DoCS undertook a review of the available literature on caseworker supervision caseloads in child and family services.[80] DoCS current target supervision ratio of 1:6 is generally in keeping with, or higher than, those identified in the literature.[81] In practice DoCS supervision ratio varies from 1:5 to 1:8 in different teams and different locations.

Caseworker Development Course

3.112 The Caseworker Development Course (CDC) is the mandatory entry level training course for caseworkers and is designed to equip new staff to a common level of relevant skills and knowledge to perform the functions of a caseworker. Caseworkers need to complete most of CDC before they are able to take on a caseload.

3.113 It consists of a series of learning modules and includes training in the KiDS system functionality relevant to each topic. The learning modes include face to face training and on the job exercises. The preferred timeframe for completion of the CDC in 2006/07 is a maximum of 22 weeks.

3.114 The modules in CDC are distributed into eight week blocks in which new caseworkers attend centralised training. The pattern of attendance (one week attending training followed by one to two weeks in the field) is designed to maximise learning. The field experience component allows caseworkers, in theory, to put into practice the new skills learned in training, in a timely and practical manner. Managers and caseworkers are provided with information about what tasks are suitable for the novice caseworker to undertake after each block of training, and how the required skills and knowledge can be developed.

3.115 The CDC program now leads to eligibility for a nationally accredited Diploma in Statutory Child Protection through an auspicing arrangement with TAFE NSW.[82]

3.116 In addition, DoCS has introduced a program known as CDC Plus to provide additional skills based support for new Aboriginal caseworkers who do not have formal qualifications in social welfare. CDC Plus is conceptually similar to a bridging program or pre-course work to provide underpinning skills and knowledge. With the addition of some minor extra assessments, caseworkers can receive a Diploma in Statutory Child Protection.

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[80] DoCS, *Technical Report 2, Caseloads in child and family services,* November 2007.

[81] ibid., pp.15-16.

[82] DoCS, *Annual Report 2007/08*, p.73

Practice Solutions

3.117 Every CSC across NSW is closed on a Thursday morning (9am –12.30pm) to enable staff to attend learning and professional development sessions related to child protection, OOHC and early intervention practice within their CSC, called Practice Solutions.

3.118 There are different types of Practice Solutions sessions:

a. briefing sessions - information on new policies or procedures

b. practice update sessions - information and analysis of changes to policy or procedures

c. practice improvement sessions - reflection on existing practice.

Early Intervention program (Brighter Futures)

3.119 Prior to working in the Early Intervention program caseworkers must complete training specific to this program.

3.120 One of the key deliverables to families in the Early Intervention program is structured home visiting. To equip staff with skills in this area, DoCS has commenced a partnership with Macquarie University to deliver a five day US accredited Parents as Teachers Program. The Inquiry understands that this program is one of the few where there is an evidence base showing improved outcomes for this population.

Ongoing Training – Post Entry Level

3.121 In 2007/08 DoCS staff attended more than 41,600 training days,[83] a substantial increase from 30,000 days in 2006/07 and 23,600 in 2005/06.[84] During 2006/07 more than 400 new staff attended 21 CDC modules. In total there were 16,229 participant training days in this program, an increase on the 13,370 training days delivered the previous year.

3.122 DoCS' average cost of training per employee in 2006/07 was $2,697, which is significantly higher than average overall industry expenditure. The training costs for DoCS as a percentage of base salary costs was 5.1 per cent in 2006/07 compared with 3.0 per cent for average overall industry base salary costs.

3.123 In 2002/03, 36.4 per cent of the DoCS workforce were provided with training. In 2006/07 this had risen to 83.3 per cent. Further, the average annual number of training hours per DoCS employee in 2002/03 was 28.6 hours, compared with 52.6 hours in 2006/07. The latter is almost double that of the overall industry average.

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[83] ibid.

[84] DoCS, *Annual Report 2006/07*, p.81.

Professional Development and Quality Assurance

3.124 The DoCS Professional Development and Quality Assurance Program was established to improve the quality and consistency of child protection, early intervention and OOHC practice. Implementation of aspects of the program commenced in 2007. The program has established aspirational practice standards to inform system and staff development and, on a practical level, offers targeted practice management training for managers, practice coaching for new caseworkers, case consultancy and review services to casework teams and quality review and practice improvement programs for CSCs.

3.125 The key components of the program are:

a. Professional Supervision Strategy (detailed earlier in this chapter)

b. Research to Practice Program (detailed in the previous chapter)

c. Development of Best Practice Standards in assessment and intervention

d. Quality Review Program.

3.126 The Best Practice Standards in assessment and intervention were drawn from an examination of external and internal reviews of practice, approaches taken in other jurisdictions, national and international research, legislation, policy and procedures and consultation with key stakeholders.

3.127 The core of the Quality Review Program is the review of the quality of practice delivered to children, young persons and families through CSCs, and the development of Practice Improvement Plans. It was intended that each CSC would be audited as part of this review over the next four years, although as noted earlier, PSA opposition has prevented these audits taking place.

3.128 Other elements of the Professional Development and Quality Assurance program include adaptation of the model to meet the needs of the Helpline, JIRTs and specialist units and the development of a CSC self assessment toolkit.

3.129 DoCS established a clinical stream within each region in 2007 and is considering its application to the Helpline. Nine Directors Practice Standards positions - have been established in regions to implement and resource the program. Casework Specialists (who are based in CSCs) report to these senior officer positions.

3.130 These positions will coordinate the quality reviews and support CSCs to assess practice quality. They will assist moving towards best practice standards and introduce new professional development resources. They will also play a mentoring role, providing coaching to staff and clinical advice to managers and directors.

3.131 In addition, within the program, a range of manager training initiatives have been developed to improve practice management capacity.

3.132 DoCS recently undertook a project to understand the current capability levels in the key roles of Caseworker, Manager Casework, Manager Client Services and Director Child and Family positions and to identify key areas that developmental programs should target. This will provide a benchmark for evaluating progress once development activities are undertaken.[85]

3.133 Recommendations arising from this project include the development of new programs according to the areas identified above, identification and integration of systematic 'immersive' techniques (for example, secondments, simulations, work based projects, on the job action learning), the creation of a succession management program, a leadership program and executive coaching for Directors Child and Family.[86]

Issues arising

DoCS workforce

3.134 The DoCS workforce operates within the broader market context of strong demand, undersupply, high turnover and an ageing community services workforce. Nearly half of the NSW public sector workforce is older than 45 years, compared with just over one third of the NSW working population.[87] In addition, in 2006, 27 per cent of NSW public sector employees stated that they intended to retire from the public sector in less than five years with an additional 30 per cent stating their intention to retire within the next decade.[88] The DoCS workforce is younger on average with only just over a third of its workforce over 45 years.

3.135 Concerns about DoCS staff were raised on many occasions with the Inquiry. One theme relates to the shortages of caseworkers and to the number of staff vacancies that have emerged particularly in some regional and remote locations, that have led to inexperienced staff being expected to perform work for which they were not adequately prepared, or to cases being closed without allocation. Planned staff reductions across all public sector agencies due to current adverse economic conditions could lead to further shortages in DoCS capacity to deliver essential services.

3.136 The Inquiry's visits to regional CSCs disclosed the following. Of the 13 caseworker positions at Griffith in April 2008, six were vacant and four caseworkers were yet to finish training. In Lismore in March 2008, of the 45 caseworkers in place, 15 were undergoing training. In Moree in March 2008, of the 17.5 caseworker positions only eight were then filled. In March 2008,

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[85] DoCS, *Professional Development Project*, 2008, p.2.

[86] ibid., p.5.

[87] Department of Premier and Cabinet, *Overview Report for the NSW Public Sector Workforce Profile 2006,* May 2007.

[88] Public Employment Office NSW, *Retirement Intentions Survey, Report and Findings,* June 2006, p.8.

Wagga Wagga CSC was carrying 6.4 vacancies, but only one was a permanent vacancy. The others were temporary due to staff on maternity leave or because people were acting in other positions.[89]

3.137 From the separation data referred to earlier, it does not appear that DoCS experiences a higher turnover than other similar agencies. Anecdotally, however, it does seem that there are many opportunities to transfer to other positions within DoCS and elsewhere in the government, which, when combined with maternity leave in a predominantly female workforce, may explain many of the vacancies.

3.138 For example, the Inquiry was advised of a CSC in northern NSW where:

> *there is NOT ONE management position filled by permanent staff. Two Managers Casework are acting up in manager client services positions, five very experienced caseworkers are acting up in Manager Casework positions. This means that five experienced workers are missing at caseworker level with no-one to backfill. In the meantime cases cannot be allocated as the majority of caseworkers … are going through CDC training. The stress on the very few experienced caseworkers is thus increasing exponentially.*[90]

3.139 The movement of staff can and, by reference to submissions, clearly has an adverse effect on CSC relations with some children, their families and their carers and can cause inconsistent practices. The Inquiry accepts the difficulties in recruiting qualified staff, particularly in rural NSW and notes that this issue is not confined to DoCS and is being addressed on a statewide basis.

3.140 A greater pool of temporary staff may assist in dealing with those relatively short term vacancies caused by leave and internal movements, although it is acknowledged that training will always impact on immediate availability. The Inquiry suggests that exit interviews be conducted, if this is not already occurring, with staff who leave CSCs but remain within DoCS. In addition, while the Inquiry notes that there has been a reduction in the time taken to recruit to less than three months, attention should be given to streamlining the process further. It also notes that DoCS has established a vacancy management team in the Workforce Planning Branch, to accelerate the filling of vacancies; and has strategies which can assist in this respect through the Permanent Caseworker Pool and the Short Term Secondment Project.

3.141 A second theme raised with the Inquiry concerns the treatment by DoCS of its workforce. The PSA summarised most of those issues as follows:

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[89] DoCS provided some different data to that provided by the CSCs for the relevant time periods: Griffith 5 vacant and 2 temporarily vacant; Lismore of 50 caseworker positions 5 vacant and 2 temporarily vacant; Moree of 12 caseworker positions, 4 vacant and 1 temporarily vacant; and Wagga Wagga of 26 caseworker positions, 5 vacant and 4 temporarily vacant.

[90] Submission: Northern Region CSC.

a. there is a lack of resources

b. compared with other public service positions, there is a low grading of positions, particularly the entry level grade for a Caseworker and Managers Casework

c. caseworkers have to do too much paperwork, including administrative tasks like arranging foster carer payments and photocopying subpoenaed files

d. KiDS is cumbersome and time consuming

e. there are insufficient Managers Casework and their workloads are too high

f. the financial delegations system is inefficient and needs to be reviewed. Managers Casework do not have a high enough financial delegation (they can only approve payments of up to $500)

g. bullying and scapegoating of staff is not addressed appropriately by DoCS

h. too many staff have been moved from ‘frontline’ positions to management positions or ‘back room’ positions

i. staff are not consulted in relation to workplace policies. Policies are not consistent or clear, and are often unrealistic in the context of available resources.

3.142 The Inquiry was advised by the PSA that caseworkers have reported spending up to 85 per cent of their time on computers doing administrative tasks that could be performed by clerical staff. Premier and Cabinet recently undertook a survey of 49 DoCS child protection caseworkers across a number of CSCs as part of a project to identify and eliminate any bottlenecks in DoCS assessment and case management practices. The survey found that approximately 20 per cent of caseworker time was spent recording or reviewing information in KiDS,[91] which does not seem unreasonable.

3.143 The Inquiry is concerned at the prevalence of the view that completing tasks in KiDS and casework practice are mutually exclusive activities. This should not be the case. The organised and accurate recording of decisions and plans means that information is documented and communicated in a logical and sequential way and promotes a coordinated and integrated response to the needs of the child or young person. It also ensures that DoCS is accountable to children and families for decisions that have been made that have an impact on their lives.

3.144 Some of the issues raised by the PSA have been acknowledged by DoCS and work is currently occurring to address issues such as KiDS useability, and providing a mechanism to define more clearly when consultation with staff and PSA on policies and procedures should occur.

[91] Department of Premier and Cabinet, *Caseworkers doing casework project*, 31 July 2008.

3.145 Many submissions from staff and the PSA were critical of the difficulty in accessing policies and practices on DoCS intranet and of the voluminous and often changing nature of these documents.

3.146 The Inquiry was thus interested to learn that, in May 2008, DoCS replaced its Business Help site following issues about its ease of use by staff in locating relevant policies, procedures and research. The intranet now contains a special section for caseworkers called Casework Practice, which contains a wide variety of materials which are more integrated, including policies, procedures, practice guides, tools and research. It also includes a five minute step by step guide to assist in navigation. The new structure was developed following workshops and testing involving more than 70 DoCS staff, mainly caseworkers. In May 2008 DoCS released a draft Caseworker Policy Manual: child protection and out-of-home care which includes all policies, standards, guidelines and links to procedures and resources. This is located on the new Casework Practice site. Briefings on how to use the manual are being provided to staff in Practice Solutions sessions.

3.147 It appears that this has made a substantial improvement.

3.148 In relation to bullying and harassment the PSA did not provide any specific examples to the Inquiry, nor did the submissions received suggest it to have been a systemic problem for DoCS in recent years. The difficulty with such claims rests on the perceptions of managers and caseworkers which may well differ when competing opinions are expressed or errors are corrected. DoCS does have a policy on bullying and harassment that appears to be adequate and avenues for complaint and independent investigation of bullying claims are available. It has co-signed the Dignity and Respect in the Workplace Charter with the PSA.

3.149 DoCS caseworker salaries appear competitive with most other states and it is noted that caseloads appear to conform to standards. The Inquiry agrees that the financial delegations appear low and recommends that DoCS review them. The question of additional resources will be addressed in Chapter 10.

Helpline

3.150 Particular issues were also raised by the PSA with regard to the Helpline concerning the following:

a. high staff vacancies, insufficient staff, too many temporary positions and inflexible working conditions

b. the lack of an up to date resources manual or reference document containing information for contacting services (for the purpose of referrals)

c. changes to legislation or policy not being communicated to Helpline caseworkers

d. the management emphasis on the quantity of calls taken which impacts on the ability of caseworkers to write quality reports and carry out proper

checks. The statistics regarding the calls taken do not take into account the type of call (that is, how complex it was, how distressed the caller was)

e. service standards have not been revised for many years

f. Helpline staff are not offered the same level of training as staff in other parts of DoCS. Helpline staff are not given enough career development opportunities

g. significant numbers of Helpline staff have workers compensation claims.

3.151 The Inquiry understands from DoCS that the Helpline:

a. is staffed over its establishment

b. has a relatively high number of temporary staff and a recent offer of permanent employment was made but not taken up by many

c. staff use the internet to source information about services

d. has revised service standards as recently as 2007

e. has the highest number of workers compensation claims, however, its average claim cost is just over half that of the Department's average claim costs.

3.152 The Inquiry also notes that staffing at the Helpline has increased by 60.9 per cent between 2001/02 (184 positions) and 2006/07 (296 positions).[92] However, as will be seen in a subsequent chapter, the number of reports has also increased.

3.153 The PSA asserted that the current vacancy rate at the Helpline was 40 out of a potential of 140 staff (or approximately 30 per cent). It was suggested that one reason for the level of vacancies at the Helpline was the decision by the Department to recruit permanent staff to Helpline positions.

3.154 According to the staff establishment as at 30 April 2008 there were 317 positions at the Helpline. Twenty-six per cent (82) of these positions were temporary full time positions. The Inquiry also notes that there were recruitment advertisements for various permanent and temporary positions for Helpline Caseworkers in mid August 2008.

3.155 As noted earlier in this chapter vacancy rates are not at the level suggested by the PSA. The Inquiry, however, recognises that further strategies are required to address the high level of workers compensation claims at the Helpline.

3.156 Strategies also need to be developed and implemented to address the professional development of staff at the Helpline to ensure consistent quality practice. Up to date resources are essential for Helpline staff to perform an enhanced triage and referral role as discussed in Chapter 10. Further, as

[92] Figures are for end of year non casual only and include permanent and temporary employees, executive staff and cadets. Figures are rounded.

indicated in Chapter 9, more by way of written guidelines is necessary to assist Helpline workers.

Recruitment process

3.157 The number of applications for caseworker positions has increased substantially over the last two years. However, while just over one fifth of the total number of applications in 2006/07 resulted in a permanent appointment, in the first three quarters of 2007/08 only ten per cent were appointed.

3.158 In 2006/07, almost 50 per cent of applications were culled prior to reaching the Assessment Centre stage. Of the applicants who attended the Assessment Centre, 58 per cent were recommended for appointment. In the first three quarters of 2007/08, 67 per cent of applications were culled prior to reaching the Assessment Centre stage. Of the applicants who attended the Assessment Centre, 53 per cent were recommended for appointment.

3.159 These figures raise questions about the effectiveness of the culling process.

3.160 Also of significance is the situation of the 284 candidates who applied for positions in the period 1 July 2007 to 31 March 2008 and who were invited to but had not attended an Assessment Centre by 24 June 2008. It may be the case that a proportion of these candidates were scheduled to attend an Assessment Centre after 24 June 2008. However, it would appear that a number of applicants who progressed to the Assessment Centre stage subsequently dropped out of the recruitment process, possibly as the result of securing employment elsewhere.

3.161 In 2007/08, 644 of the 914 recommended candidates (about 70 per cent) accepted an offer of permanent appointment. In 2006/07 about 75 per cent of recommended candidates accepted permanent employment. This low take up of positions may relate to the shrinking pool of available positions in more popular locations as the recruitment process nears completion or may be related to the time taken to make the offer.

3.162 The Inquiry has been advised that there can be lengthy delays in the time DoCS takes to recruit new staff. New DoCS casework staff have reported recruitment times from the point of lodging an application to taking up a position of between four and nine months. One rural CSC reported that an application from a temporary caseworker had been lodged 12 months earlier and the officer had only recently been informed of a date for attending the Assessment Centre.

3.163 The PSA has contended that the recruitment process is too slow and raised concerns that the length of time taken by the Commission for Children and Young People (CCYP) to complete the Working with Children Checks delays the recruitment process.

3.164 DoCS advised that as part of screening process, CCYP also conducts a broader National Criminal Record Check for DoCS, in parallel with the Working

with Children Check, and it is often the broader check that can delay a result being returned to CCYP.

3.165 The Inquiry sought information on actions that need to be completed after a candidate attends the Assessment Centre and prior to the application being finalised. DoCS advised that between January and March 2008 it took, on average, 36 days from the time a candidate attended an Assessment Centre to the time they were notified that they have been placed on an eligibility list.

3.166 It may be that the information provided to the Inquiry was of events in the past and that improvements have since been made. However, the Inquiry suggests that DoCS and Businesslink consider reviewing its processes in an effort to reduce delays and increase the quality of applicants selected to attend an Assessment Centre.

Caseworker qualifications

3.167 The PSA is of the view that TAFE qualified caseworkers with relevant life experience should be eligible for employment. DoCS has contended that the recruitment statistics do not support the criticism that new degree qualified caseworkers recruited are lacking in life experience. In the period 1 July 2007 to 31 March 2008, the median age of applicants who commenced as permanent caseworkers was 31, and their average age was 34.2.

3.168 DoCS advised of consistent feedback from Operations Managers that the average calibre and 'fit' of the new caseworkers is significantly better than was the case prior to the introduction of the degree qualifications requirement and the Assessment Centre methodology. DoCS further advised that the increased number of applications and appointments made in recent years has proven that the degree qualification has not been a significant barrier for the recruitment of generalist caseworkers. It has also pointed out that its requirements have resulted in DoCS and the NGO sector targeting different recruitment pools. This could have the benefit of reducing the potential competition for staff, a matter of some importance if the NGO participation is to increase.

3.169 The views of the PSA regarding caseworker qualifications and experience are however shared by Family Services Illawarra, CareSouth and Anglicare Canberra and Goulburn.

3.170 The Inquiry is satisfied that the qualifications sought by DoCS are necessary to ensure quality work by CSCs. The Inquiry, however, is concerned that similar qualifications are not mandatory for Managers Casework who have delegated decision making responsibilities in relation to casework. It appears that a number of caseworkers, who lacked degree qualifications at the time of their original appointment, when that was not a requirement, were promoted on an acting or permanent basis during the period of reform when many new caseworkers and managers were appointed. In the future, it is critical that appointments to Manager Caseworker positions have a recognised tertiary

qualification as well as significant field experience. Supervision is particularly important when Managers Caseworker are newly appointed.

3.171 The Inquiry recommends that from 1 July 2009 newly recruited Managers Casework be required to hold a relevant tertiary qualification.

Aboriginal staff

3.172 Premier and Cabinet noted that:

> *The Aboriginal workforce is of particular concern to the NSW child protection system. Its capacity to work successfully with Aboriginal children and families is undermined by a shortage of caseworkers…..One pathway to addressing the Aboriginal workforce issues is to build on strengths of the Aboriginal community and its organisations.*[93]

3.173 Premier and Cabinet suggested the use of flexible team based approaches, similar to those employed in primary health care in Aboriginal health services, that would allow for the employment of senior members of the Aboriginal community who are already active in looking after children, in a team of child welfare and development professionals:

> *In such a model professional staff play not only a casework role but also a leadership, standard and protocol setting role as well as providing guidance and mentoring to team members with less formal training. It may be possible to base such services within the more robust Aboriginal health services.*[94]

3.174 Premier and Cabinet supported a focus on frontline child protection workers in Aboriginal communities and recommended increased recruitment and accelerated training of Aboriginal workers, or non-Aboriginal workers with appropriate cultural awareness training, the development of co-located family centres serving Aboriginal communities and collaboration with the Commonwealth through the COAG Working Group.

3.175 The PSA suggested the appointment of an Aboriginal Casework Specialist at Helpline, the on-call availability of an Aboriginal Casework Specialist, the inclusion of at least one Aboriginal caseworker in each team and additional peer support for Aboriginal casework staff.

3.176 Aboriginal staff in DoCS reported being called upon to assist with a range of issues concerning Aboriginal families because they were Aboriginal:

> *I guess contributing to the burn-out rate of Aboriginal staff would be a big factor that, not only are you doing your job, you*

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[93] Submission: Department of Premier and Cabinet, p.42.
[94] ibid.

> *are also screening clients at the front counter because you are Aboriginal.*[95]

3.177 Some Aboriginal caseworkers reported being harassed and bullied by members of the community and suggested that this can result in a difficulty in recruiting to positions. Staff reported that members of the Aboriginal community approach them after hours and turn up at their houses:

> *As recently as this week, we approached a caseworker in Narrabri to have an AVO taken out against a client who made a number of threats. So those things happen on a fairly regular basis when you have been around for a while.*[96]

3.178 The Ministerial Advisory Panel on Aboriginal Child Sexual Assault advised the Inquiry that sole workers in communities are not sustainable and that Aboriginal staff can be isolated and very vulnerable in small communities.

3.179 Link-Up noted that Aboriginal staff need to be:

> *supported to make decisions regarding Aboriginal children, rather than being called on in an ad hoc way that devalues their potential contribution whilst still holding them answerable to the communities in which they live……Crucial decisions are often still left in the hands of non-Aboriginal workers and managers.*[97]

3.180 Aboriginal Child, Family and Community Care State Secretariat (AbSec) reported that while it is still preferable to have Aboriginal caseworkers working with Aboriginal families, there is a belief that sometimes managers use Aboriginal caseworkers as a tool to make their life easier, making them deliver the bad news without having decision making power.

3.181 Some submissions identified the shortage of Aboriginal caseworkers, and the lack of respect or of cultural awareness of some DoCS staff when dealing with Aboriginal staff members and clients. The Department of Aboriginal Affairs (Aboriginal Affairs) suggested that better support for Aboriginal workers, increased flexibility in work practices and that traineeships needs to be considered.

3.182 The Inquiry supports the current work occurring within DoCS to recruit and support Aboriginal staff and to provide for their career development. Provided they are given the training and mentoring noted above there is good reason to dispense with a degree qualification for this group. The lack of a degree is more than made up for by their knowledge of Aboriginal culture, notions of family and kinship and capacity to access relevant communities. The issue of employing Aboriginal workers in rural and remote NSW is faced by all human

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[95] Transcript: Inquiry meeting with DoCS staff, Northern Region, p.43

[96] Transcript: Inquiry meeting with DoCS staff, Western Region, p.26.

[97] Submission: Link-Up, pp.7-8.

services and justice agencies. The Inquiry is of the view that Premier and Cabinet should explore methods of employing Aboriginal workers to provide services for more than one government agency in these areas. This issue is addressed further below.

3.183 A strategy used in Western Australia to provide additional workforce support is the type of approach used by Yorganup, an Aboriginal and Islander Child Care Agency in WA that recently developed a nationally accredited Certificate III in Child Care with an additional Aboriginal component. It is delivered over one to two years in community venues and at a pace set by individual students.

3.184 The course has enrolled a wide range of young persons and adults from across the community (high school students to grandmothers) allowing them to have financial support while training. The course was designed not only as a workforce development strategy, but also as a child abuse prevention one. Participants that may have been reluctant to attend a parenting education course have gained similar skills through a workforce development course. This in turn has had an impact on their own skills in looking after children, but also on their extended families.

Building workforce capacity

3.185 The Inquiry notes that government agencies are competing with the non-government sector for the employment of graduates, and that although there may be a salary and promotion differential in favour of employment by government agencies, very often work within the non-government sector may be perceived as either less demanding or more satisfying.

3.186 The need for a sector wide workforce strategy was also recognised by a number of government and non-government submissions to the Inquiry. There were a number of recommendations that a workforce development strategy be developed through the Human Services and Justice CEOs Cluster and the NGO sector to plan for government and non-government workforce requirements over the long term.

3.187 It was suggested, and the Inquiry agrees that, NSW should seek to place the development of a workforce strategy for human services workers on the COAG agenda. Such a strategy should address financial and other barriers to tertiary study, remuneration, training and development, Aboriginal staffing levels and the possibility of a government subsidy for post-qualifying university child protection courses. It could build on work already undertaken by the Community and Disability Services Ministers' Conference in this area.

3.188 Premier and Cabinet also suggested that:

> *Workforce reform to support a more balanced approach to child protection requires more effective integration of different professional silos. In parallel with the development of one-stop-shop, coordinated and other integrated models it will be*

necessary in the midterm to engage the professions across child health, care, welfare and education in discussion about areas of skills development and knowledge acquisition each will need to facilitate these initiatives.[98]

3.189 Premier and Cabinet suggested that this responsibility could be allocated to Human Services and Justice CEOs Cluster within the NSW Government.

Expansion of casework support staff

3.190 There were numerous suggestions regarding delegating more administrative tasks to free up caseworkers, increasing the number of clerical positions or creating a 'casework assistant' position.

3.191 Ballina CSC reported having engaged staff to transport children to various appointments and contact visits. This, the Inquiry was told, worked well and freed up caseworkers. Ballina CSC also reported trialling a Senior Customer Service Officer role to take over all the financial payments through KiDS, and to support foster carers. As payments are being made on time, better working relationships are built and any questions can be answered.

3.192 The Inquiry agrees that the following tasks, currently performed by caseworkers could be carried out by a less senior position, or outsourced:

a. financial payments
b. s.248 requests
c. transporting children
d. supervising and arranging contact in less contentious circumstances
e. formal or less complex correspondence
f. entering data into KiDS of a casework nature, such as the minutes of meetings prepared by a caseworker.

3.193 The preparation and entry of case notes and the like should however remain with caseworkers to ensure their accuracy.

3.194 The recommendation made by Premier and Cabinet's review of DoCS' business processes that there be reforms to streamline select caseworker activities such as simplifying the financial payment and approval processes, is also supported.

Professional development

3.195 The importance of committing to the continuous professional development and high quality clinical supervision of DoCS staff was raised in a number of submissions to the Inquiry.

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[98] Submission: Department of Premier and Cabinet, p.43.

3.196 Some observed that it tends towards being administrative supervision rather than focusing on the quality of case management:

> *When workload pressures impinge - supervision is the first casualty. The result is technical compliance without any quality input.*[99]

3.197 Due to the crisis driven environment of DoCS work, supervision was often observed to be unavailable or cancelled.

3.198 The capacity of DoCS to deliver high quality casework services was seen to be limited by the high proportion of 'novices' in key services and roles, and the failure of DoCS to adequately support these staff.

3.199 Research by Howarth was cited by Centacare Broken Bay to identify risks posed by inexperienced staff who have not had time or support to develop practice experience:

> *Without appropriate supervision and support it is likely newly qualified staff will focus on gathering information and completing the assessment forms – the security blankets of procedurally driven practice.*[100]

3.200 A number of submissions were critical of the lack of expertise of staff in particular areas, for instance domestic violence, sexual assault, cultural difference, mental health issues, and disability issues.

3.201 The Inquiry was told by some current and former DoCS staff that the PPR process is a theoretical and pointless exercise, because in practice, there is very little supervision[101] and too many changes to procedures and systems which are introduced without training or exposure to the new system.

3.202 Following a child death in one CSC, the DoCS review identified a number of practice issues relating to assessment and intervention. DoCS initiated an audit in this CSC and a neighbouring CSC to examine the appropriateness of decision making and the adequacy of risk assessment to determine if there were any systemic patterns in the poor practice identified in the child death review. The review sampled 20 cases and concluded:

> *Many of the cases failed to show evidence of regular consultation between a Manager Casework (MCW) and a Caseworker. There was a minority of cases where case reviews were on file and showed evidence of the Caseworker and MCW both being present. There were no cases where this*

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[99] Submission: Anscombe, p.9.

[100] J Howarth, "Maintaining a Focus on the Child?" *Child Abuse Review (11)*, 2002, p.205 cited in Submission: Centacare Broken Bay, pp.22-23.

[101] Author stated he/she has had three supervision sessions in 10 years. Submission: Anonymous DoCS worker.

> *evidence was present in a regular manner over the life of the case.*[102]

3.203 One of the cases audited by the Inquiry illustrated the importance of supervision in ensuring proper decision making.

Case Study 1

There were four Judgements and Decisions for A on file all submitted for approval on the same day (17 November 2004) and approved by the manager on the same day (18 November 2004). Two Judgements and Decisions recorded that A had been assessed as safe in her current circumstances and two recorded that she had been assessed as not safe in her current circumstances.

DoCS advised that changes to processes have been made since 2004.

3.204 A Manager Client Services told the Inquiry that:

> *The caseworkers come to us. They then get sent to the caseworker training. That takes seven or eight weeks spread over a few months. They are in and out of the office. They are out of the office one out of three. You can't run a child protection system where you have that level of absenteeism. They need to come to us trained. They need to do their block training, have work experience placements, and once they start at CSC they've had that level of training when they hit the ground...We then to have an on-the-ground mentoring program when they hit the CSC.*[103]

3.205 This comment illustrates the inherent tension between high workload and the need to develop and support new caseworkers.

3.206 A Manager Casework informed the Inquiry that:

> *[Caseworkers reported that] the level of training is less then what they get at University and as such a waste of time for most of them. However, the RPLs [Recognition of Prior Learning] are so difficult to get that the caseworkers attend just to "get it over with." This is a waste of resources and adds nothing to our caseworkers abilities.*
>
> *There is no interaction between CDC and the CSC. I recently had a staff member who I had to put on performance management whilst she was at CDC because she was seen a*

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[102] DoCS, *Review of Casework Practice at two CSCs,* May 2007, p.3.

[103] Transcript: Meeting with Manager, Client Services from a metropolitan CSC.

> *number of times to abuse parents, not put information in files and to lie to myself and other Managers Casework. However, when I attempted to gain information from CDC staff they would not talk with me and when they finally did they told me that her "performance was satisfactory." It seemed incomprehensible that this person could "Pass" the assessments at CDC and then act as she did in the CSC.*[104]

3.207 Inevitably, the employment of hundreds of new caseworkers, a lengthy training schedule and the requirement for a tertiary qualification, will result in a disproportionate number of inexperienced staff, who cannot manage a full caseload. DoCS has put in place a number of strategies to manage this occurrence as well as to improve supervision, none of which have yet been operational for sufficient time to deliver observable results. However, the criticisms of the situation between CDC and CSCs warrant the attention of management. The Inquiry understands that the CDC is being overhauled, with a new CDC to be launched during 2009.

3.208 A significant issue for DoCS is in embedding a culture that embraces quality supervision and reflective practice. Further work needs to be done to assist Managers Casework and Managers Client Services to better balance the tensions between a high number of child protection reports and quality casework practice. Chapter 9 suggests changes which should be made in the area of professional development and training. The Inquiry supports the recommendations made in the Professional Development Project referred to earlier.

3.209 Positively, DoCS should be acknowledged for the following significant achievements:

a. increased training

b. its comprehensive recruitment strategies and models

c. its strategies to recruit and retain Aboriginal staff.

Recommendations

Recommendation 3.1

> From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.

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[104] Submission: Manager Casework, Western Region.

Recommendation 3.2

A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.

Recommendation 3.3

A review of financial delegations should be undertaken.

Part 2 Early intervention and child protection

4 Key child protection research

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Introduction

4.1 A broad review of literature and research on key trends, evidence and issues in child protection was undertaken to inform the Inquiry. The Inquiry drew on, *inter alia*, the various literature reviews and Research to Practice Notes commissioned or authored by DoCS, material available through the National Child Protection Clearinghouse, AIFS and some research that was made available through submissions to the Inquiry.

4.2 Key findings from data made available by DoCS indicates that for the period April 2007 to March 2008 the most common primary reported issue to DoCS was domestic violence followed, in descending order, by neglect, physical abuse, carer drug and alcohol, psychological abuse, carer mental health, sexual abuse and child/young person risk taking behaviour. Most reports concern more than one reported issue.

4.3 Detailed analysis of these data will be presented in the following chapter, however, for the purposes of this chapter the Inquiry reviewed research and literature in order to understand what is known about the categories of risk of harm, associated factors and the efficacy of interventions.

4.4 The Inquiry found generally that literature reviews and research often conclude that knowledge in the area is significantly limited due to methodological flaws, small sample sizes, over reliance on qualitative studies, poor applicability and the inability to make meaningful comparisons across jurisdictions. More research is required and more evaluations need to be done. As such, research findings are often equivocal. In a policy and practice context it is therefore often difficult to isolate 'what works.'

4.5 Research indicates that determining the underlying causes of child abuse and neglect is a complex and multifactorial issue. While a large number of factors associated with child abuse and neglect are discussed in the research there is general agreement that key risk factors are:

a. child risk factors including younger age, disability, chronic or serious illness and behavioural problems

b. parental/family risk factors including mental health, domestic violence, substance abuse, poor parent-child interaction, single parent status and low parental education levels

c. social or environmental risk factors including low socio-economic status, stressful life events, lack of access to medical care and adequate child care, parental unemployment, isolation, lack of support, homelessness and dangerous or violent neighbourhoods.[105]

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[105] J Goldman, MK Salus, D Wolcott and KY Kennedy, "A coordinated response to child abuse and neglect: The foundation for practice," *US Department of Health and Human Services,* 2003 cited in DoCS, *Child protection reports in context*, February 2007.

4.6 Researchers currently categorise five different types of child maltreatment: sexual abuse, physical abuse, psychological maltreatment (including emotional abuse and psychological neglect), physical neglect and witnessing family violence.[106] However there is:

> *a growing body of evidence that maltreatment sub-types do not occur independently and that a significant proportion of maltreated individuals experience not just repeated episodes of one type of maltreatment, but are likely to be the victim of other forms of abuse or neglect.*[107]

4.7 It has been estimated that over 90 per cent of abused children experience more than one type of abuse.[108] Bromfield and Higgins suggest that an event oriented approach to child maltreatment can result in practitioners failing to observe, or failing to respond to, a pattern of maltreatment.[109]

> *The problem with the current conceptualisation of four or five discrete categories is that the overlap between maltreatment is not well understood, and researchers or clinicians may unjustifiably blame the range and severity of negative outcomes on a single form of abuse, especially if other forms of abuse or neglect are not assessed. This is particularly likely when some chronic forms of maltreatment (such as neglect) are harder to define and measure than single episodes of a clearly defined act of physical or sexual abuse.*[110]

4.8 Higgins argues that the distinctions between categories are blurred and that whilst it may be convenient to speak of different types of maltreatment, it may be more meaningful to talk about the degree of negative parental or adult behaviour that is reported (that is, high, medium or low frequency and/or severity of maltreatment) rather than focusing solely on the type of maltreatment.[111] Higgins further argues that it is the frequency and severity of abusive and neglectful behaviours experienced by children, rather than the particular type of abuse or neglect, that is important in predicting outcomes:

> *The failure within practice to take into account the effects on children of chronic maltreatment may in part be a consequence of the framing of legislation that has forced courts and statutory child protection services to focus on assessing whether an adult*

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[106] J Stanley, "'Downtime' for Children in the Internet," *Family Matters, Australian Institute of Family Studies,* No. 65, Winter, 2003, pp.22-27. Stanley argues that given the high and increasing use of the internet by children, we must also recognise the potential of the internet as a new form of child abuse through exposure to inappropriate material, sexual exploitation and use of children in pornography.

[107] D Higgins, "Differentiating between Child Maltreatment experiences," *Family Matters, Australian Institute of Family Studies*, No. 69, Spring/Summer, 2004, p.51.

[108] F Stanley, S Richardson and M Prior, *Children of the Lucky Country?* Macmillan, 2005, p.56.

[109] L Bromfield and D Higgins, "Chronic and isolated maltreatment in a child protection sample," *Family Matters, Australian Institute of Family Studies*, *No. 70, Autumn*, 2005, p.44.

[110] D Higgins, 2004, op. cit., p.51.

[111] ibid., p.53.

> *has acted in an abusive or neglectful manner and the likely impact on the child given their age. The problem with this approach is that it tends to shape our thinking about maltreatment into a rather simplistic 'cause and effect' model….When abusive or negative behaviour occurs in isolation it may not be high risk; if it is repeated over a prolonged period of time the cumulative impact can be detrimental.*[112]

4.9 The Inquiry has identified a need for DoCS caseworkers to assess more holistically the needs of children, young persons and their families. This matter is addressed in Chapter 9.

4.10 The economic costs of child abuse are significant. According to the Productivity Commission's *Report on Government Services 2008*,[113] in 2006/07 approximately $1.7 billion was spent across Australia on child protection and supported placement services. Further, over the period 2002/03 to 2006/07, real recurrent expenditure on child protection and OOHC services increased in all jurisdictions.[114]

4.11 The personal costs of child abuse are also pronounced. Child maltreatment is associated with a variety of short and long term negative outcomes, including mental illness, drug and alcohol abuse, physical ailments and criminality.[115]

4.12 Before turning to the research on each of the categories of risk of harm as they are reported to DoCS, this chapter will present a summary of key research on risk, protection and resilience, and parenting capacity as two fundamental constructs that inform child protection practice.

Risk, protection and resilience in children and families

4.13 An understanding of risk, protection and resilience factors has critical implications for child protection assessment and practice. A risk factor is usually defined as a factor that increases the likelihood of a future negative outcome for a child. A protective factor is a variable that decreases such a probability, and can mediate against the effects of risk factors.[116]

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[112] L Bromfield and D Higgins, 2005, op. cit.

[113] Productivity Commission, *Report on Government Services 2008.*

[114] P Holzer, "Child Protection in Australia. Children see. Children do. Make your influence positive," September 2008, www.aifs.gov.au.

[115] ibid.

[116] JA Durlak, "Common risk and protective factors in successful prevention programs," *American Journal of Orthopsychiatry, 68(4)*, 1998, pp.512-520 cited in DoCS, *Risk, protection and resilience in children and families*, *Research to Practice Note,* November 2007.

4.14 The concept of resilience provides a framework for understanding the varied ways in which some children do well in the face of adversity. Encouraging positive environments within families, schools and communities to counteract risks in children's lives can enhance resilience. Of these three environments the family is the most immediate care giving environment and has the greatest impact on the development of resilience in children although there is some evidence that strengthening protection within communities can provide a buffer for risk experienced by some children within the family environment.

4.15 Edwards found that children living in the most disadvantaged neighbourhoods have lower social/emotional and learning outcomes than children living in more affluent neighbourhoods even when family income, parental employment status, mother's education and several other child and family variables were controlled for analyses.[117] This is consistent with findings from other studies that suggest neighbourhood socio-economic disadvantage is associated with poorer outcomes for children.[118]

4.16 It is important to recognise the limitations of research in this area. Risk and protective factors are often only correlated with certain outcomes; they are not causally related to these outcomes. It may be that another variable better explains the relationship between the risk/protective factor and the outcome. An example is the correlation between low socio-economic status and physical abuse. Since socio-economic status is also associated with other risks such as parental stress and poor parenting, it may be that these other factors are more directly related to physical abuse than socio-economic status itself.

4.17 It is generally recognised that child abuse and neglect are in many cases manifestations of social disadvantage and social exclusion. A cross sectional study undertaken by DoCS in 2007 examined the relationship of child protection reports with the ABS Index of Relative Socio-economic Disadvantage, and associations between child protection reports and other key socio-demographic data series. This study found a strong association between lower levels of disadvantage (high index values) and low report rates.[119] However the association between higher levels of disadvantage (low index values) and rates of reporting was less clear, although these appear to be associated with higher rates of reporting, with some exceptions.

4.18 The study also found strong positive associations between child protection reporting rates and high proportions of one parent families, low income families, Aboriginal families, adults with low educational attainment and urban location.[120]

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[117] B Edwards, "Does it take a village? An investigation of neighbourhood effects on Australian children's development," *Family Matters, Australian Institute of Family Studies*, No. 72, Summer 2005, p.41.

[118] ibid.

[119] DoCS, *Child Protection reports in context*, February 2007.

[120] DoCS, *Socio-demographic factors associated with lower than expected rates of child protection reporting in NSW*, May 2008.

4.19 Research shows, however, that it is the presence of a number of risk factors, known as 'cumulative' risk, rather than the presence of a single risk factor that affects outcomes. Two models of 'cumulative' risk have been proposed.

a. a 'threshold' model, which assumes that after a certain number of risk factors, there is a dramatic increase in negative outcomes

b. an 'additive' model, which proposes that with an increasing number of risk factors there will be a reasonably steady increase in problematic outcomes.[121]

4.20 Recent research supports the 'additive' rather than the 'threshold' model of risk.[122] This finding suggests that while children who experience more risk factors are at increased risk of problems, there does not appear to be a particular threshold beyond which their outcomes become worse. This finding is important as it suggests that a 'point of no return' beyond which services for children are hopeless does not exist.[123]

4.21 Bromfield argues that research largely treats child maltreatment as a single event.[124] Practice also focuses on single incidents/events. Case histories are used to establish a pattern of behaviour to predict future risk and there is not a focus on cumulative impact. Legislation also typically has an incident or event focus.

4.22 Cumulative harm may be caused by an accumulation of a single adverse circumstance or event, or by multiple different circumstances and events. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and well-being.

4.23 From their review of 100 case files for the period between 1994 and 2002, Bromfield, Gillingham and Higgins identified that a systemic barrier to recognising cumulative harm was that each involvement was treated as a discrete event. That is:

a. information was not accumulated from one report to the next

b. information was lost over time

c. it was assumed that problems presented in previous involvements were resolved at case closure

d. files were not scrutinised for any pattern of cumulative harm.[125]

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[121] K Appleyard, B Egeland, M van Dulmen and L Srouge, "When more is not better: The role of cumulative risk in child behaviour outcomes," *Journal of Child Psychology and Psychiatry, 46(3),* 2005, pp.235-245 cited in DoCS, *Risk, protection and resilience in children and families, Research to Practice Note*, November 2007, p.2.

[122] ibid.

[123] ibid.

[124] L Bromfield, "Cumulative Harm. The effects of chronic child maltreatment," *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2008.

[125] L Bromfield, P Gillingham and D Higgins, "Cumulative harm and chronic child maltreatment," *Developing Practice, 19,* 2007, pp.34-42 cited in ibid.

4.24 Bromfield argues that it is unlikely that a child welfare agency will receive a report explicitly due to cumulative harm, however, the majority of children who experience maltreatment experience multiple incidents and multiple types of harm. Bromfield argues that practitioners need to be alert to the possibility of cumulative harm in all reports by noting frequency, type of harm, severity, source of harm and duration. Parental and family indicators of cumulative harm indicate that families who experience cumulative harm have:

a. multiple inter-linked problems (that is, risk factors) such as domestic violence, alcohol and other drug related problems, mental health problems

b. an absence of protective factors

c. experience of social isolation/exclusion

d. enduring parental problems impacting on their capacity to provide adequate care.[126]

4.25 Bromfield argues that in these circumstances, if the parent(s) cannot or will not change, or if it will take too long, the practitioner needs to prioritise the needs of the child. The short and long term effects of cumulative harm matter for the child whether there is intent to harm or not.[127] Cousins also observes that practitioners:

> *can overlook the needs of the child and this can lead to years of postponing the inevitable, sometimes resulting in removal after it is almost too late for a successful outcome for the child.*[128]

4.26 The importance of cumulative impact from a combination of factors also appears to apply to protective factors just as it does to risk factors. With an increasing number of protective factors, there is likely to be an increase in positive outcomes.[129]

4.27 The knowledge on risk and protective factors have further implications:

a. Services and interventions should focus on evidence based risk and protective factors which are related to child outcomes. For example, when children have experienced abuse and neglect, the protective factors of personal control and a relationship with a caring adult seem particularly important for child outcomes, so interventions may try to enhance these factors.

b. The timing and nature of risk and protective factors within a child's developmental pathway is an important consideration when providing

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[126] L Bromfield, 2008, op. cit.

[127] C Cousins, "When is it serious enough? The protection of children of parents with a mental health problem, tough decisions and avoiding a 'martyred' child," *Australian e-Journal for the Advancement of Mental Health,* 2004, p.7.

[128] ibid., p.5.

[129] M Rutter, "Resilience concepts and findings: Implications for family therapy," *Journal of Family Therapy, 21(2),* 1999, pp.119-144 cited in DoCS, *Risk, protection and resilience in children and families, Research to Practice Note,* November 2007, p.2.

services and interventions. For example, as evidence shows that maltreatment early in life increases children's vulnerability to adjustment problems, providing preventive interventions as early as possible in a child's life may be critical.

4.28 However, while the research on risk and protective factors is important to guide policy and practice, risk, protection and resilience may vary depending on the individual child and family and their unique situation. What is a risk or a protective factor for one child may not necessarily be so for another.

4.29 While there is increasing research on the factors linked with resilient functioning in children who have experienced abuse and neglect, it should be noted that, according to DoCS, research in this area is still in its infancy and there are significant methodological problems with much of the research conducted to date.

Parenting capacity

4.30 The assessment of parenting capacity is a core task in child protection practice, both in the context of assessing parents' capacity to protect children from risk and to enhance their developmental experiences, as well as in deciding whether to remove and/or restore children to their care. Parenting capacity assessments are conducted both to assist in identifying areas of parental strength and needs in order to determine service provision for families, and to inform key decisions on restoration and permanency planning. Formal assessments of parenting capacity can have a significant impact on outcomes for children. However, there is some debate as to whether comprehensive parenting capacity assessments are, in fact, possible.[130]

4.31 There are few empirical studies on parenting capacity assessment. This is exacerbated by the lack of any clarity surrounding the definition of parenting. This creates difficulty in defining 'good enough' parenting, and establishing which behaviours, and the 'amount' of these behaviours that practitioners should be considering in their assessments.[131]

4.32 Parenting is predominantly seen as a task about the socialisation and supervision of children, within the context of their family, neighbourhood, the larger social structure and economic, political and cultural environment. Due to the changing needs of the child over time, parenting skills and behaviours will also change. It is unlikely any single assessment tool can capture this complexity. Definitions of parenting do not address the issue of 'minimal'

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[130] W Cann, "A conceptual model for the provision of parenting support," *Paper presented at DoCS Research to Practice Forum,* 25 November 2004 cited in DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, p.3.

[131] ibid., p.1.

parenting competence and this contributes to the difficulty of developing parenting capacity assessments.

4.33 However, assessment of parenting capacity should determine whether families need short term support and therapeutic intervention to overcome a specific problem or set of circumstances, or crisis intervention and long term support to enable them to cope with an enduring problem.[132]

4.34 The quality of parenting capacity assessment reports is crucial due, *inter alia*, to the impact of these reports on court decision making processes. Studies of these reports have found the quality to be variable.[133] Problems identified include evaluations of parents being completed in a single session, lack of home visits, using few sources of information other than the parent, not referring to previous reports, neglecting to describe the parent's care giving qualities or child's relationship with the parent.

4.35 In summary, there is consensus in the literature that parenting capacity is problematic both to define and assess. Parenting is determined by a range of factors and relationships and is not seen as fixed, but as undergoing constant change. Parenting capacity is context driven and is dependent on factors such as the socio-economic surroundings of the family, housing, culture and societal values, as well as family skills and relationships.[134]

4.36 This chapter will now focus on research related to issues as they are reported to DoCS.

Domestic violence

4.37 For each of the three years 2005/06 to 2007/08, domestic violence has been the most commonly primary reported issue to DoCS, accounting for around one quarter of all reports. Up to three issues can be reported in each report to DoCS.[135] When considering all three reported issues, domestic violence was a feature in just under one third of all reports for each of the three years 2005/06 to 2007/08.[136]

4.38 Research on domestic and family violence and child protection and DoCS data is discussed in more detail in Chapter 17.

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[132] L Bromfield and D Higgins, 2005, op. cit, p.45.

[133] C Conley, "A Review of Parenting Capacity Assessment Reports," *OACAS Journal, 47(3),* 2003, pp.16-22; KS Budd, LM Poindexter and ED Felix, "Clinical assessment of parents in child protection cases: an empirical analysis," *Law and Human Behaviour, 25(1),* 2001, pp.93-108 cited in DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, pp.17-19.

[134] DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, pp.51-52.

[135] Primary, secondary and third reported issue.

[136] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

Neglect

4.39 Neglect is the most common form, and also the fastest growing category, of reported maltreatment in Canada, the USA and the UK.[137] In Australia overall rates of reporting neglect appear to be lower. However, definitional differences make international and interstate comparisons difficult, that is, the broader the definition of neglect the greater the number of children included. In the literature 'child abuse and neglect' are often fused into one entity and most research actually focuses on abuse with the consequence that trends in neglect need to be qualified.

4.40 Several definitions of 'neglect' have been proposed. Most commonly they emphasise that a child's basic developmental needs have not been met by acts of omission on the part of those responsible for that child. In contrast, 'abuse' is associated with acts of commission resulting in harm to the child. Greater specificity of definition is hampered by debates about what constitutes basic developmental needs and the level of care considered adequate to meet these needs.

4.41 Traditionally, individual psychopathology was seen as the explanation for neglect by parents. Explanations of neglect have recently expanded to include the broader social context within which the child and family are living such as health, housing and socio-economic status.[138]

4.42 Young children (infants and toddlers) and those with a disability are most likely to be neglected, suggesting high levels of dependency are associated with neglect. Unlike other forms of child maltreatment, neglect seems to be unrelated to temperament and gender.

4.43 From a literature review undertaken by DoCS,[139] the 'typical' neglecting family is defined as likely to have a young, single mother who has experienced poor parenting herself, lives in an overcrowded chaotic household with several children and is dependent on public assistance for support. She is likely to have inadequate social support, to abuse substances, to be depressed and, if partnered, to suffer domestic violence. She may fail to adequately care for, be psychologically available to, or supervise her children. The victims are likely to be those who are most vulnerable, that is, children under four years and/or children with a disability. The risk factors for neglect are more likely to be characteristics of the parents than specific child characteristics.[140]

4.44 According to DoCS data, there is a strong correlation between chronic neglect presentations and parental drug and alcohol use, poverty, domestic violence

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[137] DoCS, *Prevention and Early Intervention Literature Review,* May 2005, p.8.

[138] U Bronfenbrenner and SJ Ceci, "Nature-nurture reconceptualization in developmental perspective: A bioecological model," *Psychological Review, 101,* 1994, pp.568-586 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.9.

[139] DoCS, *Child Neglect Literature Review*, May 2005, p.19.

[140] ibid.

and mental health problems. In these cases, the presenting problem for the parent distracts them from providing the necessary care for their child and frequently dominates the case planning and intervention strategies provided by child protection workers.

4.45 While each neglectful incident may seem trivial, the long term consequences of chronic neglect may be more damaging than isolated incidents of physical abuse. Children who have been neglected are prone to internalising problems such as low self esteem, depression, social withdrawal, apathy, passivity and helplessness. They are often delayed in their cognitive and language development, have poor communication skills and difficulty with interpersonal relationships.[141] In the longer term, neglected children lack the ability to participate fully in society as adults.

4.46 Based on international research examined by DoCS, an estimated half of maltreatment fatalities are attributable to childhood neglect. Cases of neglect that lead to a fatal incident are typically complex and chronic in nature. These deaths can be grouped into two general categories. One category comprises those children who died from chronic physical and medical neglect including malnutrition, or other illnesses, but that would have been treatable had the children been presented for medical care. The second group of deaths arise out of a chronically neglectful lifestyle where, usually as a result of overwhelming problems of their own, parents are unable to make safe decisions regarding the care of their children, who died, for instance, as a result of a car accident, drowning or injury.[142]

4.47 Childhood maltreatment fatalities are most often the result of a single life threatening incident; that is, supervisory neglect rather than chronic forms of neglect such as malnutrition.[143] The association of fatalities with a single critical incident makes the prediction and therefore prevention of fatalities extremely difficult, although younger children are more at risk of fatal neglect.[144]

4.48 The lack of precise definition of neglect, the range of behaviours it covers and the low probability of neglectful parents seeking help, predisposes these children to be further neglected by service providers. It is likely that neglect has reached chronic levels by the time the family is referred to statutory child protection services. Even then, Tanner and Turney suggest that the apparent trivial nature of each incident contrasts sharply with the competing priority of children whose safety is in immediate danger, with the result that the neglect is even more severe and chronic before the threshold of intervention by statutory child protection agencies is reached.[145]

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[141] ibid., p.21.

[142] ibid., p.25.

[143] ibid.

[144] ibid.

[145] K Tanner and D Turney, "What do we know about child neglect? A critical review of the literature and its application to social work practice," *Child and Family Social Work, 8,* 2003, pp.25-35 cited in DoCS, *Child Neglect, Literature Review*, May 2005 p.35.

4.49 Despite an increase in the incidence of neglect, effective family interventions have been difficult to demonstrate. Daro argues that interventions with child neglect cases were less likely to succeed, when compared with interventions for other forms of child abuse, because underlying severe neglect is indifference to the child and a lack of empathy.[146] The lack of interest in the children makes neglecting families particularly difficult to recruit and engage in programs.[147]

4.50 Chronic neglect in children is likely to require long term intervention. Tomison and Poole contend that even if families received an initial follow up after a neglect report, there is a lack of appropriate, intensive long term services that can support a neglecting family.[148] The lack of availability of these services is a common theme in the USA, the UK and Australia.[149]

4.51 In July 2006, DoCS published a child neglect policy to assist staff to better identify neglect and determine when and how to act in the best interests of children, particularly where neglect is chronic. The policy provides a more holistic view regarding secondary assessment and a greater focus on long term outcomes or underlying features of cases involving both neglect and abuse. However, there is still ongoing work required to identify effective evidence based interventions.

4.52 Guidelines to assist practitioners dealing with neglectful families stress the importance of treating the families with respect, targeting their strengths, being culturally sensitive, setting clear achievable goals that require only small incremental change, meeting the families' immediate, practical needs and brokerage to cover basic necessities and purchase services.[150] For maximum effectiveness services should be offered long term, that is, for at least two to three years. The threat of legal action should be used only as a last resort. While there are a number of scales which purport to measure the quality of care giving, they rarely have the predictive validity needed to be useful to practitioners.[151]

4.53 Effective interventions are those that support the parent and provide the child with the cognitive stimulation and the emotional warmth that they lack at home. For this reason high quality child care and education, home visiting programs and co-located multi-component services, which target both parent and child,

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[146] D Daro, "Child abuse prevention: new directions and challenges," *Nebraska Symposium on Motivation, 46,* 2000, pp.161-220 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.32.

[147] ibid.

[148] AM Tomison and L Poole, "Preventing Child Abuse and Neglect. Findings from an Australian Audit of Prevention Programs," *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2000 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.36.

[149] C Hallett and E Birchall, "Coordination and child protection: A review of the literature," *Edinburgh: HMSO,* 1992; KE Nelson, EJ Saunders and MJ Landsman, "Chronic child neglect in perspective," *Social Work, 38(6),* 1993, pp.661-672; AM Tomison, "Spotlight on child neglect, Issues in Child Abuse Prevention, Issues Paper 4," *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 1995 cited in DoCS, *Child Neglect Literature Review,* May 2005, p.36.

[150] DoCS, *Neglect: Key intervention strategies, Research to Practice Note,* February 2006.

[151] DoCS, *Child Neglect Literature Review,* May 2005, p.iv.

may be effective. However, the greater the severity and chronicity of neglect the more directly the intervention needs to target the child.[152]

4.54 In summary, the literature acknowledges that neglect remains the most resistant to current interventions, but given the negative impacts of neglect, service providers need to be able to recognise early indicators of neglect. Providing physical care, nourishing food, stimulating programs and emotional nurturing directly to disadvantaged children has been seen to have a more positive impact on child outcomes than if the intervention is aimed at parents.[153]

Physical abuse

4.55 Child physical abuse is harm to children or young persons that is caused by the non-accidental actions of a parent or other person responsible for their care. Acts such as beating, shaking, biting, deliberately burning with an object, attempted strangulation and female genital mutilation are examples of physical abuse.[154] There is still much debate concerning whether physical or corporal punishment of children by parents, care-givers or teachers such as smacking should be defined as child abuse.[155] In some instances, excessive discipline can constitute physical abuse and lead to criminal charges.

4.56 The impact of physical abuse on children and young persons may result in long term adverse outcomes in terms of intellectual and cognitive functioning,[156] mental health problems[157] and general ill health.[158] A strong link between adverse child experiences, including physical abuse, and later health problems has been found including heart disease, liver disease, cancer and chronic lung disease.[159] In its most extreme form physical abuse of children and young persons may be permanently disabling or result in death.

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[152] ibid.

[153] J Marshall and P Watt, "Child behaviour problems. A literature review of the size and nature of the problem and prevention interventions in childhood," *The Interagency Committee on Children's Futures,* 1999, cited in Submission: DoCS, Service models, p.21.

[154] *NSW Interagency Guidelines for Child Protection Intervention*, 2006, p.8.

[155] N Richardson, "What is Child Abuse?" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* Resource Sheet Number 6, December 2004.

[156] CM Perez and CS Widom, "Childhood Victimisation and Long-Term Intellectual and Academic Outcomes in Child Abuse and Neglect," *National Criminal Justice Reference Service, Vol. 18, No. 8*, 1994, pp.617-633 cited in Submission: NSW Health, p.9.

[157] KJ Saywitz, AP Mannarino, L Berliner and JA Cohen, "Treatment for sexually abused children and adolescents," *American Psychologist, Vol 55, No. 9,* 2000, pp.1040-1049; DM Ferguson and PE Mullen, "Childhood sexual abuse: an evidence-based perspective," *Developmental Clinical Psychology and Psychiatry series, Vol 40, Sage Publications Inc.,* Thousand Oaks, California, 1999, cited in Submission: NSW Health, p.9.

[158] VJ Felitli, RF Anda, D Nordenber, DF Williamson, AM Spitz, V Edwards, MP Kiss and JS Marks, "Relationship of Childhood Abuse and Household Dysfunction to many of the Leading Causes of Death in Adults – The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine, Vol 14, No. 4,* 1998, pp.245-258 cited in Submission: NSW Health, p.9.

[159] ibid.

4.57 Risk of harm issues involving infants require specific attention. The findings of a Welsh study into severe physical abuse of babies aged less than one year are as follows:

a. severe physical abuse is six times more common than that for children aged one to four years and 120 times more common than that for five to 13 year olds

b. brain injury and fractures are more common than for older children, and are at their most frequent in the first six months

c. the non-accidental death rate is ten times higher than that for children aged one to five years.[160]

4.58 Both mothers and fathers physically abuse children. A British prevalence study found that while mothers were more likely than fathers to be responsible for physical abuse (49 per cent of incidents compared with 40 per cent),[161] part of the difference may be explained by the greater time children spent with their mothers than fathers. Violence was also reported to be perpetrated by stepmothers (three per cent) or stepfathers (five per cent), grandparents (three per cent) and other relatives (one per cent).[162]

4.59 There is some evidence that children living with both biological parents are more likely to be physically abused by their fathers than by their mothers. For instance, Creighton and Noyes found that when the child was living with both birth parents, mothers were implicated in 36 per cent of cases and fathers in 61 per cent.[163]

4.60 Some research suggests that men living with children are most likely to perpetrate severe physical abuse, especially abuse that results in a child's death.[164]

4.61 Single parents, adolescent parents, and de facto or step parents (particularly males) have been found to be at higher risk of physically abusing children.[165]

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[160] P Dale, R Green and R Fellows, "What Really Happened: Child Protection Management of infants with serious injuries and Discrepant Parental Explanations," 2002, cited in *NSW Interagency Guidelines for Child Protection,* 2006, p.9.

[161] P Cawson, C Wattam, S Brooker and G Kelly, "Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect," *London: National Society for the Prevention of Cruelty to Children,* 2000 cited in N Richardson and L Bromfield, "Who Abuses Children?" *National Child Protection Clearinghouse, Australian Institute of Family Studies* Resource Sheet Number 7, February 2005, p.2.

[162] N Richardson and L Bromfield, "Who Abuses Children?" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* Resource Sheet Number 7, February 2005, p.2.

[163] S Creighton and P Noyes, "Child abuse trends in England and Wales 1983-1987," *London: National Society for the Prevention of Cruelty to Children,* 1989 cited in N Richardson and L Bromfield, 2005, op. cit., p.2.

[164] N Richardson and L Bromfield, 2005, op. cit., pp.2-3.

[165] RJ Gelles, "Child abuse and violence in single-parent families: Parent absence and economic deprivation" *American Journal of Orthopsychiatry, 59,* 1989, pp.492-501, cited in N Richardson and L Bromfield, 2005, op. cit., p.3.

4.62 The number of single father families is small[166] and very little is known about whether their risk of providing a context for child maltreatment differs from that of other types of families.[167]

4.63 Low levels of parental empathy have been associated with parental aggression towards one's child.[168] As child abuse is clearly a form of aggression, researchers have looked to existing models of aggression which highlight empathy as an important factor to understand the processes involved in abuse. Research notes that physically abusive parents have deficits in their perceptions, expectations, interpretations and evaluations of their child's behaviour. Furthermore, parents who have high levels of personal distress, as is often the case with parents deemed 'at risk', commonly have information processing difficulties which makes perspective taking more difficult.[169]

4.64 However, research has also found different results for high risk mothers and fathers. High risk mothers appear to be at an increased risk of using physical aggression due to high levels of personal distress when observing the suffering of their child. This is thought to be just enough distress to incite an aggressive response but not enough to facilitate perspective taking. On the other hand, high risk fathers tend to be physically aggressive because of their inability to engage in perspective taking.[170]

4.65 In summary, whilst the data on prevalence of physical abuse are available there are less data on effective interventions for those who physically abuse children. It appears, however, that interventions like home visiting and parenting programs have had some success as well as multi-component interventions that focus on reducing a variety of risk factors in several domains; that is, family, schools, teachers, and peer environments. Meta analyses show that programs using multiple interventions work better than those using a single intervention strategy.[171]

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[166] For example, according to Australian Bureau of Statistics data 2004, single father families account for 2.7 per cent of families in Australia, in ibid, p.3.

[167] AM Tomison, "Child maltreatment and family structure," discussion paper, 1, *Australian Institute of Family Studies*, 1996. cited in N Richardson and L Bromfield, 2005, op. cit., p.3.

[168] DM Zeifman, "Predicting adult responses to infant distress: Adult characteristics associated with perceptions, emotional reactions, and timing of intervention," *Infant Mental Health Journal, 24*(6), 2003, pp.597-612, cited in DoCS, *Parental Empathy and Child Maltreatment*, *Research to Practice Note*, August 2006.

[169] A Perez-Albeniz and J de Paul, "Gender differences in empathy in parents at high-and-low-risk of child physical abuse," 2004, *Child Abuse and Neglect, 28*, pp.289-300 cited in DoCS*, Parental Empathy and Child Maltreatment, Research to Practice Note*, August 2006.

[170] DoCS, *Parental Empathy and Child Maltreatment, Research to Practice Note*, August 2006.

[171] J Marshall and P Watt, "Child Behaviour Problems: A Literature Review of its Size and Nature and Prevention Interventions," *Perth, W.A., Interagency Commission on Children's Futures,* 1999, cited in DoCS, *Prevention and Early Intervention, Literature Review*, May 2005, p.3.

Carer drug and alcohol misuse

4.66 Substance abuse[172] can seriously affect parenting capacity and place children at significant risk.

4.67 Parental substance misuse has been associated with high rates of child maltreatment. A number of large scale cohort and case control studies using community samples have suggested that substance abuse is strongly and directly related to child abuse and neglect.[173] Studies using administrative records have also found an association between parental substance misuse and high rates of child maltreatment.[174]

4.68 An Australian National Council on Drugs research paper states that while the literature establishes the negative impact of parental substance misuse, there is no specific comparison between substance classes.[175] For example, it is not possible to determine whether parental amphetamine use poses a greater risk to adverse child outcomes compared with the use of a substance such as heroin.

4.69 According to the National Drug and Alcohol Research Centre there is limited research that has examined the impact of different types of illicit substances on parenting and children. Dawe et al comment that the direct effects of the substance being used is likely to influence the quality of parenting provided for the child; opioids for example may be more likely to be associated with child neglect while drugs such as amphetamines and cocaine that are associated with serious disturbances of mental state, including sub-clinical symptoms of psychosis and hostility, may be more likely to be associated with physical abuse.[176] For those using amphetamines, the effects of hyperactivity or 'speediness' may lead to actions being undertaken too quickly without regard for risk, or failure to observe hazards.[177] In addition, children who may become the focus of substance induced paranoia or hallucinations may also be at risk of

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[172] Terminology in this research area variously refers to substance abuse, misuse or dependence, drug and/or alcohol abuse, misuse or dependence.

[173] M Chaffin, K Kelleher and J Hollenberg, "Onset of physical abuse and neglect: psychiatric substance abuse and social risk factors from prospective community data," *Child Abuse and Neglect, 20(3),* 1996, pp.191-203; C Walsh, HL MacMillan and E Jamieson, "The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement," *Child Abuse and Neglect, 27,* 2003, pp.1409-1425; K Kelleher, M Chaffin, J Hollenberg and E Fisher, "Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample," *American Journal of Public Health, 84(10),* 1994 pp.1586-1590; K Street, J Harrington, W Chiang, P Cairns and M Ellis, "How great is the risk of abuse in infants born to drug-using mothers?" *Child: Care, Health and Development, 30(4),* 2004 pp.325-330 cited in Submission: National Drug and Alcohol Research Centre, p.9.

[174] S Magura and AB Lauet, "Parental substance abuse and child maltreatment: Review and implications for intervention," *Children and Youth Services Review, 18(3),* 1996 pp.193-220; BD Smith and MF Testa, "The risk of subsequent maltreatment allegations in families with substance-exposed infants," *Child Abuse and Neglect, 26,* 2002, pp.94-114 cited in Submission: National Drug and Alcohol Research Centre, p.9.

[175] Australian National Council on Drugs, "Drug Use in the Family: Impacts and Implications for Children," *Research Paper 13*, 2007, p.viii.

[176] S Dawe, S Frye, D Best, M Lynch, K Atkinson, C Evans and PH Harnett, "Drug Use in the Family: Impacts and Implications for Children," *Australian National Council on Drugs*, Canberra, 2007 cited in Submission: National Drug and Alcohol Research Centre, p.10.

[177] B Kroll and A Taylor, "Parental substance misuse and child welfare," London, UK*, Jessica Kingsley Publishers,* 2003, cited in Submission: National Drug and Alcohol Research Centre, p.10.

harm. Alcohol misuse, by male partners in particular, has the potential not only to impair partner and family relations but to contribute to physical abuse of partners and children.[178] It has been estimated that alcohol is an important factor in 50 per cent of domestic, physical and sexual violence.[179] Even if abuse and neglect are not present, poor parenting practices are likely to have long term impacts on the children.

4.70 The research on the impact of parental alcohol misuse on children's development reveals that children can and do suffer from a range of maladaptive outcomes spanning all areas of development, including cognitive, behavioural, psychological, emotional and social development.[180] It is estimated that 13 per cent of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker. It has been estimated that 31 per cent of parents involved in substantial cases of child abuse or neglect experience significant problems with alcohol use.[181]

4.71 However, children and families living with parental alcohol misuse differ according to the composition of risk factors that contribute to outcomes, and studies show that not all children experience adverse outcomes. One exception is the epidemiological research that supports an association between the excessive consumption of alcohol by pregnant women and the risk of foetal alcohol syndrome and its effects.[182]

4.72 The effects of parental alcohol misuse appear to be cumulative. The longer the child has been exposed to parental alcohol misuse, the greater the impact may be. Disruptive behaviours, such as aggression, hyperactivity and mental health problems, are particularly apparent in boys whose parents misuse alcohol. There is no clear evidence that maternal alcohol misuse has a greater or lesser impact on children than paternal alcohol misuse. However, children of mothers who misuse alcohol are more likely to be exposed to a variety of risks and it is the accumulation of risk factors that poses the greatest threat. Children from families containing three or more immediate or extended family members who misuse alcohol are more likely to have adverse outcomes.[183]

4.73 NSW research undertaken in 2006 about illicit drug use in pregnancy examined obstetric and perinatal outcomes.[184] The researchers found that births in each of the drug groups were to women who were in many cases younger, had a

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[178] DoCS, *Parental Alcohol Misuse and the Impact on Children, Literature Review*, July 2006, p.10.

[179] Australian Government, "Technical Report No 3: Preventing alcohol-related Harm in Australia: A window of opportunity," *National Preventative Health Taskforce,* 2008, p.14.

[180] DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.iii.

[181] Australian Government, "Technical Report No 3: Preventing alcohol-related Harm in Australia: A window of opportunity," *National Preventative Health Taskforce,* 2008, p.14.

[182] C O'Leary, "Foetal alcohol syndrome: A literature review," Canberra, Australia: *National Expert Advisory Committee on Alcohol,* 2002 cited in DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.iii.

[183] DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, pp.iii-iv.

[184] L Burns, R Mattick and M Cooke, "The use of record linkage to examine illicit drug use in pregnancy" *Addiction* Vol 101(6) June 2006 pp.873-882 cited in DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

higher number of previous pregnancies, were Aboriginal, smoked heavily and were not privately insured. Drug exposed babies have an increased risk of experiencing a preterm birth, being small for gestational age, having a prolonged hospital stay, being stillborn and suffering neonatal death.[185] Over the longer term these babies are at higher risk of a number of health and behavioural problems, including hyperactivity disorders, and learning and speech difficulties. The NSW research found that more than 50 per cent of children of opioid dependent women were not living with their biological parents by the time of their fifth birthday.[186]

4.74 While there is evidence of an association between substance misuse and child abuse and neglect (and poor parenting), it does not describe a causal relationship. Most of the research linking substance misuse and child abuse does not take into account the co-occurring factors in substance misusing families, such as demographic or social factors.[187] Studies that have attempted to isolate the influence of substance misuse on parenting have found that it has less of an influence than other contextual factors.[188] It is suggested that:

> *the wide range of factors associated with substance abuse may in fact be the primary causal factors in links between substance abuse and child maltreatment. Some argue that it is now well recognised that it is difficult to separate out the effects of parental substance misuse on parenting from the similar detrimental impact of a number of common psychosocial factors, such as financial, mental health, employment, and social isolation problems.*[189]

4.75 Substance abuse may however act as the "marker for the presence of, as well as compound the effects of, the other risk factors."[190]

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[185] R, Kennare, A Heard and A Chan, "Substance Use during Pregnancy: Risk Factors and Obstetric and Perinatal Outcomes in South Australia," *Australian and New Zealand Journal of Obstetrics and Gynacology* 45, 2005, pp.220-225 cited in DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

[186] DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

[187] S Dawe, S Frye, D Best, M Lynch, K Atkinson, C Evans and PH Harnett, 2007, op. cit.; J Tunnard, "Parental drug use: A review of impact and intervention studies," *Research in practice,* www.rip.org.uk, 2002 in Submission: National Drug and Alcohol Research Centre, p.9.

[188] SL Hans, "Parenting and parent-child relationships in families affected by substance abuse," in H E. Fitzgerald, B. Lester and B. Zuckerman (Eds.)," *Children of addiction: Research, health and public policy issues*, New York: Routledge Falmer; L Kettinger, P Nair, and M Schuler, "Exposure to environmental risk factors and parenting attitudes among substance abusing women," *American Journal of Drug and Alcohol Abuse, 26(1)*, 2000, pp.1-10; NE Suchman, and SS Luthar, "Maternal addiction, child maladjustment and socio-demographic risks: Implications for parenting behaviors," Addiction, 95 *(9)*, 2000, pp.1417-1428.; P Nair, ME Schuler, MM Black, L Kettinger, and D Harrington, "Cumulative environmental risk in substance abusing women: Early intervention, parenting stress, child abuse potential and child development" *Child Abuse and Neglect, 27(9)*, 2003, pp.997-1017 cited in Submission: National Drug and Alcohol Research Centre, p.9.

[189] SL Hans, "Studies of prenatal exposure to drugs: Focusing on parental care of children" *Neurotoxicology and Teratology, 24(3)*, 2002, pp.329-337; B Rittner and C Dozier, "Effects of court-ordered substance abuse treatment in child protective services cases," *Social Work, 45,* 2000, pp.131-140 cited in Submission: National Drug and Alcohol Research Centre, pp.9-10.

[190] Submission: National Drug and Alcohol Research Centre, pp.9-10.

4.76 US research has concluded that children of families with substance abuse problems tend to come to the attention of child welfare agencies at a younger age than other children, are more likely to be placed in care, and once in care are likely to remain in care longer.[191] Further:

> *amongst mothers who become involved with the child welfare system, those who have substance abuse problems are more likely to lose their parental rights, compared with non substance-abusing mothers.*[192]

Substance abuse has been shown to be "a key risk factor for re-reports or recurrence in families with child welfare involvement."[193]

4.77 Anecdotal reports suggest that:

> *significant numbers of parents are entering drug treatment services in response to the involvement of the child protection system in NSW. Entering treatment and ceasing drug use may be a condition of retaining parental responsibility for their children. However, the effectiveness of providing 'treatment' alone may be limited, particularly given the complex range of problems with which the majority of substance misusers present. Treatment programs, particularly in rural and remote areas, may not be equipped to deal with mental health, housing, financial, legal as well as parenting issues. Furthermore, substance users may not be able to access treatment that allows them to retain the care of their children although community-based programs are more likely to enable parents to continue caring for their children, very few residential rehabilitation programs cater for mothers and children.*[194]

4.78 Some research has found that entering the drug treatment system may not increase the likelihood that substance using parents already involved with the child protection system will retain care of their children. Barth, Gibbons and Guo found that families that enter substance abuse treatment have higher re-

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[191] J Semidei, LF Radel, and C Nolan, "Substance abuse and child welfare: Clear linkages and promising responses," *Child Welfare, 80 (2)*, 2001, pp.109-28 cited in Submission: National Drug and Alcohol Research Centre, p.11.

[192] MO Marcenko, SP Kemp and NC Larson, "Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers," *American Journal of Orthopsychiatry, 70,* 2000 pp.316-326; CE Grella, Y-I Hser, and Y-C Huang, "Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services," *Child Abuse and Neglect 30*, 2006, pp.55-73 cited in Submission: National Drug and Alcohol Research Centre, p.11.

[193] I Wolock, and S Magura, "Parental substance abuse as a predictor of child maltreatment re-reports," *Child Abuse and Neglect. 20 (12)*, 1996, pp.1183-1193; JM Murphy, M Jellinek, D Quinn, G Smith, FG Poitrast, and M Goshko, "Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample," *Child Abuse and Neglect, 15(3)*, 1991, pp.197-211 cited in Submission: National Drug and Alcohol Research Centre, p.11.

[194] W Swift, J Copeland, and W Hall, "Characteristics and treatment needs of women with alcohol and other drug problems: results from an Australian national survey," *National Drug Strategy Research Report Series: Report no.7*, 1995 cited in Submission: National Drug and Alcohol Research Centre, p.11.

report rates.[195] Dore and Doris found that completing substance abuse treatment was not a strong predictor of preventing the placement of children in foster care.[196] However, a longitudinal study of 1,911 women who had children placed in substitute care found that when women entered treatment more quickly, spent more time in treatment, or completed at least one treatment episode, their children spent fewer days in foster care and were more likely to be reunified with their parents.[197]

4.79 Marsh et al note that the "pervasive fear about having their children taken away"[198] prevents many substance abusing parents from accessing treatment services. This lack of engagement with treatment services increases the risk for children and it can be very difficult to assess accurately the level of risk to the child.[199]

4.80 Relevant strategies to assist families and children include parenting education and support, facilitating quality child care and educational opportunities for children, and working with families to improve social and behavioural skills. Home visiting is one of the most well researched interventions, yet there are mixed results regarding its effectiveness for families where alcohol misuse is an issue. While there is still a shortage of evidence regarding the effectiveness of parenting programs as an intervention for families with alcohol and other drug problems, further trials and evaluations suggest promising results. Providing access to quality child care and education is an effective intervention for assisting children. There have also been some positive evaluations from 'family focused' programs, which include interventions for both parents and children.[200]

4.81 Where mental illness is also present, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role.[201] This could be done through improved training opportunities for alcohol and other drug workers, improved liaison with mental health services, the provision of guidelines for drug and alcohol workers for the assessment of child protection issues[202] and access to linked websites and resources for workers in the drug and alcohol sector.

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[195] RP Barth, C Gibbons, and S Guo, "Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis*," Journal of Substance Abuse Treatment. 30,* 2006, pp.93-104, cited in Submission: National Drug and Alcohol Research Centre, p.11.

[196] MM Dore, and JM Doris, "Preventing child placement in substance-abusing families, Research-informed practice," *Child Welfare, 77(4)*, 1998, 407-426, cited in Submission: National Drug and Alcohol Research Centre, p.11.

[197] BL Green, A Rockhill, and C Furrer, "Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis," *Children and Youth Services Review. 29*, 2007, pp.460-473, cited in Submission: National Drug and Alcohol Research Centre, p.11.

[198] A Marsh, A Dale, and L Willis, "Evidence Based practice Indicators for Alcohol and Other Drug Interventions: Literature Review," *Drug and Alcohol Office, Health Department, Western Australia*, September, 2007, p.73.

[199] ibid.

[200] DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.v.

[201] Australian National Council on Drugs "Drug Use in the Family: Impacts and Implications for Children," *Research Paper 13*, 2007, p.viii.

[202] ibid. and p.xi.

4.82 According to the National Drug and Alcohol Research Centre:

> *one of the strongest messages from the literature is the need for a coordinated service response in addressing substance misuse problems, particularly when children are involved, to address the broader issues associated with substance use.*[203]

Thus, child welfare and alcohol and other drug services need to work in partnership to identify and 'treat' harmful substance use and the co-occurring psychological, physical, and social problems in order to reduce the impacts of substance use on both the parent and the child.

4.83 Participants at the 2007 National Family Alcohol and Drug Network Conference called upon Commonwealth, State and Territory Governments to recognise and respond to the connection between parental drug use and alcohol misuse and child protection as a matter of national urgency given that:

> *current research shows that at least one in eight of all Australian children are living in a household where there is parental misuse of, or dependence on, alcohol or other drugs; and that parental substance misuse puts children at direct increased risk of Foetal Alcohol Spectrum Disorder, physical and sexual abuse, neglect and exposure to family violence.*[204]

4.84 The conference resolution urged governments to:

a. include data on parental status and parental drug and alcohol use in all universally collected data sets
b. develop effective strategies to prevent alcohol misuse and alert parents to its impact on children
c. divert a portion of government revenues from the sale of alcohol to fund holistic programs for treating parents with drug and alcohol dependence and meeting the needs of affected children.[205]

4.85 In summary, the research suggests that parental substance abuse can affect parenting styles and can have a negative impact on children. While there is an association between substance abuse and child abuse and neglect the relationship is not causal and often other risk factors are present. Access to quality child care and education and coordinated service provision that

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[203] A Copello, R Velieman, and L Templeton, "Family interventions in the treatment of alcohol and drug problems," *Drug and Alcohol Review, 24 (4)*, 2005, pp.369-385; S Greunert, S Ratnam, and M Tsantefski, "The Nobody's Client Project: Identifying and addressing the needs of children with substance dependent parents: Odyssey Institute of Studies," *Odyssey House Victoria*, 2004: J Tunnard, "Parental drug use: A review of impact and intervention studies," *Research in practice,* www.rip.org.uk, 2002; B Kroll and A Taylor, "Parental substance misuse and child welfare," London, UK, Jessica Kingsley Publishers, 2003; CE Grella, Y-I Hser, and Y-C Huang, "Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services," *Child Abuse and Neglect 30*, 2006, pp.55-73 cited in Submission: National Drug and Alcohol Research Centre, p.12.

[204] "Parental Substance Use and Child Protection Resolution," *Family Alcohol and Drug Network Conference*, 2007: www.aifs.gov.au.

[205] ibid.

addresses the broader issues of substance abuse appear to be the most promising interventions.

Psychological abuse

4.86 The core issue of emotional or psychological abuse is that it is a sustained pattern of verbal abuse and harassment by an adult that results in damaging a child's self esteem or social competence, resulting in serious emotional deprivation or trauma.[206]

4.87 A US survey found that biological parents were responsible for 81 per cent of cases of psychological maltreatment, non-biological parents were responsible for 13 per cent, and extra familial perpetrators were responsible for five per cent. Of biological parents, mothers were the perpetrators of emotional abuse in 60 per cent of incidents and fathers were the perpetrators in 55 per cent (these figures exceed 100 per cent as in some instances both mothers and fathers perpetrate emotional abuse).[207]

4.88 It is difficult to determine the true extent of psychological maltreatment and to identify who is responsible for perpetrating psychological maltreatment. The difficulties in researching psychological maltreatment stem from ongoing disagreements over defining and measuring this form of maltreatment.[208] For example, there is some debate over whether to make a distinction between psychological abuse (for example, verbal abuse) and psychological neglect (for example, ignoring a child).[209]

4.89 Verbal abuse is, perhaps, the core emotionally abusive behaviour. When used as part of a chronic pattern of interaction, things that may be considered as abusive include verbal putdowns, negative prediction, constant negative comparison, scapegoating, shaming, swearing and threats.[210]

4.90 Witnessing domestic violence is often considered a form of emotional or psychological abuse. Psychological harm caused by domestic violence may vary depending on the age of the child, the length of exposure to incidents of domestic violence, the nature of the incidents and the nature of any protective factors available to the child and their family. The Inquiry noted that police reports of incidents of domestic violence sometimes reported the incident as

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[206] AM Tomison and J Tucci, "Emotional Abuse: The hidden form of maltreatment," *Issues in Child Abuse Prevention, 8, National Child Protection Clearinghouse, Australian Institute of Family Studies,* 1997 cited in N Richardson and L Bromfield, 2005, op. cit.

[207] AJ Sedlak and DD Broadhurst, "Third national incidence study of child abuse and neglect: Final report," *Washington, DC: US Dept of Health and Human Services,* 1996, in N Richardson and L Bromfield, 2005, op. cit.

[208] AM Tomison and J Tucci, 1997, op. cit.; DA Black, AM Slep, and RE Heyman, "Risk factors for child psychological abuse," *Aggression and violent behaviour, 6,* 2001, pp.189-201 cited in N Richardson and L Bromfield, 2005, op. cit.

[209] N Richardson and L Bromfield, 2005, op. cit.

[210] ibid.

psychological abuse and/or included psychological abuse as either the primary, secondary or third reported issue.

4.91 Psychological/emotional abuse is a difficult term and the Inquiry suspects that it is one that is not interpreted consistently within DoCS, or by mandatory reporters.

4.92 While research is limited in this area, it could be inferred that suggested interventions would include early intervention strategies to counteract disadvantage and enhance parental competencies and multi-faceted interventions that reduce risk factors and strengthen protective factors.

Carer mental health

4.93 The presence of parental mental illness on its own does not automatically lead to poor outcomes for children, but "it is the interaction of the parental mental illness with other variables that will enhance resilience or confer risk upon children."[211] For instance, Maybery et al cite research that found that mentally ill parents often experience concurrent difficulties with interpersonal relationships, social isolation and financial stresses. Consequently:

> *families affected by parental mental illness are not all the same; parents will experience different types of mental illness, levels of illness severity and chronicity, and their children will thus require different levels and types of support.*[212]

4.94 The diagnosis of a mental illness has been shown to impact on parenting behaviour and capacity.[213] Oyserman et al found that mothers with a severe and persistent mental illness have significantly less adequate parenting skills than mothers who do not have a mental illness.[214] However, Risley-Curtiss et al found that with appropriate diagnosis, support, treatment and medication, most people with a serious mental illness experience improvement in many areas including parenting behaviours.[215]

4.95 Several studies have suggested that the diagnostic status of mothers is not a useful predictor of either their functioning or their children's functioning, and

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[211] J Nicholson, K Biebel, B Kinden, A Henry and L Stier, "Critical issues for parents with mental illness and their families," *Centre for Mental Health Services; Substance Abuse and Mental Health Services Administration,* 2001 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, "VicHealth Research Report on Children at Risk in Families affected by Parental Mental Illness," *Victorian Health Promotion Foundation, Melbourne*, 2005, p.5.

[212] D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.5.

[213] ibid., p.6.

[214] D Oyserman, CT Mowbray, P Allen-Meares and K Firminger, "Parenting among mothers with a serious mental illness," *American Journal of Orthopsychiatry, 70*, 2000, pp.296-315 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.6.

[215] C Risley-Curtiss, LK Stromwall, D Trueet Hunt, and J Teska, "Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases," *Families in Society, 82(1),* 2004, pp.107-119 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.6.

have instead emphasised the impact of severity and/or chronicity of a parent's mental illness on child and parenting outcomes.[216]

4.96 Although difficult to separate illness, severity and chronicity it appears that higher levels of parental mental illness puts a child at higher levels of risk compared with a child whose parent's mental illness is not severe and/or chronic:

> *Such outcomes are probably an interplay of various issues including parenting, socioeconomic circumstances and social supports. Much less clear is the impact of a parent's illness diagnosis on children.*[217]

4.97 Research has indicated that children with a severely mentally ill parent,[218] particularly those in single parent families,[219] are at increased risk of later mental health and adjustment problems than other children whose parents might have a mild or moderate mental illness and/or who live in a two parent family.

4.98 People with a mental illness are also at very high risk of developing problematic drug or alcohol use. Up to 80 per cent of people with a mental illness have substance misuse problems. Similarly, up to 75 per cent of clients with drug and alcohol problems also experience mental health problems, most commonly anxiety or mood disorders, such as depression.[220]

4.99 Cousins focuses on the effects of long term emotional abuse and neglect due to parental mental health issues.[221] She proposes that it is very difficult for adult mental health workers to balance the needs of the adult client and the needs of their children, when sometimes these conflict. Cousins argues for:

> *a change in service culture where the ethical and moral nature of these decisions is discussed and debated, rather than what could be seen to be an emerging culture of fear, based on recent critical incidents and unwanted media attention.*[222]

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[216] D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.7.

[217] ibid., p.8.

[218] K Frankel and R Harmon, "Depressed mothers: They don't always look as bad as they feel," *Journal of the American Academy of Child and Adolescent Psychiatry, 35,* 1996, pp.289-298; J Harnish, K Dodge and E Valente, "Mother-child interaction quality as a partial mediator of the roles of maternal depressive symptomology and socioeconomic status in the development of child behaviour problems," *Child Development, 66,* 1995, pp.739-753; DM Teti, DM Gelfand, D Messinger and R Isabella, "Maternal depression and the quality of early attachment: An examination of infants, preschoolers and their mothers," *Developmental Psychology, 31,* 1995 pp.364-376; S Nolen-Hoeksema, A Wolfson, D Mumme and K Guskin, "Helplessness in children of depressed and nondepressed mothers," *Developmental Psychology, 31,* 1995 pp.377-387, cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.16.

[219] DA Wilson, C Bobier and EM Macdonald, "A perinatal psychiatric service audit in New Zealand: patient characteristics and outcomes," *Archives of Women's Mental Health, 7,* 2004, pp.71-79 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, "VicHealth Research Report on Children at Risk in Families affected by Parental Mental Illness," 2005, *Victorian Health Promotion Foundation, Melbourne*, p.16.

[220] DoCS, *Dual Diagnosis Support Kit, Caseworker Manual*, 2005, p.2.

[221] C Cousins, 2004, op. cit.

[222] ibid., p.1.

4.100 Finally, families affected by parental mental illness are more likely to experience crises, such as the hospitalisation of a parent, or an acute mental illness episode and the likelihood of this occurrence is higher again for families in which a parent has a severe mental illness.[223] It is sometimes under these circumstances that children come to the attention of child protection authorities. Prior planning is therefore important for all members of a family to plan for future episodes of hospitalisation or periods of illness.[224]

4.101 In summary, a wide range of factors including mental health problems can affect parenting capacity. The impact on parents' cognitions, attributions and capacity to empathise has been associated with increased risk for child maltreatment. Suggested interventions include tailored parenting programs, encouraging support systems for the child and family, and building positive social and emotional connections for the child, for example with child care workers, teachers or peers.[225] Literature also suggests enhanced interagency responses and more effective liaison between mental health, drug and alcohol, and child protection workers.

Sexual abuse

4.102 Most sexual abuse is perpetrated by someone who is known to the child, such as a family member, family friend or person with whom the child comes into contact (for example, sports coach, teacher, priest).[226]

4.103 A review of North American sexual abuse prevalence studies suggested that sexual abuse is committed primarily by males (90 per cent of cases). The review also found that the children knew most perpetrators, with 'strangers' constituting between 10 to 30 per cent of offenders.[227]

4.104 Non-biological male family members (stepfather or mother's de facto partner) are disproportionately represented as sex offenders. For example, Russell reported that girls living with stepfathers were at a markedly increased risk: 17 per cent had been sexually abused compared with 2.3 per cent of girls living with biological fathers.[228]

4.105 Although males constitute the majority of perpetrators, a review of the evidence for female sex abusers concluded that females do abuse in a small proportion

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[223] D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.18.

[224] R Kirkland and DJ Maybery, "Managing critical incidents in schools, planning your response," *Practising Administrator, 22(3),* 2001, pp.18-23, cited in ibid p.18.

[225] ibid.

[226] JM Leventhal, "Epidemiology of sexual abuse of children. Old problems, new directions," *Child Abuse and Neglect, 22,* 1998, pp.481-491 cited in N Richardson and L Bromfield, 2005, op. cit., p.1.

[227] D Finkelhor, "Current Information on the scope and nature of child sexual abuse," *The Future of Children, 4,* 1994, pp.31-53 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

[228] DEH Russell, *The secret trauma: Incest in the lives of girls and women*, New York: Basic Books, 1989 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

of cases: approximately five per cent of female victims, and 20 per cent of male victims experience sexual abuse perpetrated by a female.[229]

4.106 It is estimated that one in four girls and one in six boys experience child sexual abuse and live with its impact on their emotional, physical and psychological well-being.[230] However it is also acknowledged that child sexual assault is under reported and that, in particular, intra-familial abuse comprises the most under reported group of all sexual offences.[231]

4.107 Extensive research has demonstrated strong links between experiences of sexual assault and a range of problems in adolescence and adulthood. These problems include:

a. low self esteem, behaviour, problems and depression[232]

b. self harming behaviours[233]

c. drug and alcohol abuse[234]

d. mental health problems[235]

e. suicidal thinking or behaviour.[236]

4.108 Child sexual abuse rarely occurs in isolation but usually in the presence of other forms of abuse. Research clearly links childhood sexual abuse with higher rates in adults of depressive and anxiety symptoms, substance abuse disorders, eating disorders and post traumatic stress disorders: "there is no doubt that the physical, emotional and psychological effects accompanying sexual abuse can last a lifetime."[237]

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[229] D Finkelhor and DEH Russell, "Women as perpetrators," in D. Finkelhor (ed.), *Child sexual abuse: New theory and research, New York: The Free Press,* 1984, pp.171-187 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

[230] D Finkelhor, "The international epidemiology of child sexual abuse," *Child Abuse and Neglect, 18,* 1994, pp.409-417 cited in V Resofsky, "Stewards of Children: a primary prevention program for child sexual abuse," *Child Abuse Prevention Newsletter*, v.15 no.2, 2007, p.12.

[231] J Goodman-Delahunty and J Pratley, "The NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program: An Evaluation of Treatment Outcomes," July 2008, p.4.

[232] J Tebbutt, H Swanston, RK Oates, BI O'Toole, "Five Years after Child Sexual Abuse: Persisting Dysfunction and Problems of Prediction," *Journal of American Child and Adolescent Psychiatry, Vol 36, No. 3,* March 1997, pp.330-338 cited in Submission: NSW Health, p.9.

[233] P Beckinsale, G Martin and S Clark, "Sexual abuse and suicidal issues in Australian young people," *Australian Family Physician, Vol 28, No. 12,* December 1999, pp.1298-1303; AC Salter, "Transforming Trauma: A guide to understanding and treating adult survivors of child sexual abuse," *Sage Publications, Thousand Oaks, California,* 1995 cited in Submission: NSW Health, p.9.

[234] AC Salter, 1995, op. cit., cited in Submission: NSW Health, p.9.

[235] PE Mullen and J Fleming, "Long term effects of child sexual abuse, issues in child abuse prevention," *National Child Protection Clearinghouse Issues Paper, Australian Institute of Family Studies, No.9,* Autumn 1998 cited in Submission: NSW Health, p.9.

[236] RK Oates, A Plunkett, B O'Toole, H Swanston, S Shrimpton, and P Parkinson, "Suicide Risk following Child Sexual Abuse," *American Journal of Ambulatory Paediatrics, September, Vol 1, No. 5,* 2001, pp.262-266; P Beckinsale, G Martin and S Clark, "Sexual abuse and suicidal issues in Australian young people," *Australian Family Physician, Vol 28, No. 12,* December 1999, pp.1298-1303 cited in Submission, NSW Health, p.9.

[237] Kennedy, 2000, cited in L O'Brien and C Henderson, "Reframing responses: improving service provision to women survivors of child sexual abuse who experience mental health problems," *Auseinetter* No.27 Nov 2006, pp.20-21.

4.109 Over the last 20 years it has also become apparent that not only is significant harm caused by the sexual abuse of children, but that many of the perpetrators of this abuse are themselves young.[238] Davis and Leitenberg found that juveniles were responsible for between 30 per cent and 50 per cent of all sexual offences involving a child victim.[239] These figures are consistent with other more recent estimates.[240] Retrospective data from adult sexual offenders also indicate that many offenders began their offending behaviour in early adolescence or late childhood.[241] Some studies have found that up to half of all adult sex offenders admit to beginning sexual offending as adolescents.[242]

4.110 Prevalence studies also consistently appear to suggest high rates of sibling incest and that abuse by a sibling may in fact be more prevalent than other forms of child sexual abuse.[243] However, in spite of what appear to be high prevalence rates: "the empirical knowledge base on sibling incest is very limited. The evidence base for professional practice in this field is therefore weak."[244]

4.111 In NSW, the rate of child sexual assault of Aboriginal females under the age of 16 years in 2004 was more than double that of non-Aboriginal females in the same age group (respectively, 468.7 and 192.1 per 100,000). However, NSW Health data indicates that of all the children in NSW who accessed services that respond to sexual assault during 2003/04, only 11 per cent were Aboriginal.[245]

4.112 The literature indicates that child sexual assault in Aboriginal communities is a complex problem that is inter-connected with other aspects of Aboriginal disadvantage such as substance abuse, social and economic disadvantage, poor mental and physical health, and exposure to family violence.[246]

4.113 Many jurisdictions have enacted laws directed against perpetrators of child sexual assault, which variously provide for indeterminate sentencing, mandated treatment, community registration and protracted supervision beyond the

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[238] DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, 2005, p.i.

[239] G Davis and H Leitenberg, "Adolescent sex offenders," *Psychological Bulletin, 101,*1987, pp.418-427 cited in DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, DoCS, 2005, p.3.

[240] ML Bourke and B Donohue, "Assessment and treatment of juvenile sex offenders: An empirical review," *Journal of Child Sexual Abuse, 5,* 1996 pp.47-65; NJ Boyd, M Hagan and ME Cho, "Characteristics of adolescent sex offenders" A review of the research," *Aggression and Violent Behaviour, 5,* 1999 pp.137-146; S Righthand and C Welch, "Juveniles who have sexually offended: A review of the professional literature," *Washington DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention,* 2001; cited in DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, 2005, p.3.

[241] Department of Juvenile Justice, "Profiling Australian Juvenile Sex Offenders: Offenders and Offence Characteristics," Monograph Series Number 1, 1999.

[242] D Lievore, "Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy," *Australian Institute of Criminology*, May 2004, p.55.

[243] S Rayment-McHugh, and I Nisbet, "Sibling incest offenders as a subset of adolescent sexual offenders," cited in "Conference papers: Child Sexual Abuse: Justice Response or Alternative Resolution Conference," Adelaide, May 2003. Canberra, *Australian Institute of Criminology*, 2003: www.aic.gov.au.

[244] ibid.

[245] NSW Government, *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities, 2006-2011*, p.1.

[246] ibid.

duration of a sentence.[247] However, there is a paucity of research that demonstrates that these measures actually reduce rates of sexual offending against children.

4.114 Treatment of sex offenders is usually psychological, using a cognitive behavioural framework. This includes cognitive restructuring, training in victim empathy and social skills, and relapse prevention. Increasingly, treatment is targeted towards specific deficits and is individualised, although it may be delivered in group settings. Its effectiveness relies on proper assessment and the use of interventions justified by well constructed research evidence, which is as yet lacking.[248]

4.115 A number of biological treatments are also currently used. Some medications seem to have efficacy in reducing sexual drive, deviant sexual arousal and problem sexual behaviours. Because of their side effects, however, their use tends to be limited to those at higher risk of re-offending.[249]

4.116 However, the evidence base for both types of treatment of sexual offenders is poor. Psychological treatments seldom adhere to specified methodology and are rarely tested for integrity by blinded external raters. For biological treatments, the evidence generally comprises uncontrolled case series with small numbers and limited follow up. Despite the extensive clinical experience with these medications, there is only limited empirical support for their effectiveness.[250]

4.117 There are some reviews, however, that indicate that cognitive behavioural programs are the most effective in managing the risk of re-offending in child sexual offenders.[251]

4.118 In its review of 23 adolescent sex offender treatment outcome studies published since 1990, DoCS concluded that:

> *despite the somewhat confused state of the treatment literature and difficulties in making study comparisons, there appears to be reason to hope that well resourced and carefully constructed treatment programs can have a significant effect in reducing both sexual and non-sexual recidivism. Reductions of 13 per cent in sexual recidivism have been observed between treated and non-treated adolescents in overseas treatment programs. Programs that appear most likely to demonstrate treatment effects are those that address functioning in a broad range of*

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[247] DH Sullivan, PE Mullen and MT Pathé, "Legislation in Victoria on sexual offenders: issues for health professionals," www.mja.com.au/public/issues/183_06_190905/sul10338_fm.html.

[248] ibid.

[249] ibid.

[250] ibid.

[251] S Wright, "Managing unacceptable risk: the risk assessment and management of child sexual offenders," cited in "Conference papers: Child Sexual Abuse: Justice Response or Alternative Resolution Conference," Adelaide, May 2003. Canberra: *Australian Institute of Criminology,* www.aic.gov.au.

> *areas, including the individual, family, school and community systems. While individual service providers in private practice may contribute to a multi-system treatment intervention plan, a reliance on individual-level interventions by themselves appears unlikely to lead to the reductions in recidivism associated with the more holistic treatment approaches. It also appears that involvement of families is an adjunct to successful treatment.*[252]

4.119 A discussion of particular programs in NSW appears in Chapters 7 and 15.

4.120 With respect to prevention programs, Tomison and Poole identified personal safety programs as the most prevalent child sexual abuse prevention programs in Australia.[253] Personal safety and protective behaviours programs are generally school based prevention programs that aim to equip children with self protection strategies through educating them in how their body responds to feeling unsafe, and their right to say no. They are designed to educate children to identify, and therefore protect themselves from, situations in which they are potentially at risk of harm. However, personal safety programs target a single group; they focus on children rather than addressing adult responsibility for children's safety.[254]

4.121 Some commentators have queried whether it is appropriate to expect children to protect themselves, and whether giving this type of message to children could lead them to feel guilt and shame if they were unable to protect themselves from abuse.[255]

4.122 A review of the effectiveness of child abuse prevention programs by the National Child Protection Clearinghouse reported that personal safety programs can be effective in teaching children basic concepts and skills (for example, good touch/bad touch) and are associated with an increase in disclosures. However, "there is no evidence that personal safety programs are actually able to provide children with the knowledge and skills to avoid being abused."[256]

4.123 In terms of other interventions to reduce child sexual assault, Resofsky notes that there have been no large scale community education programs in Australia aimed at the primary prevention of child sexual abuse.[257] As a social work practitioner, Resovsky argues for a broad multi-faceted public education program on the complexities of child sexual assault which would concentrate the responsibility for child sexual abuse prevention on adults. Resofsky

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[252] DoCS, *Impacts of Programs for Adolescents who sexually offend: Literature Review*, 2005, p.i-v.

[253] AM Tomison and L Poole, 2000, op. cit., cited in V Resofsky, "Stewards of Children: a primary prevention program for child sexual abuse," *Child Abuse Prevention Newsletter*, v.15 no.2, 2007, p.12.

[254] V Resofsky, 2007, op. cit., p.12.

[255] LM Bromfield, "Child protection in Australia: Current challenges and future directions," *Paper presented at the Australasian College of Child and Family Protection Practitioners conference*, Melbourne, 2007 cited in V Resofsky, 2007, op. cit., p.12.

[256] LM Bromfield and Holzer, "Child abuse prevention: What works? Paper presented at the Australian Centre for Child Protection," *University of South Australia: Seminar Series*, Adelaide, 2006 cited in V Resofsky, 2007, op. cit., p.12.

[257] V, Resofsky, 2007, op. cit., p.19.

describes the Stewards of Children Program: a sexual abuse prevention program that educates adults to recognise, prevent and respond responsibly to child sexual abuse. The program gives adults an overview of the complex nature of child sexual abuse and is appropriate for all adults, whether they work with child focused organisations or are just concerned individuals.[258]

4.124 The program was originally introduced in nine organisations based in the USA, and the training is now available in 34 US states as well as Canada, Iceland, Spain, Peru and the Cayman Islands. An evaluation of the program indicates that it was considered to have a significant influence on participants' knowledge and understanding of child sexual abuse. Specifically, participants reported they were more likely to discuss issues of child sexual abuse with a child or another adult, pay attention to potential signs of sexual abuse, and drop in unexpectedly to ensure the safety of a child in the care of another adult.[259]

4.125 In summary, child sexual abuse is likely to be an under reported form of abuse that has far reaching consequences on the lives of those who are abused. Interventions may be medical, psychological or educative. There is some evidence of successful outcomes for perpetrators as provided through two multi-faceted, holistic programs, that is, the New Street Program and the Cedar Cottage Pre-Trial Diversion of Offenders Program, which are discussed in Chapters 7 and 15.

Child/young person risk taking behaviour

4.126 The Inquiry found that there is no clear definition for this term and a lack of guidance for caseworkers as to what constitutes risk taking behaviour and the interventions which may be appropriate. There is also a lack of relevant research with respect to risk taking behaviour and child protection.

4.127 There is a considerable body of research, however, that provides evidence linking abuse, childhood adversity, family dysfunction, stressful life events with suicidal thoughts and health risk behaviour among young people.[260] Beautrais, Joyce and Mulder, for example, found that young people aged 13-24 years in New Zealand who made medically serious suicide attempts had ‘elevated odds’ of parental separation, poor parental relationships, parental violence, alcoholism or imprisonment, being 'in care', and sexual and physical abuse.[261]

[258] ibid.

[259] ibid., p.24.

[260] A Beautrais, “Risk factors for suicide and attempted suicide among young people,” *National youth suicide prevention strategy – Setting the evidence based research agenda for Australia (A literature review)*, Canberra: Commonwealth Department of Health and Aged Care, 2000 cited in J Cashmore and M Paxman, “Longitudinal Study of Wards Leaving Care: four to five years on,” *Social Policy Research Centre*, University of New South Wales, January 2007, p.90.

[261] A Beautrais, PR Joyce and RT Mulder, “Precipitating factors and life events in serious suicide attempts among youths aged 13 though 24 years,” *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1997, pp.1543-1551 cited in J Cashmore and M Paxman, 2007, op. cit., p.90.

4.128 There is also a body of research findings and large scale mental health surveys of young people in which adolescents with depression and other mental health problems report a high rate of suicidal thoughts and other health risk behaviour, including smoking, drinking and drug use.[262]

4.129 The NSW Child Death Review Team reviewed the deaths of 187 children and young persons (aged 12-17 years) who died from suicide and risk taking in the period January 1996 to December 2000 in NSW.[263]

4.130 The key findings of this report include that while suicide and risk taking deaths are rare, accounting for nine deaths per 100,000 young persons aged between 12-17 years, this number represents almost one quarter of all deaths of young persons within these ages.

4.131 The Child Death Review Team also found that gender is significant. The majority of those who died (71 per cent) were male. Males were more than twice as likely as females to die from suicide or risk taking.

4.132 Only half of those who died from suicide or risk taking were enrolled in schools at the time of their death. This is considerably lower than the general school participation rate.[264] Forty-two per cent had no record of contact with any human services workers, for example, health workers, school counsellors or DoCS workers.

4.133 The majority of the deaths (66 per cent) occurred in young persons who were undergoing significant enduring difficulties which included family dysfunction, mental health problems and severe emotional distress or school related difficulties, or a combination of these factors.

4.134 The importance of participation in school as a protective factor which mitigates against extreme risk taking is reinforced by the Child Death Review Team study. The importance of the school as a site for education about help seeking and problem solving is also clear.[265]

4.135 Research on the effect of domestic violence suggests that impacts may be different for adolescents who have been part of an abusive system from their earliest years compared with those who experience it for the first time in adolescence. Violence against mothers in childhood is highly associated with

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[262] A Beautrais, "Risk factors for suicide and attempted suicide among young people," *National youth suicide prevention strategy – Setting the evidence based research agenda for Australia (A literature review)*, Canberra: Commonwealth Department of Health and Aged Care, 2000 cited in J, Cashmore and M, Paxman, 2007, op. cit., p.93.

[263] Child Death Review Team, *Suicide and Risk taking Deaths of Children and Young People, A study of all deaths of children and young people aged 12 to 17 years in NSW by suicide or risk-taking over a five-year period, January 1996 to December 2000*, 2003.

[264] Which was 93 per cent for 15 year olds, 82.4 per cent for 16 year olds and 62.2 per cent for 17 year olds in 2001, Child Death Review Team, "Suicide and Risk taking Deaths of Children and Young People," A study of all deaths of children and young people aged 12 to 17 years in NSW by suicide or risk-taking over a five-year period, January 1996 to December 2000, 2003.

[265] Department of Education and Training: "Suicide and Risk-Taking Deaths of Children and Young People Report: What Can We learn?" www.curriculumsupport.education.nsw.gov.au.

ongoing depression in adolescent girls.[266] Adolescents from homes where domestic violence is present are more likely to be homeless.[267] The stresses associated with violence in the home may make usual adolescent risk taking and escape behaviours worse and they may begin to participate in family violence themselves.[268]

4.136 In a recent study, Abbott-Chapman and Denholm surveyed around 1,000 parents and 1,000 Tasmanian high school and college students across five years about their perception of 'risky' behaviours. The researchers describe a 'risk taking syndrome' of young persons drinking alcohol, looking at internet pornography and truanting from school as an escape from life pressures, such as exams and finding future work. In the surveys, young people were asked to rate 26 risk taking behaviours and placed binge drinking in the lowest of five risk groups, along with watching x-rated videos, smoking cigarettes, sunbaking, missing classes and drinking alcohol. Drug related activities were ranked as the highest risk taking activities.[269]

4.137 According to Abbott-Chapman and Denholm's research, factors likely to reduce risk taking behaviour among young persons include: their ability to talk over personal problems with parents, friends or other family members; religious commitment, or membership of Christian or other religious groups; and membership of community groups (other than sport) which encourage voluntary activities.[270]

4.138 Young people also rated the advice of teachers and parents higher than health and education programs run in schools and the community.[271]

4.139 DoCS caseworkers work with children and young persons who display internalising and externalising behaviours reflecting emotional distress such as suicide attempts, sexual offending, school truancy, substance misuse, criminal behaviour, homelessness and placing themselves in 'unsafe situations' (for example with sexual offenders or paedophiles). They may have diagnosed mental health problems, including depression, anxiety, post traumatic stress disorder, conduct disorder and oppositional defiance disorder. As a result their schooling is disrupted, they lack social skills and they may display little empathy. They experience relationship difficulties across the whole spectrum: school, peers and their families. Typically it can be a breakdown of relationships or dysfunctional family relationships that may bring them to the

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[266] Office of the Status of Women, *Domestic Violence and its Impact on Children's Development*, 1998, p.5.

[267] ibid.

[268] J Howard, "Children hit out at parents physically and emotionally," *Community Quarterly, 34,* 1995, pp.38-43; D Kalmuss, "The intergenerational transmission of marital aggression," *Journal of Marriage and the Family, 46,* 1984, pp.11-19; J McInnes; "Violence within Families: The Challenge of Preventing Adolescent Violence Towards Parents," *The Office for Families and Children,* Adelaide, 1995 cited in Office of the Status of Women, *Domestic Violence and its Impact on Children's Development*, 1998, p.5.

[269] ibid.

[270] ibid.

[271] ibid.

attention of authorities. Often these children have a profound sense of loss and little trust in relationships.[272]

4.140 Caseworkers play a central role in coordinating services and interventions for children and young persons who are at risk and, at times, highly distressed. A DoCS study highlights the sensitive nature of this work and the need for caseworkers to develop effective relationships with adolescents, their families and other agencies.[273] The study also acknowledges that further research directly testing the effectiveness of particular casework strategies or approaches to case management is warranted.[274]

4.141 In summary, the definition of, and response to, child/young person risk taking behaviour is an area for further research.

Summary

4.142 Current literature establishes that child abuse and neglect are strongly correlated with other problems such as low birth weight, child behavioural disorders, low literacy, non-completion of school, juvenile drug use and teenage pregnancy.[275] These share a common set of risk and protective factors, that is, quality of early parent-child attachment, peer and school connectedness, availability of social support for families, parental poverty. This suggests that whole of government responses which are able to draw in sectors such as housing, health, education and child welfare agencies will be more effective. Durlack's analysis indicates that multi-faceted strategies, which address underlying risks and protective factors, are more effective than those that are single issue focussed.[276] Where services are easily accessible to the parents, for instance through co-location, the benefit to families increases.[277]

4.143 Evidence that early intervention can counteract biological and environmental disadvantage and set children on a more positive developmental trajectory continues to build. Early intervention, particularly from birth to three years of age has been identified as an ideal opportunity to enhance parental competencies, reduce risks and aid child development. Early intervention approaches closely linked with universal services are one of the most effective ways to ameliorate the effects of maltreatment.[278]

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[272] DoCS, *Effective Casework Practice with Adolescents: Perceptions and Practices of DoCS Staff*, December 2007.

[273] ibid.

[274] ibid., p.vi.

[275] D Scott, "Towards a Public Health Model of Child Protection in Australia," Research Article 1, *Communities, Families and Children Australia*, Volume 1, No. 1, July 2006, p.14.

[276] JA Durlack, "Common Risk and Protective Factors in Successful Prevention Programs," *American Journal of Orthopsychiatry, 68,* 1998 pp.512-520 cited in D Scott, 2006, op. cit., p.14.

[277] DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

[278] Northern Territory Government, "Ampe Akelyyernemane Meke Mekarle 'Little Children are Sacred'," *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.259.

4.144 There is also mounting evidence that, as far as possible, working with families in a respectful way can minimise the anger and distress of families whose children have been reported to statutory departments and may lead to better and less harmful interventions for children.[279]

4.145 In summary, the literature provides some indicators about 'what works', with which populations groups and under what conditions, and suggests areas for further investigation. Notwithstanding qualifications about the need for further research and evaluation, recurring themes in the literature are for a reorientation to prevention and early intervention services, multi-agency cooperation and inter-connected responses, accessible high quality child care services and flexible service provision.

4.146 Recommendations concerning additional services needed to reflect the research findings are considered elsewhere in this report, particularly Chapter 10.

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[279] G Dumbrill, "Parental experience of child protection intervention: A qualitative study," *Child Abuse and Neglect, 30,* 2006, pp.27-37; R Thorpe, "Family inclusion in child protection practice: building bridges in working with (not against) families," *Communities, Children and Families Australia, 3,* 2007, pp.4-18 cited in Submission: Cashmore, Scott, and Calvert, p.49.

5 Key child protection data

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NSW demographic data

5.1 The source for the following data is the 2006 ABS Population census.

Table 5.1 Total population of each DoCS Region, 2006

Region	*Total population*	*Children aged 0-17 as % of total population*	*Children aged 0-3 as % of total population*
Metro Central	2,032,278	20.2	4.8
Metro West	1,040,917	26.6	5.9
Metro South West	790,318	27.8	6.0
Southern	549,873	24.3	4.8
Hunter/Central Coast	849,626	24.4	5.0
Northern	713,636	24.4	4.5
Western	562,353	26.2	5.4
State total	6,549,174	24.0	5.2

Table 5.2 Indigenous population of each DoCS Region, 2006

Region	*Total population*	*Indigenous population*	*Indigenous population as % of total population*	*Indigenous children aged 0-17 as % of Indigenous population*	*Indigenous children aged 0-3 as % of Indigenous population*
Metro Central	2,032,278	11,371	0.6	33.8	7.6
Metro West	1,040,917	16,021	1.5	45.6	10.0
Metro South West	790,318	10,202	1.3	48.2	10.6
Southern	549,873	13,080	2.4	46.2	10.3
Hunter/Central Coast	849,626	20,607	2.4	46.3	10.0
Northern	713,636	34,164	4.8	46.8	10.1
Western	562,353	32,631	5.8	46.5	10.3
State total	6,549,174	138,511	2.1	45.4	10.0

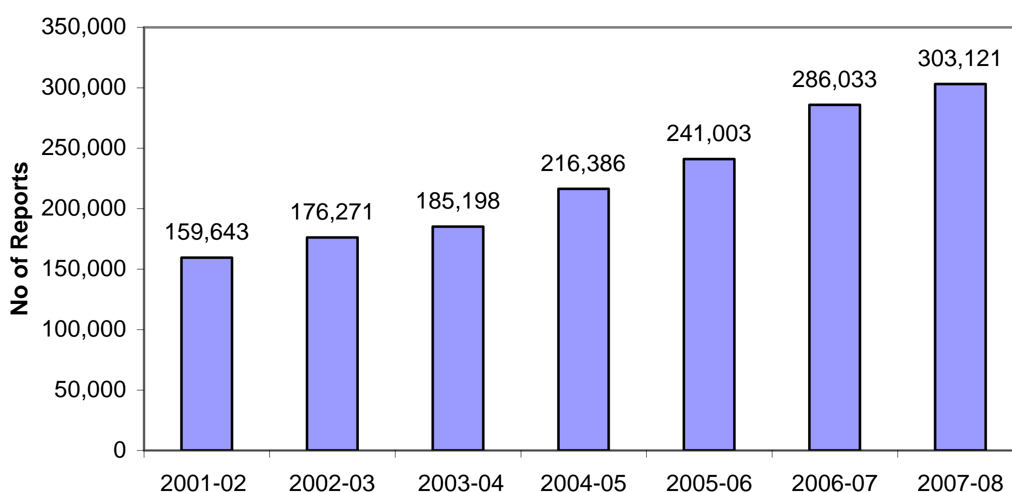
Reporting trends since 2001/02

5.2 DoCS has made its most recent data available to the Inquiry. While some 2007/08 data have been finalised, most of the detailed 2007/08 data are preliminary and will differ from finalised 2007/08 data. Where preliminary 2007/08 data are not available, the Inquiry has used data for 2006/07, or for the period April 07/March 08. Whatever are the more recent data are used in this and other chapters of this report.

Child protection reports

5.3 In 2007/08, DoCS received 303,121 child protection reports.[280] This represents an increase of about 90 per cent over the 159,643 child protection reports received in 2001/02. The number of reports received annually from 2001/02 to 2007/08 is set out in the graph below.

Figure 5.1 **Total number of child protection reports 2001/02 to 2007/08**



5.4 Total reports increased by 6.0 per cent from 2006/07 to 2007/08. This increase is far less than the 18.7 per cent recorded for the preceding period from 2005/06 to 2006/07.

5.5 NSW is not alone in experiencing increased reporting. A recent report by the AIHW noted that nationally, notifications, substantiations and the number and rates of children under care and protection orders in OOHC are all rising.[281] That report identified an actual increase in the number of children who require a child protection response and an increased awareness of child protection issues in the wider community , as factors which have influenced the rise.

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[280] DoCS, *Annual Report 2007/08,* p.4.

[281] Australian Institute of Health and Welfare, *Child Protection Australia 2006/07,* Child welfare series no. 43, 2008, p.10.

5.6 However, the Inquiry does not propose to rely on AIHW data in relation to a national comparison of performance. In relation to the states and territories, definitions of notifications differ, reports on unborn children are accepted in some jurisdictions and not others and what is substantiated is not consistent. States also differ in data collection and investigation frequency, and have different definitions of when a child is 'in need of protection' or 'abused' or 'neglected.'

5.7 As the AIHW stated in its 2008 report "the data from jurisdictions are…not strictly comparable and should not be used to measure the performance of one jurisdiction relative to another."[282]

5.8 Thus, the Inquiry will not attempt to do so to inform this report.

Children and young persons involved in reports

5.9 As shown in Table 5.3 below, there has been a 54.0 per cent increase in the number of children reported between 2001/02 and 2007/08 (preliminary). In 2001/02, the ratio of reports made to the number of children and young persons reported was 1.88:1 and by 2006/07, it had increased to 2.31:1. The ratio of reports to children remained steady in 2007/08 at 2.32:1.

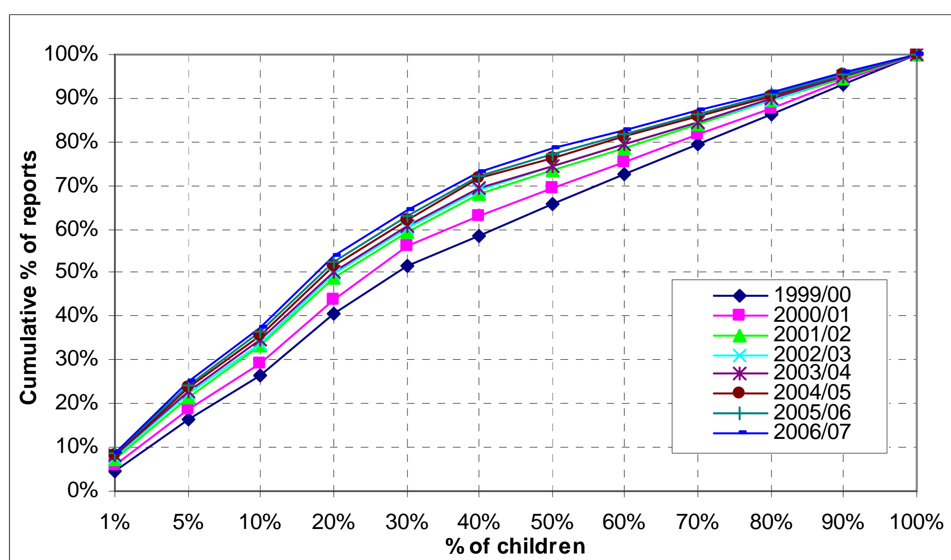
Table 5.3 **Children and young persons involved in reports 2001/02 to 2007/08**

	2001/02	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*2007/08 preliminary*
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

5.10 The occurrence of multiple reports per child has increased over time. Figure 5.2 shows that in 1999/00, the one per cent of children with the highest number of reports accounted for 4.8 per cent of total reports. By 2006/07, the top one per cent accounted for 8.9 per cent of reports. Further, in 2006/07, over half of all reports involved 20 per cent of children and young persons.

[282] ibid., p.13.

Figure 5.2 **Percentage of all reports by percentage of children and young persons, 1999/00 to 2006/07**[283]



5.11 In the period 2001/02 to 2007/08, the rate of children reported per 1,000 population increased from 52.7 to 81.0.[284]

5.12 Similar to reports, there was a 5.8 per cent increase in total number of children and young persons reported from 2006/07 to 2007/08 (preliminary). This is less than half of the 12.9 per cent increase recorded between 2005/06 and 2006/07.

5.13 In 2001/02, 54.6 per cent of all children and young persons involved in reports were reported for the first time ever. By 2006/07, children and young persons reported for the first time had fallen to 43.2 per cent of all children and young persons reported. The actual number of first time reports remained fairly steady for 2007/08, but as a proportion of the total number of children reported, the figure dropped further to 41.3 per cent. In other words, by 2007/08 (preliminary), 58.7 per cent of all children and young persons involved in reports already had a child protection history, or were 'known to DoCS.'[285]

5.14 Figure 5.3 illustrates the continuing increase in the share of children reported to DoCS each year who already have a child protection history. The percentage increase of new children reported is just 1.2 per cent from 2006/07 to 2007/08 (preliminary), compared with a growth of 9.3 per cent for known children.[286]

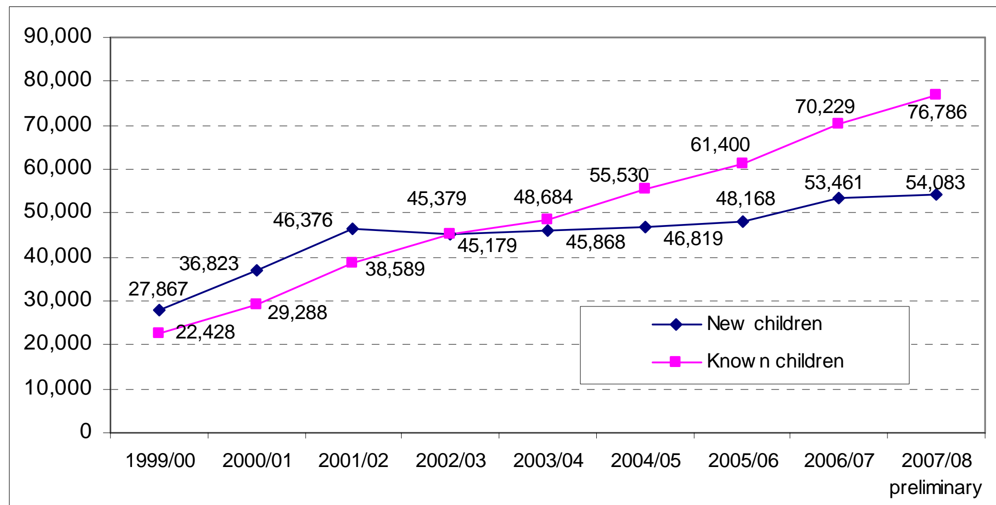
[283] DoCS, *A closer look: Recent trends in child protection reports to DoCS*, December 2007.

[284] DoCS, *Annual Report 2007/08.*

[285] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

[286] ibid.

Figure 5.3 **Numbers of new and known children reported to DoCS, 1999/00 to 2007/08**[287]



Age of children and young persons reported to DoCS

5.15 In the period 2001/02 to 2007/08 (preliminary), the reporting trends for each age group have remained relatively steady. There has been a slight increase in the proportion of children aged less than one year that were reported. In 2001/02, these children represented 8.6 per cent of all children and young persons reported and in 2007/08 (preliminary) they represented 10.1 per cent of all children and young persons reported.

Table 5.4 **The number of children and young persons reported to DoCS by age, 2001/02 to 2007/08**

Age group	*2001/02*	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*2007/08 preliminary*
< 1 year	7,342	7,162	7,479	8,308	9,652	11,729	13,158
1-2 years	10,043	10,330	10,472	11,273	12,283	13,791	14,904
3-4 years	10,427	10.823	10,832	11,779	12,500	13,955	14,776
5-11 years	33,752	35,998	36,826	39,504	42,097	46,626	49,009
12-15 years	18,309	20,239	21,283	23,875	25,308	28,225	29,565
16-17 years	3,780	3,894	4,354	4,675	5,143	6,227	6,697
Not stated	1,312	2,022	3,306	2,935	2,585	3,137	2,760
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

[287] ibid.

Table 5.5 **Child protection reports by age, 2006/07 and 2007/08**

Age group	*2006/07*	*2007/08 preliminary*
< 1 year	26,853	30,432
1-2 years	33,072	35,778
3-4 years	32,995	34,804
5-11 years	106,710	112,959
12-15 years	70,978	73,207
16-17 years	11,983	12,778
Not stated	3,442	3,019
Total	286,033	302,977

5.16 Age distributions for children reported have remained consistent across the three year period 2005/06 to 2007/08 (preliminary). When new and known children are examined by age, not surprisingly, a high percentage of new children are infants.

5.17 In 2006/07, DoCS received 5,838 prenatal reports, representing nearly two per cent of all risk of harm reports. Close to half of these were received from NSW Health (49.9 per cent) and just over a fifth from NSW Police Force (20.3 per cent). The most prevalent issues reported were domestic violence (37.6 per cent), drug and alcohol use by carer (33.9 per cent) and carer mental health issues (23.5 per cent). This was a significant increase over the number of reports made since 2004/05, as expected due to the inclusion of prenatal reports as part of the mandatory reporting regime in 2007.

Aboriginal children and young persons involved in reports

5.18 In the period 2001/02 to 2007/08 (preliminary), the number of reports involving Aboriginal children and young persons more than tripled from 18,348 to 55,303. This increase is significantly higher than for non-Aboriginal children and young persons. Part of this increase may be due to improved DoCS identification of Aboriginal children and young persons.

5.19 In 2001/02, 11.5 per cent of all reports involved Aboriginal children and young persons, compared with 18.3 per cent in 2007/08 (preliminary).

Table 5.6 **Number of child protection reports to DoCS by Aboriginality, 2001/02 to 2007/08**

Aboriginality	*2001/02*	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*2007/08 preliminary*
Aboriginal	18,348	20,017	15,495	31,526	38,297	49,443	55,303
Non Aboriginal	141,295	156,254	169,703	184,860	202,706	236,590	247,674
Total	159,643	176,271	185,198	216,386	241,003	286,033	302,977

Note: Non-Aboriginal includes 'not stated'

5.20 In the period 2001/02 to 2007/08 (preliminary), the number of Aboriginal children and young persons reported to DoCS more than doubled from 7,093 to 18,179. Again this is a greater increase than for non-Aboriginal children and young persons.

5.21 In 2001/02, 8.3 per cent of the children and young persons who were the subject of a report were identified as Aboriginal, compared with 12.8 per cent in 2006/07 and 16.1 per cent in 2007/08 (preliminary).

Table 5.7 **Number of children and young persons involved in child protection reports by Aboriginality, 2001/02 to 2007/08**

Aboriginality	*2001/02*	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*2007/08 preliminary*
Aboriginal	7,093	7,597	5,128	10,910	13,092	15,820	18,179
Non Aboriginal	77,872	82,961	89,424	91,439	96,476	107,870	112,690
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

Note: Non-Aboriginal includes 'not stated'

5.22 In 2001/02, 3.7 per cent of children and young persons reported for the first time were Aboriginal and by 2007/08 (preliminary), the figure had risen to 7.7 per cent. Over this period, there was a corresponding decrease in the percentage of non-Aboriginal children and young persons reported for the first time ever.

Table 5.8 **Children and young persons reported to DoCS for the first time ever, by Aboriginality, 2001/02 to 2007/08**

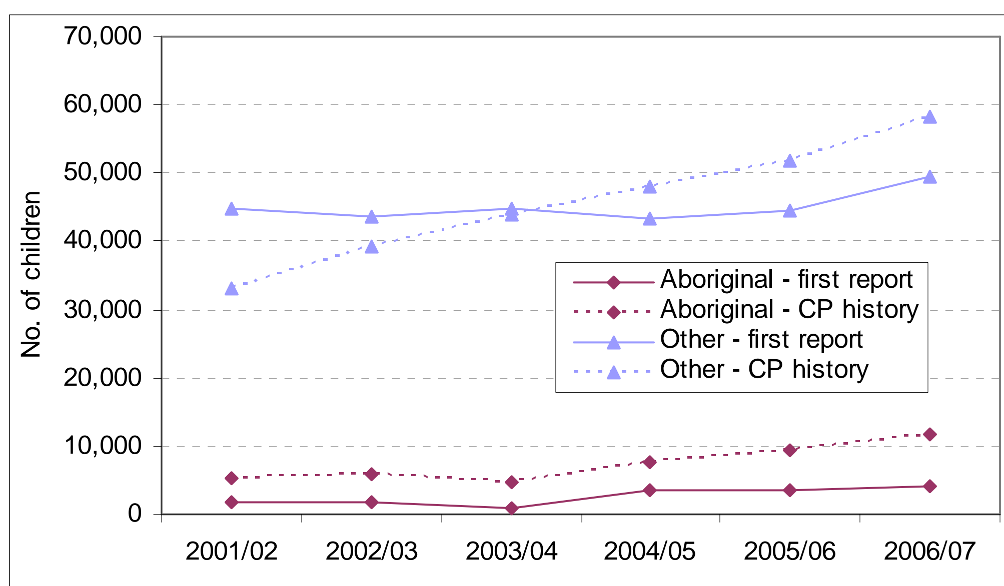
Aboriginality	*2001/02*	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*2007/08 preliminary*
Aboriginal	1,697	1,759	990	3,383	3,608	3,964	4,156
Non Aboriginal	44,679	43,620	44,878	43,436	44,560	49,497	49,927
Total	46,376	45,379	45,868	46,819	48,168	53,461	54,083

Note: Non-Aboriginal includes 'not stated'

5.23 In 2001/02, 76.1 per cent (5,396) of the Aboriginal children and young persons who were the subject of a report already had a child protection history. In 2007/08 (preliminary), 77.1 per cent (14,023) of the Aboriginal children and young persons who were the subject of a report already had a child protection history.

5.24 Figure 5.4 shows the number of Aboriginal and other children reported to DoCS by whether the child or young person had been reported previously (history from 1987/88). The pattern for Aboriginal children was quite different from that for other children. In 2006/07, 75 per cent of Aboriginal children reported to DoCS had a child protection history compared with 54 per cent of other children. For each year from 2001/02 to 2006/07 there were more Aboriginal children reported to DoCS who already had a child protection history than there were Aboriginal children who were not previously known. For non-Aboriginal children the number of new children reported to DoCS between 2001/02 to 2005/06 remained stable at around 44,000 per year and increased to 49,497 in 2006/07. Comparatively, the number of non-Aboriginal children with a child protection history increased by 76 per cent from 2001/02 to 2006/07.[288]

Figure 5.4 **Children and young persons reported to DoCS by Aboriginality and child protection history status, 2001/02 to 2006/07**



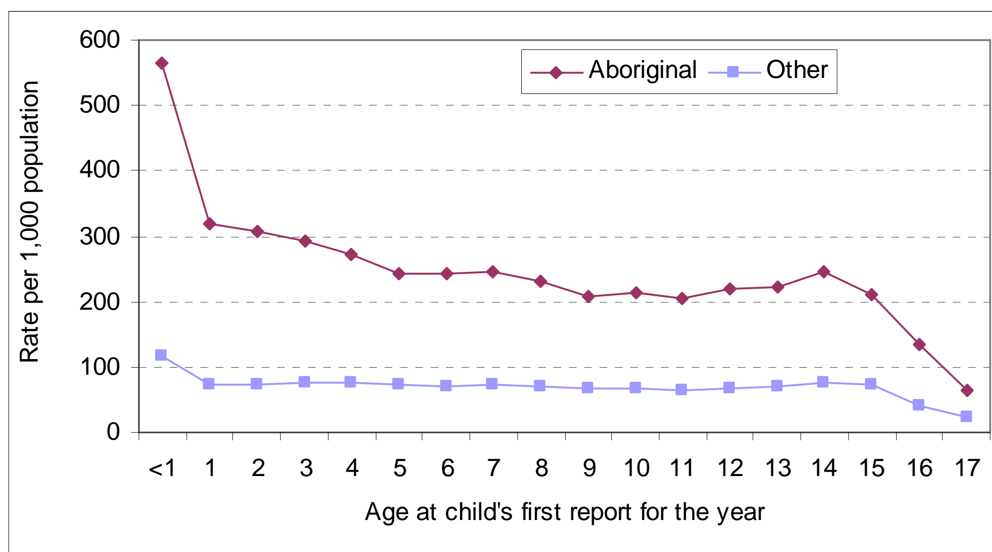
[288] DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

5.25 Aboriginal children are more likely to be the subject of a child protection report than non-Aboriginal children and young persons. In 2007/08 (preliminary), for every 1,000 Aboriginal children and young persons in NSW, 289 were reported to DoCS, compared with the rate of 75 per 1,000 for non-Aboriginal children and young persons.

5.26 The rate of Aboriginal children aged less than one year reported is higher than for all Aboriginal children or for non-Aboriginal children aged less than one year. In 2007/08 (preliminary), for every 1,000 Aboriginal children and young persons in NSW aged less than one year, 647 were reported to DoCS, compared with the reporting rate of 130 per 1,000 for non-Aboriginal children aged less than one year.

5.27 Figure 5.5 shows that for all ages, the rate of reporting about Aboriginal children in 2006/07 was higher than the rate of reporting about other children. While it varies across age groups, it is most noticeable for children aged less than one year.

Figure 5.5 **Rate of children reported to DoCS per 1,000 population by age group and Aboriginality, 2006/07**[289]



[289] ibid.

Reporter type

5.28 A comparison of the source of child protection reports by reporter type in 2001/02, 2005/06, 2006/07 and 2007/08 (preliminary) follows.

Table 5.9 **Total reports by reporter type 2001/02, 2005/06 to 2007/08**

Reporter type	*2001/02*		*2005/06*		*2006/07*		*2007/08 preliminary*	
	No	%	No	%	No	%	No	%
Police	59,989	34.4	80,406	33.4	93,069	32.5	99,367	32.8
Health	23,309	14.6	38,874	16.1	43,870	15.3	46,598	15.4
School/child care	21,952	13.8	31,557	13.1	35,741	12.5	38,412	12.7
NGO	12,751	8.0	17,165	7.1	21,318	7.5	22,427	7.4
Other mandatory	7,507	4.7	14,077	5.8	18,018	6.3	19,889	6.6
Non mandatory and Other	39,135	24.5	58,924	24.4	74,017	25.9	76,284	25.2
Total	159,643	100	241,003	100	286,033	100	302,977	100

5.29 When total reports are examined by reporter type the relative share of reports for each group varies little across the three year period from 2005/06 to 2007/08 (preliminary). During each of the three years, mandatory reporters made around three quarters of reports. Police have consistently accounted for approximately one third of all reports for each of the years, followed by health reporters at 15 per cent to 16 per cent and school/child care reporters at 12 per cent to 13 per cent.[290]

5.30 Consistently, the highest increase has been recorded for the 'other' mandatory reporter group which includes the courts and other government departments. For the period from 2005/06 to 2006/07 reports from this group increased 28.0 per cent and again by 10.4 per cent for the period 2006/07 to 2007/08. These increases are both higher than the average where increases of 18.7 per cent and 6.0 per cent were recorded for these periods respectively.

Reported issue

5.31 Tables 5.10 to 5.12 provide details of child protection reports from 2005/06 to 2007/08 (preliminary) by reporter type and reported issue:

[290] Police reporters are members of the NSW Police Force. Health reporters include doctors, nurses, dentists, mental health professionals, and all other health workers. School/child care reporters include school and preschool teachers and principals, school counsellors, child care workers and TAFE teachers.

Table 5.10 Child protection reports by reporter type and primary reported issue, 2005/06

	Police	Health	School/ child care	All other mandatory	Non mandatory and Other	Primary reported issue	Total reports
Primary reported issue	*As a percentage share of reports for each primary reported issue*					*No*	*%*
Domestic violence	72.4	9.8	3.2	7.4	7.1	64,916	26.9
Neglect	19.0	11.6	12.9	18.5	38.1	35,116	14.6
Physical abuse	15.9	16.0	26.0	13.6	28.4	34,755	14.4
Carer drug and alcohol	23.0	22.4	6.5	10.2	37.9	22,487	9.3
Psychological abuse	21.5	13.6	21.3	12.5	31.1	20,864	8.7
Carer mental health	14.6	45.7	7.3	12.7	19.9	17,631	7.3
Sexual abuse	18.7	18.6	23.0	14.9	24.9	17,355	7.2
Risk taking behaviour by child or young person	24.1	13.9	17.2	24.1	20.8	13,994	5.8
Other	16.7	12.8	16.9	15.4	38.2	13,885	5.8
Total reports						241,003	100.0

Table 5.11 Child protection reports by reporter type and primary reported issue, 2006/07

	Police	Health	School/ child care	All other mandatory	Non mandatory and Other	Primary reported issue	Total reports
Primary reported issue	*As a percentage share of reports for each primary reported issue*					*No*	*%*
Domestic violence	73.2	8.5	3.4	7.4	7.4	74,283	26.0
Neglect	17.5	11.4	12.1	19.4	39.6	41,947	14.7
Physical abuse	16.2	14.8	25.0	14.7	29.2	40,559	14.2
Carer drug and alcohol	22.4	21.8	6.8	10.3	38.7	28,295	9.9
Psychological abuse	20.8	13.3	18.2	14.3	33.5	25,589	8.9
Carer mental health	13.8	45.2	6.4	13.5	21.2	21,418	7.5
Sexual abuse	18.4	16.9	21.9	17.2	25.7	20,204	7.1
Risk taking behaviour by child or young person	23.3	13.1	18.3	25.0	20.2	15,599	5.5
Other	15.6	11.2	15.1	16.0	42.2	18,139	6.3
Total reports						286,033	100.0

Table 5.12 **Child protection reports by reporter type and primary reported issue, 2007/08 preliminary**

	Police %	*Health %*	*School/ child care %*	*All other mandatory %*	*Non mandatory and Other %*	*Primary reported issue*	*Total reports*
Primary reported issue	*As a percentage share of reports for each primary reported issue*					*No*	*%*
Domestic violence	72.7	8.3	3.4	8.2	7.4	76,910	25.4
Neglect	18.2	11.4	13.1	20.5	36.8	46,250	15.3
Physical Abuse	16.4	14.7	24.7	15.5	28.7	43,006	14.2
Carer drug and alcohol	24.4	20.7	7.2	11.4	36.3	31,909	10.5
Psychological abuse	20.9	13.6	18.7	13.4	33.4	25,559	8.4
Carer mental health	15.2	43.2	7.6	15.0	19.0	25,091	8.3
Sexual abuse	18.7	16.8	20.7	18.0	25.8	20,166	6.7
Risk taking behaviour by child or young person	27.5	14.9	19.8	18.1	19.7	14,584	4.8
Other	16.9	10.8	15.9	14.0	42.3	19,461	6.4
Total reports						302,936	100.0

Note: this table does not include reports where the primary reported issue was not recorded.

5.32 Up to three issues can be recorded in KiDS for each child protection report made. In 2007/08 (preliminary), all but 44 child protection reports had a primary reported issue. A further 50.1 per cent (151,864) had a secondary reported issue and 19.5 per cent (59,175) of all reports had a third reported issue.

5.33 When examining reported issue by the primary issue, or across all three reported issues, only a small variation in terms of percentage share is observed across the three year period from 2005/06 to 2007/08 (preliminary).

5.34 Just under one third of reports had a domestic violence issue listed as at least one of the three reported issues during each of the three years. Across this period, around one quarter of reports had issues listed which were categorised as psychological abuse. Given that across the three year period, psychological abuse was the primary reported issue in eight to nine per cent of reports, it is clear that a significant number of reports have psychological abuse as a secondary or third reported issue. Across the period, when taking into consideration primary, secondary and third reported issues, 22 per cent to 23 per cent of reports related to physical abuse and 21 per cent to 23 per cent related to neglect. Carer drug and alcohol issues were listed in 18 per cent to 20 per cent of reports and carer mental health in 12 per cent to 14 per cent. Above average growth was recorded between each of the years for the issues of

neglect, carer drug and alcohol issues, carer 'other' issues, and child drug and alcohol issues.[291]

Table 5.13 **Child protection reports referred to DoCS by reported issue, 2005/06 to 2007/08**[292]

	2005/06		*2006/07*		*2007/08 preliminary*	
	No	%	No	%	No	%
Reported issue – all 3 issues						
Domestic Violence	77,222	32.0	89,021	31.1	94,139	31.1
Neglect	50,700	21.0	61,397	21.5	68,712	22.7
Physical abuse	54,085	22.4	62,814	22.0	69,409	22.9
Carer Drug and alcohol	43,806	18.2	54,529	19.1	61,416	20.3
Psychological abuse	56,880	23.6	67,959	23.8	74,732	24.7
Carer mental health	29,912	12.4	35,574	12.4	42,493	14.0
Sexual abuse	21,615	9.0	25,064	8.8	25,186	8.3
Carer other	11,564	4.8	16,219	5.7	20,253	6.7
Child drug and alcohol	6,271	2.6	7,642	2.7	8,467	2.8
Child suicide risk	4,839	2.0	5,002	1.7	5,108	1.7
Child runaway	7,825	3.2	8,441	3.0	6,791	2.2
Child inapp. sexual behaviour	4,559	1.9	5,182	1.8	4,966	1.6
Other	92	0.0	209	0.1	230	0.1
Total reports	241,003	100	286,033	100%	302,977	100

Note: As any report can have up to three reported issues recorded the categories presented are not mutually exclusive and the percentages do not total 100 per cent.

Re-reporting

5.35 Re-reporting has significantly increased over the last five years and most children now reported have a history of prior reports to DoCS. Of particular interest to the Inquiry is short term re-reporting, which is defined as a report received, with the same issue type, within seven days of another report for the child or young person. For re-reports a report is considered to have the same issue type if any of the three reported issues match those from a previous report. Issues are grouped into physical, sexual, psychological, neglect and carer for matching.

5.36 Table 5.14 shows that while the total number of reports increased by 40.0 per cent between 2004/05 and 2007/08 (preliminary), the total number of short term re-reports on the same reported issue increased by 62.0 per cent over the same four year period. The number of short term re-reports by the same reporter type on the same reported issue increased by 76.7 per cent over the four year period. Further, in 2007/08, short term re-reports on the same reported issue accounted for 17.1 per cent of all reports made.[293]

[291] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

[292] ibid.

[293] DoCS, *Child Protection matters that are re-reported within a 7 day period*, May 2008.

Table 5.14 **Total reports and re-reports within seven days on the same reported issue as a proportion of total reports, 2004/05 to 2007/08**[294]

Year	Total reports	Re-report same reporter type, same reported issue type		Re-report any reporter type, same reported issue type	
	Number	*Number*	*% of total reports*	*Number*	*% of total reports*
2004/05	216,386	11,995	5.5	32,055	14.8
2005/06	241,003	15,023	6.2	37,736	15.7
2006/07	286,033	21,245	7.4	50,176	17.5
2007/08 preliminary	302,977	21,197	7.0	51,933	17.1
% change 2004/05 to 2007/08	40.0	76.7	-	62.0	-

Note: 'Re-report same reporter type, same reported issue type' is a subset of 'Re-report any reporter type, same reported issue type'.

5.37 While there was a large increase in overall numbers for both re-report indicators from 2004/05 to 2007/08, numbers remained relatively flat from 2006/07 to 2007/08. Despite these fluctuations, the percentage of short term re-reports by the same reporter type has remained consistent at around six per cent to seven per cent of total reports. Short term re-reports by any reporter type also remained relatively consistent across the four year period at around 15 per cent to 18 per cent of total reports.[295]

5.38 During 2006/07, reporters from NGOs (14 per cent), health reporters and relatives (10.3 per cent and 10.2 per cent respectively) accounted for the greatest percentage of short term re-reports. Despite reporting the highest number of total reports, police have a relatively low percentage of short term re-reports at 4.7 per cent, compared with the average for all reporters of 7.4 per cent.[296]

5.39 Of the top 10 primary reported issues that are re-reported within seven days, the issue of 'runaway child/young person' was far more likely to be re-reported within seven days by the same reporter (22.4 per cent) and by any reporter (42.1 per cent) than any other reported issue. Of these short term re-reports by the same reporter type with a primary reported issue of 'runaway child/young person', 64 per cent were made by NGOs.[297] The high number of reports about this issue are likely to be due to a number of factors including NGOs reporting each runaway child twice, first when they run away and secondly when they return, and the frequency with which a proportion of children in care run away.

5.40 Short term re-reports by the same reporter type were slightly more likely for infants aged less than one year and older children aged 13-15 years.

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[294] ibid. and DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

[295] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

[296] DoCS *Child Protection matters that are re-reported within a 7 day period.*

[297] ibid.

5.41 Of those reports about Aboriginal children, 20 per cent were short term re-reports compared with 17 per cent for other children. A similar pattern is seen for short term re-reports by the same reporter type.

Table 5.15 **Re-report on the same issue type within 7 days of a child protection report by selected indicators, 2006/07**[298]

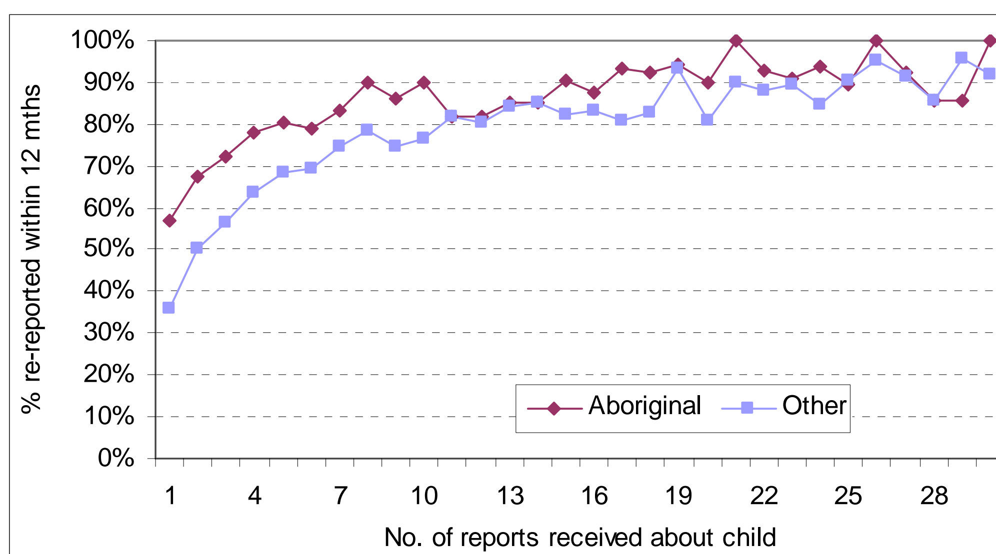
	Total reports	*Re-report same reporter type, same reported issue type*		*Re-report any reporter type, same reported issue type*	
	No	*No*	*% of total reports*	*No*	*% of total reports*
Reporter type (grouped)					
Police	93,069	4,411	4.7		
Health	43,870	4,532	10.3		
School / Child care	35,741	2,065	5.8		
NGO	21,318	3,077	14.4		
Other mandatory	18,018	752	4.2		
Total mandatory	212,016	14,837	7.0		
Relative	45,047	4,607	10.2		
Friend / neighbour	9,276	618	6.7		
Other	19,694	1,183	6.0		
Total non-mandatory / other	74,017	6,408	8.7		
Top 10 Primary reported issues (sorted on re-reports by same reporter type)					
Runaway child / young person	7,412	1,661	22.4	3,118	42.1
Carer: Other Issues: Development disability, carer	325	44	13.5	60	18.5
Carer mental health: Psychiatric disability, carer	4,341	566	13.0	1,194	27.5
Neglect: Failure to thrive, non-organic	225	27	12.0	47	20.9
Suicide risk for child	3,861	454	11.8	937	24.3
Neglect: Inadequate shelter or homeless	14,597	1,588	10.9	3,853	26.4
Suicide risk / attempt of carer	3,016	325	10.8	760	25.2
Carer: Other Issues: Legal guardianship issues	4,521	485	10.7	1,141	25.2
Drug use by child or young person	1,976	207	10.5	418	21.2
Carer mental health: Emotional state of carer	14,061	1416	10.1	3,163	22.5
Age of child at time of first report					
< 1 year	26,853	2,455	9.1	4,952	18.4
1 – 3 years	49,650	3,534	7.1	8,531	17.2
4 – 8 years	78,998	5,057	6.4	13,301	16.8
9 – 12 years	59,873	4,262	7.1	10,153	17.0
13 – 15 years	55,234	5,070	9.2	11,432	20.7
16 – 17 years	11,983	808	6.7	1,709	14.3
Not stated	3,442	59	1.7	98	2.8
Aboriginality					
Aboriginal	49,443	4,464	9.0	9,762	19.7
Non-Aboriginal / not stated	236,590	16,781	7.1	40,414	17.1
Total Reports	286,033	21,245	7.4	50,176	17.5

298 ibid.

5.42 The average number of reports per child per year has increased which suggests that there is an increased likelihood of continued contact with DoCS (being reported more times each year) for children and young persons with previous contact with the child protection system, particularly infants, adolescents and Aboriginal children and young persons.[299]

5.43 Figure 5.6 shows the likelihood of being reported again by the number of reports for Aboriginal and other children and young persons. The more reports that have been received about a child, the more likely it was that the child was reported again within 12 months. However, the overall likelihood for Aboriginal children to be reported again was greater than for other children. Once an Aboriginal child received his or her first report, they were more likely to be reported again within 12 months than not, with the likelihood of a further report being 57 per cent. This may be compared with a 36 per cent likelihood for other children. For Aboriginal children the likelihood of a further report increases to over two thirds (68 per cent) from the second report onwards, and to over 80 per cent from the fifth report onwards. Comparatively, for other children, the likelihood of being reported again within 12 months rises above two thirds (68 per cent) from the fifth report onwards and above 80 per cent for 10 or more reports.[300]

Figure 5.6 **Percentage of children and young persons aged 0-16 years reported July-September 2004 who were reported again within 12 months, by Aboriginality and number of reports received about the child in 2005/06**[301]



[299] DoCS, *A closer look: Recent trends in child protection reports to DoCS December 2007.*

[300] DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

[301] ibid.

Frequently reported children and families

5.44 Table 5.16 shows that of the frequently reported children and young persons in the period January to June 2007, there was an even gender split. School aged children from 5-15 years accounted for more than two thirds of all the frequently reported children. While in 2006/07, 12.8 per cent of children involved in child protection reports were Aboriginal, they accounted for 23.3 per cent of frequently reported children.

Table 5.16 **Children and young persons who were the subject of 8 or more reports between January to June 2007 by age, gender and Aboriginality**

Total children and young persons		*1,739*	*% of 1,739*
As a percentage of the total number of children and young persons involved in child protection reports , January to June 2007 (total estimated at 61,845)		2.8%	
Gender	Male	872	50.1
	Female	863	49.6
	Not stated	4	0.2
Age Group	Under 1 year	148	8.5
	1-2 years	186	10.7
	3-4 years	184	10.6
	5-11 years	621	35.7
	12-15 years	544	31.3
	16-17 years	56	3.2
Aboriginality	Aboriginal	406	23.3
	Non-Aboriginal	1,314	75.6
	Not stated	19	1.1
Whether in OOHC	Yes	47	2.7
	No	1,692	97.3

5.45 Table 5.17 provides some insight into the size of family groups of frequently reported children and young persons. Almost one quarter of all frequently reported children in the sample group were the subject of a plan, and in all likelihood from families, with three or more children.

Table 5.17 **Children and young persons who were the subject of 8 or more reports between January to June 2007 by number of plans and children under the plan**

Number of children and young persons per plan	*Number of plans*	*Percentage of plans*	*Total children involved*	*Percentage of children*
1	934	75.4	934	53.7
2	190	15.3	380	21.9
3	70	5.6	210	12.1
4	22	1.8	88	5.1
5	15	1.2	75	4.3
6	5	0.4	30	1.7
7	2	0.2	14	0.8
8	1	0.1	8	0.5
Total	1,239	100	1,739	100

Sibling groups

5.46 Over the three year period, from 2004/05 to 2006/07, the number of sibling groups[302] increased by 14 per cent. This compares with a 32 per cent increase in reports received by DoCS and a 21 per cent increase in children reported.

5.47 DoCS receives many reports from a small proportion of sibling groups. In each year from 2004/05 to 2006/07, around three per cent of sibling groups (ordered by the most frequently reported) accounted for a quarter of all reports while around 12 per cent of sibling groups accounted for half of all reports. For the combined three year period, reports were even more concentrated in the frequently reported sibling groups – the top 2.2 per cent and 8.5 per cent of sibling groups accounted for a quarter and a half of all reports respectively.

5.48 The most frequently encountered groups in 2005/06:

a. had the largest sibling groups

b. were relatively more likely in the regions of Hunter/Central Coast, Northern and Western and relatively less likely in the other regions (based on the sibling group's last referred report)

c. had an over representation of sibling groups where at least one child was identified as Aboriginal

d. were more likely to have reports involving neglect or carer drug and alcohol, and less likely to be reports involving sexual abuse and domestic violence

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[302] DoCS' definition of a sibling group is "children in KiDS that are related (using the 'relationship' component with types: sibling of, sibling to be of, unborn sibling, half sibling of and step sibling of) and for those not matched using the 'relationship' component, where their address was the same." DoCS, *Child protection reports, Analysis of sibling groups,* February 2008.

e. accounted for a large proportion of the assessment work undertaken by DoCS and were more likely to have reports determined to involve actual harm or risk of harm

f. were more likely to have children who had ever been in OOHC and who entered OOHC after a child protection report in 2005/06

g. had higher proportions of short term re-reports.[303]

Requests for assistance

Table 5.18 **Number of requests for assistance – s.20 and s.21, 2006/07**

Legal Basis (Caseworker's Perspective)	*Assessment – IA – Outcome*	*No of Reports*
Section 20 C/YP request assistance	To CSC/JIRT further assessment	336
	Info forwarded to DoCS unit	91
	Info only provided	38
	Advice and guidance only	16
	CW does not believe ROH	13
	Referral	6
	Reporter info already known	3
	Initial assessment end premature	1
	Not entered	0
Total – section 20 C/YP request assistance		504
Section 21 parent request assistance	To CSC/JIRT further assessment	4803
	Info forwarded to DoCS unit	863
	Info only provided	201
	Advice and guidance only	49
	CW does not believe ROH	47
	Referral	31
	Reporter info already known	18
	Initial assessment end premature	6
	Not entered	5
Total – section 21 Parent request assistance		6,023
Total section 20 and 21		6,527

5.49 The 6,527 section 20 and 21 requests for assistance made to the Helpline in 2006/07 were in addition to the 286,033 child protection reports. Of these, the great majority came from parents requesting assistance.

[303] ibid.

Outcome of assessment at the Helpline

5.50 The data in the following sections largely relates to those reports referred to a CSC/JIRT for secondary assessment. The data referred to as 2007/08 in these sections relate to the 12 month period from April 07/March 08.

5.51 Over the four years from 2004/05 to 2007/08, between 30 and 35 per cent of reports did not proceed to a CSC/JIRT for further assessment. In the last two years the percentage has been around 30 per cent. However, not all of these reports were closed at the Helpline. A significant number were forwarded as information to a CSC/JIRT. In 2004/05, such reports accounted for 21.9 per cent of all reports and in 2007/08, the figure was 17.7 per cent.

Table 5.19 **Reports assessed as not requiring further investigation at the Helpline, 2004/05 to 2007/08**

Outcome of Helpline Assessment	*2004/05*		*2005/06*		*2006/07*		*1 April 2007/31 March 2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
Information/advice or referral provided	14,853	6.9	20,616	8.6	23,299	8.1	27,505	9.3
No further assessment required	13,640	6.3	10,854	4.5	9,827	3.4	11,137	3.8
Not stated	399	0.2	318	0.1	153	0.1	214	0.1
Information forwarded to DoCS unit	47,310	21.9	48,373	20.1	51,546	18.0	52,630	17.7
Total number of reports assessed as not requiring further investigation	*76,202*	*35.2*	*80,161*	*33.3*	*84,825*	*29.7*	*91,486*	*30.8*
Total number of reports	216,386	100	241,003	100	286,033	100	296,769	100

Note: percentage is of the total number of reports received for each year

Reports referred to a CSC/JIRT for further assessment

5.52 Since 2001/02, the proportion of reports referred to a CSC/JIRT for further assessment has increased slightly. The proportion of reports referred remained fairly steady between 2006/07 and 2007/08 at around 70 per cent.

Table 5.20 **Total reports and reports referred to a CSC/JIRT for further assessment, 2001/02, 2005/06, 2006/07 and 1 April 2007/31 March 2008**[304]

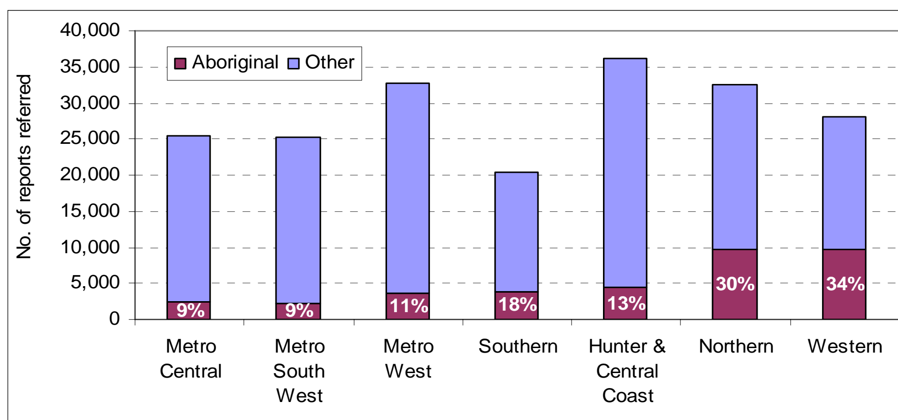
	2001/02		*2005/06*		*2006/07*		*1 April 2007/31 March 2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
Referred to CSC/JIRT for further assessment	103,074	64.6	160,842	66.7	201,208	70.3	205,283	69.2
Other	56,569	35.5	80,161	33.3	84,825	29.7	91,486	30.8
Total	159,643	100	241,003	100	286,033	100	296,769	100

Region

5.53 The percentage share of referred reports by Region has remained consistent across each year in the period 2005/06 to 2007/08. Hunter and Central Coast Region has had the highest share of reports across each of the three years at 18 per cent to 19 per cent. Metro South West (including high demand localities such as Campbelltown, Liverpool and Fairfield) is the only Region to have consistently experienced higher than average growth rates across the period – with a 29 per cent increase from 2005/06 to 2006/07 and a six per cent increase from 2006/07 to 2007/08, where the State average was 25 per cent and three per cent growth respectively.[305]

5.54 Figure 5.7 shows that Western, Northern and Southern Regions had the highest proportions of reports referred to a CSC/JIRT for further assessment involving Aboriginal children and young persons (34 per cent, 30 per cent and 18 per cent respectively). This may be compared with a rate around 10 per cent for the other regions.[306]

Figure 5.7 **Number of reports referred to a CSC/JIRT for further assessment by DoCS region and Aboriginality, 2006/07**[307]



[304] The finalised figures for 2007/08 are 209,015 reports referred to a CSC/JIRT for further assessment, which accounts for 69.0 per cent of total reports. DoCS, *Annual Report 2007/08*, p.4.

[305] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

[306] DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

[307] ibid.

Required response time and risk of harm

Table 5.21 **Selected indicators for child protection reports referred to CSC/JIRT for secondary assessment, 2005/06 to 2007/08**

	2005/06		*2006/07*		*1 April 2007/31 March 2008*	
	No	*%*	*No*	*%*	*No*	*%*
Required Response Time						
< 24 hours	17,406	10.8	19,193	9.5	18,970	9.2
< 72 hours	63,741	39.6	73,687	36.6	68,169	33.2
< 10 days	70,960	44.1	96,657	48.0	106,648	52.0
Other/missing	8,735	5.4	11,671	5.8	11,496	5.6
Risk of harm						
High	55,548	34.5	73,979	36.8	66,011	32.2
Medium	72,666	45.2	93,067	46.3	103,061	50.2
Low	24,035	14.9	22,636	11.3	24,665	12.0
Other/missing	8,593	5.3	11,526	5.7	11,546	5.6
Region						
Metro Central	19,867	12.4	25,371	12.6	25,696	12.5
Metro West	26,182	16.3	32,741	16.3	33,545	16.3
Metro South West	19,521	12.1	25,233	12.5	26,299	12.8
Southern	15,454	9.6	20,314	10.1	20,219	9.8
Hunter and Central Coast	30,373	18.9	36,171	18.0	36,425	17.7
Northern	26,485	16.5	32,622	16.2	32,828	16.0
Western	22,495	14.0	28,159	14.0	29,531	14.4
Statewide Services/other	465	0.3	597	0.3	740	0.4
Total referred for secondary assessment	160,842	100	201,208	100	205,283	100

5.55 For those reports referred to a CSC/JIRT for secondary assessment, a required response time and risk of harm level are recorded. Table 5.21 above shows that in 2007/08, 9.2 per cent of reports had a required response time of less than 24 hours, 33.2 per cent a response time of less than 72 hours and 52.0 per cent a response time of less than 10 days. Those reports with a more urgent response time (less than 24 hours or less than 72 hours) have been decreasing as a percentage of referred reports across the three year period, while those reports with less urgent response times (less than 10 days) have been increasing.[308]

5.56 Likewise, there has been a general decrease in the percentage of referred reports classified as high risk. There has however been a increase in those classified as medium risk. In 2007/08, 32.2 per cent of referred reports were classified as high risk, down from 36.8 per cent in 2006/07. Whereas medium

[308] DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

risk reports made up 50.2 per cent of referred reports in 2007/08, compared with 46.3 per cent in 2006/07 and 45.2 per cent in 2005/06.[309]

Required response time and primary reported issue

5.57 In 2006/07, of the domestic violence reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 2.3 per cent were assigned a response time of less than 24 hours

b. 31.7 per cent were assigned a response time of less than 72 hours

c. 62.4 per cent were assigned a response time of less than 10 days.

Table 5.22 **Domestic violence reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	609	10,549	23,604	1,121	35,883
Health	235	1,907	2,527	262	4,931
School/childcare	68	683	1,158	86	1,995
Other Mandatory	162	1,706	1,946	251	4,065
Total mandatory	1,074	14,845	29,235	1,720	46,874
Non-Mandatory	194	1,745	1,892	276	4,107
Total	1,268	16,590	31,127	1,996	50,981

5.58 In 2006/07, of the neglect reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 19.9 per cent were assigned a response time of less than 24 hours

b. 38.5 per cent were assigned a response time of less than 72 hours

c. 35.8 per cent were assigned a response time of less than 10 days.

Table 5.23 **Neglect reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	1,469	2,173	2,032	242	5,916
Health	816	1,739	1,044	230	3,829
School/childcare	347	1,342	2,213	202	4,104
Other Mandatory	1,248	2,259	1,681	457	5,645
Total mandatory	3,880	7,513	6,970	1,131	19,494
Non-mandatory	2,648	4,748	4,578	641	12,615
Total	6,528	12,261	11,548	1,772	32,109

[309] ibid.

5.59 In 2006/07, of the physical abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 14.3 per cent were assigned a response time of less than 24 hours

b. 42.3 per cent were assigned a response time of less than 72 hours

c. 38.9 per cent were assigned a response time of less than 10 days.

Table 5.24 **Physical abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	659	1,999	1,977	262	4,897
Health	841	2,213	1,479	268	4,801
School/childcare	1,180	3,303	3,715	208	8,406
Other Mandatory	524	1,960	1,536	265	4,285
Total mandatory	3,204	9,475	8,707	1,003	22,389
Non-mandatory	1,073	4,121	3,247	433	8,874
Total	4,277	13,596	11,954	1,436	31,263

5.60 In 2006/07, of the carer drug and alcohol reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 7.4 per cent were assigned a response time of less than 24 hours

b. 40.0 per cent were assigned a response time of less than 72 hours

c. 46.4 per cent were assigned a response time of less than 10 days.

Table 5.25 **Carer drug and alcohol reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	433	1,941	2,480	236	5,090
Health	316	2,017	2,096	370	4,799
School/childcare	90	531	858	95	1,574
Other Mandatory	181	990	928	150	2,249
Total mandatory	1,020	5,479	6,362	851	13,712
Non-mandatory	483	3,624	3,555	664	8,326
Total	1,503	9,103	9,917	1,515	22,038

5.61 In 2006/07, of the psychological abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 3.3 per cent were assigned a response time of less than 24 hours

b. 25.9 per cent were assigned a response time of less than 72 hours

c. 63.9 per cent were assigned a response time of less than 10 days.

Table 5.26 **Psychological abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	108	593	2,192	166	3,059
Health	86	927	1,293	155	2,461
School/childcare	57	518	2,150	168	2,893
Other Mandatory	96	691	1,105	249	2,141
Total mandatory	347	2,729	6,740	738	10,554
Non-mandatory	136	1,536	3,425	352	5,449
Total	483	4,265	10,165	1,090	16,003

5.62 In 2006/07, of the carer mental health reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 11.3 per cent were assigned a response time of less than 24 hours

b. 45.8 per cent were assigned a response time of less than 72 hours

c. 36.8 per cent were assigned a response time of less than 10 days.

Table 5.27 **Carer mental health reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*< 24 hours*	*< 72 hours*	*< 10 days*	*10+ days/not stated*	*Total*
Police	224	865	899	133	2,121
Health	823	3,623	2,754	443	7,643
School/childcare	88	448	469	76	1,081
Other Mandatory	344	1,076	716	157	2,293
Total mandatory	1,479	6,012	4,838	809	13,138
Non-mandatory	547	1,345	1,091	242	3,225
Total	2,026	7,357	5,929	1,051	16,363

5.63 In 2006/07, of the sexual abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

a. 8.8 per cent were assigned a response time of less than 24 hours

b. 36.5 per cent were assigned a response time of less than 72 hours

c. 47.8 per cent were assigned a response time of less than 10 days.

Table 5.28 **Sexual abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

Reporter type	*<24 hours*	*<72 hours*	*<10 days*	*10+ days/not stated*	*Total*
Police	445	1,230	1,156	149	2,980
Health	181	929	1,060	230	2,400
School/childcare	177	802	1,953	159	3,091
Other Mandatory	158	1,023	1,041	209	2,431
Total mandatory	961	3,984	5,210	747	10,902
Non-mandatory	209	1,386	1,786	301	3,682
Total	1,170	5,370	6,996	1,048	14,584

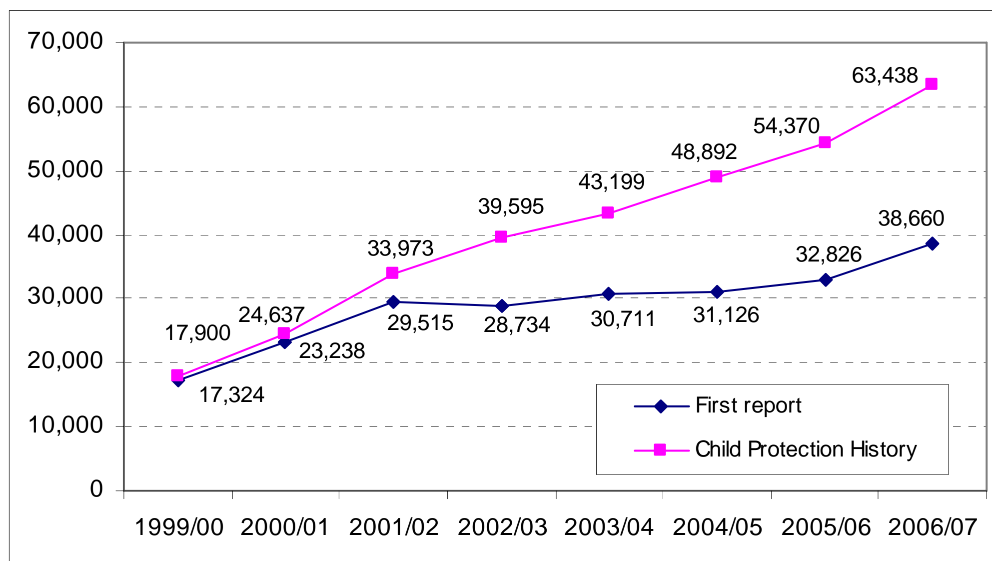
5.64 Thus, reports by mandatory reporters where the primary reported issue was neglect were more likely to be assigned a response time of less than 24 hours than any other reports. Neglect reports were followed by physical abuse reports, and then by carer mental health, sexual abuse, and carer drug and alcohol reports in this respect. The reports that were least likely to receive a response time of less than 24 hours were reports where the primary reported issue was domestic violence.

Child protection history

5.65 The number of children and young persons who were the subject of reports requiring further assessment at a CSC/JIRT and who were known to DoCS has increased at a substantially higher rate than that for the number of new children similarly referred. In 2006/07, 62.1 per cent of those children who were the subject of a report referred to CSC/JIRT for further assessment had a child protection history compared with 50.8 per cent in 1999/00.[310]

5.66 In 2006/07, a higher proportion of known children and young persons were the subject of reports that were referred to a CSC/JIRT for further assessment compared with new children and young persons similarly referred. Reports on 90.3 per cent of the 70,229 known children and young persons who were subject of a child protection report in 2006/07 were referred to a CSC/JIRT. In contrast, reports on 72.3 per cent of the 53,461 new children and young persons who were subject of a child protection report in 2006/07 were similarly referred (see Figure 5.8).

Figure 5.8 **Children and young persons who were the subject of a report referred to a CSC/JIRT for further assessment by child protection history status, 1999/00 to 2006/07**[311]



Allocation rates

5.67 DoCS calculates allocation rates based on the number of reports that have a Secondary Assessment Stage 1 (SAS1) or a Secondary Assessment Stage 2 (SAS2) commenced on KiDS as a percentage of the number of reports referred to a CSC/JIRT for secondary assessment.

[310] DoCS, *A closer look: Recent trends in child protection reports to DoCS,* December 2007.

[311] ibid.

Table 5.29 **Allocation rates by required response time and regions, 2006/07**

Region	*Required Response Time*		
	Less than 24 hours	*Less than 72 hours*	*Less than 10 days*
Hunter/Central Coast	96.6	60.7	31.6
Metro Central	99.2	65.0	38.8
Metro South West	95.5	60.7	42.6
Metro West	96.4	64.0	40.7
Northern	97.6	73.1	61.1
Southern	97.0	64.8	51.3
Western	98.0	74.9	59.1
Statewide average	97.2	66.3	45.9

Table 5.30 **Allocation rates 2006/07 and 2007/08**

Required response time	*2006/07*	*1 April 2007/31 March 2008*
Less than 24 hours	97.2%	98.0%
Less than 72 hours	66.3%	75.5%
Less than 10 days	45.9%	55.9%
Percentage of all reports referred to CSC/JIRT that were allocated	61.3%	66.9%

5.68 Allocation rates in 2006/07 were 97.2 per cent for reports with a less than 24 hours response time, 66.3 per cent for reports with a less than 72 hours response time and 45.9 per cent for reports with less than 10 days response time. Allocation rates during April 07/March 08 have increased to 98.0 per cent, 75.5 per cent and 55.9 per cent respectively.

Section 248 directions

Table 5.31 **Child protection reports with Section 248 directions made, 2006/07**

	Total number	*As a percentage of total number of reports with s.248 directions made*	*As a percentage of the total number of reports referred to CSC/JIRT*
Reports with Section 248 directions made by DoCS	15,414	100	7.7
Reports with Section 248 directions made that were closed before secondary assessment due to competing priorities (total = 77,386)	321	2.1	0.2
Reports with Section 248 directions made that received a SAS1 and then closed due to competing priorities (total = 17,705)	895	5.8	0.4

5.69 Of the total number of child protection reports received in 2006/07, 15,414 had s.248 directions made in relation to them. This represents 5.4 per cent of total reports and 7.7 per cent of reports referred to a CSC/JIRT for further assessment.

5.70 Of those 77,386 reports that were closed at the CSC before any secondary assessment due to 'current competing priorities', 0.4 per cent had been subject to a s.248 direction.

5.71 Of those 17,705 reports that were closed after a SAS1 due to competing priorities, 5.1 per cent were subject of a s.248 direction.

5.72 Overall fewer than 10 per cent of s.248 directions were made in circumstances where the case had been referred to a CSC and was subsequently closed due to competing priorities.

5.73 KiDS data do not distinguish multiple section 248 directions that may have been made about one child protection report. DoCS advises that the data in the above table have been obtained from coded fields in KiDS, and the quality and completeness of data has not been tested.

Sections 17 and 248 – Requests to NSW Health

5.74 The Inquiry has been informed that DoCS does not have the capacity to keep statistics on s.17 requests and responses. NSW Health (Health), however, does, and its data follows.

Table 5.32 **Requests made to NSW Health under ss.17 and 248, 2006/07 and 2007/08**

Health service	*Section 248 directions received*		*Section 17 requests*	
	2006/07	*2007/08*	*2006/07*	*2007/08*
Hunter New England AHS	1,016	1,203	33	22
Northern Sydney Central Coast AHS	792	983	3	3
The Children's Hospital at Westmead	272	288		
Greater Southern AHS	381	513	0	0
Greater Western AHS	190	320	0	2
South Eastern Sydney Illawarra AHS	735	765	0	2
Sydney South West AHS	1,226	1,388	25	27
South West AHS	1,650	2,415	32	16
Justice Health		30		
Total	6,262	7,905	93	72

5.75 Health received 6,262 s.248 requests in 2006/07, increasing to 7,905 requests in 2007/08, which represents a 26.2 per cent increase.

5.76 In 2006/07, 40.6 per cent of all s.248 directions by DoCS were made to Health.

5.77 The level of urgency assigned to s.248 requests varied considerably between health services. Hunter New England Area Health Service, Sydney South West Area Health Service, Northern Sydney Central Coast Area Health Service and

The Children's Hospital at Westmead reported that up to one quarter of the s.248 requests were urgent. South West Area Health Service reported up to one third were urgent and Greater Western Area Health Service reported over 40 per cent were urgent. In contrast, South Eastern Sydney Illawarra Area Health Service reported that no s.248 requests were urgent and Greater Southern Area Health Service reported that less than five per cent were urgent.

Case closure

Table 5.33 **Reports closed at CSC/JIRT before any secondary assessment**

	2001/02	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*	*1 April 2007/31 March 2008*
Reports closed before any secondary assessment							
Number	30,647	66,717	n/a	65,975	69,347	77,567	63,115
As a Percentage of the total reports referred to CSC/JIRT	29.7	58.0	n/a	47.1	43.1	38.6	30.7
Number of reports referred to CSC/JIRT for further assessment	103,074	115,000	121,368	140,184	160,842	201,208	205,283

Notes: n/a – not available. DoCS advises limited data were available for 2003/04 due to the introduction of the new client information system, KiDS. Data is not comparable between 2001/02, 2002/03 and 2004/05 to 2007/08 because of the change in the data series.

Table 5.34 **Reports closed due to current competing priorities, 2006/07 and 2007/08**

	2006/07	*1 April 2007/31 March 08*
Number of reports closed before any secondary assessment due to current completing priorities	77,386	62,568
Number of reports closed after SAS1 due to current completing priorities	17,705	23,137
Total closed at CSC/JIRT due to current competing priorities	95,091	85,705
Total closed at CSC/JIRT due to current competing priorities as a percentage of total reports referred to CSC/JIRT	47.3%	41.7%

5.78 The percentage of reports that were referred to a CSC/JIRT but were closed before any secondary assessment occurred has significantly decreased since 2002/03 when 58.0 per cent of all reports referred to a CSC/JIRT were so closed. In the period April 07/March 08, the percentage had fallen to 30.7 per cent of referred reports.

5.79 The number of reports closed at the CSC due to current competing priorities also decreased between 2006/07 and April 07/March 08. While the majority of these reports were closed prior to any secondary assessment commencing, a

significant proportion were closed after SAS1. Of all reports closed at the CSC due to competing priorities in April 07/March 08, 27.0 per cent were closed after SAS1. The corresponding figure for 2006/07 is 18.6 per cent.

Secondary Assessment Stage 2

Table 5.35 **Child protection reports subject of SAS2 by region, required response time and percentage of all reports referred, 2006/07**

Region	*Required response time*							
	< 24 Hours	*< 72 hours*	*< 10 days*	*10 days or more*	*Not stated*	*Total SAS2*	*Total reports referred*	*% of total reports referred*
Hunter/Central Coast	1,909	2,570	1,522	15	1,943	7,959	36,171	22.0
Metro Central	1,166	1,577	1,110	8	1,491	5,352	25,371	21.1
Metro South West	1,173	1,567	936	16	894	4,586	25,233	18.2
Metro West	1,359	1,700	897	11	975	4,942	32,741	15.1
Northern	1,654	2,511	1,809	23	2,230	8,227	32,622	25.2
Southern	883	1,428	1,027	6	1,098	4,442	20,314	21.9
Western	1,532	2,700	1,736	7	1,655	7,630	28,159	27.1
Statewide services	69	20	14	1	53	157	596	26.3
Total	9,745	14,073	9,051	87	10,339	43,295	201,208	21.5

Note: 'not stated figures include 'not specified'.

5.80 Table 5.35 shows a regional variation in the proportion of reports that received a SAS2 in 2006/07.

5.81 Table 5.36 indicates that the most likely outcome for children who received multiple SAS2s was to be reported multiple times in the 12 months following the six month assessment period. More than 60 per cent of the 2004 cohort who were the subject of multiple SAS2s were further reported more than twice. Over 35 per cent were subsequently reported five or more times. This was substantially higher than for children with only one SAS2 during the assessment period. Children who did not receive a SAS2 and who did not have a report allocated were most likely not to be reported again within the following 12 months.[312]

5.82 Of the children detailed in Table 5.36 with multiple SAS2s, approximately one quarter entered an OOHC placement in the six month assessment period.

[312] DoCS, *A closer look: recent trends in child protection reports-supplementary analysis*, February 2007.

Table 5.36 **Highest level of assessment received by children reported July – September 2004 in a 6 month assessment period by the number of subsequent reports in 12 months following the assessment period**[313]

Highest level of assessment		*Number of subsequent reports in 12 months following the 6 month assessment period*				
		1 report	*2-4 reports*	*5+ reports*	*Not reported again*	*Total*
More than one SAS2	No	55	94	132	93	374
	%	14.7	25.1	35.3	24.9	100%
One SAS2	No	710	957	783	1,690	4,140
	%	17.1	23.1	18.9	40.8	100%
Allocated but no SAS2	No	1,628	2,163	1,332	4,483	9,606
	%	16.9	22.5	13.9	46.7	100%
Unallocated	No	2,903	2,581	1,082	12,111	18,677
	%	15.5	13.8	5.8	64.8	100%
Total	No	5,296	5,795	3.329	18,377	32,797
	%	16.1	17.7	10.2	56.0	100%

Assessment path

Assessment path of all child protection reports

5.83 In the following pages, the action DoCS took in respect of reports in 2006/07 and in April 07/March 08 is set out in Figures 5.9 to 5.12 prepared by the Inquiry with data provided by DoCS.

313 ibid.

Child Protection Reports to DoCS 2006/07

286,033 reports
involving 123,690 children and young persons (CYP)
Unless stated otherwise, all percentages are of 286,033

Primary reported issue

Domestic Violence	**26.0%**	**74,283**
Police	19.0%	54,376
Health	2.2%	6,342
Education	0.9%	2,518
Other Mandatory	1.9%	5,534
Non-mandatory	1.9%	5513
Neglect	**14.7%**	**41,947**
Police	2.6%	7,327
Health	1.7%	4.765
Education	1.8%	5,091
Other Mandatory	2.9%	8,154
Non-mandatory	5.8%	16,610
Physical Abuse	**14.2%**	**40,559**
Police	2.3%	6,590
Health	2.1%	6,022
Education	3.5%	10,141
Other Mandatory	2.1%	5,944
Non-mandatory	4.1%	11,862
Carer D&A	**9.9%**	**28,295**
Police	2.2%	6,340
Health	2.2%	6,172
Education	0.7%	1,937
Other Mandatory	1.0%	2,901
Non-mandatory	3.8%	10,945
Psychological Abuse	**8.9%**	**25,589**
Police	1.9%	5,318
Health	1.2%	3,394
Education	1.6%	4,661
Other Mandatory	1.3%	3,647
Non-mandatory	3.0%	8,569
Carer Mental Health	**7.5%**	**21,418**
Police	1.0%	2,954
Health	3.4%	9,677
Education	0.5%	1,374
Other Mandatory	1.0%	2,882
Non-mandatory	1.6%	4,531
Sexual Abuse	**7.1%**	**20,204**
Police	1.3%	3,709
Health	1.2%	3,414
Education	1.5%	4,430
Other Mandatory	1.2%	3,467
Non-mandatory	1.8%	5,184
CYP Risk taking Behaviour	**5.5%**	**15,599***
Police	1.3%	3,632
Health	0.7%	2,046
Education	1.0%	2,859
Other Mandatory	1.4%	3,906
Non-mandatory	1.1%	3,156
Other	6.3%	18,139*

Reporter type

Police	32.5%	93,069
Health	15.3%	43,870
Education	12.5%	35,741
Other Mandatory	13.8%	39,336
Non-mandatory & Other	25.9%	74,017
All Mandatory	74.1%	212,016

Required Response Time

< 24 hrs	6.7%
< 72 hrs	25.8%
< 10 days	33.8%
10+ days	0.2%
Not stated	3.9%
Info forwarded to DoCS unit	18.0%
Stayed at Helpline	11.6%

Reports with more than one reported issue

Second issue listed	46.0%	131,582
Third issue listed	17.4%	49,677

Aboriginality

Reports

Aboriginal	17.3%	49,443
Non-Aboriginal	82.7%	236,590

Number of children and young persons
% of 123,690

Aboriginal	12.8%	15,820
Non-Aboriginal	87.2%	107,870

Children and young persons
% of 123,690

Age of children & young persons

< 1 year	9.5%	11,729
1-2 years	11.1%	13,791
3-4 years	11.3%	13,955
5-11 years	37.7%	46,626
12-15 years	22.8%	28,225
16-17 years	5.0%	6,227
Not stated	2.5%	3,137

Number of reports for each child or young person

1 to 3 reports	83.9%	103,826
4 to 10 reports	14.0%	17,291
11 to 20 reports	1.8%	2,214
more than 20 reports	0.3%	359

HELPLINE outcome of initial assessment

Reports not referred for any further assessment

84,825 reports
29.7% of 286,033 = 84,825 reports

All percentages are of 84,825

Primary Reported Issue

Domestic Violence	27.5%	23,302
Neglect	11.6%	9,838
Psychological Abuse	11.3%	9,586
Physical Abuse	11.0%	9,296
CYP-Risk taking Behaviour	7.7%	6542
Carer D&A	7.4%	6,257
Sexual Abuse	6.6%	5,620
Carer Mental Health	6.0%	5,055
Other	11.0%	9,329

Reporter type

Police	35.3%	29,932
Health	12.1%	10,266
Education	10.4%	8,859
Other	42.2%	35,768

Assessment status of these reports

All percentages are of 286,033

Information forwarded to DoCS Unit	18.0% CYP	51,546 29,386
Info/advice or referral provided	8.1% CYP	23,299 21,099
No further assessment	3.4% CYP	9,827 9,328
Not stated	0.1%	153

Reports referred for further assessment to the CSC/JIRT

201,208 reports
70.3% of 286,033 = 201,208 reports, involving 102,098 CYP

All percentages are of 201,208)

Primary reported issue

Domestic Violence	25.3%	50,981
Neglect	16.0%	32,109
Physical Abuse	15.5%	31,263
Carer D&A	11.0%	22,038
Carer Mental Health	8.1%	16,363
Psychological Abuse	8.0%	16,003
Sexual Abuse	7.2%	14,584
CYP Risk- taking Behaviour	4.5%	9,057
Other	4.4%	8,808

Reporter type

Police	31.4%	63,137
Health	16.7%	33,604
Education	13.4%	26,882
Other	38.6%	77,585

Required response time

< 24 hrs	9.5%	19,193
< 72 hrs	36.6%	73,687
< 10 days	48.0%	96,657
10+ days	0.3%	559
Not stated	5.5%	11,095*

*Almost all of these reports were related to a current SAS1 or SAS2 record at the CSC/JIRT

Note:
Primary reported issue 'CYP Risk taking Behaviour ' category comprises data on:
1. D&A use by CYP
2. Suicide risk for child
3. Runaway CYP

Reported issue 'Other' category comprises data on:
1. Carer other issues
2. Child inappropriate sexual behaviour
3. Other issues
4. No risk or harm issues
5. No primary Issues entered

Action taken at CSC / JIRT

Closed at CSC/JIRT before any Secondary Assessment

77,567 reports
27.1% of total reports
38.6% of referred reports
involving 55,774 CYP

All percentages are of 77,567

Primary Reported Issue		
Domestic Violence	32.8%	25,441
Physical Abuse	15.0%	11,657
Neglect	12.4%	9,587
Carer D&A	10.3%	7,979
Psychological Abuse	9.3%	7,207
Carer Mental Health	6.7%	5,172
Sexual Abuse	5.5%	4,235
CYP Risk taking Behaviour	4.4%	3,447
Other	3.7%	2842
Reporter type		
Police	37.9%	29,417
Education	15.2%	11,805
Health	14.4%	11,187
Other	32.4%	25,158
Required Response Time		
< 24 hrs	0.7%	528
< 72 hrs	31.8%	24,663
< 10 days	67.2%	52,119
10+ days	0.3%	257
Reason for case closure		
No further assessment required or possible	0.2%	181
Current competing priorities	99.8	77,386

SAS1 only completed

76,884 reports
26.9% of total reports
38.2% of referred reports
involving 49,589 CYP

All percentages are of 76,884

Primary Reported Issue		
Domestic Violence	23.9%	18,404
Neglect	17.3%	13,266
Physical Abuse	15.2%	11,688
Carer D&A	10.2%	7,880
Carer Mental Health	9.3%	7,178
Sexual Abuse	7.4%	5,721
Psychological Abuse	7.4%	5,691
CYP Risk taking Behaviour	4.2%	3,229
Other	5.0%	3,827
Reporter type		
Police	28.6%	21,977
Health	18.1%	13,949
Education	12.3%	9,454
Other	41.0%	31,504
Required Response Time		
< 24 hrs	10.6%	8,169
< 72 hrs	43.4%	33,395
< 10 days	44.7%	34,340
10+ days	0.3%	207

Note: 772 'not entered' and 1 'no response required'

Reason for case closure		
Eligible Early Intervention	10.5%	8,108
Other Information:		
- Early Intervention	0.6%	474
- Close	55.9%	42,940
- Referral-close	8.2%	6,325
Closed:		
- Case Closure Policy	23.0%	17,705
- Subjects not located	0.8%	643
Streamed back to intake	0.9%	689

SAS2 / Judgements and Decisions completed

43,295 reports
15.1% of total reports
21.5% of referred reports
involving 15,346 CYP

All percentages are of 43,295

Primary Reported Issue		
Neglect	19.6%	8,498
Physical Abuse	16.9%	7,299
Domestic Violence	14.9%	6,451
Carer D&A	13.3%	5,766
Sexual Abuse	10.2%	4,407
Carer Mental Health	8.6%	3,708
Psychological Abuse	6.7%	2,894
CYP Risk taking Behaviour	5.3%	2,280
Other	4.6%	1,992
Reporter type		
Police	25.1%	10,850
Health	18.1%	7,842
Education	11.9%	5,162
Other	44.9%	19,441
Required Response Time		
< 24 hrs	22.5%	9,745
< 72 hrs	32.5%	14,073
< 10 days	20.9%	9,051
10+ days	0.2%	87

Note: 10,323 'not entered' and 16 'no response required'

Ongoing secondary assessment / Investigation

3,462 reports
involving 2,794 CYP

Outcome of SAS2/J&D

Harm or risk of harm	**93.5%**	**40,472**
No risk of harm	5.9%	2,556
Missing assessed issue	0.6%	267

Substantiated Reports

40,472 reports
involving 14,010 CYP

All percentages are of 40,472

Actual Harm	**70%**	**28,335**
Psychological	27.7%	11,209
Neglect	23.4%	9,451
Physical	11.7%	4,722
Sexual	7.3%	2,953
Risk of Harm	**30%**	**12,137**
Risk of Psychological Harm	11.8%	4,794
Risk of Neglect	8.3%	3,376
Risk of Physical Harm	6.9%	2,775
Risk of Sexual Harm	2.9%	1,192

Summary:	
Psychological/Risk of Psychological Harm	39.5%
Neglect/Risk of Neglect	31.7%
Physical/Risk of Physical Harm	18.5%
Sexual /Risk of Sexual Harm	10.2%

Primary Reported Issue		
Neglect	19.8%	8,004
Physical Abuse	16.4%	6,618
Domestic Violence	15.5%	6,274
Carer D&A	13.5%	5,483
Sexual Abuse	9.6%	3,874
Carer Mental Health	8.7%	3,533
Psychological Abuse	6.7%	2,699
CYP Risk taking Behaviour	5.3%	2,136
Other	4.6%	1,850
Required Response Time		
< 24 hrs	22.3%	9,018
< 72 hrs	32.5%	13,136
< 10 days	20.9%	8,445
10+ days	0.2%	81

Note: 9,776 'not entered' and 16 'no response required'

Age when harm or risk of harm determined % of 14,010 CYP

All percentages are of 14,010

< 1 year	14.0%	1,960
1-2 years	13.0%	1,819
3-4 years	12.2%	1,710
5-11 years	37.1%	5,195
12-15 years	21.4%	3,004
16-17 years	2.2%	313
Not stated	0.1%	9

Child Protection Reports to DoCS 1 Apr 2007 – 31 Mar 2008

296,769 reports
involving 128,673 children and young persons (CYP)
Unless stated otherwise, all percentages are of 296,769

Primary reported issue

Issue	%	Number
Domestic Violence	**25.9%**	**76,792**
Police	18.9%	55,976
Health	2.1%	6,326
Education	0.8%	2,472
Other Mandatory	2.1%	6,274
Non-mandatory & Other	1.9%	5,744
Neglect	**15.0%**	**44,407**
Police	2.8%	8,197
Health	1.7%	5,011
Education	1.9%	5,513
Other Mandatory	3.0%	8,988
Non-mandatory & Other	5.6%	16,698
Physical Abuse	**14.1%**	**41,953**
Police	2.3%	6,891
Health	2.1%	6,168
Education	3.5%	10,283
Other Mandatory	2.1%	6,336
Non-mandatory & Other	4.1%	12,275
Carer D&A	**10.4%**	**30,981**
Police	2.4%	7,247
Health	2.2%	6,530
Education	0.7%	2,213
Other Mandatory	1.1%	3,388
Non-mandatory & Other	3.9%	11,603
Psychological Abuse	**8.6%**	**25,626**
Police	1.8%	5,383
Health	1.2%	3,442
Education	1.6%	4,815
Other Mandatory	1.2%	3,444
Non-mandatory & Other	2.9%	8,542
Carer Mental Health	**8.0%**	**23,759**
Police	1.2%	3,492
Health	3.5%	10,409
Education	0.6%	1,746
Other Mandatory	1.2%	3,428
Non-mandatory & Other	1.6%	4,684
Sexual Abuse	**6.7%**	**19,890**
Police	1.3%	3,776
Health	1.1%	3,309
Education	1.4%	4,158
Other Mandatory	1.2%	3,573
Non-mandatory & Other	1.7%	5,074
CYP Risk taking Behaviour	**4.9%**	**14,434**
Police	1.3%	3,859
Health	0.7%	2,131
Education	1.0%	2,892
Other Mandatory	0.9%	2,715
Non-mandatory & Other	1.0%	2,837
Other	6.4%	18,927*

Reporter type

Reporter	%	Number
Police	33.1%	98,114
Health	15.3%	45,396
Education	12.4%	36,945
Other Mandatory	13.8%	40,835
Non-mandatory & Other	25.4%	75,479
All Mandatory	74.6%	221,290

Required Response Time

Time	%
< 24 hrs	6.4%
< 72 hrs	23.0%
< 10 days	35.9%
10+ days	0.2%
Not stated	3.7%
Stay at Helpline - no response time assigned	30.8%

Reports with more than one reported issue

	%	Number
Second issue listed	48.8%	144,716
Third issue listed	18.9%	56,017

Aboriginality

Reports

	%	Number
Aboriginal	18.5%	54,760
Non-Aboriginal	81.5%	242,009

Number of children and young persons
% of 128,673

	%	Number
Aboriginal	14.0%	17,982
Non-Aboriginal	86.0%	110,691

Children and young persons

Age of children & young persons
% of 123,690

Age	%	Number
<1 year	9.9%	12,745
1-2 years	11.4%	14,661
3-4 years	11.4 %	14,623
5-11 years	37.5%	48,264
12-15 years	22.7%	29,208
16-17 years	5.1%	6,546
Not stated	2.0%	2,626

Number of reports for each child or young person

	%	Number
1 to 3 reports	83.8%	107,787
4 to 10 reports	14.3%	18,337
11 to 20 reports	1.7%	2,208
more than 20 reports	0.3%	341

HELPLINE outcome of initial assessment

Reports not referred for any further assessment

91,486 reports
30.8% of 296,769 = 91,486 reports

All percentages are of 91,486

Primary Reported Issue

Issue	%	Number
Domestic Violence	28.6%	26,127
Neglect	12.0%	10,995
Physical Abuse	11.0%	10,063
Psychological Abuse	10.8%	9,878
Carer D&A	7.8%	7,113
Carer Mental Health	6.5%	5,932
Sexual Abuse	6.4%	5,879
CYP Risk taking Behaviour	6.2%	5,631
Other	10.8%	9,868

Reporter type

Reporter	%	Number
Police	36.9%	33,788
Health	12.2%	11,164
Education	10.4%	9,525
Other Mandatory	15.1%	13,813
Non-mandatory and Other	25.4%	23,196

Assessment status of these reports

All percentages are of 296,769

Status	%	Number
Information forwarded to DoCS Unit	17.7%	52,630
Info/advice or referral provided	9.3%	27,505
No further assessment	3.8%	11,137
Not stated	0.1%	214

Reports referred for further assessment to the CSC/JIRT

205,283 reports
69.2% of 205,283
involving 104,535 CYP

All percentages are of 205,283

Primary reported issue

Issue	%	Number
Domestic Violence	24.7%	50,665
Neglect	16.3%	33,412
Physical Abuse	15.5%	31,890
Carer D&A	11.6%	23,868
Carer Mental Health	8.7%	17,827
Psychological Abuse	7.7%	15,748
Sexual Abuse	6.8%	14,011
CYP Risk taking Behaviour	4.3%	8,803
Other	4.4%	9,059

Reporter type

Reporter	%	Number
Police	31.3%	64,326
Health	16.7%	34,232
Education	13.4%	27,420
Other Mandatory	13.2%	27,022
Non-mandatory and Other	25.5%	52,283

Required response time

Time	%	Number
< 24 hrs	9.2%	18,970
< 72 hrs	33.2%	68,169
< 10 days	52.0%	106,648
10+ days	0.2%	470

Note: 11,026 listed as 'no response required' or 'not stated'

Note:
Primary reported issue 'CYP Risk taking Behaviour ' category comprises data on:
1. D&A use by CYP
2. Suicide risk for child
3. Runaway CYP

Reported issue 'Other' category comprises data on:
1. Carer other issues
2. Child inappropriate sexual behaviour
3. Other issues
4. No risk or harm issues
5. No primary Issues entered

Action taken at CSC / JIRT

Closed at CSC/JIRT before any Secondary Assessment

63,115 reports
21.3% of total reports
30.7% of referred reports
involving 46,599 CYP

All percentages are of 63,115

Primary Reported Issue		
Domestic Violence	30.6%	19,288
Physical Abuse	15.9%	10,052
Neglect	12.7%	8,019
Carer D&A	10.5%	6,617
Psychological Abuse	9.3%	5,873
Carer Mental Health	6.8%	4,265
Sexual Abuse	5.4%	3,439
CYP Risk taking Behaviour	5.1%	3,200
Other	3.7%	2,362

Reporter type		
Police	37.7%	23,809
Health	13.9%	8,798
Education	15.7%	9,907
Other Mandatory	10.0%	6,306
Non-mandatory and Other	22.6%	14,295

Reason for case closure		
No further assessment required or possible	0.9%	547
Current competing priorities	99.1%	62,568

Required Response Time		
< 24 hrs	0.5%	335
< 72 hrs	25.7%	16,252
< 10 days	73.4%	46,344
10+ days	0.3%	184

SAS1 only completed

98,656 reports
33.2% of total reports
48.1% of referred reports
involving 61,596 CYP

All percentages are of 98,656

Primary Reported Issue		
Domestic Violence	25.5%	25,163
Neglect	16.8%	16,589
Physical Abuse	14.5%	14,307
Carer D&A	11.4%	11,251
Carer Mental Health	9.7%	9,605
Psychological Abuse	7.3%	7,153
Sexual Abuse	6.2%	6,124
CYP Risk taking Behaviour	3.7%	3,686
Other	4.8%	4,778

Reporter type		
Police	30.0%	29,561
Health	17.7%	17,426
Education	12.1%	11,983
Other Mandatory	13.7%	13,476
Non-mandatory and Other	26.6%	26,210

Reason for case closure		
Eligible Early Intervention	16.2%	15,965
Other Information		
- Early Intervention	2.4%	2,375
- Close	47.1%	46,420
- Referral - Close	6.5%	6,412
Closed		
- Case Closure Policy	23.5%	23,137
-Subject Not Located	0.7%	691
Streamed Back To Intake	3.7%	3,656

Required Response Time		
< 24 hrs	8.4%	8,255
< 72 hrs	39.0%	38,484
< 10 days	50.5%	49,818
10+ days	0.2%	210

Note: 1,889 listed as 'no response required' or 'not stated'

SAS2 / Judgements and Decisions completed

38,745 reports
13.1% of total reports
18.9% of referred reports
involving 14,443 CYP

All percentages are of 38,745

Primary Reported Issue		
Neglect	20.0%	7,752
Physical Abuse	17.5%	6,764
Domestic Violence	13.7%	5,327
Carer D&A	13.7%	5,309
Sexual Abuse	10.6%	4,106
Carer Mental Health	9.2%	3,559
Psychological Abuse	6.3%	2,446
CYP Risk taking Behaviour	4.6%	1,782
Other	4.4%	1,700

Reporter type		
Police	24.8%	9,625
Health	18.6%	7,210
Education	12.7%	4,937
Other Mandatory	16.7%	6,486
Non-mandatory and Other	27.1%	10,487

Required Response Time		
< 24 hrs	24.1%	9,347
< 72 hrs	30.0%	11,613
< 10 days	22.2%	8,594
10+ days	0.1%	54

Note: 9,137 listed as 'no response required' or 'not stated'

Ongoing secondary assessment / Investigation

4,767 reports

Outcome of SAS2/J&D

Harm or risk of harm	**93.2%**	**36,129**
No risk of harm	5.8%	2,238
Missing assessed issue	1.0%	378

Substantiated Reports

36,129 reports involving 13,205 CYP
All percentages are of 36,129

Actual Harm	**69.8%**	**25,220**
Psychological	26.1%	9,422
Neglect	24.0%	8,674
Physical	12.3%	4,449
Sexual	7.4%	2,675
Risk of Harm	**30.2%**	**10,909**
Risk of Psychological	12.4%	4,498
Risk of Neglect	7.6%	2,734
Risk of Physical	6.8%	2,472
Risk of Sexual	3.3%	1,205

Summary:	
Psychological/ Risk of Psychological	38.5%
Neglect/Risk of Neglect	31.6%
Physical/Risk of Physical	19.2%
Sexual/Risk of Sexual	10.7%

Primary Reported Issue		
Neglect	20.2%	7,282
Physical Abuse	17.2%	6,219
Domestic Violence	14.2%	5,113
Carer D&A	13.8%	4,993
Sexual Abuse	10.0%	3,629
Carer Mental Health	9.3%	3,374
Psychological Abuse	6.3%	2,262
CYP Risk taking Behaviour	4.7%	1,698
Other	4.3%	1,559

Required Response Time		
< 24 hrs	23.9%	8,620
< 72 hrs	29.9%	10,811
< 10 days	22.1%	7,991
10+ days	0.1%	52

Note: 8,655 listed as 'no response required' or 'not stated

Age when harm or risk of harm determined as % of 13,205 cyp

All percentages are of 13,205

<1 year	13.9%	1,835
1-2 years	13.7%	1,804
3-4 years	12.0%	1,591
5-11 years	36.2%	4,786
12-15 years	21.7%	2,860
16-17 years	2.4%	315
Not stated	0.1%	14

Assessment path of Aboriginal reports

Figure 5.11 **Aboriginal Child Protection Reports 2006/07**

Child Protection Reports to DoCS 2006/07 focusing on Aboriginal reports

49,443 reports involving 15,820 Aboriginal children and young persons (CYP)

Reported issues

In reference to Primary, Secondary and Third reported issues, at some time during 2006/07:

Neglect was a recorded in the reports of 44% of Aboriginal CYP compared with 26% of other CYP

Carer issues were recorded in the reports of 67% of Aboriginal CYP compared with 55% of other CYP. Of these:

Carer alcohol (27% compared with 13%)

Carer drug (24% compared with 13%)

Carer drug &or alcohol (43% compared with 23%)

Domestic violence was recorded in the reports of 49% of Aboriginal CYP compared with 45% of other CYP.

Reporting trends

Reports involving Aboriginal children and young persons as a % of the total number of reports for each year:

Year	%
2001/02	11.5%
2002/03	11.4%
2003/04	8.4%
2004/05	14.6%
2005/06	15.9%
2006/07	17.3%

Reporting rates

(per 1,000 CYP)

All CYP:	79 per 1,000
Aboriginal CYP:	251 per 1,000
Non-Aboriginal children <1 year:	116 per 1,000
Aboriginal children <1 year:	565 per 1,000

12.8 % (15,820) of all CYP who were subject of a report were Aboriginal

Reporter type

At some time during 2006/07:

57% of Aboriginal CYP and 49% of other CYP were the subject of a report by Police.

34% of Aboriginal CYP and 25% of other CYP were the subject of a report by either relatives, friends or neighbours.

Frequency of Reports

Of the 123,690 CYP involved in reports:

103,826 reported between 1 to 3 times
11.1% Aboriginal (11,563)

17,291 reported between 4 to 10 times
21.0% Aboriginal (3,637)

2,214 reported between 11 to 20 times
24.0% Aboriginal (531)

359 reported more than 20 times
24.8% Aboriginal (89)

53,461 reported for the first time ever
7.4% Aboriginal (3,964)

Helpline: outcome of initial assessment

Of the 49,443 reports, 35,972 (72.8%) were referred to the CSC/JIRT for further assessment (involving 14,029 Aboriginal CYP)

Required response time

Of the 35,972 Aboriginal reports:

<24 hours 12.7%

Reports by Region

Metro Central (25,371):
9.4% Aboriginal (2,375)

Metro South West (25,233):
8.9% Aboriginal (2,244)

Metro West (32,741):
10.9% Aboriginal (3,558)

Hunter/Central Coast (36,171)
12.5% Aboriginal (4,528)

Northern (32,622):
29.7% Aboriginal (9,685)

Southern (20,314):
18.4% Aboriginal (3,746)

Western (28,159):
34.4% Aboriginal (9,699)

Of the 49,443 reports, 13,471 (27.2%) were assessed as not requiring any further assessment

(involving 1,791 Aboriginal CYP)

Action taken at CSC/JIRT

Closed at CSC/JIRT before any Secondary Assessment

8,848 Aboriginal reports
11.4% of 77,567 reports

SAS1 only completed

15,412 Aboriginal reports
20.0% of 76,884 reports

Ongoing secondary assessment/Investigation

3,462 total reports

SAS2 / Judgements and Decisions completed

11,068 Aboriginal reports
25.6% of 43,295 reports

Reports Substantiated

10,401 Aboriginal reports
25.7% of 40,472 reports

Actual Harm:

Psychological (11,029)
28.3% Aboriginal (3,170)

Neglect (9.451)
32.1% Aboriginal (3,036)

Physical (4,722)
20.0% Aboriginal (945)

Sexual (2,953)
15.3% Aboriginal (451)

Risk of Harm:

Risk of Psychological Harm (4,794)
15.2% Aboriginal (728)

Risk of Neglect (3,376)
36.3% Aboriginal (1,227)

Risk of Physical Harm (2,775)
21.3% Aboriginal (591)

Risk of Sexual Harm (1,192)
21.2% Aboriginal (253)

Figure 5.12 **Aboriginal Child Protection reports 2007/08**

Child Protection Reports to DoCS April 07/March 08 focusing on Aboriginal reports

54,760 reports involving 17,982 Aboriginal children and young persons (CYP)

Reported issues

In reference to Primary, Secondary and Third reported issues, at some time during April 2007 to March 2008:

Neglect was a recorded in the reports of 45.2% of Aboriginal CYP compared with 26.6% of other CYP

Carer issues were recorded in the reports of 67.3% of Aboriginal CYP compared with 56.9% of other CYP. Of these:

Carer alcohol (28.6% compared with 14.6%)

Carer drug (24% compared with 13.6%)

Carer drug &/or alcohol (43.3% compared with 24.5%)

Domestic violence was recorded in the reports of 48.8% of Aboriginal CYP compared with 44.8% of other CYP.

Reporting trends

Reports involving Aboriginal children and young persons as a % of the total number of reports for each year:

Year	%
2001/02	11.5%
2002/03	11.4%
2003/04	8.4%
2004/05	14.6%
2005/06	15.9%
2006/07	17.3%
Apr07-Mar08	18.5%

Reporting rates

(per 1,000 CYP)

All CYP:	82 per 1,000
Aboriginal CYP:	286 per 1,000
Non-Aboriginal children <1 year:	124 per 1,000
Aboriginal children <1 year:	657 per 1,000

14.0 % (17,982) of all CYP who were subject of a report were Aboriginal

Reporter type

At some time during April 2007 and March 2008:

56.2% of Aboriginal CYP and 49.7% of other CYP were the subject of a report by Police.

32.5% of Aboriginal CYP and 23.9% of other CYP were the subject of a report by either relatives, friends or neighbours.

Frequency of Reports

Of the 128,673 CYP involved in reports:

107,787 reported between 1 to 3 times
12.3% Aboriginal (13,219)

18,337 reported between 4 to 10 times
22.5% Aboriginal (4,128)

2,208 reported between 11 to 20 times
24.5% Aboriginal (542)

341 reported more than 20 times
27.3% Aboriginal (93)

53,525 reported for the first time ever
7.9% Aboriginal (4,232)

Helpline: outcome of initial assessment

Of the 54,760 reports, 39,666 (72.4%) were referred to the CSC/JIRT for further assessment (involving 15,960 Aboriginal CYP)

Required response time

Of the 39,666 Aboriginal reports:

<24 hours 11.7%

Reports by Region

Metro Central (25,696):
9.6% Aboriginal (2,474)

Metro South West (26,299):
9.1% Aboriginal (2,399)

Metro West (33,545):
12.0% Aboriginal (4,016)

Hunter/Central Coast (36,425)
14.4% Aboriginal (5,227)

Northern (32,828):
32.4% Aboriginal (10,638)

Southern (20,219):
19.5% Aboriginal (3,949)

Western (29,531):
36.3% Aboriginal (10,733)

Of the 54,760 reports, 15,094 (27.6%) were assessed as not requiring any further assessment

(involving 2,022 Aboriginal CYP)

Action taken at CSC/JIRT

Closed at CSC/JIRT before any Secondary Assessment

7,443 Aboriginal reports
11.8% of 63,115 reports

SAS1 only completed

20,807 Aboriginal reports
21.1% of 98,656 reports

Ongoing secondary assessment/Investigation

4,767 total reports

SAS2 / Judgements and Decisions completed

10,296 Aboriginal reports
26.6% of 38,745 reports

Reports Substantiated

9,564 Aboriginal reports
26.5% of 36,129 reports

Actual Harm:

Psychological (9,422)
27.2% Aboriginal (2,563)

Neglect (8,674)
31.4% Aboriginal (2,726)

Physical (4,449)
24.3% Aboriginal (1,082)

Sexual (2,675)
15.0% Aboriginal (400)

Risk of Harm:

Risk of Psychological Harm (4,498)
21.7% Aboriginal (974)

Risk of Neglect (2,734)
33.0% Aboriginal (901)

Risk of Physical Harm (2,472)
25.6% Aboriginal (633)

Risk of Sexual Harm (1,205)
23.7% Aboriginal (285)

Outcome of assessment of all child protection reports

5.84 Table 5.37 shows that the proportion of reports closed at the CSC/JIRT prior to any secondary assessment has fallen steadily since 2004/05. The sharpest drop is between 2006/07 and April 07/March 08. Therefore, in April 07/March 08, almost 80 per cent of all reports referred to the CSC/JIRT received some level of secondary assessment, compared with 69 per cent in 2004/05 and 73 per cent in 2006/07.

5.85 The data indicate that a greater proportion of reports received a SAS1 in April 07/March 08 than in previous years. However, the proportion of reports that were subject to a completed secondary assessment (SAS2) fell from 15.1 per cent in 2006/07 to 13.1 per cent in April 07/March 08. The actual number of reports that were the subject of a completed secondary assessment also fell from 43,295 in 2006/07 to 38,745 in April 07/March 08.[314] Between 2006/07 and April 07/March 08 the number of reports that were subject to a completed SAS2 fell by 10.5 per cent.

5.86 Therefore, in April 07/March 08, both proportionately and in actual numbers, fewer children and young persons received a completed SAS2 than in 2006/07.

Table 5.37 **Outcome of assessment, 2004/05 to 2007/08 (summary table)**

Outcome of Assessment	*2004/05*		*2005/06*		*2006/07*		*1 April 2007/31March 2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
Reports closed at the Helpline	28,892	13.4	31,788	13.2	33,279	11.6	38,856	13.1
Information forwarded to DoCS unit	47,310	21.9	48,373	20.1	51,546	18.0	52,630	17.7
Subtotal	76,202	35.2	80,161	33.3	84,825	29.7	91,486	30.8
Reports referred to CSC/JIRT for further assessment	140,184	64.8	160,842	66.7	201,208	70.3	205,283	69.2
Closed at CSC/JIRT before secondary assessment	65,795	30.5	69,347	28.8	77,567	27.1	63,115	21.3
Closed after completed SAS1	36,895	17.1	49,055	20.4	76,884	26.9	98,656	33.2
Subject of completed SAS2	18,880	8.7	35,536	14.7	43,295	15.1	38,745	13.1
Ongoing secondary assessment	18,434	8.5	6,904	2.7	3,462	1.2	4,767	1.6
Total reports	216,386	100	241,003	100	286,033	100	296,769	100
Harm/risk of harm substantiated	16,705	7.7	32,390	13.4	40,472	14.2	36,129	12.2

Note: percentage is of the total number of reports received for each year

[314] DoCS advises that the finalised figure for 1 July 2007 to 30 June 2008 is 39,559.

Outcome of assessment of reports involving Aboriginal children and young persons referred to the CSC/JIRT

Table 5.38 **Outcome of assessment of reports concerning Aboriginal children and young persons 2004/05 to 2007/08**

Assessment outcome	*2004/05*		*2005/06*		*2006/07*		*1 April 2007/31 March 2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
Closed at CSC/JIRT prior to secondary assessment	7,844	36.4	8,293	31.0	8,848	24.6	7,443	18.8
Closed after Secondary Assessment Stage 1	5,901	27.4	8,679	32.5	15,412	42.8	20,807	52.5
Completed Secondary Assessment Stage 2	3,817	17.7	8,180	30.6	11,068	30.8	10,296	26.0
Total number of Aboriginal reports referred to CSC/JIRT	21,525	100	26,713	100	35,972	100	39,666	100

Note: Percentages are of the total number of Aboriginal reports referred to a CSC/JIRT for each year. Table does not include data on the number of reports that were the subject of ongoing secondary assessment.

5.87 In 2006/07 and April 07/March 08, the percentages of reports about Aboriginal children and young persons referred to a CSC/JIRT for further assessment that were closed before any secondary assessment were lower than for all reports similarly referred in 2004/05 and 2005/06.

5.88 In each year from 2004/05 to April 07/March 08, proportionately more reports about Aboriginal children and young persons were the subject of either a SAS1 only or a completed SAS2 than reports about non-Aboriginal children and young persons.

Substantiation rates

5.89 The data show that harm or risk of harm is substantiated in a great majority of reports that are subject to a SAS2. In 2006/07 and April 07/March 08, the substantiation rate has remained steady at around 93 per cent. However, because the number of completed SAS2s fell in April 07/March 08, the number of substantiated reports also fell.

Table 5.39 **Substantiation rates, 2004/05 to 2007/08**

	2004/05	*2005/06*	*2006/07*	*1 April 2007/31 March 2008*
Total number of reports	216,386	241,003	286,033	296,769
Number of reports referred to CSC/JIRT for further assessment	140,184	160,842	201,208	205,283
Number of completed SAS2	18,880	35,536	43,295	38,745
Number of substantiated reports (harm or risk of harm determined)	16,705	32,390	40,472	36,129
Substantiated reports (as % of total number of reports)	7.7	13.4	14.1	12.2
Substantiated reports (as % of reports referred to CSC/JIRT)	11.9	20.1	20.1	17.6
Substantiated reports (as % of reports that received a completed SAS2)	88.5	91.1	93.5	93.2

5.90 Table 5.40 indicates a significant increase over time in the percentage of children who were the subject of a substantiated report and then a further substantiation within the following 12 months. However, it is likely that this increase partially reflects the increase in the number of reports that were substantiated in 2006/07 (an increase of 25.0 per cent from 32,390 to 40,472).

Table 5.40 **Percentage of children and young persons who were the subject of a substantiated report in the previous year, and were the subject of a further substantiation within the following 12 months**

2001/02	*2002/03*	*2003/04*	*2004/05*	*2005/06*	*2006/07*
11.1	13.2	No data	No data	19.8	24.0

Child protection history prior to entering OOHC

5.91 The great majority of children and young persons who entered care in 2006/07 already had a child protection history (94.1 per cent); that is, prior to the report that resulted in entry to OOHC, they had been the subject of other child protection reports. Further, children and young persons re-entering OOHC were similarly likely to have had at least one other child protection report in the period between their last OOHC episode and the report that resulted in re-entry into OOHC.

5.92 Similar proportions of Aboriginal and non-Aboriginal children and young persons had been reported prior to entering care.[315]

[315] DoCS, *Analysis of children and young people who entered OOHC in 2006/07*, June 2008.

Table 5.41 **Children and young persons entering OOHC in 2006/07 by selected indicators**[316]

	Aboriginal		*Non-Aboriginal*		*Total*	
	No	*%*	*No*	*%*	*No*	*%*
Total	1,377	100	3,271	100	4,648	100
New entry/re-entry						
New entry children and young persons	905	65.7	2,377	72.7	3,282	70.6
Re-entry children and young persons	472	34.3	894	27.3	1,366	29.4
Child protection reports (prior to report resulting in entry to OOHC)						
Not reported before entering care	61	4.4	214	6.5	275	5.9
Reported before entering care	1,316	95.6	3,057	93.5	4,373	94.1

Note: 'non-Aboriginal' includes 'not stated'
For re-entry children 'not reported before entering care' refers to no reports between last OOHC episode and the report resulting in re-entry to care

5.93 Of the 1,035 children and young persons entering relative/kinship care in 2006/07, 15.3 per cent were the subject of a report, however, there was no secondary assessment recorded. For 1.2 per cent of these children and young persons, there was no child protection report recorded prior to entering care.

5.94 In 2006/07, new entry children who were aged 1-5 years were on average the subject of 11.6 reports in total (with 1.4 reports having a required response time of within 24 hours and 4.0 reports requiring a response time of within 72 hours).

5.95 In 2006/07, a higher proportion of children aged less than one year who entered OOHC had at least one report referred to a CSC/JIRT than children of other ages. They were also more likely to have had at least one report with a SAS2 completed. This pattern is the same for new entry and re-entry children.[317]

5.96 Overall the average number of reports per child (ever) before entering OOHC were higher for re-entry children than for new entry children for all age groups and all levels of assessment.[318]

[316] ibid.
[317] ibid.
[318] ibid.

Table 5.42 **Average number of reports per child or young person prior to entering OOHC**[319]

Age	*Average number of all reports*	*Average no of reports within 1 year before entering care or after last OOHC episode if re-entry*
New entry children and young persons		
<1 year	6.0	5.9
1-5 years	11.6	6.2
6-12 years	12.7	5.2
13-17 years	12.0	5.6
Re-entry children and young persons		
<1 year	8.0	2.6
1-5 years	15.1	4.0
6-12 years	19.9	4.8
13-17 years	26.4	4.0

5.97 Over two thirds of children aged 1-5 years who entered care for the first time in 2006/07 received their first report when they were aged less than one year.[320]

5.98 More than one third of children and young persons entering OOHC for the first time in 2006/07 were more likely to have had previous reports with the same or less urgent required response times compared with their last report before entering care, indicating some degree of escalation or sustained level of urgency. The pattern for re-entry children was similar.

Table 5.43 **Children entering OOHC in 2006/07 who had at least one report after 30 June 2002, by the level of their previous reports (excluding their last report) and by the level of their last report before entering care**[321]

	Previous reports (excluding last report) before entering OOHC				
Level of last report before entering care	No previous report	Previous reports assigned same or lower levels	Previous reports assigned higher levels	Previous reports assigned various levels	Total children
New Entry Children and young persons					
Total number	269	1,117	757	870	3,013 (100.0%)
Percentage of children and young persons					
<24 hours	9.4	90.6	-	-	765 (25.4)
<72 hours	9.2	43.4	1.8	45.7	786 (26.1)
<10 days	13.0	14.1	11.5	61.5	524 (17.4)
10 days +	0.0	0.0	0.0	100.0	10 (0.3)

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[319] ibid.

[320] ibid.

[321] DoCS, *A preliminary analysis of possible patterns in the required response times of child protection reports about children before they enter OOHC*, July 2008.

Previous reports (excluding last report) before entering OOHC					
Not stated	1.4	0.3	36.1	62.2	288 (9.6)
Not referred to CSC	8.3	1.3	90.5	-	640 (21.2)
Average %	8.9	37.1	25.1	28.9	
Re-entry children and young persons					
Total number	152	358	246	283	1,039 (100.0%)
Percentage of children and young persons					
<24 hours	5.2	94.8	-	-	191 (18.4)
<72 hours	16.5	40.8	3.6	39.2	309 (29.7)
<10 days	16.4	15.8	13.3	54.5	165 (15.9)
10 days +	25.0	0.0	0.0	75.0	4 (0.4)
Not stated	4.0	2.0	25.7	68.3	101 (9.7)
Not referred to CSC	21.9	8.6	69.5	-	269 (25.9)
Average %	14.6	34.5	23.7	27.2	

5.99 Table 5.44 provides details of the number of children and young persons who entered care in 2006/07 by age group. It also provides details of the outcome of the most recent SAS2 that was undertaken in the two years prior to entry into care.

5.100 Across all age groups, neglect or risk of neglect was found in 26.7 per cent of the cases involving the 4,658 children and young persons who entered care in 2006/07. Psychological harm or risk of harm was found in 25.0 per cent of cases, followed by physical harm or risk of harm (12.8 per cent) and sexual harm or risk of harm (4.5 per cent).

5.101 Neglect or risk of neglect was found in the cases of 37.1 per cent of children entering care aged less than one year. Psychological harm or risk of harm followed neglect or risk of neglect in 34.2 per cent of cases.

5.102 In the case of children aged 1-2 years, psychological harm or risk of harm was found in 36.3 per cent of cases and neglect or risk of neglect in 33 per cent of cases.

5.103 With age, the proportion of cases where neglect and psychological harm were found gradually decreased, and the proportion of cases where physical and sexual abuse were found increased. In the case of children aged 12-15 years, physical harm or risk of harm was found in 17.9 per cent of cases, slightly higher than psychological harm or risk of harm which was found in 14.3 per cent of cases, but lower than neglect or risk of neglect, which was found in 21.2 per cent of cases.

Table 5.44 **Number of children and young persons (C/YP) who entered care between 1 July 2006 and 30 June 2007, by age group, and by the type of harm or risk of harm determined as a result of the secondary assessment**

Outcome of secondary assessment	*Age at first entry*							*Total*
	<1 year	*1-2 years*	*3-4 years*	*5-11 years*	*12-15 years*	*16-17 years*	*Unknown*	
Actual harm								
Physical	41	33	42	152	91	6	0	365
Sexual	0	6	12	50	61	11	0	140
Emotional/Psychological	152	164	135	251	86	10	0	798
Neglect	139	117	136	282	170	21	0	865
Risk of harm								
Risk of physical	44	25	21	55	85	1	0	231
Risk of sexual	5	2	11	30	20	1	0	69
Risk of psychological	64	54	44	144	55	6	0	367
Risk of neglect	95	81	53	108	39	2	0	378
No risk of harm	*6*	*10*	*11*	*29*	*29*	*6*	*0*	*91*
Missing assessed issue	*1*	*3*	*6*	*14*	*5*	*1*	*0*	*30*
Total	547	495	471	1,115	641	65	0	3,334
No Matched SAS2 records	84	105	138	540	344	110	3	1,324
Total C/YP entering care	631	600	609	1,655	985	175	3	4,658

Note: 1,324 (28.4 per cent) children and young persons (C/YP) entering OOHC during 2006/07 did not have a secondary assessment recorded within two years prior to entry to OOHC. Possible reasons include:

In 2006/07, 19.6 per cent of C/YP entered OOHC voluntarily or with no legal order.

Some C/YP may have a secondary assessment that was determined after the data extraction cut-off date for annual reporting (31 August). Hence the secondary assessment records for some C/YP may not be included in the current annual reporting extract files.

Data quality issues related to the recording of assessed issues.

5.104 Table 5.45 provides details of the OOHC status of children and young persons in the 12 months following a substantiated report in 2005/06.

5.105 Of these 11,659 children and young persons, just over 20 per cent subsequently entered OOHC in the following 12 months.

5.106 Of the 2,377 children and young persons who entered OOHC, 26.0 per cent were the subject of a SAS2 where the finding was emotional/psychological abuse. There was a finding of neglect in the case of 23.5 per cent of the children and young persons.

5.107 Emotional/psychological abuse or risk of psychological abuse was the finding of the SAS2 for 41.4 per cent of the children and young persons entering OOHC in the following 12 months.

5.108 Neglect or risk of neglect was the finding of the SAS2 in 33.7 per cent of the children and young persons entering OOHC.

5.109 Physical abuse or risk of physical abuse was the finding of the SAS2 for 19.2 per cent of the children and young persons entering OOHC.

5.110 Sexual abuse or risk of sexual abuse was the finding of the SAS2 for 5.7 per cent of the children and young persons entering OOHC.

5.111 Children and young persons who were the subject of a SAS2 where the finding was risk of neglect were most likely to enter OOHC (28.4 per cent compared with 20.4 per cent of all children and young persons entering OOHC).

5.112 The next most likely finding of harm or risk of harm to result in a child or young persons entering OOHC was risk of psychological abuse (24.7) followed by risk of physical abuse (24.5 per cent), neglect (24.0 per cent), emotional/ psychological abuse (20.6 per cent) and physical abuse (18.7 per cent).

5.113 The findings that were least likely to result in entry to OOHC were sexual abuse (7.0 per cent) and risk of sexual abuse (10.2 per cent). This may be because the person found to be causing harm had been removed from the household and therefore the risk issues were no longer current.

Table 5.45 **Children and young persons reported in 2005/06 and determined to be at risk of harm or actual harm at secondary assessment by their OOHC status in the 12 months following their last report during 2005/06 and type of harm or risk**

Outcome of secondary assessment	*OOHC status after 12 months*					
	Entered OOHC		Did not enter OOHC		Total	
	No	%	No	%	No	%
Physical	310	18.7	1,347	81.3	1,657	100.0
Sexual	89	.0	1,186	93.0	1,275	100.0
Emotional	617	20.6	2,384	79.4	3,001	100.0
Neglect	559	24.0	1,770	76.0	2,329	100.0
Risk of physical	147	24.5	454	75.5	601	100.0
Risk of sexual	47	10.2	414	89.8	461	100.0
Risk of psychological	367	24.7	1,120	75.3	1,487	100.0
Risk of neglect	241	28.4	607	71.6	848	100.0
Total	2,377	20.4	9,282	79.6	11,659	100.0

Notes: This table does not include children and young persons who were in OOHC at the time of their report.

The outcome of secondary assessment category is based on the child or young person's last secondary assessment if multiple secondary assessment were conducted.

Care proceedings

Table 5.46 **Number of care proceedings and particular applications 2005/06 and 2006/07**

	2005/06	*2006/07*
Total care proceedings commenced	4,439	5,196
Emergency care and protection applications	786	867
Care application under s.61	1,476	1,815
Applications for assessment under ss.53 or 54	308	387
Applications for variation or rescission	793	686

5.114 The Inquiry sought data on care proceedings from the Children's Court and was provided with the data in Table 5.46. It was told that the following statistics are not kept:

a. the number of children and young persons subject to applications for emergency care and protection orders, or s.61 applications for a care order

b. the outcome of applications for emergency care and protection orders (s.46)

c. the number of orders made under s.48 authorising removal

d. the Aboriginal status of children and young persons subject to care applications and care orders

e. the number of interim care orders made (s.69)

f. the grounds on which findings have been made that a child is in need of care and protection

g. the number of orders for support services (s.74), orders to attend a therapeutic treatment program (s.75), or orders for supervision (s.76)

h. the number of orders allocating parental responsibility (s.79)

i. the number of contact orders (s.86).

Time taken to complete care proceedings

5.115 The Chief Magistrate of the Local Court has imposed time standards on the disposal of care proceedings as follows:

a. 90 per cent of care matters should be finalised within nine months of commencement

b. 100 per cent of care matters should be finalised within 12 months of commencement.[322]

5.116 Data obtained from the Local Courts Statistics Unit indicate that for the period November 2006 to October 2007, 88.9 per cent of all care proceedings were

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[322] Children's Court NSW, *Time Standards for Care Applications*.

finalised within nine months, and 95.5 per cent of all care proceedings were finalised within 12 months. In the same period, 93.8 per cent of contested care proceedings were finalised within nine months, and 98.4 were finalised within 12 months.

5.117 Data obtained from the Local Courts Statistics Unit indicate that for the period November 2006 to October 2007, the Chief Magistrate's time standards were complied with at: Bathurst, Bidura, Broken Hill, Cooma, Coonabarabran, Cootamundra, Cowra, Eden, Glen Innes, Kempsey, Lithgow, Macksville, Maclean, Moruya, Mudgee, Mullumbimby, Narooma, Nyngan, Orange, Parkes, Scone, Temora, Tumut, Warialda, Wee Waa, Wentworth, Wyong and Young.

5.118 Data from the same source and in relation to the same period indicate that more than 25 per cent of care proceedings at the following locations were not finalised within 12 months: Albury, Bega, Condobolin, Griffith, Katoomba, and Walgett. Clearly, the number of new care proceedings at each location may affect the time taken. For example, at Condobolin there were eight new matters while at Bidura there were 351 new care matters in 2007.

5.119 The Children's Court provided data on the average times taken for the finalisation of care proceedings in 2005/06 and 2006/07 around the State.

Table 5.47 **Time taken for finalisation of care proceedings (in weeks)**

	2005/06	*2006/07*
All care proceedings (all locations)	18.2	16.3
Parramatta	n/a	12.7
Bidura	n/a	13.3
Campbelltown	40.7	6
Woy Woy	18	25.1
Broadmeadow	2.9	19.9
Port Kembla	27.3	6.6

Note: Parramatta Children's Court opened in November 2006. Care proceedings were not heard at Bidura Children's Court until November 2006.

5.120 During the Inquiry, DoCS and the Children's Court agreed that the mean duration of care matters was seven months. The period during which the mean duration was assessed is not clear to the Inquiry. It would appear that it represents a significant improvement on the figures reported as the average time for finalisation in the table above.

5.121 DoCS sought to locate comparable figures in other jurisdictions and advised that Magellan cases in the Family Court had a mean duration of almost 12 months in the Melbourne Registry, and about 16 months in the Sydney Registry.

5.122 In England, only a minority of care matters take less than 40 weeks.

Children's Magistrates' caseload

5.123 No statistics are held in relation to the caseload of each of the 13 Children's Magistrates, nor on the proportion of each caseload that comprises care matters (rather than criminal matters).

5.124 DoCS told the Inquiry that in 2007 the specialist Children's Court Magistrates dealt with 68 per cent of care matters, the remainder being dealt with by Magistrates whose principal workload was in the Local Court.

Future Demand

Child protection

5.125 As shown in Figure 5.1, while numbers of child protection reports have continued to increase each year from 2001/02, the size of the increase follows no clear pattern. The volatility of the variation from year to year makes it difficult to predict future trends with any certainty.

Table 5.48 **Percentage changes by year for total reports, 2001/02 to 2007/08**

	% change
2001/02 to 2002/03	10.4
2002/03 to 2003/04	5.1
2003/04 to 2004/05	16.8
2004/05 to 2005/06	11.4
2005/06 to 2006/07	18.7
2006/07 to 2007/08	6.0

5.126 Table 5.49 considers the percentage change over the most recent period from 2005/06 to 2007/08 in six-monthly segments. This shows a pattern of slowing increase – with a 21 per cent increase from the July to December 2005 period compared with the July to December 2006 period, through to a three per cent increase when the January to June 2007 period is compared with the more recent period of January to June 2008.

Table 5.49 **Percentage changes by six-month period for total reports, 2005/06 to 2007/08**

	% change from 2005/06 to 2006/07	*% change from 2006/07 to 2007/08 preliminary*
July – December	21	9
January – June	16	3
Total	19	6

5.127 If the pattern of slowing increase shown in Table 5.49 continues, there would be relatively little increase in the numbers of reports in 2008/09.

5.128 Data provided by DoCS reveal the following:

a. The number of reports and of children reported both increased by around 6 per cent from 2006/07 to 2007/08. Both these increases were far lower than those experienced in the 2005/06 to 2006/07 period.

b. The percentage of reports that were forwarded to a CSC/JIRT for secondary assessment remained constant.

c. The percentage share of total reports about known children continues to increase.

d. The percentage of reports with more urgent required response times and classified as high risk have decreased.

e. Slight changes have been observed across reported issue groups.

f. As a percentage of the total, factors such as reporter type, re-reports within seven days and the Region to which reports were referred all remained relatively constant.

5.129 Given a steady state – meaning no substantial changes to in the way that DoCS does business and no unpredictable increases in the number of reports or any significant deterioration in economic circumstances that would lead to an increase in socio-economic disadvantage or in homelessness – there are suggestions that 2008/09 will stabilise, with possibly an increase on 2007/08 of no more than three per cent to six per cent. Given past trends, it is likely that around 40 per cent of those children reported to DoCS in 2008/09 will have no child protection history. The Inquiry however notes hat current unfavourable economic conditions may lead to increasing unemployment and stresses that could have a significant impact on the recent trend.

Out-of- home care

5.130 There has been a 90 per cent increase in child protection reports between 2001/02 and 2007/08 and a significant increase in OOHC demand during the same period.

5.131 The OOHC population has steadily increased over recent years, there having been a significant increase from 30 June 2006 to 30 June 2008 of 38 per cent. The increase in the OOHC population cannot be simply attributed to increased child protection reports. The overall OOHC profile has changed and children and young persons are generally spending longer in care. For example, between 2001 and 2005, while care periods of up to two years significantly decreased there was a dramatic rise in care periods of more than four years.

5.132 DoCS have developed a funding model to estimate the number of children and young persons predicted to be in OOHC to 2011/12. Assumptions underlying this modelling include that entry rates and length of stay patterns will remain constant over time unless there is a demonstrated sustained shift in historical data. It is estimated that the number of children and young persons in OOHC

will increase by 15.3 per cent between 2007/08 and 2008/09 rising to 32.9 per cent between 2007/08 and 2010/10.

Table 5.50 **Actual and projected OOHC numbers, by OOHC status**

	Actual *As at 30 June 2005*	*Actual* *As at 30 June 2006*	*Actual* *As at 30 June 2007*	*Actual* *As at 30 June 2008*	*As at 30 June 2009*	*As at 30 June 2010*	*As at 30 June 2011*	*As at 30 June 2012*
Total Aboriginal	2,686	3,033	3,865	4,575	4,710	4,968	5,250	5,498
Total non-Aboriginal	7,271	7,562	8,822	10,073	10,895	12,025	13,045	13,997
Not entered	84	28	25	19				
Total	10,041	10,623	12,712	14,667	15,605	16,993	18,295	19,495

Table 5.51 **Actual and projected OOHC numbers, placement and expenditure**

	Actual *2005/06*	*Actual* *2006/07*	*Actual* *2007/08*	*2008/09*	*2009/10*	*2010/11*	*2011/12*
Relative/Kin	5,340	6,497	7,397	7,987	8,605	9,111	9,565
Other	5,283	6,215	6,719	7,618	8,388	9,184	9,930
Total	10,623	12,712	14,116	15,605	16,993	18,295	19,495
Expenditure $m (excludes all caseworkers	$225.3	$270.2	$253.7	$387	$407	$459	$476
Current OOHC caseworkers	334	362	512	512	512	512	512
Caseworker $m	$52.4	$56.8	$80.3	$80.3	$80.3	$80.3	$80.3

Table 5.52 **Projected OOHC population, expenditure and additional caseworkers (cumulative) required to attain DoCS caseloads of 15**

	2007/08	*2008/09*	*2009/10*	*2010/11*	*2011/12*	*2012/13*	*2013/14*
Relative/Kin	7,496	7,987	8,605	9,111	9,565	9,963	10,387
Other	7,171	7,618	8,388	9,184	9,930	10,370	10,811
Total	14,667	15,605	16,993	18,295	19,495	20,332	21,197
Current DoCS OOHC Caseworkers	512	512	512	512	512	512	512
DoCS Caseworker $m	84	84	84	84	84	84	84
1:15 Caseload: Caseworkers	-	300	400	490	550	600	650
Extra Caseworker $m	-	50	66	81	91	99	107
Estimated increase in allowances for additional children in OOHC $m	-	25	39	53	68	74	85

6 Risk of harm reports to DoCS

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Reporting trends

6.1 From the data set out in the preceding chapter the following emerges.

6.2 Between 2006/07 and 2007/08, there was the lowest annual percentage increase in reports and number of children and young persons involved in reports since 2003/04; and there was no increase in the ratio of reports to children and young persons from the past year: it remained at the 2006/07 level of 2.3:1.

6.3 There was an increased concentration of reports made about a small group of children and young persons in 2006/07, with the top 20 per cent of frequently reported children and young persons accounting for more than half the total number of reports.

6.4 As a proportion of total children and young persons, the number of children and young persons who were the subject of a report for the first time has every year fallen since 2001/02.

6.5 There has been little variation in reported issues since 2005/06. In 2007/08 (preliminary), the seven most common primary reported issues in order were domestic violence, followed by neglect, physical abuse, carer drug and alcohol, psychological abuse, carer mental health and sexual abuse.

6.6 In 2007/08 (preliminary), when considering primary, secondary and third reported issues, the same seven issues were the most commonly reported but the order was different. Domestic violence was followed by psychological abuse, physical abuse, neglect, carer drug and alcohol, care mental health and sexual abuse.

6.7 Between 2004/05 and 2007/08 (preliminary), short term re-reporting (defined as a report received within seven days of a previous report that has the same reported issue), accounted for a significant proportion of the total reports made (between 15 and 18 per cent). Of these, the number of short term re-reports by the same reporter type on the same reported issue accounted for between six and seven per cent of total reports.

6.8 The number of short term re-reports by the same reporter type and issue has increased at almost twice the rate of increase in the number of all reports. In 2006/07, the most common reported issue for short term re-reports was a runaway child or young person. The highest proportion of short term re-reports within specific reporting groups in 2006/07 were from NGOs followed by health reporters and relatives.

6.9 Reports with a more urgent response time (less than 24 hours and less than 72 hours) have been decreasing as a percentage of reports referred to a CSC/JIRT for further assessment over the three years 2005/06 to April 07/March 08.

6.10 The number of referred reports with a high risk of harm level increased between 2005/06 and 2006/07 and decreased between that year and April 07/March 08. Medium risk of harm reports increased over the three year period. Low risk of harm reports decreased between 2005/06 and 2006/07, and then increased between 2006/07 and April 07/March 08.

6.11 Of those reports made by mandatory reporters, neglect reports were most likely to be assigned a less than 24 hours response time and domestic violence reports were least likely to be so assigned.

6.12 In relation to the outcomes of assessment since 2004/05, there has been:

a. little change in the percentage of reports closed at Helpline

b. a slight decrease in the percentage of reports referred to a CSC/JIRT for information

c. an increase in the percentage of reports referred to a CSC/JIRT for further assessment to 2006/07, remaining stable for the period April 07/March 08

d. a significant decrease in the percentage of those reports closed at the CSC before any secondary assessment

e. a significant increase in the number and percentage of reports receiving a completed SAS1 before being closed

f. an increase in the number and percentage of reports receiving a completed SAS2 between 2004/05 and 2006/07

g. a decrease between 06/07 and April 07/March 08 in the number and percentage of reports subject to a completed SAS2

h. an increase in the number and percentage of reports where harm or risk of harm was substantiated between 2004/05 and 2006/07

i. a decrease in both the number and percentage of reports where harm or risk of harm was substantiated between 2006/07 and April 07/March 08.

6.13 The percentage of children and young persons who were the subject of a substantiated report in the previous year and were the subject of a further substantiation within the following 12 months, has doubled since 2001/02 and increased by about 20 per cent between 2005/06 and 2006/07.

Frequently reported families

6.14 DoCS has recently examined a number of families within each of the seven DoCS regions to identify factors driving repeat reporting.[323] DoCS has identified the following issues relevant to reporting trends:

a. The capacity of the CSC to allocate the case had a direct impact on reports, with a number of examples of mandatory reporters appearing to

[323] DoCS defines 'repeat reporting' as multiple reports in relation to the same risk issue and reports which do not meet the legislative threshold for risk of harm.

continue to make reports because of a lack of response from the CSC to their concerns.

b. There appeared to be a pattern of refuges and residential units using reports to update the Department rather than to report risk of harm. In some cases a practice of daily reporting was apparent. For example:

> *Often the reporters made a report to the Helpline as they wanted to update the allocated worker with information…. There were at times reports by Health which did not need to become a [risk of harm] report. It may have only required a phone call to the allocated Caseworker to provide the updated information as opposed to reporting directly to the Helpline.*[324]

c. Contact by children, young persons and families with multiple services led to multiple reporters each reporting the same concern or incident.

d. There were a number of examples where repeat reporting continued unabated despite good case management and interagency contact taking place.[325]

Reporter trends

6.15 Since 2001/02 around three quarters of all child protection reports have been made by mandatory reporters. There has been little variation in the share of reports by all reporters since 2001/02. Of these, over 60 per cent were made by police, health and school/child care reporters, with police making about one third, health 15 per cent and school/child care reporters slightly less at 13 per cent.

6.16 Between 2001/02 and 2007/08, there was a slight increase in the proportion of reports from other mandatory reporters, including reporters from NGOs.

6.17 In 2007/08, domestic violence was the primary reported issue in almost 60 per cent of all police reports. Police domestic violence reports accounted for almost three quarters of all reports where domestic violence was the primary reported issue. After domestic violence, the three most frequently reported issues by police were neglect, carer drug and alcohol use and physical abuse. Each accounted for approximately seven to nine per cent of all police reports.

6.18 In 2007/08, carer mental health reports accounted for almost one quarter of all health reports. Health reporters accounted for over 40 per cent of all reports where carer mental health was the primary reported issue. After carer mental health, the three most frequently reported issues by health reporters were carer

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[324] DoCS, *Frequently Reported Families Project- Report for the Child Protection Major Project Board,* July 2008, p.6.

[325] ibid.

drug and alcohol abuse, domestic violence and physical abuse. Each accounted for approximately 13 to 14 per cent of all health reports.

6.19 Physical abuse reports accounted for almost 30 per cent of all reports from the school/child care sector in 2007/08. These reports accounted for one quarter of all reports where physical abuse was the primary reported issue. After physical abuse, the three most frequently reported issues by school/child care reporters were neglect, psychological abuse and sexual abuse. Each accounted for between approximately 10 and 16 per cent of all school/child care reports.

6.20 Reports with the required response time of less than 24 hours in 2006/07 accounted for 7.0 per cent of all police reports referred for further assessment, which was below the 2006/07 average of 9.5 per cent of referred reports assigned a less than 24 hour response. School/child care reports with a less than 24 hour response time were also below the average at 7.8 per cent. On the other hand, 10.6 per cent of health reports received a less than 24 hour response rating which was higher than the average for all reports.

6.21 During 2006/07, the proportion of reports that were assigned a less than 24 hour response time where the primary reported issue was domestic violence was much lower than for most other reported issues. Only 2.3 per cent of referred domestic violence reports by mandatory reporters were assigned a less than 24 hour response time, which is much lower than the average of 9.5 per cent.

6.22 The average figures relating to required response times assigned to police reports during 2006/07 are skewed because of the large number of domestic violence reports made by police. If the data on domestic violence reports were put aside, the average proportion of less than 24 hour response ratings assigned to police reports would increase to 13.9 per cent, which is above the 9.5 per cent average. For non-domestic violence reports by health and school/child care reporters, health reports to be assigned a required response time of less than 24 hours would increase to 11.6 per cent and school/child care reports would increase to 8.2 per cent.

6.23 This would indicate that, apart from police domestic violence reports, a greater proportion of police reports were assigned a higher priority response rating than reports made by the other two key mandatory reporter groups.

6.24 During 2006/07, almost one quarter of all police reports, one quarter of all school/child care reports and one quarter of all health reports were closed at a CSC/JIRT prior to any secondary assessment.

6.25 The results for 1 April 2007 to 31 March 2008 differ from 2006/07 because significantly fewer referred reports were closed at the CSC/JIRT before any secondary assessment. In this period, almost one quarter of all police reports, over one quarter of all school/child care reports and almost one fifth of all health reports were closed at the CSC/JIRT prior to any secondary assessment.

6.26 In 2006/07, over one quarter of reports from the three key mandatory reporter groups were closed after a SAS1. From 1 April 2007 to 31 March 2008, almost one third of reports from the three key mandatory reporter groups were closed at this point.

6.27 Of the 286,033 reports received during 2006/07, 15.1 per cent had a SAS2. Of the three key mandatory reporter groups, 11.7 per cent of all police reports, 14.4 per cent of all school/child care reports and 17.9 per cent of all health reports were the subject of a completed SAS2.

6.28 The figures for 1 April 2007 to 31 March 2008 are different from 2006/07 because fewer reports progressed to a SAS2. Of the 296,769 reports received in this period, 13.1 per cent were the subject of a completed SAS2. Of the three key mandatory reporter groups, 9.8 per cent of all police reports, 13.4 per cent of all school/child care reports and 15.9 per cent of all health reports had a SAS2.

Substantiations

6.29 In 2006/07, 93.5 per cent of all reports which resulted in a SAS2, were the subject of a finding that harm or risk of harm was substantiated, compared with 93.2 per cent in 1 April 07/31 March 08. From 1 April 2007 to 31 March 2008, as a percentage of those reports which had been referred for further assessment, about 17.6 per cent were substantiated, while substantiated reports were about 12.2 per cent of all reports received.

6.30 From 1 April 2007 to 31 March 2008, over one fifth of all substantiated reports had neglect as the primary reported issue, that being the largest single category followed by physical abuse then by domestic violence.

6.31 Actual harm was found in around 70 per cent of substantiated reports and risk of harm in the remaining 30 per cent in both 06/07 and 1 April 07/31 March 08. Psychological harm then neglect were most prevalent in each category.

Reports which receive no further assessment

6.32 Over 13 per cent of reports received between 1 April 2007 and 31 March 2008 went no further than the Helpline. DoCS captures these as either information, advice, referral provided or no further assessment required. DoCS advised the Inquiry that in these cases no risk of harm had been identified. It appears to the Inquiry that these reports, some 38,856, should not be recorded as child protection reports but instead as contacts, as they do not meet the threshold test under the Care Act. DoCS routinely records other calls to the Helpline which do not amount to risk of harm, in this manner.

6.33 Nearly 18 per cent of all reports made between 1 April 2007 and 31 March 2008 were forwarded to a CSC or JIRT for information only. A distinction is made by DoCS between these reports and the 70 or so per cent which were referred to the CSC or JIRT for further assessment. The Inquiry has attempted to unravel the reasons for this distinction.

6.34 It seems that reports are forwarded to a CSC or JIRT for information only when there is an open case plan. The report may in fact be a new report (and thus should be classified as a report of risk of harm), a request for assistance (which should not be so classified) or additional information related to the current casework (which may or may not be a report). Helpline caseworkers are not required to carry out a full initial assessment on reports forwarded for information only, presumably on the basis that there is an allocated caseworker, who is aware of the child and his or her circumstances.

6.35 This issue has been identified by others. For example, in his report on reviewable deaths occurring in 2006, the Ombudsman found that:

> *Reports sent as information only contained, at least in part, additional information that raised new concerns not previously identified to DoCS. This meant that new information was not subject to analysis by the CSC. At times however, CSCs did review, and subsequently act on, information only reports containing new concerns.*[326]

6.36 In addition, a recent analysis undertaken by DoCS, based on the work done in four CSCs, found that 21 per cent of all initial assessments referred for secondary assessment were regarded as conveying additional information about known events or issues. Thus, it would have been appropriate for them to be transferred as 'information only'.

6.37 The consequences of this inconsistent recording and referral of reports are that potentially inaccurate data are collected about numbers of reports, reports are not being fully assessed by the intake caseworkers at the CSC and resources are being wasted at the Helpline and at the CSC.

6.38 To place these figures into perspective, of the nearly 30,000 police reports which were not referred for further assessment in 2006/07, just under one half (13,506) were forwarded to a CSC for information only, some of which may or may not have been reports of risk of harm. More than half (16,426) did not meet the statutory test and went nowhere. It is likely that most of these were reports involving domestic violence incidents.

6.39 In relation to health reports, 6.3 per cent similarly failed the statutory test and for school/child care reports the figure was 10.1 per cent.

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[326] NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths*, December 2007, p.45.

6.40 It is clearly a waste of police, health, school/child care and DoCS resources to make and process thousands of reports which DoCS believes do not amount to a risk of harm as defined in the Care Act. The need for further education of mandatory reporters is addressed later in this chapter.

6.41 In addition, DoCS calculates the number of substantiations as a percentage of those reports referred for further assessment. The lower the number of reports referred for assessment, the higher the potential percentage of substantiations. If some of the nearly 18 per cent, or over 52,000 reports referred for information only were included in the referral for assessment figure, and were not substantiated, then the substantiation rate may be lower.

Mandatory reporting

Current provisions

6.42 Certain members of the community are legally required to make a report to the Director-General of DoCS about children who are at risk of harm or living away from home without parental permission. 'Child' means a person who is under the age of 16 years. The mandatory reporting regime accordingly does not apply to 'young persons' who are defined as those aged 16 to 18 years, although reports may be made to the Director-General in relation to them by reference to the same considerations as apply to children.[327]

6.43 Mandatory reporting applies to all persons who deliver:

a. health care

b. welfare

c. education

d. children's services

e. residential services, or

f. law enforcement

to children as part of their professional work or paid employment, or manage those who do so.[328]

6.44 It also applies to people who:

a. are paid to provide or manage a child minding service out of school hours, for children aged at least 6 years, but less than 13 years, or

b. in the course of their professional work deliver disability services to children.[329]

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[327] *Children and Young Persons (Care and Protection) Act 1998* s.24.

[328] *Children and Young Persons (Care and Protection) Act 1998* s.27.

6.45 Mandatory reporting of children who are living away from home without parental permission applies to a person who provides residential accommodation.[330] With the consent of a young person, his or her homelessness may be reported to DoCS.[331]

6.46 A mandatory reporter must make a report to DoCS if he or she has "reasonable grounds to suspect" that a child is or a class of children are, at risk of harm.[332] Under s.23 of the Care Act, a child is defined as being at risk of harm if:

> *current concerns exist for the safety, welfare or well-being of the child or young person because of the presence of any one or more of the following circumstances:*
>
> *(a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met,*
>
> *(b) the parents or other care-givers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care,*
>
> *(c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated,*
>
> *(d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm,*
>
> *(e) a parent or other care-giver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm,*
>
> *(f) the child was the subject of a pre-natal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.*[333]

[329] *Children and Young Persons (Care and Protection) Regulation 2000* cl.10.
[330] *Children and Young Persons (Care and Protection) Act 1998* s.122.
[331] *Children and Young Persons (Care and Protection) Act 1998* s.121.
[332] *Children and Young Persons (Care and Protection) Act 1998* s.27(2).
[333] *Children and Young Persons (Care and Protection) Act 1998* s.23.

6.47 Mandatory reporting is the responsibility of the individual (rather than, for example, the employer) although the Care Act does not stipulate how the obligation is to be discharged. Failure to report can result in prosecution and a fine of up to $22,000, although there have been no prosecutions under the Care Act resulting from a failure to report.

6.48 A person who reports in good faith is not in breach of professional ethics or regarded as departing from acceptable standards of conduct, is not liable for defamation, is not exposed to specified civil proceedings, has his or her identity protected, cannot be compelled to produce the report or give evidence about it and the report itself is not generally admissible in legal proceedings apart from care proceedings.[334] It has generally been assumed that it would give rise to a lawful excuse for the purpose of the defence provisions under privacy legislation.

6.49 Significantly and, the Inquiry suspects, often overlooked, is the provision in the Care Act which, "for the avoidance of doubt", declares that a reporter is not prevented from responding to the needs of the child because of having made the report.[335]

6.50 Section 29(3A) of the Care Act extends the protections referred to above to any person who provided information on the basis of which the report was made and to any person concerned in making or causing a report to be made, in each case subject to them acting in good faith.

Selected history

6.51 The final report of the review of the *Children (Care and Protection) Act 1987*, released in 1997, noted that there was overwhelming community support for mandatory reporting. It made a number of recommendations about the mandatory reporting regime then in existence, which are largely reflected in the current Care Act. In December 2000 further amendments were made to the Care Act which clarified and extended the requirements for mandatory reporting. At the same time, the Helpline commenced operations, and became the single central intake point to receive reports.

6.52 Section 265 of the Care Act required the Care Act to be reviewed and a report on the review to be presented to Parliament by 5 December 2006. A report dated November 2006 was duly presented, indicating that amendments had been made to, among other things, provide for prenatal reporting, the admissibility of evidence of previous removal of children from a family and to introduce Parent Responsibility Contracts. The report indicated that a Discussion Paper had been prepared. *Statutory child protection in NSW: issues and options for reform* (the Discussion Paper) was published in October 2006. It identified and discussed some contentious matters including mandatory

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[334] *Children and Young Persons (Care and Protection) Act 1998* s.29.

[335] *Children and Young Persons (Care and Protection) Act 1998* s.29A.

reporting, the exchange of information, the objects, best interests and other principles of the Care Act and the role of the Children's Court. Each of those matters will be dealt with later in this report.

6.53 In relation to mandatory reporting, DoCS' position as expressed in the Discussion Paper was that the central issue was whether there was:

> *sufficient clarity about what must be reported and why, and whether reports are of sufficient quality to facilitate the most effective assessment and allocation of the report.*[336]

To that end, DoCS stated:

a. mandatory reporting is not the cause of increased reporting as the trend is evident in jurisdictions where there is not mandatory reporting

b. the expansion of mandatory reporting criteria has not led to a decrease in the proportion of reports that are investigated

c. mandatory reporting is a means of collecting information over time, particularly in cases of neglect.

6.54 Four improvements suggested in the Discussion Paper were:

a. requiring reporters to provide clearer evidence of risk

b. inserting illicit drug use as a circumstance relevant to the risk of harm in s.23 of the Care Act

c. amending s.23 to be more explicit on neglect as a risk of harm circumstance

d. specifying that evidence of past or emerging behaviour that may cause future harm to a child is a basis for reporting a risk.

6.55 There was general support in the submissions made in response to the Discussion Paper for the latter three matters, while requiring reporters to provide clearer evidence of risk was roundly rejected.

6.56 The announcement and subsequent commencement of this Inquiry has had the effect of the matters raised in the Discussion Paper being stayed.

Abolish or retain?

6.57 There was limited, and primarily academic support expressed to the Inquiry for abolition of the mandatory reporting provisions. The principal reason advanced was that the child protection system was being flooded with reports, the response to which used up scarce resources and diverted attention from those families whose children were in need of the State's intervention.

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[336] DoCS, *Statutory Child Protection in NSW, Issues and Options for Reform*, October 2006, p.21.

6.58 The Inquiry is aware of a deal of academic commentary in relation to the increasing numbers of reports and, expressly or implicitly about mandatory reporting. According to Testro and Peltola the focus of child protection services on reporting has led to:

a. a perception in the community that this is the best way to protect children

b. the dominance of risk assessment and risk management paradigms

c. an overemphasis on standardised processes and procedures and documentation

d. the 'primacy' of the responsibility of the child protection agency at the expense of the involvement of other agencies. Given the complexity of child protection issues and the need for multifaceted responses this diminishes the safety of children.[337]

6.59 Scott argues that child protection policies and laws have become increasingly applied to situations where children are seen 'at risk.' This has led to "dramatic net widening" and the subsequent "epidemic of child protection notifications."[338] However, Scott further argues that there is no evidence of an actual increase in the prevalence of child abuse and neglect in Australia.[339]

6.60 Scott also outlines the dangers of an 'overloaded system':

a. Children are missed due to a focus on escalating notifications.

b. Children who are at risk but below the threshold for statutory intervention are missed.

c. Inappropriate reporting of and subsequent investigation of low risk families, leading to increased parental stress, and thus to increased risk of harm for children.

d. Children in state care are adversely affected when resources are redirected to deal with more investigations.

e. The large gap between the threshold for making a notification and that for statutory intervention leads to strained relationships between statutory child protection services and services making notifications. Scott states this leads to 'corrosive' relationships between organisations as dynamics such as 'gatekeeping' and 'poison ball' in relation to resource hungry cases become survival strategies.

f. There are negative impacts on staff leading to stress and turnover.[340]

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[337] P Testro and C Peltola, *Rethinking Child Protection: A New Paradigm? A Discussion Paper,* Prepared for PeakCare Queensland Inc, January 2007, pp.18-21.

[338] D Scott, 2006, op. cit., p.10.

[339] ibid., p.11.

[340] D Scott, *Sowing the Seeds of Innovation in Child Protection,* Paper presented to the 10th Australasian Child Abuse and Neglect Conference, Wellington, New Zealand, February 2006, p.9.

6.61 Those working in the system were generally in favour of the retention of mandatory reporting while supporting various amendments to the manner in which it operated.

6.62 The Inquiry is persuaded that the requirement to report should remain. It agrees with DoCS that the trend towards increased reporting is evident in jurisdictions where there is not mandatory reporting. In addition, the data cited in the previous chapter indicate that the substantiation rates almost doubled from 2004/05 to 2006/07, with a slight reduction from that year to April 07/March 08. Further, the number and percentage of reports referred for further assessment have increased since 2001/02, although they have remained steady over the last two financial years. The numbers of reports that are subject to a completed SAS2 has more than doubled since 2004/05 and have also increased as a percentage of the total reports received.

6.63 While these data are probably related, at least in part, to the implementation of the DoCS Reform Package, evidence of a flood of reports with a reduction in outcomes, at least by reference to investigations and substantiations, is not evident.

6.64 What is particularly interesting, is that the extent of the increase in reporting appears to have slowed in 2007/08. Thus, the percentage change in number of reports, and the number of children and young persons reported has reduced between 2006/07 to 2007/08. However, at the same time, multiple reporting has increased and the level of seriousness of reports has decreased, with the former adding unnecessary stress to the system.

6.65 The Inquiry believes that mandatory reporting has the useful effect of overcoming privacy and ethical concerns by compelling the timely sharing of information where risk exists and of raising awareness among professionals working with children and young persons. There are other mechanisms by which professionals such as health workers and teachers are obliged to report, with the failure to do so sometimes carrying with it disciplinary consequences. To abolish mandatory reporting may leave such people obliged to report, but without the protections in the current Care Act, and could also weaken the opportunity for interagency collaboration which the Inquiry considers essential for an effective child protection system.

6.66 The preferable approach to deal with the large numbers of reports, and one which is reflected in this report, is for the system of reporting and assessment to be modified to ensure that children at risk of significant harm receive the attention of DoCS and its NGO partners while families in need of assistance are directed to services, be they universal or more targeted in orientation. Further, that those outside DoCS working in child protection, be encouraged to improve the quality of their reports, more frequently exercise their professional judgement and work collaboratively and cooperatively with DoCS to better use their resources in the best interests of children. Education of mandatory

reporters and enhancing the availability of differential responses should reduce multiple reporting rates.

The test for reporting

6.67 As set out above, the obligation on mandatory reporters arises when they have 'reasonable grounds to suspect' that a child is at risk of harm, with the latter phrase being exhaustively defined in s.23 and requiring 'current' concerns to exist for the safety welfare or well-being of that child.

6.68 The requirement of 'reasonable grounds to suspect' means that:

a. the suspicion must have some evidence to support it, although it does not require the same level of certainty as a belief, which requires that the evidence has been tested to some degree

b. it is the suspicion of the reporter and as such, may not be shared by others, including DoCS if faced with the same set of circumstances

c. it does not require the reporter to investigate or determine the source of the harm before reporting

d. what constitutes 'reasonable grounds' will vary in accordance with the professional capacity and experience of the person involved.

6.69 The *Interagency Guidelines for Child Protection Intervention 2006* advises that 'reasonable grounds' could be derived from either:

a. first hand observations about the child or family

b. what a practitioner has been told by a child, his or her parent or another person

c. what a practitioner can reasonably infer based on professional training and/or experience.

6.70 Agencies are also advised that if it is possible, likely or probable that something will occur, the mandatory reporter should consider reporting. General indicators of abuse, psychological harm, domestic violence and neglect are provided.

6.71 Not all of the key mandatory reporting agencies have provided staff with detailed guidance as to their reporting obligations. DADHC is a notable agency which has not done so.

6.72 There are differences across states and territories as to who should report and when, and whether past or present abuse or future concerns are reportable. The Inquiry takes the view that where reform is desirable, it is preferable to increase similarities in legislation with other states and territories rather than to extend the differences.

6.73 The tests for the reporting of child protection concerns to the relevant authorities in each state or territory are as follows:

a. Victoria: significant concern for the well-being of a child or an unborn child.[341]

b. Queensland: the suspicion that a child, or an unborn child, has been, is being, or is likely to be, harmed.[342]

c. South Australia: the suspicion on reasonable grounds that a child has been, or is being, abused or neglected.[343]

d. Western Australia: there is no mandatory reporting, however a person can, in good faith, provide information to the relevant authority that raises concern about the well-being of a child.[344]

e. Tasmania: for mandatory reporters, the knowledge, or belief or suspicion on reasonable grounds, that a child has been, or is being, abused or neglected (by anyone), or that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides. For non-mandatory reporters, the knowledge, or belief or suspicion on reasonable grounds, that a child is suffering, has suffered, or is likely to suffer, abuse or neglect.[345]

f. Australian Capital Territory: for mandatory reporters, the belief on reasonable grounds that a child or young person has experienced, or is experiencing, sexual abuse or non-accidental physical injury. For non-mandatory reporters, the belief or suspicion that a child or young person is, being, or is at risk of being abused or neglected.[346]

g. Northern Territory: the belief on reasonable grounds that a child has been (or is likely to be) a victim of a sexual offence, or has otherwise suffered (or is likely to suffer) harm or exploitation.[347]

6.74 Clearly, NSW has one of the lowest thresholds for reporting. Equally clear from the data cited in the previous chapter, in 2007/08, only about 13 per cent of all reports to DoCS were responded to with a sighting of the family and child and a detailed assessment.

6.75 From an examination of the data and discussions with many of those working in and around the child protection system, the Inquiry has concluded that, conservatively, 30 per cent of reports to DoCS do not warrant the statutory intervention of the State. The 13 per cent closed at the Helpline and the 17.8 per cent, comprising those closed after a SAS1 for reasons of ‘other information,’ which means the report was referred elsewhere or closed, are likely not to have warranted the State’s intervention. The families the subject of these reports may need the assistance of either a government agency or an

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[341] *Children, Youth and Families Act 2005 (Vic)* s.28 and 29

[342] *Child Protection Act 1999 (Qld)* s.22.

[343] *Children’s Protection Act 1993 (SA)* s.11(1).

[344] *Children and Community Services Act 2004 (WA)* s.240.

[345] *Children, Young Persons and their Families Act 1997 (Tas)* ss.13 and 14(2).

[346] *Children and Young People Act 2008 (ACT)* ss.354 and 356.

[347] *Care and Protection of Children Act 2007 (NT)* s.26.

NGO to better support and nurture their children. However, to obtain that assistance, a report to a body with the powers to assume the care of children should not be required, particularly as this can provide a barrier to those families seeking or accepting assistance.

6.76 This view is supported by DoCS. In 2007 it undertook an analysis to determine the appropriateness of child protection reports referred to CSCs for secondary assessment, and whether some of those reports did not reflect real child protection concerns. DoCS found that intake workers at the four CSCs selected believed that about 80 per cent of initial assessments that were referred for secondary assessment were risk of harm reports, and 20 per cent were not.

6.77 In its submission to the Inquiry, DoCS concluded that 25–35 per cent of children and young persons reported fall within this group. DoCS described them as:

> *Children and young people who enter and exit the system quickly. These cases are: (i) generally not referred to a CSC because they are assessed as below the current risk of harm threshold, or (ii) if referred to a CSC, are assessed at local level intake to be of a much lower priority than others, and as requiring minimal attention within the child protection system (that is, no further secondary assessment). This group in total comprises around 25-35 per cent of children and young people who are currently reported to DoCS in any year. A significant number of these children and young people are reported by NSW Police, with a large proportion having only Police reports. Under a raised mandatory reporting threshold, the majority of these cases will be 'out of scope' for the child protection system. While some other government (for example Health or Housing) or non-government family support services might be required, there would be no need for DoCS intervention if the risk of harm threshold is not met.*[348]

6.78 As Ms Freeland, then DoCS Executive Director for the Helpline said at the Public Forum held by the Inquiry into mandatory reporting:

> *We should not underestimate how significant and serious it is to invite the statutory child protection system into people's lives and that statutory child protection intervention ought be something that is reserved for those matters that really warrant it. Intervention by the State in private family life is a very serious thing.*[349]

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[348] Submission: DoCS, Child Protection Assessment Models and Processes, pp.14-15.

[349] Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.39.

6.79 The Inquiry has concluded that the threshold for reporting should be raised so that families and children do not have the stigma of being 'known to DoCS' in circumstances where the risk of harm does not warrant its attention.

6.80 This could be achieved in a number of ways. The Inquiry is not persuaded that the introduction of a test incorporating "reasonable evidence," or requiring consideration by the reporter of "likelihood of harm," will best achieve the goal. The former calls for a level of investigation capable of providing tangible evidence while the latter introduces a need for foresight or prediction of what is likely to occur. Similarly, it does not consider that a test based on "belief" would be appropriate as it would convey a degree of confidence in a state of affairs that could raise the threshold too high. The Inquiry is more concerned with the nature of the harm which should attract an obligation to report.

6.81 The Care Act incorporates the concept of seriousness in s.23(d) and (e) in relation to the effect of domestic violence and other behaviours by parents. It also appears in provisions concerning removal of children. Section 36(1)(c) provides that removal of a child or young person may occur only "where it is necessary to protect the child or young person from risk of serious harm" and s.43(1)(a) permits removal without a warrant if a child or young person "is at immediate risk of serious harm."[350]

6.82 The Victorian legislation employs the term 'significant' to express the level of harm which will indicate that the child is in need of protection.[351] Similarly, the Queensland legislation defines harm as "any detrimental effect of a significant nature on the child's physical, psychological or emotional well-being."[352] In Western Australia, harm is defined as any detrimental effect of a significant nature on the child's well-being[353] and Northern Territory similarly uses the phrase "significant detrimental effect."[354] The English system also uses the concept of significant harm, although it does not have mandatory reporting.

6.83 The Inquiry is concerned not to raise the threshold so as to equate it with a risk commensurate with the need to remove a child from his or her family. It is not persuaded, therefore, that an increased threshold should incorporate the concept of seriousness. It should be said that the Inquiry is of the view that the term 'serious' connotes a higher degree of risk, where used for example in ss.44 and 46 of the Care Act, than the term 'significant.'

6.84 Changing the reporting regime, for both mandatory and voluntary reporters, to one which applies in relation to children who are suspected by the reporter, on reasonable grounds, to be 'at risk of significant harm', rather than 'at risk of harm,' should have the effect of reducing the number of reports to those children who are likely to need the powers of the State under s.34 of the Care

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[350] See also: *Child and Young Persons (Care and Protection) Act 1998* ss.44, 46, 71(1)(e).

[351] *Children, Youth and Families Act 2005 (Vic)* s.162.

[352] *Child Protection Act 1999 (Qld)* s.9.

[353] *Children and Community Services Act 2004 (WA)* s.28.

[354] *Care and Protection of Children Act 2007 (NT)* s.15.

Act, exercised for their protection. This is not to say that those for whom a risk of lesser harm is suspected should be without assistance. This issue will be more fully addressed in Chapter 10.

6.85 The Inquiry is conscious that evaluations of some laws have shown that the vagueness and ambiguity of concepts like ‘reasonable cause’ and ‘significant harm’ cause problems for reporters in knowing when a report should or should not be made.[355]

6.86 It is certainly the case that reporting duties should be expressed in language that is as clear as possible, and that reporters need good training to gain knowledge of the indicators of abuse and neglect, to know when a report is and is not required, and to know how to make a report that provides useful assistance to child protection authorities.

6.87 Whether mandatory reporters have the qualifications, skills or judgement necessary to form a suspicion of risk of significant harm has been raised with the Inquiry. The data indicate that 60 per cent of reports are made by police, health and school/child care reporters. In the main, most of those who have sufficient contact with children to consider reporting, are required to exercise professional judgement daily about the safety, welfare and well-being of a child or young person. Teachers assess such matters in the learning environment, health workers do so in the context of making complex decisions about diagnosis and treatment and police officers are expected to do so in relation to making applications for Apprehended Violence Orders (AVO) and other matters.

6.88 With the exception of police and domestic violence incidents, which are addressed later in Chapter 16, none of those with whom the Inquiry spoke suggested any difficulty in having sufficient expertise to form the necessary suspicion. The Inquiry is confident that with sufficient quality training and guidelines mandatory reporters can be equipped to properly satisfy any amended statutory test.

Grounds for reporting risk of harm

6.89 The Inquiry received a number of submissions, including submissions from DoCS, Department of Education and Training (Education), and NSW Police Force (Police) supporting the amendment of s.23 to more expressly incorporate neglect, drug and alcohol use by carers, mental health issues of carers and habitual non-attendance at school, as relevant risk of harm circumstances.

6.90 In 2007/08 (preliminary), neglect was the second most common primary reported issue after domestic violence, accounting for around 15 per cent of all

[355] See for example, B Levi, G Brown and C Erb, “Reasonable suspicion: A pilot study of paediatric residents,” *Child Abuse and Neglect, 30(4),* 2006, pp.345-356; R Deisz, H Doueck, N George and M Levine, “Reasonable Cause: A Qualitative Study of Mandated Reporting,” *Child Abuse and Neglect, 20(4),*1996, pp.275-287; P Swain, “The Significance of ‘Significant’ – When is Intervention Justified Under Child Abuse Reporting Laws?” *14(1), Australian Journal of Family Law,* 2000, pp.26-35.

reports. When also taking secondary and third reported issues into account, neglect was a reported issue in almost one quarter of all child protection reports. While non-mandatory reporters made almost one quarter of all reports in 2006/07, they accounted for almost 40 per cent of neglect reports. 'Family' represented the largest group of reporters where neglect was the primary reported issue, accounting for 8,525 reports.

6.91 During 2006/07, 20.3 per cent of all referred reports with neglect as the primary reported issue were assigned a required response time of less than 24 hours. This was significantly higher than the average across all referred reports, which was 9.5 per cent. It indicates that in 2006/07 a greater proportion of neglect reports were assigned a high response priority than any other primary reported issue.

6.92 There has been no rise in the reporting of neglect as a primary issue in recent years. Rather, the number of neglect reports as a proportion of total reports has remained steady between 2004/05 and 2007/08 at about 15 per cent.

6.93 In both 2006/07 and April 07/March 08, neglect reports accounted for around 20 per cent of all reports subject to a completed SAS2, whereas in each year they accounted for around 15 per cent of total reports. Reports where the primary reported issue was neglect also accounted for around 20 per cent of all substantiated reports in both 2006/07 and April 07/March 08.

6.94 Of particular note, as evidenced in April 07/March 08 data, is that while neglect is the primary reported issue in 20.2 percent of substantiated reports, there was a finding of neglect or risk of neglect in 31.6 per cent of substantiated reports. This may be a reflection of the significant number of reports where neglect was a secondary or third reported issue.

6.95 Further, in 2006/07 more than a quarter of children entering OOHC did so after a finding of neglect or risk of neglect, which was more than any other single issue.

6.96 In April 07/March 08, drug and alcohol concerns of carers was the fourth most reported issue, being reported in 10.4 per cent of reports. It accounts for 13.8 per cent of all substantiated reports. Carer mental health was the primary reported issue in 8.0 per cent of reports and accounted for 9.3 per cent of substantiated reports.

6.97 In the view of the Inquiry, and of some others who made submissions including the Ombudsman and Health, a combination of paragraphs (a), (b), (c) and (e) of s.23 is sufficiently wide to permit or require neglect, mental health issues and drug or alcohol use by carers to be reported. Neglect is clearly a significant issue for both mandatory reporters and DoCS and has been for some time, and it seems unlikely that amendment to include it as a specific at risk circumstance would lead to any change in reporting patterns or outcomes.

6.98 The Ombudsman submitted that s.23 provides a clear framework for appropriately identifying the range of circumstances that may warrant a statutory response. The Inquiry agrees.

6.99 Health submitted that there may be difficulties in defining mental illness and substance abuse if they were included as specific at risk circumstances. Further, it pointed out that effective parenting is not necessarily compromised by those conditions, for example, if a parent is following an appropriate treatment program. It submitted that a recent Drug and Alcohol Child Protection Training Strategy has been initiated which is designed to ensure that drug and alcohol workers can identify and respond to children at risk. Similarly, mental health workers are provided with guidance and examples about the relationship between adult mental health and risk of harm.

6.100 The Inquiry agrees that many forms of mental illness are capable of being managed by medication and may have no adverse impact on parenting. It is the view of the Inquiry that where the mental health of a carer provides a risk to a child, that risk is adequately catered for in s.23. To extend it would be to potentially capture families who should not be subject to child protection oversight or intervention.

6.101 The Inquiry accepts that, as submitted by DoCS, there is a "significant body of evidence to support the assertion that parental drug misuse (and particularly use of illicit drugs) is inherently risky for children."[356] However, if there was a suspicion of serious and persistent parental illicit drug use and as a consequence the child or young person was at risk of not having his or her basic physical or psychological needs met, it is clear that paragraph (a) of s.23 would apply.

6.102 DoCS also observed that the reference to 'current concerns' in s.23 is open to the interpretation that the perceived risk of harm must be immediate and present. However, it seems to the Inquiry that this blurs the distinction between the concerns which in fact exist at any given moment and their possible consequences either now or in the future in terms of the safety, welfare or well-being of this child. As most of the paragraphs expressly advert to 'risk', any amendment to remove 'current' would seem to be unnecessary and may result in reporting matters which will not warrant intervention.

6.103 On balance, the Inquiry is of the view that s.23 is sufficiently broad and has not been a barrier to issues of drug and alcohol, mental illness and neglect being reported.

6.104 However, the Inquiry is of the view that there is some force in including habitual non-attendance at school as a risk circumstance in s.23. It is acknowledged that habitual non-attendance is more likely to meet the increased threshold when accompanied by one or more other risk factors.

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[356] Submission: DoCS, Mandatory Reporting, p.23.

6.105 In addition, the Inquiry is attracted to the provision in the Victorian legislation which states that harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances. An amendment to this effect would capture the concept of ongoing and persistent concerns about a child which may arise from non-attendance at school, neglect or attributes of a child's carer. Further, the research referred to in Chapter 4 supports an emphasis on the impact of cumulative harm to children and young persons.

Who should report?

6.106 No submissions have been made, or other material gathered which suggests the need for any change to those categories of people currently mandated to report risk of harm. It is noted that of the states and territories in Australia, NSW has one of the broadest groupings of those who must report.

6.107 The Care Act imposes a personal obligation to report.

6.108 DoCS, Education, the Catholic Education Commission NSW and the NSW Association of Independent Schools have a Memorandum of Understanding (MOU) in place to facilitate centralised reporting from schools. Under this MOU, each school has a designated central officer (usually the principal) who reports to the DoCS Helpline on behalf of school staff. However, the obligation remains on the individual to report to the principal who retains no discretion; he or she must make the report to DoCS.

6.109 DoCS commenced an electronic reporting pilot in February 2008. Forty-one public schools are participating in the pilot of the system known as 'e-reporting.' As at 30 June 2008, 153 reports had been made using the system. A further 440 public schools will join the pilot in the second half of 2008.[357] Rather than phoning the Helpline or faxing in a risk of harm report, the principals of participating schools key information directly into KiDS via the DoCS Connect portal. Reports are forwarded to the Helpline, which then undertakes an initial assessment to determine whether to refer the report to a CSC or JIRT for further assessment. Non-urgent matters are reported in this e-reporting pilot.

6.110 DoCS has recently evaluated e-reporting. The evaluation was generally positive, and found that overall the system was straight forward for users and resulted in some savings in the Helpline's average report processing time compared with phone and fax reports. However, the quality of information contained in the e-reports was not as good as reports received by fax. It appears that DoCS now proposes to expand the trial to a more diverse group of mandatory reporters including Health staff, general practitioners and Department of Juvenile Justice (Juvenile Justice) staff. The Inquiry supports this approach and suggests that it also be extended to Police with whom a

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[357] DoCS, *Vox*, May 2008, p.6.

system should be developed with compatibilities with the Police client database, COPS.

6.111 From the data referred to above, it appears that NGOs, health reporters and relatives are more likely to be responsible for making multiple reports than other reporter groups. This is supported by information gathered during the Inquiry. It seems that not infrequently, for example, a child or parent attending an Emergency Department of a hospital may be reported by the Emergency Department medical officer and nurse, by the nurse and attending medical officer on the ward, by the social worker attached to the ward, and by any specialist who comes into contact with the child or parent.

6.112 Also, the Inquiry was aware of examples where a child may be reported by a hospital social worker, parent's mental health worker, parent's drug and alcohol counsellor and community nurse for the same incident without apparent awareness that the other reports had been made. Given the volume of calls to the Helpline, these reports are likely to be assessed by different DoCS workers, who are required to, in each case, access the history of the family, if any, and undertake an initial assessment.

6.113 Clearly, this is not an efficient use of time by DoCS or health workers. There appears to be a deal of merit in the arrangement with the schools. Those within the education sector with whom we spoke, gave favourable evidence about its operation. The benefit of a central point of reporting in all key mandatory reporting agencies would permit the organisation to play a more active role in the subsequent support provided to the child and family, and would also be likely to provide a more comprehensive initial report through the pooling of information available to individual staff members.

6.114 The Inquiry believes there is merit in establishing positions or a Unit in each of the key agencies to triage risk of harm reports as well as to take a case management role in relation to those reports which do not reach the increased threshold of a significant risk of harm. These positions can also provide value in enhancing interagency collaboration, a matter addressed in Chapter 24.

6.115 The approach reflects the view of the Inquiry that child protection is the responsibility of all in the community including every government agency. It is responsive to the reality that DoCS carries out a detailed investigation including a home visit for only about 13 per cent of reports received. It enables better interagency cooperation to the ultimate benefit of the child and family. Most importantly, it should provide a service to those families who do not belong in the statutory child protection system and need assistance to stay out of that system.

6.116 An essential part of this structure would be the creation of a common assessment framework. The Inquiry notes that work is being done in the area of domestic violence towards developing a cross agency risk assessment approach. This work, led by Health and involving Police, DoCS and the Attorney General's Department (Attorney General's), has arisen from a number

of reports by the Ombudsman. This matter will be discussed at greater length in the following chapter.

6.117 In its submission, Health supported an institutional based reporting system, while noting that the Sydney Children's Hospital and The Children's Hospital at Westmead effectively make team reports. The Director-General of Health noted that any system would need also to work at a rural hospital in the middle of the night.[358]

6.118 In its submission, Education supported a system by which reporters may refer:

> *appropriately defined 'low level' matters to alternate services – such as family support, early intervention or specialist disability services – this may also assist in ensuring the capture of data about risk while enabling a direct service response for matters which are unlikely to warrant statutory intervention.*[359]

6.119 Education noted that the 78 School Education Directors in NSW monitor and support schools in relation to risk of harm reports. Further, it noted that with the introduction of the enrolment and registration number, "there may also be potential in the future to maintain information centrally about risk of harm reports made by schools."[360]

6.120 Police submitted that the current arrangements should remain, largely because individual reporting aligns with the obligation to report and investigate crime and with timeliness.

6.121 The Inquiry's view of the changes which need to be made to the system, as a whole, to improve reporting practices and outcomes for children and young persons, appear in Chapter 10. Generally, however, it supports a greater centralisation of reporting, preserving the right of individual members of the relevant agencies to make a direct report where, by reason of the imminent nature of the risk, a considered decision is made to follow that course.

Feedback

6.122 The *Interagency Guidelines for Child Protection Intervention 2006* (Interagency Guidelines) advise mandatory reporters that, with the exception of Police, they will be advised in writing either that the report has been closed at the Helpline or transferred to a specified CSC or JIRT. The Interagency Guidelines note that a 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. They note that a case meeting might be indicated and encourages mandatory reporters to initiate contact and request feedback.

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[358] Transcript: Public Forum, Mandatory Reporting, p.13.

[359] Submission: Department of Education and Training, p.4.

[360] Submission: Department of Education and Training, p.12.

The Inquiry agrees with these guidelines, however, they seem not to be followed in practice.

6.123 Sections 248 and 254 of the Care Act permit feedback to be provided to mandated reporters where the disclosure is for the purpose of furthering the safety, welfare and well-being of the child or young person.

6.124 In its advice to CSCs, DoCS states that a response to a request for feedback is dependent on the capacity of the CSC to respond and, if it has sufficient capacity, only occurs where the feedback is requested by a mandated reporter who has an ongoing relationship with the child or family and feedback will enable that work to continue.

6.125 There was much dissatisfaction expressed to the Inquiry from mandatory reporters that they received no, inadequate or delayed feedback. A frequent response by them to that unhappy situation was to report the same incident repeatedly in an attempt to receive action from DoCS. Alternatively, some reporters lost confidence in DoCS and sought intervention for children through other means. This contrast with the conclusions of the evaluation of the NSW Interagency Guidelines which found that:

> *information exchange is occurring smoothly – mandatory reporters seeking feedback are receiving it, and case meetings are being held to ensure that children and young people can access services.*[361]

6.126 Those working in the education field provided the following advice to the Inquiry:

> *Mr Coutts-Trotter (Director-General, Education): Beyond that there is the frustration that principals particularly don't get adequate feedback about where in the processes within DoCS a report is up to and I think, as you described, that can lead to a range of behaviours. At one extreme, school staff doing things that are deleterious and actually create problems in the managing of a child's and families' interests or, alternatively, as we have heard from many people, that there is a re-reporting of the same incident. We would be very strongly in favour of earlier and more constant feedback.*[362]
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> *Mr Wilson (Director, Compliance, Association of Independent Schools of NSW): Generally the level of feedback is not what our schools would desire. They would like to have more information so that they can help with supporting that child.*[363]

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[361] DoCS, *Evaluation of the NSW Interagency Guidelines for Child Protection Intervention 2006, Final Report, Volume 1,* 24 September 2008, p.46.

[362] Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.58.

[363] ibid., p.60.

Mr Chudleigh (Deputy Chairperson, Public Schools Principals Forum): Many principals continue to report until they do get some response.[364]

6.127 Health representatives said the following:

Dr Gliksman (Chairperson, Australian Medical Association (NSW) Limited): We believe that providing that feedback really would be very helpful in terms of practitioners knowing what to do next and being able to refine their practice and ability to detect where and when a report should be made and where it shouldn't.[365]

Dr Tzioumi (Director, Child Protection, Sydney Children's Hospital): If we feel that the child remains in significant risk, but whatever information has been given on the first report to the Department does not translate into an intervention, then we will make further reports, essentially on the same issue, and sometimes multiple reporters, multiple members of the health team who have come into contact with the family who don't have a response, will make reports.[366]

6.128 The DADHC representative said:

Ms Mills (Deputy Director-General, Development, Grants and Ageing, DADHC): What is the information we can use to build our knowledge base around the appropriateness of reporting? A lot of the discussion today has been about anecdotes, of necessity because that's all the information we have: do we over-report or do we under-report. We really don't have a handle on some of those issues and the more we get feedback, the more we can build up an evidence base.[367]

6.129 The Police representative said:

Det Supt Begg (Detective Superintendent (Child Protection and Sex Crime Squad) NSW Police Force): Generally, there is no feedback to Police and obviously if that could be done in some form of electronic format, that would be most beneficial. My one concern is that if feedback is given by DoCS, if there is an ongoing or there's going to be a criminal investigation, that that may jeopardise that.

[364] ibid., p.18.
[365] ibid., p.62.
[366] ibid., p.15.
[367] ibid., p.63.

Any information given would have to be done in a format that wouldn't jeopardise any future activity being undertaken, particularly by the JIRTs.[368]

6.130 As is clear from above, feedback is useful at two levels. First, to inform the reporter of the action taken by DoCS and to provide an opportunity for discussion as to the work which can be done by the reporter to assist the family and secondly, to equip the agency to better educate its mandatory reporters by advising of aggregated data as to the number, nature, assessments and outcomes of reports made by those within the agency.

6.131 However, there are also complexities to do with privacy, the integrity of any criminal investigations, the use of electronic means and the cost.

6.132 DoCS estimate that providing feedback to a range of mandatory reporters in the health and school/child care sectors to be $5.76 million per annum. It is not clear to the Inquiry precisely what those costs entail, given that a letter of acknowledgement, albeit brief and often delayed, is now sent to these reporters. Electronic feedback may reduce these costs.

6.133 It may also be the case that if feedback results in reduced re-reporting, savings may be made.

6.134 The Inquiry accepts that there is force in DoCS submission that:

It has been the experience of DoCS that some people who make a report then consider that their obligation to the child will have transferred to DoCS and therefore ceased in terms of their own response. While it carries no weight at law, section 29A was recently specifically included within the legislation to provide guidance that may correct this misunderstanding about the need for everyone to take appropriate steps to care for and protect children. Any mandatory reporting scheme should therefore recognise the respective roles of both the reporter and DoCS. The provision of information is just part of the role of the reporter in responding to the needs of the child. Making a report does not absolve the reporter or the reporter's employer from taking such other steps as are reasonable in the circumstances. It is reasonable for DoCS to expect that this will be the case and to base its response on the assurance that normal responses of others are happening.[369]

6.135 Communication between DoCS and reporters and constructive relationships between agencies are essential and the provision of feedback is one method by which that may be accomplished. It can assist in overcoming the very problem

[368] ibid., p.64.
[369] Submission: DoCS, Mandatory Reporting, p.13.

which DoCS identified. If the reporter is informed that DoCS does not intend to intervene then the reporter is better placed to determine, and if necessary to carry out further investigations, and to decide what action it should take. Conversely, if armed with information that DoCS intends to intervene, the reporter can hold back from taking action that might interfere with a CSC or JIRT response.

6.136 Feedback needs to be lawful, timely, meaningful and useful. Electronic means of forwarding the advice is clearly preferable. DoCS and Education are currently trialling e-reporting which uses a standardised form to record and lodge risk of harm reports and to generate an instant receipt. This is managed through a secure online system accessed through the DoCS website. Use of this technology should be explored to provide feedback.

6.137 As noted above, this provides a valuable opportunity for an interagency response to be made to the family where necessary. At the very least it should ensure that the reporter does not make a further report out of frustration at the silence which followed the initial report.

6.138 Clarifying, and where necessary changing the privacy laws, to permit exchange of such information is necessary. This will be discussed in Chapter 24. In addition, DoCS should provide aggregated data to each of the key mandatory reporters to better educate them about the matters reported and their outcomes, if not for the families, at least as to DoCS processes. That data should be made public.

Breach of the Act

6.139 For mandatory reporters, a failure to report is an offence. In the *Children (Care and Protection) Act 1987*, a breach of the mandatory reporting requirements was punishable by a fine of 10 penalty points or imprisonment. In the current Care Act, the penalty was raised to 200 penalty units, currently equivalent to a fine of $22,000, and imprisonment was removed.

6.140 It was anecdotally asserted to the Inquiry that the criminalisation of the failure to report may have resulted in a risk averse approach to reporting and thus an increase in reports. This was most prevalent with education workers. The health mandatory reporters with whom the Inquiry spoke strongly rejected that view. They report because of what they refer to as a ‘duty of care.’ However, Health noted that some workers may be motivated to report cases against their professional judgement when they do not believe that a child is facing a real risk of harm.

6.141 There has been no prosecution brought under the current Care Act and, the Inquiry understands that only in Education and Police has there been any internal disciplinary action taken against an employee for any deficiency in reporting.

6.142 The Inquiry is of the view that the key agencies which employ mandatory reporters should have adequate systems in place to ensure compliance with the terms of the legislation. Those systems should include disciplinary consequences for failure to report. The power to prosecute has not been exercised, may result in over cautious reporting and should be unnecessary in the presence of adequate internal systems. The Inquiry accordingly favours the repeal of the penal consequences attaching to a failure to report particularly in circumstances where the prosecution power has never been used, and those potentially subject to its application are subject to professional obligations. This reflects the consensus of most of the key agencies that dealt with this issue in their submission to the Inquiry.

The need for education of mandatory reporters

6.143 The Inquiry has been informed by DoCS of significant work which was undertaken since 1999 to inform relevant professionals of their obligations to report to DoCS. The main current source of information is the Interagency Guidelines referred to earlier, the DoCS website and procedures published by each of the key agencies.

6.144 However, it is clear from the data presented in this chapter that at least 13 per cent of all reports, over 38,000 reports, most of which are from mandatory reporters are not considered by DoCS to meet the test of 'risk of harm.' In addition, there is significant multiple reporting which does little to protect children and much to require unnecessary work by DoCS and others. The Public Schools Principals' Forum advised the Inquiry that it:

> *does have data based or gathered from the six surveys that they have conducted during the last six years. …It was obvious from that, when you looked at the type and location and size of school, that there are clearly … numbers of principals who are, for whatever reason, reporting excessively. Schools, for example, some in western and south western Sydney, in a six month period are reporting several thousand reports from a school with a pupil population around 400 students. You compare that with a school just down the road in a very similar context with nowhere near the same number of reports being made.*[370]

6.145 While it is hoped that the implementation of the recommendations in this report would alleviate the burden of dealing with some of these reports, more by way of education of all reporters is needed, not only to avoid unnecessary reporting but also to achieve a greater consistency in reporting.

6.146 DoCS has undertaken a comparison with other jurisdictions in relation to communication strategies with mandatory reporters. That work has revealed

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[370] Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.29.

that there is value in evaluating the reporting behaviour of particular groups and targeting strategies to meet the gaps in skills and knowledge of those groups, as well as in the quality of the reports provided. Quality is important for the identification of assessment of children who are at risk, and for efficiency in reducing the need for extensive follow up with the reporter or further research.

Recommendations

Recommendation 6.1

DoCS should revise its case practice procedures to develop clear guidelines for classifying risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.

Recommendation 6.2

In relation to the *Children and Young Persons (Care and Protection) Act 1998:*

a. Sections 23, 24 and 25 should be amended to insert 'significant' before the word 'harm' where it first occurs; and s.27 amended to insert 'significant' before the word 'harm' wherever it occurs.

b. Section 23 should be amended to insert as paragraph (g) "the child or young person habitually does not attend school."

c. A provision should be inserted defining that (with the exception of s.23 (d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.

d. The penalty provision in s.27 should be deleted.

Recommendation 6.3

Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.

Recommendation 6.4

DoCS should provide the key agencies employing mandatory reporters, namely NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training with quarterly aggregated data about the reports made by the agency and its staff. These data should be made public.

Recommendation 6.5

Targeted training strategies for each of the key mandatory reporters, namely the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training in relation to the circumstance in which reports need to be made and in relation to the information required, so as to ensure its relevance and quality, should be developed and implemented by each agency in collaboration.

Recommendation 6.6

The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children's Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force.

7 Early intervention

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Introduction

> *Early intervention is a collection of service systems whose roots extend deeply into a variety of professional domains, including health, education, and social services … It is a field whose knowledge base has been shaped by a diversity of theoretical frameworks and scientific traditions, from the instruction-oriented approach of education … to the psychodynamic approach of mental health services … and from the conceptual models of developmental therapies ... to the randomised control trials of clinical medicine … At its best, early intervention embodies a rich and dynamic example of multidisciplinary collaboration. Less constructively, it can reflect narrow parochial interests that invest more energy in the protection of professional turf than in serving the best interests of children and families.*[371]

7.1 Prevention and early intervention programs operate across the continuum of support. They aim to prevent or lower the incidence or prevalence of specific problems or issues in a population or a sub-population.[372] Early intervention is a key concept in the NSW Government's State Plan priorities F4 and F6.

7.2 Primary or universal services are offered to whole communities or population groups in order to build public resources and attend to the social factors that contribute to child abuse and neglect. The aim of these services in the child protection context is to prevent the development of risk factors/vulnerabilities that lead to family dysfunction and to build resilience in children and families.

7.3 Examples of primary or universal services include the supports and services available through maternal and child health clinics, the provision of high quality child care services and universal home visiting programs.

7.4 While primary or universal services are offered to whole communities or population groups, they are not necessarily offered evenly across the State. They may only be available in particular geographic areas.

7.5 Secondary services target families who may exhibit risk factors for child abuse and neglect and need additional support or help to alleviate identified problems so as to prevent them from either entering, or escalating in the child protection system. The services may target particular communities because of the existence of high levels of disadvantage or they may target particular families who have identified vulnerabilities or needs. Generally, secondary services are categorised as early intervention services because they seek to address risk

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[371] J Shonkoff and D Phillips (eds), *From Neurons to Neighbourhoods: The Science of Early Childhood Development,* 2000, p.339 cited in Submission: Department of Premier and Cabinet, p.36.

[372] DoCS, *Prevention and Early Intervention Literature Review*, May 2005.

factors and build resilience in children and families so that they can stay together.

7.6 Examples of targeted secondary services with an early intervention focus include sustained home visiting, parent education, supported playgroups and counselling services.

7.7 Tertiary services target children and families where child abuse or neglect has already occurred. In the first instance, tertiary services involve protective action to ensure that the children in the family are safe. Generally, they are provided directly by the government agency with statutory responsibility for child protection. This may involve court action. Tertiary services also seek to reduce the long term implications of child abuse and neglect and to prevent it recurring. They are also known as 'acute' services.

7.8 In the child protection context, tertiary services include:

a. protective intervention and support, such as sexual assault counselling, intensive family support services and therapeutic services

b. OOHC and support, such as foster care, kinship care or residential care

c. crisis support, such as crisis accommodation for women and children escaping domestic violence, and youth homelessness services.

7.9 There is significant overlap between the three service types because some service models can be offered as a primary or universal service but also as a more targeted secondary service (such as supported playgroups). Similarly, some service models can be offered as a secondary service, but can also be offered to clients who require tertiary services (such as drug and alcohol counselling). As a result, it is more useful to envisage a continuum of care and support services rather than three distinct and separate service types.

7.10 According to the public health model, there should be sufficient universal interventions available for all families. These services can then be used to leverage targeted services. That is, when necessary, families can be identified at the universal stage and referred for more intensive services in a non-stigmatising way.

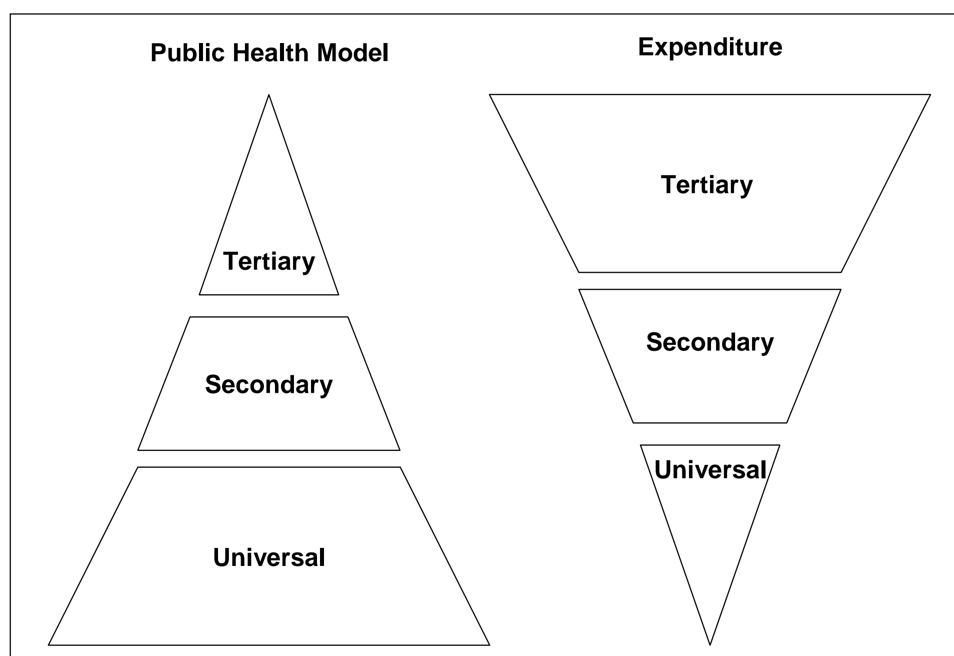
7.11 The public health model only works if there are sufficient targeted services available to meet the needs of identified families. From this perspective, tertiary child protection services are a last resort, and the least desirable option for families or the state. In submissions received by the Inquiry it was clear that there are presently significant gaps in targeted services for children and families in NSW.

7.12 The AIFS has observed that:

> *From a public health perspective, the capacity of health and welfare services are conceptualised as a pyramid. However, spending in these areas more closely resembles an inverted*

pyramid or an hourglass (see Figure 7.1). Such observations are emblematic of a critical problem within the continuum of child welfare services: child protection is currently the most visible entry point for raising concerns about families in need and facilitating their access to services.[373]

Figure 7.1 **Services for vulnerable children: the public health model compared with government services**



7.13 There is significant potential to reconfigure children's universal health and education services so that they reduce the risk factors associated with child maltreatment by working more effectively with vulnerable families and communities. Scott argues that this can be achieved through broadening the role of primary service providers and using a multi-stranded approach to overcome a number of organisational and professional obstacles.[374]

7.14 Scott suggests that a significant benefit of a public health approach to child protection lies in the fact that it lends itself to tackling the underlying causal and contributory factors related to child abuse and neglect from a whole of government perspective which includes health, education and child welfare service and draws in sectors such as housing and employment services.[375]

7.15 The limitations of the public health model are that some programs are both secondary and tertiary, or primary and secondary. For example, a parenting

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[373] Submission: Australian Institute of Family Studies, p.13.

[374] D Scott "Towards a public health model of child protection in Australia," *Communities, Families and Children Australia, 1(1),* July 2006, p.13.

[375] ibid., p.14.

program may contain parents who have been referred because their children are considered to be at risk of abuse and neglect, as well as parents who have been referred from child protection services because their children have already experienced actual abuse and neglect and they are required to complete the program to help ameliorate the risk of further maltreatment.[376]

7.16 A 2008 report prepared by the National Child Protection Clearinghouse for the Community and Disability Services Ministers' Advisory Council observes that historically, tertiary interventions have been the dominant feature in child protection systems. However, it notes:

> *primary and secondary interventions have gained increasing attention as government bodies, non-government organisations, and community alliances have recognised the importance of proactive strategies, which intervene before maltreatment occurs. Further, government agencies have recognised the benefits of providing composite interventions (e.g. secondary and tertiary responses) to maximise a family's opportunity for sustained success.*[377]

7.17 Table 7.1 outlines the continuum of services needed to support the range of needs that children, young persons and families may have at a point in time.

Table 7.1 **Service types by aim and target client group**

	Service Types		
	Universal Services	*Secondary Services*	*Tertiary Services*
Aim of the service	Prevention Early intervention	Prevention Early Intervention	Protective Intervention and Support Prevention Early Intervention
Target client group	All children and families based on the premise that supporting the whole community can prevent problems occurring	Children and families with identified vulnerabilities either at risk of entering or at the low to medium risk end of the child protection system	Children and families where abuse has already occurred. Often with intensive and complex support needs.

Research

7.18 Current thinking about early intervention:

> *increasingly accepts the premise that early childhood experience crucially determines health and well-being and the attainment of competencies at later ages, and that investment*

[376] L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2008, pp.54-55.

[377] ibid., p.54.

in the early years will be reflected in improved education, employment, and even national productivity.[378]

7.19 Further, there is evidence that:

early intervention can counteract biological and environmental disadvantage and set children on a more positive developmental trajectory continues to build.[379]

7.20 Apart from the human capital return, savings from early intervention in the critical early years have been estimated from $4 to $17 for every $1 invested.[380]

7.21 Interventions before the age of three years are:

deemed particularly important in relation to the prevention and treatment of child abuse and neglect as this is a high risk period as well as a crucial time for the development of the infant-parent relationship.[381]

7.22 Generally, programs that intervene earlier have stronger effects.[382]

7.23 Universal services are some of the most effective ways to ameliorate the effects of maltreatment.[383] For instance, maternal and child health services such as home visiting have been noted for their success in identifying families at risk of maltreatment prior to the concerns reaching a level requiring protective intervention.[384]

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[378] D Keating and C Hertzman (eds), "Developmental health and the wealth of nations: social, biological and educational dynamics," 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

[379] J Brookes-Gunn, L Berlin and A Fuligni, "Early childhood intervention programs: what about the family?" cited in J Shonkoff and S Meisels (eds), *Handbook of early childhood intervention,* (2nd ed), pp.549-599), cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

[380] J Heckman, "The Economics, Technology and Neuroscience of Human Capital Formation –Discussion Paper," *Institute for the Study of Labour,* 2007.

[381] F Press, *What about the kids? Policy directions for improving the experiences of infants and young children in a changing world*, prepared for the NSW Commission for Children and Young People, Queensland Commission for Children and Young People and The National Investment for Early Years, 2006, p.12.

[382] J Waldfogel, "Early Childhood Interventions and Outcomes," *Centre for analysis of social exclusion,* 1999 cited in F Press, 2006, op. cit., p.12.

[383] C Widom, "The cycle of violence," *Child Protection Seminar Series No.5, NSW Child Protection Council,* 1992, R Clarke, "A research agenda-what does it mean?" paper presented to *Research Agenda Workshop, Youth and Family Services Division, Department of Human Services Victoria,* Melbourne, March 20, 1997, A Tomison and S Wise, "Community-based approaches in preventing child maltreatment," *National Child Protection Clearinghouse Issues Paper No.11, Australian Institute of Family Studies,* 1999 cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

[384] D Olds, C Henderson, R Chamberlain and R Tatelbaum, "Preventing child abuse and neglect: A randomised trial of nurse intervention" *Pediatrics, N.78,* 1986, D Olds, J Eckenrode, C Henderson, H Kitzman, J Powers, R Cole, K Sidora, "Long term effects of home visitation on maternal life course and child abuse and neglect," *Journal of the American Medical Association, Vol.278, No.8,* 1997; R Chalk and P King (eds), *Violence in families: assessing prevention and treatment programs,* 1997, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.260.

7.24 Studies show that exposure to chronic violence, a lack of nurturing and or chaotic, 'socially toxic' environments[385] may significantly alter a child's neural development and result in a failure to learn, in emotional and relationship difficulties and in a predisposition to violent and/or impulsive behaviours.[386] That is, the brain may develop in ways that are maladaptive. A child may develop a chronic fear response or may become unresponsive and withdrawn which may aid in adaptation to a violent home environment but will be maladaptive in other environments like school or when making friends.

7.25 Infants of adolescent mothers with depressive symptoms show developmental and growth delays if their mother's symptoms persist over the first six months of the infant's life, thus highlighting the importance of identifying those mothers for early intervention.[387]

7.26 Research demonstrates a link between specific violence related stressors in childhood, including child abuse and neglect or repeated exposure to domestic violence, with risky behaviours and health problems in adulthood.[388]

7.27 The relationship between an infant and his or her parent or carer, known as 'attachment' also has implications for the child's future outcomes. The most important time for a primary attachment to develop is between six and 18 months. Attachment is generally categorised as being either 'secure', 'insecure' or 'disorganised.'[389]

7.28 Secure attachment to parents or carers has been associated with a range of indices of well-being, including high self esteem and low anxiety. Children are better able to cope with traumatic experiences when their earlier experiences are of being safe and protected.

7.29 Children raised by a carer who is reluctant to respond to their needs, or reacts in an angry resentful way when they express distress, may experience insecure attachment. Insecure attachments may lead to an inability to trust adults, a lack of interest in learning, difficulty in recognising their own feelings, and a lack of empathy for others.

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[385] J Garbarino, *Raising Children in a socially toxic environment,* 1995, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

[386] R Pynoos, A Steinberg and R Wraith, "A developmental model of childhood traumatic stress," in D Cicchetti and D Cohen (eds), *Developmental Psychopathology, Volume 2: Risk Disorder and Adaptation,* 1995, pp.72-75, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

[387] T Field, J Pickens, M Prodromidis, J Malphurs, N Fox, D Bendell, R Yando, S Schanberg and C Kuhn, "Targeting Adolescent Mothers with Depressive Symptoms for Early Intervention," *Adolescence, Volume 35, No.138,* 2000, pp.381-414.

[388] J Middlebrooks, N Audage, "The Effects of Childhood Stress on Health Across the Lifespan," prepared for the US Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, 2008, p.5.

[389] DoCS, *Attachment: Key Issues, Research to Practice Note*, August 2006.

7.30 Disorganised attachment is commonly observed in children whose carers are abusive, neglectful, addicted to drugs or alcohol, victims of domestic violence and/or have had disrupted attachments in their own childhood.[390] Disorganised attachment is generally thought to arise when a child experiences his or her carer as either frightening or frightened. Disorganised attachment behaviour in infancy has been linked to a high risk of serious behaviour problems in later childhood.[391]

7.31 While the early years are crucial there also remains an imperative to address the needs of children, adolescents and their parents across multiple life phases and transition points like birth and starting school.[392]

7.32 Failure to provide effective services to vulnerable children and young persons can increase the demand for child protection and OOHC services, as well as for health and justice services. In an ideal world intervention services would form the greater proportion of the child and family welfare service provided by the State.

Types of early intervention services

Home visiting

7.33 Research has found that home visiting programs can be effective in ameliorating risk factors for child maltreatment (for example, by addressing poor family functioning), although there is limited evidence to suggest that home visiting assists specifically in preventing child maltreatment.[393] Home visiting may also be less beneficial where there is domestic violence.[394] Enhancements such as group sessions or cognitive retraining appear to increase the effectiveness of home visiting.

7.34 There are significant debates about the characteristics of successful home visiting programs concerning: the nature of the program; the problems that home visiting might influence; the nature of the relationship that should be established; and the qualifications, training and support required for home visitors.

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[390] For example, P Svanberg, "Attachment, resilience, and prevention," *Journal of Mental Health, 7(6),* 1998, p.555.

[391] ibid.

[392] M Wise, D Bennett, G Alperstein and P Chown, "Better futures for young people-a discussion paper," prepared for the NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead, 2003; Commonwealth Attorney-General's Department, *Pathways to prevention: developmental and early intervention approaches to crime in Australia*, 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

[393] J Higgins, L Bromfield, N Richardson, "Child abuse prevention: What works? The effectiveness of home visiting programs for preventing child maltreatment." *National Child Protection Clearing House, Australian Institute of Family Studies*, 2006.

[394] S Packer, "Good practice in responding to children in a medical setting," *Journal of Interpersonal Violence*, *10, 1*, pp.3-25, cited in DoCS, "Domestic violence and its impact on children's development," edited version of presentation delivered at the Fourth Domestic Violence Forum, 24 September 2002, p.6.

7.35 Watson and Tully conclude that the evidence for the effectiveness of home visiting is mixed, particularly as a stand alone strategy to improve outcomes for children from vulnerable families.[395]

> *Some of the reason so little can be gleaned about home visiting is that the evaluations are based on 'satisfaction' type rating scales with a few open-ended questions added. This approach only provides clues as to what might or might not work rather than the harder evidence base that more rigorous research would deliver. More data is needed on the practicalities of how to enrol and engage families and the reasons behind high attrition rates. Closer examination, of which families are helped, how many visits are needed, and to which home visitor qualities parents respond, is required.*[396]

7.36 Nevertheless, they further state that home visiting may be an excellent platform in identifying those families who need extra support.[397]

7.37 It has been suggested that parenting interventions that have the strongest evidence base:

> *send nurses into the homes of high risk families, focussing on the improvement of prenatal health, the child's health and development, and parent's own economic self-sufficiency.*[398]

7.38 A program of prenatal and early childhood visitation by nurses can reduce the number of subsequent pregnancies and the risks of child welfare intervention, child abuse and neglect, and criminal behaviour on the part of low income, unmarried mothers for up to 15 years after the birth of the first child.[399]

7.39 Research suggests that in the Australian context positive outcomes are most likely to be gained from home visiting with the following characteristics:[400]

a. programs for mothers from low socio-economic groups, some of whom may be identified on the basis of membership of a population group such as teenage or unmarried mothers, or by race

b. home visiting by nurses commencing antenatally where a broad range of outcomes is desired, with a focus on improving both maternal and child outcomes

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[395] DoCS, *Prevention and Early Intervention Update: Trends in Recent Research, Literature Review,* June 2008, p.44.

[396] ibid., p.17.

[397] ibid., p.44.

[398] D Olds, L Sadler, and H Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials," *Journal of Child Psychology and Psychiatry, 48(3-4)*, 2007, p.383.

[399] D Olds, J Eckenrode, C Henderson, H Kitzman, J Powers, R Cole, K Sidora, 1997, op. cit., p.637.

[400] H Aslam, L Kemp, "Home Visiting in South Western Sydney – an Integrative Literature Review, Description and Development of a Generic Model," *Centre for Health Equity Training and Research*, April 2005, p.6.

c. highly targeted interventions by psychologists/counsellors for mothers with post-natal depression

d. programs that include child development, parenting skills, parent-infant interaction and direct and indirect provision of resources

e. programs of long enough duration to impact on parenting or risk factors that contribute to child maltreatment.

7.40 A greater emphasis on understanding how to best work with Aboriginal, refugee and non-English speaking groups is required, as is developing better strategies to reach clients with complex needs and under-served groups such as grandparent and non-parental care-givers.[401]

Sustained health home visiting

7.41 The NSW Miller Early Childhood Sustained Nurse Home Visiting (Miller) trial is the first longitudinal Australian randomised control trial to determine the impact of a comprehensive sustained nurse home visiting program in a population group living in an area of known disadvantage.

7.42 Mothers allocated to the Miller intervention receive a program of at least 20 home visits in total primarily by the same nurse during the remainder of their pregnancies and the first two years post birth. Mothers also have access to early childhood health services, volunteer home visiting services, family support services and group activities including parenting groups within the area.

7.43 Preliminary analysis shows that when compared with the control group, the children and mothers who received the intervention have achieved better outcomes in knowledge of 'sudden infant death syndrome,' breastfeeding, respiratory illness, child mental development and maternal health, including a positive impact on depressed mothers.[402] Results of the trial are due in December 2008.

7.44 South Australia is the only jurisdiction in Australia which has a population based sustained nurse home visiting program. A major evaluation of the outcomes is underway.

Early childhood education programs

7.45 The developmental gains associated with attending high quality early childhood education and care programs are well documented.[403] High quality child care is

[401] Ibid., p.10.

[402] Sydney South Western Area Health Service, NSW Health, *Improving Outcomes of vulnerable children through Sustained Home Nurse Visiting,* www.archi.net.au.

[403] DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.18-24.

associated with improvements in school readiness, expressive and receptive language, positive social behaviour and a reduction in behaviour problems.[404]

7.46 Conversely, where the quality of child care is low, detrimental effects are apparent.[405] The critical factor in the provision of child care programs is quality. Quality is referred to as being 'structural' (for example, staff to child ratios, staff qualifications, group sizes and staff stability, physical space) or 'process' (for example, warm, attentive care-givers, positive discipline, appropriate and varied activities) in nature.[406]

7.47 The longer the duration and the higher the frequency of access to high quality child care, the greater the associated gains in IQ and school achievement.[407]

7.48 Research evidence suggests that of all single strategy interventions, high quality child care is the most effective in improving child outcomes and providing children with a chance to start school on a more equal footing. To be effective child care does not have to be all day or all year but it must be high quality and programs need to be goal oriented. Centre based care can provide greater quality assurance than home based care, which is likely to be more variable in the quality of its delivery. Availability and affordability are critical.

School readiness programs

7.49 Recent studies have found that children from disadvantaged backgrounds tend to be less 'ready' for school and that: "the cost of beginning school significantly behind one's peers is substantial and a deficit from which children may never recover."[408] It is recognised that it is better to prevent these deficits occurring and to eliminate the need for these children to catch up with their peers.[409]

7.50 There have been some positive results from school readiness programs but only a small number have been studied.[410]

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[404] D Vandell and B Wolfe, "Child care quality: Does it matter and does it need to be improved?" 2000, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.18.

[405] A Hausfather, A Toharia, C La Roche and F Engelsmann, "Effects of age of entry, day-care quality and family characteristics on preschool behaviour," *Journal of Child Psychology and Psychiatry and Allied Disciplines, 38(4),* 1997, pp.441-448, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.18.

[406] D Vandell and B Wolfe, 2000, op. cit., cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.23.

[407] DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.23.

[408] D Stipek and R Ryan, "Economically disadvantaged preschoolers: ready to learn but further to go," *Developmental Psychology, 33(4),* 1997 cited in DoCS, *Prevention and Early Intervention, Literature Review*, May 2005, p.34.

[409] V Halfon, C Sutherland, M View-Schneider, M Guardiani, Kloppenburg, J Wright, K Uyeda, A Kuo and E Shulman, 2001 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.34.

[410] N Richardson et al, "Making the right choices about child protection programs," 2005, cited in C Peltola and P Testro, *Towards a better future for children: preventing child abuse and neglect*, prepared for the National Association for the Prevention of Child Abuse and Neglect, 2006, p.9.

Parenting programs

7.51 A parenting program is "a focused short term intervention aimed at helping parents improve their relationship with their child, and preventing or treating a range of problems including behavioural and emotional adjustment."[411]

7.52 There is little research into the long term effects of attending these programs. However, programs for specific groups of parents tend to be included in the literature as 'promising programs.'

7.53 There are three key empirically supported behavioural parenting programs that have built an evidence base over recent years: Triple P (Positive Parenting Program); Incredible Years; and Parent Child Interaction Therapy.[412] These programs were originally developed to reduce child behavioural problems but have been adapted as interventions for the child protection context.

7.54 Parenting programs can usefully be offered as a population intervention. This reduces stigma around seeking help[413] and helps to target children who are at risk of poor outcomes.[414] The effects of parenting programs appear to be long term[415] and 'booster' sessions seem to be important in maintaining or increasing outcomes from parenting programs.[416]

Multi-component interventions

7.55 Meta-analyses show that programs using multiple interventions work better than those using a single intervention strategy.[417] Where these services are easily

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[411] J Barlow and J Parsons, "Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children," *The Cochrane Library, 2,* 2004 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.29-30.

[412] DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.29-30.

[413] A Williams, S Zubrick, S Silburn and M Sanders, *A population based intervention to prevent childhood conduct disorder: the Perth Positive Parenting Program demonstration project,* paper presented at the Ninth National Health Promotion Conference, Darwin, Northern Territory, Australia, 1997; D Offord, H Chumera Kraemer, A Kazdin, P Jensen and R Harrington, "Lowering the burden of suffering from child psychiatric disorder: trade-offs among clinical, targeted and universal interventions," *Journal of the American Academy of Child and Adolescent Psychiatry, 37(7),* 1998; S Zubrick, *Forecasting the mental health futures of Australian children,* presentation to Third International Conference on Child and Adolescent Mental Health, 15 June 2002, Brisbane Australia, 2002, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

[414] M McCain and J Mustard, *The early years study three years later: from early child development to human development,* prepared for Toronto: The Founders Network, 2002 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

[415] P Long, R Forehand, M Wierson and A Morgan, "Does parent training with non-compliant children have long term effects?" *Behaviour research and therapy, 32(1),* 1994, A Kazdin, "Practitioner review: psychosocial treatments for conduct disorder in children," *Journal of Child Psychology and Psychiatry, 38(2),* 1997, pp.161-178, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

[416] S Eyberg, E Schuhmann and J Rey, "Child and adolescent psychotherapy research: developmental issues," *Journal of Abnormal Child Psychology, 26(1),* 1998, pp.71-83, J Durlak and A Wells, "Primary prevention programs for children and adolescents," *American Journal of Community Psychology, 25(2),* 1997, pp.233-243, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

[417] J Marshall and P Watt, *Child behaviour problems: A literature review of its size and nature and prevention interventions,* prepared for Interagency Commission on Children's Futures, Perth, Western Australia, 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

accessible to the parents, for instance through co-location, the benefit to families increases.[418]

> *The service model consisting of a multi-component, co-located, accessible, affordable community based intervention, and which incorporates high quality child care as a key feature has retained its effectiveness when rolled out as public policy.*[419]

7.56 No single strategy is as effective as a combined approach, which targets both child and parent.[420]

Family preservation services

7.57 There is no clear definition of the term 'family preservation services.' However, they are generally considered to be intensive, short term, in-home crisis intervention services that teach skills and provide supports for families in which a child is at imminent risk of OOHC placement.[421] While OOHC placement prevention is a major goal, the safety of children and improvement in functioning of parents, children and families is of primary importance.

7.58 The term 'family preservation' was originally applied to the US Homebuilders Model. Key characteristics include:

a. contact with the family within 24 hours of the crisis

b. small caseload sizes for workers

c. flexible service delivery

d. service duration of four to six weeks

e. intensive service delivery.[422]

7.59 Overall, there is a lack of good quality research about the effectiveness of family preservation services.

7.60 Positive outcomes are thought most likely to be gained from family preservation services that:

a. adhere to the Homebuilders Model

b. target families at imminent risk of the children being placed in OOHC

c. target families with all vulnerabilities, except where sexual abuse has occurred

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[418] DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

[419] J Temple and A Reynolds, "Benefits and costs of investments in preschool education: Evidence from the Child-Parent Centres and related programs" *Economics of Education Review 26(1),* 2007 cited in Submission: DoCS, Evidence Base for Effective Service Models, p.13.

[420] Submission: DoCS, Evidence Base for Effective Service Models, p.14.

[421] National Family Preservation Network, "Intensive family services protocol," 2003 cited in DoCS, *Family preservation services, Literature Review,* January 2008, pp.iii.

[422] DoCS, *Family preservation services, Literature Review,* January 2008, pp.iii-iv.

d. offer a combination of concrete assistance (such as payment of bills, housing assistance) and clinical services that meet the assessed needs of families.

Early intervention with older children

7.61 The importance of intervening in late childhood and early adolescence (that is, 8-14 years) has been largely overlooked in research.[423] However, an 'early in the pathway' approach has relevance across all life stages, including middle childhood and adolescence.[424]

7.62 Interventions delivered during the transition to adolescence are necessary in order to capture three groups of vulnerable children and young persons, that is:

a. those who are currently experiencing problems but who did not receive an intervention during early childhood

b. those who received an intervention in early childhood but who continue to experience problems

c. those who are not currently experiencing problems but are at risk of developing problems during adolescence. Given the high rates of mental health problems, substance use and child protection notifications for 8-14 year olds, there is a critical need to provide early intervention for this age group.[425]

7.63 Research suggests that 'school connectedness' is an important protective factor for behavioural, emotional and school related problems and there is evidence that multi-component interventions that specifically target school connectedness improve children's academic, behavioural and psychological outcomes.[426]

7.64 There is mixed evidence to support the effectiveness of extracurricular activities, after school programs and mentoring programs as a strategy for high risk children and young persons, although these approaches may be beneficial for low risk children. Community programs appear to be effective when delivered as part of a multi-component intervention.[427]

Inter-jurisdictional models

7.65 The Inquiry has learned of a number of examples of multi-agency services delivering early intervention programs both nationally and internationally.

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[423] DoCS, *Early Intervention Strategies for Children and Young People 8 to 14 Years, Literature Review*, November 2007, p.iii.

[424] A Hayes, "Why early in life is not enough: timing and sustainability in early intervention and prevention," in A France and R Homel, *Pathways and crime prevention,* 2007, p.205.

[425] DoCS, *Early Intervention Strategies for Children and Young People 8 to 14 Years, Literature Review*, November 2007, p.2.

[426] ibid., p.v.

[427] ibid.

7.66 Multi-agency working is a key component of the new approach to service design and delivery in the UK. The *Children Act (2004)* obliges all local authorities to have multi-agency Children's Trusts in place by 2008. Initiatives such as Sure Start Children's Centres and extended schools have been set up to provide services to meet this early intervention, integrated family support remit.

7.67 Sure Start Children's Centres are one stop places that aim to support young children and their families by integrating early education, child care, health care and family support services in disadvantaged areas. They provide services to children under five years and their families who can access help from multi-disciplinary teams of professionals. A recent evaluation found positive outcomes for children and parents living in Sure Start program areas.[428]

7.68 The Quebec model of integrated perinatal and early childhood services for vulnerable families aims to intervene early with mothers and families to encourage optimal development of the children, improve the family living conditions and reduce social problems including child abuse and neglect. The program targets two identified major predictors of risk: a maternal age of 20 years or less; and maternal educational attainment below the level of a high school diploma. This translates to a target group comprising about five per cent of births in Quebec.[429]

7.69 The program involves intensive nurse home visits weekly throughout pregnancy until the child is six months old, reducing to monthly for up to two years. The primary intervention during the home visits, which last about half a day per visit, is instruction in and modelling of parenting skills. It is complemented by provision of free long day care.

7.70 Quebec has also established 95 new 'one stop shop' community centres that build on a well resourced system of child, youth and family services.[430]

7.71 Dr Richard Matthews, Deputy Director-General, Health, told the Inquiry that the system operating in Quebec:

> *has some very solid outcomes, not just in that broad area of health but in other measures such as high school completion rates, which are secondary measures but very good proxies for community functioning through life.*[431]

7.72 In Victoria, Best Start, is an example of a multi-service, universal program administered by several agencies and delivered to specific areas. It is based on a range of core activities and service delivery principles, with regional

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[428] The National Evaluation of Sure Start Evaluation Research Team (UK), *The Impact of Sure Start Local Programmes on Three Year Olds and Their Families*, March 2008.

[429] Correspondence: NSW Health, 14 August 2008, Attachment: Quebec, p.1.

[430] Submission, Department of Premier and Cabinet, Appendix A, p.59.

[431] Transcript: Public Forum, Interagency Cooperation, 4 April 2004, p.42.

differences in programs based on identified need. The program commenced in 2002 and is being progressively implemented.[432]

7.73 The South Australian Government is in the process of establishing 20 Early Childhood Development Centres by 2010. These centres will offer integrated child care, preschool, early years of school, child health and family support services and will be located on school sites.[433]

7.74 Queensland is in the process of establishing four Early Years Centres under a new strategy, The Best Start – Supporting Families in the Early Years. The centres will offer universal and targeted services for children from pre-birth to eight years of age and their families, and will operate as part of an integrated prevention and early intervention service system.[434]

NSW Framework

7.75 In 2006 the Government released its *State Plan: A New Direction for NSW,* a 10 year plan for improving service delivery in NSW, in which addressing child abuse and neglect is specifically identified as a priority along with a range of other issues (for example, domestic and family violence) that can have a bearing upon the incidence of child abuse and neglect.

7.76 The Inquiry agrees with the comments made in the submission to the Inquiry from Premier and Cabinet:

> *Most vulnerable families have chronic, not simply acute, problems. This has profound implications, making it essential that the whole range of health, education and social agencies stay involved with families and children at risk, including after a referral to child protection. It is not sufficient for other service agencies to consider that their involvement with a family should cease once a child protection agency has accepted a referral. Agencies should, as a matter of policy, remain involved with families they refer for child protection interventions.*[435]

7.77 That submission accepts that prevention and early intervention strategies should be shared more broadly across government and with the non-government sector. The Inquiry agrees.

7.78 Priority F4 of the State Plan commits the Government to embedding the principle of prevention and early intervention into agency decision making.

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[432] Australian Research Alliance for Children and Youth, *Early Childhood Services: Models of Integration and Collaboration*, November 2007, p.27.

[433] ibid., p.33.

[434] ibid., p.36.

[435] Submission: Department of Premier and Cabinet, p.24.

7.79 The NSW Government's Policy Framework on Prevention and Early Intervention 2007 is being trialled and strategies include the following:

a. Every year two public sector agencies will each review an 'acute' program that accounts at least five per cent of the agency budget, with a view to identifying ways to reduce demand. In 2008, the agencies are DoCS and Health.

b. Premier and Cabinet will develop an assessment tool for agencies to use in developing capital and recurrent proposals to examine whether prevention and early intervention alternatives offer a better buy for the investment made.

c. Chief Executive Officer (CEO) clusters will develop a research and analysis agenda, to be initially led by the Human Services and Justice Cluster which will include focusing on Aboriginal children aged less than one year to five years and domestic and family violence. These groups will also be used as a vehicle for cross agency collaboration in this area.

d. Premier and Cabinet and NSW Treasury, together with relevant agencies will explore innovative funding mechanisms to mobilise resources for prevention and early intervention initiatives including measures for attracting contributions from the Commonwealth and private/not for profit sectors.[436]

7.80 Getting the balance right between the acute and supportive roles of a broad child protection system is a key policy dilemma that NSW and other jurisdictions face. In this context, there are a number of associated policy challenges:

a. ensuring that primary responsibility for rearing and supporting children continues to rest with families and communities, with government providing support where it is needed

b. facilitating sustained system wide responses to families' chronic problems

c. building an evidence base for prevention and early intervention practice.

7.81 Premier and Cabinet offers a number of possible responses to improve prevention and early intervention approaches, including strengthening and quarantining prevention and early intervention resources and personnel, promoting evidence based interventions and creating stronger models of interagency service delivery.

7.82 The Inquiry supports the directions of the current NSW approach to prevention and early intervention although, it suspects that delivering and measuring its performance will be a challenge. However, as the CEO of UnitingCare Burnside said at the Inquiry's Public Forum on Early Intervention:

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[436] Department of Premier and Cabinet, Premier's Memorandum No. 2007-20 – State Plan Priority F4: *Embedding the principle of prevention and early intervention.*

> *I don't think that we yet as a State in New South Wales have agreement about what it is that we want prevention and early intervention to achieve. When we read your fact sheet, it becomes very apparent that everything is described in terms of a program, and that program has, by definition, inclusions and exclusions.*[437]

7.83 The Inquiry acknowledges that a fundamental issue that appears to characterise NSW prevention and early intervention is the focus on programs rather than on what children and families need. As Professor Ilan Katz, Director, Social Policy Research Centre, University of NSW, stated at the same Public Forum:

> *If you are a family in difficulties, or you are a woman who is being beaten by your partner, et cetera, where would you go for help in different circumstances? … I am a very strong believer in multi-agencies working at all levels - at the planning level, at the delivery level, and at the management level. Your briefing paper really illustrates to me the range of different programs available - and there are 30, or even more programs, that are not in this briefing document – but none of them join up together. If I were a family, which one of these 10 or 12 different programs would I access and how would I know how to get into them?*[438]

7.84 The CEO of NSW Family Services advised the Inquiry:

> *When I first came into this job seven years ago, I went to learn about Families First [now Families NSW] from the person who was then in charge of it. She made it very clear that it wasn't a funding program. It wasn't just a funding program; it was a way of viewing families and children, and I agree. I think it is a terrible shame that that has been lost. But some of the processes it brought in are still working beautifully at a local level.*[439]

7.85 The NSW Government's whole of government prevention and early intervention strategy for families expecting a baby or with children aged less than nine years is the Families NSW strategy. It is administered from DoCS and sits within the Communities Division of DoCS, which contains a raft of programs and functions which are also delivered as part of a whole of government approach and in partnership with the non-government sector.

[437] Transcript: Public Forum, Early Intervention, 16 May 2008, p.6.
[438] ibid., p.17.
[439] Ibid., p.28.

7.86 Families NSW is based on the premise that all families need support and assistance, and that some families need additional support because of their circumstances. The strategy is jointly run by DoCS, Health, Education, Housing, and DADHC, together with local government and community organisations. In 2007/08 the total Families NSW budget was $40.4 million, of which $29.6 million was managed by DoCS.[440]

7.87 The strategy provides a combination of universal and targeted support services in relation to supporting parents who are expecting or caring for a new baby or who are caring for infants and young children and assisting families who need extra support and linking families and communities.[441] Families NSW projects include supported playgroups, family workers, volunteer home visiting, early literacy projects, transition to school programs, toy libraries, parenting resources and family events.

7.88 Each DoCS region has a dedicated budget and resources, and through regular planning cycles, regions determine, identify and address local priorities. DoCS stated that:

> *this allows agencies to move away from their traditional 'silos' and engage in more population based planning. Families NSW is informed by data and outcomes at a state and regional level, and by a robust research and evaluation agenda.*[442]

7.89 The effectiveness of Families NSW activities is measured against the following set of population level indicators:

a. birth weight – proportion of babies born with a low birth weight (less than 2,500 grams)

b. prematurity – proportion of babies born before 37 weeks gestation, and fully breastfed at four and five months

c. child injuries – hospital separation rates for child injuries, children aged less than one year to five years

d. educational achievement – basic skills test scores in school years Three and Five

e. maternal health and well-being – rate of risk taking behaviours (smoking) during pregnancy

f. breastfeeding – babies exclusively breast fed at discharge from hospital.

7.90 Over the four years to 2011, Families NSW will focus largely on population groups such as Aboriginal mothers, teenage mothers and mothers in low socio-economic areas through the provision of antenatal and postnatal care. One of the key initiatives to be funded over the four years is the Triple P positive

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[440] DoCS, *Annual Report 2007/08,* p.25.

[441] NSW Government *Families First Outcomes Framework NSW Data Report*, June 2004, p.1.

[442] Transcript: Inquiry meeting with DoCS senior executives, 11 February 2008, p.8.

parenting program for families with children aged 3-8 years. The program aims to train up to 1,200 health, welfare and education professional to deliver the Triple P across NSW. Funding for the program is $7.6 million over four years from 2007 to 2011.[443]

Universal service system

7.91 Universal services are provided by a number of government and non-government agencies, with health and the school/child care sector the key players.

Universal maternal and infant health services in NSW

7.92 Health provides a range of universal services:

a. Antenatal care is available through maternity services, general practitioners and increasingly for Aboriginal women through specific Aboriginal Maternal and Infant Health Strategy services.

b. Safe Start – Integrated Perinatal and Infant Care is part of the Families NSW initiative. This involves a psychosocial assessment for postnatal depression to allow for women's early referral to appropriate intervention services. It is being progressively implemented statewide.

c. A Universal Health Home Visit from a child and family health nurse is available as part of Families NSW. Health reported that since 2001, the Universal Health Home Visit has been provided to over 260,000 families. A 2003 evaluation of the Universal Health Home Visit performed by the former Central Coast Area Health Service was positive.[444]

d. Health provides the Personal Health Record, known as the 'Blue Book' for all babies born in NSW. This parent held child health and development record holds details of the recommended screening and surveillance schedule of health checks for child health and development. Health advised the Inquiry that this tool had the potential to "be the instrument for every agency to pick up kids who are not meeting their milestones."[445]

e. Early Childhood Health Centres are located in all Area Health Services across NSW. They target families with children with a special focus on children aged 0-5 years. Child and family health nurses in these Centres offer primary health care, parent education, support, and child health and development services. Early Childhood Health Centre staff deliver a range of programs and services, including the universal home visit, parenting groups, supported playgroups, and the health checks.

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443 DoCS, *Annual Report 2007/08,* p.25.

444 NSW Health, *Universal and Sustained Health Home Visiting,* p.2.

445 Transcript: Inquiry meeting with NSW Health senior executives, 12 December 2007, p.12.

f. Domestic Violence Routine Screening. Under the program all women over 16 years of age and presenting to Health services are screened.

Early childhood education and care services in NSW

7.93 In NSW, DoCS has responsibility for regulating, licensing and setting standards for all children's services providers. Services that provide care or education for one or more children under the age of six years who do not ordinarily attend school, are required to be licensed by DoCS under the *Children's Services Regulation 2004*. The Regulation requires the licensee to develop policies that set out "the ways in which children will be assisted in the transition to other early childhood programs or to school."[446]

7.94 Services that provide before and after school and vacation care for children who have started school and are up to 12 years of age are not currently regulated by DoCS. However, under ss.42-46 of the Care Act, out of school hours services are now required to register with DoCS.

7.95 NSW does not appear to compare favourably with other states and territories in relation to participation rates in preschool services. According to the Productivity Commission, in 2006/07, 64.6 per cent of four year olds in NSW were enrolled in NSW government funded and/or provided preschool services.[447] The average percentage of enrolment across Australia is 87.2 per cent, and is 96.8 per cent in Victoria.[448] DoCS disagrees with the Productivity Commission's figures and provided a different statistic, stating that approximately 88 per cent of children in NSW accessed a preschool service prior to commencing school.

7.96 There is also a significant difference in the cost of preschool services in NSW compared with other jurisdictions. The Productivity Commission noted that, *inter alia,* after subsidies, the median weekly cost per child attending preschool in NSW in 2005 was $40. The next most expensive jurisdiction was Victoria at approximately $16. The average median cost in all other states and territories was less than $10 a week.[449] However, DoCS advised a cautionary approach to these figures as they do not take into account the number of hours a child is attending a preschool service, which is a key determinant in the average weekly cost.

7.97 Two factors seem to indicate that affordability may be a barrier for many NSW families wishing to access preschool services for their children. These are the significant proportion of 'for profit' services providing preschool services or programs and the high median weekly cost for preschool services in NSW. DoCS has advised that a key issue affecting affordability is that children

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[446] *Children's Services Regulation 2004* cl.64(1)(c).

[447] This figure includes children attending child care services in recognition that in NSW age appropriate developmental programs are required by Regulation regardless of the child care setting.

[448] Productivity Commission, *Report on Government Services, Volume 1,* 2008, Table 3A.11 and pp.3.19-20.

[449] ibid., Table 3A.11 and p.3.27.

attending, stand alone, limited hours preschools are not eligible for the Commonwealth Child Care Rebate or the Child Care Tax Rebate. However, this is a factor at play in all jurisdictions across Australia and therefore does not account for the differences in both the cost of, and the rate of participation in, preschool services between NSW and the other states and territories as advised by the Productivity Commission.

DoCS Children's Services Program

7.98 DoCS provides operational and capital funding to community based children's services through its Children's Services Program. The different service models that are funded under the Children's Services Program include: centre based long day care; occasional care; preschool services; mobile children's services; toy libraries; and vacation care.[450] DoCS has projected that in 2008/09 it will fund 47,700 places per day in funded children's services and provide support for over 12,000 children from low income families.

7.99 In most circumstances, these services would be classified as universal services, as they are offered to whole communities. However, the blurring that can occur when attempting to classify these services in line with the public health model is evident. Children's services are also offered as part of a targeted secondary intervention such as the Brighter Futures program. The developmental gains associated with participation in high quality early childhood education and care programs, or children's services, are well documented.[451]

7.100 The NSW Government has indicated that it will provide an additional $85.5 million over four years to strengthen the community based preschool sector in NSW under the Preschool Investment and Reform Plan. The plan aims to bring levels of attendance at preschool programs in NSW to 95 per cent and give every four year old in NSW access to a preschool program two days a week.[452] Recurrent funding is however needed for its enhancement.

7.101 DoCS advised that there is no evidence of a reduction in demand for preschool services, and that the baby boom of 2005 will contribute to ongoing need.

COAG Early Childhood Development Agenda

7.102 The Commonwealth and the States have recently commenced work on developing implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional

[450] DoCS, *Annual Report 2006/07*, p.34.
[451] DoCS, *Early Intervention and Prevention, Literature Review*, May 2005, p.18.
[452] DoCS, *Annual Report 2006/07*, p.36.

260 child care centres on primary school grounds and other community land in areas where there are service gaps.[453]

7.103 A longer term reform program is also being developed in relation to Aboriginal early childhood development to ensure sustained engagement by all jurisdictions.

7.104 Other Commonwealth election commitments relating to early childhood development include establishing a National Health and Development Assessment System, specifically a 'Healthy Kids Check' upon starting school and the national rollout of the Australian Early Development Index in Australian primary schools.[454]

7.105 In the past, the division of responsibility between the Commonwealth and the States for child care and early childhood education "has been an obstacle to the most effective and efficient use of children's services across the system."[455] So while it is still early days, the Inquiry recognises that this new Commonwealth-State collaboration on early childhood development has the potential to remove such obstacles. Premier and Cabinet advised:

> *The emerging COAG agenda provides an opportunity to deliver significantly improved outcomes for children's early development, which will have flow-on benefits across the whole society. If the ambitious goals of the emerging COAG agenda can be achieved – strengthening families in need of support, giving children a healthy start to life and ensuring that they develop well - the flow-on effects for the child protection system will be significant. Stronger families and healthier children will mean a reduced demand for child protection responses, both in the short term (by supporting at-risk families) and in the long term by breaking intergenerational cycles of disadvantage).*[456]

Commonwealth initiatives

7.106 In addition to funding support for child care, the Commonwealth Government provides all eligible four year old children in Australia with a health check under Medicare to ensure they are healthy and ready for school. To be eligible, the child must be a permanent resident or be covered by a reciprocal agreement, and the parent must be in agreement with the child being immunised.[457]

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[453] Community and Disability Service Ministers' Conference, Agenda Item 3: COAG Early Childhood Development Agenda, 23 July 2008, p.1.

[454] The AEDI is a community-level measure of young children's development based on a teacher-completed checklist. It consists of over 100 questions measuring five developmental domains: language and cognitive skills; emotional maturity; physical health and well-being; communication skills and general knowledge; and, social competence. The Royal Children's Hospital Melbourne website is www.rch.org.au.

[455] Submission: Department of Premier and Cabinet, p.40.

[456] ibid., pp.40-41.

[457] Department of Health and Ageing, *Medicare Healthy Kids Check – Fact Sheet*, www.health.gov.au.

Targeted service system

7.107 NSW government agencies provide a range of secondary and tertiary services that, from a child protection perspective, have either a prevention or early intervention focus.

NSW Health services

7.108 Health, through its hospitals and Area Health Services, provides a range of targeted services to support children, young persons and their parents with health related needs.

7.109 Child and Adolescent Mental Health Services play an important role in the child protection system as a considerable proportion of children and young persons with developing mental health problems are likely to have experienced child abuse and neglect. These services include:

a. 47 acute funded child and adolescent mental health beds

b. 56 non-acute funded child and adolescent mental health beds

c. day patient, outpatient and inpatient programs for children aged 5-12 years and their families at Redbank House, Westmead

d. an alternative care clinic providing mental health services specifically for children in OOHC, also at Redbank.

7.110 The Children of Parents with Mental Illness program, is a national program that targets children of parents with a mental illness. In relation to this program, Dr Josey Anderson of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) advised the Inquiry that “greater collaboration and perhaps even joint initiatives between DoCS and Health around children and parents with medical illness would greatly enhance that work.”[458]

7.111 The NSW School-Link Initiative aims to formalise partnerships between education providers and mental health services to improve the way in which they work together, to achieve better mental health outcomes for children and adolescents, to support child and adolescent mental health services and schools to work collaboratively to promote mental health, to prevent mental health problems and to facilitate early identification, management and support of students with mental health problems. An evaluation of the initiative was positive.

7.112 While drug and alcohol services focus on adults, they also have a role to play in the assessment and identification of children and young persons who may be at risk of harm as a result of their parents or carers having substance abuse problems.

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[458] Transcript: Public Forum, Health and Disability, 11 April 2008, p.60.

7.113 Similarly, adult Mental Health Services play a significant role in the support of parents with a mental illness. Northern Sydney Central Coast Health advised the Inquiry that a snapshot survey of their adult mental health service clients in April 2004 showed that 20 to 30 per cent of their clients were parents, a finding they said was consistent with national surveys. Further, they found that about 24 per cent of those clients who were parents had current or previous involvement with DoCS. For a further 13 per cent of those parents, it was not known if they had had a history of contact with DoCS.[459]

7.114 The Aboriginal Family Health Strategy is designed to address issues relating to the occurrence of family violence and sexual assault in Aboriginal communities. In addition, the Education Against Violence Strategy was funded in partnership with the Centre for Aboriginal Health to develop and run an accredited certificate for family/domestic violence and sexual assault course.

7.115 Aboriginal Medical Services deliver a range of primary health care services and host a number of specialist services. The funding of these Aboriginal specific primary health services is the responsibility of the Commonwealth Government. The services also work in partnership with NSW Health services to deliver services to Aboriginal children and families.

7.116 NSW Health also provides a network of sexual assault services that deliver medical examinations, crisis counselling and ongoing treatment to victims of child and adult sexual assault. These services provide an intervention for children displaying problematic sexualised or sexually abusive behaviours, where those children have disclosed that they have been the victim of sexual assault. These children who have not disclosed a history of sexual victimisation can be provided a service by Child and Family Health Teams (providing early intervention and health promotion programs delivered by a range of professionals including nurses, social workers, psychologists and psychiatrists) or by a Child and Adolescent Mental Health Team.

7.117 In addition, Health provides Physical Abuse and Neglect of Children (PANOC) services to children who have been abused or neglected, and who also display problematic sexualised or sexually abusive behaviours. Referrals to PANOC services must be made by DoCS.

7.118 While these services are intended to be available throughout NSW it appears from information provided to the Inquiry at the Public Forums and otherwise that they are not available in all locations.

7.119 The New Street Adolescent Service (New Street), based at North Parramatta, commenced operations in June 1998 under the auspices of the Sydney West Area Health Service. It provides a specialised, community based early intervention program for adolescents aged 10-17 years who display sexually abusive behaviours, which involves both the adolescent and family. Typically,

[459] Northern Sydney Central Coast Health, *Parenting Mental Health Audit*, April 2004.

New Street, which is only available to adolescents who have not been charged with an offence, lasts for two years, and the service is overseen by an Inter-departmental Advisory Committee comprising representatives from DoCS, Education, Juvenile Justice, Health and Police. It is understood that with current resources it is able to accept approximately 25 per cent of the referrals made to it.

7.120 The first of the two planned evaluations delivered in May 2006 found strong evidence for the effectiveness of the New Street program both in reducing re-offending, and in protecting the target group from themselves becoming victims of crime and/or of abuse or neglect. The evaluation report made the point that, in addition to posing a risk to other children and young persons, the members of this group are themselves "an extremely vulnerable group whose needs should be highlighted within the child protection system."[460]

7.121 The evaluation report further stated:

> *The high cost of reoffending by untreated young people and young people who fail to complete treatment in terms of numbers of victims and level of severity of reoffending, presents a strong argument for the continuation and enhancement of the New Street treatment program and for its location within a coordinated interagency response that expedites referral to the program and supports the participation of the young people and their carers to complete the program.*[461]

7.122 The evaluation report made a number of recommendations for expansion of New Street, and for the provision of additional resources to enable that to occur, as well as for a commitment by the interagency partners to expedite referrals to and assessment by the service.[462]

7.123 The New Street budget is just under $500,000 per annum, and a cost benefit analysis undertaken by DoCS shows the total benefits of a "systemic community based program such as New Street" to be $101,494 per client, outweighing the calculated total cost per client of $27,010.[463]

7.124 A proposal for a similar service to be based in the Hunter New England area with an Aboriginal focus, was provided to the Inquiry.[464] The proposed 'Rural New Street' program has been funded, the service manager commenced duties in Tamworth in February 2008, and clinical staff have been recruited with the expectation that the service would start taking referrals in September 2008. This service is also referred to in relation to the *NSW Interagency Plan to*

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[460] L Laing, J Mikulsky, and C Kennaugh, "Evaluation of the New Street Adolescent Service," *Faculty of Education and Social Work, University of Sydney*, 2006, pp.5-6.

[461] ibid.

[462] ibid., p.27.

[463] NSW Health, *Service Proposal, Rural New Street program for adolescents who sexually abuse to be based in Hunter New England Area Health Service,* p.3.

[464] ibid.

Tackle Child Sexual Assault in Aboriginal Communities 2006-2011. Action 56 of that plan deals with the establishment of the rural program (see Chapter 18 for further discussion of this plan).

7.125 It is understood that the new service is based on the same principles as New Street but with a particular emphasis on addressing issues within the families and communities of young Aboriginal offenders.

7.126 It may be noted that similar programs in New Zealand for Aboriginal child sex offenders, such as the Te Piriti Special Treatment Program have been the subject of positive evaluation. The experience with that program, it has been said, is that it provides support for designing and implementing a program that is attuned to the cultural background of those involved.[465] Other community based programs in New Zealand have also reportedly shown a reduction in recidivism.[466]

7.127 The accepted wisdom that adolescents do commit a significant number of sexual offences, and that a sizeable proportion of all adult sex offenders against children began offending during their adolescent years[467] strongly supports the need for the retention and development of programs based on the New Street model for those within the 10-17 year age group, who have not yet reached the stage of being charged with a sexual offence.

7.128 Although children under 10 years of age are conclusively presumed to be incapable of committing a criminal offence,[468] and are therefore outside the JIRT process, it is of concern that NSW Health Sexual Assault Services data suggest that during 2002 and 2003 there were respectively 79 and 49 child sexual assault cases reported where the perpetrators were aged under 10 years.[469]

7.129 The incidence of mental health problems, learning difficulties, negative social interactions, and the increased risk of victimisation that these children are likely to experience, emphasises the need for Health to provide an effective therapeutic intervention for them, and for DoCS to be notified of any at risk issues for that child or other relevant children.

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[465] S Macgregor, "Sex Offender Treatment Programs: effectiveness of prison and community based programs in Australia and New Zealand," *Indigenous Justice Clearinghouse*, April 2008, pp.4 and 7.

[466] ibid., p.5.

[467] Department of Juvenile Justice, *Profiling Australian Juvenile Sex Offenders*: *Offenders and offence characteristics*, p.1, 1999; D Lievore, "Recidivism of Sexual Assault Offenders, Rate, Risk Factors and Treatment Efficacy," prepared for the Office of the Status of Women by the Australian Institute of Criminology, May 2004, p.54.

[468] *Children (Criminal Proceedings) Act 1987* s.5.

[469] NSW Health, *Issues Paper, Responding to Children under ten who display problematic sexualised behaviour or sexually abusive behaviour*, 2005, p.8.

Department of Education and Training services

7.130 Education provides a range of targeted programs to support vulnerable students and students with additional needs across NSW. The aim of the majority of these programs is to establish protective factors and build resilience in children and young persons. The Federation of Parents and Citizens Association advised the Inquiry that “schools must be recognised as an essential sphere of influence for prevention and early intervention.”[470]

7.131 The Priority Schools Program is a targeted prevention and early intervention program which supports government schools in NSW with the highest concentrations of families from low socio-economic status backgrounds. Additional funding, staffing and consultancy support are provided to assist schools in the program to focus on improving the literacy, numeracy and participation outcomes for students. Currently, one quarter of the 2,216 NSW government schools receive funding under this program.[471]

7.132 Education reported that over 200 breakfast programs operate at schools across NSW. The services vary from school to school and are often run either by, or in conjunction with, the parents and citizens association, charities and local businesses. The Red Cross was identified as a sponsor, participant or service provider in over 40 of the breakfast programs.

7.133 Education also operates programs targeting Aboriginal students with the aim of improving literacy and numeracy results, school retention rates and school attendance.

7.134 The Home School Liaison Program aims to provide “a supportive service to students, parents and schools to encourage the full participation of all students in education.”[472] There are currently 84 home school liaison officers and 11 Aboriginal student liaison officers located across the State on a needs basis. The liaison officers are authorised attendance officers who can provide intensive support for students and their families through a case management plan.

7.135 All government schools have access to the services of a school counsellor. School counsellors are experienced teachers with post-graduate training in school counselling whose work includes counselling students, assisting parents or carers to make informed decisions about their child’s education and liaising with other agencies concerned with the well-being of students. There are 790.8 equivalent full time school counsellor positions across NSW government schools.

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[470] Submission: Federation of Parents and Citizens’ Association of New South Wales, p.8.

[471] Department of Education and Training, *Priority Schools Program.*

[472] Department of Education and Training, *Home School Liaison Program Guidelines 2008*, p.3.

7.136 Education delivers a range of programs to support learning for children and young persons with additional needs. This includes children and young persons with learning difficulties, disabilities and/or with challenging behaviours.

7.137 Education has an OOHC program to support the learning needs of children and young persons in OOHC. There are 22.6 equivalent full time teacher positions funded as part of this program located within the regional student services teams.

7.138 As part of the Families NSW strategy, Education operates 47 Schools as Community Centres across the State. Local Schools as Community Centres facilitators, schools and interagency partners plan activities designed to develop capacity in young children up to eight years, their families and the local community. Activities include supported playgroups, play and learn groups for parents and children, transition to school programs, home literacy and transport programs, parenting workshops and support groups, information and resource services, nutrition and child health screening.

7.139 In recognition of the importance of a continuing involvement in education for the development of children, the Inquiry has recommended the addition of "habitual absence from school" as a risk factor requiring notification. It will be important for Education to have strategies available to respond to these cases, particularly where the report becomes a trigger for early intervention.

Housing NSW services

7.140 In 2006/07, Housing provided property and tenancy management for over 126,300 public housing homes and for more than 4,300 properties owned by the Aboriginal Housing Office. Through the Office for Community Housing, the Department also funded and regulated not-for-profit organisations to provide property and tenancy management for more than 15,600 homes.[473]

7.141 Housing has a Priority Housing Policy for applicants who are eligible for public housing, are in urgent need of housing and are unable to resolve their housing need through the private rental market. People approved for priority housing are housed ahead of most other public housing applicants on the Department's housing register.[474]

7.142 A factor that Housing considers when assessing an applicant's need for priority housing is whether the applicant, or a member of the applicant's household is at risk of harm due to domestic violence, sexual assault, child abuse, threatening behaviour by someone the applicant is living with or torture and trauma. Another factor considered is whether the applicant is homeless, at risk of homelessness or living in crisis or emergency accommodation.[475]

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[473] NSW Housing, *2006/07 Annual Report*, p.8.
[474] NSW Housing, *Priority Housing Fact Sheet*, July 2008, p.1.
[475] ibid., pp.2-3.

7.143 Housing offers financial assistance to eligible low income clients to move to accommodation in the private rental market.[476]

7.144 People who need immediate housing assistance can seek help from Housing. Temporary accommodation is found in low cost motels, hotels, caravan parks or similar accommodation to assist people who are in housing crisis or homeless. Accommodation is provided for one or a small number of nights. Clients that need support are generally referred to supported crisis accommodation funded through the Supported Accommodation Assistance Program (SAAP) (see Chapter 17).[477]

7.145 The Housing and Human Services Accord was released in April 2007 and established "a framework for formal cross agency housing and support agreements to assist social housing tenants with complex needs to access support required to sustain their tenancies."[478]

7.146 As with other statements of intent by way of MOUs and the like, the objectives are laudable, but whether they achieve any change for children and their families remains to be seen.

7.147 One of the schedules currently being trialled under the Housing and Human Services Accord is the Shared Access initiative. DoCS is participating in seven of the 14 Shared Access trials with Housing and other departments including Juvenile Justice and some NGOs. As part of these trials, DoCS identifies vulnerable people for priority access to public housing and provides ongoing case support for nominated clients. Examples include providing housing and support services to: young people leaving OOHC in the Hunter Area who are assessed to be at risk of negative outcomes, without additional support; young women who are currently, formerly, or at risk entering or re-entering Juniperina Juvenile Justice Centre; families in Moree who are affected by domestic violence; and young persons who are homeless or at risk of homelessness and need support in Tamworth.[479]

Local government services

7.148 DoCS advises that 491 or 13.9 per cent of funded projects are delivered by local government. In 2007/08, about two thirds of the 152 local councils in NSW received a total of approximately $20 million in DoCS funding for the provision of a range of services.

7.149 More than half of this funding was for the provision of children's services. The extent of service provision by local councils in the children's services area varies considerably across the State. For instance, in 2007/08, about one

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[476] NSW Housing, *RentStart Fact Sheet* July 2008.

[477] NSW Housing, *After Hours Temporary Accommodation line.*

[478] NSW Housing, *2006/07 Annual Report*, p.49.

[479] DoCS, "Agency partnership boosts support for people with complex needs," *Inside Out*, September/October 2008.

quarter of all local councils received DoCS funding to assist in the operation of long day care centres. Of these councils, most operated only one long day care service, while other councils operated multiple services. For example, in 2007/08, Blacktown City Council received DoCS funding for 21 long day care centres and Penrith City Council[480] received DoCS funding for 17 long day care centres. In addition to long day care, DoCS provided funding to councils for preschools, vacation care and occasional care services.[481] Local councils operating children's services also receive funding from the Commonwealth through its Child Care Support Program.

7.150 Local councils were also funded by DoCS in 2007/08 to provide a range of services including family support services, supported playgroups, counselling services and refuges, and for family worker, community worker and youth worker positions.

Commonwealth targeted services

7.151 The Stronger Families and Communities Strategy is a Commonwealth initiative "giving families, their children and communities the opportunity to build a better future."[482] Currently funded under this strategy is Communities for Children, a place based early intervention and prevention approach to child protection and development under which NGOs are funded in 45 disadvantaged sites throughout Australia. It offers services that include: home visiting; early learning and literacy programs; early development of social and communication skills; and parenting and family support programs.[483] The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) informed the Inquiry that the Communities for Children initiative was funded at $37.45 million for 2007/08.

7.152 An evaluation of the Communities for Children program is underway. Overall the findings to date indicate that the program has had a significant impact on the delivery and configuration of services in the sites in which it is operating:

> *There is universal agreement with the basic principle underlying this initiative - that coordination of services and community engagement are crucial for the effective provision of services to children in their early years and their families.*[484]

7.153 However, lessons learned from the implementation of Communities for Children initiatives include longer funding periods, longer lead-in times, more flexible use

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[480] DoCS, *Annual Report 2007/08,* pp.174-175.

[481] DoCS, *Annual Report 2006/07,* pp.176-200.

[482] Department of Families, Housing, Community Services and Indigenous Affairs www.facsia.gov.au

[483] ibid.

[484] Department of Families, Housing, Community Services and Indigenous Affairs, *Stronger Families and Communities Strategy National Evaluation Baseline Report on Communities for Children Process Evaluation,* www.facsia.gov.au/family/sfcs_report/sec6.htm

of resources, engagement of state and territory policy makers and a better understanding and communication of what is required in each site.[485]

7.154 The Responding Early Assisting Children Program is intended to improve the capacity of families and care-givers to respond appropriately to children's needs for care, development and safety through timely access to community resources that can support them in their parenting role. FaHCSIA reports there are 43 such funded projects throughout Australia.[486]

DoCS Brighter Futures early intervention program

7.155 A number of provisions under the Care Act provide a mandate for prevention and early intervention strategies. The objects in s.8 include, among other things:

> *(c) that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the performance of their child-rearing responsibilities in order to promote a safe and nurturing environment.*

7.156 The principles contained in s.9 provide that in the administration of the Care Act,

> *(d) … 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.*

7.157 The legislation enables assistance to be sought by a child or young person[487] or his or her parent.[488] These provisions can be used to provide preventative and early intervention support to families, such as housing and referrals to a range of community based services.

7.158 In addition, under the *Community Welfare Act 1987,* the Minister and/or the Director-General can fund others to provide services including early intervention services.

7.159 Approximately 22 per cent ($260 million) of the DoCS Reform Package was committed to expanding the NSW early intervention system with the establishment of the Brighter Futures program. It included an additional 350 caseworkers in CSCs and $150 million to Lead Agencies and their partners to provide these services.

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[485] ibid.

[486] Correspondence: Department of Families, Housing, Community Services and Indigenous Affairs, 15 September 2008.

[487] *Children and Young Persons (Care and Protection) Act 1998* s.20.

[488] *Children and Young Persons (Care and Protection) Act 1998* s.21.

7.160 Brighter Futures was established in an effort to address demands on the child protection system through intervening earlier with an integrated set of services to meet the needs of vulnerable children and families. DoCS informed the Inquiry:

> *The program is set up as a demand management for child protection reports but with associated benefits such as improving children's readiness for school, for parents, increasing their parenting skills in being able to look after those children and, of course, reducing the notification rates to the Department.*[489]

7.161 Underpinning this model is the notion of integrated service delivery, whereby the full range of resources and services are accessible by families through a single entry point. This 'one stop' style service may not necessarily mean that all services are delivered under the one roof by a single service provider. Integrated service delivery arrangements, through consortia, alliances, sub-contracting or brokerage arrangements, can provide a mix of services in one or a number of locations via a coordinated single service access point. Research suggests that this style of service delivery has the potential to improve services delivered to children and families delivering benefits such as easier and more convenient access to services, and a reduced number of agency contacts which can assist families to navigate the maze of agencies.

7.162 The program commenced in 2003/04 in five CSCs. As at October 2008, there were 68 CSCs in NSW with Early Intervention Caseworkers and work continues in securing office accommodation and recruiting to the remaining positions, which DoCS advises will be complete by the end of 2008.

7.163 Nearly all Lead Agencies have started working with families with the remainder in the process of establishing their services. DoCS anticipate that all Lead Agencies will be providing services to families by the end of 2008.

Brighter Futures service model

7.164 Brighter Futures was developed following the merging of two early intervention projects in 2003/04:

a. The Level Three Project which aimed to assist families who were the subject of reports assessed as Level Three by the Helpline or 'low risk' families (now the 80 per cent of families entering the Brighter Futures program through the Helpline referral pathway).

b. The Vulnerable Families Project which aimed to assist families with child protection risk factors that made them vulnerable to entering and then escalating in the child protection system (now the 20 per cent of families

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[489] Transcript: Public Forum, Early Intervention, 16 May 2008, L Mallett, Acting Deputy Director-General, Service System Development, DoCS, p.24.

entering the Brighter Futures program through the community referral pathway).

7.165 Brighter Futures is a voluntary, targeted program designed for low to medium risk families encountering problems that impact on their ability to care for their children. It provides a differential entry point for lower risk families with children, aged under nine years. In practice, however, DoCS largely limits entry to families with children aged under three years. The aims of this program are to:

a. reduce child abuse and neglect by reducing the likelihood of family problems escalating into crisis within the child protection system

b. achieve long term benefits for children by improving intellectual development, educational outcomes and employment chances

c. improve parent-child relationships and the capacity of parents to build positive relationships and raise stronger, healthier children

d. break inter-generational cycles of disadvantage

e. reduce demand for services that otherwise might be needed down the track such as child protection, corrective or mental health services.[490]

7.166 Following an initial assessment of a report by the Helpline, and referral of the family to a CSC, caseworkers determine whether families will be allocated to a child protection worker or are eligible to be offered a voluntary service under Brighter Futures.

7.167 Families must have at least one vulnerability that, if not addressed, is likely to escalate and impact on a parent's or care-giver's capacity to parent, or on the well-being of the child/ren. Family vulnerabilities include:

a. domestic violence

b. parental drug and alcohol misuse

c. parental mental health issues

d. lack of extended family or social support

e. parent(s) with significant learning difficulties and/or intellectual disability

f. child behaviour management problems

g. lack of parenting skills/adequate supervision.

7.168 Priority of access is given to:

a. families previously participating in the Brighter Futures program who have moved and transferred to a new area

b. Aboriginal Maternal and Infant Health Strategy (AMIHS) referred families (see Chapter 18)

c. families with children under three years of age

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[490] DoCS, *Brighter Futures Caseworker Manual*, April 2007, pp.8-9.

d. families who have been on the eligibility list the longest.

7.169 Families are initially assessed as eligible if the level of risk is low or medium and the required response time assigned to the child protection report is less than 72 hours, less than 10 days or 10 days or more.

7.170 Families participating in Brighter Futures are assessed as likely to need services of approximately two years duration and require case management and at least two of the following services:

a. quality children's services which include any of the services that are licensed under the *Children's Services Regulation 2004*, such as long day care, preschools, and family day care

b. parenting programs which are designed to assist parents to enhance their parenting competencies by increasing their knowledge of child development and parenting practices.

c. home visiting which is a structured support program to help parents develop coping and parenting skills. This includes: both professional and volunteer home visiting; providing information, practical support and advice about the care of babies and children; modelling good parenting practices; and assisting families to develop supportive networks.

7.171 There are currently three entry pathways to the Brighter Futures program. The first involves a report of risk of harm or a request for Brighter Futures assistance to the Helpline that is then forwarded to a CSC for determining eligibility for the program. The second pathway is via a referral from a community agency or individual to a Lead Agency. A third pathway, currently being trialled, is a direct referral of families from AMIHS to this program (this service is outlined further in Chapter 18), some of whom will be referred by the community pathway and some by the Helpline.

7.172 Regardless of the pathway into the Brighter Futures program, DoCS always makes the eligibility decision. Lead Agencies can only begin working with families once they have received confirmation from DoCS that the family is eligible. As indicated earlier, it is necessary for a family to consent to participate in the program. A refusal to consent can be relevant to any assessment of the level of risk of children within that family.

7.173 Once the program reaches capacity under the current model:

a. 80 per cent of families referred into the program will come via a report or request for assistance to the DoCS Helpline

b. 20 per cent of families referred into the program will come via the community referral pathway.

7.174 DoCS will provide case management, casework and home visiting services for 50 per cent of the total families in the Brighter Futures program. Lead Agencies will provide the other 50 per cent and also provide access to parenting programs and child care places for DoCS case managed families.

Role of DoCS

7.175 Once assessed as meeting the initial criteria for the program, the family either remains with DoCS Early Intervention team or the family's case is transferred (using s.248 of the Care Act) to a Lead Agency.[491]

Table 7.2 **Reports assessed as eligible for Early Intervention at Secondary Assessment Stage 1, 2006/07 – 2007/08**

	2006/07	*1 April 2007 – 31 March 2008*
Total number of reports that were subject to a completed SAS1 only	76,884	98,656
Number of reports assessed as eligible for Early Intervention	8,108	15,965
Reports assessed as eligible for Early Intervention as a percentage of all reports receiving a SAS1	10.5%	16.2%
Reports assessed as eligible for Early Intervention as a percentage of total child protection reports	2.8%	5.4%
Reports assessed as eligible for Early Intervention as a percentage of reports referred to CSC/JIRT for further assessment	4.0%	7.8%

7.176 A more comprehensive assessment is then completed for each family following their referral to the Brighter Futures program, including contact with the family. This seeks to determine that referred families require, and will be appropriately supported by the range of services and supports offered through this program. As part of this assessment DoCS Early Intervention Caseworkers seek to identify that:

a. a universal preventative service is unlikely to provide an intervention sufficient to alleviate current family concerns

b. the family is likely to require an intervention for two years, on average, to achieve lasting change

c. the family requires case management and at least two of the Brighter Futures funded services

d. the family requires sustained case management providing coordinated delivery of a range of support services and is not currently receiving this from another agency.

7.177 When a risk of harm report is made concerning a child participating in the program that does not warrant a child protection response, the DoCS Early Intervention Caseworker and Lead Agency Brighter Futures Caseworker should continue to provide services to the family. This work may involve modification of the plan to reflect the recommendations and advice of child protection staff.

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[491] DoCS' Brighter Futures Teams only provide case management for families who enter the program via the Helpline pathway. Lead Agencies will case manage eligible families that enter Brighter Futures via the community referral pathway as well as some families who enter the program via the Helpline.

7.178 If a reported risk of harm to a child in the program is serious enough to warrant a child protection response, the current procedure contemplates that the family would be transferred to a Child Protection Caseworker and services to the family would be maintained, especially those services that are in the best interests of the child, such as, child care.

Evaluation of the Brighter Futures program

7.179 DoCS has appointed a consortium of academic institutions, led by the Social Policy and Research Centre at the University of NSW, to undertake a four year independent evaluation of Brighter Futures. The evaluation design began in 2006 and the evaluation will continue until 2010. The evaluation comprises a results and process evaluation, an economic evaluation and an intensive research study.

7.180 The first Interim report of the evaluation was completed for the period to October 2007.[492] This report provided a baseline, and while it drew no conclusions at that stage, it presented information on the outcomes of the referral process and the number and characteristics of the families entering the program:

a. as at October 2007, 975 families had participated in the program with 882 families still in the program and 93 having left

b. 39 per cent were managed by DoCS and 61 per cent were managed by Lead Agencies

c. 59 per cent of the families entered through a report from the Helpline while 41 per cent of families entered the program through the community referral pathway

d. all community referrals were managed by the Lead Agency. For families that entered through a report to the Helpline, 32.5 per cent were managed by Lead Agencies

e. the main vulnerabilities recorded for families entering the program were lack of social support (51 per cent), parental mental health (47 per cent) and domestic violence (46 per cent). Seventy-four per cent of families had more than one identified vulnerability.[493]

7.181 Of the 975 families, 780 families (involving 1,711 children) had been reported[494] to the DoCS Helpline with a total of 6,976 reports received by the Helpline for the period of 24 months prior to entering the program, with almost 90 per cent having a low to medium level of urgency. Of the 6,976 reports, the following is known:

a. 11 per cent of these families were reported only once to the Helpline

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[492] DoCS, *Brighter Futures Evaluation Program, Interim Report 1,* (Draft), March 2008.

[493] ibid.

[494] This figure includes families who were reported via the community referral route as they may have been subject to reports not associated with their referral into the program.

b. the mean number of reports per child was 4.1 and the median was three reports

c. almost seven per cent of children in the program accounted for more than 10 reports each

d. ten per cent of reports were assigned a required response time of less than 24 hours, 42 per cent with a response time of less than 72 hours and 47 per cent with a less than 10 days response time[495]

e. the most frequent primary reported issues were domestic violence (30 per cent), disability of carer (15 per cent), and risk of physical, psychological or sexual harm/injury (13 per cent). Inadequate clothing, nutrition, shelter or supervision made up 12 per cent of the reported issues.[496]

7.182 A greater proportion of families who entered the program from the Helpline, as compared with the community pathway, had identified vulnerabilities of domestic violence (50.8 per cent compared with 27.2 per cent) and parental drug and alcohol misuse (28.7 per cent compared with 16.8 per cent). Families with the vulnerability of parental mental health issues were more likely to have entered the program through the community pathway than through the Helpline (56 per cent compared with 44 per cent).[497]

7.183 For DoCS managed families, the most prevalent vulnerabilities were domestic violence, parental mental health and lack of social support. For Lead Agency managed cases, the vulnerabilities most prevalent were lack of social support, parental mental health and child behaviour management.[498]

7.184 The Inquiry, in agreement with most of those who made submissions on this topic, is of the view that Brighter Futures is a significant achievement that should continue and be expanded. As The Benevolent Society said:

> *Brighter Futures really lays out that concern and they have a well designed program in terms of its components. It has set a benchmark in Australia about setting out provisions of child care in terms of an early intervention and prevention project. They have really led the way on that. It is a long term project that has sustainability and tries to meet those needs long term, and a lot of thought and good research has gone into it.*[499]

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[495] Note 2,016 of the 6,976 reports had missing data. DoCS, *Brighter Futures Evaluation Program, Interim Report 1,* (Draft), March 2008, pp.8-9.

[496] DoCS, *Brighter Futures Evaluation Program, Interim Report 1,* (Draft), March 2008, pp.8-9.

[497] ibid., p.10.

[498] ibid., p.11.

[499] Transcript: Public Forum, Early Intervention, 16 May 2008, p.8.

Issues arising

Gaps in the service system

7.185 Professor Graham Vimpani, Clinical Chair Hunter Children's Health Network, advised the Inquiry:

> *Fraser Mustard has always said that you shouldn't run early intervention out of spare parts repair shops. That applies equally to Health and to an agency that is providing welfare services. I think that we need to fill some of the gaps that currently exist in the suite of early intervention strategies, and sustained home visiting would be one of those. There are some programs of early intervention which need to be provided by health workers and therapists, just as there are some programs that are better provided by people with community development skills, and all those people need to be involved in the planning and implementation and evaluation of an early intervention service system.*[500]

Gaps in the health service system

7.186 Dr Matthews informed the Inquiry that "there are significant resources available statewide. Whether they match the need or not, of course, is another matter."[501]

7.187 The Inquiry heard that some services were lacking across the State. Sometimes the issue was that the services were staffed, but could not keep up with workload and had long waiting times for services. There were insufficient positions funded, or services were limited because they were provided by outreach part time and not based in the community. Sometimes there was exclusive criteria for access to services which meant that certain groups of children were not eligible for services. Very often the position was funded, but Health struggled to recruit and retain trained clinicians to the position.

7.188 The services most frequently cited as deficient were mental health, drug and alcohol services, sexual assault services, PANOC services, medical forensic services, counselling services for families and children (including domestic violence counselling), allied health services especially speech therapy, services for men, services for perpetrators, and assessment and treatment services for children in OOHC. The Inquiry also heard of the poor availability of parenting interventions in some parts of the State, especially for particular groups such as teenage parents in remote areas, and about a lack of culturally specific parenting programs for Aboriginal people despite courts requiring some

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[500] ibid., p.16. Note: Dr. Fraser Mustard is a Canadian academic whose work on early childhood development and early intervention has gained international recognition.

[501] Transcript: Public Forum, Interagency Cooperation, 4 April 2008, p.37.

Aboriginal parents to attend courses. Regional areas reported greater difficulties in accessing health services of these kinds. It is of concern that these are the very services that are necessary for families that are struggling to raise their children, or who are likely to be involved in their abuse or neglect.

7.189 The Inquiry heard little about duplication of services, apart from the efforts made by agencies when developing services to avoid duplication.

7.190 Accessing services across state borders was also raised. In Boggabilla, the Inquiry heard that:

> *We have had lots of problems over the years with mental health issues. Goondiwindi will not accept our clients. We have to rely on Queensland Ambulance and the Police Service and an RN with a client who is medicated to get them to Moree. Once they're at Moree, they're transported by ambulance from there to Tamworth. There are a lot of people handling one client in something that could be quite easily fixed up if the person was scheduled in Queensland.*[502]

7.191 Access to health services for children and young persons was an issue in a number of locations. The distance that children or young persons and their families had to travel to access such programs was a barrier to them starting and completing the programs.

7.192 A DoCS worker in a CSC in the Southern Region advised the Inquiry of the increasing severity of the issues facing families, and the interplay between drug use, domestic violence and mental health issues which required an increasingly complex service response.

7.193 For Aboriginal communities, the Inquiry heard that there were specific gaps in services to support healing, especially for men. The Director-General of Aboriginal Affairs stated that:

> *As to healing, people did mention psychiatric services, but the healing programs is another area that needs further development. They are not, I don't think, really hitting the road out there - the healing programs and mental health programs and men's groups. We do get a lot of call for men's groups to be supported, to take on these issues as well, but also for their own purposes and strength, doing some more work with men's groups.*[503]

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[502] Transcript: Public Forum, Communities of Toomelah and Boggabilla, 11 June 2008, Community Nurse, Toomelah, pp.5-6.

[503] Transcript: Public Forum, Aboriginal Communities, 24 April 2008, pp.57-58.

7.194 The Inquiry was informed that there were specific communication issues contributing to poor child protection outcomes for young persons with a mental illness. The Ombudsman said that:

> *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 ... In particular, we found that most of the young people who had committed suicide ... 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.*
>
> *. . .*
>
> *Over the past three years we have made a series of recommendations directed to DoCS and 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:*
>
> *a. the systems for assessing the particular needs of individuals*
>
> *b. effective and coordinated interagency responses to those needs*
>
> *c. the systems for actually meeting the needs of individuals.*[504]

7.195 Perpetrator programs were raised as a separate issue requiring counselling interventions in a number of areas.

7.196 The availability of sufficient services is not a new issue and it is not one which can be solved alone by the injection of further funding. Attracting and retaining staff in rural and remote areas is a significant barrier to getting enough universal and targeted services throughout NSW. These matters are discussed in more detail in Chapter 10 where consideration is given to directions for the way forward.

Referrals to Lead Agencies in the Brighter Futures program

7.197 At the end of June 2008, there were 2,707 families comprising 6,515 children and young persons in the Brighter Futures program, of which 22.6 per cent

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[504] Submission: NSW Ombudsman, Young People at Risk, 26 May 2008, p.7.

(612) of the families were Aboriginal. DoCS was case managing 43.4 per cent (1,175) of these families and Lead Agencies was case managing 56.6 per cent (1,532) of these families.

7.198 The total planned contracted capacity to be provided by Lead Agencies is 2,757 families. As table 7.3 below shows, at the end of June 2008, Lead Agencies case managed just over one half of the target they had contracted to provide.

Table 7.3 **Number of Families case managed by Brighter Futures Lead Agency by Region and Referral pathway including contracted targets**

	Community Referral			*Helpline Referral*			*Total LA Managed*		
Region	*No of Families*	*LA Target*	*% of Capacity*	*No of Families*	*LA Target*	*% of Capacity*	*No of Families*	*LA Target*	*% of Capacity*
Hunter & Central Coast	92	178	52%	117	265	44%	209	443	47%
Metro Central	96	133	72%	105	199	53%	201	332	61%
Metro South West	73	179	41%	89	266	33%	162	445	36%
Metro West	73	134	54%	66	201	33%	139	335	41%
Northern	138	187	74%	171	285	60%	309	472	65%
Southern	83	103	81%	121	156	78%	204	259	79%
Western	158	188	84%	150	283	53%	308	471	65%
Total	713	1,102	65%	819	1,655	49%	1,532	2,757	56%

7.199 For cases being managed as at June 2008 by Lead Agencies, 54 per cent were families that have been reported through the Helpline and referred by DoCS and 47 per cent have come through the community pathway. If the program was operating as designed, it would be expected that Lead Agencies would be managing 60 per cent of the families that were reported through the Helpline and 40 per cent of those reported through the community pathway.

7.200 Further, as Table 7.3 above indicates, there is a 35 per cent vacancy rate in the Lead Agencies community referral pathway, with a much higher vacancy rate of 51 per cent for families, who following a report through the Helpline, should be referred by DoCS to Lead Agencies. These figures suggest that referral of families by DoCS is slow.

7.201 The total planned DoCS capacity is 2,757 families. Presently DoCS has a vacancy rate of 57.4 per cent (1,582 families). Nearly all of the 350 DoCS Early Intervention Caseworkers have been recruited and thus lack of staffing Is unlikely to account for this high vacancy rate. The vacancies may be as a result of a reluctance by families to engage with DoCS Early Intervention teams or while recruited, staff may not have completed training, or it may be that the CSCs are slow at referring.

7.202 It is acknowledged that it is early in the program and that eight of the 34 Lead Agency services have not been operational for the full period (Metro South

West, Hunter/Central Coast and parts of Northern Region), equally not all CSCs have reached maximum caseloads. Nevertheless, the Inquiry suspects that CSCs are not referring families to Lead Agencies in circumstances where they are or should be aware of families who may or do meet the eligibility criteria.

7.203 This is supported by written submissions from Lead Agencies and information provided at Public Forums held during the Inquiry. The Benevolent Society said:

> *We have figures with regard to referrals that we get from DoCS compared to the referrals we get from the community, and I think that DoCS' families are something like four times less likely to get referred and four times less likely to engage in the service than the community referred services. So we don't think that DoCS should be in the business of trying to build that service component to its own suite of services.*[505]

7.204 A key concern for many of the current Lead Agencies is the delay in referring and completing eligibility processes to enable these agencies to start working with families. In response to these concerns DoCS said:

> *I think there is a large volume of reports, as we've indicated, coming through our system from the Helpline to our CSCs, and they get a number of reports that they will have to go through each day … Yes, it is workload. We have said to our CSCs for a while, until we get better at doing that, some of the Early Intervention Caseworkers need to come and sit on the intake teams and go through those as well – so taking them off direct service delivery and putting them into an intake team to try to speed up the process.*[506]

7.205 DoCS informed the Inquiry that in March 2008 it agreed to some of the DoCS Early Intervention Caseworkers being used to assess users and refer families to Lead Agencies to increase the number of referrals.

7.206 It may be the high volume of reports being referred to CSCs that is inhibiting the capacity of CSCs to fully assess all appropriate cases that could be referred. It may be that the process itself is impeding referrals. In some areas hubs[507] determine eligibility and in others, caseworkers perform the task.

7.207 The Inquiry sees merit in equipping the Helpline to refer families to Brighter Futures after determining eligibility. This may reduce the vacancy rates and relieve CSCs of performing the task for families who can be identified earlier in

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[505] Transcript: Public Forum, Early Intervention, 16 May 2008, p.8.

[506] ibid., p.26.

[507] Hubs have been established in some regions to undertake this function on behalf of groups of CSCs where Early Intervention caseworkers have not yet been recruited.

the process, namely at the time of reporting. This will be addressed further in Chapter 10.

Inconsistent practices by DoCS in the Brighter Futures program

7.208 Whether the child protection histories of families or children render them eligible or ineligible for Brighter Futures is not clear from DoCS' various policies and procedures. Families do not appear to be excluded on the basis of the *number* of Helpline reports made, rather that seems to relate to their *type and severity*; which, it must be said, makes sense.

7.209 Even allowing for the exercise of discretion by caseworkers when examining a child's history, there would appear to be an inconsistent application of the DoCS' policies by caseworkers. A number of Lead Agencies also raised this concern. From its case file audit, the Inquiry identified the case set out below.

Case Study 2

A was born on 10 April 2007. A's mother, B, who was 17 years old at the time, had an extensive child protection history with DoCS. Over 50 reports had been received on B concerning domestic violence, non-attendance at school, running away, drug abuse of carers and sexual assault.

When B became pregnant DoCS received eight prenatal reports. When A was born reports continued to be made regarding both A and B, primarily regarding domestic violence.

Reports were streamed to the Early Intervention program on 17 April 2007 and 1 May 2007. In response to a further report on 13 May 2007, the Helpline noted that "14 reports for a 12 month old child is extensive. This and the previous reports indicate that A is at serious risk of harm/abuse." The Helpline recorded its disagreement with the practice at the CSC: "The records for A advise that this matter is allocated to Early Intervention. This report and the history advise that this matter in accordance with Departmental Early Intervention Policies does not meet the considerations for allocation to Early Intervention. This matter should be given allocation to full child protection intervention."

The CSC however, streamed the report to Early Intervention.[508]

B commenced participating in the program on 15 May 2007. A further report received was streamed to Early Intervention on 7 August 2007. B withdrew from the program on 3 December 2007 and the Early Intervention file was closed.

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[508] DoCS advised that the CSC can override the Helpline rating in accordance with the *Brighter Futures Caseworker Manual*.

A further report was received on 29 December 2007 regarding another incident of domestic violence but there is no documentation on file regarding further action.[509]

7.210 Reviews undertaken by DoCS also identified inconsistency in early intervention casework practice in a number of areas including the development of case plans, documentation, the completion of the required assessments within defined timeframes, the use of s.248 of the Care Act and the success with engaging families to participate in the program.[510] This is illustrated by the following case.

Case Study 3

The file showed that DoCS had assumed care of an 11 month old girl, T, and placed her back in the care of her mother with Parental Responsibility to the Minister. Interaction between the mother and an older child "raised ongoing concern about mother's parenting capacity, which is currently being addressed through caseplan."

T was placed in the care of her father by the following year, and lived with him, his wife, and his wife's two children, with access to her mother weekly. After having T in their care for about two years, T's father and stepmother began to raise concerns about her sexualised behaviour, the possibility she was at risk of sexual harm while with her mother, and requested assistance in dealing appropriately with T's behaviour from DoCS and other service providers who made reports.

The file also holds reports expressing concern about the parenting T was receiving from her stepmother and the stepmother's parenting of her own children. After a report about conflict and violence between T's father and step mother, the case was referred to Brighter Futures.

The file notes that the "natural father appears to have shown an increased interest in T. Natural mother failure to act as she had suggested she could indicate a concern, although it is predictable given her history of failure to engage unless compelled to."

This appears to indicate that the parents being assessed are T's natural parents, who do not live together. The family is referred to child protection with the notation that, "Given that the subject children and parents are known to the department it would appear that Brighter Futures would not be an appropriate program to offer this family. They already have child care in place and natural mother has been offered parenting program type

[509] DoCS advised that the report of 29 December 2007 was an information only stage one report. The case was closed at the CSC on 14 January 2008 after B declined a transfer to another CSC.

[510] DoCS, Early Intervention Program steering committee, *Operational Consistency Review* August 2007.

assistance and home visiting in the past and will only engage if she feels she has to. Therefore as natural mother is primary carer and known to the local office as unlikely to be willing to engage in the services the program has to offer Early Intervention is not considered appropriate."

There is no mention of a stepmother or step children, or of the domestic violence incident in the report just prior to referral of the family to Brighter Futures. The names of T and her two step siblings appear, but the case plan number is not the one which appears on the recent report concerning the three children, or anywhere on T's Personal History. It is not clear which parent(s) are being assessed in relation to which children. There is also no mention of services offered by Brighter Futures other than preschool and parenting support.

7.211 DoCS states that the lack of consistency is partly attributable to the limited length of the time that the teams have been operating, Lead Agency capabilities and client demographics.

7.212 The Inquiry notes that DoCS is monitoring implementation within the CSCs and has put in place a range of training and other strategies to address these inconsistencies. The Inquiry is of the view that there needs to be much greater clarity about the assessment process DoCS uses to rule families in or out of the program based on previous child protection history.

Needs too high for Brighter Futures but too low for child protection

7.213 Brighter Futures was initially developed to provide a service for those families who were reported and assessed as low risk, or as nor requiring urgent attention, but who had factors present which, if left unaddressed, could escalate to the point where statutory intervention might be required. The experience of Lead Agencies, as described to the Inquiry, is that referrals to them under the Brighter Futures program are of children at a higher level of risk and in need of more urgent attention, than was originally envisaged. Their concern is twofold. First, other children and families in need of early intervention services in order to avoid entry into care are missing out because their risk level is too low. Alternately, their child protection history precludes referral into the program but does not reach the level of risk where child protection interventions are made. Secondly, Lead Agencies are effectively being required to carry out child protection work, which should have been reserved for DoCS staff.

7.214 Further, that if sufficient child protection concerns emerge for children while in the Brighter Futures program, they are either removed from the services which are offered under the program and, short of being removed from their families, then receive little attention from the Child Protection Caseworkers.

7.215 The Inquiry shares the concern that while Brighter Futures is meeting a previously unmet need, some children remain unprotected. The Inquiry also

shares the concerns of the Ombudsman that while there are procedures in DoCS to refer cases back to the Child Protection team, there is no requirement for these cases to be allocated for further secondary assessment by that team.[511]

7.216 The Inquiry is of the view that a different pathways model may provide some assistance to these children, which together with the changes recommended in Chapter 10, should result in more of these children being assessed and assisted.

7.217 In contrast to the comments of some NGOs, other agencies stated that they had considerable experience working with high risk families. Nevertheless, as the needs of families reported to DoCS become increasingly complex, NGOs should be assisted by DoCS to develop greater capacity to help prevent these families from becoming involved in the child protection arm of DoCS. This might require the provision of specialised training and possibly short term secondments of experienced DoCS caseworkers to the larger NGOs that could manage the more challenging cases.

7.218 DoCS' policies state that if a reported risk of harm to a child in the program is serious enough to warrant a child protection response, the family should continue to receive services after being transferred to Child Protection teams. However, it appears that this does not always occur.

7.219 The Inquiry understands that DoCS is conscious of each of these matters and has recently completed an expression of interest process for more intensive services, namely 'family preservation services,' to address some of the current gaps.

7.220 The Inquiry supports the view raised by many agencies, including DoCS that there are only limited family preservation and similar models currently in place in NSW to cater for the needs of this group of children and families, and that this deficiency should be addressed. In addition there is a need to ensure that there are ongoing services for some of these families after the intensive delivery of these services. Recommendations are made about these and related matters in Chapter 10.

7.221 DoCS informed the Inquiry that recurrent funding should be made available to enhance lower intensity family support services to meet the needs of more than 10,000 families assessed each year as requiring prevention and early intervention services, including an expansion of the current Community Services Grants Program (CSGP) and other early intervention services, such as those offered under the Brighter Futures program. The Inquiry accepts that this would be desirable, although it is critical of the current funding structure, as detailed in Chapter 25. Chapter 10 contains recommendations in relation to this aspect.

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[511] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.48.

DoCS role as a provider and gatekeeper to the Brighter Futures program

7.222 The NGOs have consistently submitted to the Inquiry that the Brighter Futures Program should be undertaken by NGOs and that DoCS should limit itself to funding, monitoring and evaluating the delivery of these services by NGOs. Highlighted in many, if not all NGO submissions, was the assertion that DoCS' role in direct service provision of the program creates fear in clients, makes them reluctant to engage, and represents a conflict of interest between the focus of Brighter Futures and the focus of child protection work. If the fear of becoming 'known to DoCS' because of its role in delivering an early intervention program is the reason for families declining the opportunity of participation, then this could amount to a serious and potentially insurmountable barrier to its success.

7.223 DoCS, on the other hand, states that it would be preferable to maintain a mixed government and non-government delivery of these services, particularly when there is a higher level of child protection risk, and to develop an integrated approach across both sectors. This was supported by Professor Katz who stated:

> *I profoundly disagree with a lot of my colleagues, unfortunately, about the question of whether DoCS should be involved. I feel very strongly that the idea that DoCS should not be involved in Brighter Futures is based on a misconception and an idea that child protection operates on Venus and family support or early intervention operates on Mars, and the two are completely different activities. I disagree with that. I think it is based on the view that child abusers are evil people who beat their children and, therefore, children should be removed, and that early intervention is so-called strengths based, et cetera… From my point of view, both those types of families, going to what Professor Vimpani said, you need trust to work with them both within the child protection system and in the early intervention system. So the relationship between the family and the service provider is crucial.*[512]

7.224 As noted in Chapter 3, DoCS informed the Inquiry that it undertook an exercise to examine data and to obtain information about caseloads in Brighter Futures. Findings from this exercise showed the following.

7.225 First, a number of Early Intervention teams, similar to other teams, reported very fluid staffing arrangements as a result of higher duties, staff absences, and transfers between teams. Some managers expressed a reluctance to backfill

[512] Transcript: Public Forum, Early Intervention, 16 May 2008, pp.17-18.

Early Intervention Caseworkers when staff were absent for periods of time given the longer term nature of the program.

7.226 Secondly, while most DoCS Early Intervention teams reported positive working relationships with Lead Agencies, some teams stated that there was frequent turnover of staff in the Lead Agency, lack of communication, problems with the DoCS Connect system, misunderstanding of case management and casework methods, and Lead Agencies distancing themselves from DoCS and Brighter Futures.

7.227 Thirdly, some DoCS managers reported that they did not have confidence in the case management abilities of the Lead Agency staff and were therefore reluctant to transfer the more complex cases to the Lead Agency.

7.228 The Inquiry is of the view that effective early intervention with families requires a relationship of trust between providers and parents. The fear of child protection involvement can act as a major barrier to parents accessing the specialist services that they need, such as drug treatment and domestic violence services. Further, many families may not engage with DoCS as they fear their children could be taken away. Improving access to such services without involving DoCS is important.

7.229 However, families cannot neatly be categorised and their needs are not static. The continuum of care and support services discussed earlier in this chapter, does not only operate lineally and in one direction. Families can be coping, then a catastrophic event might occur which places the child or children at risk. For this reason, DoCS child protection workers will always need to be available to work with families receiving Brighter Futures services, and in some cases to work in conjunction with an NGO.

7.230 There are obvious tensions that have arisen in operating a parallel system with both Lead Agencies (and their partners) and DoCS caseworkers providing the Brighter Futures program. Different operating environments only serve to exacerbate these inevitable tensions.

7.231 The issue for the Inquiry is what arrangement is likely to lead to better outcomes for the children and families participating in this program.

7.232 In practice, the DoCS Early Intervention program operates within a CSC environment which will inevitably prioritise urgent child protection reports and staffing resources to meet these needs, despite best efforts by DoCS.

7.233 Research and information examined by the Inquiry highlights tensions in delivering a voluntary program in the same environment that also works with involuntary clients. For many families, engaging with DoCS will be viewed with suspicion and may not assist families in feeling safe to disclose the problems they are experiencing.

7.234 The Brighter Futures program aims to build a greater capacity to integrate services for children and families in the program as well as linking them in with other local services. Two key services within the Brighter Futures program, child care and parenting groups, are not provided directly by DoCS to the families it manages. These services are provided by Lead Agencies for DoCS families. As such this may lead to less well integrated services.

7.235 Many lead agencies contracted to provide the Brighter Futures program also provide a range of other services that potentially families could access once their needs have lessened. Thus it would be possible to maximise gains made through the program by establishing links to other services. This would assist in developing more integrated services for children and families at the local level.

7.236 It is preferable, in the Inquiry's opinion, that much of the early intervention work be carried out by the non-government sector. There will necessarily have to be a somewhat gradual transition from DoCS to NGOs, which would require, among other things, NGOs to build increased capacity and expertise to meet the needs of a diverse range of families. This will be addressed further in Chapter 10.

7.237 In addition to the role of delivering early intervention services, most submissions from Lead Agencies raised concerns about the DoCS gate keeping process in that families have to be reported or assessed by DoCS as eligible prior to accessing the Brighter Futures program. This, they stated, creates a great deal of red tape and in their experience, most families do not like their details given to DoCS.

7.238 DoCS argued that the gate keeping process was required as:

> *One of the key issues for us is if that is a high-risk child already receiving services from either our child protection program or is in out-of-home care, one of the things we need to do, when we check our KIDS system, is make sure that they are not in any of those programs.*[513]

The 80/20 split

7.239 As noted earlier in this chapter, 80 per cent of referrals to the program come via a referral/report to the Helpline, whilst 20 per cent come via a referral from a family or service provider to the Lead Agency without a report to the Helpline.

7.240 Many submissions from Lead Agencies stated that the current 80 per cent of Helpline referrals should be reduced to encompass a greater community pathway referral capacity. The Benevolent Society advised the Inquiry:

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[513] ibid., p.25.

> *We do want this [Brighter Futures] to go to the families who most need it and who have critical vulnerabilities, but I think you can do that by a referral system.*[514]

7.241 Research on engagement of families supports the assertion of the Lead Agencies, and indicates that to increase uptake of services, agencies should recruit families through the community rather than through statutory agencies. Many NGOs stated that families are more likely to engage well with the program if they have entered via the community pathway.

7.242 They argued that DoCS has inadvertently created a situation where once the Lead Agency has met its percentage of community pathway referrals, families who are eligible for the program but who have not been the subject of a report are effectively forced to wait months for a vacancy or, potentially, until their situation escalates into a report to DoCS before they have a chance of entry to the program. By the time that arises their problems may even have escalated to a point where they are only suitable for a statutory intervention, with the result that an opportunity for a timely intervention will have been lost.

7.243 DoCS argued that the current referral, screening and service delivery arrangements should be maintained. The program is in its infancy and there is no objective evidence at this time that the program or its policy settings are failing or unable to meet the objective set by government.

7.244 In contrast to the submissions by Lead Agencies, DoCS stated that some of the DoCS Early Intervention teams were reporting that their Lead Agency had advised them that they were not able to accept further transfers for case management, as they were experiencing recruitment difficulties and staff turnover.

7.245 As the data set out earlier in this chapter reveals, no region has yet reached its capacity for families referred through the community pathway or the Helpline. As at June 2008 there was a 35 per cent vacancy rate for families referred through the community pathway and a 51 per cent vacancy rate for families referred by the Helpline.

7.246 These data tend not to support the concerns expressed by the Lead Agencies, although, no doubt, in some CSCs, the trends differ.

7.247 In addition, these data and the preliminary evaluation, suggest that there has been no wholesale refusal to engage with DoCS.

7.248 One file examined by the Inquiry suggests that it is not the case that all NGOs always work effectively.

[514] ibid., p.10.

Case Study 4

The first report on A's brothers (A unborn) was received at the Helpline on 27 April 2006 and entered onto the KiDS system on 10 May 2006. A's brothers were two years old and six months old at the time. A's mother was two months pregnant with A.

The report concerned domestic violence and was referred to Early Intervention on 12 May 2006. DoCS did an initial home visit on 9 June 2006 to facilitate the mother's participation in the Early Intervention program and the mother agreed. A referral was made to the Early Intervention Lead Agency on 15 June 2006.

The worker from the Lead Agency rang DoCS on 11 July 2006 stating that she had been unable to make contact with the mother and 'could not attend the family home unannounced' so the case would be closed. The DoCS caseworker asked the agency to keep the case open and indicated she would re-contact the mother.

The DoCS caseworker conducted another home visit on 25 July 2006 and the mother once again agreed to participate. This was passed on to the Lead Agency but they were again unable to make contact. The DoCS caseworker suggested a joint home visit.

The joint home visit was arranged for 31 August 2006 at which time the Lead Agency 'informed the caseworker that she has tried to contact (the mother) a few times on her mobile and has been unsuccessful. (She) advised that due to this she will not be able to attend the home visit.' The DoCS caseworker went ahead with the visit and rang the Lead Agency during the visit with the mother to make an appointment. An appointment was made for 5 September 2006.

On 5 September 2006 the DoCS caseworker transported the mother and her children to and from the appointment, which was held at the premises of the Lead Agency.

The Lead Agency's policy on 'unannounced' home visits meant that the DoCS caseworker needed to stay involved with the family for nearly three months after the referral had been made.

7.249 The Inquiry is of the view that the current referral and screening process should remain while the program is bedded down. Given the relative infancy of this program and the associated rigorous evaluation framework in place, the current gate keeping, eligibility criteria and quota should remain until evidence is provided which supports change. Once the NGO capacity is fully established and found to be delivering effective early intervention, the eligibility criteria and quota restrictions can be reviewed, and if necessary revised.

Brighter Futures – concluding observations

7.250 The Brighter Futures program has been well conceived and is based on the available research. It is too early to recommend changes to essential elements of its design including the referral pathways, the quotas and the determination of eligibility.

7.251 However, the Inquiry is concerned that DoCS has been too slow in referring families to Brighter Futures, that DoCS' policies are not clear as to what child protection history disentitles a family from the program and that DoCS' process is somewhat duplicative with the Helpline and CSC caseworkers considering eligibility.

7.252 The Inquiry is of the view that DoCS should take steps now to remedy these deficiencies by way of preparing guidelines.

7.253 Chapter 10 suggests a way forward whereby the Helpline would assume responsibility for determining eligibility and referring families to Lead Agencies.

7.254 DoCS should also gradually reduce its case management of families in the Brighter Future program and allow that responsibility to be transferred to the Lead Agencies.

Children aged 9-14 years not eligible for Brighter Futures

7.255 Currently there is no integrated, evidenced based statewide targeted early intervention program for this age group. The Inquiry understands that investment in the middle childhood years still gives considerable individual and economic returns, and that there are relatively high rates of reports for children in this age group, especially of Aboriginal children. Diversion from the juvenile justice system, educational attainment and delay of early commencement of child bearing / rearing would be objectives of this program.

7.256 One submission identified the need for early intervention services with a strong education focus which increases the family's understanding of the school culture in which the child or young person is involved.

7.257 As noted elsewhere in this report school based support is an excellent site for universal prevention and early intervention services. Targeted service provision through school counsellors and through support for children and young persons with intensive needs are important programs that need to be resourced and utilised.

7.258 DoCS has recommended the establishment of a targeted early intervention program with recurrent funding for vulnerable families with children aged 9-14 years, with priority of access to services for Aboriginal children and their families. The Inquiry agrees but notes that currently any such extension of Brighter Futures to this age group lacks funding. Evidence about what works from research, the literature and similar effective programs in other jurisdictions

should determine program settings. Chapter 10 contains relevant recommendations.

Responsibility for 'whole of government' early intervention and prevention

7.259 The Inquiry is aware of concerns about the transfer of responsibility for Families NSW from The Cabinet Office to DoCS in 2004. Professor Vimpani noted that:

> *prior to it occurring, concerns were expressed about the capacity of a line agency to also act as an umpire, concerns that have been borne out by the less participatory style of decision making that has been evident in the governance of Families NSW since this occurred.*[515]

7.260 In particular, Professor Vimpani believes there has been a lack of consultation with Health regarding the programs being implemented under the Families NSW strategy.

7.261 The Benevolent Society's view is in line with that of Professor Vimpani, noting that Families NSW showed great promise in coordinating the delivery of services, but lost its momentum when it was transferred to DoCS. It recommended transferring the coordination of initiatives such as Families NSW back to Premier and Cabinet.

7.262 UnitingCare Burnside contended that DoCS is not in practice a 'community services' department and as a result, programs such as Families NSW, Better Futures and the Children's Services Program "struggle to find a place with their universal prevention and/or early intervention focus."[516]

7.263 Health stated that Families NSW "provides the framework and mechanisms for Health and other human services to facilitate coordinated integrated services."[517] This view is not shared by everyone working in the health sector. The Inquiry has been advised by senior health professionals that it is increasingly difficult for staff in human service agencies such as Health to see themselves as equal partners in Families NSW; it is a whole of government strategy in name only.

7.264 Concerns have also been expressed that the scope of Families NSW has narrowed over time. Professor Vimpani commented that the strategy was:

> *supposed to be a suite of early intervention services, universal through to targeted. What seems to have progressively happened is that the targeted services have been hived off and*

[515] Submission: Professor Graham Vimpani, p.7.
[516] Submission: UnitingCare Burnside, Early Intervention, p.5
[517] Submission: NSW Health, p.11.

become part of Brighter Futures, so there is now not an integrated set of early intervention strategies.[518]

7.265 UnitingCare Burnside stated that whilst there are a range of programs and services in place, there is not a strong prevention and early intervention framework.

It is essential to move beyond the current view that NSW is doing well at prevention and early intervention because it has established Brighter Futures and before that Families NSW (formerly Families First). Both programs are valuable though Families NSW has never been fully implemented – it has a nurse home visiting component but this essential aspect of Families NSW is not widespread, and the Level Three services (for more vulnerable families) were never developed. The existing programs are necessary components of the range of services needed in NSW for a comprehensive and effective prevention and early intervention service system but without place based co-ordination and access to resources, we will continue to have people falling through the gaps, either because they do not receive basic assistance or because their needs escalate and will require more intensive intervention.[519]

7.266 NSW Family Services Inc. has reported that at a local level, the establishment of Families NSW has had a positive impact on relationships between service providers. Involvement in the strategy has meant attending more meetings, which, rather than being a negative consequence:

has been a brilliant thing… because the people at local levels across all those very complex funding streams and programs and criteria and administrative arrangements know each other and they get to be able to identify the gaps.[520]

7.267 Health noted that a key concern has been the current division of responsibility for parenting support services between NSW Health and DoCS. While not recommending where they should sit, NSW Health stated that “as a minimum these services need to be integrated or ideally provided by one agency.”[521]

7.268 In the seven regional strategic overviews completed by DoCS prior to the Brighter Futures Expression of Interest process, all regions identified the need for Brighter Futures to be integrated into the existing service system and not run as a parallel service system.

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[518] Transcript: Public Forum, Early Intervention, 16 May 2008, p.14.

[519] Submission: UnitingCare Burnside, Early Intervention, p.8.

[520] Transcript: Public Forum, Early Intervention, 16 May 2008, p.28.

[521] Submission: NSW Health, p.39.

7.269 A related issue was whether NSW Health should take primary responsibility for the delivery of early intervention services. Dr Matthews told the Inquiry:

> *I don't think this is something that Health should take over. I think that Health has a central and pivotal role, but I see the role of DoCS, of the NGOs, of alternative maternal care, however supplied, and I think there is a range of ways in which that can be done, but one thing is for certain, it needs to be high quality, we need to develop a team approach, but our most critical impact can be if we work together to get in early on those that we predict, rather than waiting for those where a problem has occurred.*[522]

7.270 Professor Katz advised the Inquiry that while Health services were important as a point of contact and coordination in the early years, in middle childhood and adolescence other agencies would be more appropriate to lead the whole of government response.

> *Obviously, if early intervention were going to straddle a wider range of ages, it would not necessarily be appropriate for Health to deal with the eight to twelve or eight to fifteen age group and there, Education would probably be the most logical home for funding or coordination. So whatever you do, there would be breaks and the way to deal with those cracks breaks between different sectors is to have, as I said, multi-agency planning at all stages. I think this was the original concept of Families NSW.*[523]

7.271 The problems facing families are often multi-faceted. While there are a range of strategies and programs in place within NSW, the Inquiry is of the view that there are significant gaps and fragmentation in the coverage of the services, including where they are located and their purpose. The Inquiry is of the view that attention needs to be given to identifying the outcomes for the varying level of needs of children and their families and developing one integrated prevention and early intervention framework. The Families NSW framework as originally intended appears to be a way forward. It uses population level indicators to measure the effectiveness of its services as outlined earlier. Chapter 10 advances the way forward proposed by the Inquiry to develop an integrated service model, an outcome that is consistent with its general support for enhanced interagency cooperation.

7.272 The Inquiry is not minded to recommend that the Communities Division, the umbrella for Families NSW and other whole of government functions, be re-located more centrally in Premier and Cabinet or otherwise in Health. The Inquiry makes recommendations for significant funding reform in Chapter 25

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[522] Transcript: Public Forum, Early Intervention, 16 May 2008, p.13.
[523] ibid., p.18.

and is of the view that the Communities Division programs and functions would benefit from this reform and subsequently would be well placed in DoCS.

Proposed school attendance measures

7.273 Premier and Cabinet has advised the Inquiry that the preparation of a Bill to amend the *Education Act 1990* to strengthen compulsory attendance at school has begun.

7.274 If enacted, the legislation would give courts the power to make school attendance orders to require parents to take positive action to ensure school attendance, that could include requirements to attend mediation or counselling. Stronger options for prosecuting a parent in the Local Court are understood to be under consideration including the imposition of increased fines, imprisonment and alternative sentencing options to imprisonment. Education estimates that approximately 250 parents could be prosecuted in the first year under the proposed amending legislation. This is an increase on the average prosecution rates under the current legislative framework of between 60 to 100 per year.

7.275 Education states that imprisonment would only apply in extreme cases for repeat offenders: "in such extreme cases, it may be that the parent's presence in the child's home is the very thing preventing the child from attending school."[524]

7.276 The Ombudsman has been critical of Education in the past for failing to take decisive action regarding habitual non-attendance of children at school. The Ombudsman raised concerns about the high rates of non-attendance by Aboriginal children in particular locations. He stated:

> *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.*[525]

7.277 The Inquiry shares concerns that frequent and habitual non-attendance at school jeopardises future development and for that reason it has recommended that this should be a risk factor for reporting, as noted earlier. Imprisoning the offending parent or parents may, however, result in increased child protection concerns without addressing the underlying issues. More appropriate options might include the imposition of bonds subject to conditions requiring counselling or participation in parenting courses, the breach of which could attract more serious sanctions.

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[524] Correspondence: Department of Premier and Cabinet, 22 May 2008; Correspondence: Department of Education and Training, 2 April 2008.

[525] Submission: NSW Ombudsman, Young People at Risk, p.13.

7.278 The Inquiry, however, recognises that wilful or persistent refusal to send children to send children to school should attract sanctions such as imprisonment.

7.279 The Inquiry also cautions that the imposition of increased fines can be counter productive for the reasons identified by the NSW Sentencing Council in its Report, *The Effectiveness of Fines as a Sentencing Option: Court Imposed Fines and Penalty Notices.* By reason of the fact that many people in this group will have reduced economic circumstances the burden of a fine and the sanctions for non-compliance may serve to increase the family's stress and lead to further disengagement. Effective intervention to bring the children back to school and to deal with the underlying problems that are causing truancy or non-attendance, would involve a more positive approach.

Enhanced role for school counsellors

7.280 The Federation of Parents and Citizens Association called for additional school counsellors in schools because they "open more windows of opportunity to address problems before the child is in immediate danger."[526] The NSW Secondary Principals' Council also called for additional school counsellors.

7.281 The situation at Bourke High School provides an example of how school counsellors are thinly spread across the State. The Inquiry has been advised that the school has the services of a school counsellor one day a week. The same counsellor services Bourke Pubic School and the schools in Cobar, Nyngan and Brewarrina.

7.282 UnitingCare Burnside also called for additional school counsellors, and recommended:

> *That the NSW Government increase access to school counsellors for children and young people in the middle years by reducing the student to counsellor ratio significantly, particularly in disadvantaged areas.*[527]

7.283 Education, on the other hand, does not see the need to expand the role of school counsellors and views such a move as being likely to cause a duplication of services provided by other human service agencies. The Inquiry is unable to determine what these other services might be, given their overall shortage, and in any event sees no reason why any possible duplication cannot be addressed on the ground, by reserving counselling for those families who are not otherwise receiving relevant support.

7.284 The Inquiry agrees that the Government needs to fund additional school counsellor positions, and sees potential in an enhanced role for school

[526] Submission: Federation of Parents and Citizens' Association of New South Wales, p.8.
[527] Submission: UnitingCare Burnside, Early Intervention 9-14 years, p.5.

counsellors in supporting the child protection system, including undertaking regular home visits in the case of students who are known to be experiencing difficulties at home, or who are not attending school on a regular basis.

Availability of and criteria for social housing

7.285 From advice received by the Inquiry, it would appear that while there is a shortage of public housing in some parts of the State, there is capacity in other areas. The two main reasons for there being capacity in some areas appears to be due to the fact that some locations, particularly those within housing estates are not popular or to the fact that the quality of the available housing stock is poor. For instance, the Inquiry was informed by Housing staff that the public housing estate in East Nowra was not popular. It is in a socially disadvantaged area with a high Aboriginal population and it has: "very poor stock, yes, ageing 30 year old, you know, flat fibros."[528]

7.286 The Inquiry has been further advised that:

> *in the far south coast, in Eden in particular where Aboriginal clients are not presenting now because they don't want to live in our stigmatised estates, in our 40 or 50 year old houses, even though you suspect there's an underlying demand.*[529]

7.287 The Inquiry also heard of areas where there is a lack of public housing stock that is suitable for the requirements of those who need it. A Housing officer in Wagga Wagga noted "our major needs are for two bedroom accommodation whereas 65 per cent of our stock is three and four bedroom. We have an oversupply."[530] If this is the case, then it would seem that consideration could be given to a sale of excess stock and to the purchase of more needed housing.

7.288 The Housing criteria for priority housing includes assessing whether there is affordable and available "private rental accommodation that matches your basic housing requirements in your preferred area as well as other suitable areas."[531] Concerns have been raised with the Inquiry as to the proof required. UnitingCare Burnside cited a recent case where a young mother with four young children who was moving between motel rooms and refuges was told she needed proof that she had unsuccessfully applied for private rental ten times before she would be considered eligible for priority housing.

7.289 When the Inquiry raised the circumstances of this particular case at a number of interagency meetings, the responses from Housing staff were equivocal. During these meetings, the Inquiry was not able to elicit a clear response from

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[528] Transcript: Interagency meeting, Nowra, 12 May 2008, Manager, Housing NSW, p.33.
[529] ibid., Area Director, Housing NSW.
[530] Transcript: Interagency, Wagga Wagga, 11 March 2008, p.14.
[531] Housing NSW, *Priority Housing Fact Sheet*, December 2006, p.2.

Housing staff about the specific eligibility criteria that must be met when a person applies for priority housing. The most specific advice given was:

> *We have policy guidelines around things like that. If clients have family or they have other capacity of their own, as I said, we would look at every other aspect of the case like that.*[532]

7.290 Affordable, accessible and liveable housing is essential for families, particularly women and children escaping violence. Its provision is a necessary component of a universal response to supporting families and in ensuring child safety.

Local government service provision

7.291 While many submissions to the Inquiry highlighted the need for local organisations to identify and meet local needs, there was no specific reference to the role of local councils.

7.292 The Inquiry recognises that councils play an important role in community capacity building and support through the provision of facilities such as community halls, community centres, neighbourhood centres, libraries, swimming pools and sports playing fields. The Inquiry is particularly mindful of the role many councils play in supporting the child protection system in locations where there is limited existing infrastructure. For example, the Central Darling Shire Council received DoCS funding in 2007/08 for the Wilcannia Women's Safe House. If Central Darling Shire Council did not provide this emergency accommodation, the nearest alternative safe house for women and children in Wilcannia escaping domestic violence would be 200 kilometres away in Broken Hill.

7.293 While Central Darling Shire Council would appear to have stepped in to fill a service gap, it is not a common action taken by councils in the west, central west and north west of the State. The majority of these councils did not receive funding from DoCS in 2007/08 for the provision of community services. Nevertheless, the Inquiry sees the potential for these councils to take on an expanded role in community service provision, particularly in locations where NGOs do not have the capacity to provide services.

Conclusion

7.294 The principles which the Inquiry believes should underpin the provision of universal, secondary and tertiary services to children, young persons and their families to reduce the likelihood of, ultimately their entry into OOHC are developed in Chapter 10, along with recommendations relevant to this chapter.

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[532] Transcript: Interagency, Newcastle, 31 March 2008, Area Director, Housing NSW, p.38.

7.295 The outcomes for the varying level of needs of children and their families must be identified and an integrated prevention and early intervention framework developed. In short, the government and non-government sector should deliver an integrated, coordinated suite of services to these families.

Recommendations

Recommendation 7.1

> **DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.**

8 Assessment and response

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NSW Assessment Framework

Introduction

8.1 The Care Act identifies DoCS as the agency responsible for the assessment of reports concerning a child or young person who is suspected of being at risk of harm.

8.2 There are different points in the assessment pathway for determining which children or young persons require a statutory service from DoCS. The test at the Helpline is whether the child or young person may be at risk of harm, and the decision about referral to a CSC or a JIRT centres on whether the child or young person may be in need of care and protection. The secondary assessment process undertaken by CSCs and JIRTs tests that hypothesis. 'Risk of harm' and 'in need of care and protection' are related but separate concepts that are explored at different points in the DoCS assessment process.

8.3 Section 24 of the Care Act allows for a report to be made to the Director-General when there are reasonable grounds to suspect that a child or young person is at risk of harm. Section 27 of the Care Act requires a report from certain people where they have current concerns about the safety, welfare or well-being of the child, and have reasonable grounds to suspect the child is at risk of harm. Under s.30 of the Care Act, on receipt of such a report, the Director-General is to make such investigations and assessment, as the Director-General considers necessary, to determine whether the child or young person is at risk of harm or may no take further action if, on the basis of the information provided, he or she considers that there is insufficient reason to believe that the child or young person is at risk of harm.

8.4 Then, in relation to taking action, s.34(1) of the Care Act, states that if the Director-General forms the opinion, on reasonable grounds, that a child or young person is in need of care and protection, the Director-General is to take whatever action is necessary to safeguard or promote the safety, well-being and welfare of the child or young person.

> *(2) Without limiting subsection (1), the action that the Director-General might take in response to a report includes the following:*
>
> > *(a) providing, or arranging for the provision of, support services for the child or young person and his or her family,*
> >
> > *(b) development, in consultation with the parents (jointly or separately), of a care plan to meet the needs of the child or young person and his or her family that:*

i. does not involve taking the matter before the Children's Court, or

ii. may be registered with the Children's Court, or

iii. is the basis for consent orders made by the Children's Court,

(b1) development, in consultation with one or more primary care-givers for a child or young person, of a parent responsibility contract instead of taking a matter concerning the child's or young person's need for care and protection before the Children's Court (except in the event of a breach of the contract),

(c) ensuring the protection of the child or young person by exercising the Director-General's emergency protection powers as referred to in Part 1 of Chapter 5,

(d) seeking appropriate orders from the Children's Court.

8.5 Section 35 of the Care Act states that:

(1) The Director-General may decide to take no action if the Director-General considers that proper arrangements exist for the care and protection of the child or young person and the circumstances that led to the report have been or are being adequately dealt with.

(2) If the Director-General decides to take no action, the Director-General must make a record of the reasons for the decision.

8.6 Section 36 of the Care Act outlines the following principles that should guide intervention:

(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 care-giver may occur only where it is necessary to protect the child or young person from the risk of serious harm.*

8.7 DoCS stated that:

> *information on [the] care plan, [and] emergency protection and orders from the Children's Court are recorded in the Legal Record in KiDS for which certain data are not remediated. Data quality cannot be ascertained, hence information is not available for reporting.*[533]

8.8 DoCS further stated that while there is the capacity to record support services provided by external organisations, it is often the case that details of these services are recorded in text fields in KiDS, and cannot easily be extracted. In addition, while there is a place in KiDS to record whether the client referred by DoCS was accepted by an external organisation, "it's not possible to tell whether the client actually took advantage of the services offered."[534]

8.9 Thus, little is available in the way of reliable data from DoCS as to the actions it has taken and the services offered to children, young persons and their families.

8.10 The Care Act does not prescribe the methods by which DoCS investigates or assesses a report about a child at risk of harm. DoCS, in its submission to the Inquiry identified the following principles as underpinning best practice assessment in child protection:

a. *The use of integrated/holistic information on status of the child, which is up to date (that is, aggregation of all reliable sources that will provide accurate and timely information regarding the child in their family/carer in their environment, which is revised when new/different information is available)*

b. *Assessment that is culturally relevant*

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[533] Correspondence: DoCS, 5 June 2008, p.6.

[534] ibid., p.5.

c. *Accurate documentation of the process (including clear logic about how conclusion is reached)*

d. *The use of a single assessment that is available to all practitioners (that is, minimise multiple assessments and improve efficiency of system*

e. *Assessment that is solution-focussed, with intervention linked to assessment.*[535]

8.11 DoCS incorporates a consensus based Risk Assessment Framework (a modified version of the Victorian Risk Framework) in child protection, and the Structured Decision Making Family Strengths and Needs Assessment in the Brighter Futures program for the purpose of identifying required early intervention services.

8.12 The current DoCS system can be classified as a guided professional judgement model which after the initial contact stage can be divided into two broad components: Initial Assessment and Secondary Assessment. These two components are each divided into two stages. Therefore five key steps make up the current risk assessment system:

a. Contact

b. Initial Assessment Stage One

c. Initial Assessment Stage Two

d. Secondary Assessment Stage One

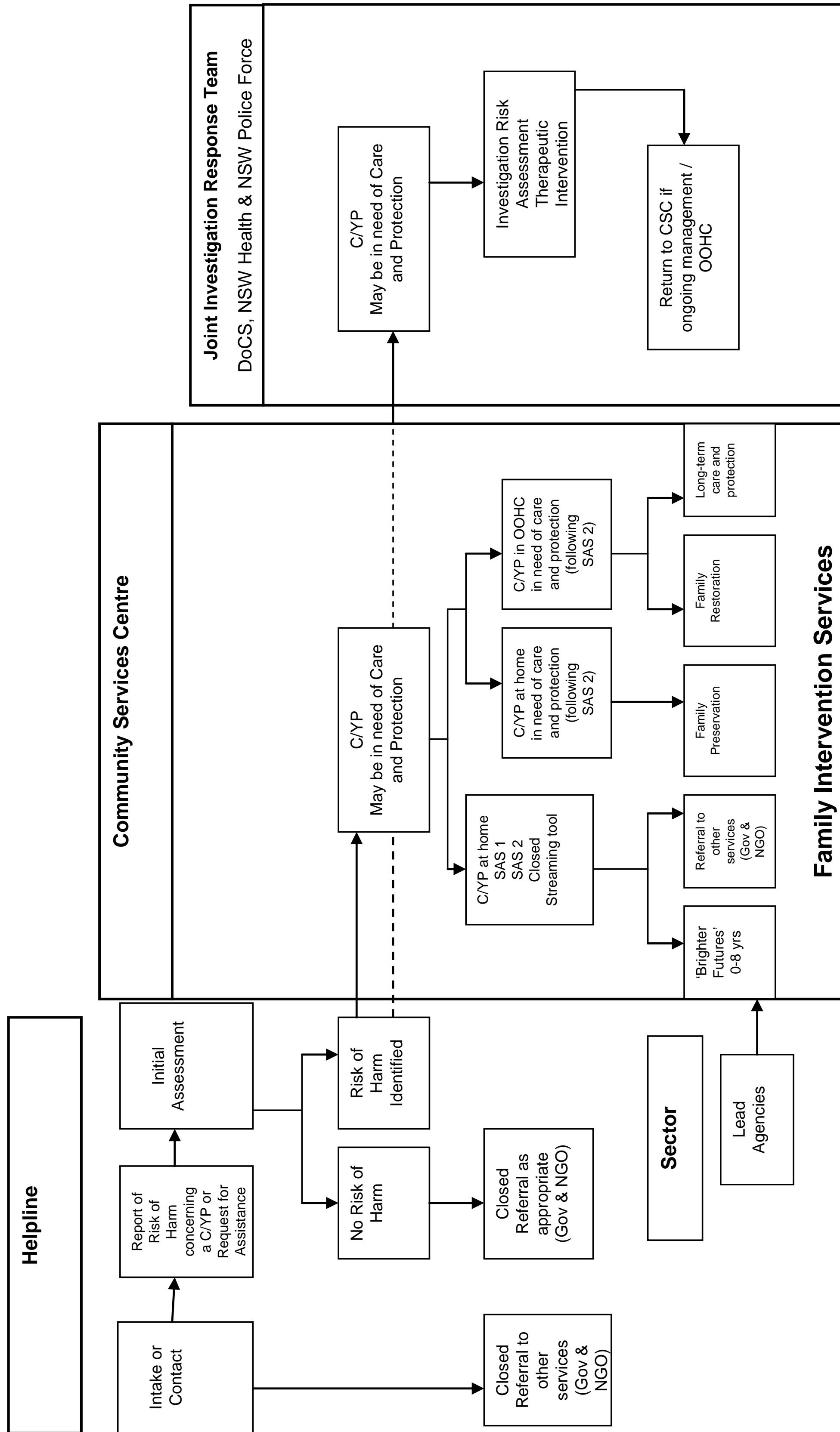
e. Secondary Assessment Stage Two.

8.13 At each of these stages the process can be stopped and the case closed if the conclusion is reached that there is insufficient risk of harm to continue assessment. Whilst KiDS provides guiding questions for caseworkers during the initial assessments there is no formal weighting of the variables that are investigated.

8.14 In this chapter the Inquiry identified the current framework for assessment, and the range of casework interventions that are available. In the following chapter the issues arising and possible solutions are examined.

[535] Submission: DoCS, Child Protection Assessment Models and Process, p.38.

Figure 8.1 **Overview of Child Protection Intake, Investigation and Assessment Process**



Assessment by the Helpline

8.15 The Contact and Initial Assessment stages occur at the DoCS Helpline. The Helpline is a 24 hour a day, seven days a week service that handles over 5,200 contacts a week including inquiries, requests for assistance, comments and complaints, and child protection reports. It also provides an after hours response service for the Sydney metropolitan area, and directs the work and exercises statutory casework delegations for the after hours response in non-metropolitan areas.

8.16 The Helpline was established in December 2000 in response to a recommendation of the Police Royal Commission and the recommendations of a number of prior reviews that DoCS improve its child protection intake services.[536] The opening of the Helpline coincided with the commencement of the Care Act, which also broadened the definition for a report of a child at risk of harm. The Helpline was initially staffed with 54 caseworkers.[537] Prior to that time, child protection concerns were directed to CSC intake teams, with no prior triage and no prior recording of the total workflow to each CSC.

8.17 More than 95 per cent of reports are made to the DoCS Helpline, where staff record the details of contacts and initial assessments into KiDS. The Helpline is required to answer calls in an average of three minutes. In 2007/08, calls were answered in an average of two minutes and 56 seconds, which was a slight improvement on the 2006/07 average of two minutes and 59 seconds.[538]

8.18 Child protection reports are recorded and assessed at the Helpline by caseworkers. The Helpline has over 250 staff working in shifts. There are 30 caseworker teams each comprising a Team Leader and six caseworkers. Six teams make up a Unit, which is led by a Manager Helpline. There are six Managers at the Helpline. They report to the Director Helpline who is accountable to the Executive Director Statewide Services for the day to day operations of the Helpline and the Domestic Violence Line. Supporting the frontline work are first, teams of Community Service Officers that handle general inquiries, secondly, subject matter experts and finally, business support staff.

Contact

8.19 The first point of communication between DoCS and a person or agency is documented in a contact record. At the Helpline a caseworker or a Community Service Officer gathers information from the reporter and records it on the KIDS contact record. Reasons for contact are classified as one of the following:

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[536] Performance Audit of the Helpline, *Auditor-General's Report*, June 2005, p.6.

[537] ibid., p.11.

[538] DoCS, *Annual Report 2007/08*, p.45.

a. report of concern for a child, young person or unborn child (risk of harm or homelessness)

b. request for information, advice or assistance about DoCS business (for example, adoption or fostering).

8.20 At this point a decision is made on whether an Initial Assessment is required. The Care Act identifies the separate situations when an Initial Assessment should be carried out:

a. suspected risk of harm (Chapter 3, Part 2)

b. report of homelessness (Chapter 7, Part 2)

c. request for assistance from a child, young person or parent/care-giver (Chapter 3, Part 1), although this is a very small proportion of DoCS work

d. request for assistance by a child, young person, a parent or another person regarding serious and persistent family conflict or parental inability to adequately supervise a child or young person (Chapter 7, Part 1).

8.21 If the information gathered at the Contact stage does not meet any of these criteria then the matter is closed and no further action is taken.

Initial Assessment Stage One

8.22 This is the first stage in the gathering and analysis of information to determine if a child, young person or unborn child is at risk of harm. A plan in KiDS is created to document the information. Generally situations requiring this assessment fit into two types – requests for assistance and risk of harm.

8.23 The key action for a request for assistance is to determine whether it does or does not constitute a risk of harm. If it does not, information and advice is provided as required.

8.24 The caseworker makes an assessment of whether the child or young person is at risk of harm by taking into account age, development and vulnerability of the child or young person. Risk of harm is defined in s.23 of the Care Act. If, after assessing the information and after consultation and approval by a Helpline Team Leader, the caseworker determines that no safety concerns exist or that the child is not at risk of harm then the Initial Assessment is closed at Stage One. However if risk is identified the report proceeds to Stage Two of the Initial Assessment.

Initial Assessment Stage Two

8.25 This stage is undertaken without direct contact with the child, young person or family, unless the reporter is the child or young person or a family member.

8.26 Where there is an open case plan recorded in KiDS,[539] the Helpline caseworker will determine if the information received constitutes a new report or whether it should be forwarded to the CSC for information only. If it is determined that the information received constitutes a new report, the Helpline will open a new plan and undertake an Initial Assessment.

8.27 Information retrieved from a history search undertaken by the Helpline caseworker is considered in conjunction with the reporter's concerns. This is an important step because consideration of previous reports and/or protective action taken by DoCS may change the significance of the information provided by the reporter. Information that is of particular relevance includes:

a. previous episodes of abuse and neglect and any patterns arising from these

b. previous or current Children's Court orders and placements in OOHC

c. previous assessments or actions by DoCS

d. any complicating parenting issues such as domestic violence, parental misuse of drugs or alcohol or mental health concerns.

8.28 The Helpline caseworker is then required to undertake an analysis of the issues. Decisions are then made about the safety of the child or young person (extremely unsafe, moderately safe, safe or unknown); the degree/severity of the harm (high, medium or low); and the future risk of harm (highly likely, likely, unlikely, unknown).

8.29 If the Helpline assesses that a child or young person may be in need of care and protection, a case plan is generated and referred to a CSC or JIRT[540] for further assessment. If it is determined the child or young person is at immediate risk of serious harm, and it is out of hours, the Helpline or the relevant regional after hours response team, will initiate an immediate field response.

8.30 A timeframe for a required response and an assessed level of risk is given in the plan. They are within 24 hours (commonly known as a Level 1 report), within 72 hours (commonly known as a Level 2 report) and within 10 days (commonly known as a Level 3 report).

8.31 In addition to the general Helpline response teams handling incoming calls from reporters, there are a number of specialised teams. There is a dedicated response team that takes calls from school/child care mandatory reporters. The Helpline is also in the process of trialling a similar specialised team for health

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[539] A 'case plan' is an accurate record of the plan that has been developed to address the needs of a child or young person that are identified through assessment. DoCS develops a case plan when the outcome of the Initial Assessment is referral to the CSC/JIRT for further assessment: DoCS, Intranet, *Case planning and casework practice.*

[540] In the Metropolitan region these are co-located teams of Police and DoCS. In rural areas these services are generally not co-located although provide the same joint response.

mandatory reporters, and preliminary advice to the Inquiry suggests that this is working well.

> *I have information in front of me that two of the three Team Leaders and eight caseworkers have a very strong background working in the health system. They use that background to assist them when they are making assessments that come in from health professionals. We believe that we are making some improvements in that area already.*[541]

8.32 The then Executive Director, Helpline provided the Inquiry with the following case example:

> *I was informed about a call that involved a baby who was at an immunisation clinic. This was a child under 12 months. As the injection was given, the child was crying but very, very softly. Because that piece of information was heard by somebody who understood failure to thrive and some other indicators around that particular form of emotional abuse and developmental issues for that child, that information was picked up as a very high priority. The CSC intervened very quickly and got the child to the doctor. The child was assessed by that doctor as being almost life threateningly ill. I know that is one story, but I don't think that before November last year we would have been as confident that we would regularly pick up and be able to recognise those signs because we didn't have a cluster in place with the specialised expertise working on calls to the Helpline.*[542]

8.33 CSCs generally have dedicated child protection staff whose specific role is to manage the receipt of reports from the Helpline at the point of intake. The number of staff dedicated to this function in each CSC is determined by the number of child protection casework staff in the CSC and the average annual reports sent through to the CSC.[543]

Assessment and response by CSCs

8.34 The primary function of caseworkers performing an intake function at the CSC is to manage the receipt of all plans from the Helpline and to prioritise matters requiring a field response. This process builds on, or clarifies, the information obtained by the Helpline during Initial Assessment and takes local knowledge into account for the purposes of analysis.

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[541] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, A Gallard, Deputy Director-General, Operations, DoCS, p.34.

[542] ibid., p.35.

[543] DoCS, *CSC Intake Discussion Paper*, Tab C, Intake at a CSC, pp.1-2.

8.35 As discussed earlier, DoCS uses a guided professional judgement model known as Secondary Assessment – Risk of Harm Framework that includes the collection and analysis of information and the exercise of professional judgement. The outcome is a professional opinion about safety, risk and harm that informs a decision about a child's or young person's need for care and protection and subsequent case planning. For this purpose Secondary Assessment - Risk of Harm is divided into two stages: Secondary Assessment Stage One (SAS1) and Secondary Assessment Stage Two (SAS2).

Case allocation

8.36 The December 2002 report of the Kibble Committee found that the allocation rate across all reports, that is the number of reports which were allocated to a caseworker at a CSC was around 30 per cent.

8.37 As discussed in Chapter 2, at that time, the allocation rate of reports with a required response time of less than 24 hours was 55 per cent, for reports with a required response time of less than 72 hours it was 26 per cent and for reports with a required response time of less than 10 days it was 12 per cent.[544] The findings of the Kibble Committee were influential in relation to the NSW Government's decision to increase the DoCS budget and therefore substantially increase DoCS caseworker numbers.

8.38 DoCS has advised that, based on KiDS data, recent statewide allocation rates for child protection reports referred to CSCs/JIRTs for further assessment are as follows:

Table 8.1 **Allocation rates for child protection reports**

Required response time	*Allocation rate (%) 2006/07*	*Allocation rate (%) 2007/08*
Less than 24 hours	97.2	98.0
Less than 72 hours	66.3	75.5
Less than 10 days	45.9	55.9

8.39 At first blush it appears that, on this indicator, remarkable improvements have occurred. However, the Inquiry is of the view that these figures should be viewed with caution. DoCS defines the allocation rate as "the proportion of all reports referred to a CSC/JIRT for further assessment that had a secondary assessment (SAS1 or SAS2 recorded as completed or ongoing)." This means that DoCS allocation rates do not equate to the number of cases that receive a field response (that is, a face to face visit) or are subject to ongoing case management.

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[544] Information provided to Government by DoCS, March 2008.

8.40 If the definition of case allocation were to mean that a case received a field response, then allocation rates would have to be calculated using data on the number of reports that proceeded to a SAS2 (including those reports that were subject to an ongoing secondary assessment at the time the data was captured). If this were the case, then DoCS 2007/08 allocation rates for reports with a response time of less than 24 hours would be much lower than 98 per cent.

8.41 It is not clear what counting rules were used by the Kibble Committee. At the time of the Kibble Committee's deliberations, DoCS Priority One Policy was in force. While allocation was not formally defined under Priority One, the policy does refer to determining "priorities for allocation and field action response,"[545] which seems to indicate that allocation involved a field response. The Kibble Committee report appears to take a similar view, distinguishing between action taken after a case is allocated and initial action taken prior to allocation. An indication that the allocation rate in 2002 may have been calculated using different counting rules from those in 2007/08 is found in the advice DoCS provided to government in 2002:

> *DoCS is only able to allocate 55 per cent of Level 1 Reports to a caseworker. Of the 45 per cent unallocated, six per cent are closed under the Priority One policy…The other 39 per cent receive a minimal level of assessment and some telephone follow-up and monitoring.*[546]

8.42 This 'initial investigation or action' or 'minimal level of assessment' could refer to the Initial Assessment at the Helpline or it could refer to the office based investigation/assessment undertaken at the CSC (currently known as the SAS1). Therefore, given the lack of clarity over the definition of allocation rates in 2002, the Inquiry is of the opinion that it is of little value to compare 2002 allocation rates with 2007/08 allocation rates. It may be a case of comparing apples and oranges.

8.43 The Inquiry has found that there is a difference between CSC staff perception of case allocation and the way DoCS counts the allocation rate centrally. Many but not all CSC staff the Inquiry spoke with appeared to equate case allocation with a field response and therefore a SAS2.

8.44 The Inquiry is of the view that DoCS should adopt a more realistic approach to reporting on its allocation rates which differentiates between SAS1 and SAS2.

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[545] DoCS, *Priority One Policy*, February 2002, p.4.
[546] Information provided to Government by DoCS, March 2008.

Secondary Assessment Stage One at the CSC

8.45 At a CSC an Intake team/worker undertakes a SAS1, which generally does not involve face to face contact with the child or family. The key objectives of CSC intake through a SAS1 are to:[547]

a. ensure all relevant information held by DoCS about reported children and young persons and their parents/carers is reviewed – this includes the most recent approved SAS1 or SAS2 that contains an analysis of prior child protection history, recent assessments or information on file from agencies and other professionals that informs the child protection history and reference to whether or not there have been recent reports without a secondary assessment

b. confirm or change the initial rating of safety as assessed by the Helpline and commence the process of reviewing risk

c. provide the groundwork for an assessment where the resulting professional opinion provides a rationale to support decisions by DoCS to intervene in the life of a family where necessary to stop harm, reduce risk of harm and provide increased safety

d. assign priority for any further intervention as required including making a decision about further CSC intervention.

8.46 The Manager Casework[548] with responsibility for intake, reviews the plans received from the Helpline, and either:

a. refers the plan to the Early Intervention team following application of a case streaming tool to determine eligibility

b. refers the plan to the OOHC team (if the child or young person is in OOHC and the issue does not appear to require a child protection investigation)

c. refers the plan directly to the Child Protection team for a SAS2 which involves a field based assessment

d. closes the plan because there is information, which indicates that the reported child or young person is no longer at risk of harm, or there are other, more urgent or higher risk, 'competing priorities.'

8.47 Presently (as a result of different practices and inconsistency) DoCS is in the process of standardising its intake function within CSCs.[549] New procedures to bring about greater consistency include the following:

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[547] DoCS, *CSC Intake Discussion Paper*, p.4.

[548] In CSCs, caseworkers report to a Manager Casework who generally manages one of the DoCS program areas: Early Intervention, Child Protection or OOHC. Depending on the size of the CSC, there may be either a dedicated Intake Child Protection team or in the case of smaller CSCs, one of the managers will be given responsibility for Intake. Typically, this may be the Child Protection Manager or the Early Intervention Manager. DoCS, *CSC Intake Discussion Paper*, p.4.

[549] DoCS, *CSC Intake Discussion Paper*, p.4.

a. intake roles will not be rotated amongst other teams as is presently the case in some CSCs

b. larger metropolitan/regional CSCs will have a team of intake caseworkers reporting to the Manager Casework (Intake)

c. for smaller CSCs, the intake caseworker will be part of the Child Protection team at the CSC.

Secondary Assessment Stage Two at the CSC

8.48 In determining which matters proceed to a SAS2, consideration is given to the immediate safety factors and the potential harm impacts for the child or young person. Where there have been multiple previous reports about a child or young person, the DoCS policy states that potential for cumulative harm impacts for the child or young person must be also taken into account.[550] Consideration must also be given to the characteristics of the child or young person such as the child's or young person's age, functioning or special needs that can increase reliance on a parent/carer, and any protective factors that may exist for the child or young person, such as a supportive school or the involvement of other services.

8.49 Specific factors that may signal high risk and therefore the need to proceed to a SAS2 include:[551]

a. inability of the primary care-giver to function due to alcohol, other drug misuse or mental illness

b. a history of suspicious death within the family, or injury to the child or other siblings

c. a report of serious injury

d. any history of parent/carer delay in seeking necessary medical attention or failure to meet health care needs for a child/young person in their care

e. current access to the child or young person by a person known to DoCS as a Person Causing Harm

f. previous protection action by DoCS for the subject child/young person, siblings other children/young persons in the same household

g. a pattern of recurring harm or risk and an escalation in the seriousness and/or frequency of reports

h. a history of parent/carer not providing adequate supervision relative to the age of the child or young person

i. the family having a transient lifestyle following contact by DoCS or another child protection agency

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[550] Submission: DoCS, Assessment Model and Process, p.40.

[551] DoCS, Intranet, *Secondary Assessment – Risk of Harm, Casework Practice.*

j. a pattern of multiple reports of a child under five years that may suggest chronic neglect.

8.50 As part of a SAS2, the caseworker makes contact with and visits the reported child or young person and his or her family, conducts investigative interviews, gathers information from other sources such as schools, Police and relevant non-government services, and arranges for assessments from doctors, psychologists and other professionals, as necessary. Once the information is compiled, an assessment is made regarding the child's or young person's safety and well-being. This information is recorded on the KiDS system.

8.51 Following completion of the SAS2 a determination is made by DoCS as to whether the child or young person appears to be in need of care and protection. There are three possible decisions that can result from a completed secondary assessment:

a. actual harm substantiated: where there is sufficient information to indicate on reasonable grounds that the child or young person has been harmed physically, sexually, psychologically or through neglect

b. risk of harm substantiated: where there is sufficient information about the likely harm consequences and harm probability to enable a judgement on reasonable grounds about the level of risk for the child or young person

c. unsubstantiated: where the secondary assessment has determined that there are no reasonable grounds to suspect that the child or young person had experienced actual harm or is likely to be at future risk of harm.[552]

8.52 Where a case is substantiated and the child or young person is found to be in need of care and protection a case plan is developed which aims to address the care and protection issues identified in the SAS2.

8.53 Where risk of harm or actual harm has been identified, immediate court action may be considered to ensure the safety of the child or young person. Ongoing work with the child or young person and family may be through intervention with parental agreement or through a care order in the Children's Court.[553] Otherwise, case planning, in conjunction with the child or young person and family, commences. Case management incorporates ongoing assessment of the child's or young person's safety and well-being, coordinating service provision, monitoring, reviewing outcomes and case closure when a child's or young person's ongoing safety is secured.

8.54 DoCS has a statewide review of secondary assessment practice underway to identify supports that need to be put in place to improve practice, such as whether any streamlining of the secondary assessment framework is required.

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[552] The analysis of likelihood of harm is focused on the adults in the life of the child or young person. *NSW Interagency Guidelines for Child Protection Intervention,* 2006, Chapter 3, at 3.3.5.

[553] See Chapters 11 and 13 for actions in the Children's Court.

Case closure

8.55 In principle, all plans transferred from the Helpline to a CSC for further assessment should receive a secondary assessment. However, the level of demand for further assessments has often exceeded the available CSC resources. Community expectations are that most reports to DoCS will result in allocation of the report to a caseworker for a comprehensive assessment and intervention. The reality of the current system is that while all reports receive a level of preliminary assessment by the DoCS Helpline, DoCS prioritises its child protection casework services to those children who are most at risk with a particular focus on children with specific vulnerabilities.

8.56 Case closure can occur at any stage during the various child protection assessment processes, including after commencement of a SAS2. Reasons for case closure include relative priority of the report compared with other reports and current casework resources of the CSC.

8.57 DoCS' new Intake Assessment Guidelines have recently been implemented and aim to increase consistency by assisting Managers Casework responsible for intake in deciding which matters to allocate and when to close cases.

8.58 According to the guidelines:

> *1.1 All Plans transferred from the Helpline to a CSC for further assessment/investigation should receive a Secondary Assessment. However, where the level of demand for further assessments exceeds the available CSC resources, the Manager Casework will exercise professional judgement in determining relative risk/priority amongst plans.*
>
> *1.2 All Plans must receive secondary assessment OR be closed within 28 days of receipt at the CSC.*[554]

8.59 High priority cases which will not normally be closed without a secondary assessment are those where a response is required within 24 hours and the child is under five years of age and those where a response is required within 24 or 72 hours and one or more of the following factors exist:

a. The primary (or significant) care-giver's functioning or ability to parent is impaired due to: current alcohol and/other drug use; unmanaged mental illness; intellectual disability; emotional state of the carer; persistent care-giver hostility; and/or suicide risk/attempt of carer.

b. Reported issues relate to neglect, such as: necessary medical care not arranged; basic physical or psychological needs not met or at risk; non-

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[554] DoCS, *Intake Assessment Guidelines*, November 2007, p.3.

organic failure to thrive; inadequate supervision for age; inadequate shelter/homeless; and/or children abandoned in the car.

c. Reported issues relate to domestic violence involving injury or use of a weapon where the child or young person is exposed to the violent incident and is likely to have suffered physical or psychological harm.

d. The child has high support needs, such as, disability or illness.

e. Within the past six months, there have been two or more plans for the child (or sibling living in the same circumstances) closed without a SAS2 completed.

f. The child has siblings with a significant[555] DoCS history of abuse or neglect, or have been removed, or are in care.[556]

g. The plan concerns an allegation against an 'authorised carer', DoCS employee or employee who works with children in a non–government or government agency.

8.60 The guidelines state that plans should be closed immediately without secondary assessment where either:

a. the child or young person is deemed safe and not in need of care and protection

b. the plan does not meet the high priority criteria and/or is of lower risk/priority relative to other plans on hand and the Manager Casework determines that it will not be possible to conduct a SAS1 with existing resource levels within the required 28 day period (in such plans the reason should be recorded on KiDS as 'Current Competing Priorities' in the 'Plan Closure Reason' field).

8.61 The guidelines state that at a minimum a weekly case allocation meeting should occur with the Manager Casework responsible for the intake function, and one other Manager Casework, to review the plans listed as unallocated or listed for immediate closure. Where high priority cases cannot be allocated they are to be referred to line management to see if there is the possibility that another team or CSC can assist.[557]

8.62 The Ombudsman in a review of a child death raised concerns about these guidelines stating:

> *It is apparent to us that allocation decisions which are made on the basis of relative risk will, under the proposed guidelines as now, favour young children and those who are at immediate risk*

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[555] Significant means history of serious abuse and neglect.

[556] Including all children with siblings who have a significant history of risk of harm reports and/or DoCS intervention that may or may not include Children's Court proceedings, and/or a history of placement in short or long term OOHC as a result or DoCS intervention. This also includes all children with siblings who are or have previously been subject to a Temporary Care Agreement.

[557] DoCS, *Intake Assessment Guidelines*, November 2007, pp.9-11.

of harm. Whilst at one level this appears reasonable, it remains unclear to us how the system will ensure children reported to be neglected over time, will receive timely child protection intervention. This is even more so given that the department's practice rules for streaming reports to early intervention teams exclude reports assessed by the Helpline as high risk.[558]

8.63 The Ombudsman has correctly noted that there is a need to give appropriate weight to the urgency of the response required as well as the assessed risk level. This is particularly so for cases involving neglect.

8.64 Child protection work will always involve prioritising resources which will affect the allocation of cases. These guidelines seek to do so based on available research. Elsewhere in this report, suggestions and recommendations are made designed to ensure that more families receive assistance, not just from DoCS, and that caseworkers become more skilled and have access to the necessary expertise to assess reports and families. The particular position of adolescents is also addressed, since it is they who are most likely to suffer from the application of these guidelines.

NSW casework practice

Case management

8.65 Case management is a strategy that aims to mobilise, coordinate and maintain a diversity of services for the individual child or young person and his or her family.[559] It has been described as the "glue that holds the system together,"[560] or the "lynchpin for an effective interagency system."[561]

8.66 Case management performs a range of functions. It ensures that services are suited to the individual child and family, are clinically and culturally appropriate, and lead to desired outcomes.

8.67 The Interagency Guidelines describe case management as the process of assessment, planning, implementation, monitoring and review that aims to support families and decrease risks to children and young persons. The

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[558] NSW Ombudsman, *Investigation into the death of a child*, *Provisional Statement,* 2008. At the time of writing the guidelines had not been fully implemented.

[559] BA Stroul and RM Friedman, "A system of care for children and youth with severe emotional disturbances (revised edition)," *Georgetown University Child Development Center,* 1986, cited in DoCS, *Models of service delivery and interventions for children and young people with high needs, Literature Review*, 2006, p.35.

[560] ibid.

[561] M J England and R F Cole, "Building systems of care for youth with serious mental illness," *Hospital and Community Psychiatry 43(6),* 1992; pp.630-633; E M Z Farmer, S Dorsey and S A Mustillo, "Intensive home and community interventions," *Child and Adolescent Psychiatric Clinics of North America, 13(4),* 2004, pp.857-884, cited in DoCS, *Models of service delivery and interventions for children and young people with high needs*, *Literature Review,* 2006, p.35.

process should have an emphasis on ongoing analysis, decision making and record keeping.

8.68 The Interagency Guidelines state that where there are no risk of harm concerns, or where these have been sufficiently resolved, and other agencies continue to provide services to a family, any agency can assume the role of case manager.[562]

8.69 For child protection matters, case management remains with DoCS, primarily because of the Department's statutory responsibilities, which include investigation, decision making regarding removal and court work. However, interventions with children, young persons and families are often achieved without the need for a care order.[563]

8.70 Case planning is a key component of the case management process and is the mechanism for decision making and directing DoCS work with children and their families and/or their carers. The case planning process in child protection should be informed by ongoing assessment of the circumstances of the child or young person in the context of the family and/or carers.[564] A case plan is developed to address the assessed needs of the child, young person or his or her family. DoCS' policy states:

> *A case plan is an accurate and up-to-date record of the plan for DoCS action to address the needs of the child identified through assessment. Case planning ensures that all parties are clear about the goals and objectives of DoCS involvement, the issues to be addressed and responsibilities of all parties for the tasks involved.*[565]

8.71 Most of the casework decisions, which have been delegated from the Minister or Director-General rest with the caseworker's supervisor, the Manager Casework.

Referral, monitoring and supervision of families in statutory child protection

8.72 Referrals within the context of casework are made in accordance with the legislative requirements and principles as contained in the Interagency Guidelines and include:

a. Requests for services (s.17 of the Care Act) which authorises DoCS to make a request to another government department or a community partner

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[562] *NSW Interagency Guidelines for Child Protection Intervention,* 2006*,* 3.7 at p.15.

[563] DoCS, *Child and Family and Out-Of-Home Caseworker Manual (draft) Chapter 5, Ongoing Casework Interventions*, 2007, p.60.

[564] DoCS, Intranet, *Case Planning Policy.*

[565] ibid.

in receipt of government funding to provide services to promote the safety, welfare and well-being of the child or young person.

b. Best endeavours (s.18 of the Care Act) means using a genuine and considered effort by a government department or agency to respond to a request for service. The service does not have to be provided if it is out of the range of the service provider's expertise or responsibility.

8.73 DoCS' policy states that referrals for current DoCS clients involve:

> *making contact with the service provider for or on behalf of the client. The referral process is followed by seeking information from the service provider as to whether or not the client engaged the service and discussion about outcomes of service provision."*[566]

The policy also states that referrals need to be monitored for various reasons including their uptake, the ability of an agency to provide a service, and the immediate and ongoing safety, welfare and well-being of children, young persons and adults. Details of the agency providing the service and the type of service should also be recorded.

8.74 DoCS' policies and procedures also stipulate that monitoring is a key element of case planning and requires regular feedback from the child, carers, and service providers as to whether services are being provided in the manner determined by the case plan and whether the needs of the child have changed.

8.75 DoCS advised the Inquiry that it has introduced a portal, which now enables Brighter Futures Lead Agencies to receive electronic referrals from DoCS and provide information on casework services. This however is limited to Brighter Futures but DoCS states that over time this could be expanded to non-government services for child protection and OOHC. Presently KiDS has the capacity for caseworkers to record information about referrals to services but DoCS advised that follow up relies on the caseworker establishing contact with the service provider on a regular basis.

Casework interventions

8.76 Some of the key strategies in NSW follow.

Prenatal reports

8.77 In 2006/07 for every 1,000 children in NSW, around 78 were reported to DoCS. The rate of reporting about children aged less than one year is considerably

[566] DoCS, Intranet, *Information and Referral Policy*.

higher than for all other age groups.[567] For every 1,000 children aged less than one year in NSW, 136 were reported to DoCS.[568]

8.78 The evidence base indicates that the period of pregnancy and the period immediately following the birth of a child are among the most vulnerable periods in human development. It is critical that at risk pregnant women are identified and engage with appropriate support services to reduce the risks to children in utero and at birth. The research also suggests that pregnancy is a key life stage where a pregnant woman may be more inclined to make positive changes for her child.[569]

8.79 In NSW, research undertaken by the Ombudsman as part of his review of child deaths, has also highlighted the need for an improved health and statutory child protection response to prenatal reports. For example, the *Report of Reviewable Deaths in 2004* found that 11 of the 72 children who died and who were known to DoCS were the subject of a prenatal report and that maternal substance use during and after pregnancy was a factor in most of the deaths. The report also found that prenatal reports are commonly given a low child protection response level, closed at the CSC without undergoing any further assessment (of future risks or relevant history) and rarely involve interagency meetings with Health staff or others.[570]

8.80 The *Report of Reviewable Deaths in 2005*, noted similar concerns to the 2004 report and stressed the particular importance of improving protection for children born into a family where serious parental drug use is occurring. Of the total 117 reviewable child deaths in 2005, 51 per cent of the children were aged less than 12 months.[571] The report noted that in at least 10 of the 69 deaths of children known to DoCS, there were prenatal reports that raised concerns about substance abuse on the part of the mother.[572] In reviewable death cases where parental substance abuse was evident, almost two thirds of the children were under 12 months of age when they died.[573] In 2006, 59 per cent of reviewable deaths were children less than 12 months, of which 48 per cent were children aged less than one month.[574]

8.81 Amendments were made to the Care Act which came into effect in March 2007, to extend the circumstances in which a child or young person is taken to be at risk of harm. Section 23 now includes as a risk circumstance the fact that the child was the subject of a prenatal report under s.25 and that the birth mother

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[567] The rate for children aged less than one year is likely to be artificially inflated by small amount because DoCS data contain prenatal reports, whereas the base population only includes born children: DoCS, *A closer look: recent trends in Child Protection Reports*, December 2007.

[568] DoCS, *A closer look: Recent trends in Child Protection Reports*, December 2007.

[569] M Butler, "Pregnancy, opportunity or invasion," *Of Substance, Volume 5 (1),* 2007 cited in DoCS, *Responding to Prenatal Reports Policy Draft*, August 2007, p.7.

[570] NSW Ombudsman: *Report of Reviewable Deaths in 2004*, December 2005, p.83.

[571] NSW Ombudsman: *Report of Reviewable Deaths in 2005*, *Volume 2: Child Deaths,* November 2006, p.6.

[572] ibid., p.18.

[573] ibid., p.9.

[574] NSW Ombudsman: *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths,* December 2007, p.14.

did not engage successfully with support services to eliminate or to minimise the risk factors that gave rise to the report to the lowest level reasonably practical. The note to s.25 clarifies that prenatal reports are to enable assistance and support to be provided to the expectant mother to reduce the likelihood that her child when born will need to be placed in OOHC, and to provide early information that a child who is not yet born may be at risk of harm subsequent to his or her birth, and in conjunction with ss.23(f) and 27 to provide for mandatory reporting if there are reasonable grounds to believe that the child will be at risk of harm subsequent to his or her birth.

8.82 DoCS, together with Health have developed a Responding to Prenatal Reports Policy in response to the need for DoCS to provide clearer policy guidance for caseworkers to help them respond to prenatal reports. This was endorsed in March 2008. NSW Health currently provides services for drug and alcohol of misuse in pregnancy and mental health issues, such as Safe Start, which, as outlined earlier, includes psychosocial assessment and depression screening for pregnant and postnatal women.

8.83 A two tier system forms part of the prenatal policy:

a. After receiving a prenatal report DoCS will issue a s.248 direction for information relating to the safety, welfare and well-being of an unborn child. This direction will be issued via the Area Health Service Section 248 Central Contact Point and will act as notification of a prenatal report to the specific health service to which it is directed.

b. In high risk cases DoCS will issue an Unborn Child High Risk Birth Alert form to s.248 Central Contact Points. The Central Contact Points will distribute the form to relevant health services within their auspices and this will act as notification of a prenatal report to those services.

8.84 The policy provides directions to caseworkers at the Helpline and CSCs about the required response to prenatal reports of risk of harm to an unborn child. This may reduce the likelihood that the child, when born, will need a child protection response. Health is currently consulting with its Primary Health and Community Partnerships Division about discharge options and follow up services for mothers whose babies develop Neonatal Alcohol Syndrome.

8.85 A trial of the policy commenced in June 2008 in three CSCs and the Helpline, and will be evaluated externally. A list of antenatal and maternity services across the State has been developed. This service mapping across NSW Area Health Services and DoCS regions provides a picture of service availability not previously collated by either DoCS or Health, and it is an initiative that this Inquiry fully supports.

8.86 It is intended that the prenatal reports policy will impact on the expanded AMIHS, which is outlined in Chapter 18, as Aboriginal women are likely to be strongly represented in the target group of prenatal reports. Along with the mainstream antenatal and maternity services mapped in the policy, the mapping

of current and planned services under the strategy should ensure caseworkers are aware of this service stream.

Intensive support and family preservation services

8.87 Family preservation programs are a key part of the service spectrum in many Australian and overseas jurisdictions. The most well known family preservation program is the Homebuilders Program, developed in 1974 through the US Institute for Family Development as an alternative to unnecessary out-of-home placements.

8.88 Family preservation services are primarily designed to maintain children aged from 0-15 years with their family and/or extended family and to encourage engagement with appropriate support networks to prevent these children from entering OOHC.

8.89 DoCS recently conducted an expression of interest process to establish this model across NSW. Under the new service model family preservation services will target families where children are reported at risk of harm and are most likely to escalate into OOHC without this service intervention. The model also includes provision of intensive support services to restore children in OOHC to their family or to better engage older children (12-15 years) with appropriate support networks where they may be living with their family or living independently of their family but not in formal OOHC.

8.90 Health notes in its submission to the Inquiry that:

> *… other Australian States also have models for intensive family treatment that may be useful for informing future service planning in this area. Queensland has established 'Evolve' Interagency teams which provide therapeutic and behaviour support services for children on child protection orders and in out-of-home care who have significant behavioural and psychological issues and/or disability behaviour support needs. Mental health professionals and psychologists, speech and language therapists work in collaboration with school guidance officers and child safety officers.*[575]

8.91 The Inquiry is aware that, in comparison with Victoria, Queensland, ACT and Western Australia, NSW has significantly fewer children and young persons accessing intensive family support services.[576]

8.92 The Inquiry supports the establishment of this model and the extension of these services in NSW. A recommendation is made to this effect in Chapter 10.

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[575] Submission: NSW Health, 3 March 2008, p.13.

[576] Australian Institute of Health and Welfare, *Child Protection Australia 2006-07,* Child welfare series no. 43, 2008, p.66.

Aboriginal Intensive Family Based Services

8.93 DoCS Intensive Family Based Service (IFBS) is a child protection intervention program primarily for Aboriginal families in NSW. Presently there are six Aboriginal IFBS and one generalist IFBS operated by UnitingCare Burnside.

8.94 Families at risk of having their children removed, or families requiring intensive intervention so that reunification can occur, are eligible for IFBS. The IFBS aims to protect children, prevent potential OOHC placement and build on family skills and competencies working in partnership with the family and community.[577]

8.95 IFBS is delivered primarily in the home or in a community setting with caseworkers available to families 24 hours a day, seven days a week, for the time limited 12 week intervention. IFBS is provided by a small service team, comprising a manager, and up to four caseworkers each with a caseload of two families.[578]

8.96 The service comprises a mix of concrete and clinical supports. Skills development such as parenting, self-management, household management and budgeting, hands on assistance in areas such as house cleaning and transport, provision of basic furniture, white goods, and assistance to organise government benefits and other needs are among the concrete supports provided by IFBS.

8.97 IFBS was funded in 2007/08 to a total of $3.2 million. This included $1.98 million funded through DoCS operating funds, plus $1.22 million through *Two Ways Together*[579] in 'special initiative' funds.

8.98 In 2006/07, 265 children were receiving IFBS services, and one half of these children were aged under 10 years.

8.99 A 2008 evaluation of the DoCS IFBS program demonstrated that families receiving IFBS received significantly fewer reports on average in the three, six and 12 month post-intervention periods and in the three, six and 12 month pre-intervention periods.[580] The impact on reported issues of carer drug and alcohol, carer mental health and neglect were found to be significant.

8.100 The program was described by stakeholders participating in the evaluation as a "highly appropriate service for Aboriginal client families"[581] and the evaluation recorded client families as providing positive views about their involvement with

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[577] DoCS, *Aboriginal Intensive Family Based Service (IFBS) (Family Preservation Service) Principles and Service Model Description*, October 2007, pp.4-5.

[578] DoCS*, Draft IFBS Evaluation Report*, March 2008 p.9.

[579] *Two Ways Together* is the NSW Government's ten year whole of government Aboriginal Affairs plan (see Chapter 18).

[580] DoCS, *Draft IFBS Evaluation Report*, March 2008, p.29.

[581] ibid., p.11.

the program, indicating that IFBS "provided a holistic intervention in which they did not feel threatened."[582]

8.101 Economic evaluation was also positive, demonstrating a net average benefit per family of $44,712 in the long term, which showed that the program benefits outweighed program costs and provided value for money to the community.[583]

8.102 The evaluation identified strategies to improve the referral rates to IFBS and also to improve post-intervention support, including funding a step down worker, the use of Brighter Futures services and greater use of CSGP funding to assist these families.[584] DoCS informed the Inquiry in June 2008 that the Aboriginal Services Branch within DoCS had commenced work on an action plan to address these recommendations, to be progressed under the Child Protection Major Project.[585]

8.103 However, DoCS states that the capacity of Brighter Futures to absorb post-IFBS intervention clients is currently limited, given that the largest single age range (40 per cent) represented in the IFBS client population is 9-14 years, which is outside the current Brighter Futures program range. In addition, a number of families require more intensive ongoing support than that which can be provided through the Brighter Futures program.[586]

8.104 DoCS recently approved a strategy for enhancing post-intervention support pathways to ensure IFBS families receive between three months to two years support following the intervention. Key components of the strategy include:

a. a structured pathway into the Brighter Futures program for eligible and suitable IFBS families post-intervention

b. funding of new case management, family and specialist support services within the CSGP for IFBS families post-intervention.

8.105 The Aboriginal Legal Service advised the Inquiry that:

> *A handful of Aboriginal Legal Services clients have been on the IFBS program with mixed success. The issues are that, back from the IFBS agency, people are now seeing IFBS as another arm of the Department of Community Services, and possibly as an evidence-gathering exercise to bring the matter before the court and have somebody in the home for a longer period than a DoCS worker can possibly be, to gather that evidence, view them, and then remove the child. That evidence is then used*

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[582] ibid.
[583] ibid., p.36.
[584] ibid., p.37.
[585] DoCS, *Child Protection and Out-of-Home Care Major Projects Update June 2008,* p.2.
[586] DoCS, *Draft IFBS Evaluation Report*, March 2008, p.38.

as prior alternative action, which is something that has to be satisfied through the court process.[587]

8.106 The Benevolent Society expressed concern about the fact that the IFBS services were only available in particular localities:

Part of our concern would be that they are not statewide; they are very localised, and they are very short term. So you can't build a service system around a few services here and there; you need a service system where these are fully embedded in the continuum of services.[588]

8.107 UnitingCare Burnside concurred with The Benevolent Society regarding concerns over the short term nature of the services, and stated that post-intervention, families needed to have continued, less intensive support available over a longer period to consolidate the benefits of the intensive intervention.

8.108 The UnitingCare Burnside IFBS provided services to 114 children in 2006/07 of whom 100 were non-Aboriginal.

8.109 In 26 February 2008, the Inquiry visited UnitingCare Burnside's North Campbelltown Family Centre at Minto. The agency informed the Inquiry that they had run an IFBS, funded by DoCS as a pilot, since 1994, taking referrals from Campbelltown and Ingleburn CSCs only. The Inquiry was informed that families often make 'amazing gains' while in the program, but that families often 'slipped back' after the intensive intervention finished. As a result, UnitingCare Burnside used their broader family support services to provide a continued intervention to families once the six week intensive program was over.

8.110 It appears that the IFBS is a successful service model, especially for Aboriginal people. The evaluation appears to have identified two of the three main concerns about IFBS that were raised with the Inquiry, and DoCS has told the Inquiry that it is planning ways to address the problems with referrals to IFBS, and the issues identified with a lack of post-intervention support.

8.111 The remaining issue is the negative impact of the association between IFBS and DoCS statutory child protection role for some participants, and the perception of some families raised by Aboriginal Legal Service that the IFBS is more about the collection of evidence to remove children than it is about preventing removal and keeping children safe with their family.

8.112 A potential solution of separating IFBS from DoCS has been suggested. However, as the families referred to IFBS are the subject of serious child protection concerns and are at the point of having children removed, or have had children removed, separating the program from the child protection arm of DoCS may not be appropriate.

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[587] Transcript: Public Forum, Aboriginal Communities, 24 April 2008, pp.61-62.

[588] Transcript: Public Forum, Early Intervention, 16 May 2008, p.35.

8.113 The Inquiry notes that the evaluation of the IFBS program found evidence that the program was having positive impacts on subsequent OOHC placements for children, and specifically, had reduced the likelihood of placements by up to one third where children and young persons had a prior placement in the OOHC system in the 12 months prior to the intervention.

8.114 The Inquiry supports DoCS' strategies for enhancing post-intervention supports as well as those related to improving referrals from CSCs to these services. As outlined in Chapter 5, Aboriginal children and young persons are over represented in reports to DoCS and in OOHC. Services such as IFBS are critical to providing the services and support that are needed to prevent unnecessary entry of those within this group into care.

Parental drug use

8.115 Parental Drug Testing Guidelines for DoCS child protection staff commenced in April 2007. These are being trialled in seven CSCs. Drug use by parents is a prevalent feature in the risk of harm reports DoCS receives and drug testing is used to verify that a person is drug free or that their drug use is reducing over time.[589] Whether they remain drug free or not can be important for restoration.

8.116 An external evaluation of the parental drug testing policy has begun and will assess the effectiveness of the policy, the implementation of the policy's trial and the outcomes achieved, thereby helping to guide statewide implementation.

8.117 Parental responsibly contracts, or an undertaking as part of a court order are necessary to secure formal parental consent to drug testing.[590] A parent that does not consent to undergo drug testing is advised that refusal will be interpreted as a presumption of ongoing (serious and persistent) drug use and will be viewed as evidence to support removal.

8.118 An information sharing protocol regarding clients receiving opioid treatment was developed by Health and DoCS and implemented statewide in July 2007. The aim is to improve interagency cooperation and information sharing for parents and carers on methadone or buprenmorphine opioid treatment programs. It relates to the exchange of information between public and private prescribers and permits caseworkers to discuss with the prescriber the parent/carers compliance with treatment, whether children have been sighted and whether there are concerns for the child and whether parenting is compromised as a result.

8.119 A review was undertaken by the DoCS Drug and Alcohol Expertise Unit in September 2007 to examine the effectiveness of the protocol. The review indicated that even with a limited time for implementation, 65 per cent of the

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[589] 'Drug' includes all illicit drugs and the misuse of prescription drugs: DoCS, *Parental Drug Testing Guidelines*, p.2.

[590] *Children and Young Persons (Care and Protection) Act 1998,* s.38A and 73.

caseworkers were already aware of or had some knowledge of the protocol, almost 60 per cent could identify how to access information on the protocol and 15 per cent had already implemented the protocol. Ongoing promotion of the protocol is continuing via the unit staff in consultancies and relevant staff training courses. The unit is also working with regions to facilitate the establishment and running of interagency meetings when required.

8.120 The Inquiry considers it important that caseworkers are able to have better access to health expertise, and that the significant role of health in child protection work is acknowledged. As the research set out earlier indicates, women entering treatment earlier and spending more time in treatment, results in children being more likely to be reunited. Parental drug testing policies are positive in this respect. Chapter 10 sets out the Inquiry's views on a model for better integrating health workers with DoCS work.

Siblings

8.121 The DoCS policy on siblings commenced in 2006 and states that all reports to DoCS involving a recent child death[591] or a report on siblings or any other children or young persons in a household where a child or young person has recently died should usually result in a home visit. The policy states that at this home visit the caseworker is to:

a. check that the family has the support and assistance they need in relation to the care and protection for other children or young persons in the home

b. sight the remaining children to ascertain they are safe and well

c. determine whether a secondary risk of harm assessment of siblings and other children in the household is required.

8.122 This is a sensible policy which the Inquiry understands, followed on from a number of deaths of children. There is no evidence available to the Inquiry that it is or is not being implemented. It clearly should be. An awareness of siblings should permeate all of DoCS work, not just when a child has died.

Permanency planning

8.123 One of the most contentious and difficult issues in child welfare policy and practice is achieving some certainty and permanence in the lives of children. As can be seen in Chapter 16, significant numbers of children are moving in and out of care. It is also clear that a number of children entering care are doing so for a second or even third time.[592] The consequence of children moving in and out of care, or remaining at home in unsafe and inadequate care

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[591] A 'recent death' is defined as the child having died less than 90 days before the Department received the report: DoCS, *Sibling Safety Policy.*

[592] See Chapter 5.

for too long, means that when they do come into care they bring with them significant levels of disturbance and attachment difficulties.[593]

8.124 Research shows that the timeframe for decision making is critical for placement stability.[594] The initial six months emerges as a crucial period for restoration and therefore decisions about reunification should be a priority.[595] Specialist expertise is needed in an increasing number of cases to determine the prospects of a parent being able to manage their substance dependence or other issues and provide appropriate parenting. This work also needs to be informed, the Inquiry was advised, by an evidence base and good longitudinal research and monitoring of outcomes.

8.125 Section 78A of the Care Act defines permanency planning as the making of a plan that aims to provide a child or young person with a stable placement that offers long term security that:

> *(b) meets the needs of the child or young person*
>
> *(c) avoids the instability and uncertainty arising through a succession of different placements or temporary care arrangements.*

8.126 As soon as child protection intervention commences with a child or young person and his or her family, consideration must be given in case planning to the issues of stability and permanency. Section 83 of the Care Act provides that where DoCS applies for a care order (other than an emergency order) for the removal of a child or young person, an assessment must be made about whether there is a realistic possibility of restoration. This is to avoid the detrimental impact on children and young persons of failed attempts at restoration with birth parents, which can lead to children and young persons being adrift in the care system and experiencing unplanned multiple placements.

8.127 A permanent placement may be achieved by:

a. restoration to the care of a parent or parents

b. placement with a member or members of the same kinship group as the child or young person

c. long term placement with an authorised carer

d. placement with an authorised carer (after two years continuous care) under an order for sole parental responsibility under s.149

e. adoption.

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[593] A Osborn and PH Delfabbro, "National comparative study of children and young people with high support needs in Australian Out-of-Home Care, Final Report," *University of Adelaide, South Australia,* 2006 cited in DoCS, *Models of Services Delivery and Interventions for children and young people with high needs, Literature Review,* 2006, p.1; Submission: Cashmore, Scott and Calvert, 10 March 2008, p.43.

[594] DoCS, Intranet, *Permanency Planning Policy*, p.3.

[595] DoCS, *Permanency planning: A review of the research evidence related to permanency planning in out-of-home care*, 2006 cited in Submission: DoCS, Evidence base for effective services, May 2008, p.25.

8.128 Where restoration is the goal, appropriate resources should be directed to its achievement from the outset and maintained. If the case plan determines that restoration of the child or young person to the birth family is not a viable option, a Care Plan which outlines the permanency plan for the long term care of the child or young person must be prepared for the Children's Court. The Care Plan needs to be approved by the Manager Casework.

8.129 The DoCS Permanency Planning Policy requires that a decision about the realistic possibility of restoration must be made within six months of the Children's Court action being initiated for children less than two years of age, and within twelve months for all other children and young persons.

8.130 Twelve specialist permanency planning caseworkers have been employed to facilitate permanency planning in four CSCs[596] and a further 21 specialist caseworkers are currently in the process of being trained and recruited. It is intended that these permanency planning caseworkers will provide mentoring and support for caseworkers when assessing the needs of children and young persons, working with families and planning for and managing permanent placement outcomes.

8.131 DoCS acknowledges that at present, practice in the field on early case planning that focuses on issues of permanency is variable,[597] and is attempting to address this through its Permanency Planning Project.

8.132 As at 30 June 2008, there were 467 children in the Permanency Planning Project, because of parental dual diagnosis, drug and alcohol misuse, neglect, and parental mental illness.[598] By the end of June 2008, there were 83 final orders recorded for children in the project, most of whom had parental responsibility placed with the Minister (to 18 years) or with a relative.

8.133 Project data for children with final court orders over a six month period from July 2007 to January 2008, showed a trend towards more children being placed with relative carers compared with other long term placements.[599]

8.134 The results evaluation of the Permanency Planning Development Project Stage 1 suggests that decisions about the realistic possibility of restoration are being made within the policy timeframes for children aged 0-2 years. The report states that 12 months into the project, a higher proportion of children are in permanent placements compared with children in the comparison sites (where this project was not in place), and the data indicate that these children are safer as measured by child protection reports.[600]

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[596] Penrith, Campbelltown, Eastern Sydney and Central Sydney. A further 12 sites commenced in July 2007 a further 12 CSC commenced permanency planning, St George, Sutherland, Ingleburn, Fairfield, Blacktown, Mt Druitt, Goulburn, Yass, Wagga, Albury, Lismore and Tweed Heads. Further implementation commenced in 2008 for 26 further sites: Submission: DoCS, OOHC, p.48.

[597] DoCS, Intranet, *Permanency Planning Policy*, p.7.

[598] DoCS, *Annual Report 2007/08,* p.60.

[599] ibid., p.60.

[600] DoCS Report, *Evaluation of the Permanency Planning Development Project Stage 1*, December 2007, p.3.

8.135 Restoration Guidelines have been also developed to assist caseworkers in making decisions about whether restoration is a viable option for a child or young person. These guidelines have been incorporated into training for caseworkers in the Permanency Planning sites.

8.136 In Chapter 11 the report addresses the tension referred to by DoCS between the least intrusive principle and permanency planning.

Responses to Aboriginal children, young persons and families

8.137 There are two particularly impressive examples in Victoria and the Northern Territory of interventions with Aboriginal children, young persons and their families.

Lakidjeka *Aboriginal Child Specialist Advice and Support Service*

8.138 Lakidjeka Aboriginal Child Specialist Advice and Support Service (Lakidjeka) is an Indigenous specific response to child protection intervention in Victoria. The service has been profiled in the Human Rights and Equal Opportunity Commission *2007 Social Justice Report*, and in a 2007 publication from the AIFS and the Secretariat of National Aboriginal and Islander Child Care (SNAICC) examining Indigenous responses to child protection issues. The Inquiry visited Lakidjeka in Victoria to gain further insight into its role and function.

8.139 Lakidjeka is provided through a partnership between the Victorian Aboriginal Child Care Agency and the Victorian Department of Human Services. The 2007/08 partnership agreement provides $2.5 million for Lakidjeka, which the Inquiry was informed funds 28.5 positions. The positions are primarily caseworkers. Lakidjeka covers all of Victoria except for the Mildura Local Government Area where another Aboriginal service performs a similar role.

8.140 Lakidjeka aims to provide an Aboriginal perspective into child protection risk and safety assessment, planning processes and decision making about Aboriginal children. It aims to improve case planning and decision making about Aboriginal children and young persons who have been notified to child protection services, and to improve the engagement of those children and young persons and their families with the support services they need. It also aims to improve the involvement of Aboriginal family and community members in the support of Aboriginal child protection clients. This in turn is expected to improve Aboriginal children's connection with their community and to strengthen their cultural identity.

8.141 Lakidjeka staff provide a 24 hour on call response to notifications made to child protection services about a child or young person identified as Aboriginal. Lakidjeka staff are then involved in and/or consulted about the Department's decisions about that child or young person.

8.142 In response to a child protection report, Lakidjeka workers undertake joint visits with child protection workers to help child protection workers understand Aboriginal child rearing practices and to help Aboriginal families understand child protection concerns and processes. Lakidjeka workers also attend case conferences, case planning meetings, family group conferences and court, where they can provide verbal and written evidence and assistance at pre-hearing conferences.

8.143 Lakidjeka workers have a role in advising child protection staff of the most culturally relevant referrals. They also provide input into departmental cultural support plans, and help families to be more involved in decision making about their children. Lakidjeka workers are consulted about OOHC placements and provide advice to mainstream OOHC service providers about how to improve community and cultural connections for Aboriginal children in their care.

8.144 Higgins and Butler reported that:

> *Lakidjeka workers have status to act as a 'friend of the court' during court hearings and are able to give unsworn statements in the court room ... This means that Lakidjeka workers are recognised by the court as having a legitimate role in the proceedings, and having expertise in Indigenous child and family welfare matters.*[601]

8.145 Lakidjeka has been formally evaluated although the report has not been made public and the Inquiry understands that Lakidjeka has reservations about its methodology. The Social Justice Report and the work of Higgins and Butler claim that the staff believe that the program has resulted in fewer Aboriginal children being removed from their families because child protection workers have a better cultural understanding, with the result that there are more referrals to family support services, which has in turn resulted in higher compliance with the Aboriginal Child Placement Principles for those cases where children are removed.

> *The establishment of Lakidjeka has had a significant impact on reducing the number of placements of Aboriginal and Torres Strait Islander children outside their communities. There is an increasing number of Indigenous children who now remain more connected to their families and communities, which strengthens positive cultural identity.*
>
> *As Indigenous people with connections in their local communities, Lakidjeka staff are often able to identify family members with whom the child can be placed and engage key*

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[601] J Higgins and N Butler, "'Indigenous Responses to Child Protection Issues', Promising Practice in Out-of-Home Care for Aboriginal and Torres Strait Islander Children and Young People and their Carers," Booklet 4, *Australian Institute of Family Studies*, 2007, p.11.

people in the family who can participate in the planning and decision-making process regarding a child's well-being.[602]

8.146 However, Lakidjeka informed the Inquiry that from the data kept by it (the quality of which may be reduced by some reluctance or dilatoriness on the part of caseworkers to keep file notes) there had not been a reduction in the removal of Aboriginal children from their families over the last few years, and that there may have had been an increase. That is not necessarily a negative outcome, since it may be that some of these children had been inappropriately left in positions of risk in the past.

8.147 Unpublished data provided to the Inquiry by Lakidjeka included the following:

a. in 2006/07, a total of 2,306 reports were received, 2,034 through the day services, 272 through the after hours service

b. of these reports, 1,155 were investigated

c. of the possible 1,038 first home visits, 856 were attended by Lakidjeka

d. the service reported 91 per cent attendance at Best Interest Planning meetings, and 77 per cent attendance for planning reviews in 2006/07.[603]

8.148 Higgins and Butler claim that Lakidjeka has built a reputation for providing sound advice about the child's Aboriginal community to the child protection department, as well as valuable information to promote the child's cultural identity. Lakidjeka has been reported to be successful partly due to the willingness to take a collaborative approach on child protection issues rather than being adversarial in their approach.[604]

8.149 Lakidjeka staff are also regularly involved in providing advanced training courses to child protection workers and other child and family welfare staff on working with Aboriginal families and organisations. Lakidjeka's success in this training is significant because it can have a real influence on informed decision making by child protection services and other child and family welfare services. Lakidjeka's involvement in child protection service provision is said to have resulted in a more flexible and creative response to addressing risk issues.[605]

Fundamentally, the program has been instrumental in assisting child protection staff to make more informed decisions about Indigenous children.[606]

8.150 Lakidjeka has also reported a number of challenges to the implementation of the program. These have included: recruiting Aboriginal staff; ongoing education of child protection staff about understanding the role of the program;

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[602] ibid.

[603] Lakidjeka Aboriginal Child Specialist Advice and Support Service, *Annual General Meeting Report,* July 2006-June 2007, pp.5-7.

[604] J Higgins and N Butler, 2007, op. cit., p.12.

[605] ibid.

[606] ibid., p.13.

understanding the role of cultural and community connections in the promotion of children's best interests;[607] and in some cases suspicion that they represent the welfare.

8.151 Lakidjeka informed the Inquiry that its staff understand their role as advising the Department on how to act in the best interests of Aboriginal children. Lakidjeka staff do not provide case management. Their interactions with families are focused on helping families to understand why they have come to the attention of child protection agencies.

8.152 The model appears promising and provides an alternative model for compliance with the requirements for consultation contained in the Aboriginal Placement Principles of the Care Act. However, the data available from Lakidjeka are currently not sufficient, in terms of quality or quantity, to definitively demonstrate the success of the program.

8.153 NSW Aboriginal community controlled services appear to be at an earlier stage of development than those in Victoria in terms of the volume of service provision, the level of coordination in the sector, and their capacity to undertake statutory work. So far as the Inquiry can see, there is no single organisation in NSW which is sufficiently skilled or resourced, at this time, to carry out a similar role to that of Lakidjeka. It would appear accordingly that NSW would require a planned, consistent and long term approach to building capacity in Aboriginal organisations before the introduction of a similar program could be considered. It is an initiative that should form the basis for a greater involvement of Aboriginal input into child protection work in the widest sense of that term. A recommendation is made to this effect at the end of this chapter.

Safe Families

8.154 Safe Families is a Northern Territory based program that takes an Indigenous family inclusive, community centred approach to responding to child protection issues. It aims to keep Aboriginal children and young persons out of the care system. The program is an initiative of the Tangentyere Council in Alice Springs. Safe Families provides services to Aboriginal people living in Alice Springs and the 18 town camps on the town's fringes.[608]

8.155 Safe Families helps children up to 14 years of age who have been identified as being at risk, or who are the subject of child protection intervention and who present with multiple and complex issues. Safe Families can intervene early to help the family and prevent the need for statutory child protection involvement. This can include providing voluntary OOHC placements for children at risk within their kinship and community networks.[609]

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[607] ibid.

[608] ibid., p.19.

[609] ibid.

8.156 The Safe Families model was developed in consultation with local Indigenous leaders, community groups and service providers.[610] The program aims to empower communities to become more skilled and to know more about child protection issues, so that they can develop the capacity to addresses protective concerns themselves and keep their children in their community.[611] The program commenced in 2002. The Safe Families model includes a six step intervention strategy:

a. referrals from the child protection service, police, youth services, youth night patrol and the courts

b. crisis accommodation, which may be town based, with the family of origin of the child, with identified community members or extended family, or in a town camp based accommodation

c. assessment, where the young person is referred to a youth service through participation in a family meeting

d. medium to long term accommodation through a family mapping process where the need for placement is identified and assessed

e. case management, where the need for support services for both the child and his or her family is identified and services are allocated. A broad range of services are available

f. review and assessment of placement and progress. At the end of the assessment the child may be returned to his or her natural family, or may remain in placement with an exit plan drawn up. A referral may be made to the Department of Health and Community Services where a placement has been unsuccessful and there are no other family placement options. Or, an ongoing case management plan may be drawn up where further involvement of the Safe Families service is required.[612]

8.157 The Safe Families model is based on the idea that Aboriginal people working in an Aboriginal service have an advantage when working with Aboriginal families because they operate in a culturally appropriate way, and are likely to be trusted by the people with whom they are working. Workers may have known the family for many years and are likely to have known the child since they were small. Therefore they have background knowledge about the family and the issues that the child may be experiencing that departmental workers simply do not have:

> *Our greatest strength is our ability to provide clarity [about a case]: our workers have known the families for years. We've also become quality assurance for the department, because we see families in greater depth and greater detail.*[613]

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[610] ibid., p.20.

[611] ibid., p.19.

[612] ibid., pp.21-22.

[613] ibid., p.23.

8.158 One of the strengths of Safe Families cited in the literature is its capacity to provide up to six weeks in residential care for children who need alternative accommodation so that they do not have to leave their community. Children may stay in the facility for longer than six weeks if no suitable alternative is available. The service takes the perspective that it is better to keep the child until a suitable placement is found, rather than placing a child in a situation that may not meet their needs in the longer term.[614]

8.159 Safe Families aims to prevent children from being in physically unsafe placement, but also aims to keep them from being based in culturally unsafe placements. The service claims to have been successful in case managing Aboriginal children who could not be placed elsewhere, or where previous placements have broken down. According to the AIFS, the result of the Safe Families model is that children stay with Safe Families longer than they do with other services, and all of the children that have come through service and have not returned to their parent's care have ended up in a stable placement.[615]

Responses to culturally and linguistically diverse children and young people

8.160 The Inquiry acknowledges the importance of child protection workers operating in a culturally sensitive and appropriate way. This is fundamental to good casework and to achieving the best outcomes for children.

8.161 NSW is a culturally diverse community. 23.3 per cent of the NSW population was born overseas with 16.1 per cent from non-English speaking countries. 18.9 per cent of the NSW population speaks a language other than English at home.[616]

8.162 One of the objectives of the *Community Relations Commission and Principles of Multiculturalism Act 2000*[617] is to promote access to government and community services that is equitable and that has regard to the linguistic, religious, racial and ethnic diversity of the people of NSW.

8.163 The submission of the NSW Community Relations Commission to the Inquiry stated that reforms to the child protection system must take into account the cultural and linguistic diversity of NSW. The Community Relations Commission drew particular attention to the needs of newly arriving refugee communities and the wide range of parenting approaches, definitions of family and what constitutes acceptable or unacceptable forms of punishment that may exist in NSW.

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[614] ibid.
[615] ibid.
[616] Community Relations Commission, *The People of NSW,* Section 2, NSW Overview, www.crc.nsw.gov.au.
[617] *Community Relations Commission and Principles of Multiculturalism Act 2000,* Part 3, S.12(b).

8.164 There is very limited research literature on the nexus between children and young persons of culturally and linguistically diverse (CALD) backgrounds and child protection, and very limited reliable data on the numbers involved in the child protection system. However, DoCS estimates that approximately one in five DoCS clients is from a family where a language other than English is spoken at home. Further, DoCS estimates that 15 per cent of children and young persons in OOHC are from a family where a language other than English is spoken at home and 25 per cent have a cultural identity of non-English speaking origin.[618]

8.165 Section 9(c) of the Care Act requires that in all actions and decisions made under the Act 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.

8.166 Section 9(e) stipulates that 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.

8.167 DoCS has acknowledged

> *the urgency of DoCS establishing infrastructure to support the increasing number of families utilising its services from culturally and linguistically diverse backgrounds….CALD issues have assumed increasing importance, in both volume and sensitivity.*[619]

8.168 Accordingly, DoCS has a number of initiatives underway, for example it has:

a. implemented data procedures to collect data on CALD clients for evaluation and planning and provision of services for DoCS' CALD clients

b. developed cultural competencies and provided advice about effective practice in relation to CALD clients to caseworkers

c. developed a CALD foster carer recruitment strategy

d. an Ethnic Affairs Advisory Group and a Multicultural Staff Reference Group,[620] is finalising a five year Multicultural Strategic Commitment and is funding a three year collaborative research project on child protection practice with CALD clients to identify good practice strategies

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[618] Cultural identity is broader than language spoken, for example a second or third generation migrant may only speak English at home, but their cultural identity may still be of non-English speaking origin.

[619] Information provided to Government by DoCS, March 2008.

[620] DoCS, *2007/08 Annual Report*, pp.129 and 131.

e. established a Multicultural Caseworker Program, with 61 identified positions covering 22 languages. It is expected that this program will be fully operational in 2008/09

f. developed a draft Contact Policy Guidelines that stress that “particular efforts should be made to promote the child’s sense of identity and belonging to their culture”

g. funded 211 projects for CALD clients

h. developed a Good Practice Guide for caseworkers on working with CALD people and communities. This includes information on cross cultural practice, assessment and casework and guidance about the use of interpreters and language services. DoCS also has a practice resource for secondary risk of harm assessment with migrant and refugee families and a practice guide for funded OOHC services on assessing the needs of CALD children and families in OOHC.

8.169 At the casework level, the Inquiry’s case file audit included examples of files where caseworkers inconsistently identified or confused the language and cultural backgrounds of clients. For example, the following list details the different ways four people had their cultural identity described in case files viewed by the Inquiry:

a. Middle Eastern even after the mother has identified as Sudanese

b. Maori, Anglo, Samoan, Islander

c. Dutch, Polish, Australian

d. Greek, Australian, Lebanese.

8.170 There was also one instance where no interpreter was used despite notes on file that an interpreter be used as the mother’s English was limited, particularly under stress.

8.171 There were no submissions to the Inquiry from particular communities of CALD backgrounds and very few submissions raised this issue, except in generic terms.

8.172 The Inquiry is concerned that the submissions and representations received were almost silent on this issue. It is possible that the cultural and related factors, recognised in the Care Act as being so important to a sense of self and identity, are being largely ignored by the broader child protection system. If so that is unacceptable, and it is a matter that should be addressed by the research project mentioned above.

Interagency work

8.173 In addition to the work carried out by DoCS, other agencies contribute to the assessments conducted on at risk families and the interventions which then

occur. Of particular significance is the work of Health and the interagency work undertaken in the JIRTs.

Child Protection Units

8.174 Child Protection Units offering specialised multidisciplinary assessment of children referred with child protection concerns are located in the three specialist children's hospitals: Sydney Children's Hospital at Randwick, The Children's Hospital at Westmead and John Hunter Children's Hospital in Newcastle. Each offers a specialist response to children and young persons who have experienced abuse, and to their families. These services include 24 hour crisis counselling and medical services, specialist assessment, forensic medical assessment, ongoing therapeutic and counselling services, medical treatment, complex consultation and expert testimony in court.

8.175 The Inquiry was informed that these services provide statewide 24 hour specialist consultation and support to DoCS and Health workers.

The Education Centre Against Violence

8.176 The Education Centre Against Violence was established in 1985 and provides training to health workers and their interagency partners on sexual assault, domestic violence, and child abuse. The centre delivers over 180 training programs annually, and has developed a range of resources for training and working with children and their families, including DVDs, CD-Roms and training manuals.

8.177 The Inquiry also learned of the centre initiative *Weaving the Net*, which has been developed for Aboriginal communities wanting to promote community and family based solutions to child abuse and family violence.

Joint Investigation Response Team

The Model

8.178 A joint investigative model, then called a JIT, involving Police and DoCS was first established in the early 1990s to achieve a more coordinated approach to investigating sexual assault, serious physical assault and neglect. During the following decade, co-located teams which ultimately became Joint Investigation Response Teams (JIRTs) were established in a number of areas in NSW.

8.179 There are currently 12 non co-located and 10 co-located JIRTs in NSW.

8.180 JIRT services are provided under two models: Co-located (metropolitan) and non co-located (rural). In the co-located model, DoCS and Police officers are located and respond to matters together, undertaking joint decision making. In the non co-located model, DoCS and Police officers are located separately, but still provide a joint response. DoCS trained JIRT caseworkers undertake both

general and JIRT casework, and are located within a CSC under the supervision of the Manager Casework (general position).[621]

8.181 Rural JIRT coordinators provide support to non co-located DoCS JIRT caseworkers in the Regions. JIRT Coordinators organise training, and liaise between DoCS and the other JIRT agencies.

8.182 As a result of the recommendation of a recent JIRT Review, Health is now also a joint decision maker in JIRT matters along with DoCS and Police. A new centralised management structure is being implemented so that all JIRTs whether co-located or non co-located, will have a direct reporting line to the centrally located Director JIRT rather than the Regional Directors.

8.183 The current JIRT process essentially involves the following steps:

a. referral to a JIRT from the Helpline or from a CSC after initial consideration of whether the risk of harm report qualifies for the JIRT process

b. a decision to accept or reject made on the basis of the referral, after consideration by the DoCS and Police team members, with Police having the final say

c. referral back to a CSC of rejected cases, or to a Police Local Area Command for further investigation or action

d. engagement with Health for forensic examination and a therapeutic response via a sexual assault service or PANOC service as required, for accepted cases; rejected cases will only receive such services if, after further assessment by a CSC, a referral is made.[622]

8.184 Acceptance of the referral has depended upon JIRT being satisfied that there is, or will be, sufficient evidence to commence criminal proceedings against an alleged perpetrator.

8.185 The Police team members have had the responsibility of initiating any necessary protection action by way of an Apprehended Violence Order (AVO), of deciding whether to charge the perpetrator and of preparing the brief for the Office of the Director of Public Prosecutions (DPP) and dealing with that office during any prosecution that follows. In the course of the process they generally take the lead in the interview with the child or young person, although normally with the assistance of a DoCS caseworker. They also interview the perpetrator and other witnesses.

8.186 The interview is routinely recorded by video, and back up audio, and the electronic recording of the interview is admissible in evidence, subject to the provisions of the *Criminal Procedure Act 1986*.[623]

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[621] DoCS, *Overview of the JIRT program structure and governance arrangements, September 2008*, p.1.

[622] DoCS, NSW Health and the NSW Police Force, *JIRT Policy and Procedures Manual*, 2001.

[623] *Criminal Procedure Act 1986* ss.76, 306Q-306Z.

8.187 Guidance is provided in relation to the interview process in the manual which is provided to participants in the training course for JIRT staff.[624]

8.188 The DoCS caseworkers have the responsibility of undertaking a secondary risk of harm assessment, and of determining whether action should be taken for removal of the victim and of any other relevant children or young persons, for whom the perpetrator presents a risk of harm.

DoCS statistics

8.189 The preliminary data for 2007/08 set out in Chapter 5 indicate that 6.7 per cent of total reports to DoCS had sexual abuse as the primary reported issue, rising to 8.3 per cent when taking primary, secondary and third reported issues into account. The corresponding figures for physical abuse for 2007/08 were 14.2 per cent rising to 22.9 per cent. A slightly higher percentage of reports about each issue was referred to a CSC or JIRT than for total reports. In the period 1 April 2007 to 31 March 2008, sexual abuse reports were less likely to be closed at the CSC/JIRT before any secondary assessment, whereas physical abuse cases were slightly more likely to be closed at this stage.

8.190 In the period 1 April 2007 to 31 March 2008, sexual abuse and physical abuse reports were more likely to receive a SAS2 than the average across all reports. However, these reports were less likely to be substantiated.

8.191 The data for accepted and rejected referrals appears in the tables below.[625]

Table 8.2 **Accepted and rejected JIRT referrals**

Financial Year	*Referral*	*Accepted*	*Rejected*
2006/07	5,363	56.4%	43.6%
2004/05	6,456	56.1%	43.9%

Table 8.3 **JIRT co-located data only**

Financial Year	*Referral*	*Accepted*	*Rejected*
2006/07	3,352	53.8%	46.2%
2004/05	3,823	50.4%	49.6%

Table 8.4 **Non co-located data only**

Financial Year	*Referral*	*Accepted*	*Rejected*
2006/07	2,011	60.7%	39.3%
2004/05	2,633	64.4%	35.6%

8.192 These figures suggest that there has been a successive reduction in the annual referrals over the period 2004/05 to 2006/07, notwithstanding the upward trend in child protection reports over that period.

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[624] NSW Police Force, *Joint Investigative Interviewing of Children Course – Audio Recording and Video Recording of Investigative Interview with Children and Young People,* May 2007.

[625] Data for 2005/06 has not been included due to data quality issues.

8.193 It is clear from Police data in 2005/06 that the majority of the referrals have involved allegations of child sexual assault.[626]

8.194 In addition, the data indicate relatively low referral and acceptance rates for physical abuse and neglect cases which is of concern, and may have been due to the vagueness of the original criteria as well as a level of uncertainty among paediatricians and Emergency Departments as to the aetiology of injuries or appearance in a child of malnutrition or illness. Unfortunately, DoCS was unable to provide data on the nature of the referrals to JIRT.

Some statistics on child sexual assault

8.195 Some information in relation to the incidence of substantiated child sexual abuse is provided by the recent report on the evaluation of the Cedar Cottage Program run by Health, which noted:

> *In 2004, 3,752 child sexual offence incidents were reported to the police in NSW (Fitzgerald, 2006). Of these incidents, 1,042 (27.8%) were cleared up by the police within 180 days of reporting. In the NSW Local and Higher Courts 547 persons were charged with at least one child sex offence. Of these, 243 (44.4%) were found guilty of at least one child sex offence. Of all the persons found guilty, 138 (56.8%) received a sentence of full-time imprisonment and once received periodic detention. One thousand and fifty-seven individual charges of child sexual offences were finalised, of which 481 (45.5%) were proven.*
>
> *Whereas child sexual abuse cases constitute a significant proportion of all criminal trials (16% in the Sydney District Court and 42% in regional District Courts)(Gallagher & Hickey, 1997), only approximately eight percent of all reported cases result in a conviction (Fitzgerald, 2006).*
>
> *The rate of guilty pleas in child sexual assault cases increased between 2004 and 2006 according to BOCSAR (Cossins, 2008). However, defendants are less likely to plead guilty to a sex offence compared to other offences and less likely to be found guilty at trial (Fitzgerald, 2006; Taylor, 2007). Accordingly, a steadily decreasing conviction rate of child sexual abuse compared to convictions for all other criminal offences combined was observed during the 1990s. More recent data confirm this trend, with the likelihood of conviction in the NSW higher courts for a child sex offence falling between*

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[626] DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, p.87.

one fifth and one quarter, where the accused pleads not guilty (Cashmore, 1995; Cossins, 1999).[627]

2006 review

8.196 A number of reviews of the JIRT model have been conducted, with the most recent being undertaken in 2006. That review identified the following problems:

a. the wide variations in the rates of acceptance of referrals between different JIRTs, and the emphasis that was being placed on the immediate incident, rather than on the context in which it occurred, or on the broader history of the relationship between the perpetrator and victim

b. the focus that was placed on success in prosecution, rather than on the safety and well-being of the victim

c. the delays that were occurring in interviewing children

d. an under representation in the acceptance of physical abuse cases

e. an over dependence on the need for disclosure by the victim of sexual abuse before acceptance and investigation

f. the difficulties in engaging Aboriginal children and their families, associated with insufficient cultural awareness and local knowledge on the part of JIRT staff, when working with these communities, as well as a limited involvement of Aboriginal staff in the JIRTs and, in turn with a lack of understanding by Aboriginal Communities in the JIRT model

g. an imperfect coordination of the input of members of the teams, and the absence of Health as a full partner contributing to decision making or planning

h. a lack of timely referral to forensic medical services and allied health services, including counselling

i. imperfect communications between the agencies, particularly in the sharing and exchange of information, and difficulties in establishing an integrated regional approach to governance because of the differing geographical boundaries of all three agencies

j. a lack of reliable and accessible data on JIRT processes and outcomes.[628]

8.197 The recommendations which were made by that report have been endorsed and are the subject of an implementation plan.

Internal audit review in 2006

8.198 An audit of JIRT rejections carried out by Ernst & Young in 2006 also identified a number of deficiencies in the management of referrals to JIRTs across the

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[627] J Goodman-Delahunty and J Pratley, 2008, op. cit., pp.5-6.

[628] DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, pp.4-5 and see also pp.14-15, 17, 19, 20-21.

several regions, and in the way that the rejected referrals were processed. This audit noted several persistent failures in relation to the adequacy of the documentation for the rejected matters, and also identified several cases where there had been:

a. delays by the JIRTs in the assessment of referrals

b. a lack of review of rejected matters by Managers Client Services and of referral to the Director Child and Family

c. delays in the management of cases referred back to CSCs

d. some lack of understanding by the staff involved of the relevant procedures.[629]

Reforms post 2006

8.199 As a result of the findings of the 2006 review, there has been significant change to the operations of JIRT. The key outcomes from the reform process are as follows:

a. A trial commenced on 10 September 2008 to implement a Central Decision Making team titled the JIRT Referral Unit (JRU), involving senior representatives of the three agencies, responsible for the decision to accept or reject a referral, and for undertaking the further inquiries needed in the case of a matter regarded as appropriate for provisional acceptance. This takes this function away from local JIRT Units.

b. A new structure has been established which removes operational reporting responsibilities from the seven regions and establishes a single reporting and accountability line from JIRT caseworkers through to the Director JIRT in DoCS Head Office.

c. Revised Operating Procedures have been developed including those relating to the sharing of information and the development of safety and welfare and well-being plans.

d. A Rapport Building Project has been taken over by Health employing a consultant.

e. There is a JIRT at Tamworth which is co-located.

f. A revised MOU is under consideration for the exchange of information between Police and DoCS.

g. Revision of the physical abuse criteria has occurred; and consideration is being given to the suggested revision of the sexual abuse criteria.

h. JIRT governance has been revised.

i. The new JIRT structure includes a Director Practice JIRT

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[629] Correspondence: DoCS, 20 March 2008, Ernst and Young Audits: Regional Operations, Metro Central, April 2006; Metro West, April 2006; Western, June 2006; Metro South West, June 2006; Northern, August 2006; Southern, August 2006; Hunter and Central Coast, August 2006.

j. Forensic medical services have been reviewed, although the implementation of this review awaits further consideration and approval by Health, and additional work may be required in relation to its costing.

8.200 The JRU is of particular importance. It has a DoCS Manager Client Services, a Zone Coordinator from Police, a Health Services Manager from Health, and a staff comprising a DoCS Caseworker, a Police Team Leader, a Police Constable, a Health Service worker and administration staff.

8.201 During the trial, the JRU will receive referrals, decide whether the referral meets the JIRT criteria, undertake any additional inquiries, distribute accepted matters to a local JIRT and refer rejected matters back to a CSC after completing a SAS1.

8.202 The Inquiry supports the JRU initiative, which could assist in overcoming the problem brought to its attention in several submissions, concerning the incomplete and sometimes inaccurate information obtained via the Helpline and passed to a JIRT, which has either resulted in a need for further work by the JIRT, or a rejection of the referral which has commonly been followed by case closure without any field visit.

8.203 There is however an imperative to avoid delay in these cases, given the relatively brief window available to obtain forensic evidence, and the possibility of witness collaboration or pressure on a complainant to retract an allegation of abuse. The adoption of a central gate keeping team should be contingent upon it not being a cause for delay in the commencement of investigations.

8.204 Rejected cases have been referred back by the DoCS Manager Casework to a DoCS CSC for further management; or by the Police Team Leader to a Local Area Command for further investigative action if there is reason to suspect that a criminal offence outside the JIRT criteria has occurred. This procedure will continue pending the further trial of the Central Decision Making team.

8.205 In addition, and in response to the Ernst & Young review, DoCS has advised the Inquiry of a number of changes made to reports and procedures and has introduced an audit process.

8.206 The reform process following the 2006 JIRT Review may result in at least some of the issues previously noted becoming more of historic interest. However, the fact is that they have caused problems in the past, and unless suitably addressed, they are likely to re-appear.

8.207 An illustration of a key problem can be seen in the following case which the Inquiry considered.

Case study 5

Over a period of several years, DoCS received 27 reports about one or more of three children with the same mother. Taken together these reports raised concerns about the family's itinerancy, the domestic violence the children were exposed to, and the impact of parental drug and alcohol abuse on them. The children were also variously reported to be neglected. The girl, on more than one occasion, was reported to be subjected to physical assault by the people variously caring for her. At the age of three years she was exposed to the alleged rape of her young aunt by a partner of her mother. At the age of five years she herself was allegedly indecently assaulted by a family member. JIRT became involved but responded to the sexual assault allegations only, and appears to have focused exclusively on the criminal aspects of the case.

Subsequently, the girl's sibling died. DoCS accepts that the JIRT investigation was too narrow.

DoCS advises that this example highlights the difficulties that rural areas have with access to trained JIRT staff.

A number of initiatives have been put in place since these events to address the issues raised by this case.

Acceptance of referral

8.208 As was noted in the 2006 JIRT Review earlier there has been a wide divergence between individual JIRTs as to the proportion of cases accepted.

8.209 The additional physical assault and neglect training now to be provided, and the revised physical assault criteria, should help to reduce any inconsistency in practice in relation to these forms of abuse.

8.210 They should also assist in increasing the limited number of physical assault cases that have been referred and accepted to date. That low level of referral and acceptance is of concern having regard to the possibility of these cases escalating and resulting in the infliction of more serious injury or even in a death, unless addressed at an early stage.

8.211 It was suggested to the Inquiry that a problem for physical abuse and neglect cases has been the fact that the focus for JIRT has been on the current incident, without reference to the context and history of the relationship between the victim and the alleged perpetrator including evidence of earlier abuse. If so this appears to have been an inappropriate practice, which risks missing escalating and potentially serious cases. The Inquiry understands that work is being done to identify patterns of abuse in cases referred to a JIRT.

8.212 The problem identified may have been due to some misunderstanding of the law in relation to the circumstances in which evidence can be introduced in a trial of events that go beyond the incident which has led to a referral, investigation and possible prosecution. If that be the case, then training is required for JIRT officers about the circumstances in which relationship or context evidence can be adduced, and in relation to tendency and coincidence evidence.[630]

8.213 Until the sexual assault criteria are clarified, problems are likely to persist with their application. It is important that the trial of the JRU be completed and that a clear set of criteria be finalised to assist in the assessment of cases for referral to a JIRT, both at the Helpline, and at the JRU if that model is adopted.

8.214 It is recognised that JIRTs will always face a difficulty where the victim is young and fails to make a sufficient disclosure of sexual or physical abuse that would provide a basis for a prosecution. Premature closure of these cases without an informed understanding by JIRT members of the dynamics of disclosure of abuse, including the fact that it will often be delayed or emerge progressively, and that it will depend upon the establishment of a relationship of trust and confidence on the part of the child with the interview team, may well have contributed, in part, to the high rejection rate in these cases.

8.215 The relatively low conviction rate in defended cases and earlier decisions of the High Court concerning the reliability of delayed disclosures, and of a need for corroboration[631] may also have contributed to the reluctance of some JIRTs to accept these referrals. However the law has caught up with accepted professional knowledge in relation to the sexual abuse of children, and relaxed the need for some of the warnings that were previously needed.[632]

8.216 In some instances the choice of interviewer may be critical as is illustrated by the following case study.

Case Study 6

A 14 year old child whose allegation of a sexual assault was referred to a JIRT, was reluctant to speak to male detectives, but was able to make a disclosure once the interview was conducted at her request by female officers.

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[630] *Evidence Act 1995* ss.97 and 98.

[631] For example, *Longman v The Queen* (1989) 168 CLR 79; *Crampton v The Queen* (2000) 2006 CLR 161; *Doggett v The Queen* (2001) 208 CLR 343; *Crofts v The Queen* (1996) 186 CLR 427.

[632] *Evidence Act 1995,* ss.165A and 165B and the unproclaimed *Evidence Amendment Act 2007* Schedule 1 (34) which will allow expert evidence to be given in relation, *inter alia*, to the development and behaviour of children who have been victims of sexual offence; as well as the *Criminal Procedure Act 1986* ss.294 and 294AA.

Response to rejected referrals

8.217 Of concern has been the experience of rejected referrals being sent back to a CSC without any ongoing case plan, and then closed without a secondary assessment or other action. Police raised this as a matter that could lead to repeat referrals and it was also an issue that was raised at several of the rural interagency meetings, including those at Dubbo, Ballina, Newcastle and Wagga Wagga.

8.218 It was similarly raised in the draft report of the Ombudsman's investigation into the response by DoCS and JIRT to risk of harm reports concerning the death of a child.[633] In that report, several problems were identified concerning the management of the case by the relevant CSCs following a JIRT rejection, particularly in relation to its transfer, the lack of a sufficient secondary risk of harm assessment, and inappropriate management and review following the rejection, as well as problems in record keeping.

8.219 DoCS has responded to these issues by way of the revised Casework Practice document for rejected JIRT referrals, and the revised Intake Assessment Guidelines. It has also pointed to the JRU Trial which should improve record keeping and ensure at least a SAS1 occurs.

8.220 The experience with the earlier audits, and the introduction of the revised practice document points to the desirability of an ongoing audit, at suitable intervals, to ensure that there is compliance with current JIRT policies and procedures, either by the Ombudsman, or in the course of DoCS Internal Audit Program.

8.221 Additionally it means that cases rejected by JIRTs by reason of insufficient disclosure, where suspicion remains as to the occurrence of sexual assault should not be closed without attention being given to referral for counselling and a therapeutic response.

Full participation of Health

8.222 Clearly there are advantages in including Health as a full partner in the JIRT process, in so far as that could:

a. permit an improvement in the sharing of information held by Health concerning any history of injury or neglect known to it

b. facilitate the prompt development of a safety welfare and well-being plan for accepted cases as well as for rejected cases

c. assist in securing immediate access to counselling and other therapeutic assistance for the victim and family.

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[633] NSW Ombudsman: *Investigation into the death of a child,* July 2008.

8.223 The Inquiry accepts that, in principle, it is desirable for Health staff to be involved as a full partner in the JIRT process from the time of referral, and to be in a position to contribute to the assessment, investigation and planning process.

8.224 While Police supports the full involvement of Health it has also raised some concerns from past experience, as to the consistency of its involvement, and its capacity to contribute to the initial decision making process and consequent planning.

8.225 Clearly there would be considerable resource implications for Health generally, as well as logistic difficulties for some Area Health Services, in recruiting sufficient staff and in making them available to individual JIRTs, as well as a need for some change in the culture of Health workers if they are to become more closely involved in an agency that has, among its principal objectives, a criminal investigative function.

8.226 Otherwise, the Inquiry considers that the potential input from Health into the development of safety, welfare and well-being plans can be achieved through the other strategies discussed in this report, including placing Health workers within CSCs, and the JRU where they can have a wider role in assessing cases for JIRT referrals, or for care and protection or early intervention.

Quarantined or co-located?

8.227 As a general principle, and as discussed elsewhere in this report, the Inquiry supports the concept of locating staff from DoCS and from other relevant human services agencies within the same general location, for example in a state government office centre, so as to facilitate cross agency client access to services.

8.228 This is likely to be more necessary in rural and remote areas of the State than it is in the larger metropolitan centres.

8.229 JIRT units have been located separately from Police Stations and from DoCS offices, for reasons that are obvious and are not questioned by this Inquiry. This does, however, raise the question whether JIRT staff from DoCS and Health should be co-located with the Police team, or remain in the premises of their respective agencies and be available when required.

8.230 The advantages of co-location are obvious, although in the more remote areas of the State there may not be enough JIRT work, and too much work for DoCS and Health in their core responsibilities to justify co-location.

8.231 The Inquiry considers that this will need to be worked out on a case by case basis depending on the availability of local staff, and on how well the boundaries of the JIRT coverage match those of the DoCS CSCs and Area Health Services involved. The lack of alignment between agency boundaries was identified by Detective Superintendent Begg, the former Commander of the

Sex Crimes and Protection Squad, as creating some inflexibility in the ability of a co-located worker to respond to some of the referred cases.[634] The Inquiry acknowledges the validity of this concern.

8.232 The associated question which arises is whether there should be a large pool of DoCS workers, in particular, trained for JIRT work, who can be called up from their normal duties for JIRT referrals as and when required, or whether there should be a smaller pool of specialists quarantined for this form of work. Again this seems to be a matter for which there is no single answer. It will depend on the potential caseload, the location of each JIRT and of the relevant CSC or Area Health Service, and the level of their staffing and demand for their core services. In general, the Inquiry believes that co-location is preferable for those JIRTs that have a consistently heavy work load, and that otherwise the quarantined model is preferable. In each case this will permit deployment of the specialisation and acquired expertise that is needed for this work, and will enhance a consistency of and stability in the management of ongoing cases, including the support of the victim and family. However, it is recognised that in some instances, the level of demand and resources will not permit or justify either course.

8.233 What is required, accordingly, is a process that will match, as far as possible, DoCS and Area Health Service staff with JIRTs, on a regional demand and resourcing basis, with preference being given in descending order of priority to co-location, quarantining of JIRT specialists, and secondment of JIRT trained casework managers or caseworkers as required.

Staffing and training

8.234 The Inquiry has been informed of the difficulties that each of the agencies has experienced, or expects to experience in providing and maintaining the staffing required for JIRT units particularly in rural and remote areas, of the resulting lack of stability in key positions and of the need to rely on the provision of services on an outreach basis. This difficulty was raised with the Inquiry at a number of the rural interagency meetings, including those at Inverell, Dubbo, Broken Hill, and Coonamble.

8.235 Clearly, the employment and training of suitable staff is necessary, as is the engagement of Aboriginal workers for JIRTs that are likely to receive referrals involving Aboriginal victims and families. This has been recognised by the reform process, the objectives of which, in this respect, are endorsed by the Inquiry.

8.236 It is however a problem that will require innovative strategies for all agencies that may require the provision of incentive packages, and a positive program for recruitment and training.

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[634] Transcript: Inquiry meeting with NSW Police Force senior executives, 8 January 2008, pp.17-18.

8.237 The Inquiry considers that these strategies and particularly that of rotation are sensible occupational and health strategies, that should be extended, with any suitable modifications if not already in place, to all JIRT staff, to address the special demands and stresses of this work.

Sharing of information

8.238 The requirements of confidentiality and the perceived restrictions on the exchange of information between the JIRT members, and the need to deploy the DoCS worker to act as an intermediary and to initiate action under s.248 of the Care Act, in order to obtain and exchange information have been identified as an ongoing problem.

8.239 The ability of JIRT members to share the information that is contained within their databases and that is relevant for the investigation of a possible criminal offence concerning a child, or for managing a care and protection issue is critical.

8.240 This is addressed in more detail in Chapter 24 in which the Inquiry discusses the need for a legislative scheme that will permit the provision and sharing of information, by and between human service agencies, where that is consistent with the paramount interest of securing the safety, welfare and well-being of a child or young person, within which could be included its provision and sharing where that is reasonably required for the purpose of a JIRT.

8.241 So far as the Inquiry can ascertain the Privacy Commissioner has not issued a Privacy Direction in relation to the JIRT model, with the consequence that the general privacy principles, outlined in an annexure to this report, apply subject to the several exemptions for which they provide.

8.242 The JRU Casework Practice document notes that:

> *As full Partners in JIRT, DoCS, Health and Police are able to share information relevant to the safety, welfare and well-being of a child without the need for a s.248 request.*

8.243 This appears to have given rise to an assumption that there is no need to continue with a process which had been commenced for the preparation of a Privacy Direction.

8.244 The Inquiry understands that there have been conflicting opinions of law expressed in this respect. If doubt does persist then this needs to be addressed either by the issue of a Privacy Direction or by a broader amendment of the law, which is addressed later in this report. Pending legislative amendment, a Privacy Direction would seem sensible to ensure that current work is not prejudiced by privacy concerns.

8.245 A specific problem has been identified by Health in relation to its system for the collection and retention of data, in respect of which it noted:

> *Implementation of the JIRT recommendations in four trial sites in November-December 2007 has flagged the significant impediments to the three agencies working together well as a result of the lack of standardisation of and timely access to clinical information within the NSW Health system. Many components of the health system continue to rely on manual systems of information storage and retrieval. Health workers in the decentralised NSW Health system are frequently unable to access information as readily as their interagency partners in Police and DoCS.*[635]

8.246 This can obviously be a problem in the case of mobile families who may reside from time to time in locations covered by different Area Health Services, as well as for those families who deliberately access different services, or move residence, to avoid reporting by Health or DoCS scrutiny. One such case was brought to the Inquiry's notice concerning a child with serious malnutrition who had been presented at each of the Children's Hospitals, in circumstances where the treatment recommended was not provided, as the treating paediatricians at each hospital were prevented by the child's mother from obtaining access to the medical records at the other hospital.

8.247 As the recent JIRT Review also revealed, an issue of law arises concerning the ability of a Health worker from one Area Health Service, working in a JIRT Unit, to obtain health information from another Area Health Service.

8.248 The Inquiry recognises that there are substantial issues arising as a result of the absence of any central or universal electronically based system within NSW Health for the collection and retrieval of data. This is attributable to the Area structure under which it operates, and to the *Health Records and Information Privacy Act 2002*. The benefits, and consequences, of any wholesale revision of systems for Health data management are beyond the scope of this Inquiry, beyond noting that consideration needs to be given to the development of a means whereby Health workers can provide the information that is needed by JIRTs, for individual cases.

Availability of forensic and sexual assault and PANOC services

8.249 A network of 55 Sexual Assault Services across NSW provides services to adults and children who have experienced sexual assault. Forty-six of these services see children and young persons. The services offer free counselling, information and access to medical services. Most services are funded through Area Health Services, and a small number are funded under the CSGP specifically to provide counselling to child sexual assault victims. Details of the DoCS funded programs are discussed in Chapter 25.

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[635] Submission: NSW Health, 3 March 2008, p.44.

8.250 Health also provides required medical examinations and treatment for children who are suspected or known to have been abused or neglected. The service includes a full physical examination and brief behavioural and developmental assessment in addition to the taking of the history regarding the sexual assault. The service is restricted to medical practitioners working with the sexual assault service unless training has been provided or they are experienced in these examinations.[636] An estimated 475 examinations were provided to children in 2004/05.[637]

8.251 Health informed the Inquiry that a review of these services was commissioned in January 2007, in response to:

> *concerns that arrangements to secure medical officers for forensic and medical services for sexual assault and child physical abuse and neglect are variable across NSW in regard to the timeliness, consistency, and quality of services available. The availability and willingness of medical officers to provide these services was of particular concern.*[638]

8.252 The report of the review was delivered in August 2007. It found that forensic and medical examination of children who report sexual assault is a highly specialised medical activity that rarely produces conclusive findings, and that medical care and forensic examination must be provided by medical practitioners trained in child sexual assault and child development and conducted in a child focussed and friendly environment The consultations by the review team with stakeholders revealed a similar range of issues with the forensic and medical services to those found by the Inquiry, including the following:

a. Victims were choosing to opt out of having a forensic examination due to time delays or the need to travel to access the service, limiting the opportunities for Police to proceed with a criminal justice response.

b. Many medical practitioners were not interested in providing a forensic and medical response to victims of sexual assault because of inadequate pay, training and support. There were very few paediatricians available and willing to examine children who may have been sexually abused especially in rural and regional areas.

c. There was limited coordination between the health response and that of other services, which led to confusion about the roles and responsibilities for the three key agencies. There were also limited numbers of trained medical practitioners available to conduct examinations. This was reported to be due to a shortage of paediatricians and general practitioners in rural

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636 NSW Health, *Sexual Assault Services Procedures,* 9.8 and 9.18.

637 NSW Health, *Review of Forensic and Medical Services for Victims of Sexual Assault and Child Abuse, Part 2*, August 2007, p.75.

638 Submission: NSW Health, 3 March 2008, p.42.

and regional areas. It was also reported that doctors found the system an unattractive one in which to work.

d. Provision of culturally appropriate and accessible services for Aboriginal victims needed to be addressed, in order to overcome barriers to disclosure and reporting.

e. Data systems for sexual assault needed strengthening, while data systems for forensic and medical responses to child physical abuse and neglect did not exist.[639]

8.253 The review examined the concepts of 'one-stop shops' and networked responses to victims of abuse and neglect, that involve a coordinated and/or co-located response across agencies such as DoCS, Health and Police, and found that they improve outcomes for victims.[640]

8.254 The review recommended a whole of government approach to the provision of these services, with the Health aspects including the establishment of clinicians within each Area Health Service with a responsibility to provide leadership, coordination and direction to practitioners, the establishment of forensic and medical hubs in each Area Health Service, and the training and employment of accredited, trained medical and nursing personnel to conduct examinations. Examinations of children would not be conducted by nurses in the recommended model.[641]

8.255 Health advised the Inquiry that a staged implementation of the review was currently being examined, and that it was in the process of developing a business case and an implementation plan in response to the KPMG review report.

8.256 PANOC services were established in 1997 to provide a dedicated counselling response to children who are victims of physical or emotional abuse or neglect, where abuse has been substantiated.[642] Children can be referred to these services through DoCS, JIRT, and the Children's Court. The Inquiry was informed that PANOC services are located in each Area Health Service across NSW.

8.257 The need for prompt access to forensic services, sexual assault and PANOC (or Child Protection Counselling) services in relation to JIRT referrals is obvious.

8.258 Not all of the available positions in the Child Protection Units at the three Children's Hospitals, or in the PANOC and Sexual Assault Service Units within the Area Health Services across the State, have been filled, with the result that

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[639] NSW Health, *Review of Forensic and Medical Services for Victims of Sexual Assault and Child Abuse, Report 1 – A new approach*, August 2007, p.19-29.

[640] ibid., pp.23-24.

[641] ibid., p.34.

[642] NSW Health, *Child Protection Counselling Services Policies and Procedures* 2007 (DRAFT).

there are delays, while some victims find it necessary to travel significant distances to attend a relevant service.

8.259 This has been identified as a factor that can cause victims to disengage from the JIRT process, and it can leave them without the support and therapeutic response that is needed to address the harm occasioned by the assault.

8.260 In this regard the Police informed the Inquiry that:

> *The system in relation to the delivery of forensic medical examination currently in place is not working. NSW Health have recently completed a significant review of these services however there would need to be significant financial resources and time invested before the recommendations come to fruition. There needs to be immediate access to forensic, counselling and medical services in rural and remote areas. This may be able to be achieved via the appointment of a Government Medical Officer in local areas who is trained to provide these services to victims.*
>
> *Currently a child may pass many medical officers en route to a 'major' medical location for the examination. The other challenge linked to this is the transport of such victims. If taken in Police vehicles there is a potential risk of cross contaminations. Confusion currently exists regarding who has the responsibility for transport to and from forensic medical examinations.*
>
> *A major issue for rural-based medical practitioners is the challenge presented in giving evidence in court. This requires them to disrupt their practice and travel to the location of the court with limited financial compensation. An alternative and more efficient method would be the use of audio visual links for rural medical practitioners in giving evidence in child sexual assault matters, (thus limiting) the time they are absent from their practices and eliminating many logistical issues.*[643]

8.261 The difficulties that were experienced in obtaining forensic examinations were identified in several rural interagency meetings including those at Dubbo, Moree, Bourke, Wagga Wagga, Coonamble and at Newcastle.

8.262 Police in its submission noted that:

> *JIRT teams and specialised investigators could also benefit from improved access to experts in the field of child abuse matters, rather than relying on paediatricians, where and when*

[643] Submission: NSW Police Force, Regional Interagency Forums, February 2008, p.2.

> *available, whose expertise in determining how injuries are caused is often limited. One approach might be to establish a "register of experts", whose advice is considered, robust and tested, who are able to be appointed as JIRT consultants to assist any JIRT team and to provide expert testimony in Court proceedings.*[644]

8.263 The problems with the lack of expertise in this area were also identified by The Children's Hospital at Westmead in its submission, which noted that there is no adequate training in NSW in forensic medicine, particularly in injury identification, and that practitioners interested in working in this area need to gain the necessary expertise through the Victorian Institute of Forensic Medicine. It made the point that "mediocre reports" from doctors in Emergency Departments can lead to a poor presentation of evidence and to an unsatisfactory outcome.[645]

8.264 The Inquiry was informed of widespread concerns as to the insufficiency of Sexual Assault Services or PANOC services, at its rural interagency meetings including those held at Griffith, Inverell, Dubbo, Coonamble, Moree, Nowra, Bourke and Wagga Wagga.

8.265 The difficulties in filling positions for these services were also of concern to Health. Dr Matthews advised the Inquiry:

> *Take, for instance, the PANOC services in Greater Western Area Health Service, only 50 per cent of those funded positions are filled, despite fairly desperate attempts by the Area Health Service. It is extremely difficult to get workforce in those places.*[646]

8.266 Health informed the Inquiry that as part of the interagency response to child sexual assault in Aboriginal communities, funding had been allocated for an additional six specialist Aboriginal sexual assault counselling positions, with four of those positions established to date, two of which have been filled.

8.267 The lack of sufficient staff in Child Protection Units and in the Sexual Assault and PANOC units will lead to undesirable waiting lists, particularly for those needing longer term support, since priority needs to be given to acute crisis interventions, counselling and forensic services for both adults and children.

8.268 The Inquiry's attention was drawn to the existence of waiting lists by The Children's Hospital at Westmead, in its submission, which also invited

[644] Submission: NSW Police Force, 19 May 2008, p.47.

[645] Submission: The Children's Hospital at Westmead, pp.9 and 11.

[646] Transcript: Public Forum, Health and Disability, 11 April 2008, pp.17-18.

consideration to the establishment of additional Child Protection Units at other public hospitals, located in areas of high demand.[647]

8.269 It is noted in this respect that Health has in the past funded or supported a range of non-government sexual assault programs, some of which have been co-located with Area Health Services, with additional support from Neighbourhood Centres. The possibility of engaging these services, where they continue to be funded, merits consideration, at least for longer term specialised therapeutic intervention.

8.270 Whatever approach is taken, the absence of readily accessible expert forensic services, and of counselling and support through Sexual Assault and PANOC services, is a serious obstacle to the successful operation of the JIRT model, and consequently for the provision of an acceptable care and protection system. As such it needs to be addressed by Health.

8.271 The Inquiry also heard that for a child to be seen by a PANOC worker, policy required that the case be open and have an allocated DoCS caseworker. One health service coordinator informed the Inquiry:

> *I think it's perhaps one of the changes that we would like to see within Health, that our PANOC services are able to see children and able to accept referrals direct other than through the DoCS process, because that is a bit of a barrier, I think, and hindrance.*[648]

8.272 The Inquiry was informed that sexual assault counselling has not normally been provided to children under the age of 14 years until they had been interviewed by a JIRT team and their disclosure confirmed. The justification for that approach is understandable in that it was designed to avoid the risk of an allegation of contamination in the event of a subsequent disclosure being made. The Inquiry learned that this has presented a problem in those cases where, despite the absence of a disclosure or sufficient disclosure to JIRT, there was some evidence supportive of the report, yet the case was closed without any secondary assessment or additional investigation by the CSC.

8.273 The Inquiry understands, that as presently structured, children and young persons who are subject to physical assault or neglect, require a referral from a JIRT or DoCS, or from the Children's Court, in order to access a PANOC service. This can prove problematic in the case of JIRT rejections where the case is closed without an ongoing care or well-being plan, which includes a referral to such a service.

8.274 The Inquiry expects that this problem should be solved by the revised Health policy that would allow counselling to take place, but to be suspended in the

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[647] Campbelltown cited as one such area, for which a response could be provided through a Child Protection Unit located at Liverpool Hospital, Submission: The Children's Hospital at Westmead, p.11.

[648] Transcript: Public Forum, Inverell, 20 March 2008, p.11.

event of a disclosure being made in the course of that counselling, followed by a referral to the Helpline and on to a JIRT.

8.275 In one regional Public Forum, a private psychologist working with Life Without Barriers informed the Inquiry:

> *The other issue I wanted to address is sexual assault. That is a really huge issue and it is ongoing. For any child under 10 to get sexual assault counselling, it is usually very, very difficult because, especially in foster care, they do not trust adults. If they make a disclosure, it is usually to the foster carer. Then when DoCS interviews or JIRT interviews, they won't say anything, they won't make another disclosure; therefore, the referral can't be made for a sexual assault and the counselling doesn't happen. That is the most appropriate counselling for a child who makes a disclosure. You can send them to a private psychologist, you can send them to another service, but that's not necessarily the most appropriate. What they need at that time is skilled workers to work with them.*[649]

Engagement of Aboriginal Communities

8.276 The difficulties in engaging Aboriginal children and their families in the JIRT process are acknowledged.[650]

8.277 The Inquiry was also informed during the rural Public Forums of the extent to which investigations into allegations of sexual assault within a community on the North Coast had caused serious divisions within that community.

8.278 A consequence has often been the subsequent retraction of a disclosure, and, in many cases, an insufficiency of evidence to justify interviewing a suspected perpetrator. The development of a culturally appropriate JIRT model, for which work has been undertaken may help to address this problem. It envisages making a support person available to a victim during a JIRT intervention, utilising Aboriginal agency staff for a JIRT consultation, improving JIRT staff cultural awareness, and informing JIRT engagement with Aboriginal communities through a community awareness and education package and other strategies.

8.279 The initiatives of DoCS and Police in response to the 2006 Review are positive and need to be supported and maintained. In this respect probably the most important element is engagement with the community and building an understanding of and confidence in the JIRT system. The Toomelah/Boggabilla Project and the further projects considered for other communities, including

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[649] Transcript: Public Forum, Nowra, 13 May 2008, p.22.

[650] According to the JIRT Review in 2006 Aboriginal children represent 3.4 per cent of accepted JIRT cases, a percentage of well below the proportion of such children reported to the Helpline (11.8 per cent). DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, p.21.

Nowra, need to be monitored for lessons about how the JIRT process can be made more relevant for Aboriginal families. Additionally agencies need to demonstrate that they are committed to tackling child abuse in these communities by ensuring that they have specifically trained staff available, and that they will follow through with prosecutions.

Support facilities

8.280 Police drew attention to the fact that while considerable capital expenditure has been incurred in acquiring suitable JIRT facilities away from Police Stations and DoCS offices, and in constructing interview suites with up to date equipment for the recording of interviews, in rural areas particularly those involving Aboriginal communities JIRTs generally have to travel to the location of the victim to interview them.

8.281 It identified that further work was needed to develop practical options for effective portable recording facilities, beyond the current hand held videos mounted on a tripod, that are currently used in these situations.

8.282 The Inquiry acknowledges the force of this submission since the quality of the audio and visual recording of any interview that is to be tendered in Court as the evidence of a child, is vital to the success of a prosecution.

Safe houses and alternative accommodation

8.283 Police also drew attention to the fact that:

> *When a child discloses a sexual assault, particularly those in small Aboriginal communities, there is a need to be able to secure safe accommodation immediately. If a child is placed in an alternative home in an Aboriginal community, they may still be at significant risk.*
>
> *In rural areas there is generally a lack of alternative emergency accommodation available for children at risk.*[651]

8.284 Again the need for this kind of facility is critical given the risks of reprisal and pressure which can be exerted upon a complainant and his or her family in a small community, within which particular problems are likely to arise, in practice, in maintaining confidentiality as to the fact of disclosure and investigation.

Conclusion

8.285 The Inquiry accepts that there are strong reasons in principle, and in practice, for the use of the JIRT model. They lie in its ability to:

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[651] Submission: NSW Police Force, 19 May 2008, p.4.

a. provide a timely and comprehensive investigative process, drawing upon the combined expertise and experience of the team members

b. enhance the quality of investigations and the preparation of briefs of evidence

c. pave the way for the victim and non-offending family members (where the case involves intra familial abuse), to have timely access to therapeutic interventions and counselling

d. lessen the stress for victims by providing a more focussed interview structure that should avoid the need for repetitive interviewing

e. allow, in conjunction with the investigative process, case planning for the well-being and welfare of the victim

f. provide an effective basis, subject to the changes considered elsewhere in this report in relation to privacy and confidentiality issues, for a more comprehensive exchange of information

g. provide a platform for greater interagency cooperation and cross jurisdictional training in the complex and challenging issues that arise in relation to child sexual and physical abuse, and neglect.

8.286 In the light of these considerations and of the experience with the JIT and JIRT process since it was first trialled in 1994/1995, this Inquiry supports its continuation and action to complete the reform process that was instituted following the 2006 Review.

8.287 It is recognised that full involvement of Health as a JIRT partner, enhancement of the Forensic Medical Service, and implementation of the strategies designed to make the JIRT process more accessible and productive in relation to the Aboriginal community, will involve a substantial commitment of resources on the part of all partners, that will have financial implications. The Inquiry, however, considers that there is no alternative other than to complete the reform program, and to maintain an auditing and monitoring process in order to identify whether any of the issues mentioned above continue to emerge, or whether new problems arise that need to be solved.

8.288 In Chapter 9 consideration is given to the issues that arise in relation to the assessment and casework processes outlined in this chapter, and in Chapter 10 recommendations are made to deal with those issues.

8.289 In relation to JIRT, the Inquiry makes the following recommendations.

Recommendations

Recommendation 8.1

The JIRT Reform Program, as set out in the Implementation Plan should be completed.

Recommendation 8.2

JIRT should be regularly audited.

Recommendation 8.3

Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and DoCS.

Recommendation 8.4

NSW Health should provide an appropriately trained workforce to provide forensic medical services where needed for children and young persons who have suffered sexual assault and physical injury.

Recommendation 8.5

The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.

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Assessment tools

Current debate

9.1 In recent decades, child protection practice has become increasingly risk adverse. This is partly as a consequence of intense scrutiny and the fear of the public fall out if a 'wrong' decision is made.[652] In response many child protection systems have had a tendency to resort to increasing proceduralism with a heavy emphasis on risk assessment and investigation processes.[653]

> *It has led to an emphasis on identifying abuse to the detriment of developing services to offer constructive help to families which might enable them to offer a safer and more nurturing environment. In addition, practitioners have been required to devote their efforts to determining whether or not a case meets the threshold for child protection to the detriment of a wider assessment of the family's functioning and consideration of whether the child's needs are not being met for reasons other than serious parental abuse.*[654]

9.2 The factors leading to reports to child protection agencies, such as carer drug and/or alcohol abuse, domestic violence and mental illness, are usually long term issues requiring sustained intervention and support. Research evidence and practice in the USA reveal that in such circumstances a 'family assessment' and support approach tends to be more effective than an investigative approach.[655]

9.3 Predicting whether a child needs to be removed from an unsafe home, or which families would benefit from the provision of services to assist them to parent more effectively, underpins the decisions that a child protection worker makes daily. The task of gathering information, making sense of this information and deciding what action to take are all dependent on the skills that child protection staff have in developing relationships with families to elicit this information.[656]

9.4 A key challenge in child protection services is the identification of effective tools and models that assist caseworkers, managers and organisations to ensure that decisions are based on evidence.

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[652] P Gillingham, "Risk assessment in child protection: Problem rather than solution?" *Australian Social Work, 59(1),* 2006 pp.86-98 cited in L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2008, p.14.

[653] A Cooper, R Hetherington and I Katz, "The Risk Factor: Making the child protection system work for children," *DEMOS,* www.demos.co.uk*,* June 2003, p.23.

[654] Correspondence: E Munro, *Can you design a safe child welfare system*, p.1.

[655] See, for example, US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Alternative Responses to Child Maltreatment: Findings from NCANDS," July 2005; L A Loman and G D Siegal, "St Louis, Missouri: 'Differential Response in Missouri after Five Years: Final Report," *Institute of Applied Research*, February 2004.

[656] Correspondence: E Munro, *Can you design a safe child welfare system*, p.3.

9.5 The Inquiry notes that this task is complicated by the knowledge that expecting complete accuracy in child protection risk assessments, regardless of the model, is unrealistic.[657]

9.6 The accuracy of any risk assessment instrument is determined by three variables:

a. the sensitivity of the instrument (how many high risk families are correctly identified – true positives)

b. the specificity of the instrument (how many low risk families are correctly identified – true negatives)

c. the base rate or prevalence of the problem being measured (child maltreatment).[658]

9.7 Risk assessment approaches can be over inclusive and generate a high number of false positives and on the other hand they can be insufficiently sensitive and generate a high number of false negatives. There are fiscal costs in assessing families who were not at risk for maltreatment as well as in responding to those families who abused their children but were then not identified as being at risk. Personal costs to the families who are labelled incorrectly as abusing their children can also lead to unintended consequences.[659]

9.8 It is important to note that:

> *there is no present risk assessment system that defines, in quantitative terms, 'high', 'medium' or 'low risk.' For example, we do not know if classifying a family as 'high risk' means there is a 10 per cent, 30 per cent or an 80 per cent probability that a family will, in fact, re-abuse children … The best that can be said for existing instruments is that they are able to rank cases, more or less accurately, along a risk continuum, without specifying how close the case is to either end of the continuum, or how much difference there is between cases with different rankings.*[660]

9.9 Risk assessment instruments are in essence risk classification tools rather than abuse prediction tools.[661] Thus, instead of predicting what will occur,

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[657] E Munro "Common errors of reasoning in child protection work," *Child Abuse and Neglect, Vol 23, No 8,* 23 August 1999, pp.745-758.

[658] E Munro, "The Impact of Audit on Social Work Practice," *British Journal of Social Work, No. 34,* 2004, cited in Submission: DoCS, Structured Decision Making, p.7.

[659] RA Caldwell, GA Bogat and WS Davidson, "The assessment of child abuse potential and the prevention of child abuse and neglect: a policy analysis," *American Journal of Community Psychology, 16*, 1988, pp.609-624 cited in Submission: DoCS, Structured Decision Making, p.8.

[660] MS Wald and M Woolverton, "Risk assessment: the emperor's new clothes?" *Child Welfare, 73,* 1990, pp.483-511 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.10.

[661] A Shlonsky and D Wagner, "The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management," *Children and Youth Services Review, 27(4),* 2005, pp.409-427; D DePanfilis and SJ Zuravin, "Assessing risk to determine the need for services," *Children and Youth Services review, 23(1),* 2001, pp.3-20 cited in DoCS, "Risk Assessment in Child Welfare:

classification of greater or lesser degree of risk simply informs practitioners and agencies about which cases are more likely than others to be high risk. As a result, the professional judgement of workers is still crucial. Consequently, the use of risk assessment instruments is not seen as replacing the need for professional and well trained staff.

9.10 Munro concludes that "analytical tools are needed to supplement intuitive skills and shift practice reasoning along the continuum towards the analytical end"[662] and that risk assessment instruments have the potential to improve practitioner reasoning and decision making.

9.11 Dale et al observe, "the application of systematic thinking and analytical skills are notoriously lacking in assessments."[663] Assessments can be susceptible to significant cognitive and emotional bias:

> *In this context, a requirement to record the thinking processes behind the taking of fundamental decisions would instigate practitioners, supervisors and managers to take much more consistent and carefully considered decisions. An audit trail of rationale could have a crucial effect on many key decisions and reduce inconsistency in decision making. To record the rationale for these decisions would focus thinking in a systematic way and ensure that the evidence base of the decision would be transparent and available as a contemporary record in any subsequent dispute.*[664]

9.12 The frameworks for risk assessment vary between jurisdictions. Some rely on frameworks based on professional judgement while others use an actuarially based assessment process or a mixture of both processes.

9.13 Recent debates concern the relative merits of these models for assessing risk. However, numerous analyses of risk assessment instruments have identified the lack of agreed definitions of risk as a fundamental problem, affecting both the empirical validation of these instruments and their implementation in the field.[665] No method of risk assessment will have 100 per cent reliability. Citing relevant research, DoCS informed the Inquiry:

> *An underlying problem is two different approaches to human reasoning: analytical and intuitive. Analytical reasoning is described as 'a step-by-step, conscious, logically defensible*

An Issues Paper," September 2006, p.8; B Saunders and C Goddard, "A Critique of Risk Assessment Procedures: Instruments of Abuse? A review of the literature," *Australian Childhood Foundation*, June 1998, p.22.

[662] E Munro, 1999, op. cit., p.754.

[663] P Dale, R Green, and R Fellows, *Child protection assessment following serious injuries to infants – fine judgments,* November 2005, pp.194-195.

[664] ibid., p.195.

[665] MS Wald and M Woolverton, 1990, op. cit., pp.483-511; T McDonald and J Marks, "A review of risk factors assessed in child protective services," *Social Service Review, 65,* March 1991, pp.113-132 cited in DoCS, *Risk Assessment in Child Welfare: An Issues Paper*, September 2006, p.10.

process' as opposed to intuitive reasoning which is 'a cognitive process that somehow produces an answer, solution or idea without the use of a conscious, logically defensible, step-by-step process.'[666] *In child protection practice, many professionals rely heavily on intuitive skills*[667] *despite the evidence that 'intuition is a hazard, a process not to be trusted, not only because it is inherently flawed by 'biases' but because the person who resorts to it is innocently and sometimes arrogantly overconfident when employing it.'*[668]

9.14 Further:

The literature on human reasoning and decision making indicates that personal judgement is often influenced by contextual factors such as the representativeness of the case, the availability or vividness of information, and the presumed relevance of the available information to the decision being made.[669] *Munro found that most determinations of risk were based on a limited range of data, often with the most memorable cases (those that aroused emotion or were most recent) factoring into the assessment of risk more than the 'dull, abstract material in research studies, case records, letters and reports.'*[670] *Subsequently, even with evidence contrary to the workers initial case disposition, revision of judgement about cases was slow or non-existent.*[671]

9.15 There is a strong body of research indicating that actuarial approaches are superior to clinical judgment approaches in assessment of risk,[672] particularly in relation to the classification of families at risk for child maltreatment.[673] Current estimates of the accuracy of actuarial instruments in predicting child

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[666] KR Hammond, "Human Judgement and Social Policy: Irreducible uncertainty, inevitable error, unavoidable injustice," *New York: Oxford University Press,* 1996, p.60, cited in Submission: DoCS, Structured Decision Making, p.4.

[667] E Munro, 1999, op. cit., pp.745-758 cited in Submission: DoCS, Structured Decision Making, p.4.

[668] KR Hammond, "Human Judgement and Social Policy: Irreducible uncertainty, inevitable error, unavoidable injustice," *New York: Oxford University Press,* 1996, p.88 cited in Submission: DoCS, Structured Decision Making, p.4.

[669] L Cicchinelli, "Risk assessment: expectations and realities," *The Apsac Advisor, 8(4),* 1995, pp.3-8 cited in Submission: DoCS, Structured Decision Making, p.4.

[670] E Munro, 1999, op. cit., p.754 cited in Submission: DoCS, Structured Decision Making, p.4.

[671] Submission: DoCS, Structured Decision Making, p.4.

[672] J Ruscio, "Information integration in child welfare cases: an introduction to statistical decision making," *Child Welfare*, *3(2),* 1998, pp.143-156; RM Dawes, D Faust and PE Meehl, "Clinical vs Actuarial Judgement," *Science, 243(4899),* 1989, pp.1668-1674; AW Leschied, D Chiodo, PC Whitehead, D Hurley and L Marshall, "The empirical basis of risk assessment in child welfare: the accuracy of risk assessment and clinical judgement," *Child Welfare, 82(5)*, 2003, pp.527-540 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

[673] D DePanfilis and SJ Zuravin, "Assessing risk to determine the need for services," *Children and Youth Services review, 23(1),* 2001, pp.3-20; C Baird and D Wagner, "The relative validity of actuarial and consensus based risk assessment systems," *Children and Youth Services Review, 22(11/12),* 2000, pp.47-64 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

maltreatment range from around 70 per cent to 80 per cent[674] compared with 64 per cent for clinical decision making.[675] Anglin contends that accuracy of such tools is not likely to exceed 80 per cent.[676]

9.16 Actuarial methods are not infallible.[677] These models have considerably less accuracy in determining which moderate risk families are most likely to become high risk, or which families are at risk for tragic outcomes such as child death.[678] There is also recognition that there has been little work done on whether the factors that predict abuse are the same as those predicting re-abuse.[679]

9.17 While there is a strong body of research favouring actuarial approaches, a number of criticisms have been voiced. Dr Leah Bromfield, Manager of the National Child Protection Clearinghouse, AIFS advised the Inquiry:

> *key criticism of actuarial models is that, over time, they will de-skill your workforce. The workforce will, over time, look to the tool and not trust their own professional judgement.*[680]

9.18 Other limitations of actuarial approaches include implementation difficulties, where risk assessment scores may be inflated by child protection workers, often with the best intentions of ensuring ongoing services for select families. Results from these tools can also be ignored due to doubt about the psychometric properties of the instrument. As Doueck and colleagues conclude without good quality control and worker supervision, the system can be used to support potentially poor decisions.[681] This problem is shared with professional judgement models.

9.19 In a literature review undertaken by the Australian Childhood Foundation the authors outline various concerns about actuarial based risk assessment tools noting that "the haste with which they are being designed and adopted does not…reflect the sudden availability of valid knowledge based on scientifically rigorous research findings."[682] The authors argue that these tools are seen as

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[674] AW Leschied, D Chiodo, PC Whitehead, D Hurley and L Marshall, 2003, op. cit., pp.527-540; HJ Doueck, Dj English, D DePanfilis and GT Moore, "Decision making in child protective services: a comparison of selected risk-assessment systems," *Child Welfare, 72(5),* 1993, pp.441-453 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.10.

[675] Submission: DoCS, Structured Decision Making, p.10.

[676] JP Anglin, "Well-being and paramountcy in child protection: the need for transformation," *Child and Youth Care Forum, 31,* 2002, p.233-255 cited in Submission: DoCS, Structured Decision Making, p.7.

[677] J Ruscio, 1998, op. cit., pp.143-156; RM Dawes, D Faust and PE Meehl, "Clinical vs Actuarial Judgement," *Science, 243(4899),* 1989, pp.1668-1674 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

[678] B Saunders and C Goddard, 1998, op. cit., cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

[679] P Lyons, HJ Doueck and JS Wodarski, "Risk assessment for child protective services: a review of the empirical literature on instrument performance," *Social Work Research, 20(3),* 1996, pp.143-156; MS Wald and M Woolverton, 1990, op. cit., pp.483-511 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

[680] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.57.

[681] HJ Doueck, D English, D DePanfilis and GT Moore, 1993, op. cit., cited in Submission: DoCS, Structured Decision Making, p.6.

[682] B Saunders and C Goddard, 1998, op. cit., p.22.

'quick fixes' by child protection systems that are under increasing stress[683] and as a means of protecting the organisation from blame when tragedies occur.[684] They conclude by recognising that risk assessment tools may be useful aides to professional judgement but not as predictive tools.

9.20 Another criticism is that the inflexibility of the actuarial model may lead to the exclusion of critical 'left field' factors in assessing risk in a family. Dr Bromfield advised:

> *If we take mental health, though, as an example, most parents who have a mental health problem will not abuse their children. What an actuarial tool is not sensitive enough to do is to tell us why some parents who have that risk factor will and other parents won't, need child protection involvement.*[685]

9.21 On the other hand, the flexibility built into the professional judgement model could have a similar effect, because subjectivity could lead to inadvertently 'selecting out' critical factors.

9.22 In summary, the risk assessment debate accepts that there will always be some inaccuracy associated with risk assessment tools. Recent discourse has begun to move away from an 'either/or' approach and to recognise that whilst some tools more accurately classify risk, this does not rule out the need to use other approaches (consensus based, clinical judgement) in conjunction with risk assessment tools in working out what services will help to ameliorate risk and to engage families with services.

Assessment frameworks used in other Australian jurisdictions

9.23 Australia, like the USA, the UK and Canada, has traditionally adopted an investigative approach to child protection, which focuses on investigating and responding to discrete episodes of reported risks to the child.

9.24 Child protection legislation in each jurisdiction prescribes the role and scope of child protection services and guides child protection practice. Many jurisdictions are currently reviewing how they assess and respond to child protection reports with an emphasis on the importance of assessing both 'risks' and 'needs' at all stages of child protection involvement (that is, intake, investigation, case planning and management).[686]

9.25 Recently, Victoria has developed a Best Interests Framework that has built on its existing Victorian Risk Framework, a professional judgement model, by

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[683] ibid.

[684] ibid., p.34.

[685] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, pp.56-57.

[686] L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2008, p.40.

introducing differential categorisation for statutory and non-statutory reports. Reports are classified as either: a Child Wellbeing Report; a Protective Intervention Report; an Unborn Child Report; or as having Inappropriate/Insufficient information. An outcome of an intake assessment has also been expanded so that a Child Wellbeing Report is referred to a Child and Family Information, Referral and Support Team (Child FIRST) for family support services.[687]

9.26 In 2006, the ACT's assessment process was broadened to include a risk assessment tool and a needs assessment framework. In assessing risk, the ACT uses a Risk Assessment Tool based on the Victorian Risk Framework and the Manitoba Risk Estimation System. In determining a family's needs, the UK Framework for the Assessment of Children in Need and their Families is used.[688]

9.27 Western Australia introduced the Child Safety Assessment Framework in 2005, which is a modified version of the previous assessment tool employed by the Department (the Risk Analysis and Risk Management Framework). The new framework adopts a strengths based approach to safety assessment, and has two elements: an initial assessment framework and a comprehensive analysis of information.[689]

9.28 South Australia and Queensland use a suite of actuarial tools called Structured Decision Making (SDM), developed by the US based Children's Research Center (CRC). The CRC has customised these tools for use in a number of jurisdictions in the USA and Australia. Queensland has adopted the whole suite of SDM tools in a staged approach.[690]

Structured decision making

9.29 The SDM case management model, an actuarial model, is designed to improve decision making in child welfare cases. It identifies multiple decision points and guides workers through each discrete decision point with a structured assessment. The principle behind SDM is that decisions can be improved by clearly defined and consistently applied decision making criteria and readily measurable practice standards, with expectations of staff clearly identified and reinforced. Key factors that are known to have a strong association with future abuse or neglect are included in the risk assessment and are score based on pre-determined rating.

9.30 One of the criticisms of the research on SDM is that in most cases it has been undertaken by the US based CRC. However, the key issue relates to the extent

[687] ibid., p.39.
[688] ibid., pp.33-34.
[689] ibid., pp.39-40.
[690] Submission: DoCS, Structured Decision Making, p.9.

to which it conforms to acceptable standards of research quality and rigour.[691] In any event, there has been a recent review of the research literature on different instruments for assessing risk and safety in child welfare focusing on instrument reliability, validity and outcomes by researchers at the University of California.[692] It found that the SDM has a stronger predictive validity than consensus based instruments.

Use of structured decision making within DoCS

9.31 When asked to explain the difference between the two approaches, the then Executive Director, DoCS Helpline advised:

> *An actuarial system would be embedded in KiDS, so you would put information in and there would be some algorithms running in the background that would weight the information. So what is the combined composite weight that you might put on domestic violence and particular kinds of drug and mental health? In a professional judgement model, which is the one we run, the caseworker does all of that in their head and then tests their perceptions with a third party, their supervisor, and they come up with a judgement together.*[693]

9.32 While DoCS uses professional judgement to guide its assessments at the Helpline, it appears that there is little written guidance or criteria that are provided to Helpline staff to assist them in making judgements about required response times and urgency. DoCS in its own internal review of a child death found poor assessment of history at the Helpline and noted that there is currently no clear procedural protocol in place guiding the level of response.[694]

9.33 In 2005, DoCS reviewed the viability of incorporating SDM into the DoCS assessment process. This review concluded that that there was not a strong case for immediate or full implementation of SDM as its benefits were not sufficiently significant to warrant investment at that time. A key issue identified was that full information was not available to measure the 'errors' in the current DoCS process. Because not all reports receive a secondary assessment, the actual incidence of 'false positives' and 'false negatives' arising from the current process could not be accurately determined. According to DoCS, this is still the case. DoCS decided that work would occur to improve its current assessment system, while at the same time monitoring the implementation of SDM in other jurisdictions.

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[691] C Baird and D Wagner, 2000, op. cit., pp.47-64 cited in Submission: DoCS, Structured Decision Making, p.10.

[692] D'Andrade, Austin and Benton, "Risk and Safety Assessment in Child Welfare: Instrument Comparisons," 2008, p.31. http://jebsw.haworthpress.com.

[693] Transcript: Inquiry meeting with DoCS senior executives, 30 November 2007, p.77.

[694] DoCS, *Child Death Review Report*, 2008.

9.34 In its submission to the Inquiry, DoCS stated:

> *Based on recent experience in other jurisdictions which have introduced SDM™ approaches, DoCS has concluded that there would be benefit in examining the introduction of a structured analysis approach, involving clearly defined and consistently applied decision making criteria, to assist initial assessment at the Helpline of a child's safety…. As in all such systems, caseworkers would be expected to complement the structured analysis outcomes with the exercise of their professional judgement.*[695]

9.35 DoCS further stated that the SDM tools would fit into a revised child protection framework as follows:

> 1. *At Helpline intake a decision-tree such as SDM's Response Priority Assessment would assist with determining the urgency and prioritising action once transferred to the CSC – immediate, within 24 hours, or within 10 days. The less urgent cases are likely to proceed down a family assessment path, pending confirmation through subsequent safety and risk assessments, while more urgent cases have a higher likelihood of investigation and statutory intervention.*
> 2. *At CSC first point of contact with families, a Safety Assessment would determine the 'threat' and extent of 'protective' mechanisms. This would further assist in determining the initial response and the likely recommendations of services.*
> 3. *After the Safety Assessment has instigated immediate intervention where necessary, a Family Risk Assessment, in combination with the Safety Assessment, would confirm the likely path for the family.*[696]

9.36 DoCS stated that while SDM could fit into a reformed child protection system, the tools would need to be tailored and tested within the DoCS environment, and DoCS would need to work closely with the CRC and with the two Australian jurisdictions who are presently implementing SDM. A key issue identified by DoCS is the impact on the workload of CSCs if all cases that meet the criteria are to be assigned a field response, as is part of the SDM model. DoCS recognised that an SDM model would need to build in some alerts or overrides to pick up members of those groups likely to be at high risk, for example, Aboriginal children, children under one year of age, and children whose siblings

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[695] Submission: DoCS, Assessment Model and Process, pp.23-24.

[696] Submission: DoCS, Structured Decision Making, p.11.

have been the subject of high risk reports. Such cases would then be streamed for immediate assessment.

9.37 Dr Raelene Freitag, Director of the CRC, in evidence to the Inquiry, stated that to develop SDM for DoCS, a workload analysis would need to be undertaken, involving a random sample of cases. The analysis would identify the standards for which a worker was accountable and would keep track of the time spent on assessment of a case.

9.38 DoCS recommended to the Inquiry that further analytical work be undertaken before SDM is tested within DoCS. The Ombudsman in his submission to the Inquiry supported the adoption of a structured decision making assessment tool of the type recommended by DoCS. Support for such a tool, he states, 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.

9.39 Dr Bromfield told the Inquiry there is a very limited independent evidence base against which to assess the effectiveness of SDM. She indicated that the 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."[697] In light of this evidence, the Ombudsman is in favour of an initial testing of the tool to ascertain whether it improves assessment, and addresses some of the fundamental weaknesses associated with the current assessment system.

9.40 The Inquiry agrees that such a testing is warranted at the Helpline and at CSCs in relation to assessments and interventions, including restorations.

Common assessment tools

9.41 In a number of jurisdictions, such as England, there is a move towards other services, including all child health and education services, using a 'common assessment framework' to identify and respond to the needs of a child and family, and to refer only those cases requiring a more specialised statutory child protection assessment to statutory child protection services. This common risk assessment framework is thought to enable potential reporters to make more balanced judgements so that the cases reported are those more likely to reach a threshold for statutory investigation and intervention. Such a system if effective is likely to prevent the waste of the scarce resource of child protection workers and to provide earlier assistance to families.

9.42 Research and information provided to the Inquiry suggests that there is merit in exploring the development of common assessment tools, for example through the current project between Health, DoCS, Attorney General's, Police and non-government services to develop a cross agency risk approach on domestic

[697] Transcript: Public Forum, Assessment Models and Process, 18 April 2008, p.57.

violence. Similar work is being progressed for mental health, for drug and alcohol between DoCS and Health.

9.43 As many families present with multiple issues there is also a need to consider an assessment framework that provides tools for all key workers within the child protection system and that encompass all risk factors for the purpose of referral to DoCS. As noted earlier each agency within the system brings different levels of expertise and knowledge to the task. Understanding how risk factors impact on a child is critical to this assessment framework. The common assessment process would operate across agencies, and cases referred to DoCS would then be subject to SDM if adopted, or to its current procedures for assessing risk and for deciding whether to exercise the statutory intervention powers.

Work at the Helpline

9.44 Key issues before the Inquiry have concerned the work of the Helpline. They include the accuracy of the information which is recorded and the completeness and accuracy of history checks undertaken by caseworkers. DoCS has identified the inconsistent use of the category of 'information only,'[698] inconsistent classification of risk levels,[699] and delay in entering data and referring reports to CSCs.[700] In addition, it has found significant variation between CSCs and the Helpline as to whether a report meets the threshold of risk of harm[701] with the result that 21 per cent of reports referred to a CSC in 2006/07 may have been unnecessary.[702]

9.45 The existence of the these issues is illustrated by the findings of the NSW Auditor-General in his 2005 performance audit of the Helpline, and in reviews undertaken by the Ombudsman.

9.46 In his *Report of Reviewable Deaths in 2006*, the Ombudsman noted:

a. In some cases it was not clear whether the Helpline's recommendation adequately reflected the risks to the child indicated in the information at hand, or in information previously held on previous reports in DoCS.[703]

b. In some cases, reports sent as information only contained, at least in part, additional information that raised new concerns not previously identified to DoCS, meaning that new information was not subject to analysis by the CSC. Other reports considered to be 'information only' were closed at the Helpline and some of these cases contained information from the reporter

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[698] DoCS, *Frequently Reported Families Project*, 29 August 2008, p.8.

[699] ibid.

[700] DoCS, *Child Death Review Report*, 2008.

[701] DoCS, *Analysis of the decision to refer child protection reports to a CSC for secondary assessment*, September 2007.

[702] DoCS, *Statistical analysis of the child protection system – a summary*, September 2007.

[703] NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths*, December 2007, p.42.

about the level of risk and for some children there was also a recent child protection history.[704]

c. There were cases where history checks were wrong or did not sufficiently capture relevant family background, including long term parental substance abuse, or mental health issues or where they did not establish significant links to previous incidents or relationships, including where children of a previous relationship had been removed.[705]

d. Factual errors in the assessment of a report were sometimes carried over either wholly or in part, resulting in assessments for subsequent reports replicating an inaccurate history.[706]

e. Multiple reports at times appeared to be assessed on an incident basis, although records indicated escalating risk.

9.47 As an example, the Ombudsman stated in relation to the death of one child, whose sibling was already in OOHC, there had been nine reports made to DoCS concerning the child and her siblings. Of these reports, the Helpline completed history checks, but only three of the reports identified that the child's sibling was in care, and none of the reports identified that her other siblings were the subject of care applications previously. Only in relation to one of the reports is there any evidence of Helpline staff analysing the reported concerns against the children's child protection history in terms of determining the possibility of serious harm, given the cumulative risks from the reports over time.[707]

9.48 DoCS in its own internal review of this case identified that two of the reports took between five and six weeks to be transferred to a CSC and that Helpline history checks were not thorough and did not adequately detail the child protection history.[708]

9.49 The Ombudsman reported that: "Under the current KiDS system, for a user to apprise themselves of a family's child protection history, they may need to spend hours navigating their way through numerous data fields."[709]

9.50 Similar issues were also identified in cases reviewed by the Inquiry where children and young persons had not died. The Inquiry undertook a review of 75 case files to examine casework practice compliance against DoCS policies and procedures.[710] These files included children and young persons from all

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[704] ibid., p.45.

[705] ibid., p.46.

[706] ibid., p.46.

[707] NSW Ombudsman, *Investigation into the death of a child*, *Provisional Statement*, 2008.

[708] DoCS, *Child Death Review Report*, 2008.

[709] Submission: NSW Ombudsman, Assessment and Early Intervention and Prevention, p.12.

[710] The 75 files reviewed represented cases from 41 CSCs of which 63 files were of children and young persons who had been the subject of eight reports to DoCS under Part 2, Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* between 1 January 2007 and 30 June 2007; two files of children and young persons who on 14 November 2007 were reported to DoCS for the first time and that report was referred to a CSC and directly allocated for a SAS 2; seven files representing 20 children who in the week beginning 1 July were referred to and accepted by a Brighter Futures team; and three files of

program areas (Child Protection, OOHC and Brighter Futures), all age groups, 37 female and 38 male children and young persons, 30 Aboriginal children and young persons and nine children from CALD backgrounds. The files were from 41 CSCs representing all regions.

9.51 The Inquiry's case file audit findings were consistent with those of the Ombudsman.

9.52 In relation to reports assessed at the Helpline, the Inquiry's case file review found that only half of the files reviewed had substantial information on the file to show that the child's history of previous reports had been reviewed, with about 40 per cent having some information to indicate that their history had been reviewed.

9.53 The variability of the assigned responses was reflected in one file reviewed by the Inquiry. In that file, between 29 March 2007 and 7 July 2007 nine reports were made about inadequate supervision of a child, specifically a 10 year old child playing on a busy road. The first report was assigned a response of less than 72 hours, it was then transferred to a CSC and allocated. Subsequent reports about the same issue were variously assigned responses of less than 24 hours, less than 72 hours and less than 10 days. It was unallocated and then a later report received a response of less than 72 hours. At some stage, a report was assigned a response of 'information only.'[711] It appears that whether or not the child was actually on the road at the time that the reporter telephoned the Helpline, also affected the assigned response.

9.54 In July 2007, DoCS undertook a root cause analysis, to examine the ongoing concerns regarding history searches conducted at the Helpline.[712] Not surprisingly, one of the key findings of the root cause analysis was that the current structure of KiDS did not support caseworkers when conducting history checks.

9.55 A 2007 business process review also identified the need for tools to assist in identifying risk patterns, in prioritising cases and in ensuring adequate history checks.

Case Study 7

Health workers made eight reports about risk to a child concerning the mother's mental illness and the parents' capacity to care for their child. DoCS performed three SAS1 and one SAS2 before a caseworker from the CSC called the mother's mental health nurse, S, after a report from the

children and young persons who were referred by the Helpline to a JIRT. The sample was not intended to be representative of DoCS clients or statistically significant but rather to provide information on casework practice compliance with DoCS policies and procedures and the outcomes achieved by DoCS for children and young persons.

[711] All reports raised concerns that child was playing on road – one assigned a level 1, 5 were given a level 2 and 1 was given a level 3.

[712] Correspondence: DoCS, 5 June 2008.

Mental Health Unit had been received and allocated a Stage 1 response. The caseworker recorded the conversation in a file note, the last paragraph of which states:

> *S was very concerned for the welfare of V and relayed again Dr's [psychiatrist] fear of the baby dying if left in the care of the parents. As we were speaking I looked up the Helpline report on V. The report was labelled as Information Only and did not contain the doctor's fear of the baby dying and did not fully relay the concerns of the doctor and S. I informed S of this who was very upset as she felt this information was important. S stated that Dr – told the Helpline Caseworker several times about her grave concerns for the baby being left in the care of her parents and her fear of the baby dying.*

The next document in the file was a removal order for the child, made the same day.

9.56 Work has been done at the Helpline to address a number of these issues and the Inquiry is conscious that there have been delays in replacing technology which has impeded the effectiveness of the Helpline. However, of considerable concern is that criteria have still not been established for caseworkers to use in screening all contacts before proceeding to an initial assessment. Further, no written guidance is given to caseworkers in determining the response time which should be assigned to a report and there is no requirement for reports to be placed on the KiDS system and referred within a specified period of time.

9.57 A range of measures are needed to address these deficiencies. They include testing SDM at the Helpline, redesigning KiDS to enable it to be an effective tool rather than the impediment it has increasingly become, clarifying the procedures for referral for 'information only' and the circumstances in which particular response times are assigned and encouraging caseworkers through training and professional development to adopt a more holistic approach. Recommendations have been made in earlier chapters about the first three matters, and recommendations appear at the end of this chapter concerning the remaining matters.

Work at the CSC

9.58 The Inquiry acknowledges that the work done by caseworkers and their managers is difficult, challenging and requires them to be inordinately resourceful to achieve gains with children and their families. The stress of the position is compounded by their inability to effectively engage with all of those who need their services.

> *We read the reports every week. We cringe because we have to close them. We know that we should be getting out there. We know that we will get out there because another report will*

come through and that report that we have unallocated will then become a higher priority than the current priority that week.[713]

I see the two Managers Casework juggling their red in-trays which has got the new unallocated high needs children in it daily, looking at "Who can I change? What is happening for these children? Can I now allocate it?"[714]

I'm faced with five Managers Casework who each have 70-odd cases on their caseload. I'm thinking "How? How am I going to manage in the way that I think is best practice when there's 300-odd cases here … How am I going to sit down with these managers in supervision and ask them to tell me what they have done in the last month when they have got 40 cases in court?" …if you want best practice, if you want a level of analytical reflective casework and decision making, that is not the environment where it will happen……We only see the red flashing lights. The amber we just miss. We are set up to be a system that is in crisis, and we have developed a way of responding that is highly formulaic and highly prescribed, and anything outside of that we are likely to miss.[715]

9.59 As one DoCS employee informed the Inquiry:

It is not so much the amount of work given to each individual (caseworker)…, it is the inability as a human being to help those cases that are screaming out for help but do not fit into the 'emergency category' and therefore need to be passed over in order to work with those needing immediate assistance.[716]

Sufficiency of assessments

9.60 The data indicate that between 2006/07 and April 07/March 08 there has been a significant increase in the number and proportion of reports receiving a SAS1. Over the same period, however, there has been a 10 per cent decrease in the number of reports receiving a SAS2. The number of children and young persons involved in reports receiving a SAS2 has also decreased by 5.9 per cent.

9.61 In addition, multiple reporting in relation to the same child or young person has significantly increased over the last five years and most children and young persons now reported have a history of prior reports to DoCS.

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[713] Transcript: Inquiry meeting with DoCS staff, Hunter and Central Coast Region, p.9.

[714] Transcript: Inquiry meeting with DoCS staff, Western Region, pp.19, 27-30.

[715] Transcript: Inquiry meeting with DoCS staff, Metro Central, p.16.

[716] Submission: current DoCS staff member.

9.62 The average number of reports per child per year has increased which suggests that there is an increased likelihood of continued contact with DoCS; that is, of being reported and then re-reported.

9.63 There has been a significant increase over time in the percentage of children who were the subject of a substantiated report and a further substantiation within the following 12 months.

9.64 It appears that the most likely outcome for children who received multiple SAS2s was to be reported multiple times in the 12 months following the last SAS2. Children who did not receive a SAS2 and who did not have a report allocated were most likely not to be reported again within the following 12 months.

9.65 Of the children with multiple SAS2s, approximately one quarter entered an OOHC placement in the assessment period, indicating an increasing level of seriousness of the risk to these children and young persons.

9.66 The Inquiry sought to explore whether children and young persons entering OOHC did so after a pattern in which reports increasingly received a more urgent response level. DoCS carried out a preliminary analysis, at the Inquiry's request, which revealed that children and young persons follow many different pathways before entering care – some have a long history of child protection reports, some have only a few reports or one serious report and some have no child protection history. However, a preliminary conclusion that may be drawn, is that children and young persons entering care were more likely to have had previous reports with the same or less urgent response levels compared with their last report before entering care.

9.67 There may a number of reasons which explain the data summarised in paragraphs 9.60-9.65. First, the response by DoCS to the initial and even subsequent reports may not have resulted in a decreased risk of harm. This may be because of no action or ineffective action, or the assessment may have been incident based rather than holistic. As noted in some cases reviewed by the Ombudsman, DoCS action has resolved immediate risks – such as homelessness or safety in the context of domestic violence – but has failed to address the serious and ongoing chronic child protection concerns.

9.68 Secondly, it may reflect that DoCS' intervention has resulted in more mandatory reporters becoming aware of the plight of the children and their families and thus making further reports. Thirdly, there may have been an unpredictable change in the families' circumstances.

9.69 Finally, as the Ombudsman has noted cases may be closed after a report has been referred for further assessment, in circumstances where the record indicates that a secondary assessment has taken place, without any work having been done.

> *We also identified some cases where secondary assessment records appear to have been created for purposes other than assessment. This included 'data remediation purposes only', that appears in the child's history as completed assessments, although there is no information to indicate assessment of risk. In other cases we saw SAS1 records that appear to have been created as a tool to close a case, without any apparent gathering or assessment of information. In one record, the only information documented in the record of assessment is CSC will not be responding due to workload and other cases having a higher priority.*[717]

9.70 The Ombudsman also noted that many of the completed SAS1 records contained an effective analysis of risk and safety and provided an adequate basis for a decision on the need for further assessment. However, he also noted that there were instances where SAS1s were very limited in the information gathered, leading to poorly informed decisions not to proceed to a comprehensive assessment. In addition, there were instances where SAS1 information gathering was adequate, but the information gained did not appear to inform decisions about case closure.

9.71 From information available to it, the Inquiry concludes that assessments carried out at the CSC tend at times to be incident based, sketchy and without sufficient regard to potentially relevant information held by other agencies

9.72 The Inquiry has also found that assessments do not always reflect all the available information and do not accurately record the information contained on the file or in KiDS and the decisions made are not always consistent or supported by the available information.

9.73 These findings are supported by reviews by the Ombudsman and DoCS of the following cases.

Case Study 8

Following the death of an 11 month old child, DoCS' review found that the majority of the workers involved in the child's care, though experienced, had failed to consider all of the information available about the characteristics of the child and her family. The case involved the Helpline, two CSCs and a JIRT and the assessment practice was characterised by DoCS as fragmented.

Other problems identified by DoCS included first, a disagreement regarding the case management responsibility between two CSCs which caused unnecessary delay in the assessment, secondly, delays and omissions in

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[717] NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths,* December 2007, p.52.

interagency communications, and finally the fact that new concerns about the child were advised to each of the CSCs but were not added to KiDS appropriately.

Case Study 9

In another case, the DoCS review acknowledged that while there were limited caseworker resources, the risk assessment was generally superficial and of poor quality, it lacked rigour and there was an absence of known facts recorded over time. A critical fact in this case was that the child the subject of an assessment by DoCS over a period of six months was not sighted as part of this process.

Case Study 10

A report was made to the Helpline on 2 June 2006 by the de facto of the maternal grandmother of a 13 year old girl. This was the fifth report received on this child. The assessment recorded that "the caller said A hates her father and she has been sleeping with knives in her bed and not attending school." The case was open and allocated.

There were four further reports over the next 3 months where callers repeated the assertions that A had 'knives' or a ' fork' to be used as a weapon or to protect herself from her father.

The case was open and allocated at the CSC but there is no record of these statements being followed up by the caseworker with the child.

A year or so later, in a referral to PANOC after an alleged rape, under 'DoCS action to date' the history of reports and action is detailed. In the description of one of the reports which included the assertions regarding 'knives', forks' and/or 'weapons' the referral records that "A made allegations that she had been bashed up by her natural father and she goes to bed with weapons." A had never been recorded as making any such allegations herself - they had all come from other reporters.

9.74 From its examination of families who were the subject of the Frequently Reported Families Project, DoCS has identified the following issues relevant to work at CSC level:[718]

a. 66 per cent of the 50 cases reviewed were allocated cases within CSCs. Thus, notwithstanding work being done by a caseworker, fresh reports were still being made.

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[718] DoCS, *Frequently Reported Families Project*, 29 August 2008, p.6.

b. Most of the children whose cases were reviewed had siblings who had also been reported. This may suggest a response by DoCS on the child reported, rather than the family as a whole, including siblings.

c. All of the reviewed cases included at least one type of repeat report with most including two or three. All of the cases reviewed included a risk of harm. This suggests a pattern of repeat reports plus risk, not a pattern of repeat reports without risk.

9.75 From this review DoCS identified some suggested strategies at a CSC, Helpline and service system level, including the following:

> *The most commonly suggested strategy is unsurprising: more comprehensive Secondary Assessments leading to targeted intervention which is clearly communicated to, or jointly delivered with the family and interagency partners.*[719]

9.76 The Inquiry agrees that this should be the goal.

9.77 Further, the review identified a "lack of timely, child focused and holistic assessments for some of the reviewed matters."[720] This further supports the need for reviews (audits) to be undertaken in CSCs to monitor the quality and compliance of casework practice with what are essentially sound policies.

9.78 This is particularly needed as DoCS has tried to respond to these problems through policy and training initiatives, which have included specialised training in critical areas such as substance abuse and neglect as well as revising its secondary assessment procedures. How well these are implemented and monitored in CSCs has been identified by the Inquiry as variable in quality. The need to regularly review the systems and practices within CSCs is critical to improving the quality of services. This is even more necessary where, as noted in Chapter 3, there are significant workforce capacity issues.

9.79 Recommendations about these matters appear in Chapter 3 and at the end of this chapter.

Communication with families

9.80 DoCS' casework policy states that engaging families is an interactive process that is fundamental to all casework with children, young persons and their families.[721] However, a number of submissions and cases reviewed by the Inquiry raised concerns about the lack of effective communication and engagement by DoCS caseworkers and their managers with families. In some circumstances the level of communication was reported as demeaning, overly judgemental and not such as to encourage cooperation.

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[719] ibid., p.7.

[720] ibid., p.8.

[721] DoCS, Intranet, *Engaging Families Policy*.

9.81 Many families stated they have had multiple caseworkers over a year, that caseworkers are difficult to access and that monitoring and supervision of families is minimal.

9.82 In addition, the clarity of communication between caseworkers and clients and the challenges posed in engaging with families when the 'welfare' is held by some in poor regard, were raised.

Case Study 11

At a meeting between the family and DoCS the family was informed "that a rehab entry and participation was the only way that the department felt the family was able to care for the child, otherwise the dept would look at a care application."

The mother agreed and entered a rehabilitation facility. She was due to complete her program on 15 June 2007. DoCS provided support to her during this time, liaised with the facility and assisted with transport to and from medical appointments for her child.

On 14 June 2007 DoCS called the rehabilitation facility to see 'if it was deemed appropriate for her to stay longer' as the mother had requested to leave the program. The rehab worker is recorded as saying:

> *N/M is able to stay longer, that there is nothing that would be classed as overt in regards to n/m behaviour and (she) is on time in relation to picking up her methadone, that they (rehab facility) are trying to assess (that) if n/m goes home is it a safe environment?*

The DoCS worker then spoke with the mother who stated she was clear she would be going home the following day as she had completed the program. She became abusive towards the DoCS caseworker and hung up the phone.

DoCS then assumed care of the child and removed him from the facility on 15 June 2007 due to concerns about the impact of the parents' drug use on their ability to parent and because of the high medical needs of the infant. The notes of the removal record the mother saying:

> *No, you're not taking him, where's A (caseworker), I want to talk to A…..I want to talk to her and tell her she's a fucking liar, she told me all I have to do is stay here for 21 days that's it and that's all I'd have to do, she's a fucking liar.*

DoCS' noted to the Inquiry that the rehabilitation centre (after an initial assessment period of around 21 days) determines the length of time individual clients need to remain in the facility.

Case Study 12

A and B are Aboriginal and were four years old and one year old when they were removed from their mother and placed in foster care on 16 May 2007. There had been 12 reports to DoCS prior to their placement regarding inadequate shelter/homelessness, inadequate nutrition and concerns about physical and psychological harm.

Their mother had been a 'state ward' and it had been acknowledged that she had issues dealing with 'the welfare.' She also had mental health issues, lacked stable accommodation and was not managing her epilepsy. The mother was resistant to DoCS intervention and DoCS was not able to successfully negotiate a working relationship with her. For instance, there was a breakdown of contact visits and contact with extended family.

This breakdown in communication resulted in a lack of inclusive care planning for the children and a potentially unsafe placement with the father.[722] DoCS initial care plan (6 July 2007) proposed an Order of restoration to the mother over two years and recommended participation in the Intensive Family Based Service Program and comprehensive strategies which would assist the mother and support restoration. However this care plan was never able to be discussed and negotiated with the mother. An addendum to the care plan (24 September 2007) records that the ‘mother has refused to work with the Department hence the Department is unable to ascertain if restoration is a realistic option’. The Department then proposed an order allocating Parental Responsibility to the father until the children are 18 years old with a 12 month s.76 supervision order. This was the Final Order made by the Court on 8 January 2008.

9.83 Clear communication is essential, although not always attainable when families will not engage. Strategies to provide caseworkers with enhanced supervision, reduce the pressure of work by diverting cases not requiring statutory intervention and improving the tools available to them are set out at the end of this chapter and in Chapter 10.

Documentation

9.84 Maintaining accurate and up to date records is an essential component of effective casework practice and is stipulated in DoCS’ policies and procedures:

> *case planning processes, including assessments, case plans, minutes of case plan meetings, and reviews, must be recorded and documented in an organised way that is easily accessible*

[722] Serious allegations had been made against the father regarding sexual assault of A.

> *to anyone taking part in these processes. Records should also note when case plan actions are completed and objectives achieved so that this information is taken into account during ongoing planning and reviews.*[723]

9.85 Organised recording of decisions and plans ensures that information is documented and communicated in a logical and sequential way which promotes a coordinated and integrated response to the child's or young person's needs. It also allows for some accountability to children, birth families and carers (as well as other stakeholders) for decisions that have been made.

9.86 There was significant evidence before the Inquiry that the documentation of decisions and actions taken by DoCS staff was at best inconsistent. A number of DoCS own internal reviews identified that there was poor documentation of the reasons for decisions. This affected the completeness and accuracy of information on the file/KiDS and impeded making holistic assessments.

9.87 The DoCS audit of 20 cases in two CSCs undertaken in 2007 identified a number of issues in relation to documentation:

> *There were some files that were very well kept and included almost all of the records from KiDS and other information … there were also some that were quite poor. There were records on KiDS that were not present on files; handwritten information on the files that was not reflected in KiDS; information that was not in chronological order. This made it difficult in some cases to understand the progress of the case and why particular actions took place.*[724]

9.88 In this same audit the reviewer found that in many of the cases reviewed there were not well articulated case plans and it was difficult to assess whether or not the actions planned reflected assessed risks.

9.89 DoCS Frequently Reported Families Project found that there was difficulty in "accurately commenting on the actions and decisions of CSCs due to inconsistent or lack of documentation of decision making in relation to case closure and un-allocation."[725]

9.90 The Ombudsman's *Group Review Report: Children Under Five in OOHC* found that DoCS failed to obtain health records detailing children's health histories for a significant number of children, and documented action relating to medical assessments by specialists was often not contained on the child's file.[726]

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[723] DoCS, *Child protection and OOHC caseworker policy manual*, p.36.

[724] DoCS, Audit report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.5.

[725] DoCS, *Frequently Reported Families Project*, 29 August 2008, p.7.

[726] NSW Ombudsman, *Group Review Report: Children Under Five in OOHC*, November 2007, p.5.

9.91 In the Inquiry's review of the 75 DoCS case files there was inconsistent documentation of investigation, assessment, planning, analysis and casework evident in many of the files. This made it difficult to determine how well the case management policy was implemented in practice. Documentation of the reasons for decisions and actions was sometimes unclear or absent in the files.

9.92 There were also many examples in the Inquiry case file audit where the file was chronologically out of order, contained many duplicates, had missing pages and/or significant gaps in information. This would make it very difficult for a caseworker to build a holistic or sequential picture, particularly if there was not sufficient time to review the file. This could have a major impact on the adequacy of the assessment and subsequent action.

9.93 There were also examples where up to date information concerning an allocated matter was not recorded on KiDS by CSC staff. As DoCS operates a 24 hour, seven day a week service it is critical that information is recorded in one place so that in the event of an after hours report all available information is accessible.

9.94 An internal review by DoCS of a particular file following the death of a child also highlighted these risks:

> *The paper file and KiDS records for this case suggest the case was allocated in April 2006 but no casework was undertaken until after [the child's] death in July 2006, a period of more than two months…..this means that when the matter was viewed on KiDS, by both the Helpline and other staff within the office, the matter appeared to be allocated when in fact no casework was being done and no staff were assigned the tasks of monitoring the matter in the absence of the allocated caseworker.*[727]

9.95 The risks associated with operating a dual system (both KiDS and paper files) for recording information about children, young persons and their families are obvious and significant.

9.96 KiDS should be the only system used by casework staff. This is even more critical when reports are made after hours to the Helpline. Decisions based on full access to all information may make a difference to whether a response is made to the report.

Case Study 13

The Inquiry requested the files on a particular Aboriginal child, who was a member of a large family. DoCS provided the Inquiry with three volumes of hard copy file information, one volume of KiDS records, and a KiDS Person History. The file contained records of 17 reports, including contact records

[727] DoCS, *Child Death Review Report,* 2007.

and the related initial assessments. The KiDS Person History listed 30 Initial Assessments. Of these 30, 11 appear to have no corresponding reference material in the file.

From the history section of some reports, it appeared that there were additional reports concerning this child that did not appear in the file, or the KiDS Person History. One report in 2003 referred to 15 prior reports dating from 1993. The KiDS Person History listed 10 reports, and commenced in 2000. The Child Protection History section of another report in 2003 stated that in the preceding 15 months there were 17 previous reports for this child. For this period, the KiDS Person History listed 10, and the file contained five of these.

The file was difficult to follow, as the reports and other material did not always appear in chronological order. The third volume contained information in chronological order for 2007, however some of the information for 2007 was not in this file, and appeared in a different volume between paperwork from 2005.

Of the reports listed on the KiDS Person History, seven appeared to have been given a response time of less than 24 hours, requiring caseworkers to quickly access and assimilate the child protection history to inform their decisions. While it is possible that some of the missing information is listed in the files of this child's multiple siblings, it is difficult to see how a worker can effectively and swiftly access the relevant information to inform practice from a disorganised and disjointed file such as this one. It is of concern that the files refer to reports and information that is not referenced in the Person History.

Changes in caseworkers and CSCs

9.97 The Inquiry's audit demonstrated problems when caseworkers change and where a case needs to be moved between CSCs. In some of the files reviewed by the Inquiry a change of caseworker resulted in inconsistent approaches. One case had 11 different caseworkers assigned from 2003 to early 2008. In another case, initial work was positive, and a case plan was developed for handover to a new caseworker when the initial caseworker was transferred. However, after this good start the case could not be re-allocated due to staff shortages and the case plan was not implemented.

9.98 As is evident from Chapter 3, the issue is not so much retention of staff but movement within the organisation. While there can be clear benefits to staff and to DoCS from this flexibility, clients can suffer. As has been noted by the Ombudsman, good handover procedures are essential.

Case closure

9.99 The 2002 Kibble Committee report found that:

> *The ongoing dilemma at the CSC is how to find a balance between addressing as many cases as possible with limited service levels, with addressing fewer cases with a higher level of service. The vast majority of work undertaken at a CSC is reactive; that is, the incident has usually already occurred by the time DoCS are involved. The triage approach and management focus on a satisfactory response to level 1s appears to favour an allocation of resources to as many cases as possible…. The triage approach and emphasis on Level 1s may have inadvertently caused a number of more serious Level 2s and 3s to have escaped the attention of Caseworkers. There does not appear to be clear guidelines for Casework Managers as to how they weigh up the significance of risk and probability against the matter of urgency, and allocate work accordingly.*[728]

9.100 While there are now guidelines that provide some greater direction for CSCs and for the Brighter Futures program, the picture remains similar to that of 2002 as described above. The Inquiry visited a number of CSCs whose staff provided concerning examples of cases that they were not able to allocate, even though the risks were high, due to other more serious matters. Examples of such cases provided by a CSC in Metro South West Region follow.

Case Study 14

One case involved two children aged eight and 11 years who live with their mother. Since 2004, there have been 16 reports received with 15 of these occurring in 2007.

The reports concerned a suicide attempt by the mother, drug and alcohol abuse of the mother resulting in alleged physical abuse, and inadequate nutrition of the children. Mother has a 20 year intravenous drug use habit and approaches her daughter's friends to sell them drugs. Mother is bi-polar and is currently not being treated and not taking her medication. There is verbal and physical abuse between the mother and her new boyfriend. Mother drinks every day and the eldest child gets breakfast and makes lunch herself.

Recently the mother was found by one of the children unconscious with blood coming from her eyes and frothing at the mouth. It is suspected that drug users attend the home to shoot up in the garage. The last report

[728] Joint DoCS/Public Service Association, Working Party Report, June 2002, p.49.

stated that the mother's care of the children was deteriorating and the children are described as depressed, reacting badly to any loud voice and at times covered and hid.

None of the reports that were received have been able to be allocated by the CSC.

Case Study 15

A second case concerned a family where there have been 13 reports since July 2003 to DoCS.

The parents both seem to have a long history of drug use and have been in and out of jail for several years. Both parents have been on the Drug Court program and are still using. The children do not appear to have any stability in their lives and are constantly exposed to drug use by their parents as well as domestic violence incidents.

Four other children have been removed from the mother's care. The reason for removal of these children was due to physical abuse, severe verbal abuse, exposure to domestic violence and neglect.

A report in 2005 was received regarding concerns about the mother's ongoing drug use (amphetamines and ecstasy) and the lack of insight that the mother showed regarding the effects of her drug use. There were also concerns over the mother's relationship with the child as probation and parole had witnessed the mother threaten to 'flog' the child for disobedience and continues to use inappropriate and explicit language.

The last report was received in January 2008 and was not able to be allocated at the CSC. This report was made by Police who had attended the family home after both parents called the Police. Mother alleged father assaulted the child by kicking him and making him fall in to the wall. Mother claimed the father head butted her. In the report Police stated the child did not say a single word but had no visible injuries. Both parents were aggressive towards each other and the Police.

Case Study 16

A third case relates to a family where there have been 22 reports from 8 June 2000 to 21 December 2007, 18 of which related to domestic violence. Mother has a reportedly significant problem with marijuana abuse.

A report received on the 22 May 2007 related to the mother being physically aggressive towards her child, which resulted in him falling over and sustaining an injury to his head. Other issues identified related to the mother being observed as being heavily under the influence of substances.

A report received on 26 October 2007 stated that one of the children had rotten decaying teeth with a large abscess forming. Parents had not sought medical treatment for this. This child also had a large patch of hair missing behind her left ear.

The most recent report on the 21 December 2007 stated that the father physically assaulted the mother in front of the children. The mother attended a refuge and was transported by police, the children remained with the father. Concerns were raised that the children have been left with their father.

Father uses heroin and deals and the children have reported to their teacher that they are scared of both of their parents. Other reports state that the children do not bring enough food for lunch and they are like scared 'rabbits.' Case closed unallocated.

Case Study 17

In 2006, five reports were received regarding issues of drug abuse by the carer, domestic violence and risk of physical harm.

In 2007, five reports were received about the same issues. None of the reports were allocated for ongoing casework and the only work that was conducted consisted of investigative phone calls. This was done at intake level.

In 2008, one report was received regarding issues of sexual harm, domestic violence and drug abuse by the carer. Of these reports only one is currently open.

That report relates to an 11 year old boy disclosing that the mother's partner sexually abused him. The child disclosed that his mother's partner was performing fellatio on him. The boy had also expressed concerns that his two sisters may also have been sexually abused. He no longer resides with the mother and her partner however the two sisters and a newborn child do.

He was interviewed by JIRT in January 2008 and made clear disclosures however his mother did not believe his disclosure and has maintained a relationship with the alleged perpetrator. Police attempted to arrest the perpetrator but he was not located although the mother said he visits on and off. The Police will be charging the mother's boyfriend with an act of indecency with a child under 16 years and aggravated sexual assault.

The CSC state they have strong concerns for the other siblings who still reside with the mother as a result of her not believing or minimising the seriousness of her son's disclosure. There is also concern that she seems to be hiding the perpetrator from Police or not disclosing his whereabouts.

The CSC could not allocate the case.

9.101 In reviewing 75 DoCS case files, the Inquiry gave attention to whether the case closure policy is routinely followed by in CSCs. In some cases there was evidence that the policy was fully implemented, with the non-allocation of the case properly and completely recorded. The reasons usually included the number of trained staff on leave, the number of staff at training, the number of staff awaiting training, and information concerning a full caseload for available staff such as the number of court matters and case allocations they had.

9.102 In one case, the file note provides similar information on caseworker and manager caseloads in the reasons for non-allocation, in conjunction with the observation that the "unit was instructed to function five per cent below budget." In some cases, the file notes documenting case closure under this policy also noted that the case warranted a risk of harm assessment, although it was not possible to allocate the case. In some cases, Priority One review meetings were documented as having occurred, with the outcome that the case remained unallocated and was closed, or occasionally was allocated.

9.103 There were other examples, however, of instances where no reason for closure was provided. In the case of many of the cases closed under the policy, there was no response to the reporter on file.

9.104 In addition to the information gained through the Inquiry's case file audit, the data indicate that, at the most, 0.4 per cent of reports which were closed before any secondary assessment due to competing priorities, had been subject of a s.248 direction. That percentage increased to 5.1 per cent of those closed after a SAS1 due to competing priorities.

9.105 This may suggest difficulties in obtaining information from other agencies, or inadequate assessment practices in DoCS in making inquiries of those agencies.

9.106 While CSCs have received an increase in the number of caseworkers under the Reform Package, there are at times significant periods when these new resources cannot be used to respond to reports being received. This is related in part to delays in the recruitment of new staff once vacancies occur, absences for the training required for new caseworkers, the relative inexperience of new caseworkers and casework managers, and leave arrangements. However, it is noted that the percentage of reports closed at CSCs or JIRTs before any secondary assessment, generally and by reason of competing priorities has reduced between 2006/07 and 2007/08. In addition, in the last financial year, more SAS1s were completed before closing the file due to competing priorities.

9.107 Recommendation 29 of the Legislative Council Standing Committee On Social Issues December 2002 report, *Care and Support: Final Report on Child Protection Services,* called for DoCS to establish a formal strategy to reduce the number of unallocated cases, both those which are requests for assistance and

those which are reports of children at risk of harm, and to also establish data collection systems to monitor levels of unallocated cases. It was recommended that the data be made public. This report makes that data public.

9.108 The Ombudsman stated that one of the predominant and ongoing issues identified in his reviews of child deaths is the number of reports closed due to current competing priorities once they reach a CSC, observing:

> *many of the cases closed on the grounds of 'competing priorities' 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.*[729]

9.109 The Ombudsman noted that the new Intake Assessment Guidelines provide an important tool for promoting consistent assessment and allocation decisions but is of the view that they do not deal with the problems of closing cases where significant risks have been assessed but for which DoCS is not able to provide a response. The Ombudsman has recommended previously 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.*[730]

9.110 DoCS 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. DoCS' advice to the Ombudsman has consistently stated that it is not possible to identify a risk threshold beyond which a case cannot be closed.

9.111 The Inquiry has concerns in relation to the function of the DoCS Intake Assessment Guidelines as a second stage mechanism for prioritising cases for allocation within the CSC. Information provided to the Inquiry suggests that inconsistent practice in conducting thorough child protection histories at both the Helpline and during a SAS1 at a CSC are still evident leaving cases where there are at harm risks unaddressed. This together with the level of further reporting for children who have previously received some form of assessment by DoCS suggests that there may be a more fundamental issue related to the quality of assessment practice within CSCs (SAS1 and SAS2).

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[729] Submission: DoCS, Assessment and Early Intervention and Prevention, p.8.

[730] NSW Ombudsman, *Reviewable Deaths Annual Report 2003/04*, December 2004, p.67.

9.112 In Chapter 10, the Inquiry addresses the need for the expanded use of universal, targeted and tertiary services, the adoption of different pathways for responding to risk of harm reports and a greater responsibility for other government and non-government agencies in providing services for families in need. Together the initiatives could help in addressing the current gap in those cases which have been closed due to a lack of resources, but which still pose risks for the children or young people concerned.

Restoration

9.113 The Inquiry has found that DoCS does not consistently carry out a comprehensive assessment before returning children to the parents from whom they were removed.

9.114 In 2007, the Ombudsman reported:

> *In one case we investigated, a child was removed from their parents and placed in temporary care, due to risks presented by domestic violence, homelessness, substance abuse and poor parenting capacity. After some months, the child was restored to the parents following DoCS advice to the Children's Court that the family had demonstrated significant changes in the circumstances that had led to the child's removal, and that the parents would continue counselling and had agreed to random drug testing. However, our review found there was inadequate assessment or verification of these changes. Records indicate the parents disengaged with support services following restoration of the child and closure of the case by DoCS.*[731]

9.115 One non-government service met with a number of their service users to canvass their experiences with the child protection system so as to inform the Inquiry. A consistent theme that was raised by service users included the following:

> *The operation of the system does not always result in better outcomes for children. This was particularly of concern where children were removed subject to a number of assessments that did not seem to be completed and returned to families with no real sense of anything being different.*[732]

9.116 DoCS *Child Deaths Report 2006* similarly found cases where siblings were restored, notwithstanding the lack of evidence of changed practices to parental behaviour.[733]

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[731] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.57.
[732] Submission: UnitingCare Burnside, 20 May 2001, p.1.
[733] DoCS, *Child Deaths Report*, 2006, p.29.

9.117 An audit of 20 cases in two CSCs undertaken by DoCS in 2007 identified a number of issues in relation to restoration practices:

> *In a significant number of the cases restoration occurred with comments about parents having being referred to other support services and therefore the safety of the children was increased. On these files there was little evidence that DoCS had actually assessed whether the parents were attending the services as required or on any regular basis, and whether or not the services were having any impact on the range of issues that were identified in reports as being risk issues for the children.*
>
> *It is apparent however in many of them there is little evidence of continuing work from DoCS and significant change on the part of the parent which would indicate sufficient safety. It does appear that there is a tendency towards 'trying' restoration plans as a first move, and attempting to get consented care plans rather than considering and planning for permanency for the children.*[734]

9.118 The same audit found that where restoration plans are agreed to in court, there is a significant drop off in the work caseworkers are able to do, or are asked to do, on the restoration plan. The audit found that in some cases a number of months pass without any indication of casework in the file other than organising contact visits.[735]

9.119 It should however be noted that a follow up review undertaken by the Ombudsman in 2007, into the adequacy of case management, including care planning and permanency planning of children under five years of age managed by DoCS, found that, *inter alia*, there were improvements in the quality of care planning for children who were the subject of short term orders.[736]

9.120 Ineffective casework practices in this respect poses a significant risk to children and young persons, who may be placed back in situations where the same risks that necessitated DoCS intervention have not been adequately addressed. In a cohort study undertaken by DoCS in 2007, an analysis of children aged 0-16 years reported in July-September 2004 showed that overall, children who had previously been in placement were more likely to be reported again than children with no placement history.[737] This suggests that restoration practices may be a factor in both multiple reporting and re-entry into care. This matter is further addressed in Chapter 11.

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[734] DoCS, Audit Report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.7.

[735] ibid., p.8.

[736] NSW Ombudsman, *Group Review Report: Children Under Five in OOHC*, November 2007, p.4.

[737] DoCS, *A closer look: recent trends in child protection reports*, December 2007.

Referral to services for children and families

9.121 As indicated earlier, DoCS provided limited data to the Inquiry on the work done with families once an assessment has been completed, although some information was gained through the Inquiry's visits to CSCs. Many of the CSCs visited outlined significant issues with accessing external services for children and families, particularly health related services:

> *One of our biggest issues when we are working with families is finding other agencies or departments where we can refer, like, say for argument sake, families with alcohol or drug issues, there is no drug and alcohol counsellors in the area, so it is really difficult. Most of the follow up needs to be by caseworkers or an attempt to get services from outside the area to support the families or get the families to that support. That is not only with drug and alcohol, it is with sexual assault counsellors.*[738]

> *All we can do is refer them to mental health and then when you go to mental health, there is no one really there to support them. The resources levels here are just unbelievable at the moment; there's nothing there to refer to half the time.*[739]

> *There is a huge waiting list for PANOC counselling services and child and family counselling services.*[740]

9.122 Many submissions from non-government service providers commented on the lack of referrals of children and families by DoCS to agencies and subsequent monitoring by DoCS. Barnardos informed the Inquiry:

> *We are also heavily involved in the child protection system through the provision of children's family centres - that is centres providing eight, nine, different practical programs in areas of high socioeconomic need. They receive a lot of referrals -sadly few from the department. The issue of referrals is a sore point with us. We have given evidence at previous inquiries into the department's functioning. There was a Senate inquiry about the department. We gave evidence there that the department is extremely poor at referring out. One arm of the department funds us to provide service delivery and the operational arm simply does not refer the children. We get to know them because they come to us from varieties of other sources.*[741]

[738] Transcript: Inquiry meeting with DoCS staff, Western Region.
[739] Transcript: Inquiry meeting with DoCS staff, Northern Region.
[740] Transcript: Inquiry meeting with DoCS staff, Southern Region.
[741] Transcript: Inquiry meeting with Barnardos, CEO and Director of Welfare, 18 December 2007, p.3.

9.123 Further, The Benevolent Society told the Inquiry:

> *The DoCS workers are so backed up with responding to crises, they are not actually getting around to phoning us with the referrals. I used to manage a number of our services as a senior manager, and I'd be saying to my managers, "You have to be phoning them twice a week. We have room for 20 families. We have 15 and we know DoCS has the families." We actually assertively have to go to them and have meetings with them to get the families, which is remarkable. The PANOC services in Health, they certainly used to say that. It is another system issue where DoCS are so busy dealing with the reports that they can't get to the referrals.*[742]

9.124 A related issue concerns the appropriateness of referrals and follow up the outcome. In a recent DoCS internal review of 20 cases at two CSCs it was noted:

> *In some of the cases there were interviews with parents regarding the risks and where they denied the allegations, or said they had stopped the behaviour (for example using drugs) their word was taken as proof of change. In one case where there were reports regarding physical abuse, drug and alcohol use and mental health issues including suicide attempts by the mother, the case was recommended for closure following a referral to mental health services. Prior to recommending closure there was no evidence that the referral had been taken up, despite evidence on the file that previous referrals to mental health had been unsuccessful.*[743]

9.125 As is clear from Chapter 7 there are too few services, however in the view of the Inquiry, DoCS does not refer sufficient families to those services which do exist. Chapter 10 makes recommendations in this regard.

Aboriginal children, families and communities

9.126 Many of the initiatives being taken to improve DoCS caseworkers' capacity to make appropriate decisions about risk of harm, removal and placement of Aboriginal children are in the early stages of development or implementation. DoCS stated that this makes it difficult to assess the impact that these measures will have on practice and the service system, and ultimately on Aboriginal children and families.

9.127 DoCS identified in its submission to the Inquiry that while more formal consultation processes are in place in relation to placement and maintenance of

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[742] Transcript: Inquiry meeting with The Benevolent Society senior representatives, 12 December 2007, p.17.

[743] DoCS, Audit report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.6.

cultural identity, the processes in relation to investigation and the decision to remove are less clear. DoCS is currently developing a resource that will assist DoCS caseworkers to develop effective working relationships with Aboriginal children, young persons, families and communities.

9.128 In addition, there is work currently being implemented within DoCS to improve practitioner knowledge and skills in working with Aboriginal clients and their communities. Some of these projects include the development of cultural care plans; the Aboriginal Strategic Commitment and local plans for each CSC and region; as well as cultural training and increasing the number of Aboriginal staff within the organisation.

9.129 DoCS also identified some significant barriers in many rural and remote Aboriginal communities for implementing case plans to address risks for these children:

> *A lack of options in many of these communities for family support, services for children or possible placements can also lead caseworkers to more quickly remove children from the community back to a regional centre. An alternate response to these same conditions can lead some caseworkers to fail to act, by making a judgement that the child isn't in as much need as others.*[744]

Case Study 18

Child B was born in 1992 in Campbelltown, the second child of two Aboriginal parents. His birth certificate, applied for and obtained when he entered voluntary temporary care in 2007, shows that his mother was born in Gilgandra NSW, and father was born in Taree NSW. It appears that the family history with DoCS commenced in May 1993.[745] B was placed in care more than once before DoCS obtained the birth certificate, which is the only evidence on file of his mother's place of origin. There is one other reference to her being of a different origin to local Aboriginal people in Wyong, when she said she could not access services because she was of the 'wrong blood.'

Over B's history of involvement with DoCS, the exploration of family relationships reflected in the file concentrated on his nuclear family. In a report early in 2003, the mother of B made an unsolicited statement that the child's natural father had a child from a previous relationship. There is no indication on file that further information was sought, although names

[744] Submission: DoCS, Aboriginal Communities, p.27.

[745] In a report dated 29 May 2003, it is noted that fifteen prior reports exist dating from May 1993 to April 2003. Later in the file material interspersed with reports from different years are reports dating 3 January 2002 and 19 April 2002. The material prior to 2002 was not reflected in the files.

and addresses of a mother and child of a different surname are recorded in the report without a stated relationship.

This potential half sibling of B is not named in the relationships section of the person history. Nor is B's paternal grandmother named in this section, although DoCS had direct contact with her at least once, in 2002. Cousins, aunts and uncles appear in the person's history relationship section, but there is no information to show whether their relationship to B is through his mother or his father, or how meaningful those relationships are to him.

In an interview with the natural mother in 2007 a caseworker asked the mother "Have you got family in Sydney? Is your mother there?" The mother's recorded answer was "Mum passed away in '89. I come from a big family, five boys and five girls." The caseworker responded "Do you see your other children?" The narrative then says that the mother provided the children's names and ages details as follows: A 18, B 15, C 13, D 11, E 8, F 7, G 4.

Only B and child H, almost 12 months old, were in her care and she was expecting child I. One caseworker asked the mother whether the two sons that she has with her were full brothers. The mother said that they were step brothers. It appears from the file that they are in fact half brothers, as they both have the same mother. This was not clarified in the interview. The notes do not document any exploration of the mother's relationship with her four sisters and five brothers.

This mother is called CI, but also known as CBe. Throughout the file reports variously identify B as being born in 1991, 1992, or being twins with his older sister A or younger brother C. His first name is spelled several ways, and he seems to be identified under at least three surnames – BI, BBr, and BC.

Children A, B, C and D appear to share the same father. It is not clear from the file who the father of E is. F and G appear to share an unnamed father. In 2006, H was born followed by I in 2007, apparently to two different fathers named in the file. In an Initial Assessment in 2005 it is noted that there was a "previous record of a prenatal report for twins that were due in April 2005 and also a record showing a prenatal report for a baby due to be born in 2004. No further information about these pregnancies are clear." In terms of extended family, the only other person mentioned in the file is the paternal grandmother of A, B, C and D, with whom B and some of his siblings were placed informally or formally (it is not clear) for a period or periods of time.

In the 2005 initial assessment above, the Helpline quotes the reporter as saying that "mother said the rest of the children are "with their father, sort of", mother refused to explain further."

In the interview in 2007 referred to above, the mother volunteered the information about her family of origin, and the caseworkers did not seek any further information. There is no record in the file of any questions regarding the extended family of B's father, the presence of any siblings of the natural father, or any further information being sought about other children of the natural father.

At one point in 2007 B's father was not contactable, and the mother was observed to be intoxicated and then could not be located. The DoCS worker recorded "the only adult that I was able to access concerning this was B's sister – A who is 19 years old. She said to me that she was travelling to Tamworth tomorrow being 12 February 2007 to pick B up and see her mother. A was able to give me verbal permission to take B into temporary care until she arrives."

For B, who had four recorded entries into care, there was no genogram in the file, and it was a very time consuming process to sift through the file to find the relevant information. The aunts and uncles referred to in the KiDS Person History did not have contact details in the files provided to the Inquiry.

9.130 Clearly more needs to be done. In Chapter 18 of this report, recommendations are made.

Good casework

9.131 As is clear from this chapter, the quality of casework at CSCs is variable. However, the Inquiry was made aware of examples of good casework, including successful engagement with families, implementation of supportive casework practice, and appropriate use of mechanisms such as s.248 requests to access relevant information. Some files documented a clear case plan, regular case meetings with multi agency involvement, effective liaison with other agencies and case management review.

Case Study 19

Five prenatal reports had been received and the file was allocated at the birth of the child. There was clear evidence of a timely and ongoing response by DoCS and ongoing liaison with other agencies to coordinate services. The mother moved to WA and DoCS wrote to WA child protection services outlining their involvement with family (assistance with child and family health services, supported accommodation, parenting course, Alcohol and other Drug counselling). DoCS involvement recommenced when the mother returned to Sydney. The risks related to the mother's mental health issues and drug use. The risk of harm fluctuated but DoCS kept in regular, weekly contact, conducted home visits and worked with other agencies to ensure supports were in place.

9.132 It is not suggested that this is the only example of good casework seen by the Inquiry, but it is indicative of what can be achieved when there is an effective commitment to provide a follow up.

Supervision and professional development

9.133 Many of the casework practice issues identified in this chapter can be addressed by enhancing the supervision structures in place and ensuring that professional development is ongoing and targeted at areas of poor practice. It should specifically address the need for, and encourage and support the implementation of, policy and procedure.

9.134 The Inquiry is of the view that the establishment of the DoCS clinical structure comprising Casework Specialists and Directors Practice Standards should be retained to focus on coaching new frontline caseworkers and newly appointed managers, as well as to provide and facilitate access to other key clinicians, external to DoCS, so as to assist in managing complex cases.

9.135 For all caseworkers and managers there should be a structured program for ongoing professional development which is incorporated into annual PPR agreements. This should focus on the development of skills in evidence based assessment and intervention and on obtaining knowledge and skills from other key specialists, such as those practising in mental health, substance abuse and domestic violence.

9.136 In addition to individual supervision, there should be a facilitated monthly group case practice review of selected cases within each CSC, in which all caseworkers and managers, participate, and which may include specialists from other agencies, where the case requires.

9.137 DoCS should seek to develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine that require safety and risk factors to be taken into account in decision making. This may include a period of structured internship where new caseworkers (with limited experience and newly qualified) have the opportunity to engage in a range of supervised work activities. A cohort of experienced practitioners should be identified to support these staff.

9.138 DoCS should explore the establishment of specialised training in child welfare and child protection practice as part of key undergraduate courses in disciplines such as Social Work. Incentives could be considered for new recruits who complete this specialised component including placement with DoCS commence at a higher remuneration level. Under this model those without specialised prior training would start at lower grade and receive intensive induction support.

Inquiry's review of four CSCs

9.139 The Inquiry visited and met with the staff at a number of CSCs and subsequently collected and reviewed data concerning Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC. The Inquiry also held Public Forums and interagency meetings at or near Shellharbour and Moree.

9.140 The demographics, staffing composition and capacity of these four CSCs vary significantly as do the number of reports they handle. The following table provides details of the number of casework staff positions in each of the four CSCs as at 30 April 2008.

Table 9.1 **Casework staff establishment numbers in Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC, as at 30 April 2008.**

	Campbelltown	Eastern Sydney	Shellharbour	Moree
Managers Client Services	2	1	1	1 (shared-Narrabri)
Managers Casework	12	6	6	2
Caseworkers	74	36	33	13
Casework Specialists	2	2	2	1 (shared-Narrabri)
Total Casework Staff	90	45	42	17

Note: IFBS staff based at Campbelltown were not included in this table as their work involves intensive case management of specific families.

9.141 At 30 April 2008, the four CSCs were carrying varying numbers of vacancies. At Campbelltown 5.4 per cent of the above caseworker positions were vacant, at Eastern Sydney 19.4 per cent were vacant, at Shellharbour 12.1 per cent were vacant, and at Moree 46.2 per cent were vacant.

9.142 The supervision ratio for Managers Casework to caseworkers at 30 June 2007 ranged from 1:3 in Moree to 1:8 in Shellharbour. The State average for 2006/07 was 1:6.

9.143 At 30 June 2007, a significant proportion of caseworkers in all four CSCs had been employed by DoCS for one year or less. In Eastern Sydney they accounted for almost two thirds of all caseworkers, in Shellharbour they accounted for over 60 per cent, and in Campbelltown and Moree, they accounted for about half of all caseworkers.

9.144 Managers Casework had on average more experience working for DoCS than caseworkers, particularly at Eastern Sydney where all managers had six or more years experience as DoCS employees, and Campbelltown where all but two managers had four or more years experience working as DoCS employees.

9.145 At 30 June 2007, the average rate of separation for DoCS caseworkers was 7.18 per cent. The separation rates in Campbelltown and Shellharbour were below the average while in Moree and Eastern Sydney the rates were significantly higher than the average, at 16 per cent and 22.2 per cent respectively.

9.146 The table below shows that as at 30 April 2008, the caseworker capacity for all four CSCs was significantly lower than the number of caseworkers occupying positions. Given the significant proportion of caseworkers employed in all four CSCs who had been employed by DoCS for one year or less, it is assumed that many of these caseworkers had not completed CDC training and as a result were not counted when CSC caseworker capacity was calculated.

9.147 The impact of training on the caseworker capacity of CSCs should not be underestimated. During 2006/07 DoCS staff undertook 127,169 hours of CDC training, which averages at around 50 hours for every caseworker position. A further 83,160 hours of other training was undertaken by DoCS staff, which averages at just over 20 hours for each staff member.

Table 9.2 **Caseworker capacity and caseloads for Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC, as at 30 April 2008**

	Campbelltown	Eastern Sydney	Shellharbour	Moree
Caseworker establishment	74	36	33	13
Caseworker positions filled	70	29	29	7
Caseworker capacity	36.94	11.70	8.26	4.27
Caseload per caseworker (on open plans)	8.55	17.10	8.31	16.28

9.148 As at 30 April 2008, caseworkers at Campbelltown and Shellharbour were carrying caseloads that were lower than the State average of 11.33 open plans per caseworker. Eastern Sydney and Moree were carrying caseloads that were higher than the State average.

9.149 In 2006/07, 7,748 reports were referred to Campbelltown CSC by the Helpline for further assessment. Shellharbour CSC received 4,889 such reports, Eastern Sydney CSC received 3,171 such reports, and Moree CSC received 1,262 such reports.

9.150 The proportion of referred reports involving Aboriginal children and young persons varied significantly across the four CSCs in 2006/07. Of all referred reports in NSW in 2006/07, 17.9 per cent involved Aboriginal children and young persons. In Campbelltown, Eastern Sydney and Shellharbour the proportion of reports involving Aboriginal children and young persons was below the State average at 10.5 per cent, 12.5 per cent and 13.1 per cent respectively. The opposite was true of Moree, where the proportion of reports involving Aboriginal children and young persons was much higher than the State average at 68.6 per cent.

9.151 Between 2004/05 and 2006/07, there was a 43.5 per cent increase in the number of reports referred to a CSC/JIRT for further assessment. The percentage increase in the number of referred reports to Moree over this period was close to the State average at 43.9 per cent. It was slightly higher than the State average at Campbelltown at 48.1 per cent and was significantly higher at Shellharbour, which experienced a percentage increase in referred reports of 64.2 per cent. At Eastern Sydney there was no increase in the number of referred reports from 2004/05 to 2006/07. In both years, 3,171 reports were so referred.

9.152 After a series of meetings with CSCs it became clear to the Inquiry that casework staff across the State were under considerable pressure as a result of the volume of reports flowing into their CSCs on a daily basis. Staff at the Campbelltown CSC described the backlog of reports with a response time of less than 72 hours and less than 10 days as "unmanageable." During 2006/07, 7,748 reports were referred to Campbelltown, which averaged at about 150 reports every week.

9.153 The Inquiry does not have data on the caseworker capacity of the four CSCs for the years 2004/05 or 2006/07. However, as all CSCs have more caseworker positions now than they did in 2004/05, it is assumed that as the number of reports increased over the period (with the exception of Eastern Sydney), so too did caseworker capacity. This assumption would appear to be supported by the increase in the proportion of reports that were the subject of a completed SAS2 in all four CSCs between 2004/05 and 2006/07.

9.154 In 2004/05, 13.5 per cent of all referred reports were the subject of a completed SAS2. This increased to 21.5 per cent of all referred reports by 2006/07. While the proportion of referred reports that were the subject of a completed SAS2 also increased across all four CSCs over this period, the proportion of reports so assessed at Campbelltown and Shellharbour in 2006/07 was below the State average, at 17.2 per cent and 17.9 per cent respectively. Eastern Sydney was on the State average at 21.4 per cent and Moree was significantly higher than the State average with 34.8 per cent of all referred reports being subject to a completed SAS2.

9.155 The above data could suggest different levels of SAS2 assessment being undertaken on SAS2 across CSCs. Information that is missing from this picture is the percentage of cases that were subject to a SAS2 which required ongoing casework, and what that casework involved.

9.156 While the proportion of completed SAS2 reports at Eastern Sydney was about the same as the State average, what happened to the remaining reports does not align with the trend across the State. Proportionately more reports than the average were closed before any secondary assessment, and correspondingly, proportionately less reports were the subject of a SAS1 only.

9.157 The assessment path for reports referred to Campbelltown in 2006/07 more closely approximated the State trend, although proportionately, slightly more

reports were closed prior to any secondary assessment or after a SAS1 and proportionately fewer were subject to a completed SAS2.

9.158 At Shellharbour, proportionately less reports were closed prior to any secondary assessment, but proportionately more were closed after a SAS1. The proportion of reports that were subject to a completed SAS2 was lower than the State average.

9.159 At Moree, the assessment path for reports was quite different again. Very few reports were closed before any secondary assessment, although a significantly greater proportion were closed after a SAS1. However, the proportion of reports to receive a completed SAS2, at 34.8 per cent, was significantly higher the State average.

9.160 In 2006/07, the substantiation rate varied, both across the four CSCs and with the State average of 93.5 per cent. At Campbelltown, there was a finding of harm or risk of harm in 94.5 per cent of reports that were the subject of a completed SAS2. At Shellharbour, the substantiation rate was higher again at 96.3 per cent and it was highest at Eastern Sydney at 98.1 per cent. At Moree, on the other hand, the substantiation rate was significantly lower than the State average at 86.8 per cent.

9.161 So even though reports at Moree were more likely to receive a completed SAS2, a greater proportion had a finding of no risk or harm than in the other CSCs. That said, however, 30.2 per cent of all reports at Moree resulted in a finding of harm or risk of harm, which was higher than for the other CSCs and higher than the State average.

9.162 The substantiation rates across three of the CSCs increased between 2004/05 and 2006/07, which is in line with the State trend. At Moree, however, the substantiation rate dropped slightly over the period, from 87.0 per cent to 86.8 per cent.

9.163 The proportion of referred reports assigned a required response time of less than 24 hours fell across all four CSCs between 2004/05 and 2006/07, which aligns with the statewide trend. In 2006/07, 9.5 per cent of all referred reports were assigned a response time of less than 24 hours. At all but Eastern Sydney, the proportion of referred reports so assigned was lower than the State average. At Eastern Sydney, the proportion of reports so assigned was slightly higher than the State average at 10 per cent.

9.164 Across the four CSCs, between 93.4 and 100.0 per cent of all reports with a required response time of less than 24 hours (often referred to by staff as Level 1 reports) were allocated for some level of secondary assessment, whether a SAS1 only or a SAS2. It was an inability to provide this level of assessment for reports with a required response time of less than 72 hours (often referred to by staff as Level 2 reports), particularly those that were considered high risk, that concerned many staff in the four CSCs. A staff member from Shellharbour stated:

> *…we rarely get to Level 2s. We seem to be getting quite a few coming through to Level 2 highs. They grade them. It's almost a Level 1, it doesn't quite get there, but you read the report and it's obviously extremely concerning, but it's a Level 2 high and pretty much because of the lack of resources and the staffing and the issues that we have here, we're only quite often responding to Level 1s.*

9.165 This exercise reveals the differences between CSCs in terms of their capacity, the experience of their staff, the number and type of reports which they allocate and those which received little attention, and the significant periods of time spent in training.

9.166 As has been evident from this and preceding chapters, the Inquiry is concerned that the implementation in CSCs of policies and procedures developed by Head Office is patchy. This exercise suggests that the procedure to educate staff in one CSC about good practice should not necessarily be the same as in another. The Inquiry is of the view that Regional Directors and those who report to them, should be tailoring their support for CSC staff in understanding and applying practice changes, dependent on the particular needs and circumstances of the community which comes within the catchment of that CSC.

Involving other agencies in assessment and response

Health

9.167 In order to gauge the extent to which DoCS formally sought information from other agencies to assist in assessing families and determining the most appropriate response, the Inquiry sought information from DoCS and Health as to the number of requests for assistance or directions for the supply of information made by DoCS.

9.168 The Inquiry was surprised that the data provided by DoCS revealed that the number of directions made under s.248 of the Care Act equated to only 7.7 per cent of the reports which were referred to a CSC or a JIRT for further assessment. Health informed the Inquiry that it accounted for about 40 per cent of those directions.

9.169 DoCS does not collect data about requests made under s.17. However, Health reported to the Inquiry that it had received 93 such requests from DoCS in 2006/07 and 72 in 2007/08.

9.170 From that data and from submissions and the various audits and reviews available to the Inquiry, the Inquiry has concluded that caseworkers do not routinely involve other agencies in deciding and planning assessments or interventions nor do they routinely communicate with them or seek information

about their work with families. Of course, there will be cases where no other agency is involved, however, in many cases, Police, Education or Health will have had some involvement with the family and will hold relevant information which should be sought formally. In some cases, the relationships will be such that the information can be obtained informally, although the frequent reference to the impediments posed by the privacy legislation suggests this is not the usual approach.

9.171 In addition to formally or informally seeking information, there is the issue of communication about events relevant to agencies other than DoCS.

9.172 A number of health services identified that communication with caseworkers is a frequent problem and impacts on effective case management of children. For example, the Sydney Children's Hospital at Randwick stated that while its Child Protection Counselling Service only works with families where DoCS remain involved, it is not uncommon to have DoCS fail to return calls or emails sometimes for as long as six weeks. Multiple calls are made to managers and caseworkers that respond to some matters but not to others.

9.173 The Ombudsman's review of a child death found:

> *No secondary assessment was ever completed by Blacktown CSC to which the case was referred… they concluded there was no immediate risk of harm concerns and closed the file as SAS1. They did not advise the hospital of this action notwithstanding that the hospital had repeatedly asked for the child to be returned to the hospital for further assessment…The internal review concluded that the assessment by Blacktown CSC lacked holistic rigor. There was no information to suggest protective factors were in place or risks assessed.*[746]

9.174 An issue which emerged early in the Inquiry and gave rise to frequent comment by mandatory reporters was the perception that DoCS did not give sufficient weight to the expertise of the reporter. This was of particular concern to Health.

9.175 The Ombudsman's review of a child death found:

> *DoCS risk assessment did not take into account the mother's history of drug addiction, gave insufficient weight to an opinion of a medical practitioner and did not make any assessment of the mother's home including sleeping arrangements for the baby. The focus of DoCS' attention appeared to be on securing supported accommodation for the mother.*[747]

9.176 In this case the Ombudsman concluded that:

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[746] NSW Ombudsman, *Investigation into the death of a child, Provisional Statement,* 2008.

[747] NSW Ombudsman, *Investigation into the death of a child*, 2006.

Despite the imperative set by the Government guidelines that agencies work together in relation to protecting children and young people in need of care and protection, there is little evidence that this effectively occurred in this case. Part of this failure can be linked to the inadequacies in DoCS's risk assessment and the Department's lack of appreciation of the relevant issues potentially placing the child at risk even when these were reported by the baby's specialist. While the Department sought information from Area Health Services, when this was provided it had little bearing on the case plan. There was sufficient reason for DoCS to request information from NSW Police, but this did not occur.[748]

9.177 Recently, DoCS and Health prepared a paper that examined practice and systemic issues for each Department arising from seven child deaths between May 2003 and August 2006.[749] The paper considered the balance between a statutory child protection focus on ensuring the safety of children and the treatment/social rehabilitation perspectives where drug dependency was an issue. This revealed a number of practice, treatment, intervention and interagency issues for both agencies.

9.178 First, it was evident that there is a lack of information sharing between DoCS casework staff and Health staff and between staff in each agency, including hospital and drug and alcohol professionals. Also identified was a cultural divide between professionals from the two agencies with the stereotypical perception that "Health is there to support the parent and DoCS is there to support the child."[750]

9.179 The paper refers to a Canadian study which describes how historically the two delivery systems (health and child protection) have had different orientations, goals and organisational cultures which have led to fragmentation and a lack of coordination of services and case planning. The study also states that coordination of services can be further impeded when women fear that they may jeopardise custody of their children if they reveal the full extent of their substance abuse problems or enter substance abuse treatment.

9.180 Secondly, there was a need identified for child protection staff to regularly update their skills in engaging these families, and their knowledge about drug issues, and for drug and alcohol workers to have knowledge about child protection issues.

9.181 Thirdly, it was evident that there was confusion about the delineation of roles between Health and DoCS.

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[748] ibid.

[749] DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008.

[750] ibid., p.33.

9.182 Confusion about service roles and responsibilities can result in a loss of focus on the child protection issues and impede effective case planning for the child and parent. A simple example is where a DoCS worker may need an interpretation of a toxicology screen or a drug and alcohol worker may have concerns that a child is not meeting developmental milestones.

9.183 Fourthly, the paper noted that liaison persons from each agency needed to be identified.

9.184 The DoCS Drug and Alcohol Expertise Unit is working with Health to scope a cross agency project that will identify how to better integrate service delivery across DoCS and drug and alcohol systems, with a view to trialling it in metropolitan and rural sites. Health is also developing a training package on child protection issues for all government and government funded drug and alcohol workers across the State. It is anticipated that this will strengthen cross agency practice and promote caseworker access to experts in drug and alcohol services in their region.

9.185 The Inquiry is of the view, which is shared by many participants in the NSW child protection system, that there is a need to bring the expertise of professionals from other non-government and government agencies more closely into the assessment process. As a senior doctor from Sydney Children's Hospital working in this area informed the Inquiry:

> *What we've been asking for a number of years is some dedicated staff within the Department of Community Services to investigate, not just the Helpline, but when they go to the next level of assessment and investigation of complex and serious medical matters.… one can't expect the average caseworker to be able to comprehend and work within that complexity…. We're not talking about multiple or many cases. It is a small but very complex and very time-consuming number of cases that obviously both Health and the Department of Community Services put a lot of resources into currently and they are not ideally managed from both our services.*[751]

9.186 The Inquiry is supportive of the Drug and Alcohol Expertise Unit and is of the view that a similar strategy should be developed for dealing with mental health issues and domestic violence. The greater involvement of Health in child protection work is addressed in Chapter 10.

Multi-agency response

9.187 A multi-agency systems approach involves identifying the underlying patterns in the work environments of the different agencies which support good practice, as

[751] Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.22.

well as those that create unsafe conditions in which poor practice is more likely, and then applying the lessons learned.

9.188 This approach would enable all agencies working with children, young persons and families to understand casework practice better in order to improve the quality of services. It could focus on the influence of different assessment practices, as well as an communication and collaboration practice that can affect and decision making. A recommendation to this effect is made in Chapter 10.

Different pathways

9.189 As is evident from the data, only a small number of children reported receive a detailed assessment and planned intervention from DoCS. Some children do not need statutory intervention and some families need some assistance, which could be equally or better provided by an agency other than DoCS.

DoCS view

9.190 Presently, NSW treats all information about a risk of harm to a child or young person as a report, and then a decision is made whether to refer the matter to a CSC or a JIRT. DoCS contended to the Inquiry that NSW is well suited to adopt a new differential child protection system and recommended an approach which combines the current Helpline function with a multi-track system whereby children and their families are streamed either to a statutory response or to family support and early intervention services.

9.191 This new approach would group current clients based on service needs and on the likelihood of needing statutory intervention. Its purpose would be to provide a better basis for assessment and for ensuring referral to the most appropriate services. This system would cover the needs of children and young persons in NSW requiring no DoCS action (though possibly support services from health and other social services) through to those requiring OOHC services. DoCS recognised that the distinction between the groups was not always clear cut, that overlap existed and a family's need for services, and the intensity of service need, would vary over time. Further, assigning families to a specific classification (such as family support or child protection) and then proposing services that would most effectively meet their needs would depend on robust systematic assessment throughout the lifetime of the case.

9.192 In broad terms there are three groups of clients who are currently reported to the DoCS Helpline.

9.193 Group A comprises lower needs children and young who enter and exit the system quickly. These children and young persons are generally not referred to a CSC because they are assessed as below the current risk of harm threshold, or if referred to a CSC, are assessed at the CSC intake to be of a much lower

priority than others, and as requiring minimal attention within the child protection system (that is, no further secondary assessment).

9.194 DoCS estimated this group comprises around 25 to 35 per cent of children and young persons who are currently reported to DoCS in any year (in 2006/07 this would have equated to between 30,922 to 43,291 children). While some other government agency (for example, Health or Housing) or non-government family support services might be required, under a raised reporting threshold, there would be no need for DoCS intervention if the risk of harm threshold was not met.

9.195 Group B comprises children and young persons who enter the system and are generally reported several times, possibly over a long period of time. This group comprises around 45 to 60 per cent of children and young persons currently reported (in 2006/07 this would have equated to between 55,660 to 74,214 children). With the current level of resources within the system, a proportion of these children and young persons are assessed and prioritised for intervention, but a large number currently do not receive any further DoCS case management or any targeted services. A mix of services of varying intensity is required for these children and young persons. A large proportion would benefit from intensive early intervention services, such as those offered under the Brighter Futures program, while others would only require lower intensity, shorter term family services, delivered by the non-government service sector with support from other government agencies, and enhanced through expansion of the CSGP.

9.196 Group C comprises children and young persons who require immediate intervention (statutory child protection) to address their situation of child abuse and/or neglect and to protect them from harm or imminent entry into OOHC. This group is estimated to comprise 10 to 20 per cent of children and young persons reported (in 2006/07 this would have equated to between 12,369 to 24,738 children). These children and young persons require a full face to face assessment (currently SAS2), family preservation services (possibly followed by intensive early intervention, such as a Brighter Futures type service, in a step down approach) and/or OOHC. In April 07/March 08, 14,443 children and young persons were the subject of a completed secondary assessment (SAS2) by DoCS.

9.197 DoCS identified that:

> *Our whole system is organised by the triage principle where the most urgent, the most serious things do increasingly and very significantly I think get a response and we work very closely and well I think with our colleagues in Health and Police and Education in an interagency response to those matters. I think where issues collectively come is in those matters that fall below that threshold of immediate urgent seriousness where you have a range of concerns of risk that may fall just short of a*

> *threshold of seriousness, but you are at the limit of the system's capacity to provide a response.*[752]

9.198 DoCS anticipated that a new model would use the NGO sector to case manage Group B and some Group A clients who were assessed as requiring the lower intensity family support services, with DoCS retaining program funding. Alternatively, it noted that consideration could be given to Health managing the program funding for family support services, or at least co-locating those services with Health services, subject to a service level agreement and monitoring.

9.199 DoCS has recommended maintaining the Helpline for all contacts/receipt of information and continuing recording of this information on a centralised database, subject to improvements in KiDS. DoCS stated that a centralised model enables consistent recording of information about risk of harm to children, establishes consistent intake decision making processes that are transparent, and provides for case prioritisation that is the same across the State. This is important as families and children often move throughout the State between local DoCS regions, and it is critical that the information about child protection concerns can be accessed on a statewide basis and allow DoCS to respond to after hours child protection cases.

9.200 DoCS argued that:

> *Decentralised, locally based contact and intake processes can result in fragmentation of child protection information and lower service capacity, due to logistical difficulties and cost benefit inefficiencies in providing 24/7 access in each location. In addition, although decentralised intake can appear to offer the attraction of more immediate linkages between reporters and local service providers, such a potential benefit is unlikely to be significant in very busy CSCs or, given the size of NSW, rural and remote locations such as Western Region.*[753]

9.201 DoCS also proposed an alternative pathway in which mandatory reporters could make a report to the Helpline at the same time as referring children and their families to locally based services. Most mandatory reporters, DoCS argued, are involved in local service networks. This approach would include mandatory reporters getting feedback from the Helpline.

9.202 DoCS advised that referral from the Helpline to one of the 14 Brighter Futures Lead Agencies would be possible, but would require amendment of the current Case Streaming Tool and clarification about those referrals which are not accepted by Lead Agencies. Referrals from the Helpline to other non-government services could operate in a similar manner, if non-government

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[752] ibid., pp.19-20.

[753] Submission: DoCS, Assessment Model and Process, p.21.

agencies were prepared to aggregate referral points in a particular geographic community. Rather than DoCS referring families to hundreds of services across the State, it could refer to a smaller number whose role in a particular community (apart from any projects they manage) would be to refer on to services within the network of the community.

9.203 This approach would require:

a. capacity for the Helpline to take on this additional function, and design of appropriate business processes with supporting technology, such as extension of the DoCS portal

b. identification through Initial Assessment of children and families for whom passive referral by DoCS was appropriate, including some clients who are currently lower risk needs clients and not likely to be reported again to DoCS

c. client consent to make referrals or some other arrangement for the exchange of information apart from consent. While passive service referrals by the Helpline in these circumstances are possible, the ability of this centralised contact centre to make active referrals would be constrained by its capacity to engage with families at the local level, many of whom would not be aware that a report had been made to the Helpline.

Other views on establishing different pathways

9.204 Other jurisdictions in Australia and overseas are attempting to move from an exclusively investigative child protection approach to alternative models that allow more flexibility for intake and service delivery.[754] These 'differential response' systems (also known as 'dual' or 'multi-track') include a second non-investigative or family assessment pathway that provides assessment of the needs of the child and family and referral to appropriate services without first requiring a determination of risk of harm.

9.205 Some of these options include: promoting and enhancing referral pathways down from and between tertiary services; promoting and enhancing referral pathways directly into secondary/targeted services; creating a single visible entry point where families are assessed and referred to the most appropriate service response (for example, primary/secondary family services or tertiary child protection services); and/or not creating a specific visible referral point, but enabling community members and professionals to make referrals to those services that exist within the local area to meet the identified need.[755]

9.206 Health recommended to the Inquiry that integration of a needs assessment into the DoCS assessment processes should occur. Health argued that the current

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[754] J Waldfogel, (Forthcoming 2008), op. cit., cited in Submission: DoCS, Assessment Model and Process, p.13.

[755] L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2008, p.57.

DoCS triage processes for accessing and maintaining access to specialist child protection services do not always capture those that are most vulnerable to harm due to family circumstances and the characteristics of the children and parents.

9.207 Priority allocation does not adequately address the risks to children and young persons who are vulnerable to future harm, who are experiencing lower levels of harm, or who are subject to neglect. As models of decision making are based on incidents of abuse or neglect rather than on holistic assessment of the needs of children and young persons in the context of their family and community, the systemic response is reactive not proactive.

9.208 Needs assessment, Health argued, addresses aspects of functioning, strengths and issues that may not be illuminated through the risk of harm assessment. Health is of the view that concurrent needs and risk of harm assessment by DoCS as a process of case management would best ensure that issues of safety and harm are addressed for children and young persons, with essential links made to aspects of welfare and well-being.

9.209 A number of submissions recommended the introduction of a differential system for responding to risk of harm reports. As noted by the Ombudsman:

> *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...We also support the department's 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 in providing support.*[756]

9.210 Education identified the need for a stronger emphasis on early intervention and support and clear pathways for making referrals to support agencies. For example, a school may identify concerns for a child that relate to parenting capacity or need for support due to complex and challenging child care issues, which may lead to risk of harm if not addressed. Education stated it may be helpful to establish clear mechanisms for schools to refer such matters directly to relevant support services, which may assist families to access the support they need and engage with support services without the stigma of being 'reported to Community Services'.

9.211 The Ombudsman noted that there was merit in DoCS' grouping of the reports into the three categories (A, B, C), although he pointed out that a 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 Ombudsman also supported the Helpline model proposed by DoCS.

[756] Submission: NSW Ombudsman, Assessment and Early Intervention, p.13.

9.212 Many non-government agency submissions supported a differential pathway stating that the current system lumps all reported children into the same harm category instead of differentiating between harm and need for assistance. Many submissions stated that there was a need to distinguish between children in need of support and children at risk of significant harm. The Benevolent Society said:

> *The system does not respond favourably to parents who recognise they need support in their parenting role and would like help. Because of the policing nature of social services and the lack of services, parents know that the likely outcome of seeking help is an abuse report, in some instances followed by removal of the child. Clearly there needs to be a different approach to service provision.*[757]

9.213 Other submissions suggested amending the Care Act to create two entry pathways for services. One pathway would be for responding to children, young persons and families 'in need of support' with the second for reporting children and young persons at risk of significant harm. This approach would involve establishing a series of local/regional intake and referral centres for children, young persons and families in need of support which could be co-located with service providers. This is not dissimilar to the model in place in Victoria with its two pathways, under which lower risk families can be subject to a decentralised voluntary assessment and service orientated response through Child FIRST, and those with high risk who come within the statutory child protection regime.

9.214 Other versions of this model include introducing a community based intake and referral for cases that fall below the statutory reporting threshold. Both models support maintaining a centralised intake system while introducing a range of supplementary systems to improve intake (for example, a statewide advisory service, regional CSC support roles, community based intake).

9.215 Other suggestions to embed a differential response system include the placement of a child protection consultant in agencies to divert cases not requiring a statutory intervention. This position would be located in key government and non-government agencies and these positions would make a call as to whether to report to DoCS or refer the family to other services. DoCS would accredit these people.

9.216 The Commissioner for Children and Young People advised the Inquiry:

> *It is about helping them [agencies] really to send only those cases to DoCS that DoCS require a statutory intervention. Importantly, it is to say, "If DoCS are not going to be involved,*

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[757] R Lawrence-Karski, "United States: California's reporting system in N Gilbert (ed) 'Combating child abuse: international perspectives and trends'," *New York, Oxford University Press,* 1997, pp.3-6 cited in Submission: Centacare, Broken Bay, p.10.

> *what will we put in place? Who will we work with? How else can we get other agencies engaged to meet the needs of this child so that those needs are met? At the moment, our system seems to be that children are being reported to DoCS, but a lot of them do not end up with their needs being met. It is about reducing the demand on DoCS, so they can focus on those that only they can focus on; but at the same time where DoCS are not involved, it means those other agencies making sure that the children's case are met through designing case plans.*[758]

9.217 Health acknowledged that such a person within Health who could act as a central point to consider information gathered by Health workers may be of some value.

9.218 The Inquiry is of the view that a critical issue driving demand for child protection services is the need for appropriate responses for those families who fall below the threshold for statutory intervention, or whose cases have to be closed by reason of competing priorities or lack of resources, yet are families that would benefit from specific services to address their current problems and prevent escalation. Decisions regarding which referral pathways will be provided, and which of these will be promoted in the community can have a significant impact on the role that child protection services play in the child welfare continuum and demand on tertiary services.

9.219 Chapter 10 describes the model preferred by the Inquiry.

9.220 The Inquiry is not in favour of creating a separate department to manage those reports which do not require statutory intervention and matters of child development more generally. There is a continuum of services required for children and young persons, which is better coordinated from the one agency.

9.221 The creation of a separate department would have significant cost implications. It would risk duplication of effort, and increase the risk of children or young persons falling between the cracks. There could be significant problems attributed to inconsistent practices or policies. Overall the Inquiry is not satisfied that the establishment of a separate department would add value to the system.

9.222 The Inquiry agrees with the comments made in one submission that rather than organisational change, what is called for is a shift in the way in which the needs of children and young persons' are understood and services for children and young persons are delivered.

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[758] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.52.

Conclusion

9.223 As can be seen from this and the preceding chapters, there is a deal of data available about the numbers of children and young persons by reference to DoCS processes. Thus, while the reader knows the number who have had SAS2s, it does not know what, if any service was provided to them or whether it was taken up and was beneficial. Were they referred to a mental health service, if so, did they receive counselling, did the parents access child care, did the mother attend a rehabilitation service and complete it, and what were the outcomes?

9.224 Of the children and young persons who were the subject of a finding of substantiated neglect or risk of neglect in 2005/06, around three quarters did not subsequently enter care. Even fewer entered care where the risk issues involved psychological harm, physical harm, sexual harm and risk of harm. The question as to what happened to these children and young persons is important and largely remains unanswered.

9.225 The data on the reporting history of children and young persons, particularly following a substantiation is the best evidence potentially available of the effect the child protection system has had on children and young persons who were reported. The data are of qualified use however for the reasons set out in Chapter 5.

9.226 The Inquiry's observations are therefore based on an analysis of the process data, the information obtained by other reviews and audits and the submissions made to the Inquiry.

9.227 The Inquiry concludes that the assessment and response work of DoCS is based on sound policies and procedures which are, in turn, reflective of current research. However, the implementation of those policies is inconsistent and too many assessments lack a holistic approach, lack rigour and do not take advantage of the expertise or information of others. Significantly a number of families are excluded from the intervention or services that they need because of the emphasis on prioritising the responses to the high risk cases that need urgent intervention.

9.228 Consistent with the Inquiry's findings, DoCS has identified five themes arising from its analysis of the deaths of children 'known to DoCS' in 2007. Those themes: are the importance of supervision of casework staff; maintaining a child focus in assessment work; use of medical opinion in assessment of serious abuse; working with hostile or aggressive clients; and the challenges of working with domestic violence.

9.229 It is acknowledged that DoCS has initiated or completed a number of projects designed to deal with the issues raised in this chapter. Each is dealt with elsewhere in this report. They include implementing the Professional Development and Quality Assurance project; requiring caseworkers, although

not Managers Casework, to possess a tertiary qualification; developing a significant research function within DoCS and working on a better way of communicating and embedding policies with caseworkers and their managers.

9.230 The Ombudsman noted that over the last five years the Department has sought to respond to these problems in a number of ways, including through policy and training initiatives. He noted that with the recruitment of a large number of new staff over the past five years, and the overhaul of its business practice, it was inevitable that there would be significant challenges in delivering high quality assessment decisions at the CSC level, at least in the short to medium term.

9.231 The way in which new policies and research are communicated to staff, the adequacy and quality of their supervision and the volume of material to be digested are significant matters to be addressed, as is the need for a differential response model. Recommendations are made in this chapter and in Chapter 10.

Recommendations

Recommendation 9.1

DoCS should test the use of Structured Decision Making tools at the Helpline and at CSCs in relation to assessments and interventions including restoration.

Recommendation 9.2

A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors.

Recommendation 9.3

DoCS should develop a strategy to move to electronic record keeping and abolish the use of paper records.

Recommendation 9.4

DoCS should revise its case practice procedures to provide Helpline caseworkers with greater guidance as to determining response times for reports of risk of harm.

Recommendation 9.5

For all caseworkers and casework managers there should be a structured program for ongoing professional development which is incorporated into annual Personal Planning and Review agreements.

Recommendation 9.6

> In addition to individual supervision, there should be a facilitated monthly group case practice review of selected cases within each CSC and at the Helpline, in which all caseworkers and managers participate and which may include specialists from other agencies, if the cases require it.

Recommendation 9.7

> DoCS should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.

Recommendation 9.8

> The work of the Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.

10 Directions for the way forward

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10.1 This chapter collects together the principles which the Inquiry believes should underpin the child protection system in NSW, the goals to be reached, and what needs to be done to achieve these goals. The Inquiry has not costed the recommendations contained in this chapter, however, where DoCS has provided the Inquiry with a estimate of costs, that estimate has been included.

10.2 This chapter is focused on the broad system which encompasses all relevant government agencies and NGOs. Commentary and recommendations about the internal workings of DoCS can be found in the preceding chapters.

10.3 Specific comments and recommendations concerning OOHC appear in Chapter 16 while those concerning court processes and the statutory basis for intervention appear in Chapters 11 to 13.

Principles

10.4 Child protection is the collective responsibility of the whole of government and of the community.

10.5 Primary responsibility for rearing and supporting children should rest with families and communities, with government providing support where it is needed, either directly or through the funded non-government sector.

10.6 The child protection system should be child focused, with the safety, welfare and well-being of the child or young person being of paramount concern, while recognising that supporting parents is usually in the best interests of the child or young person.

10.7 Positive outcomes for children and families are achieved through development of a relationship with the family that recognises their strengths and their needs.

10.8 Child safety, attachment, well-being and permanency should guide child protection practice.

10.9 Support services should be available to ensure that all Aboriginal and Torres Strait Islander children and young persons are safe and connected to family, community and culture.

10.10 Aboriginal and Torres Strait Islander people should participate in decision making concerning the care and protection of their children and young persons with as much self-determination as is possible, and steps should be taken to empower local communities to that end.

10.11 Assessments and interventions should be evidence based, monitored and evaluated.

Goals

10.12 The outcomes sought from the service system should be to ensure that, at the very least, children are able to grow up unharmed by their social, economic and emotional circumstances and are supported to do so by parents who are competent and confident.

10.13 The child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion.

10.14 There should be a mix of low, medium and high intensity services that are flexible to the changing needs of children, young persons, families, and of the communities in which they reside.

10.15 Universal, secondary and tertiary services for families who are, or may be, at risk of requiring statutory intervention, should be funded, monitored and/or regulated by the State and/or the Commonwealth, and, within NSW, principally by DoCS, Health, Education, Juvenile Justice, DADHC and Housing. The principles of performance based contracting should apply and there should be funding cycles that permit stability in the provision of services.

10.16 Universal and secondary services should be delivered by a mixture of the NGO sector and state agencies, the latter being primarily delivered by Health, with DoCS being a provider of last resort.

10.17 DoCS, and where necessary, Police, should remain responsible for interventions mandated under the Care Act.

10.18 Health related tertiary services such as sexual assault and PANOC services and other specialist assessment and therapeutic services should be delivered primarily by NSW Health, Area Health Services and the The Children's Hospital at Westmead with other non-Health tertiary services being primarily delivered by a mix of DoCS and NGOs.

10.19 All services should be integrated and, where possible, co-located or operated in 'hubs', with outreach capacity.

10.20 All services should be delivered as close as possible to where children and families live. For example, schools should be used as community centres, transport should be available and the hours of operation should be flexible.

10.21 There should be integrated locally based universal, secondary and tertiary services for Aboriginal communities which should include those services described above as well as healing programs and services for perpetrators.

10.22 Casework actions should connect the child, young person and family with other providers and community supports that can identify, and mutually commit to addressing the needs of the child and family through an integrated system of services and care.

10.23 There should be a consistent common framework for the evaluation of service outcomes.

10.24 Each human service agency should have a statutory obligation and a professional commitment to ensure interagency cooperation in the provision of child protection services.

10.25 Measures of the performance of agencies engaged in child protection work at the local, regional and state level, should be compatible, population and outcome based, as well as process focused.

10.26 Annual reporting requirements for all government agencies and NGOs should include reporting on their child protection functions and outcomes.

10.27 Data should be collected, shared and published so as to inform research and further the safety, welfare and well-being of children and young persons.

10.28 A research agenda should be developed across governments and should include NGOs.

What needs to be done

10.29 As has been shown in Chapter 5, while the numbers of child protection reports have continued to increase each year from 2001/02, the size of the increase follows no clear pattern. The volatility of the size of the variation from year to year makes it difficult to predict future trends. However, there are suggestions that reports in 2008/09 will stabilise, with possibly an increase on 2007/08 of no more than three per cent to six per cent.

10.30 Service availability, therefore, needs to take into account current demand, which is generally only being met for a fraction of those children and young persons at risk of harm, as well as modest, rather than significant, increases in reporting. The economic situation as well as the natural increase in population will also have an effect. While raising the statutory threshold will affect the number of reports, it may not significantly affect those families who need assistance and come to attention other than through a report to DoCS.

10.31 The Inquiry makes the following recommendations.

The creation of different pathways

Recommendation 10.1

Members of the community and mandatory reporters who are not those described below, who suspect that a child or young person is at risk of significant harm (“the statutory threshold”) should report their concerns to the Helpline. Reports should be as comprehensive as the knowledge and professional or expert experience of the reporters permits.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is at risk of significant harm, which is imminent, should report directly to the Helpline.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency ("the Unit"). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work (see below).

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

a. The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.

b. Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

c. A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.

d. The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.

Recommendation 10.2

Reports made to DoCS should be assessed at the Helpline with the use of Structured Decision Making tools (after being tested and applied). If a

report is assessed as meeting the statutory threshold, the report should be dealt with in one of the following ways:

a. Families who are assessed by the Helpline as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.

b. Where a child or young person is:

   i. assessed as in need of a response within 24 hours, or

   ii. assessed as in need of a response within 72 hours and the risk is assessed as high, or

   iii. under five years and the primary care-giver's functioning or ability to parent is impaired due to current substance abuse, unmanaged mental illness or intellectual disability, and:

      - the child has high support needs, or
      - the primary reported issue is neglect or actual injury, or
      - the child or a sibling has been previously removed from the family by reason of care and protection concerns

   then such child or young person should be referred to a CSC that will apply the Structured Decision Making tools in assessing, intervening and, if ultimately found to be appropriate, removing the child or young person from his or her family.

c. Children and young persons who are assessed as in need of a response within 72 hours with a risk assessed as less than high, or as in need of a response within less than 10 days and who do not meet the criteria for Brighter Futures, should be referred to the Regional Intake and Referral Service which should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for such assistance as may be reasonably available and likely to meet the relevant need.

The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkers seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer to the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS Region.

DoCS structure

Recommendation 10.3

DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key

agencies and each region should contain such number of CSCs (see Chapter 23) as are appropriate for the level of demand within the region.

Service availability

Recommendation 10.4

Services should be integrated, multi-disciplinary and co-located, wherever practicable and child and family services should be established in locations of greatest need, by outreach if necessary.

NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:

a. home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs

b. sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance

c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents aged 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services

d. secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed

e. the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case.

Recommendation 10.5

a. Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system (DoCS estimates that this should assist an additional 1,200 families).

b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to

services for Aboriginal children and their families (DoCS estimates that this should assist an additional 3,400 families).

c. The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families (DoCS estimates that this should assist an additional 3,000 families).

d. The Aboriginal Maternal and Infant Health Strategy should be delivered statewide (funds have been allocated for this service).

e. Young, first time, isolated mothers with low educational attainment should receive secondary services, particularly sustained home visiting where the focus should be on positive maternal and child outcomes.

f. One year of free early childhood education before school should be provided to low income families.

g. Co-located child and family centres servicing Aboriginal communities, involving health and education services should be developed.

h. In relation to domestic violence, the commitment to the Domestic Violence Court Intervention Model, Integrated Case Management, Non-government sector grants, Staying Home Leaving Violence, the Court Assistance Scheme, Indigenous Programs and police equipment should be implemented.

i. The commitment to establish the Safe Families Program – Orana Far West should be implemented.

j. The commitment to fund the Preschool Investment and Reform Plan should be implemented.

k. The implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional 260 child care centres on primary school grounds and other community land in areas where there are service gaps, should be progressed.

Recommendation 10.6

The capacity of NGOs, Aboriginal and non-Aboriginal, to staff and deliver the services detailed in Recommendations 10.4 and 10.5 a, b, c, e, f and g to children, young persons and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed. The principles underpinning performance based contracting should apply.

Working collaboratively

Recommendation 10.7

DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of Education and Training and NGOs should use a common assessment framework to identify and respond to the needs of children, young persons and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, high risk adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency, namely DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, Housing NSW, the Department of Juvenile Justice and the Department of Education and Training should identify their high end users, referred to by DoCS as Frequently Reported Families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant NGOs should be provided including the adoption of mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including NGOs should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (see Chapter 24).

A multi-agency systems approach to case review should be established (see Chapter 9).

Workforce needs

Recommendation 10.8

A workforce strategy should be established which takes into account the needs of NGOs to employ additional staff and to accommodate the progressive transition of early intervention and OOHC (see Chapter 16) casework to the NGOs.

NGOs should receive sufficient funding to develop the infrastructure needed to attract experienced staff, and be assisted in providing uniform training for caseworkers and carers.

Recommendation 10.9

A Unit of one or more positions, depending on the size of the agency, should be created in each Area Health Service, The Children's Hospital at Westmead, the Department of Education and Training, the NSW Police Force, the Department of Ageing, Disability and Home Care and the Department of Juvenile Justice to receive reports of risk of significant harm from staff of the agency and to take appropriate action for the protection of children and young persons, including reporting to DoCS. In addition, the Unit should ensure communication with other agencies, primarily the human services agencies and relevant NGOs, and provide advice to the Human Services and Justice CEOs Cluster about any problems or emerging trends concerning interagency collaboration.

The Unit in each agency should:

a. report to the agency's CEO or a defined and consistent second tier within the agency
b. use data systems and processes that are common across agencies
c. meet regularly with the positions created in the same agency and with those in other agencies
d. keep relevant data which is then shared across agencies
e. be child protection trained
f. be positively named.

Recommendation 10.10

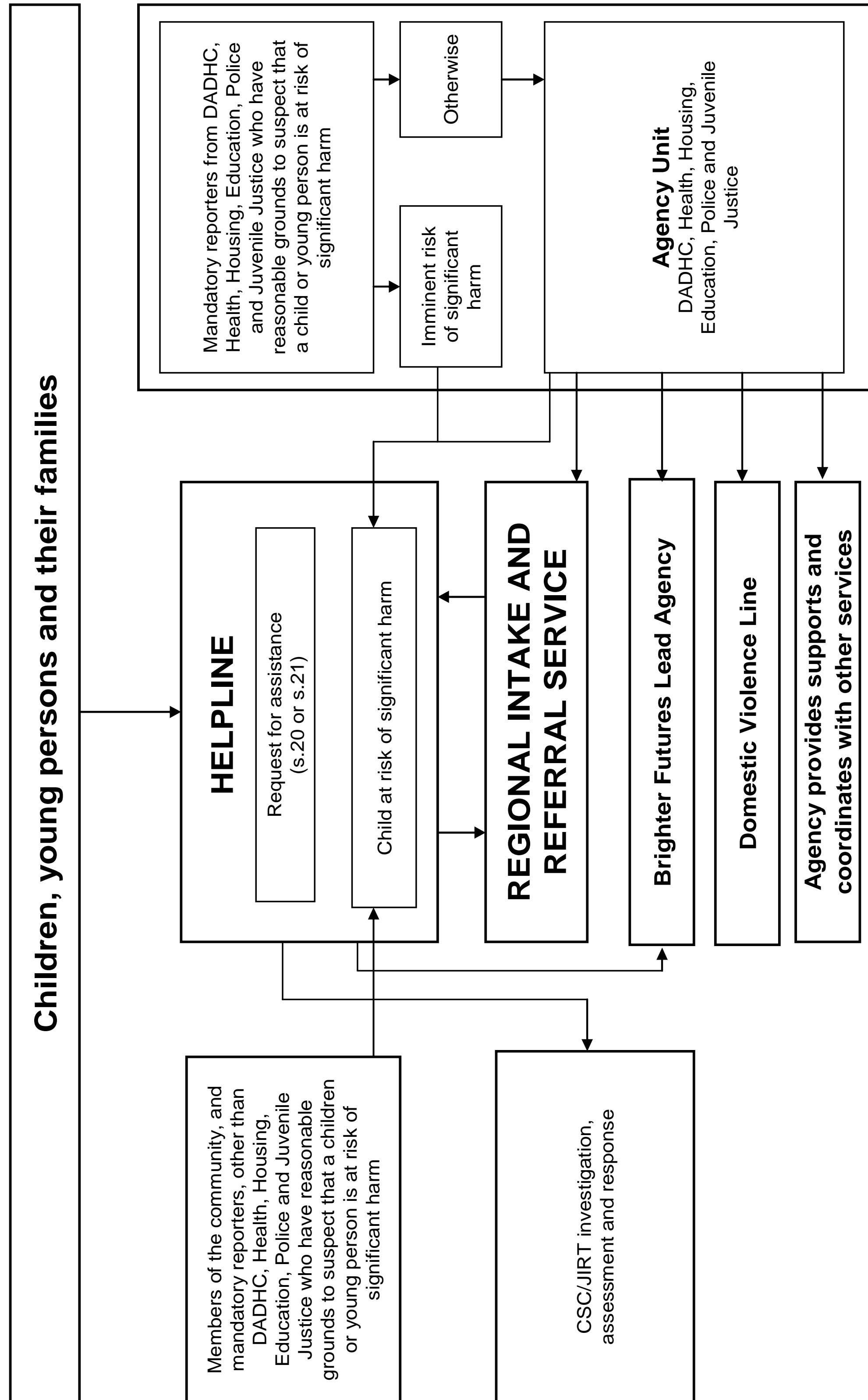
Caseworkers should be employed on a temporary basis or re-assigned from Brighter Futures or OOHC work as case management is transferred to the NGO sector, to manage those reports meeting the criteria set out in 10.2 b above until Recommendations 6.2, 10.1 and 10.2 are implemented (DoCS estimates that 300 temporary caseworkers are required).

Brighter Futures

Recommendation 10.11

Within three to five years, case management of all families in Brighter Futures should be by Lead Agencies.

Figure 10.1 **Different response pathway**



Report of the Special Commission of Inquiry into Child Protection Services in NSW

Volume 2

The Hon James Wood AO QC

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Acronyms

Acronyms	*Phrase/meaning*
1987 Act	*Children (Care and Protection) Act 1987*
AAE	Allegations Against Employees
AAS	Area Assistance Scheme
Aboriginal Affairs	Department of Aboriginal Affairs
Aboriginal Placement Principles	Aboriginal Child Placement Principles
ABS	Australian Bureau of Statistics
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACSAT	Aboriginal Child Sexual Assault Taskforce
ACWA	Association of Children's Welfare Agencies
ACYFS	Aboriginal, Child, Youth and Family Strategy
ADR	alternative dispute resolution
ADT	Administrative Decisions Tribunal
AHS	Area Health Service
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMIHS	Aboriginal Maternal and Infant Health Strategy
AODP	Alcohol and Other Drugs Program
Attorney General's	Attorney General's Department
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
CALD	culturally and linguistically diverse
Care Act	*Children and Young Persons (Care and Protection) Act 1998*
CCYP	Commission for Children and Young People
CCYP Act	*Commission for Children and Young People Act 1998*
CCYP Act	*Commission for Children and Young People Act 1998*
CDC	Caseworker Development Course
CDCRU	Child Deaths and Critical Reports Unit (DoCS)
CDRT	Child Death Review Team
CEC	Chief Executives Committee
CEO	Chief Executive Officer
CIW	Corporate Information Warehouse
Clinic	Children's Court Clinic
COAG	Council of Australian Governments
Community Welfare Act	*Community Welfare Act 1987*
Corrective Services	Department of Corrective Services
CRC	Children's Research Center
CS CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993*
CSC	Community Services Centre
CSGP	Community Services Grants Program
CYP	Children and young persons
DADHC	Department of Ageing, Disability and Home Care
Discussion Paper	DoCS Discussion Paper, *Statutory child protection in NSW: issues and options for reform,* October 2006
Displan	NSW State Disaster Plan

Acronyms	*Phrase/meaning*
District Court	District Court of NSW
DoCS	Department of Community Services
DPP	Office of the Director of Public Prosecutions
Education	Department of Education and Training
EOI	expression of interest
ESD	Enhanced Service Delivery
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
Family Court	Family Court of Australia
Family Law Act	*Family Law Act 1975*
FGC	family group conferencing
FTE	full time equivalent
Health	NSW Health
HNEAHS	Hunter New England Area Health Service
Housing	Housing NSW
HREOC	Human Rights and Equal Opportunity Commission
HRIP Act	*Health Records and Information Privacy Act 2002*
IFBS	Intensive Family Based Services
Interagency Guidelines	*Interagency Guidelines for Child Protection Intervention 2006*
Interagency Plan	Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011
JIRT	Joint Investigation Response Team
JRU	JIRT Referral Unit
Juvenile Justice	Department of Juvenile Justice
KiDS	Key Information and Directory System
LAC	Legal Aid Commission NSW
LAC proposal	Draft Proposal for a Care and Protection Mediation Pilot (Legal Aid NSW)
LAT	Less Adversarial Trial
Law Society	Law Society of NSW
Magellan	Magellan Case Management Model
MOU	Memorandum of Understanding
NCOSS	Council of Social Services of NSW
New Street	New Street Adolescent Service
NGO	non-government organisation
NTER	Northern Territory Emergency Response
OHS	Occupational Health and Safety
Ombudsman	NSW Ombudsman
Ombudsman Act	*Ombudsman Act 1974*
OOHC	out-of-home care
PANOC	Physical Abuse and Neglect of Children
Police	NSW Police Force
PPIP Act	*Privacy and Personal Information Protection Act 1998*
PPR	Personal Planning and Review
Premier and Cabinet	Department of Premier and Cabinet
PSA	Public Service Association
RACP	Royal Australian College of Physicans
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCMG	Regional Coordination Management Group

Acronyms	*Phrase/meaning*
Regulations	*Children and Young Persons (Care and Protection) Regulation 2000*
Rules	*Children's Court Rule 2000*
SAAP	Supported Accommodation Assistance Program
SACS Award	Social and Community Services Award
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment State 2
SCAN	Suspected Child Abuse and Neglect
SCI	Special Commission of Inquiry
SDM	Structured Decision Making
SDRC	State Disaster Recovery Centre
SERM Act	*State Emergency and Rescue Management Act 1989*
SNAICC	Secretariat of National Aboriginal and Islander Child Care
Treasury	NSW Treasury
Triple P	Positive Parenting Program
Usher Review	Review of Substitute Care Services in NSW 1992
Young Offenders Act	*Young Offenders Act 1997*

Part 3 Legal basis of child protection

11 Statutory basis of child protection

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Introduction

11.1 Much of the power of DoCS to intervene in the lives of children and young persons derives from legislation, primarily the *Children and Young Persons (Care and Protection) Act 1998* (the Care Act) and the *Children and Young Persons (Care and Protection) Regulation 2000* (the Regulations).

11.2 The Care Act establishes a regime under which the ultimate decision making about the removal of children from their families without their consent, and the consequent allocation of parental responsibility, rests with the courts. The Children's Court is the court with primary responsibility for making these decisions. The composition of the Children's Court will be dealt with in the next chapter.

11.3 The Care Act vests responsibility for decisions about the exercise of parental responsibility and the day to day care of the child or young person in the person who (for the time being) holds office as either the Director-General of DoCS (the Director-General) or the Minister for Community Services (the Minister). Each has delegated much of the relevant powers to the holders of specified positions within DoCS.[1] For reasons of simplicity, the term 'DoCS' is used in this chapter when dealing with the power of the Director-General, the Minister, and their delegates (as well as being used to refer to the Department in a more general sense).

Principles

11.4 In exercising any of the powers under the Care Act, DoCS (and others) must adhere to the principles set out in s.9 and s.10. In summary, they require that:

a. The safety, welfare and well-being of the child or young person is to be the paramount consideration.

b. The safety, welfare and well-being of a child or young person who has been removed from his or her parents is to be paramount over the rights of the parents.

c. An opportunity is to be provided for the child or young person to express his or her 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.

d. Account is to be taken of the culture, disability, language, religion and sexuality of the child or young person and, if relevant, of those with parental responsibility for the child or young person.

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[1] The Minister and the Director-General have also delegated to others apart from DoCS, for example, the Minister has delegated parental responsibility for some children to Barnardos and the Director-General has delegated powers as to child employment to the Children's Guardian.

e. 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 child's or young person's development.

f. A child or young person in OOHC is entitled to:

   i. special protection and assistance from the State, and the preservation so far as possible of his or her name, identity, language, and cultural and religious ties

   ii. the provision in a timely manner of a safe, nurturing, stable and secure environment, recognising the child's or young person's circumstances and also recognising that, the younger the age of the child, the greater the need for early decisions to be made in relation to a permanent placement

   iii. 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

   iv. the provision of information and the opportunity for the child or young person to express his or her views, to enable participation in decisions that have a significant impact on his or her life.

11.5 A person who suspects that a child or young person is at risk of harm (that is, a person who has current concerns for the safety, welfare and well-being of the child or young person) can (or in some cases, must) make a report to DoCS. Upon receipt of such a report, DoCS must make such investigations and assessment as it considers necessary to determine whether in fact a risk of harm exists. In the case of a young person, DoCS is to take into account any known wishes of that young person.[2]

11.6 The definition of risk of harm and a consideration of the adequacy of that concept, and of the circumstances in which persons must or may report their concerns to DoCS, are dealt with in Chapter 6 of this report.

11.7 A suspicion of risk of harm is sufficient to enliven the power of DoCS to investigate and assess a case after receiving a report. If it forms the opinion on reasonable grounds that the child or young person *is in need of care and protection* then it must take whatever action is necessary to safeguard or promote the safety, welfare and well-being of the child or young person.[3] By virtue of s.39, it can at any time during or after the investigation and assessment of a report (or of a request for assistance) exercise any function conferred or imposed on the Director-General if in its opinion it is necessary or desirable to do so having regard to the safety, welfare and well-being of the child or young

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[2] *Children and Young Persons (Care and Protection) Act 1998* ss.30 and 31.

[3] *Children and Young Persons (Care and Protection) Act 1998* s.34.

person. Section 41 provides additionally that temporary care arrangements under s.151 can be made if DoCS forms the opinion that the child or young person is in need of care and protection.

11.8 A child or young person is in need of care and protection if the Court is satisfied as to one of a number of matters set out later in this chapter.

11.9 The action DoCS can take if it forms the view that a child or young person is in need of care and protection includes providing support services, developing a care plan or parent responsibility contract or exercising its emergency protection powers. DoCS can choose to do nothing if satisfied that proper arrangements exist for the care and protection of the child or young person and the circumstances that led to the report have been or are being dealt with adequately.[4]

11.10 In deciding the appropriate response to a report, DoCS must have regard to the principles that 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 is the paramount consideration. Further, the action taken must be appropriate to the age of the child or young person, any disability that he or she or his or her family members have, and the circumstances, language, religion and cultural background of the family. Finally, removal of the child or young person may only occur where it is necessary to protect the child or young person from the risk of serious harm. These principles are to be applied in priority to the principles in s.9 set out in paragraph 11.4(a) to (f) above in deciding the appropriate response to a report concerning a child or young person.[5]

11.11 In addition to the principles set out above, specific principles apply to Aboriginal and Torres Strait Islander children and young persons. Sections 11 and 12 of the Care Act reflect the principle that Aboriginal and Torres Strait Islander people are to participate in decision making with as much self-determination as possible, and s.13 deals with the placement of Aboriginal and Torres Strait Islander children who are removed from their parents.

Aboriginal child placement principles

History

11.12 The Aboriginal Child Placement Principles (the Aboriginal Placement Principles) were first proposed in 1979, by the Commonwealth Department of Aboriginal Affairs.[6] In 1986, Ministers of state and territory social welfare agencies agreed

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[4] *Children and Young Persons (Care and Protection) Act 1998* ss.34 and 35.

[5] *Children and Young Persons (Care and Protection) Act 1998* s.36.

[6] NSW Law Reform Commission, Research Report 7, *The Aboriginal Child Placement Principle*, 1997, Chapter 3, www.lawlink.nsw.gov.au.

to implement the Aboriginal Placement Principles as policy, but not necessarily as legislation. In 1989, the need for the Aboriginal Placement Principles to be contained in legislation was among the recommendations of the Royal Commission into Aboriginal Deaths in Custody and the Human Rights and Equal Opportunity Commission report into homeless youth.[7]

11.13 The Aboriginal Placement Principles first appeared in s.87 of the *Children (Care and Protection) Act 1987* (the 1987 Act). The review of the 1987 Act recommended that:

> *The Aboriginal Child Placement Principle should apply to all non-voluntary placements of Aboriginal and Torres Strait Islander children. There should be an exception for emergency placements made to protect a child or young person from the serious risk of immediate harm, and other placements required for less than two weeks. The Act should require that where an Aboriginal or Torres Strait Islander child or young person has been removed on an emergency basis, as soon as practicable after the child or young person's safety has been ensured, consultation should take place with the relevant Aboriginal or Torres Strait Islander community in accordance with recommendation 6.5.*[8]

11.14 Recommendation 6.5 was that the Care Act should require Aboriginal participation in placement and other significant decisions made under the Care Act concerning the care and protection of an Aboriginal child or young person.[9] Discussion of the recommendation noted that under the 1987 Act, consultation occurred in limited circumstances where the placement of an Aboriginal child outside the Aboriginal community was being considered.

11.15 However, the review said that:

> *A requirement for participation in decision making was identified as a key way of ensuring that intervention in Aboriginal and Torres Strait Islander families and communities was culturally appropriate and more likely to be effective in protecting children and young people.*
>
> *Many people argued that consultation with the Aboriginal family and community must happen early on in the process so that all those connected with the child or young person can be identified and intervention is appropriate for the particular child or young person and family.*[10]

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[7] ibid., Chapter 3, paras. 3.4 and p.35.

[8] DoCS, *Review of the Children (Care and Protection) Act 1987, Recommendations for Law Reform*, December 1997, p.130.

[9] ibid., p.128.

[10] ibid., p.129.

11.16 The review suggested that the Care Act could require that participation involve an accredited Aboriginal organisation, a recognised Aboriginal person with expertise in child protection, a person nominated by the Aboriginal community to which either or both parents belonged, and/or an Aboriginal person or organisation nominated by the family.[11]

11.17 The final wording of s.13 of the Care Act reflects the recommendations made.

Section 13

11.18 Section 13 outlines a preference for the placement of Aboriginal children and young persons with Aboriginal people when they are placed outside their families. The general order of preference for placement is that an Aboriginal child or young person be placed with a member of his or her extended family or kinship group, or if this is not practicable, a member of the Aboriginal community to which he or she belongs, *or* if this is not practicable, a member of another Aboriginal family residing in the vicinity in which the child or young person normally lives, *or* if this is not practicable, a suitable person approved by the Director-General after consultation with the child's or young person's Aboriginal family or kinship group and an appropriate Aboriginal organisation.

Requests for services from other agencies

11.19 Under ss.17 and 18, DoCS can request a government department or agency, or a non-government agency in receipt of government funding to provide services to the child or young person or his or her family. When DoCS makes such a request, the government department or agency must use its best endeavours to comply.

Requests for assistance from DoCS

11.20 Under ss.20 and 21 of the Care Act, a child or young person or his or her parent may seek assistance from DoCS. The matters on which the child or young person can seek assistance are not limited by the Care Act, although a parent can do so in order to obtain services that will enable the child or young person to remain in, or return to the care of, his or her family.

11.21 A parent, child or young person, or any other person, may ask DoCS for assistance if there is a serious or persistent conflict between the parents and the child or young person, or if the parents are unable to provide adequate supervision for the child or young person, and this conflict or lack of supervision jeopardises the safety, welfare or well-being of the child or young person. On receiving such a request for assistance, DoCS may provide or arrange for the

[11] ibid.

provision of such advice or assistance as is necessary to help resolve the conflict or to ensure the child or young person is adequately supervised, or to enable access to appropriate services.[12]

11.22 If the differences between the child or young person and the parent are such that it is no longer possible for the child or young person to continue living with his or her parents, the child, young person or parents may request DoCS to attempt to resolve the differences. On receiving such a request, DoCS must seek to resolve the differences by any form of dispute resolution appropriate before making any application to the Children's Court. If DoCS is a party to proceedings in the Court in relation to persistent conflict, then it must formulate an alternative parenting plan in seeking to resolve the conflict. DoCS may apply to the Children's Court for an order approving an alternative parenting plan.[13]

Parent responsibility contracts and s.38 care plans

11.23 DoCS can develop a parent responsibility contract that is aimed at improving the parenting skills of the primary care-givers and encouraging them to accept greater responsibility for the child or young person.[14] The contract can deal with attendance for treatment of the primary care-giver or testing for alcohol, drug or other substance abuse, counselling and participation in courses such as behavioural and financial management. The contract cannot exceed six months and must be registered with the Children's Court.

11.24 The breach of a parent responsibility contract gives rise to a rebuttable presumption that the child or young person is in need of care and protection.[15]

11.25 DoCS can also develop a care plan by agreement which may be registered with the Children's Court; if it allocates parental responsibility or aspects of it to a person other than the parents of the child or young person then an order from the Children's Court is needed for the care plan to take effect.[16]

Emergency care and protection and assumption of care

11.26 DoCS (and Police) may remove a child or young person from a place of risk without first seeking the Children's Court approval. This power can only be exercised by DoCS or by Police if satisfied on reasonable grounds that the child

[12] *Children and Young Persons (Care and Protection) Act 1998* s.113.
[13] *Children and Young Persons (Care and Protection) Act 1998* ss.114-116.
[14] *Children and Young Persons (Care and Protection) Act 1998* Chapter 4 Division 2 of Part 3.
[15] *Children and Young Persons (Care and Protection) Act 1998* s.38E.
[16] *Children and Young Persons (Care and Protection) Act 1998* s.38.

or young person is at *immediate risk of serious harm* and the making of an AVO would not provide sufficient protection.[17]

11.27 Additionally, DoCS or a police officer may remove a child from any public place or particular premises if they suspect on reasonable grounds that the child or young person is in need of care and protection, is not subject to the supervision of a responsible adult and lives in or habitually frequents a public place; or if they suspect on reasonable grounds that such person is in need of care and protection, and is participating in child prostitution or pornography, or has recently been on premises associated with those activities.[18]

11.28 Reasonable suspicion lies "somewhere on a spectrum between certainty and irrationality… Something substantially less than certainty is required."[19]

11.29 Alternatively, if DoCS suspects on reasonable grounds that a child or young person is at risk of serious harm but is satisfied that it is not in the best interests of the child or young person to be removed from the premises where he or she is currently located, DoCS may instead assume the care responsibility of the child or young person by means of an order served on the person in charge of the premises.[20] Such action does not require that the risk of serious harm is immediate.

11.30 If the child or young person is removed, or his or her care assumed, DoCS must apply to the Children's Court at the first available opportunity but no later than the next sitting day for a care or assessment order; or, if no order is sought, DoCS must explain the reasons for no care application being made.[21]

11.31 In accordance with the practice of the Children's Court, an emergency care and protection application must be heard by a Magistrate no later than three days after the application is filed.[22]

11.32 The Children's Court can make an order for the emergency care and protection of a child or young person if it is satisfied that the child or young person is *at risk of serious harm.*[23] The order has effect for a maximum of 14 days. The order can be extended (by application) once only for a further maximum period of 14 days.[24]

11.33 The emergency care and protection order, while in force, places the child or young person in the care responsibility of the Director-General or other person specified in the order.[25] The care responsibility may be vested in a designated

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[17] *Children and Young Persons (Care and Protection) Act 1998* s.43.
[18] *Children and Young Persons (Care and Protection) Act 1998* s.43.
[19] *Goldie v Commonwealth of Australia* [2002] FCA 433 at [5] per Gray and Lee JJ.
[20] *Children and Young Persons (Care and Protection) Act 1998* s.44.
[21] *Children and Young Persons (Care and Protection) Act 1998* s.45.
[22] Children's Court NSW, *Practice Direction No.28*, para.7.1.
[23] *Children and Young Persons (Care and Protection) Act 1998* s.46(1).
[24] *Children and Young Persons (Care and Protection) Act 1998* ss.46(3) and (4).
[25] *Children and Young Persons (Care and Protection) Act 1998* s.46 (2).

agency and that responsibility may be delegated by the Director-General or designated agency.[26]

11.34 DoCS is obliged to inform various persons of its actions and can discharge the child or young person from its care responsibility.[27] Care responsibility includes the authority to consent to certain medical and dental treatment, to correct and manage the behaviour of the child or young person, to give permission to participate in activities such as school excursions, and to make other decisions that are required in the day to day care and control of the child or young person.[28]

11.35 DoCS or a police officer may apply for and be granted a warrant to enter, search premises and remove a child or young person from those premises if there are reasonable grounds for believing that there is, in those premises, a child or young person at risk of serious harm and the making of an AVO would not provide sufficient protection.[29] The requirement for satisfaction of the child being at 'immediate' risk of serious harm, which is necessary for the exercise of the emergency removal power discussed above, does not apply in this instance.

Care applications

11.36 Care applications seek from the Children's Court a determination that a child or young person is in need of care and protection, and often seek that some or all aspects of parental responsibility[30] for the child or young person be allocated to someone other than the person (or persons) who currently holds it.[31] Care applications include emergency applications,[32] of the kind mentioned earlier although some of the requirements in relation to emergency applications differ from those relating to other care applications.

11.37 Generally, care applications can only be made by DoCS. A care application must specify the particular care orders sought and the grounds on which they are sought,[33] and must be accompanied by an affidavit in support of the application.[34] The order sought can be varied without leave at any time before a determination as to care and protection has been made, or thereafter only with leave.

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[26] *Children and Young Persons (Care and Protection) Act 1998* s.49.

[27] *Children and Young Persons (Care and Protection) Act 1998* ss.50 and 51.

[28] *Children and Young Persons (Care and Protection) Act 1998* s.157.

[29] *Children and Young Persons (Care and Protection) Act 1998* s.233(2)

[30] 'Parental responsibility' in relation to a child or young person means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children: *Children and Young Persons (Care and Protection) Act 1998* s.3.

[31] *Children and Young Persons (Care and Protection) Act 1998* Chapter 5, Part 2.

[32] *Children and Young Persons (Care and Protection) Act 1998* s.60.

[33] *Children and Young Persons (Care and Protection) Act 1998* s.61(1) and (2).

[34] *Children's Court Rule 2000* cl.21.

11.38 When making a care application, DoCS must provide the Children's Court with details of the support and assistance provided and the alternatives to a care order that were considered by DoCS before the application was made, and the reasons why those alternatives were rejected. However, the Children's Court cannot dismiss a care application only because it is of the opinion that an appropriate alternative action that could have been taken was not considered or taken.[35]

11.39 DoCS must notify the child or young person who is the subject of the care application that the application has been filed and must also make reasonable efforts to notify the child's or young person's parents, and (if they are able to be located) must serve them with a copy of the care application and all supporting evidence.[36]

11.40 Once a care application has been filed and the relevant parties notified, a Children's Registrar may arrange and conduct a preliminary conference between the parties.[37] The purpose of the preliminary conference is to identify areas of agreement, issues in dispute, the possibility of alternative dispute resolution, and any interim orders. Parties can be legally represented at the preliminary conference.

11.41 'Establishment' is the term commonly used within the care jurisdiction to describe the finding by the Children's Court that a child or young person is in need of care and protection.

11.42 DoCS informed the Inquiry that:

> *The 'establishment phase' is to satisfy the preliminary threshold question of whether the child is in need of care and protection. Without an affirmative answer to this question, the care jurisdiction has no further role.*[38]

Examination and assessment orders

11.43 An application to the Children's Court for an assessment order can be made by the Director-General or by any party to care proceedings. An assessment order is an order for an expert report in relation to the physical, psychological, psychiatric or other medical status of a child or young person, or in relation to the parenting capacity of a person who has parental responsibility or is seeking that responsibility.[39] An application for an assessment order should be made no more than seven days after establishment.[40]

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[35] *Children and Young Persons (Care and Protection) Act 1998* s.63 (1) and (2).

[36] *Children and Young Persons (Care and Protection) Act 1998* s.64.

[37] *Children and Young Persons (Care and Protection) Act 1998* s.65.

[38] Submission: DoCS, Operation of courts in the child protection system, (abridged), pp.4-5.

[39] *Children and Young Persons (Care and Protection) Act 1998* Chapter 5, Part 1, Division 6.

[40] Children's Court NSW, *Standard Direction in Care Matters,* para. 4.

11.44 In considering an application for an assessment order, the Children's Court will have regard to a number of factors including whether it is likely to provide relevant information which is unlikely to be obtained elsewhere.[41]

11.45 If the child or young person is of sufficient understanding to make an informed decision, he or she may refuse to submit to being assessed. A person may also refuse to submit to an assessment of his or her parenting capacity.[42]

11.46 If the order is made, the assessment is carried out by the Children's Court Clinic (the Clinic) which submits a report to the Children's Court (although there is no obligation for the Clinic to accept that appointment if it is unable or unwilling to carry out the assessment and prepare the report, or if it is of the opinion that it is more appropriate for the work to be carried out by another person, in which event the Court may appoint another person to prepare a report).[43]

11.47 If the Children's Court makes an assessment order, it will direct the party who made the application for the assessment to compile a file of documents to be sent to, read, and used by the Clinic as part of the assessment. This file must contain, *inter alia*, any documents that have not been filed in the proceedings which the parties agree should be included, or which the Court orders should be included.[44]

11.48 Depending on the particular case, the Clinic might be asked to address issues such as:

a. the individual characteristics of the child or young person, including any particular cognitive, adaptive, emotional, social and other individual developmental needs, and any mental health or behavioural issues

b. the characteristics of relevant parents or carers, including an exploration of any alcohol or other drug dependence, domestic violence or mental health issues, and any intellectual or other disabilities

c. the parenting capacity of the parents or carers, including the ability to meet the specific needs of the relevant child or young person;

d. strategies that can be put in place to deal with the needs of the child or young person and to promote his or her development, including identification of the kinds of services that should be accessed.[45]

11.49 An assessment report submitted to the Children's Court as a result of an assessment order is taken to be a report to the Children's Court rather than evidence tendered by a party.[46] This independence from any one party is in part aimed at limiting the expert evidence in care proceedings to that of a single

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[41] *Children and Young Persons (Care and Protection) Act 1998* s.56.
[42] *Children and Young Persons (Care and Protection) Act 1998* s.54(2) and (4).
[43] *Children and Young Persons (Care and Protection) Act 1998* s.58.
[44] Children's Court NSW, *Practice Direction No.28*, para.31-32.
[45] Children's Court Clinic suggestions for revision of the DoCS Business Help Application for an Assessment Guidelines, p.3.
[46] *Children and Young Persons (Care and Protection) Act 1998* s.59.

expert witness. In a document submitted to the Inquiry by the Clinic, Senior Children's Magistrate, Scott Mitchell is quoted as saying:

> *No longer is there likely to be the cacophony of conflicting reports which bedevilled care proceedings… in earlier times.*[47]

11.50 The Clinic does not undertake physical medical assessments, emergency assessments, or counselling. The Clinic informed the Inquiry that it prefers not to undertake placement assessments, defined as an assessment of the environmental characteristics of a potential placement.

11.51 When the Clinic accepts a referral from the Children's Court, the Clinic's Director will allocate the assessment to a clinician who is either employed by the Clinic, or who is a member of the Clinic's panel of external clinicians (both employees and panel members are referred to as 'Authorised Clinicians'). Since the Clinic's inception, 85 per cent of the assessments have been carried out by external clinicians.

11.52 From the time that he or she is allocated an assessment, the Authorised Clinician becomes a Court-appointed expert in the relevant proceedings, and is bound by the Expert Witness Code of Conduct contained within Schedule 7 of the *Uniform Civil Procedure Rules 2005.* Adherence to this Code of Conduct must be acknowledged in the Authorised Clinician's report.

11.53 The Clinic expects Authorised Clinicians to undertake a number of tasks during the course of their assessment, including obtaining background information in relation to the child or young person (from carers or other relevant people); observing and/or interviewing the child or young person, and where appropriate, carrying out psychometric testing of the child or young person; observing and/or interviewing the parents or carers, and where appropriate, carrying out psychometric testing of the parents or carers and interviewing other relevant people (sometimes referred to as carrying out 'collateral interviews').

11.54 Authorised Clinicians are encouraged by the Clinic to make contact with the relevant DoCS caseworker to obtain information about the relevant child and his or her family dynamics. All contact made with the caseworker should be recorded in the report.[48]

11.55 Authorised Clinicians submit their reports to the Clinic's Director for review, and then the Clinic's Director, if satisfied that the report meets the Clinic's quality standards, submits the report to the Children's Court. The parties to the proceedings can then test the report, and can cross examine the Authorised Clinician in relation to his or her assessment, report, and recommendations.

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[47] Senior Children's Court Magistrate cited in *Report on the Children's Court Clinic*, Attorney General's Department of NSW, August 2007, p.2.

[48] Children's Court Clinic, *Authorised Clinicians' Handbook*, p.5.

11.56 Clinicians are remunerated on a per report basis at a rate of $140 per hour. A maximum number of hours are allowed for that purpose, depending on the number of children and young persons in the matter. The rate includes all reading, interviews, observation, analysis and report writing.

11.57 It usually takes about six weeks for the Clinic to prepare a report from the time the assessment order is made.[49]

11.58 In 2006/07, 702 matters involving 1,264 children were referred to the Clinic, a small increase from 690 in 2002/03. The Inquiry has been informed that most of the assessments sought are in relation to parenting capacity and most of the children are aged under one year.

Other expert evidence

11.59 Practice Direction 28 specifies that if the child or young person is to be examined or assessed by any other expert and any subsequent report prepared, the leave of the Children's Court is required for its admission.[50] The expert report can be obtained for therapeutic purposes without the leave of the court.

Care plans and permanency planning

11.60 A care plan must be presented to the Children's Court before final orders are made, if an order for the removal of a child or young person from the care of his or her parents is sought. The care plan must provide for, *inter alia*, the proposed allocation of parental responsibility, the kind of placement proposed, contact arrangements, supervision of the placement and the services that need to be provided to the child or young person.[51]

11.61 The Children's Court must not make a final care order in relation to the care and protection of a child or young person unless it expressly finds that permanency planning for the child or young person has been appropriately and adequately addressed.[52] This includes a finding as to whether or not there is a realistic possibility of the child or young person being restored to his or her parents.

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[49] Children's Court NSW, *Standard Direction in Care Matters,* para. 4.

[50] Children's Court NSW, *Practice Direction, No.28,* para.33. The status and operation of practice notes in the care jurisdiction of the Children's Court NSW are discussed in Chapter 13.

[51] *Children and Young Persons (Care and Protection) Act 1998* s.78.

[52] *Children and Young Persons (Care and Protection) Act 1998* s.83(7).

Care orders

11.62 The Children’s Court can make a care order in relation to a child or young person if it is satisfied that the child or young person is in need of care and protection for any of the following reasons:

a. there is no parent available to care for the child or young person

b. the parents acknowledge that they have serious difficulties in caring for the child or young person

c. the child or young person has been, or is likely to be, physically or sexually abused or ill-treated

d. the child's or young person's basic physical, psychological or educational needs are not being met, or are likely not to be met, by his or her parents or primary care-givers

e. the child or young person is suffering or is likely to suffer serious developmental impairment or serious psychological harm as a consequence of the domestic environment in which he or she is living

f. in the case of a child who is under the age of 14 years, the child has exhibited sexually abusive behaviours and an order of the Children's Court is necessary to ensure his or her access to, or attendance at, an appropriate therapeutic service

g. the child or young person is subject to a care and protection order of another state or territory that is not being complied with.[53]

11.63 Once it has been determined that a child or young person is in need of care or protection, the Children’s Court can make an order allocating some or all aspects of parental responsibility for the child or young person to the Minister, or to one or both parents or another suitable person or persons, or to a combination of these people. The Children’s Court must first have given consideration to the least intrusive intervention principle, and be satisfied that any other order would be insufficient to meet the needs of the child or young person.[54]

Contact

11.64 In 2000, s.86 of the Care Act was proclaimed, permitting the Court to make orders as to contact as part of the orders made in care proceedings. The child or young person must be the subject of proceedings before the Court, and the application must be made by a party to the proceedings.

[53] *Children and Young Persons (Care and Protection) Act 1998* s.71.

[54] *Children and Young Persons (Care and Protection) Act 1998* s.79.

11.65 The wording of s.86 makes it clear that any order made under that section relates to the minimum requirements in relation to the frequency and duration of contact, and does not prevent more frequent contact with the child or young person, with the consent of the person who has parental responsibility.

11.66 Supervised contact can only be ordered with the consent of the putative supervisor (usually supervision is provided by an employee of DoCS). As stated by McDougall J of the Supreme Court:

> *It is for the Children's Court, taking into account, among other things, the paramount consideration referred to in s 9(a), to decide whether supervision is required. If it is, the Court should, with the consent of the proposed supervisor, order it. If the supervisor does not accept the requirement then contact should not be given.*[55]

Monitoring

11.67 If the Children's Court makes an order allocating parental responsibility for a child or young person to a person other than a parent, it can order that a written report be made to it within a specified period, in relation to the suitability of the arrangements for the care and protection of the child or young person. Such a report must include an assessment of progress in implementing the care plan, including progress towards the achievement of a permanent placement.[56]

11.68 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, it may order that the case be brought before it so that the existing orders may be reviewed.[57]

Other orders

11.69 The Children's Court may also:

a. make an order accepting written undertakings given by a person responsible for the child or young person or given by the child or young person

b. order that support services be provided by a person or organisation who consents to provide such services

c. order that a parent or child less than 14 years of age attend a therapeutic program relating to sexually abusive behaviours, provided that the child has

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[55] *Re Liam* [2005] NSWSC 75 at [48].

[56] *Children and Young Persons (Care and Protection) Act 1998* s.82(1) and (1A).

[57] *Children and Young Persons (Care and Protection) Act 1998* s.82 (2).

not been convicted in criminal proceedings arising from the same behaviours

d. order that the child or young person be placed under the supervision of DoCS for a maximum of 12 months, (subject to possible extension for a further 12 months) in situations where, for example, a child or young person has been found to be in need of care and protection, but there is a plan for his or her restoration.[58]

Rescission and variation of care orders

11.70 An application for the rescission or variation of a care order previously made by the Children's Court can be made by DoCS, the Children's Guardian, or a person who has (or previously had) parental responsibility for the child or young person, or any person with a sufficient interest in the welfare of the child or young person. Such application requires leave of the Children's Court.[59]

11.71 Leave is granted if the Children's Court is satisfied that there has been a significant change in any relevant circumstances since the care order was made or last varied.[60] Factors which indicate a relevant significant change include (but are not limited to) the following:

a. the parents of the child or young person concerned have not met their responsibilities under an applicable care plan or restoration plan

b. a finding has been made by the Children's Court under s.82(2) of the Care Act that proper arrangements have not been made for the care or protection of the child or young person.[61]

Jurisdiction of the Supreme Court

11.72 Nothing in the Care Act limits the jurisdiction of the Supreme Court.[62] Section 23 of the *Supreme Court Act 1970* states that the Supreme Court "shall have all jurisdictions which may be necessary for the administration of justice in New South Wales."

11.73 The Supreme Court also has a 'parens patriae' or welfare jurisdiction derived from the common law. This jurisdiction has been described in the following way:

> *The parens patriae jurisdiction derives from the royal prerogative and although its origins probably go back to the*

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[58] *Children and Young Persons (Care and Protection) Act 1998* ss.73-76(1) and (3).
[59] *Children and Young Persons (Care and Protection) Act 1998* s.90(1), (3) and (4).
[60] *Children and Young Persons (Care and Protection) Act 1998* s 90(2).
[61] *Children and Young Persons (Care and Protection) Regulations 2000* cl.6.
[62] *Children and Young Persons (Care and Protection) Act 1998* s.247.

time of Edward III, in more recent centuries the Chancery Division in England and the Equity Court in New South Wales have been responsible for exercising the Queen's power to do good to all her subjects, particularly to those who are children or otherwise incapable of looking after themselves. In exercising that jurisdiction the court's concern is predominantly for the welfare of the person involved. It is not a jurisdiction that is bogged down at all with any technicalities. It is a quite separate jurisdiction to the supervisory jurisdiction that is committed to this court by way of prerogative orders under which this court supervises inferior courts and tribunals to make sure that they do justice and right to all people before them.[63]

11.74 In addition, the Guardianship Tribunal has jurisdiction to determine applications concerning the special medical treatment of children as well as, financial management for children and young persons with an intellectual disability.

11.75 In relation to questions concerning the care and protection of children and young persons, the Supreme Court has stated that the Care Act clearly sets out the legislature's intention that the Children's Court should be the primary forum for the determination of applications under the Care Act (*Re Liam*[64] - discussed below). It has also stated that the legislature clearly intended that appeals from the Children's Court should be heard in the District Court. In the Supreme Court decision of *Re Victoria*[65], followed by the decisions in *Re Liam* and *Re Elizabeth,*[66] it was determined that the parens patriae jurisdiction of the Supreme Court should not be used as a means to bypass the appeal process set out in the legislation. Accordingly parties should not resort to the parens patriae jurisdiction of the Supreme Court in order to appeal interim decisions of the Children's Court. However, the Supreme Court will exercise its parens patriae jurisdiction in 'exceptional circumstances' where "to do so is in the best interests of the child, such as where some form of protective order is urgently required and there is no other curial process available to provide it."[67]

11.76 In *Re Liam*, in which the Children's Court had made an order delegating its responsibility to determine whether the best interests of the child required that contact be supervised, the Supreme Court determined that the Children's Court, in delegating its responsibility, had failed to consider a matter of real significance (that is, the best interests of the child in relation to contact), and that therefore there was sufficient justification for the Supreme Court to intervene.[68]

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63 *Re Frances v Benny* [2005] NSWSC 1207 at [17].

64 *Re Liam* [2005] NSWSC 75 at [30]-[31]; *Re Victoria* [2002] NSWSC 647 at [36].

65 *Re Victoria* [2002] NSWSC 647 at [36]-[40].

66 *Re Elizabeth* [2007] NSWSC 729 at [17]-[18].

67 *Re Elizabeth* [2007] NSWSC 729 at [17].

68 *Re Liam* [2005] NSWSC 75 at [41], [48]-[50].

11.77 In relation to the Supreme Court, the Legal Aid Commission NSW (LAC) submitted:

> *The majority of 'appeals' currently heard by the Supreme Court are either applications made pursuant to the Court's parens patriae jurisdiction (in which DoCS either seeks different orders than those made by the Children's Court or seeks orders that are unable to be made by the Children's Court at all, such as forced medical treatment or detention of the child) or challenges to the powers of the Children's Court to make the orders it has made (usually, such challenges are made to interim orders since interim orders cannot be appealed to the District Court, but they are not necessarily limited to these). These appeals are heard, most often, in the Equity Division of the Supreme Court, though it is not unheard of to find them in the Common Law or Administrative Law Divisions.*[69]

11.78 The Supreme Court will, in exceptional circumstances, hear applications for prerogative writs[70] concerning orders of the Children's Court. The Supreme Court also determines parentage under the *Status of Children Act 1996*, and deals with adoption applications under the *Adoption Act 2000*.

Issues arising

11.79 The Care Act establishes a regime whereby ultimate decision making about the removal of children and young persons from their families without their consent and the consequent allocation of parental responsibility, rests with the Court. Decisions about the exercise of that parental responsibility and the day to day care of the child or young person generally reside with DoCS or the agency into whose care the child or young person has been entrusted.

11.80 A range of issues were raised with the Inquiry concerning both the operation of the substantive law, and the procedural aspects of the care jurisdiction. Issues in relation to the latter are dealt with in Chapter 13. Matters of substantive law are addressed below.

11.81 The Children's Court has some powers after final orders have been made, notably a continuing role in determining contact between the child or young person and his or her family, and a monitoring power requiring DoCS to report back to the Court on the suitability of the arrangements for the care and protection of the child or young person.

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[69] Submission: Legal Aid NSW, 20 February 2008, p.110.

[70] A prerogative writ is a determination by a superior court that a lower court or an administrative agency has exceeded its legitimate power.

11.82 At the heart of the submissions made to the Inquiry was whether the Children's Court should be empowered to embrace a more inquisitorial approach to care matters or confined to the more traditional role of deciding cases brought before it on the evidence adduced by the parties. Often this translates to competing arguments as to the powers that the Children's Court should, and on a 'proper' interpretation of the Care Act, does have, in relation to children and young persons once they have been subject to care proceedings and placed in OOHC.

11.83 DoCS recommended that the roles of the Children's Court and designated agencies be clarified, and that only it and the latter should have any responsibility for decisions concerning contact and the like in relation to children in OOHC, subject to review by a tribunal that considers the context in which a decision is made, and subject also to accreditation and monitoring (from a systemic perspective) by the Children's Guardian.

11.84 By contrast, the Children's Court, often supported by the LAC, submitted for an extension to its powers.

11.85 Integral to understanding the positions adopted by those before the Inquiry, is the extent of oversight, in contrast to judicial decision making, which exists in relation to DoCS. These matters are dealt with later in the report, however, for current purposes it should be noted that the Ombudsman has significant power to review DoCS' decision making and the Children's Guardian has an accreditation and monitoring role with respect to children and young persons in OOHC.

Participation in Children's Court proceedings

11.86 An issue before the Inquiry concerned the experience of DoCS caseworkers and legal officers in care proceedings in the Court, as recounted to the Inquiry. While DoCS acknowledged the need for judicial determination in relation to proceedings involving the potential removal of children or young persons from their families, it was critical of many aspects of the Court's operations and performance.

11.87 A significant concern which was entertained related to the difficulties which, it was reported, caseworkers often found in dealing with a process that they viewed as unduly adversarial. Where that led to overt criticism from the bench of those caseworkers, or of the Director-General of DoCS, or of DoCS itself, it was asserted that this left them "disempowered and shattered" and with a difficulty in continuing to work with the family involved in the proceedings.[71]

11.88 As it was put in DoCS' submission to the Inquiry:

> *The experience of caseworkers and legal practitioners appearing for the Director-General is that they encounter far*

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[71] Transcript: Public Forum, Role of Courts, 22 February 2008 p.13.

> *greater criticism, and sometimes intemperate and personal attack, than is usually the case elsewhere. These comments are made from both presiding judicial officers and other practitioners appearing in the jurisdiction…*
>
> *Caseworkers find that appearing in Court is a stressful experience. They feel, and sometimes, are, under personal and professional attack. This is exacerbated by caseworkers wishing to convey their general concerns about the child and the child's circumstances and the Court and the legal profession wanting to concentrate upon the specific circumstances of why the matter is currently back before the Court.*[72]

11.89 DoCS added that as a result some experienced Departmental legal officers have "refused to practice at Parramatta Children's Court or have asked to be transferred from that Court to other Courts exercising the care jurisdiction" and that some "caseworkers appear to prefer positions that do not require Court attendance."[73]

11.90 The PSA informed the Inquiry, similarly, that some of its members reported that Magistrates "often treat caseworkers in an inappropriate manner, undermining and insulting them for the work they have produced."[74]

11.91 Additionally, the attention of the Inquiry was brought to the matter of *Re Frances and Benny* [2005] NSWSC 1207, where his Honour Young CJ in Eq. quoted the Senior Children's Magistrate (from the transcript of the Children's Court) as having observed:

> *This is appalling. The Director-General has got more solicitors working for him than enough and he has got the resources of the profession, but he just deliberately, it seems to me, puts up a case that is… almost impossible to deal with. No reason, just - I don't think it is obtuseness. I don't know if it is stupidity or what it is.*[75]

11.92 That was a case where the application for a care order was dismissed by reason of the finding in the Children's Court that there was insufficient evidence to support the application. In holding that it was incorrect for the application to have been dismissed, Young CJ in Eq. said of the Senior Children's Magistrate's approach to the evidence:

> *I can well understand him being peeved, though it is not really the fault of the Department alone. Unfortunately, in this area,*

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[72] Submission: DoCS, Operation of courts in the child protection system, (abridged), p.10.
[73] ibid.
[74] Submission: Public Service Association, 17 March 2008, p.8.
[75] *Re Frances and Benny* [2005] NSWSC 1207 at [13].

case officers spend a very, very short time with the Department and one tends to find a large number of them in any particular case. There are a tremendous number of children in need in New South Wales. Unfortunately, those who have to attend to their problems and the courts can well understand why every witness is not available on every occasion and why the evidence presented by the Department would not necessarily be in a perfect state. However, that is no reason why proceedings involving children should be dismissed.[76]

11.93 Another area of concern that was raised by DoCS, by the LAC, and by the Aboriginal Legal Service was the practice of the Court in displacing fixtures, and bringing the proceedings on for hearing at an earlier date, and sometimes at a different venue, without sufficient regard being given to the impact on the parties in terms of maintaining the continuity of legal representation, with a knowledge of the case and the confidence of the parties, or to the costs occasioned to the LAC where this occurs.[77]

11.94 In a submission provided to the Inquiry in response to the Public Forum concerning the operation of the Courts, and in response to the DoCS submission, the Senior Children's Magistrate took issue with the suggestions that the proceedings in the Court are conducted with undue legalism, that personal and intemperate attacks were made on caseworkers and legal practitioners, and that hearing dates were changed or cases moved without the arguments of the parties being given proper consideration.[78]

11.95 In this submission, the Senior Children's Magistrate drew attention to a number of cases that he suggested showed that DoCS' decisions had been inappropriate, some of which he variously described as "idiosyncratic," "inexpert" or "unprofessional," and noted the "occasional need for the Court…to advise and, when that advice is rejected, warn and cajole DoCS to lift its game regarding vulnerable children."[79] Transcripts of the cases were attached in an addendum to this submission.

11.96 He accepted that, on occasions:

Children's Magistrates have expressed their frustration and sometimes outrage regarding the behaviour of the department and/or its apparent failure to act protectively towards children the subject of proceedings.[80]

11.97 One of the transcripts provided contains observations to the following effect:

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[76] *Re Frances and Benny* [2005] NSWSC 1207 at [22].

[77] Transcript: Public Forum, Role of Courts, 22 February 2008, pp.18-21.

[78] Submission: Children's Court NSW, 18 April 2008, pp.4-6.

[79] Submission: Children's Court NSW, 18 April 2008, pp.8, 13 and 14; Transcript: Inquiry meeting with Senior Children's Court Magistrate, 29 April 2008, p.60.

[80] Submission: Children's Court NSW, 18 April 2008, p.4.

His Honour: And they were wrong about that…

…I have no reason to be uncomfortable about the father, I don't know the father, I withdraw that, I am not able to say I have no reason, but I don't know the father and I'm certainly not making any accusations against the father and I note that the Director-General is comfortable with the father as a protective person for the child and I note that the allegation has never been made by the child against the father but the Director-General was recklessly able to believe the mother but now seems to have been a really negligent and dangerous thing for the Director-General to have done. I do not want to do the same thing by assuming that the allegations that the mother makes are without foundation just in case I am wrong about it. I'd like to be a little bit more protective than the Director-General obviously wanted to be.[81]

11.98 A second transcript provided records the Senior Children's Magistrates observing:

I can't understand how the Director-General could allow that litany of danger, a fair way of describing it, to go unattended for so long without apparently satisfying herself that those four children are in safe hands. I mean the Director-General knows about those matters because they are contained in his officer's affidavit but he appears to have done nothing about it.

…Well I must say if I had anyone else in whom I could place the parental responsibility for this child I would be doing it because on the track record that is shown in your officer's affidavit, you have to wonder if she is going to be properly cared for but I have no choice.[82]

11.99 When the concerns which had been raised by DoCS, and the observations in the several transcripts, were brought to the attention of the Senior Children's Magistrate, he made it clear that his purpose had been to "raise the standard" of the work performed by DoCS, and also to ensure that cases were heard without delay.[83]

11.100 The Senior Children's Court Magistrate informed the Inquiry additionally that it had not been his experience that DoCS legal officers had refused to practice at Parramatta;[84] and he drew to its attention the visits to the Children's Court

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[81] Children's Court NSW, transcript in the matter of *Re A,* 11 April 2008, Senior Children's Magistrate Mitchell, pp.5, 6 and 7.

[82] Children's Court NSW, transcript in the matter of *Re C, 7* April 2008, Senior Children's Magistrate Mitchell, pp.12-14.

[83] Transcript: Inquiry meeting with representatives of the Children's Court NSW, 29 April 2008, pp.54-55 and 23-26.

[84] ibid., p.51.

which he had encouraged DoCS officers to make, as well as the occasions on which he had met with DoCS staff on social occasions and had given talks to them on a variety of relevant topics.

11.101 The Inquiry acknowledges the value of the kind of interaction mentioned, and notes the existence of a working group which could, with a degree of mutual trust, address some of the issues raised. At the same time it notes the cogent caution of the former President of the Court of Appeal of NSW, given in another context but equally relevant for all judicial officers that "the obligation to act without fear or favour does not authorise the venting of personal spleen even when error is clearly established."[85]

11.102 It is accepted that the transcripts provided relate to proceedings that represent only a fraction of the Court's hearings, and that the Inquiry has only received the view of the Senior Children's Magistrate in relation to the concerns expressed to the Inquiry by DoCS and by the PSA concerning the perceptions of DoCS staff; and in relation to the views of DoCS Director Legal Services and of the legal officers representing the LAC and Aboriginal Legal Service, concerning the problems said to arise from the changes in fixtures and venues for hearing.

11.103 It also acknowledges that the individual cases brought to notice may well have involved errors of judgement or insufficient attention on the part of DoCS to the safety, welfare or well-being of the children involved.

11.104 The Inquiry is, however, concerned with the reported perception of DoCS caseworkers and legal officers that their professionalism and that of DoCS, the primary litigant in the care jurisdiction of the Court, is undervalued, and that they are prone to personal criticism from the Bench.

11.105 The context in which care proceedings arise cannot be overlooked. Proceedings of this kind in the Children's Court almost always commence in an atmosphere of acrimony and of great concern on the part of the family that they might lose their child; as well as concern on the part of DoCS staff as to the safety, welfare and well-being of the child, and of the need to be able to establish a positive working relationship if the child is in fact removed, either temporarily or on a long term basis.

11.106 In these circumstances of a potentially fraught relationship, the parties need to be confident that their cases will be advanced by those lawyers who they know, in whom they have established confidence, and who are appropriately apprised of the facts. Moreover, there is a risk that comments made in the presence of the family which are unduly critical or dismissive of DoCS, are likely to impact adversely on the trust that is essential if DoCS staff are to work constructively with the child or young person who is the subject of the proceedings, and his or her parents, for example in relation to contact, restoration and support if that

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[85] The Hon K Mason AC, "Throwing Stones: A Cost-Benefit Analysis of Judges Being Offensive to Each Other," *The Judicial Review Vol 9 No.1*, September 2008, pp.66-67.

child is taken into care. Additionally if DoCS workers feel, whether justifiably or not, that they are likely to be subject to sustained criticism, then this may adversely affect the quality of their case preparation or appearance in Court.

11.107 It is not the purpose of this Inquiry to ascribe fault to any party in relation to the matters canvassed, or to express any view in relation to the correctness or otherwise of the decisions reviewed in the submissions. Rather, its concern relates to the clear impression it has formed, from the material placed before it, that the relationship between DoCS and the Court does appear at least at times, to be strained, to the point where the best interests of the children and young persons involve may not always be served.

11.108 The reasons for this may include the nature of the jurisdiction which lends itself to strong emotional reactions, the strong and understandable desire of the Court to reach a correct decision, the pressure placed on DoCS staff working in a very challenging environment, a perception of and, at times, the reality of poor practice on the part of DoCS, the fact that it is a party in every case, the small pool of lawyers (mainly legally aided) who appear before the Court, and the personalities of those involved.

11.109 The Inquiry is strongly of the view that the relationship between DoCS and the Children's Court should change to one which is less adversarial, and more conducive to working cooperatively so as to ensure the safety, welfare and well-being of the children and young persons involved in care proceedings. This objective would be assisted by DoCS placing relevant, accurate and fair material before the Court in a timely way, and by the Court giving due respect to the professionalism of DoCS staff and making due allowance for the substantial pressures under which they necessarily work.

11.110 What follows in this, and the succeeding chapters, is an examination of various matters which may have contributed, collectively, to an unnecessary degree of complexity or conflict in care proceedings. The recommendations that are later set out are designed to restore a better working relationship between the Children's Court and DoCS, and to improve the relationships between the parties appearing in the Court in the best interests of the children and young persons who are subject to care proceedings.

Principles to be applied in care proceedings

11.111 Much has been said about the principles in the Care Act, both to the Inquiry and in various discussion papers which preceded it, in particular the Ombudsman's discussion paper, *Care Proceedings in the Children's Court* dated July 2006, and DoCS' discussion paper, *Statutory Child Protection in NSW: issues and options for reform* (the Discussion Paper) dated October 2006.

11.112 Concerns have been expressed, *inter alia,* about balancing the least intrusive intervention principle with the principle that, in all actions and decisions made

under the Act, the safety, welfare and well-being of the child or young person, is the paramount consideration.

11.113 The Ombudsman, from his investigations and reviews, 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. Others, most notably the LAC, gave examples to the Ombudsman and to the Inquiry of cases where, in the view of its lawyers, DoCS had intervened to remove a child in circumstances where there were other less intrusive measures available.

11.114 The Inquiry agrees with the comment made by DoCS that a number of these examples do not necessarily address the question of whether there is confusion about the concept of the least intrusive intervention.[86]

11.115 The Senior Children's Magistrate was of the view that the principles are clear in the legislation and well understood by lawyers and by the Court.[87]

11.116 In a meeting with the Inquiry, DoCS' Director, Legal Services also expressed the view that the courts properly apply the principles. In his view "the biggest problem I think comes in terms of the caseworkers rather than from the courts."[88]

11.117 In its Discussion Paper, DoCS opined that the practical effects of the least intrusive intervention principle, the framing of the paramount interest principle, and the reference to parental rights in the objects of the Care Act[89] appear to be that the child centred approach of decision making is disrupted.[90]

11.118 In addition, in its Discussion Paper DoCS also noted that the least intrusive intervention principle is in conflict with the policy goal of providing stability for children in OOHC.[91] DoCS noted that s.9(f) of the Care Act was introduced in 2001 in order to promote placement stability. DoCS argued that stability and permanency would be assisted if the conflict between the least intrusive intervention and permanency planning principles was addressed.[92]

11.119 It suggests a revision of the principles in its Discussion Paper by reframing s.9 as follows:

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

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[86] NSW Ombudsman, *Care Proceedings in the Children's Court, Discussion Paper*, 2006, p.6.

[87] ibid.

[88] Transcript: Inquiry meeting with DoCS lawyers, 1 February 2008, p.3.

[89] *Children and Young Persons (Care and Protection) Act 1998* s.8(a) and 9(a).

[90] DoCS, *Statutory Child Protection in NSW: issues and options for reform*, *Discussion Paper for review,* October 2006, p.28.

[91] ibid.

[92] ibid., p.31.

In all actions and decisions concerning a particular child or young person that are made under this Act the safety, welfare and well-being of the child or young person must be the paramount consideration.

a. *A child or young person must (wherever a child or young person is able to form his or her own views) be given an opportunity to express views freely on a matter concerning his or her safety, welfare and well-being. Those views are to be given due weight in accordance with the developmental capacity of the child or young person and the circumstances in which a decision is to be made or action taken.*

b. *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 in all actions and decisions made under this Act that significantly affect a child or young person, and be reflected in any care planning and cultural care plan for the child or young person.*

c. *If a child or young person is in need of care and protection and is temporarily or permanently withdrawn from his or her family environment then:*

   i. *the earliest practicable consideration must be given to the possibility and appropriateness of restoration to the birth family. A decision on the viability of restoration should, other than in exceptional circumstances, be taken within six months of the child or young person entering out-of-home care where the child is under two years of age and, for any other child or a young person, within 12 months of entry into out-of-home care.*

   ii. *the child's or young person's placement should not be disrupted unless required for the safety, welfare and well-being of the child or young person.*

   iii. *unless it is contrary to his or her best interests and taking into account the views of the child or young person, the child or young person should retain relationships with people significant to the child or young person, including birth or adoptive parents, siblings, extended family, peers, family friends and community.*

d. *In considering whether restoration of a child or young person is possible and appropriate the relevant considerations are whether restoration:*

i. could be achieved within a timeframe that is likely to minimise significant developmental disruption to the child or young person.

ii. will provide the child or young person with the opportunity to meet developmental milestones appropriate to that child or young person, and in any event, whether restoration can and should (other than in exceptional circumstances) occur within two years of the child or young person entering out-of-home care.

e. If restoration is not considered possible and appropriate for a child or young person in out-of-home care, then the provision of a safe, secure, nurturing and stable environment is to be sought for the child or young person in a timely manner. In seeking this, regard is to be had to:

i. the circumstances and needs of the child or young person;

ii. the views of the child or young person;

iii. the principle that, the younger the age of the child, the greater the need for early decisions to be made in relation to a stable and permanent placement;

iv. the need to avoid the instability and uncertainty arising from a succession of different placements or other care arrangements;

v. the paramount consideration in all decisions and actions, as set out in (a), is to take priority over any interests of parents; and

vi. proposed contact between a child or young person and other significant people in his or her life being designed to meet the needs of the child or young person.[93]

11.120 DoCS stated that it would also be necessary to amend the objects of the Care Act, so that s. 8(a) could read:

that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them.[94]

11.121 In submissions responding to the Discussion Paper, the redrafting of s.8(a) was generally supported by the Ombudsman and the LAC.[95] The proposed change

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[93] ibid., pp.32-33.

[94] ibid., p.33.

[95] NSW Ombudsman Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, p.10; Legal Aid NSW Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, p.6.

to s.9 received a mixed reaction, with many suggested variations. Generally, Police, Education, Health, the Children's Guardian, the Foster Care Association, and Barnardos were in agreement with clarifying the principles and reducing conflict with the 'least intrusive' principle.[96]

11.122 By contrast, a number of agencies wanted the 'least intrusive' principle retained, including the Law Society of NSW (the Law Society) and UnitingCare Burnside.[97]

11.123 In submissions made to the review of the Care Act, prior to the publication of the DoCS Discussion Paper, a number of parties submitted that the objects and principles of the legislation do not adequately reflect the importance of early intervention. For example, UnitingCare Burnside submitted that a principle should be included that when a child or young person is at risk or has made a request for assistance, intervening early with support services will be a priority.

11.124 The Ombudsman submitted that where grounds for a care order had been established, there should be a presumption that the child will not be returned to the family unless and until risks are ameliorated and there should be an amendment to s.9(d) to this effect.

11.125 In his submission to the Inquiry, the Ombudsman supported the removal of the 'least intrusive' principle because of evidence suggesting that, in practice, it can be open to misinterpretation. He also questioned whether that principle is necessary in light of the clear and overriding principles of intervention in s.36.

11.126 The LAC informed the Inquiry that it is not always apparent what is in the best interests of a child for the purposes of applying the principles specified in s.9 of the Care Act. The LAC stated:

> *There can sometimes be some difficulty I think with people making determinations as to what is in the best interests of the child because the Act does not set out what should be considered when considering what is in the best interests of the child and there are a number of factors that go into that.*[98]

11.127 The Combined Community Legal Centres Group stated:

> *In relation to s.9 of the Act, we would suggest consideration of an expansion to include a reference to the Court considering*

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[96] NSW Police Force Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, p.4; Department of Education and Training Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper,* 21 March 2007, p.7; NSW Health Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, p.3; Children's Guardian Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, 4 April 2007, p.2; Foster Care Association Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, 20 March 2007, p.4; Barnados Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper,* 28 March 2007, p.1.

[97] Law Society of NSW Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, 3 April 2007, p.6; UnitingCare Burnside Submission to DoCS, *Statutory Child Protection in NSW: Discussion Paper*, March 2007, p.16.

[98] Transcript: Public Forum, Role of Courts, 22 February 2008, p.31.

> *the psychological and/or harmful consequences of removal as opposed to the child remaining in the current circumstances.*[99]

11.128 Women's Legal Services submitted that DoCS situates the paramount principles contained in s.9 against the rights of parents. It submitted that the best interests of children are frequently aligned with the interests of parents, and that it is not necessary to diminish the rights of parents in order to maintain a primary focus on the rights of the child. It stated that the *UN Convention on the Rights of the Child* explicitly recognises the rights, as well and the responsibilities and duties, of parents.

11.129 A retired Children's Magistrate submitted:

> *The application of the 'least intrusive' provision is not assisted by the shorthand way in which it is commonly referred to, overlooking the qualification "that is consistent with the paramount concern to protect the child from harm and promotes the child's development" …Further [s 9(d) of the Care Act] introduces the additional consideration of intervention in the life of the child's 'family' that is not followed through to other provisions of the Act.*[100]

11.130 At the Public Forum on the Role of Courts, a representative from Health suggested that a further principle be inserted into the Care Act to reflect what it sees as a 'desirable object,' being the "continuity or permanency of placement."[101]

11.131 The Inquiry is of the view that the principles set out in s.9 and s.36 are not, of themselves, inconsistent or poorly drafted. However, the evidence before the Inquiry, particularly of caseworkers who may be reluctant to remove a child or young person because of a mistaken belief of the paramountcy of the 'least intrusive' principle or who may delay a removal while attempting other possible interventions, is of great concern.

11.132 The Inquiry has carefully considered the amendment proposed by DoCS. It finds a number of aspects attractive, in particular elevating the safety, welfare and well-being of the child by having the other principles enumerated below it, and making reference to early consideration of restoration and the need for a stable, permanent placement. It also agrees that the combination of s.9(d) and s.36 has the effect of diluting the least intrusive principle. On balance, however it is not persuaded that the difficulties or tensions exposed to the Inquiry are best resolved by repeal of the least intrusive principle.

11.133 Ultimately, the Inquiry agrees with Professor Patrick Parkinson, Professor of Law, University of Sydney, who told the Inquiry:

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[99] Submission: Combined Community Legal Centres Group, p.6.

[100] Submission: John Crawford, 29 February 2008, p.5.

[101] Transcript: Public Forum, Role of Courts, 22 February 2008, p.69.

> *The least intrusive principle has been a staple of child protection legislation around the world for the last 20 or 30 years. It is nothing new and if one looks at other legislation you will find it is pretty well established. It is just an obvious principle of social work. One does not go to the option of removing the children from parents unless interventions are needed - basic human rights. I don't see it as conflicting with paramountcy because both of them have always been principles of child protection legislation.*[102]

11.134 The Inquiry, however, is of the view that the objects as currently set out in s.8(a) can be interpreted to 'disrupt' the best interests of the child being the prevailing consideration. The reference to the rights, powers and duties of a parent or other responsible person sits uneasily with ss.9(a), 9(d) and 36(a). Accordingly, the Inquiry accepts the desirability of adopting the alternative wording suggested by DoCS for s.8(a) of the Care Act.

11.135 In addition, the Inquiry is of the view that section 9 should be recast so that the paramount consideration currently contained in s.9(a) sits above the remaining principles.

11.136 DoCS' current Casework Practice policy, Taking Action in the Children's Court, states that action in the Children's Court is taken when all less intrusive casework actions have not met the care and protection needs of a child or young person. This policy suggests that court proceedings are not appropriate unless other casework actions have previously been attempted. The policy does not identify clearly the distinction between the principles of ensuring the child's or young person's safety, welfare and well-being are paramount and how this interfaces with the least intrusive principles. As such the Inquiry is of the view that this policy requires review to ensure there is better guidance for its staff in understanding these principles, that would accord with the amendments proposed.

11.137 Further, the changes recommended to casework practices and supervision (discussed elsewhere in the report) should improve the decision making of caseworkers and align decisions with the principles enunciated in Care Act.

Aboriginal and Torres Strait Islander principles

Self-determination

11.138 The review of the 1987 Act resulted in self-determination being included in s.11 of the Care Act. This section does not, however, address the recommendation made following the review of the 1987 Act that to support self-determination:

[102] Transcript: Inquiry meeting with Professor Parkinson, 27 February 2008, p.34.

> *The Act should give the Minister for Community Services the power to delegate certain departmental functions to Aboriginal and Torres Strait Islander people to enable a greater degree of self-determination in the work of child protection.*[103]

11.139 SNAICC recommended that the implementation of self-determination would require the transfer of aspects of control and resources from government agencies to local Aboriginal communities.

11.140 The Inquiry notes the finding of the NSW Children's Guardian following her analysis in 2007 that in NSW:

> *The results of the 2006/07 audit showed that Aboriginal children and young persons under the parental responsibility of the Principal Officer [of an Aboriginal agency] were the least likely to have the following essential information recorded: birth family contact details, developmental history, current medication, doctor's contact details, past school reports, current school reports and immunisation status. In addition, they were the least likely to have a case conference convened to conduct the plan or review.*[104]

11.141 The example of Manitoba, Canada, discussed in Chapter 18, shows that where such functions have been delegated, responsibility is dependent on the presence of Aboriginal agencies with capacity to discharge them effectively. Particularly in the case of the Métis people in Manitoba, a period of capacity building was required to enable the community to be in a position to start to undertake these responsibilities.

11.142 Referring to the concept of a statutory child protection service controlled and run by the Aboriginal community in Australia, Tomison and Stanley in 2001 referred to attempts to develop Indigenous led child protection and family support services in Canada. They stated:

> *Unfortunately, implementation of such a model is [not] easy, nor has it necessarily led to significant improvements in Canadian First Nation communities' health and well-being and/or a reduction in violence. Although providing an example of how to move forward with more effective services … [the] model has some serious 'gaps'. It does not seem to address issues of how to place a child within their Indigenous community if the community is beset by familial violence, substance abuse etc. Nor does it provide a solution to the mainstream statutory authority's (or Aboriginal authority's) reluctance to intervene with Aboriginal families, which may leave children in serious*

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[103] DoCS, *Review of the Children (Care and Protection) Act 1987*, *Recommendations for Law Reform*, December 1997, p.126.

[104] Correspondence: NSW Children's Guardian, 21 July 2008, p.1.

> *harm. Finally, it does not address the issue of effective prevention and/or community development to minimise the removal of children and violence in the first place.*[105]

11.143 Under the DoCS *Aboriginal Strategic Commitment 2006-2011*, (discussed in Chapter 18) DoCS has an obligation to work with Aboriginal communities and Aboriginal and non-Aboriginal NGOs funded by DoCS to increase their capacity to deliver prevention and early intervention services for Aboriginal children and young persons and their families and communities, and to work with DoCS funded Aboriginal organisations to ensure they are fully functional, sustainable and have good governance.

11.144 However, the quantity and difficulty of the work required to bring the Aboriginal NGOs to the point where they can realistically take full responsibility for the safety and welfare of Aboriginal children should not be underestimated. The Inquiry would hold similar concerns to those documented above about any attempt to delegate functions for the care and protection of children to agencies that were not sufficiently prepared, supported, staffed or funded to perform such functions to the level required to keep children safe and to protect their welfare. This matter has been addressed in Chapter 9.

Aboriginal child placement principles

11.145 Although welcomed for its intent to preserve the identity, culture and heritage of each child and young person and its recognition of the rights of Aboriginal people to keep their culture and identity alive by passing them on to their children, the Aboriginal Placement Principles have also been criticised for their limitations. In a recent examination of Aboriginal OOHC in Australia, Valentine and Gray state that the most significant limitation is that:

> *There is no requirement for Aboriginal children to be placed via an Aboriginal agency and many Aboriginal caregivers, for historical reasons, will not work with state agencies. In addition, even if an Aboriginal child is placed with an Aboriginal family by a non-Aboriginal agency, particularly if not supervised by an Aboriginal worker, Aboriginal culture is suppressed because the placement is subject to the dominant rules, mores, and conventions that inform non-Aboriginal policies, procedures, and practices as well as the values of non-Aboriginal workers.*[106]

11.146 Similar concerns were raised by a number of agencies which made submissions to the review of the Care Act, prior to the publication of the DoCS Discussion Paper.

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[105] A Tomison and J Stanley, "Strategic Directions in Child Protection: Informing Policy and Practice", 2001, *South Australian Department of Human Services*, p.85 www.aifs.gov.au.

[106] Valentine and Gray, "Keeping Them Home: Aboriginal Out-of-Home Care in Australia*", Families in Society, Vol.87 Issue 4*, 2006, p.538-539.

11.147 It became apparent to the Inquiry that there exists among DoCS caseworkers, and the community more generally, a range of views about actions that must be undertaken in order to satisfy the Aboriginal and Torres Strait Islander principles within the Care Act (both the Aboriginal Placement Principles, and the principles at ss.11, 12 and 14). This range of interpretations in turn influenced the range of views about whether the principles are themselves satisfactory, and whether they are being satisfactorily applied in practice.

11.148 The Inquiry heard that there were concerns regarding the frequency and adequacy of consultation by DoCS with Aboriginal people and Services particularly in relation to the cultural and family background of those involved in care proceedings. AbSec informed the Inquiry:

> *The legislation and the regulations and the policies that are written say that DoCS needs to consult Aboriginal people. Usually they rely on consulting an Aboriginal DoCS worker who has been in the Department for 20 years and has more of a DoCS mentality than a strong relationship with the community. There are a lot of Aboriginal caseworkers out there who still have a relationship with the community, but it is often different when you're working within the Department from working with a community organisation. That feedback that an Aboriginal caseworker would give from within the Department would be a lot different, I think, from what would be received if they had asked a community organisation for advice.*[107]

11.149 Concerns were expressed regarding the differences in compliance with s.13 from CSC to CSC, and from caseworker to caseworker. A representative of the Aboriginal Legal Service said:

> *There are certain areas, and in particular Wagga, has a very high compliance with s.13(1)(a) where that child goes directly to family or kinship groups. The rest of the regions the Aboriginal Legal Service is covering have a relatively poor compliance with that particular section of the Act.*[108]

11.150 In its submission, the Aboriginal Legal Service stated:

> *Section 13 of the Care Act should be considered even before the matter comes to court. In the experience of the Aboriginal Legal Service, the s.13 principles are only addressed at the final stages of a matter and in the development of a Care Plan.*[109]

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[107] Transcript: Inquiry meeting with representatives of the Aboriginal Child, Family and Community Care State Secretariat, 18 December 2007, p.22.

[108] Transcript: Public Forum, Aboriginal Communities, 24 April 2008, p.43.

[109] Submission: Aboriginal Legal Service NSW, p.7.

DoCS' comments on the application of the Aboriginal Placement Principles

11.151 DoCS reported that a growing number of Aboriginal children are placed in accordance with the Aboriginal Placement Principles, rising from 2,262 (84.2 per cent) at 30 June 2005 to 3,284 (85 per cent) at 30 June 2007.[110] This number remained steady as at 30 June 2008.[111] However, the Inquiry heard that DoCS, in common with other agencies, has recognised that the recording of children's Aboriginal status has not been consistent, and that it is now taking steps to improve the collection and recording of information about children's Aboriginality.

11.152 Further, the Inquiry heard that data extraction and analysis is currently not sufficiently sophisticated to report on compliance with the Aboriginal Placement Principles. The Inquiry asked DoCS, if it was possible to provide the number of children and young persons placed in compliance with each of the sub-paragraphs of the Aboriginal Placement Principles. Ms Mallett, Acting Deputy Director-General, DoCS, responded:

> *I don't think the system would be that sophisticated in terms of all individual boxes. What it would have is an overall - 'tick' is not the right word, but anyway - mark, or indicator, that one of those four has been followed, or believed to be followed, in these circumstances.*[112]

11.153 The presence of a mark placed by a caseworker on the file is not a sufficient basis for a claim that Aboriginal Placement Principles have been met. For any such conclusion to be reached more is needed by way of a commentary as to what in fact was done.

11.154 DoCS advised the Inquiry, in relation to consultation:

> *We don't have one standard protocol for across the State, but every region has a regional protocol that identifies what the individual differences may be for that individual region and their units.*[113]

11.155 Regional DoCS staff members provided information on the current implementation of the Aboriginal Placement Principles. At many CSCs, consultation occurred with Aboriginal caseworkers rather than with people living in the relevant community from which the child or young person came. For example, an Aboriginal caseworker informed the Inquiry:

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[110] DoCS, *Annual Report 2006/07*, p.55.
[111] DoCS, *Annual Report 2007/08,* p.56.
[112] Transcript: Public Forum, Aboriginal Communities, 24 April 2008, p.36.
[113] ibid., p.37.

Caseworker: I did actually recommend that because one of the children had high needs in regards to education and if we did place him with a family member, it would have taken him away from gaining the supports that he would get from that. It was at (X School) and it's such a hard school to get into. This child actually needed that school more than he would have needed the cultural identity. That was my decision because if we did relocate him, they don't have those services available.

Counsel Assisting: Did you talk to anyone from his extended family or the broader community before coming to that decision?

Caseworker: No, I did not. That was purely my decision on the evidence and the information that I had.[114]

11.156 One manager described how, because of the confidentiality issues involved, consultation may occur with Aboriginal community members employed in other agencies who understood the confidentiality needs, such as Aboriginal health workers.

11.157 In one CSC in Western Region, caseworkers advised the Inquiry of the extent to which the limited number of carers, and the large geographical area, impacted on their ability to place children and young persons in their own community.

11.158 The Inquiry was informed that a lack of Aboriginal carers was a barrier to proper implementation of the Aboriginal Placement Principles in another CSC in Western Region.

11.159 In a third CSC in the same Region, the Inquiry was advised of some strategies that the CSC used to try to engage effectively with the Aboriginal community:

We tend to work on a case by case basis. I meet with the local Aboriginal elders and due to some of our former staffing, the Aboriginal staff who have actually left our office at the moment, we enjoy a very good relationship with the women elders group who have good oversight of family issues and needs. We also have a process in the Western Region of Aboriginal consultation around every report that comes at certain points where there is decision making about a child who is an Aboriginal child. We work together on that. I think that is the whole area of work that we could do a lot more on. Our Aboriginal staff positions have been vacant now for the last nine months or so.[115]

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[114] Transcript: Inquiry meeting with DoCS staff, CSC Southern Region.

[115] Transcript: Inquiry meeting with DoCS staff, CSC Western Region.

11.160 The Inquiry notes that the third projected result of the *DoCS Aboriginal Strategic Commitment 2006-2011* is that the Aboriginal Placement Principles will be consistently applied across all DoCS Regions. Quality of data on Aboriginal identity is likely to remain an issue in assessing progress against this aim, and the current lack of capacity of the system to provide reports on the level of compliance with each of the subsections of s.13 of the Care Act will also influence DoCS ability to measure progress.

11.161 Given the way in which consultation has been interpreted in different CSCs, and the fact that such practices may or may not meet the requirements of s.13 of the Care Act, depending on the connection of the specific Aboriginal caseworker or consultant to the family and/or community of the Aboriginal child or young person, it would appear that clear guidelines need to be developed and implemented to assist caseworkers to consistently and meaningfully apply the Aboriginal Placement Principles. There may be regional differences in their application which should be accommodated.

11.162 DoCS is currently developing Aboriginal consultation guidelines in order to provide an operationally consistent framework for the process of Aboriginal consultation, an initiative which the Inquiry supports, and which is further discussed in Chapter 18.[116]

DoCS' requests for services from other agencies

11.163 A number of agencies submitted that s.18 of the Care Act should be amended to oblige non-government agencies in receipt of government funding, for relevant services, to use their best endeavours to supply those services in response to requests from DoCS. The Act currently requires only government agencies to do so. The Inquiry agrees.

Requests for assistance

11.164 Submissions were made to the Inquiry and to previous reviews that although a request for assistance from DoCS can be sought without a report being made to DoCS, in practice a report must be made in relation to a child or young person before any assistance is considered. This seems to contradict the reason for inclusion of this section in the Act, namely to provide an entry point for assistance without the need for any assumption or stigmatisation that the family is now one that is 'known to DoCS.'

11.165 A number of peak bodies submitted that ss.20 and 21 of the Care Act should be amended to widen the class of persons able to request assistance on behalf of a parent or child or young person. The Inquiry agrees.

11.166 The Inquiry sought details on the numbers of requests for assistance made by children or young persons (s.20) or by parents (s.21). The data provided is set

[116] DoCS, *Update on child protection and out-of-home care major projects*, June 2008, p.3.

out in Chapter 5. The numbers in 2006/07, fewer than 7,000 are remarkably low. Either DoCS' recording is less than perfect or too few people understand the availability of a right to seek assistance from DoCS or are concerned about seeking assistance in case it sets care proceedings in motion. The Inquiry agrees that the scope of such assistance should be expanded and it could play a role in providing a 'soft entry point' to families needing help rather than statutory intervention.

Reports to DoCS

11.167 A number of peak bodies recommended that s.28 of the Care Act, which requires the Director-General to keep a record of reports made, actions taken and any subsequent disposition of and dealings with children and young persons to whom such reports or actions relate, should be proclaimed. The Inquiry agrees.

11.168 Education recommended that the s.29(1)(f) prohibition on disclosure should extend not only to the person who actually makes the report (for example, school principals) but also to the staff member who initially raises a concern with the school principal or counsellor that a student may be at risk.

11.169 The recommendations made in Chapter 10 concerning the triaging of risk of harm reports should obviate the need for a specific amendment as sought by Education. There will, however, need to be an amendment of s.29 more generally to reflect the changed reporting regime set out in that chapter.

11.170 Police recommended that the s.29(1)(f) prohibition on disclosure be amended to provide for the disclosure of the reporters' details to a law enforcement agency pursuant to the investigation of a serious crime committed upon a child or young person, where that might impact on the child's safety, welfare or well-being.

11.171 The Inquiry agrees with the recommendation made by Police.

Grounds for the making of a care order

11.172 The Children's Court recommended that s.71 be amended in relation to the way in which the grounds for a care order are currently specified. It stated:

> *Presently the ground provided in s.71 is a finding that the child or young person 'is in need of care and protection' but the various subsections of section 71 go on to describe, and therefore to limit, the circumstances in which that finding can be made and this sometimes introduces difficulty and fruitless complexity. It is submitted that the section should be amended either by deleting the subsections altogether so that the Court is at large in determining the question of need of care and protection or else by reproducing the English provision provided*

in the Children Act 1989 (UK) that 'the child or young person has suffered or is likely to suffer significant harm.'[117]

11.173 On the other hand, a retired Children's Magistrate stated that he did not agree with the proposition that either there be no specific grounds upon which a child or young person needs be found to be in need of care and protection, or that there only be very general grounds (such as in the Children Act UK). He stated:

The justification for State intervention is too important to be left to no or vague and ill-defined limits.

The apparent simplicity of the English test (Children Act s.31.(2) – the child is suffering or is likely to suffer significant harm and the harm is attributable to the care given to him etc) actually has given rise to much litigation.

…One possible area of concern is that the present grounds could be too limited in picking up 'neglect' cases. No case comes to my mind where 'neglect' was not also accompanied by emotional abuse adverse emotional/developmental consequences.[118]

11.174 DoCS informed the Inquiry that it:

has no objection to the proposal of the Court to amend s.71 so that the determination of the need for care and protection can be on any basis and is not limited to the sub-categories set out in that section.

This Department would not be prepared to agree to delete the subcategories (rather than making the definition one that included, rather than was limited to, the subcategories) for fear that Magistrates may not accept that certain circumstances support the need to establish that a child is in need of care and protection.

The Department does not agree to adding the words about risk of harm. This suggestion fails to recognise a significant role differentiation between this Department and the Court which the Act establishes. This differentiation is that this Department receives information about risk (s.23) but the response of both the Department and the Court is predicated not on the existence of possible harm but on whether action will achieve a better position for the child. If no action is possible, or no further action will improve the situation, then neither the

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[117] Submission: Children's Court NSW, 14 January 2008, p.33.

[118] Submission: John Crawford, 13 February 2008, p.9.

Department nor the Court should be taking action – see ss.30 and 71.[119]

11.175 The Inquiry sees benefit in amending s.71 to ensure that the grounds are not limited to those enumerated, while still retaining each subsection. This should ensure that emerging areas of abuse and neglect can be accommodated, while keeping the current categories in the mind of the parties, and at the same time, preserving the important difference between the circumstances that give rise to an obligation or entitlement to report concerns to DoCS and the matters that justify statutory intervention once those concerns are assessed.

Allocating parental responsibility

11.176 Section 79 of the Care Act provides, in part, that the Children's Court can make an order allocating parental responsibility to one or both parents, the Minister or another suitable person (or to a combination of these people).

11.177 DoCS has recommended that s.79 be amended to make specific provision for the allocation of parental responsibility to a designated agency.

11.178 In a recent decision by the Children's Court, *In the matter of Director-General of the Department of Community Services and the BW children,*[120] the operation of this section was considered in the context of an application by DoCS seeking an order allocating parental responsibility to the Principal Officer of the Hunter Aboriginal Children's Service, a designated agency. Truscott CM declined to make that order, and in doing, described the Care Act in the following way:

> *A Designated Agency is limited to delegations of functions and tasks of supervision of residential care and control. This is called Care Responsibility, which is different to Parental Responsibility. It is significantly and importantly less than Parental Responsibility and suggests that there is legislative policy to limit the role of a Designated Agency rather than widen it to include Parental Responsibility…*
>
> *But where a child is removed from his/her parents and is going to be placed in out-of-home care, there is no basis for treating those children differently from one another, by allocating Parental Responsibility to various organisations involved in providing that out-of-home care. There are good policy reasons for the Parental Responsibility for those children to remain with the Minister and the consequent administration of out-of-home care be consistent for all children who are subject to it…*[121]

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[119] Submission: DoCS, Operation of courts in the child protection system (abridged), p.26.

[120] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2.

[121] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2 at [30]-[35].

11.179 After considering various provisions of the Care Act, her Honour went on:

> *Where sole Parental Responsibility is allocated to a natural person under s.79, [children] are deemed not to be in out-of-home care and where placed with a carer not supervised by a designated agency the provisions of Chapter 8 and 10 do not apply...*[122]

> *If Parental Responsibility was allocated to a Principal Officer pursuant to s79(1)(a)(iii) then there would be an anomaly whereby the Designated Agency would be subject to the Children's Guardian supervision in discharging its out-of-home care functions, but would be outside any such framework in discharging its duties of Parental Responsibility.*[123]

11.180 Her Honour found as follows:

> *I am of the view that the term 'person' in s.79 (1)(a)(iii) means an individual or natural person in his/her personal capacity and does not empower the Court to make s.79 orders allocating persons such as a Principal Officer of/or a Designated Agency.*[124]

11.181 Professor Parkinson informed the Inquiry:

> *It was never intended that a suitable person is … an agency - that was subverting the entire out-of-home care system that we had set up, and this decision, going against submissions from the Crown extraordinarily enough, has confirmed the intent. There should not be a single child who is directly placed in the care of an agency.*[125]

11.182 DoCS informed the Inquiry:

> *It is the view of this Department that parental responsibility should be exercised by a person as close as possible to the child so that information and decisions can be informed by direct knowledge of the child's circumstances. Where an agency is accredited by the Children's Guardian to perform a task then it is suggested that the agency should be able to perform all related aspects. This performance can currently be monitored either by the Children's Guardian under section*

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[122] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2 at [37].

[123] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2 at [43].

[124] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2 at [56].

[125] Transcript: Inquiry meeting with Professor Parkinson, 27 February 2008, p.27.

> *181(1) (e) or by the Children's Court where it has ordered a report under section 82.*
>
> *The Department suggests that consistency can be encouraged by accreditation, monitoring and funding arrangements to achieve as great an extent (if not higher) level of consistency than may currently exist.*

11.183 DoCS suggested that once accredited there should not be any further need to inquire as to suitability, which should overcome the concerns expressed in *the BW children* case.[126] It further submitted that the decision was wrong in so far as it stated that a placement in relation to which parental responsibility for a child had been directly allocated to the designated agency, would be outside of the power of the Children's Guardian to monitor. Section 135 of the Care Act does not restrict OOHC to placements where the Minister is allocated parental responsibility.

11.184 The Inquiry agrees that this aspect of the decision appears not to correctly reflect the legislation. However, the Inquiry is troubled by other aspects of the allocation of parental responsibility by the Court to a designated agency.

11.185 The Inquiry understands that the Minister has established procedures for the delegation of her parental responsibility to designated agencies where the agency has been granted accreditation for five years. In these cases residual powers are retained by DoCS, and a Deed of Agreement between the Minister and the agency details the roles and responsibilities of each. If the Court allocated parental responsibility, residual powers would also be allocated and no safeguards such as are contained in the Deed of Agreement would apply. The Inquiry is of the view that these safeguards are essential.

11.186 Truscott CM's decision is not binding on her colleagues on the bench. It has been brought to the Inquiry's attention that other decisions have been made that are inconsistent with that of Truscott CM. The Inquiry is of the view that, in other than emergency care and protection orders made pursuant to s.46(2), there should not be power for the Court to allocate parental responsibility to a designated agency or a principal thereof, but that the Minister should be able to delegate the parental responsibility that has been allocated to her, subject to the safeguards discussed above.

Permanency planning and care plans

11.187 There has been some debate between, among others, the Children's Court, DoCS, and various NGOs who facilitate OOHC, about the level of detail and certainty required in a care plan in order for the Children's Court to be satisfied that permanency planning has been satisfactorily addressed.

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[126] *In the matter Director-General of the Department of Community Services and the BW children* [2008] CLN 2

11.188 The matter of permanency planning was considered in the Children's Court decision of *Re Rhett*.[127] The Children's Court found that the lack of sufficient information available to the Court about the proposed carers meant that permanency had not properly been addressed, and that as a result the Children's Court was not able to make final orders.

11.189 In that discussion, Mitchell SCM cited the House of Lords decision in *S. v S. and Ors*, in which it was held that:

> *The Court should normally have before it a care plan which is sufficiently firm and particularised for all concerned to have a reasonably clear picture of the likely way ahead for the child for the foreseeable future. The degree of firmness to be expected, as well as the amount of detail in the plan, will vary from case to case depending on how far the local authority can foresee what will be best for the child at that time.*[128]

11.190 His Honour stated that there will be some cases where, given the exceptional circumstances in relation to the particular child's needs, DoCS might be less able "to know what lies in store" for the child. His Honour said that in such a case DoCS should still be able to tell the Court of the type of arrangements that it thinks will be suitable for the child, and of the steps it has taken and will continue to take to secure such arrangements.[129]

11.191 DoCS has interpreted *Re Rhett* as meaning that permanency planning requires a high level of detail in the care plan:

> *It is certainly the Department's view that the obligation there upon the Court is to be able to understand what the plans are for the child, and the plans have to be grounded in reality, but that doesn't require the level of detail which would require a specific carer to be identified. You would say this child must remain in a particular high school, because the high school appears to be appropriate for that child. Therefore, you want to look for a carer who lives within a geographical proximity to that high school. You would be looking at those sorts of plans rather than coming down to particular details.*[130]

11.192 It has advised the Inquiry that it accepts that the decision correctly interprets the Act, however, it is concerned that other Magistrates may not follow *Re Rhett*, or may read it as requiring too much in the way of detail as to the placement.

11.193 Some agencies have a policy of not recruiting long term carers for children until the final orders of the Children's Court are known. Barnardos is one such

[127] *Re Rhett* [2008] CLN 1.
[128] *S v S and Ors* [2002] UKHL 10.
[129] *Re Rhett* [2008] CLN 1 at [27].
[130] Transcript: Public Forum, Role of Courts, 22 February 2008, p.39.

agency. Barnardos informed the Inquiry that it is not possible to tell the Children's Court who the permanent carer for a child placed in long term OOHC will be. It stated:

> *Carers are not like a hotel room in which you can just pop anybody…*
>
> *Many of us recruit carers to match to children. Those of us who have good research in relation to the permanency that we're able to achieve for children are those who do match placements, which are very carefully constructed. This means getting to know the child well and matching it with a carer who is suitable…*
>
> *Many, many people will come forward before a carer is recruited who is likely to be able to achieve permanency with a child. Therefore, to be not able to say to a carer, "Yes, we have orders on a child" would mean that one could not recruit a matched carer. This would pose real difficulties.*
>
> *It isn't simply that we are being awkward as organisations. It really is the long-term future of the child. Unless we know what the orders are, we are not able to actually seek the right sort of carer for that particular child.*[131]

11.194 The Children's Court, in its submission, stated the following:

> *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 be 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*

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[131] ibid., pp.37, 38.

> *Court needs and is entitled to have proper information available to it in order to perform its duty.*[132]

11.195 At the Public Forum on the Role of Courts, Deputy Chief Magistrate Syme stated the following:

> *The Court only requires certainty in a Care Plan. We have never sought, nor do we seek, that there be cross-examination or identification of particular foster carers before a final order is made. That has never been the Court's position in any case.*[133]

11.196 The Children's Court's position was generally supported by the LAC[134] and the Law Society.[135]

11.197 The Ombudsman stated:

> *Section 83(7) (a) places an obligation on the Court to expressly make findings "that permanency planning for the child or young person has been appropriately and adequately addressed," and so concentrates on the planning rather than the actual arrangements.*[136]

11.198 The Inquiry does not share the concerns which have been raised in relation to the decision, nor does it believe that s.83 should be amended to require care plans to inform the Court of more precise details of the child's placement. They are matters properly for the person who is allocated parental responsibility and supervision of the care placement. Sufficient safeguards exist in relation to the oversight of DoCS' decision making concerning children and young persons in OOHC, including monitoring under s.82, review by the Ombudsman and exercise of the functions of the Children's Guardian. The Inquiry notes that *Re Rhett* is not binding on other Magistrates; however, the Inquiry is of the view that *Re Rhett* accurately reflects the law and represents good policy. It should be applied by all Magistrates exercising jurisdiction in care proceedings.

Contact orders

11.199 Determining the duration, frequency and supervision needs for contact between children and young persons in care and those significant to them, is a complex matter. The Inquiry is aware of the competing views in the literature concerning the benefits which may accrue to a child or young person from contact being maintained, and balancing the need for stability, the likelihood of restoration, the developmental requirements of a child or young person as well as changes in

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[132] Submission: Children's Court NSW, 14 January 2008, pp.5-6.

[133] Transcript: Public Forum, Role of Courts, 22 February 2008, p.43.

[134] Transcript: Public Forum, Role of Courts, 22 February 2008, p.41.

[135] Submission: Law Society of NSW, pp.6 and 7.

[136] NSW Ombudsman, *Care Proceedings in the Children's Court*, July 2006, p.27.

the circumstances of birth families and the quality of the contact, all within the context of the best interests of the child or young person.

11.200 A key issue before the Inquiry was whether the Children's Court should retain jurisdiction to make final contact orders. Further, whether it should have power to enforce those orders, and whether it should have the power to require DoCS to supervise contact.

DoCS' position

11.201 DoCS has recently issued a draft Policy Statement on Contact that provides a guide to the supervision of contact by a DoCS caseworker. The type and frequency of contact is noted to depend upon the case plan goal, for example, whether it involves assessment, restoration, permanent care or adoption, and the child's or young person's assessed needs and views.

11.202 The minimum frequency of contact extends from three times a week for at least six hours per week (for 0-2 months of age where the purpose of contact is assessment, or the plan is restoration) to two to six times per year for the same age group (where the case plan goal is permanent care or adoption). The minimum levels then vary according to the age of the child.

11.203 The draft contact policy is not prescriptive as to whether contact is supervised or unsupervised. It notes that there should be some supervision, whether or not so ordered, where there is a potential risk to the safety of the child or young person, or where there is a need to assess the interactions between the child or young person and family members or the effect of contact on the child or young person.

11.204 Supervised contact can be provided by DoCS caseworkers or by casual employees, non-government OOHC agency employees, foster carers, or by a contracted service that specialises in contact. For unsupervised contact, the child or young person can be dropped off and picked up from the place of contact by foster carers, DoCS carers, DoCS caseworkers, DoCS casual employees or NGO employees.

11.205 During the assessment phase, the draft provides that contact should generally be supervised once a month and then after six months have passed, once every two months, in the absence of an order requiring more frequent supervision by DoCS.

11.206 DoCS carried out an impact analysis for the draft contact policy. It estimated the cost in 2007/08 dollars based on whether all contact is supervised (A); contact is supervised about two thirds of the time for the children under twelve years and just over a third of the time for those aged over twelve years (B); as with (B) but with higher average hours per visit (C); and as with (B) but with higher visit frequency (D). The annual costs for each would respectively be around $49 million, $34 million, $38.5 million and $44.2 million. (A) and (D) reflect significant increases over current costs (increases in the order of 35 per

cent and 21 per cent) whereas the cost for (B) is seven per cent less than current costs and (C) represents a six per cent increase.

11.207 Supervised contact is a particularly vexed issue. There is literature to suggest that no program for supervised contact has yet been demonstrated to significantly improve parent/child relationships.[137] Notwithstanding, according to DoCS, there is still strong judicial support for supervised contact.

11.208 DoCS also stated "no other jurisdiction appears to give so extensive a power to order contact to the courts."[138] DoCS recommended that the Children's Court's ability to make contact orders be limited to interim orders and to orders for a specified period of time following the making of final orders.

11.209 DoCS also urged the Inquiry to consider costs as a relevant consideration:

> *These are matters which the Court of Appeal has said are quite properly taken into consideration. They are relevant factors in the consideration of any parent. They are certainly relevant for any agency who must decide how best to use the finite resources available to it.*[139]

The Children's Court's position

11.210 The Children's Court submitted that it should retain its power with respect to contact and its jurisdiction should be extended to enable an order requiring the Director-General to supervise contact.

11.211 The Senior Children's Magistrate argued that contact is:

> *too important a matter to be left to the internal process of the Department of Community Services or to private arrangements between the Department and agencies whose own interests in that regard may not entirely coincide with those of the child or young person.*[140]

11.212 In addition, the Senior Children's Magistrate noted that litigation in relation to varying contact orders has been relatively rare, a position with which DoCS agrees.

11.213 In a submission to an earlier review, the Children's Court and the LAC submitted that the Court should have power to order contact during the period of an emergency care and protection order.[141]

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[137] R Birnbaum and R Alaggia, "Supervised Visitation: A call for a second generation of research," *Family Court Review*, 2006, DoCS, Intranet, Topic 20, Contact between a child and the child's family.

[138] Submission: DoCS, Operation of courts in the child protection system (abridged), p.24.

[139] ibid.

[140] Submission: Children's Court NSW, 14 January 2008, p.27.

[141] ibid., p.28.

The Children's Guardian's position

11.214 The Children's Guardian submitted that s.86 of the Care Act should be amended to allow the Children's Court to make interim contact orders only, with ongoing contact arrangements being determined through case review and planning. The Children's Guardian stated that parties should have a right to apply to the Children's Court or another review body for review of contact arrangements if they are dissatisfied with contact arrangements.

Legal agency positions

11.215 The LAC submitted that the Children's Court is best placed to make contact decisions. The Aboriginal Legal Service and the LAC both favour the Children's Court retaining the ability to make contact orders as a way of ensuring that the needs of the child or young person in relation to contact are not dwarfed by the resource considerations of DoCS or other agencies.

11.216 The Aboriginal Legal Service submitted that the Children's Court's power to make contact is particularly important for Aboriginal families. It stated:

> *In the vast majority of care and protection maters where children are placed in out of home care, the Department recommends contact with birth parents four times per year…. In Aboriginal communities, this standard contact regime is insufficient to give children adequate exposure to their culture.*[142]

11.217 The Law Society submitted that contact with birth parents is critical to the development and identity of a child, and stated that the importance of the issue renders judicial determination the appropriate approach. It also stated that:

> *Limiting the power of the Court to make contact orders only during interim proceedings would return us to the problems that occurred under the Children (Care and Protection) Act 1987. Under the 1987 Act, contact could not be ordered in the context of final care orders and one significant adverse impact of this was that parents seeking additional contact would seek to rescind the final order to achieve this. This led to significant disruption to placements even where there was no genuine desire on the part of the birth parent to reassert parental responsibility for the child.*[143]

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[142] Submission: Aboriginal Legal Service, pp.4 and 5.

[143] Submission: NSW Law Society, p.5.

11.218 The Redfern Legal Centre advised the Inquiry that in many cases, despite the existence of orders for more frequent contact, "DoCS informs the parents that they will be granted the minimum four visits per year."[144]

11.219 The Inquiry notes that in response to assertions that DoCS usually "proposes minimal contact of two to four occasions per year,"[145] the recent draft policy suggests that this should not continue to be the case, if it has been in the past.

11.220 Woman's Legal Services, in relation to the introduction in the current Care Act of the power of the Court to make contact orders, stated:

> *There was significant advocacy at the time for this change, due to the failure of the Department to facilitate continuing contact between children in care and their family of origin. Consequently we consider that it is crucial that the Children's Court retain its power to make contact orders, as per section 86(1) of the Act.*[146]

11.221 In relation to the ability of the Children's Court's to enforce contact orders, the LAC submitted that a contact order must be enforceable if it is to be adhered to. Similarly, the Combined Community Legal Centres Group submitted that it is currently difficult for a person in favour of whom a contact order is made to have that order enforced if the person with parental responsibility for the child refuses to allow contact to take place. The Law Society also recommended that the Children's Court have power to enforce contact orders.

11.222 The Inquiry however notes that these orders are enforceable under the *Family Law Act 1975* if registered in the Family Court under that Act, as discussed in Chapter 14.

NGOs and peak bodies' positions

11.223 The Council of Social Service of NSW (NCOSS) supports the retention of the Court's power to make contact orders, noting that:

> *The development of a strong policy framework to support decisions made by the Court – including better provision of information by caseworkers and designated agencies – may improve decisions made by the Court, but should not replace the role of the Court.*[147]

11.224 Foster care groups did not agree with removing or limiting the Court's role in ordering contact, but were concerned about the impacts of contact orders on foster families, particularly where that required extensive travel, or where

[144] Submission: Redfern Legal Centre, p.7.
[145] Submission: Children's Court NSW, 14 January 2008, p.26.
[146] Submission: Women's Legal Services, p.7.
[147] Submission: NCOSS, p.67.

contact was arranged but cancelled or ignored by the parents of the child or young person.

11.225 Other NGOs sought flexibility and the introduction of "evidence-based guidelines or benchmarks" to assist Magistrates determine appropriate levels of contact.[148]

11.226 The Association of Children's Welfare Agencies (ACWA) supported retaining the Children's Court's ability to make contact orders in relation to interim arrangements pending final orders.

Inquiry's view

11.227 The Inquiry is of the view that, on balance, the Children's Court should retain its power to make contact orders with respect to those children and young persons about whom the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration. For all other children and young persons, that is those where the Court has accepted that there is no such possibility, the Court should have no power with respect to making orders as to contact.

11.228 Contact is of great importance where restoration is contemplated and the Court properly has a role in those decisions. However, where permanency planning does not include restoration, it is appropriate that decisions as to contact are made by DoCS or the designated agency to whom parental responsibility has been delegated. They can take account of changing circumstances as the child or young person grows older. Any dispute should be dealt with by the use of alternative dispute resolution mechanisms as described in the next chapter. The principles set out in DoCS draft contact policy appear appropriate to guide its decision making, and that of others when acting in that capacity.

11.229 The Inquiry considers that the development of evidence based guidelines or benchmarks as suggested by Catholic Social Services NSW/ACT merits the attention of the Children's Court or the Judicial Commission. The Inquiry notes that DoCS has carried out some excellent research in this area which could form the basis for educational material for the use of Magistrates (both specialist and non specialist).

11.230 Whether or not contact is supervised should be a matter for the Children's Court during the period it has power to order contact, however, the consent of the agency with responsibility for any supervision should remain a pre-condition to the exercise of that power by the Children's Court.

11.231 Of significant concern is the cost of contact. The Inquiry is aware of the existence of Contact Services, funded by the Commonwealth Government for the purpose of facilitating contact within the family law jurisdiction. In the

[148] Submission: Catholic Social Services NSW/ACT, p.26.

Inquiry's view, there should be discussions with the Commonwealth in order to obtain access to those services for the purpose of satisfying contact (both supervised and non-supervised) within the care jurisdiction.

11.232 The Inquiry understands from its discussions with caseworkers and from the review undertaken by the Premier's Delivery Unit, Premier and Cabinet that a deal of caseworkers' time is spent carrying out contact orders (primarily in driving children to the place of contact, supervising the contact, and returning the children to their authorised carers).

11.233 The Inquiry understands that DoCS has established a Parental Contact Centre in Northern Region. A recent evaluation suggests that the cost of centre based contact services is significantly less than the cost of casual NGO contact service provision and that service quality is better in the former.

11.234 Encouraging or requiring foster carers to deliver children and young persons to contact visits, minimising the role of caseworkers and increasing the use of Commonwealth or State provided contact centres are all supported by the Inquiry.

Rescission and variation of care orders

11.235 The Children's Court informed the Inquiry that the child's legal representative has no clear entitlement under s.90(3) of the Care Act, on behalf of the child, to bring an application for variation or rescission:

> *The Children's Court has developed a mechanism to avoid this problem - the child representative writes to the Court suggesting that the Children's Magistrate, of his own motion, may wish to re-list the matter but it is submitted that this shortcoming should be corrected.*[149]

11.236 DoCS stated that it supports amending the Care Act to permit a child or young person to make an application for the variation or rescission of a care order. The Inquiry agrees.

Compulsory Assistance

11.237 DoCS advises that there are a small but consistent number of serious matters raised before the Court where the issue for the care and protection of a child relates to their need for intensive care and support to protect them from suicide or other life threatening or self destructive behaviour.

11.238 The Care Act addresses this with a series of provisions for compulsory assistance orders, which have never been proclaimed. The making of a compulsory assistance order would depend on there being an identified

[149] Submission: Children's Court NSW, 14 January 2008, p.14.

therapy, treatment or service that, in a short period of time, would assist the child or young person to deal with the problem and that would more likely than not lead to a significant improvement in the circumstances of the child or young person. DoCS advised that such involuntary therapeutic services are unavailable in this State and it was unlikely either that such orders could be made or if an order could be made that it would have the appropriate outcome.

11.239 The Supreme Court's inherent parens patriae jurisdiction is usually invoked in these circumstances. The Ministerial Advisory Committee considered that there may be a need for the Supreme Court (or another Court), to have the power to have a child examined to determine what therapeutic treatment might be necessary, and that this may not be currently covered within the parens patriae jurisdiction. The committee therefore recommended to the Minister that a new power for medical intervention be included.

11.240 In response to the DoCS Discussion Paper, the Ombudsman submitted that there is a case for compulsory assistance provisions, but said they can only be used effectively if adequate supports or services are established.[150] Others, including NCOSS, and AbSec have recommended that these provisions be proclaimed in the same or a revised form.

11.241 DoCS was generally supportive of the Ministerial Advisory Committee's proposal, however, it was of the view that the length of stay for the child or young person should be no longer than absolutely necessary for the assessment, that there should be a clear process available for children or young persons to quit the assessment process and that when they did leave the assessment there would be treatment and support in the community for them.

11.242 The Inquiry is of the view that in the event that the powers set out in Chapter 9 of the Care Act are not sufficient, the parens patriae jurisdiction of the Supreme Court is capable of dealing with the very small number of children who may require an intervention of the type contemplated by the unproclaimed section. Part 3 of Chapter 7 of the Care Act should be repealed.

Extended role of the Court

11.243 The Inquiry received a number of submissions in relation to the extent of the Court's powers under the Care Act to make decisions about children and young persons who are in OOHC and more generally to act on its own initiative. In considering these submissions, the Inquiry was mindful that the courts exercising power under the *Family Law Act 1975* have own motion powers[151] and more generally, in child related proceedings, are able actively to direct, control and manage the conduct of the proceedings.[152]

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[150] NSW Ombudsman, Submission to DoCS, *Statutory Child Protection in NSW: issues and options for reform*, *Discussion Paper for review, October 2006*, p.47.

[151] *Family Law Rules 2004* rules 15.71 and 15.72

[152] *Family Court Act 1975* s.69ZN.

11.244 As a matter of principle, the Inquiry agrees that Children's Court proceedings should be conducted in a way that permits the Court to direct, manage and control the proceedings in so far as that is designed to, and does, achieve better outcomes for the safety, welfare and well-being of the child or young person before it, and in so far as that is within the powers expressly vested in it.[153]

11.245 However, the Inquiry is hesitant to recommend that further and extended powers be granted to the Children's Court. In the event that the Children's Court is headed by a District Court Judge, generally has specialist and trained Magistrates sitting in the care and protection jurisdiction, is staffed by an appropriate number of qualified Children's Registrars, has simpler procedures, practitioners who appear before it are accredited and conform to a Code of Conduct, and DoCS' caseworkers present fair and balanced evidence, there may be an argument to endow the Children's Court with greater powers. Each of these matters is addressed in this and the following two chapters.

Section 82 monitoring of orders concerning parental responsibility

11.246 Section 82 is a mechanism whereby the Children's Court can seek a report as to the arrangements that have been made for the care and protection of a child or young person and, if that report is not satisfactory, order that the case be brought back before it so that the existing orders may be reviewed.

11.247 There are two interpretations of the review contemplated by s.82. One is that 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 under s.90 for rescission or variation of an existing care order.

The Children's Court view

11.248 In the matter of *Re Calvin*,[154] Mitchell SCM determined that the 'review' referred to in s.82 allows the Court to take further action, in that it can order a further report pursuant to s.82. His Honour adopted a definition of 'review' which permits the revisiting of proceedings and, if necessary, re-working the decision and orders.

DoCS' view

11.249 DoCS submitted that the Children's Court interpretation of s.82 is contrary to the intention of the section.

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[153] Such Courts do not have an inherent jurisdiction: *Walton v McBride* (1995) 36 NSWLR 440.
[154] *Re Calvin* [2003] CLN 6.

11.250 DoCS referred the Inquiry to the House of Lords decision in *Re S (Minors) (Care order: implementation of care plan)*,[155] which considered the jurisdiction of the Court after the making of a final order. In that case, Lord Nicolls said:

> *The particular strength of the courts lies in the resolution of disputes: its ability to hear all sides of a case, to decide issues of fact and law, and to make a firm decision on a particular issue at a particular time. But a court cannot have day-to-day responsibility for a child. The court cannot deliver the services which may best serve a child's needs. Unlike a local authority, a court does not have close, personal and continuing knowledge of the child. The court cannot respond with immediacy and informality to practical problems and changed circumstances as they arise. Supervision by the court would encourage 'drift' in decision making, a perennial problem in children cases. Nor does a court have the task of managing the financial and human resources available to a local authority for dealing with all children in need in its area. The authority must manage these resources in the best interests of all children for whom it is responsible.*
>
> *The Children Act, embodying what I have described as a cardinal principle, represents the assessment made by Parliament of the division of responsibility which would best promote the interests of children within the overall care system. The court operates as the gateway into care, and makes the necessary care order when the threshold conditions are satisfied and the court considers a care order would be in the best interests of the child. That is the responsibility of the court. Thereafter the court has no continuing role in relation to the care order. Then it is the responsibility of the local authority to decide how the child should be cared for.*[156]

11.251 The Ombudsman informed the Inquiry that there is some uncertainty and inconsistency surrounding the use and status of s.82 reports and concluded that:

> *We believe that provisions such as ss.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*

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[155] *Re S (Minors) (Care order: implementation of care plan* [2002] 1 FLR 815.

[156] *Re S (Minors) (Care order: implementation of care plan)* [2002] 1 FLR 815 at [27]-[28].

> *fairness could be addressed through legislative amendment or court rules.*[157]

Legal Aid Commission's view

11.252 The LAC submitted that the Children's Court should have a greater role in monitoring the implementation of its final orders in care and protection matters and that the Care Act should be amended to require the Court to conduct a review of any case in relation to which there had been, or is proposed to be, a change to the permanency plan upon which the Court's final orders were based. It stated:

> *Legal Aid NSW takes this view because we are aware of many cases in which the permanency plan initially proposed by DoCS for a child (and that formed the basis on which the Court has made long term care orders) is ultimately not proceeded with... These issues have only come to light as a result of the Act's current requirement for the provision of section 82 reports.*[158]

Proposal of the Honourable Mr Crawford

11.253 The former Children's Magistrate, Mr Crawford, has proposed a model to amend s.82 to clarify the powers of the Children's Court.[159]

11.254 Mr Crawford suggested that, properly construed, the Care Act means that the Children's Court receives a s.82 report, considers it and makes a finding as to whether the proper arrangements have been made for the care and protection of the child. If the Children's Court is not satisfied that proper arrangements have been made, the Magistrate then exercises a discretion in determining whether or not to order that the matter be brought back before the Court. If the matter is brought back, the order is then reviewed by the Court (first by returning notionally to the position when the order was originally made, and then by considering whether the original order still remains appropriate in light of any new information). Mr Crawford suggested that what was intended was a consideration of whether the existing order is appropriate rather than inviting a speculative examination of whether some other order may be better suited even if the existing order is appropriate.

11.255 Mr Crawford stated that bringing the matter before the Court for a review hearing would be of limited use if there is no opportunity to alter the situation. He also stated that the process should be quick, simple and responsive. He stated that if there are factual matters in dispute, the Court cannot resolve them as it is not able to call witnesses or mount a case, but he suggested that where

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[157] Submission: NSW Ombudsman, 10 March 2008, Part 1, p.23; NSW Ombudsman, *Care Proceedings in the Children's Court, A Discussion Paper*, 2006, pp.30 and 31.

[158] Submission: Legal Aid NSW, 20 February 2008, pp.96 and 97.

[159] J Crawford, "Monitoring and Review of Court Orders: Section 82 of the *Children and Young Persons (Care and Protection) Act 1998*," CLN 8, 2004, p.34.

there is a significant factual dispute, it could make a finding that the proper arrangements are not being made and leave it to a party to bring an application to rescind or vary.

Inquiry's view

11.256 The Inquiry takes the view that the Children's Court appropriately has decision making power in relation to matters requiring a judicial response. The ability to monitor the decisions it makes is entirely consistent with this approach. However, the Children's Court is not and should not be an oversight body. The Children's Guardian and the Ombudsman ably fulfil that role.

11.257 The Inquiry is of the view that the Children's Court should have the power to order that a written report to be made to it and, if not satisfied that proper arrangements have been made, to re-list the matter with notice to the parties to the original proceedings in order to give any of them an opportunity to make an application pursuant to s.90 or for any other ancillary or incidental order. However, if no party wishes to apply for an order varying any of the orders made, the matter should be taken no further. In the absence of a moving party, the Children's Court cannot act. It would be an odd outcome if the Court, based on nothing more than the s.82 report, and in the absence of any party indicating a desire for some alteration or calling evidence, determined to alter the existing state of affairs.

11.258 The Children's Court should develop rules concerning the timing, provision of notice, confidentiality and procedure to ensure that reports are made to it in a timely fashion, that all parties are provided with a copy of the report and that the process by which a date is set for any hearing is also clear.

Own motion powers

11.259 The Senior Children's Magistrate informed the Inquiry that he would like the Children's Court to have the ability to initiate action, particularly in cases where DoCS has removed some but not all of the children from a particular household, and where the Court feels that the remaining children are likely to be at risk of harm or where concerns become evident in proceedings in the Court's criminal jurisdiction. He said:

> *The Court remains what some might describe as a junior partner in the child care and protection system. Only the Director-General may initiate proceedings and, even where care and protection issues regarding a child or young person come to the attention of the Court, there is no power to require the Director-General to take any protective action. It frequently happens that, when a child is removed from a dangerous or abusive home, his or her young siblings are left in that home in most unsatisfactory conditions and the Court has no jurisdiction*

> *to influence events and must rely on seeking to persuade the Director-General to take action.*[160]

11.260 The Deputy Chief Magistrate of the Local Court suggested, during the Public Forum on the Role of Courts, that it would be useful if the Children's Court could, of its own motion, call for particular evidence. She said:

> *The way that the Court would currently get around that would be to suggest to a party or another that the Court may benefit from evidence from this particular area, but if that party doesn't want to bring that evidence, there's nothing that we can do about it at this stage.*[161]

11.261 The Inquiry believes that the Court should have the power to order that expert evidence be provided to it, in the form of Clinic reports or otherwise. In relation to lay evidence, the Inquiry believes that as the child is usually separately represented in care proceedings, as are parents or other interested parties, and DoCS, there are sufficient safeguards to ensure all appropriate evidence is before the Court.

11.262 In relation to the position of siblings, the Inquiry understands that there is a process whereby the Senior Children's Magistrate can report concerns to DoCS' Director, Legal Services. That is the appropriate route to take with any concerns the Court has arising from proceedings before it.

11.263 While the Inquiry notes that the Family Court has powers akin to 'own motion' powers, it understands that they are rarely used, and in any event that is a superior court of record. The Inquiry is of the view that such powers should not reside in the Children's Court.

Re Josie

11.264 In the matter of *Re Josie,*[162] the Children's Court made an order granting interim parental responsibility to the Minister, and later made an order in relation to the interim placement of the child contrary to a decision DoCS had made. DoCS appealed this latter order. Levine J of the Supreme Court found that when parental responsibility has been allocated to the Minister, the Children's Court cannot derogate the Minister's power to exercise it in accordance with the discretion reserved to that office. In this case, the Supreme Court found that the Children's Court had acted beyond power in ordering that the child remain in a particular placement.

11.265 In relation to this decision, the LAC informed the Inquiry:

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[160] Submission: Children's Court NSW, 14 January 2008, p.6.

[161] Transcript: Public Forum, Role of Courts, 22 February 2008, p.23.

[162] *Re Josie* [2004] NSWSC 642.

This decision has been the cause of much concern to Legal Aid NSW, and in particular to our solicitors who act as the direct or independent legal representative for the children involved. Whether children are placed by DoCS in out-of-home-care, with their parents or with other relatives pursuant to an interim order allocating parental responsibility to the Minister, the current state of the law according to the Supreme Court is that they can be removed from that placement without anyone – even the child's legal representative – being notified or heard in regards to whether such a removal would be in the child's best interests. Indeed, as a result of this decision in several cases in which Legal Aid NSW has been involved DoCS has even refused to consent to giving an undertaking to the Court to notify the Court or the child's legal representative in the event that a removal of the child from his or her interim placement is planned.[163]

11.266 The LAC stated that allowing DoCS to have this discretion even in relation to a grant of interim parental responsibility can lead to multiple short term placements for children.

11.267 The Combined Community Legal Centres Group stated:

We consider it to be a highly unsatisfactory situation that the Court cannot make orders incidental to the primary orders for the purposes of rendering the primary orders capable of being complied with. We consider that the ability to make ancillary orders is a useful and necessary tool.[164]

11.268 For reasons consistent with those set out above in relation to s.82, the Inquiry is not of the view that it is in the best interests of children and young persons for the Children's Court to have the power to intervene in the discretionary exercise of parental responsibility by the Minister or her delegate. It is not, in the Inquiry's view, an ancillary power as described by the Combined Community Legal Centres Group.

Restoration

11.269 The Children's Court is concerned that once parental responsibility has been allocated to the Minister, DoCS can choose to restore a child to his or her parents without any requirement to consult the Children's Court. The Deputy Chief Magistrate of the Local Court said:

It would be a matter of logic that if a Court has made a finding already that there is no realistic prospect of a child being restored to the parents' care and therefore made an order for

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[163] Submission: Legal Aid NSW, 20 February 2008, p.79.

[164] Submission: Combined Community Legal Centres Group, pp.9 and 10.

> *parental responsibility in the Minister and before it has made that order approved a permanency plan that places the child in out-of-home care, as a matter of logic if there then becomes a reasonable prospect of restoration of the child to a parent then that is something that the Court should know about.*[165]

11.270 The Children's Court accordingly submitted that where the Minister proposes to restore a child or young person to the care of a parent after a finding of "no realistic possibility of restoration", she should be required to apply to the Children's Court so that the matter may be canvassed and determined, by the Court.

11.271 This issue is complicated by the lack of data available on failed restorations. The Inquiry does not know the frequency with which restoration fails, and if so, the number of such failures, or the reasons for them.

11.272 As noted above, the Inquiry agrees with the decision in *Re Josie*, and with the general proposition that while the decision as to the allocation of parental responsibility properly lies with the Court, decisions in relation to the exercise of parental responsibility properly should lie with the person to whom that responsibility has been allocated. This would generally include decisions as to placement (subject to matters properly the concern of the Court, as already discussed in relation to *Re Rhett*).

11.273 Decisions as to whether, and if so when, to restore children and young persons to their parents will rarely be straightforward. It is clear from the earlier chapters that poor judgements will be made from time to time. It is also clear that the circumstances of the child or young person and parents may change from time to time in ways that were incapable of prediction when the original assessment as to the realistic possibility of restoration was made. The Inquiry notes that DoCS has a Permanency Planning strategy operating in 42 CSCs, and that more than 1,000 caseworkers have received training on Permanency Planning, including restoration decision making.[166]

11.274 However, the Inquiry is persuaded by the argument expressed by Deputy Chief Magistrate. It is of the view that the decision to restore a child or young person, who was removed from his or her parent by order of the Children's Court, and in respect of whom, the person with parental responsibility is now of the view should be restored, that decision should be made by the Children's Court, upon application of the person with parental responsibility.

Supervision orders

11.275 The Senior Children's Magistrate submitted that the Care Act should be amended to impose specific duties and responsibilities on the Director-General

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[165] Transcript: Public Forum, Role of Courts, 22 February 2008, p.47.

[166] DoCS, *Annual Report 2007/08,* p.60.

when a supervision order is made (and/or to provide the Children's Court with power to specify those duties or responsibilities), and in addition, to allow a supervision order that is longer than 12 months' duration to be made. He stated that it is a shortcoming of s.76 that the form of supervision remains entirely a matter for the Director-General, and can in practice involve little more than a theoretical supervision.

11.276 The Inquiry received no other submissions, nor is it aware of any submissions being made to earlier reviews, recommending that a similar power be granted to the Children's Court. Nor is it aware of any specific evidence of inadequacies or deficiencies in the exercise of supervisory obligations by DoCS. It is unfortunate that insufficient data are available to understand the extent of the use of these orders, or of the form of the supervision provided where it is ordered.

11.277 Consistent with the approach adopted by the Supreme Court and Court of Appeal as set out above and below, the Inquiry believes no change is warranted. In any event it is of the view that there are a wide variety of ways in which a person may be supervised and that flexibility would be preferable to the rigidity of a formula. That is not to say that the Court could not make recommendations to assist the parties when it makes a supervision order.

Section 74: order for provision of support services

11.278 This provision was considered in *George v Children's Court of New South Wales*.[167] In that case, Ipp JA with whom the other members of Court agreed, said:

> *The pool of funds available to DoCS for carrying out its manifold duties is finite. No doubt, as with all government departments, DoCS works out its budget each year by reference to the amount allocated to it under the governing Appropriation Act. In doing so it will allocate a particular sum for the provision of services to children and young persons in need of care and protection. If the Children's Court is empowered to order DoCS to expend money other than in accordance with the current budget applicable, the result will be that some children who otherwise would have benefited will not receive the services intended. The money available for the services to be provided to them will have to be used to accommodate the orders of the Children's Court.*
>
> *In essence, the allocation of money and other resources for the care and protection of children and young persons is a matter of policy. It is preferable that such policy decisions be made by the body vested with the administrative responsibility for the*

[167] *George v Children's Court of New South Wales (2003)* 59 NSWLR 232.

proper use of the resources in question, and not by a Court on an ad hoc basis.

Next, I would point out that the overall amount likely to be involved in the provision of transport and accommodation expenses to parents of children in foster care, generally, is not necessarily trivial.

….all parents have to make choices in regard to their children. These choices involve such matters as the place of family residence, the kind and place of education each child is to receive, and the kind and standard of medical treatment each child is to receive. The number of choices that parents are required to make through the lifetime of their children is infinite. While parents will ordinarily have the welfare of their children at heart, the choices that parents will make will be dictated, largely, by the funds that they have at their disposal. It would be unthinkable to compel parents to make choices which they could not afford simply because those choices would advance the interests of a child.

In my view, the same approach has to be taken when parental responsibility is allocated to the Minister pursuant to the [Care Act]. What is in the best interests of the child one would readily expect to be left to the discretion of the Minister and the Director-General, having regard to the limited funds allotted to DoCS for the protection of children in need of care, generally.[168]

11.279 Many submissions which recommended that the Director-General be required to provide support services if ordered to do so were received by the Inquiry and by the 2006 Discussion Paper.

11.280 DoCS submitted that the approach taken in *George v Children's Court of New South Wales* and restated in *Re Josie* is the correct approach. The Inquiry agrees, and does not consider amendment of the section necessary or appropriate.

Apprehended violence orders

11.281 The Senior Children's Magistrate submitted to the Inquiry that the Children's Court should have the power to make AVOs, or orders similar to AVOs, against parents or other persons in order to protect a child or young person. He described it as "a very handy weapon in the child protection armoury."[169] He advised of a case where Police were not willing to apply for an AVO in

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[168] *George v Children's Court of New South Wales (2003)* 59 NSWLR 232 at [132]-[133].

[169] Submission: Children's Court NSW, 14 January 2008, pp.32-33.

circumstances where it was in the best interests of the child that one be obtained.

11.282 DoCS opposes giving this power to the Children's Court for a range of reasons, including the undesirability of the involvement of Police in care proceedings, altering the nature of the DoCS caseworkers work to enforcement and making the person against whom the order was sought a party to proceedings and as such giving them access to information, not otherwise available.

11.283 On balance, the Inquiry is persuaded by DoCS' arguments. Additionally it notes the recent statutory amendments which provide a more comprehensive structure for the obtaining of Apprehended Domestic Violence Orders and Apprehended Personal Violence Orders which make it more likely that Police will act in circumstances of the kind mentioned.[170]

Order to attend therapeutic or treatment program

11.284 Health told the Inquiry that an order under s.75 to attend therapeutic or treatment program has not, to its knowledge, been made. Health's New Street Adolescent Program, which is discussed in Chapter 7, has argued for a greater use of this provision to reduce the likelihood of children and young persons dropping out of the program before benefits can be realised.

11.285 The Inquiry agrees and urges DoCS to have regard to the provision in appropriate cases. If in the future, its benefit is demonstrated, the Inquiry can see no reason for it to continue to be confined to children aged under 14 years.

Children's Court Clinic

Expanding the role

11.286 A number of bodies have submitted that the role of the Clinic should be broadened. Health submitted that the Clinic's role should include making physical health assessments of children and young persons and risk assessments in relation to adolescents who sexually abuse, and providing appropriate treatment services.

11.287 Health noted that Justice Health staff provide advice to the Children's Court in its criminal jurisdiction and indicated that it would support consideration being given to a transfer of responsibility for the Children's Court Clinic from the Attorney General's portfolio to Justice Health, on the basis that those who are providing Health interventions should work for the Health portfolio. Health noted that Justice Health currently provides forensic mental health and drug and alcohol services for both adults and adolescents in the community. The team providing these services to the Children's Court includes psychiatrists, drug and

[170] *Crimes (Domestic and Personal Violence) Act 2007.*

alcohol staff, specialist mental health nurses and a social worker. The team also provides community based assessments and referrals to appropriate community services, discharge planning for young persons in custody and case management of a small number of clients. The clinicians receive regular supervision, and while the team does not employ psychologists, a framework to extend the current supervision could be created to include this group.

11.288 The Inquiry is particularly interested in assessments for children or young persons who have sexually abused other children or young persons. Justice Health has staff with expertise in this area.

11.289 The Inquiry supports a feasibility study into the transfer of the Clinic to Justice Health and its possible expansion to provide the kind of services currently offered by Justice Health in the criminal jurisdiction.

11.290 In other submissions, it was suggested that the Clinic should be used to assess the parenting capacity of people who are not seeking parental responsibility, but with whom a child has been placed pending final orders. In his 2006 discussion paper, the Ombudsman expressed some concern about leaving the assessment of such carers to an 'in-house' placement assessment by DoCS (as opposed to an assessment by the Clinic).[171]

11.291 Against this, DoCS stated that any expansion of the Clinic's role without a significant enhancement of its budget would result in an increased delay in the time between the making of assessment orders and the provision of an assessment report to the Court, which would in turn delay care proceedings.

11.292 DoCS' internal guidelines in relation to making an application for assessment state: "it is not appropriate to lodge an application for an assessment when the assessment is required for therapeutic or case management purposes." However, a number of DoCS officers informed the Inquiry that the Clinic's reports are sometimes used by caseworkers as a basis for their casework decisions or for reaching a settlement. The Ombudsman also stated that: "people familiar with the specialist courts said that DoCS uses the Clinic to inform its casework decisions, including the question whether there is a realistic possibility of restoration."[172]

11.293 The Inquiry agrees that the work of the Clinic should be expanded. The Inquiry sees no reason in theory or practice why the Clinic's reports should not assist caseworkers' decision making and be used as a basis for discussion between the parties which may result in matters being finalised without a court order. Section 56 of the Care Act provides a safeguard for children and young persons against the over use of assessments. Whether assessments are sought for temporary carers should be decided on a case by case basis. Clearly matters such as the length of time that temporary carers are expected to care for a child

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[171] NSW Ombudsman, *Care Proceedings in the Children's Court, A Discussion Paper*, 2006, p.18.
[172] ibid., p.19.

or young person, and other matters known about the carers, will influence whether an assessment is sought or ordered.

Completeness of material forwarded to the clinic

11.294 What emerged as a significant issue was the number of people unhappy with the documents provided to the Clinic for use in the preparation of its assessments. The rules are clear that all parties are to agree to the documents to which the Clinic has regard. However, it appears in practice that this does not always occur. It clearly should.

11.295 More generally, the Clinic also informed the Inquiry that it is often the case that either Authorised Clinicians do not receive all the information relevant to the assessment from the parties, or else they receive the entirety of the DoCS file, irrespective of the relevance of most of the documents on that file.

11.296 The Inquiry investigated a number of the claims made, usually by a parent, that all relevant documents had not been sent to the Clinic. None of those investigations supported the assertion that DoCS has sought to mislead the Clinic by the selection of documents forwarded to the Clinic.

11.297 However, more needs to be done to ensure that the documents forwarded are complete, only as voluminous as necessary to answer the questions posed in the assessment order, and that each party has consented to them. DoCS should ensure, where it is the applicant for an assessment order, that this occurs.

Timeframes

11.298 One concern raised with the Inquiry in relation to the production of reports by the Clinic was the delay between the Children's Court making assessment orders, and the report being submitted to the Court. In one case, the period taken was cited as being between eight and 18 weeks. Any reduction in that timeframe can only be in the best interests of children involved in care proceedings.

Communication

11.299 The extent to which the relevant DoCS caseworker should be able to communicate with the Authorised Clinician appointed to complete an assessment was raised by the Inquiry. As noted above, Authorised Clinicians are encouraged by the Clinic to make contact with the relevant DoCS caseworker to obtain information about the relevant child or young person and his or her family dynamics.[173] The Clinic's Director advised the Inquiry that

[173] Authorised Clinicians Handbook, p.5.

contact with the DoCS caseworker might be necessitated by the quality of the file of documents provided to the Authorised Clinician.[174]

11.300 DoCS' internal guidelines in relation to making an application for an assessment order, place restrictions on the contact that a caseworker can have with an Authorised Clinician by stating that, outside of the file of documents provided to the Authorised Clinician pursuant to the directions of the Children's Court:

> *other information may only be provided by the caseworker to the clinician upon their specific request. If the additional information is in writing then copies are to be distributed to all parties. Any other extra information should be limited to verbal clarification of the information already provided.*[175]

11.301 In the event that information becomes available after the material has been forwarded to the Clinic, and it is information relevant to the Clinics' work, there should be provision for that material to be provided to the Clinic after each relevant party has been informed of its existence and of the intention to forward it to the authorised clinician thus giving them an opportunity to object.

11.302 The LAC submitted that the independent legal representative for the child in care proceedings should be able to communicate with the Clinic and to provide and receive information from the Authorised Clinician as currently occurs in the family law jurisdiction.

11.303 The Inquiry is of the view that the value of the Authorised Clinician's reports is enhanced by their independence from the process. It believes that DoCS' internal guidelines should be the standard governing communication between Authorised Clinicians, DoCS caseworkers and others. Additionally, it considers it important that each party should ensure that the documents provided to the Authorised Clinician reflect any information they wish him or her to take into account.

11.304 The Inquiry understands that there is no requirement that the Court advise parties that a Clinic's report has been received. The Inquiry is of the view that the Court should advise parties when such a report is received. The Court should be empowered to release a copy of the report to a person who is not a party to the care proceedings but nevertheless has an interest in the safety, welfare and well-being of the child or young person, by virtue of the professional services being provided to that child or young person, such as a health professional.

[174] Transcript: Inquiry meeting with representatives of the Children's Court Clinic, 26 May 2008, p.28.

[175] DoCS, Intranet, Casework practice, Courts and legislation, Court order procedures, Application for an assessment.

Quality of reports

11.305 The Inquiry received a variety of submissions (written and verbal) in relation to the quality of the Clinic's assessment reports. These submissions ranged from the comment of a caseworker in a CSC in Southern Region who stated that she had recently been involved in a matter where she felt that the Clinic carried out "an absolutely outstanding assessment,"[176] and the statement of the Clinic that its surveys of Magistrates in relation to the usefulness of Clinic assessments have generally resulted in positive feedback, to some submissions providing examples of what were asserted to be poor quality reports. The Inquiry has been advised on a number of occasions that reports submitted to the Court by the Clinic are of 'variable' quality.[177] In some cases, the quality of the Clinic's assessments were criticised on the basis of a failure to interview the subjects of the report.

11.306 Against this, the Clinic's Director informed the Inquiry that the Authorised Clinician would almost always observe or interview the child.

11.307 The Clinic acknowledged that work needs to be done to educate the Children's Court and the parties to care proceedings about what may be reasonably asked of the Clinic in the short time available for these assessments. The Clinic said that a presentation has been recently given to Children's Magistrates about this issue, during which the Magistrates were asked to simplify the areas to be addressed by Authorised Clinicians to ensure a useful assessment report.

11.308 The Clinic stated that it is exploring ways of achieving greater participation from Authorised Clinicians in group supervision and in the Clinic's Professional Development program generally, and stated that it has submitted a proposal for a new Panel application process to Attorney General's that explicitly requires participation in Professional Development.

11.309 The Clinic indicated that it will also be providing more outreach Professional Development opportunities for Authorised Clinicians located in rural and regional areas, which will include better use of the Clinic's website to convey relevant clinical information.

11.310 The consistency and quality of reports is an important matter and the Inquiry is of the view that the work proposed by the Clinic is positive. However, since the clinician's report will normally constitute the only expert evidence before the Court it is critical that it be impartial, fair and correct.

11.311 On a related matter, s.58 permits the Clinic to indicate it is "unable or unwilling to prepare the assessment report." While it is understood that there may be very good reasons why a lack of resources and the like mean that the Clinic is

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[176] Transcript: Inquiry meeting with DoCS staff, CSC Southern Region.

[177] Transcript: Public Forum, Health and Disability, 11 April 2008, p.32; Transcript: Inquiry meeting with DoCS staff, CSC Northern Region; Transcript: Inquiry meeting with representatives of the Law Society of NSW, 29 April 2008, p.22.

unable to prepare a report, the concept of unwillingness does not properly reflect the Clinic's role as an expert consultant to the Court. That portion of the section should be deleted.

Payments

11.312 In relation to payment, the rate at which Authorised Clinicians are currently paid is (according to the Clinic) well below the hourly rate recommended by the Australian Psychological Society.

11.313 The Inquiry was provided with a copy of a proposal for a budget enhancement for the Clinic, and was told by Attorney General's that the proposal is currently being evaluated. The proposal states that the Authorised Clinicians' fees have not increased since June 2001.

11.314 The Inquiry supports an increase in payment in order to attract sufficiently skilled and experienced clinicians.

The data challenge in the care jurisdiction

11.315 Obtaining accurate data in relation to proceedings in the care jurisdiction has proven to be a challenge. Neither the Children's Court, nor Attorney General's, keeps detailed or reliable statistics in relation to care proceedings. The Children's Court publishes some of the decisions it makes in care proceedings on its website, whilst the District Court publishes very few, and, until recently, it did not provide a copy of decisions on appeal from the Children's Court to that Court. Decisions of the Administrative Decisions Tribunal in relation to appeals concerning care and protection issues are, however, routinely published on its website, as are those of the Supreme Court on its website.

11.316 The data limitations were lamented by many before the Inquiry. For example, DoCS stated:

> *In understanding the current working of the Children's Court, any discussion is severely hampered by an absence of reliable data and an inability to study a sample of cases.*[178]

11.317 The Commissioner for Children and Young People, in a joint submission with two academics, stated that even though the Children's Court played a critical role in making significant decisions in children's lives:

> *We know little about the processes in terms of the profiles of cases that come before it and the orders that are made. There is no reliable information on a court data base, and no*

[178] Submission: DoCS, Operation of courts in the child protection system (abridged), p.6.

> *comprehensive record of judgments or appeals from the Court.*[179]

11.318 DoCS recommended that the Children's Court improve its data collection methods and procedures in relation to all care proceedings.

11.319 The Ombudsman stated:

> *In our Children's Court Discussion Paper we highlighted the paucity of relevant data captured relating to Children's Court proceedings. We are also aware that there was a meeting in August 2004 between a range of agencies to better identify data needs.*[180]

11.320 It appears that the meeting referred to by the Ombudsman identified the data that would be useful to capture. The Inquiry strongly encourages the Children's Court, Attorney General's and DoCS to move quickly to collect that data (independently of Justice Link if necessary). It also encourages the District Court to publish the decisions made in the exercise of its appellate jurisdiction, in relation to care proceedings as a matter of course.

11.321 The limited statistics currently available are set out in Chapter 5.

Recommendations

Recommendation 11.1

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

i. Section 8(a) should be amended to provide as follows:

   that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them.

ii. Section 9 should be amended to provide:

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

   In all actions and decisions concerning a particular child or young person that are made under this Act the safety, welfare and well-being of the child or young person must be the paramount consideration.

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[179] Submission: Commission for Children and Young People, p.48.

[180] Submission: NSW Ombudsman, 10 March 2008, p.6.

Paragraphs (b) to (g) should then be renumbered commencing with (a).

iii. Section 18 should be amended to insert the words "or a non-government agency in receipt of government funding for the requested services" after "or agency".

iv. Section 21 should be amended to permit an NGO in receipt of government funding for the requested services to apply on behalf of a child or young person for assistance.

v. Section 28 should be proclaimed.

vi. Section 29(1)(f) should be amended to reflect the changed reporting structure as set out in Chapter 10.

vii. Section 29(1)(f) should be amended to permit the disclosure of the reporter's details to a law enforcement agency pursuant to the investigation of a serious crime committed upon a child or young person, where that might impact on the child's safety, welfare or well-being.

viii. Section 71 should be amended so that the grounds are not limited to those enumerated, while still retaining each sub-section.

ix. The Act should be amended to make clear that, other than emergency care and protection orders made under s.46(2) of the Care Act, the Children's Court can not allocate parental responsibility to a designated agency or a principal thereof.

x. The Act should be amended to limit the power of the Children's Court to make contact orders to those matters where the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration.

xi. Section 90(3) should be amended to permit the child or young person to make an application pursuant to that section.

xii. Part 3 of Chapter 7 should be repealed.

xiii. Section 58 (1) (a) should be amended to delete "or unwilling."

xiv. Pursuant to s.82, the Children's Court should have the power to order that a written report be made to it and, if after receiving that report, it is not satisfied that proper arrangements have been made, it should have the power to re-list the matter with notice to the parties to the original proceedings in order to give any of them an opportunity to make an application pursuant to s.90 or for any other ancillary or incidental order. However, if no party wishes to apply for an order varying any of the orders made, the matter should be taken no further. In the absence of a moving party, the Children's Court should not be empowered to make orders of its own motion.

In addition, the Children's Court should develop rules concerning timing, notice, confidentiality and procedures to ensure that reports are made to it in a timely fashion, that all parties are provided with a copy of the report and that the process by which a date is set for hearing is also clear.

xv. The Children's Court should have the power to order that expert evidence be provided to it, in the form of reports provided by the Children's Court Clinic or otherwise.

xvi. Relevant amendments should be made to ensure that *Re Rhett* [2008] CLN 1 is followed.

xvii. The Act should be amended to provide that a decision to restore a child or young person to the care of the parents from whom he or she had previously been removed by an order of the Children's Court, in circumstances where the Children's Court had accepted the assessment of the Director-General that there was not a realistic possibility of restoration, must be made by the Children's Court upon application by the person with parental responsibility.

Recommendation 11.2

There should be a feasibility study into the transfer of the Children's Court Clinic to Justice Health that should also investigate its expansion to provide the services of the kind currently offered by Justice Health in the criminal jurisdiction, as well as an extension of the matters dealt with in the current assessments so as to provide greater assistance in case management decisions.

Recommendation 11.3

Data in relation to all aspects of proceedings pursuant to the *Children and Young Persons (Care and Protection) Act 1998* should be kept by DoCS and the Children's Court and made public.

Recommendation 11.4

DoCS should review its Casework Practice Policy, Taking Action in the Children's Court, to ensure it is consistent with the *Children and Young Persons (Care and Protection) Act 1998,* in particular, the principles set out in ss.9, 10 and 36.

Recommendation 11.5

DoCS should develop Guidelines for staff in order to ensure adherence to the Aboriginal and Torres Strait Islander Child and Young Person

Placement Principles in s.13 of the *Children and Young Persons (Care and Protection) Act 1998.*

Recommendation 11.6

Evidence based guidelines for Magistrates should be prepared in relation to orders about contact made under s.86 of the *Children and Young Persons (Care and Protection) Act 1998.*

12 Other models of decision making

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Introduction

12.1 The Inquiry considered whether the existing model by which statutory child protection is delivered remains appropriate.

12.2 As noted earlier, the Children's Court, a court sitting at the fourth tier of the judicial hierarchy in NSW, is the principal decision maker in relation to matters concerning the removal of children and young persons, the allocation of parental responsibility and contact. The Children's Court, which for the purposes of this section encompasses the Local Court when it is sitting as a Children's Court, comprises both specialist and non-specialist Magistrates, with the work allocated roughly two thirds to one third respectively. Appeals from the Children's Court proceed to a higher court, generally the District Court.

12.3 DoCS, an administrative body, makes most other decisions in relation to children and young persons who are at risk of harm, and who may be or are in need of care and protection. Appeals from the administrative decisions of DoCS (and other agencies who have been delegated responsibility for the care of children and young persons) proceed to the Administrative Decisions Tribunal and occasionally to the Supreme Court.

12.4 The Inquiry is of the view that judicial oversight is necessary in this important jurisdiction. However, whether some of the decisions in relation to all or some children and young persons could be made in a forum other than the Children's Court, has been a live issue.

12.5 The Inquiry initially raised the issue of whether the Children's Court should be replaced by a tribunal, following from the DoCS 2006 Discussion Paper where this approach was suggested by DoCS. Since that time, DoCS has retreated from that position.[181] It appears to the Inquiry that it was not strongly embraced by any other party, and it is not something which the Inquiry would support.

12.6 The Inquiry however considered a range of other decision making models or processes that might be used as an adjunct to, or in connection with, proceedings in the Children's Court.

12.7 First, the Inquiry considered whether the alternative dispute resolution mechanisms which are provided for in the Care Act, but which are apparently not used to any significant extent, could be more effectively utilised.

12.8 The Inquiry also considered the Family Court processes including the Magellan case management model (involving modification of the existing court processes), the NSW Care Circles pilot (which comes into play after the establishment phase of care proceedings, and involves an alternative process for decisions in relation to care plans), the New Zealand Family Group

[181] Transcript: Public Forum, Role of Courts, 22 February 2008, p.5.

Conferencing model (a mediation model designed to resolve issues before court proceedings are initiated) and finally, the Scottish Children's Hearings Tribunal.

12.9 The unifying feature of all of these models or processes is that each is less formal and technical in nature than proceedings in the Children's Court.

Alternative Dispute Resolution

12.10 Notwithstanding that the Care Act specifically provides for alternative dispute resolution (ADR), the Inquiry has been consistently informed that in practice, there is no real form of ADR operating in the care jurisdiction.

12.11 The recommendations resulting from the 1997 review of the 1987 Act included a recommendation that mechanisms should be available as an early intervention strategy, both as an alternative to a care application and during the course of a care application.[182] It was recommended that the Care Act should not be prescriptive about how or what form of ADR was used, nor mandate its use in all circumstances. The Care Act should allow for the widest possible range of options to accommodate the complexities and unique requirements of care and protection cases, and such options might include family group conferencing, mediation and preliminary conferences.

12.12 It was further recommended that the Minister should be responsible for establishing and funding ADR services that are independent of DoCS.

12.13 The legislation was amended along the lines suggested by the review.

12.14 There are three provisions in the Care Act that govern the use of ADR in care proceedings. Section 37 states:

> *(1) In responding to a report, the Director-General is to consider the appropriateness of using alternative dispute resolution services that are designed:*
>
> *(a) to ensure intervention so as to resolve problems at an early stage, and*
>
> *(b) to reduce the likelihood that a care application … will need to be made, … and*
>
> *(c) to reduce the incidence of breakdown in adolescent-parent relationships, and*
>
> *(d) if an application for a care order …is made, to work towards the making of consent orders*

[182] DoCS, *Review of the Children (Care and Protection) Act 1987: Recommendations for Law Reform*, 1997, p.49.

> *that are in the best interests of the child or young person concerned.*
>
> *(2) Attendance at a preliminary court conference is mandatory.*
>
> *(3) Participation in all other forms of counselling and conferencing is voluntary.*

12.15 A notation below this section states:

> *Within this provision, models for counselling and conferencing may be developed to accommodate the unique requirements of a community (whether cultural, geographic or language), the complexities of the case, or the nature and severity of the abuse suffered by the child or young person.*

12.16 In addition, s.38 of the Care Act provides that care plans, developed by agreement in the course of ADR, may be registered with the Children's Court and used as evidence of an attempt to resolve the matter without bringing a care application.

12.17 The Senior Children's Magistrate advised the Inquiry that s.38 plans are used 'reasonably often' but said that it does not keep figures as to the frequency with which such care plans are filed with the Court.[183]

12.18 Section 65 of the Care Act deals with preliminary conferences. Subsection 2 states:

> *The purpose of a preliminary conference is:*
>
> *(a) to identify areas of agreement between the parties, and*
>
> *(b) to identify issues in dispute between the parties, and*
>
> *(c) to determine the best way of resolving any issues in dispute, including by referring the application to independent alternative dispute resolution, and*
>
> *(d) if it is not appropriate to refer the application to Independent alternative dispute resolution, to set a timetable for the hearing of the application by the Children's Court, and*
>
> *(e) to formulate any interim orders that may be made by consent.*

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[183] Transcript: Inquiry meeting with representatives from the Children's Court NSW, 29 April 2008, p.46.

Preliminary Conferences

12.19 Professor Parkinson informed the Inquiry that the concept of preliminary conferences to be conducted by Registrars in the Children's Court had been an attempt at early resolution in care matters. The Inquiry understands that their intended role was twofold: first, to ensure that the matter was ready for hearing, in that the evidence was filed and served and the like; and secondly, to resolve issues in dispute.

12.20 DoCS informed the Inquiry that:

> *Preliminary conferences were to be meetings held on an appointment basis which were to be less alienating than court proceedings and allow greater accessibility to people with low levels of literacy... In fact, the preliminary conference is often little different to a directions hearing and the Court consistently seeks all parties to be legally represented. This denies individuals the ability to directly participate and adds to the sense of formality… The suggestion by the Court that it uses preliminary conferences as a form of 'in-house ADR' is rejected, as the experience of DoCS is that Children's Registrars have no training or demonstrated skills in ADR and instead use this forum as a directions hearing.*[184]

12.21 The LAC effectively agreed.

12.22 Caseworkers had different experiences. Some said that preliminary conferences were being used primarily as mediation sessions, and that agreement was reached in relation to the major issues in the case at about half of the preliminary conferences held. Some noted that preliminary conferences had been run like mediation when led by a particular, experienced Children's Registrar.

12.23 Others said that preliminary conferences have simply become another delay in the court process.

12.24 A legal practitioner who was present at the Nowra Public Forum stated that preliminary conferences were not being used as forums for settlement discussions, and said:

> *I don't believe Registrars have had mediation training, the DoCS solicitor doesn't attend and so usually nothing gets resolved. It seems to me to be a bit of a waste of time.*

12.25 A particular issue raised was the timing of preliminary conferences. The LAC stated:

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[184] Submission: DoCS, Operation of courts in the child protection system, p.13.

> *The preliminary conference is … held at a time in proceedings where all parties have often already taken a strong position, leaving little room for discussion or compromise… the preliminary conference should be held earlier in the proceedings than is currently the case, and certainly before the filing of the care plan. The preliminary conference should be the vehicle by which an agreed care plan, with orders by consent, is drafted wherever possible… The preliminary conference could be used to identify and limit issues in dispute and to identify what parents may need to do for restoration to even be considered by DoCS.*[185]

12.26 A Children's Registrar informed the Inquiry that in cases where the preliminary conference is held prior to the establishment phase of the proceedings, and the meaning of establishment is explained to the parties, establishment is often settled. However, data are not kept as to the number of preliminary conferences held in which settlement discussions have occurred.

12.27 A current and former Children's Magistrate had different views. The Senior Children's Magistrate stated that in nearly every case, the child has been removed prior to the commencement of care proceedings, and that such circumstances are not conducive to effective ADR.

12.28 A former Children's Magistrate advised the Inquiry that the parties are reluctant to negotiate before they have all the information before them, and that it is unlikely that this will occur early in the proceedings.

12.29 The role, as originally envisaged, of the Registrars is an important one in facilitating early resolution of matters by way of agreement or ensuring that the matter is ready for hearing. It is clear that the former role is not occurring sufficiently often to make a real difference.

12.30 The Inquiry is not convinced that the prior removal of the child will always or necessarily mean that ADR will not be effective. Given that establishment is more often than not conceded, it should be possible for matters such as parental responsibility and contact to be resolved through ADR.

12.31 The Inquiry is of the view that DoCS, the parties and the Court need to do much more to bring ADR into child protection work. As a start, there should be more Children's Registrars and each of them should be legally trained and qualified as mediators. Recommendations are made about these and related matters in this and the following chapter.

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[185] Submission: Legal Aid NSW, 20 February 2008, p.113.

Other alternative dispute resolution mechanisms

12.32 There have been no referrals to external ADR nor is there any arrangement in place whereby such referrals can be made. Nor is DoCS currently equipped to offer ADR.

12.33 However, in 2002 DoCS entered into an MOU with the Community Justice Centres whereby the Centres agreed to provide all clients referred under s.65 of the Care Act with an independent and confidential mediation service. It appears that this avenue has never been used.

12.34 In 2006, the LAC developed a Draft Proposal for a Care and Protection Mediation Pilot (the LAC proposal), based on its Family Dispute Resolution Service (used in the family law jurisdiction) which is geared towards multi-party dispute resolution and is child focused.[186]

12.35 The LAC proposal involves a combination of mediation and conciliation, and the appointment of an impartial, trained and accredited chairperson to assist parties in a conference setting to discuss problems, consider options, and develop plans. Parties must agree to be referred to conferencing.

12.36 The LAC proposal envisages that the following people would attend the conference:

a. the DoCS caseworker and/or manager as well as the DoCS legal officer

b. the children's representative

c. any other parties and their legal representatives

d. in some circumstances relevant others such as a carer grandparent, aunt or uncle.

12.37 The conference would only be held after a determination has been made that a child is in need of care and protection, and under the LAC proposal, only the Court would have the power to refer a matter to this process, and the Court would specify the issues which should be addressed.

12.38 Under the LAC proposal, any agreements reached during the course of the conference in relation to issues referred by the Court would be drafted into 'consent orders' for approval by the Court. All attendees would be required to enter into a confidentiality agreement.

12.39 A conference would not occur in circumstances where there was violence, where an AVO was in place and may be breached or where a party suffers from impaired functioning.

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[186] Legal Aid NSW, "Care and Protection Mediation Pilot: Draft Proposed by Legal Aid Commission NSW – Alternative Dispute Resolution Section," 6 February 2006, pp.1-2.

12.40 The LAC proposal states that matters should be referred back to the Court where:

a. a party had not cooperated in the timely organisation of the conference

b. a party withdrew consent to the holding of the conference

c. the chairperson considered that the matter was no longer suitable for a conference

d. the conference was complete.

12.41 DoCS informed the inquiry that it would have ‘no problems’ in adopting the model put forward by the LAC.[187]

Family Court Processes

Less adversarial trial

12.42 Since 1 July 2006, the Family Court of Australia (the Family Court) has dealt with applications for orders concerning children by way of a Less Adversarial Trial (LAT). The relevant provisions are found in Part VII Division 12A of the *Family Law Act 1975 (Cth)*.

12.43 The Inquiry understands that the model is not followed in every respect in every Family Court in Australia, and this report describes the model rather than the details of its implementation.

12.44 The aims of the LAT model are to:

a. focus on the children in the case and their future

b. be flexible so as to meet the needs of the family situation

c. be less costly compared with judicial trials and to save time in court

d. allow for participation of the family in the process

e. be less formal than is usually the case in a court.[188]

12.45 The LAT has the following elements:

a. the matter is heard on all occasions by the same Judge

b. the Judge (rather than the parties) decides what information is to be put before the Court

c. the Judge controls how the trial is run

d. the focus is on what is best for the children

e. a Family Consultant is made available to the parties throughout the hearing

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[187] Transcript: Inquiry meeting with DoCS lawyers, 1 February 2008, p.13.

[188] Family Court of Australia, *Less adversarial trials*, 2008, p.1.

f. technical rules of evidence are not applied.[189]

12.46 Prior to the first day of the LAT, the family meets with the Family Consultant who has been allocated to the case.

12.47 The Family Consultant who is a psychologist or social worker attached to the Family Court attends the first day of the LAT to give general expert advice and information to the Judge to help identify the relevant issues in dispute. On the first day of the LAT, the parties are asked to talk about the case, and to indicate the orders they are seeking (either in their own words, or if they prefer, via their lawyer).[190] The Judge then identifies the issues to be decided.

12.48 Decisions are also made about the evidence to be heard (including which witnesses, if any, will need to attend), who should provide evidence in writing and what it should be about, what expert reports will be required if any, and whether a family report will be required. Where ever possible this report will be prepared by the Family Consultant allocated to the matter.[191]

12.49 In cases where there are concerns about family violence, the Family Court will make arrangements to enable parties to be both safe and able to participate fully in LAT. This might involve a person being heard by video or teleconference.[192]

12.50 The LAT has been described as follows:

> *In children's cases, Division 12A [of the Family Law Act 1975] swept away restrictive rules of evidence and the control of the proceedings was placed in the hands of the judge, rather than the parties or their legal representatives. The focus is a future looking one, geared to the needs of a child. As a consequence of the new procedures, parties are no longer free to conduct litigation as a forensic war between each other at the expense of the interests of the child. At the same time the best features of the Court's highly developed system for mediation and resolution of disputes has not only been preserved but also enhanced, and the role of … the family consultant has become even more significant. The unique approach retains and relies on the special assistance provided by family consultants, whilst providing a clear child focus underpinned by active judicial leadership and direction.*[193]

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[189] Family Court of Australia, *Fact sheet: Less Adversarial Trial,* 2008, pp.1-3.

[190] Transcript: Inquiry meeting with representatives of the Family Court of Australia, 9 May 2008, pp.31.

[191] Family Court of Australia, *Less adversarial trials*, 2008, p.3.

[192] ibid.

[193] M Harrison, *Finding a Better Way: A bold departure from the traditional common law approach to the conduct of legal proceedings,* April 2007, p.ix.

12.51 The LAC recommended to the Inquiry that the Children's Court trial a LAT program.

12.52 In 2008, the Family Court implemented the Child Responsive Program nationally.[194] It appears that the program enhances the pre-court assessment role of the Family Consultant, and allows for a more thorough assessment of the child's needs. The Child Responsive Program involves the Family Consultant interviewing and assessing school aged children involved in family law proceedings. The Family Consultant assesses the developmental needs of the child, the child's emotional response to the parents' dispute, and considers the child's views on the various options available (for example, who they will live with). The assessment is summarised in a preliminary report by the Family Consultant, which is presented and discussed with the parents in a feedback session.[195]

12.53 A 2006 study of the Child Responsive Program identified it as an important screening tool in the early detection of children who require child protection involvement, or therapeutic services, and in the identification of parents who required early, specialist services to assist the management of their separation, particularly those with personality or mental health disorders.[196]

Magellan

12.54 The Magellan case management model (Magellan) was introduced to Family Court registries in 2003, and was designed to expedite children's matters in the family law jurisdiction in cases where one or both parties had raised serious allegations of child abuse.

12.55 Where a Notice of Child Abuse and Family Violence containing allegations of serious physical and/or sexual abuse is filed in a case involving an application for parenting orders, the application is referred to the Magellan Registrar for consideration for inclusion in the Magellan list.

12.56 Magellan has the following elements:

a. cases are managed throughout by one Judge

b. each case is allocated a Registrar, who becomes familiar with the details of the case and coordinates the process

c. each case is allocated a Family Consultant, who prepares an early, detailed family report analysing the family dynamics and the needs of the child

d. every child has a court ordered legal representative (Independent Children's Lawyer) funded by Legal Aid

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[194] Family Court of Australia, *Annual Report 2007/08,* p.20.

[195] J McIntosh and C Long, *The Child Responsive Program, operating within the Less Adversarial Trial: A follow up study of parent and child outcomes*, July 2007, pp.5.

[196] ibid., p.7.

e. the amount of Legal Aid funding is not capped for parents who qualify for Legal Aid.

f. interagency protocols are in place, and there is a multi-agency committee in each registry

g. resources are provided early in the case, including uncapped legal aid, provision of information by other agencies such as statutory child protection agencies and early access to the Judge, counsellors, and the registrar

h. there is a separate Magellan court list and there are timeline goals, with the aim to finalise matters within six months of commencement

i. the Court orders expert investigations and assessments from the state child protection service and the court counsellors.[197]

12.57 Early in the Magellan process, the Family Court makes an order requesting the state/territory child welfare agency to intervene in the Family Court proceedings.

Magellan Report

12.58 DoCS provides its initial evidence in Magellan cases by way of a 'Magellan Report', which is essentially a summary of DoCS' involvement with the child and family, and of DoCS' recommendations (if any) in relation to the case. The Magellan Report typically sets out:

a. family details, including names, ages, place of residence

b. a summary of the child protection history – including reports made to DoCS, primary risk of harm issues recorded, whether or not a secondary risk of harm assessment was carried out, and, if so, the outcome

c. an analysis of the issues

d. any recommendations

e. details of any current or proposed action by DoCS in response to the Family Court's request to intervene.

12.59 DoCS stated:

> *One reason the Magellan model is considered effective in the Family Court context is because evidence is provided to the Court by DoCS in a manner other than by way of affidavit and in the process, DoCS caseworkers can, as experts in child protection, offer practical solutions to the problems facing the family in question.*[198]

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[197] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters,* February 2008, p.14-15: Family Court of Australia, *Magellan Manual: National procedures for conduct of Magellan cases*, 2 May 2007, p.2.

[198] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters,* February 2008, p.17.

Evaluations and comments

12.60 Two evaluations of Magellan have been carried out. The first, in 2001, evaluated the pilot. The second, in 2007, followed the implementation of Magellan nationally (it commenced in different registries at different times).

12.61 The 2007 evaluation found that Magellan cases, when compared with Magellan-like cases[199] in the Family Court:

a. were shorter (from commencement to finalisation)

b. involved fewer court events

c. were dealt with by fewer judicial officers

d. were more likely to settle.[200]

12.62 Qualitative results of the evaluation also found that the following occurred in Magellan cases:

a. cooperation between all agencies involved

b. good individual case management (Judge-led) with consistency of approach

c. child focused processes, including timely reports from Family Consultants and other experts.[201]

12.63 It was noted in the 2007 evaluation:

> *Participants felt that Magellan delivers better outcomes for children and families. A critical element to this is the tight case-management procedures, particularly the role of the Magellan Judges and Registrars.*[202]

12.64 A Family Court Judge was quoted in the 2007 evaluation as saying:

> *It must be achieving good things. You get the early reports in. Then the parties can come to an acceptable agreement about what's in the best interests of the children promptly. The fact that the decisions are being made on proper supporting evidence, and you have the cooperation of the various people involved: police, the child protection department and the Court. That's got to work in children's favour. The sharing of information. They're not getting caught up in unnecessary bureaucratic quagmire.*[203]

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[199] Cases in the Family Court, where one or both parties have raised allegations of sexual abuse or physical abuse of children in a parenting dispute, filed in a registry where Magellan was not operating at the time.

[200] D Higgins, "Cooperation and coordination: An evaluation of the Family Court of Australia's Magellan Case Management Model," *Australian Institute of Family Studies,* 2007, p.16.

[201] ibid. pp.16-17.

[202] ibid., p.18.

[203] ibid., p.123.

12.65 Another Family Court Judge was quoted in the 2007 evaluation as saying:

> *The Judge can – despite high workloads – retain a level of familiarity with the file, and can remember the previous interim proceedings, the reports, and those outcomes. Whereas if you always had a different Judge every time, there wouldn't be that level of familiarity, and that could extend the proceedings. They may try to argue the same thing before a different Judge for the third or fourth time.*[204]

12.66 The evaluation also noted that in some registries, due to judicial resources, although Magellan cases were being managed by a single Judge, if they proceeded to a final hearing, they may have been heard by a different Judge.[205]

12.67 The Inquiry also understands that a substantial number of Magellan cases are resolved prior to hearing.[206]

12.68 In terms of efficiency, DoCS informed the Inquiry that the 2001 evaluation of the pilot examined costs and found that they had reduced for Victorian Legal Aid involvement in the Family Court by 50 per cent. In general, Magellan required a higher workload earlier in the case, which was however offset by requiring less work later, partly because more cases were resolved.[207]

Family Consultants

12.69 As noted earlier Family Consultants are social workers or psychologists attached to the Family Court and are used in all children's cases in that Court (both in Magellan cases and in LATs). When a children's matter comes before the Family Court, each family member meets with the Family Consultant prior to the matter coming before a Judge. The Family Consultant then prepares a brief report for the Court about the relevant issues in the matter. The Family Consultant remains associated with the matter for the duration of the proceedings, providing expert evidence about child development and the appropriate orders that might be made in relation to specific children.

12.70 The Inquiry understands that the Family Consultant generally provides the Judge with an 'issues assessment' early in the proceedings. The Judge then asks each parent to outline the orders they are seeking and, with the involvement of the Family Consultant, determines whether further reports are required. The Inquiry also understands that in cases involving child protection issues, the Family Consultant makes inquiries with service providers and schools to gather information about the child and the family. The Inquiry was told that the Family Consultants do not undertake confidential ADR.

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[204] ibid., p.130.

[205] ibid., p.131.

[206] Transcript: Representatives from the Family Court of Australia, 9 May 2008, p.4.

[207] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters*, February 2008, p.17.

12.71 The Sydney Registry of the Family Court currently has eight full time Family Consultant positions. The Family Court also provides funding for external consultants to be contracted when internal resources cannot meet demand.[208]

12.72 The Inquiry was told that each Family Consultant in the Sydney registry has, on average, more than 80 matters allocated to them.[209]

Alternative dispute resolution in the Family Court

12.73 In most family law matters, ADR is compulsory.[210] The Law Society informed the Inquiry that mandatory ADR has worked well in the Family Court, and that as a result, only very complex cases proceed to a full hearing. However, compulsory ADR does not apply to matters in which there is an allegation of family violence or child abuse[211] – and ADR is not compulsory in Magellan matters.

Care Circles

12.74 Attorney General's, in combination with DoCS, has this year commenced work on a Care Circle pilot as an alternative way of resolving care matters involving Aboriginal children and young persons. The Care Circle pilot will be run at Nowra,[212] and the first Care Circle has been listed to occur on 10 December 2008.

12.75 The Care Circle is intended to be activated after the establishment phase of care proceedings (that is, after the Children's Court has determined that the child or young person is in need of care and protection) either on the Court's own volition, or on the application of one of the parties to the proceedings. The Care Circle is intended to provide a model for the increased participation of the child's or young person's family and community in relation to their future care arrangements.

12.76 Suitability of a matter for referral to the Care Circle would be based on consideration of:

a. the child's or young person's and parent's connection to the local Aboriginal community

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[208] Correspondence: Family Court, 10 June 2008.

[209] ibid.

[210] Family Court of Australia, *Fact sheet: Compulsory Family Dispute Resolution court procedures and requirements,* 2008.

[211] ibid., p.2.

[212] Attorney General's Department of NSW and DoCS, *Care Circles: an alternative court process for Aboriginal children at risk*, November 2008, p.5.

b. the potential benefits to the parents, child or young person and community.

12.77 DoCS advised the Inquiry that matters would be excluded from the Care Circle in certain circumstances, for instance if there was a dispute about whether the child or young person was Aboriginal or where one of the participants had been physically violent towards other participants.

12.78 The model envisages involvement of the following people in the Care Circle:

a. three respected Aboriginal community members, who will have been provided with some training in relation to the operation of the Care Circle, the relevant legislation, and the concept of the paramountcy of the safety, welfare and well-being of the child or young person

b. the child or young person (the legal representative and the Magistrate are to agree that it is appropriate for the child or young person to attend)

c. the mother and father

d. the legal representatives of the child, mother and father (the mother and father may have separate legal representatives in attendance)

e. a DoCS legal officer

f. the DoCS caseworker and casework manager

g. the Care Circle Project Officer (an employee of the Attorney General's Crime Prevention Division)

h. the Magistrate (the Registrar coordinates the administrative aspect of the Care Circle and may attend)

i. other family members and advocates at the discretion of the Magistrate.[213]

12.79 Participation in the Care Circle is to be voluntary and the consent of all parties to participate is required. The model envisages that the Care Circle should be held in a community environment, but should be confidential and closed to the public.

12.80 The model involves two Care Circle conferences. The first should be held as soon as possible after establishment, allowing time for the Care Circle coordinator to organise community members to sit on the Care Circle, and allowing time for any assessment reports (DoCS informed the Inquiry that five to six weeks after establishment should be an adequate timeframe).

12.81 The Care Circle proposal states:

> *The first circle conference is an opportunity for the parties to come together to discuss what is in the best interests of the child or young person. The care circle may provide valuable input into the following:*

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[213] ibid., pp.13-15.

If there is to be a restoration

What interim arrangements there should be for the care of the child,

What services/supports can be made available to the family; or,

If there is to be no restoration, then

Where the child should live

What contact arrangements should be put in place

Alternative family placements[214]

12.82 A summary of why the child is in need of care and protection and any issues to be discussed by the Care Circle will be agreed by all parties to the proceedings who are present at court when the matter is set down by the Magistrate for referral to a Care Circle.

12.83 DoCS informed the Inquiry that it is envisaged that the first Care Circle conference would typically run for about three hours. After the first Care Circle conference, the DoCS caseworker should prepare a care plan based on the discussion and outcomes.

12.84 The second Care Circle conference should be held about three weeks after the first. The purpose of the second Care Circle conference is to consider and discuss the proposed care plan, and to discuss and decide on appropriate care orders for the care and protection of the child. DoCS informed the Inquiry that it is envisaged that the second Care Circle conference would typically run for about 90 minutes.[215]

12.85 In cases where agreement on care orders cannot be reached by all parties at the second Care Circle conference, the matter would be referred back to the Children's Court to be determined using the usual care proceedings processes.

12.86 One of the aims of the pilot is to demonstrate DoCS' recognition of the importance of kinship relations in the care and protection of children and young persons consistent with s.13 of the Care Act and to improve the effectiveness of undertakings agreed upon by parents.

12.87 DoCS informed the Inquiry:

> *…it is questionable whether this model of participation would work in the broader community, or even in Aboriginal communities in metropolitan areas or regional centres. In the broader community, there are unlikely to be persons generally*

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[214] ibid., p.10.

[215] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters*, February 2008, p.39.

acknowledged to be in the position of Aboriginal elders or their equivalents. In metropolitan and regional centres, even Aboriginal community ties are likely to be less in evidence and families more isolated and transient.[216]

12.88 The Children's Court submission to the Inquiry stated that:

the Children's Court believes that the proposal holds out great hope for the more sensitive and efficient provision of child care and protection services in the ATSI communities with a marked enhancement of community involvement in the lives of indigenous children and young persons.[217]

12.89 However, it also raised specific concerns regarding the potential of alternative mechanisms such as Care Circles to cause a delay in proceedings and exacerbate placement instability, the potential for a level of rigour in proceedings to be lost, and the need for the benefits of community participation to be balanced against "the right to confidentiality, the right to a fair hearing and the various presumptions which can be found, particularly in section 9 of the Act."[218]

12.90 The Inquiry supports the trial as a means of exploring an alternative method by which decisions can be made concerning Aboriginal children and young persons and which actively engages members of the Aboriginal community. The evaluation should be closely considered and if successful, Care Circles should be implemented in appropriate locations in NSW for the same client group.

Family Group Conferencing

12.91 Family group conferencing (FGC) involves bringing together the child or young person, members of their immediate and extended family, and child protection professionals to discuss issues, come to a resolution and develop a plan for future action.

12.92 FGC began in New Zealand in the late 1980s and was based on Maori cultural practice. Its use in Australia is now supported in a number of States (Tasmania, Queensland, and Victoria). In NSW FGC has been strongly promoted and developed by UnitingCare Burnside, which has well established FGC programs in partnership with DoCS. Burnside has also developed an accredited training course for FGC facilitators.[219]

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[216] ibid., p.20.

[217] Submission: Children's Court NSW, 14 January 2008, p.31.

[218] ibid.

[219] N Harris, "Family Group Conferencing in Australia 15 years on," *Australian Institute of Family Studies, Child Abuse Prevention Issues, No.27,* 2008, pp. 9, 17.

12.93 The FGC model is based on the following assumptions:

a. families have a right to participate in decisions that affect them

b. families are competent to make decisions if properly engaged, prepared and provided with necessary information

c. decisions made within families are more likely to succeed than those imposed by outsiders.

12.94 In New Zealand, conferences occur in three stages. The first stage of the conference involves the sharing of information by child protection workers and other professionals with the family. This will usually include discussion of the concerns that are held for the child or young person, as well as the services that are available. The second stage of a conference involves the family having time on their own to deliberate and agree on possible solutions. In the final phase of the conference the aim is to arrive at agreement on first, whether the child or young person is in need of care and protection, and secondly, on the formulation of a plan that will address these concerns. This may involve negotiation between the family, care and protection workers, and other agencies about the services and supports that can be provided. For a conference agreement to come into effect it is necessary that all participants agree. If there is not agreement in the conference about whether a child or young person is in need of care and protection, or on a plan to address these needs, the conference can be reconvened or the case can be referred to the court.[220]

12.95 Conferences have particular significance because New Zealand's legislation prescribes that they are a key decision making process that must be used in particular situations, and that decisions made within them have a legal status that must be recognised by participants. In these respects, the decisions made in a conference are accorded no lesser status than that of court decisions.[221]

Effectiveness

12.96 According to Huntsman's review on FGC, there is considerable evidence that families prefer FGC to other case planning processes, and some evidence that negative perceptions of the child protection agency and workers (as well as family/agency communication) lessen following the FGC experience.[222] Evidence is accumulating that children and young persons are more likely to be placed with relatives if FGC is used.[223]

12.97 However Connolly notes that, despite the success of FGC and consistent research evaluations indicating that FGC compares favourably in terms of child

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[220] ibid., p.3.

[221] ibid.

[222] DoCS, *Family Group Conferencing in a child welfare context, Literature Review*, July 2006, p.15.

[223] M Connolly, "Family Group Conferences in child welfare," *Developing Practice 19, Winter/Spring,* 2007, p.27.

safety and stability measures, the general shift of child protection services towards a more interventionist and forensic focus diminishes the focus on creating statutory environments within which families can participate and be involved in decision making.[224]

12.98 Harris provides a recent overview about the extent to which conferencing has become part of child protection practice in Australia over the last 15 years. Harris observes that the use of conferencing in Australian child protection systems is fairly limited and "that while conferences have had an impact on practice, they have not yet become part of mainstream practice."[225] The following table provides information on when FGC is used and how its outcomes are implemented.[226]

Table 12.1 **Comparison of when conferences are used and how their outcomes are implemented**

	When	*Outcome requires*	*Implementation*
New Zealand	When it is believed a child is in need of protection – prior/alternative to seeking court orders.	Agreement of the family, child protection worker and facilitator.	Outcome must be implemented by Department unless impractical or inconsistent with the Act.
Victoria	Various decision making points, for example, development of case plans or when significant decisions are to be made about an Aboriginal child.	There is variation in use of conferences, but agreement of the family and caseworker is usually required.	Expectation is that agreed outcomes will be implemented by the Department.
South Australia	Prior to seeking care and protection orders. Can be an alterative seeking court orders, but orders are still sought in some cases.	Agreement of the family and the facilitator. Agreement of child protection worker is usually sought.	Families SA has discretion whether to implement agreements and/or seek additional court orders.
Western Australia	An early intervention program was conducted for children younger than 10 identified as having behavioural problems.	During the trial, agreement of the family, child protection worker and facilitator.	When used, expectation was that outcomes would be implemented by the Department.
Australian Capital Territory	When it is believed a child is in need of protection – prior/alternative to seeking court orders.	Agreement of child's parents, the child where appropriate, and child protection worker.	Department must implement outcome but may take further action.

[224] ibid., p.28-29.

[225] N Harris, "Family Group Conferencing in Australia 15 years on," *Australian Institute of Family Studies, Child Abuse Prevention Issues, No.27,* 2008, p.16.

[226] ibid., p.12.

	When	*Outcome requires*	*Implementation*
Tasmania	Usually in conjunction with court orders (for example, when an 8-week Assessment Order is made or a 12-month Care and Protection Order is extended), but can be used separately.	Agreement of the child's guardian, the child or their advocate, and the facilitator.	Department has discretion to endorse the outcome. If it is not endorsed, the conference can be reconvened, or the family's plan and a Departmental alternative are presented to the court.
Queensland	In most cases where it has been assessed that a child is in need of care and protection and ongoing intervention is required. A case plan must be developed before the court can make a Child Protection Order.	Unspecified in legislation.	Department has discretion to endorse the outcome agreement or amend if for submission to court.

12.99 The role that conferencing plays varies, so that in some states conferences focus "on early intervention, in others they occur en route to court, and in still others they are used to reach agreements once orders have already been sought in court."[227] However:

> *a distinct advantage of conferencing is precisely that they are a 'high tariff', formal process that engages and empowers family in making decisions when this is required because less formal approaches have not succeeded or are considered inappropriate. They provide a forum that communicates to families that the concerns are very serious, not least because the next option for statutory services is often to seek court orders, while at the same time allowing families to contest that opinion or to engage in finding solutions.'*[228]

12.100 DoCS conducted a literature review in 2006, which found "some general consensus on the potential benefits as well as on the difficulties posed by FGC practice."[229] Findings, in relation to client outcomes, included the following:

a. inclusion in the decision making process can empower families who previously feel powerless in regard to their relationship with statutory authorities

b. FGC positions child abuse as a community responsibility, potentially leading to more reporting of neglect and child abuse cases by communities

[227] ibid., p.16.

[228] ibid., pp.16-17.

[229] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters*, February 2008, p.22.

and families and greater awareness of child protection issues by the community in general

c. plans developed in negotiation with families are more likely to work.[230]

12.101 In relation to operational effectiveness, the literature review found that:

a. there was an improved commitment and attitude of families towards implementation of decisions (as a result of families' higher satisfaction about their interaction with statutory child protection agencies and the outcomes of the process)

b. children are more likely to be placed with extended family members which assists in retaining children's links to their family and increases the likelihood of finding a culturally appropriate placement.[231]

12.102 However, DoCS stated that a potential problem of the FGC is that it positions the family as the primary source of protection in cases where statutory authorities should be retaining a larger proportion of protection responsibility. It also informed the Inquiry that in New Zealand "plans for the protection of children developed during the FGC are often not implemented due to lack of support services and funding."[232]

12.103 DoCS also stated that:

> *… managing confidential disclosures and sensitive information in a conference setting can be complex and difficult for FGC practitioners. The FGC process can also lack clarity on who holds responsibility for convening a conference, negotiating attendance and reviewing progress against the original plan. Families may not always have the capacity or cohesion to cooperate and communicate to develop adequate plans.*
>
> *FGC also may not be useful in all contexts. Families with serious mental health issues, small extended networks, or substantial internal conflict may be better served by a more formal child protection procedure. In these cases, anecdotal evidence suggests that the FGC can become an administrative hurdle that must be legally completed before the agency can take the matter to court, where it may be more appropriately dealt with.*
>
> *The flexibility provided by the FGC can also mean an absence of due process and inadequate legal representation and the conference structure may prevent disclosures from family*

[230] ibid., p.22.
[231] ibid., p.23.
[232] ibid.

members intimidated by perpetrators present at the Conference.[233]

12.104 DoCS submitted that the Care Act does not present a barrier to utilising FGC, and stated:

FGC could be used to assist in the development of contact orders and care plans prior to resolution of matters in court, promoting early resolution of matters where an application to the Children's Court has been made.[234]

12.105 Catholic Social Services NSW/ACT, in a joint submission with the Catholic Education Commission, recommended that the Inquiry investigate the efficacy of FGC and its potential as a mandatory precursor to care proceedings. Centacare Broken Bay made a similar submission.

UnitingCare Burnside's Family Group Conferencing Pilot

12.106 The Inquiry was informed that from 1996 to 1999, UnitingCare Burnside, in partnership with DoCS, piloted an FGC model of ADR in western Sydney, which dealt mostly:

with matters that were post-court or with non-court matters, in which the issues involved decisions about placements for children, contact between the child and family members or the supports required to maintain or restore the children to the family.[235]

12.107 DoCS said that outcomes of the pilot demonstrated:

a. improved relationships between families and DoCS

b. better relationships between family members

c. an enhanced capacity to reach agreement

d. a reduced risk to children and children remaining at home in about two thirds of cases.

12.108 Dr Judy Cashmore, Research Academic, University of Sydney, who conducted an evaluation of the UnitingCare Burnside FGC pilot spoke positively of it to the Inquiry.

12.109 The LAC informed the Inquiry that since the conclusion of the pilot, UnitingCare Burnside has continued to conduct family group conferences (Family Mediation Service) on an as needed basis but the program itself has not been taken up as a model for dealing with child protection issues in general. UnitingCare

[233] ibid.
[234] ibid., p.24.
[235] Submission: Legal Aid NSW, 20 February 2008, p.40.

Burnside informed the Inquiry that its Family Mediation Service is used primarily in the family law jurisdiction.

Other Conferencing Models

12.110 There are a number of other models that have grown out of the family conferencing movement. For example, the Inquiry received information on the Family Engagement Model operating in Cannington, Western Australia. An evaluation indicated that while almost all stakeholders had a very positive attitude toward the model and reported that it was very empowering for families, the outcomes on select indicators were unclear. The evaluation recommended further analysis, evaluation and comparison with existing case management processes.

Children's Hearings (Scottish tribunal model)

12.111 In Scotland, care and protection matters, as well as juvenile crime matters, are heard by a tribunal (and are referred to collectively as 'Children's Hearings'). The key elements of this model are:

a. a unitary system for hearing matters of juvenile justice (including truancy) and care and protection

b. the use of lay panels of volunteers comprising representatives of local communities to hear matters in a non-adversarial and informal setting (each Children's Hearing is heard by three panel members)

c. the use of straightforward procedures which minimise legal technicalities

d. the provision of an opportunity for parents and children to participate in the discussion of their difficulties and proposed solutions during the hearing

e. a separation of the responsibility of deciding upon the need for compulsory orders from the determination of the facts of the case. The role of the court is limited to establishing facts (where they are in dispute), hearing appeals and dealing with more serious offenders.[236]

12.112 Matters are referred to a Children's Hearing where the grounds for referral can be proven in court, were compulsory measures of supervision are required and where legal intervention will be more beneficial for the child than not making an order.

12.113 If a matter is referred to a Children's Hearing, the Children's Hearing Tribunal (Tribunal) can appoint a 'safeguarder' to offer an independent view of what is in the child's best interests. If the case is legally complex or secure

[236] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters*, February 2008, p.27.

accommodation for the child is being considered, the Tribunal will appoint a legal representative to represent the child's views.

12.114 Attendees at the Children's Hearing are:

a. the child

b. the parents/carers

c. relevant professionals

d. the safeguarder (if appointed).

12.115 The panel members discuss the circumstances with the attendees. If a safeguarder is appointed, he or she also assists the panel in its decision making.

12.116 The hearing is more inquisitorial than adversarial, and the Tribunal has the right to call for reports, require assessments of the child and adjourn the hearing to allow further investigations to take place. However, if the parents do not accept the 'grounds' or reasons for calling the Children's Hearing, the matter is referred to the Sheriff Court for a determination in relation to establishment. The Sheriff Court operates on an adversarial model, and DoCS informed the Inquiry that about 80 per cent of care and protection matters end up being referred to the Sheriff.

12.117 Decisions are made in the Children's Hearing itself, in the presence of the child and parents/carers.

12.118 DoCS informed the Inquiry that participants in a study of the Children's Hearings felt that they were less adversarial and formal than court hearings, and provided greater opportunity for party participation. However, DoCS indicated that evaluations of the Children's Hearings have found that the establishment phase is conducted in an adversarial manner, that children and young persons participated in a limited way, and that parents were not aware of their rights and needed to be provided more information on how the system works. These shortcomings were, it seems, based on resource considerations rather than on the model per se.

12.119 DoCS submitted that the advantage that the Scottish model has over the current NSW care proceedings model is that it is more inquisitorial, does not limit evidence to that provided through affidavits, and is, as a result, able to look at the needs of the child more holistically.

12.120 DoCS stated:

> *Research suggests that tribunals, particularly those not involving legally trained personnel, can fail to provide procedural fairness due to lack of proper reasoning, lack of proper representation, failing to apply legal principles, perceptions of bias and formation of views prior to the hearing.*

> *Anecdotal evidence and research findings in the first decade of the operation of the Scottish Children's Hearing system indicated that informality led to procedural laxity as well as wide variations in practice between hearings. This is supported by 2007 research into the relationship between social work recommendations to Scottish Children's Hearings and the decisions taken, which found that widely different policies and practices operated between different regional localities throughout Scotland. There is a risk that a failure to provide procedural fairness can lead to complex, costly and formal appeal processes.*[237]

12.121 The Inquiry does not however favour a model that includes lay, volunteer panels who often lack the rigour and experience in decision making that is necessary in such a sensitive and complex area.

Conclusion

12.122 The Inquiry does not consider it necessary to replace the existing model of decision making by the Children's Court. It makes recommendations as to its operation in the previous and following chapters.

12.123 The Inquiry is, however, of the strong view that ADR should be used before and during care proceedings. Most of those who spoke to the Inquiry or submitted information to it supported the greater use of ADR in child protection including the Benevolent Society, Centacare, ACWA, UnitingCare Burnside, the Intellectual Disability Rights Service and the Aboriginal Legal Service.

12.124 In this respect, the Inquiry favours adopting an approach that would preserve flexibility and be capable of using FGC and aspects of other models including that proposed by the LAC.

12.125 In relation to the model proposed by the LAC, the Inquiry understands that the presence of violence may be a feature not always present in family law matters. Child protection work however, has violence, actual, threatened or apprehended, as a constant feature. It presence should not operate to exclude ADR, rather those conducting it should have appropriate training.

12.126 The Inquiry agrees with DoCS that all of the following should be able to be dealt with, or at least discussed, with the assistance of one or more of the ADR mechanisms discussed in this chapter:

a. placement plans

b. contact arrangements

---

[237] ibid., p.30.

c. treatment interventions

d. long term care issues

e. determination of the timing/readiness for returning a child or young person to the home

f. determination of when to discontinue protective supervision

g. the nature and extent of a parent's involvement

h. parent/child conflict

i. lack of, or poor, communication between a worker and parents due to hostility

j. negotiation of length of care and conditions of return

k. foster carer/agency/parent issues.

12.127 ADR should not be used to resolve a dispute about whether a child or young person has been abused or neglected or is otherwise in need of care and protection or in cases where an AVO has been granted, (where the process of ADR or the desired outcomes would lead to a breach of the AVO). If used effectively there would be no need to introduce the resource intensive procedure employed in the Family Court.

12.128 The Care Act needs no amendment to achieve the goal mentioned. It can be attained by a combination of the greater use of trained and legally qualified Children's Registrars, access to externally operated services such as those described in the LAC submission, or the MOU with the Community Justice Centres, or through FGC offered by an NGO, or by trained DoCS staff. The last option is perhaps the least attractive because of perceptions by those involved in the jurisdiction of DoCS partiality. The benefits are obvious and include improved participation by the children and families in the decision making process.

12.129 Detailed guidelines will need to be developed to determine who is entitled to apply for and whether a matter is referred to ADR. Practically, ADR will have to be funded by the State regardless of which party initiates proceedings. This means that the person presiding or mediating will be funded by the State. However, the appearance by the parties in any ADR proceedings should be funded in the same manner as if they were attending court proceedings. It is noted that DoCS has estimated that the additional resources required for its Legal Services area alone would amount to about $1.44 million (presumably annually). Costs, of course, are likely to be saved by reduced hearing times, if ADR is successful.

12.130 In addition, for those matters which are dealt with by the Children's Court, the Inquiry is of the view that there should be consistency of judicial officers, a Children's Registrar allocated to each matter, less formal requirements for adducing evidence and an enhanced role for the Children's Court Clinic. Each of these is addressed in the preceding or following chapter.

Recommendations

Recommendation 12.1

Adequate funding should be provided so that alternative dispute resolution is used prior to and in care proceedings in order to give meaning to s.37 of the *Children and Young Persons (Care and Protection) Act 1998*, in relation to:

a. placement plans
b. contact arrangements
c. treatment interventions
d. long term care issues
e. determination of the timing/readiness for returning a child to the home
f. determination of when to discontinue protective supervision
g. the nature and extent of a parent's involvement
h. parent/child conflict
i. lack of, or poor, communication between a worker and parents due to hostility
j. negotiation of length of care and conditions of return
k. foster carer/agency/parent issues.

Recommendation 12.2

The Nowra Care Circle Pilot should be monitored and evaluated. If successful, consideration should be given to its extension to other parts of the State with significant Aboriginal communities.

13 Court processes in statutory child protection

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Court processes

13.1 The Report thus far has considered matters of substantive law in relation to child protection. However, just as frequently (if not more so), real issues arise in relation to the processes by which significant decisions about the lives of children and young persons are made. This chapter deals with these matters.

The Children's Court

13.2 As noted above, the Children's Court deals with matters related to the care and protection of children and young persons (care proceedings), and also criminal cases in which the alleged perpetrator is a child or young person.

13.3 The Children's Court is composed of Children's Magistrates and Children's Registrars, as well as generalist Magistrates and Registrars in situations where the Local Court sits as a Children's Court. Children's Magistrates are from time to time appointed by the Chief Magistrate of the NSW Local Courts (the Local Court). A person is qualified to be appointed as a Children's Magistrate if the person:

a. is a Magistrate

b. has (in the opinion of the Chief Magistrate) the knowledge, qualifications, skills and experience in the law and the social or behavioural sciences, and in dealing with children and young persons and their families, necessary to enable the person to exercise the functions of a Children's Magistrate.[238]

13.4 Children's Magistrates are appointed for a three year term, however they are eligible to be re-appointed at the expiry of a term. A Children's Magistrate does not cease to be a Magistrate during the term of his or her appointment as a Children's Magistrate.[239]

13.5 The most senior judicial appointment within the Children's Court is that of the Senior Children's Magistrate.[240] Currently, this position is held by his Honour Mr Scott Mitchell.

13.6 The functions of the Senior Children's Magistrate are to:

a. administer the Children's Court

b. arrange sittings of the Children's Court

c. convene, at least once every six months, a meeting of Children's Magistrates and such other persons as the Senior Children's Magistrate thinks fit

[238] *Children's Court Act 1987* s.7(2).
[239] *Children's Court Act 1987* Schedule 1(1), (2) and (6).
[240] *Children's Court Act 1987* s.8.

d. confer regularly with community groups and social agencies on matters involving children and the Children's Court

e. provide judicial leadership to the Children's Court

f. develop practice directions and recommendations for rules, in conjunction with the Chief Magistrate

g. oversee the training of Children's Magistrates and prospective Children's Magistrates in accordance with the *Children's Court Rule 2000* (the Rules).[241]

13.7 Children's Registrars are employed under the *Public Sector Management Act 1988*, and can have any function of the Children's Court or of a Children's Magistrate conferred on them.[242] The Children's Registrars are attached to the specialist Children's Courts. They undertake both quasi-judicial and administrative functions. They conduct call overs and preliminary conferences, hear applications for adjournment, make procedural directions, assist in case management, and sometimes assist in ADR.[243] The Children's Registrars also conduct research and provide advice to the Children's Court on case flow management systems, listing and other practices.[244]

13.8 There are seven dedicated Children's Courts in NSW. These are: Parramatta Children's Court (six courts), Bidura Children's Court – Glebe (two courts), Campbelltown Children's Court, Woy Woy Children's Court, Wyong Children's Court, Broadmeadow Children's Court and Illawarra Children's Court – Port Kembla. The Children's Court currently has 13 Children's Magistrates.[245]

13.9 In regional NSW, the Local Court sits as a Children's Court (that is, it hears and determines matters that are within the jurisdiction of the Children's Court), and is presided over by either a Local Court Magistrate, or occasionally by a Children's Magistrate from one of the above Children's Courts. In 2007, there were 135 generalist Magistrates (including Children's Magistrates) located throughout NSW.[246]

13.10 The Senior Children's Magistrate has issued a number of Practice Directions relevant to care proceedings including: Practice Direction No.20 – Hearing dates and applications for adjournment (PD 20), Practice Direction No.25 – Requirement for conference of expert witnesses in Care Proceedings (PD 25), Practice Direction No.28 – Case management in the Care Jurisdiction (PD 28), and Practice Direction No.30 – Access to and Publication of Confidential Children's Court documents. Four Practice Notes have also been issued by the predecessor in the office of Senior Children's Magistrate.

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[241] *Children's Court Act 1987* s.16(1).

[242] *Children's Court Act 1987* s.10A.

[243] Local Court of NSW, *Annual Review 2007,* p.22.

[244] Children's Court: www.lawlink.nsw.gov.au/lawlink/children's_court.

[245] Transcript: Inquiry meeting with representatives from the Children's Court NSW, 12 December 2007, p.14.

[246] Local Court of NSW, *Annual Review 2007,* p.5.

13.11 In *KF v Parramatta Children's Court* [247] Hidden J held that Practice Direction 30 is *ultra vires* as it is inconsistent with the Care Act. The Inquiry understands that this decision is unlikely to be appealed by DoCS. While the Inquiry makes no comment in relation to the decision, there is a wider issue alive concerning the issue of general Practice Directions, so far as the Children's Court is concerned.

13.12 Its power in relation to making directions is derived from Rule 17 of the Rules, which provides as follows:

> *(1) In any proceedings, the Court may, in respect of any matter for which this Rule does not make provision, give any directions that it considers appropriate in connection with the practice and procedure to be followed in relation to that matter.*
>
> *(2) A practice direction given under this Rule that is inconsistent with:*
>
> *(a) the Act under which the Court has jurisdiction to hear proceedings in respect of that matter, or*
>
> *(b) any regulation under that Act,*
>
> *does not apply to the extent of the inconsistency*

13.13 The Inquiry interprets this provision as permitting directions to be made in relation to particular proceedings before the court. On its face it would not seem to authorise the issue of general practice directions. If this is correct, then all Practice Directions made in the Children's Court in relation to matters at large, are arguably, invalid. The Inquiry notes, by way of contrast, that the *Local Court Act 2007* empowers the Chief Magistrate to issue practice notes in relation to any matter with respect to which rules may be made, and establishes a Local Court Rule Committee which is empowered to make rules in relation to the practice or procedure of the Court.[248] The Children's Court does not have a similar authority to establish a Rules Committee with equivalent power to make rules, nor does it vest in the Senior Children's Magistrate any power to issue practice note or directions.

13.14 In this respect, while the functions of the Senior Children's Magistrate include a function, in conjunction with the Chief Magistrate to "develop Practice Directions and recommendations for rules" this would seem to fall short of authorising their issue. The authority to make rules for the practice and procedure of the Children's Court lies with the Governor.[249] It would appear, accordingly that as

[247] *KF v Parramatta Children's Court* [2008] NSWCA 1131.
[248] *Local Court Act 2007* ss.25-27.
[249] *Children's Court Act 1987* s.23.

the Act is currently framed, general Practice Directions would need to be incorporated in the Rules.

13.15 The Inquiry considers that this situation needs to be regularised in order to remove any doubt in relation to the validity of any practice directions or notes which the Court sees fit to issue.

13.16 The Inquiry recommends that the *Children's Court Act 1987* be amended to insert a provision similar to s.27 of the *Local Court Act 2007*, and that the Rules be reviewed to ensure that they are consistent with the *Children's Court Act 1987* and the Care Act, and that any Practice Directions or notes that are issued after amendment of the Act similarly accord with the legislation.

General procedure in care proceedings

13.17 Hearings in care proceedings are not public,[250] and consistent with provisions in relation to many tribunals that have been established in NSW, care proceedings are not to be conducted in an adversarial manner, and are to be conducted with as little formality and legal technicality and form as the circumstances of the case permit.[251]

13.18 Similarly, they should proceed as expeditiously as possible.[252] Legal practitioners and parties involved in care proceedings must do all they can to facilitate the just, quick and cost effective disposal of those proceedings.[253]

13.19 To aid this expeditiousness, hearing dates will not be vacated and adjournments will not be granted without "cogent and compelling reasons."[254]

13.20 The rules of evidence do not apply in care proceedings, unless the Children's Court determines that they should apply in a particular case.[255]

13.21 A recent amendment to the Care Act has resulted in a requirement that the Children's Court admit evidence that a parent (or primary care-giver) of a child or young person who is the subject of care proceedings has had a child previously removed from his or her care and not restored, or is a person who has been named or otherwise identified (by the coroner or a police officer) as a person who may have been involved in causing a reviewable death of a child or young person.[256]

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[250] *Children and Young Persons (Care and Protection) Act 1998* s.104B.

[251] *Children and Young Persons (Care and Protection) Act 1998* ss.93(1) and (2).

[252] *Children and Young Persons (Care and Protection) Act 1998* s.94.

[253] Children's Court NSW, *Practice Direction No.20*, *Hearing Dates and Applications for Adjournments in Criminal and Care Jurisdictions*, para.1.

[254] Children's Court NSW, *Practice Direction No.20*, *Hearing Dates and Applications for Adjournments in Criminal and Care Jurisdictions,* para.7 and 11; see also *Children and Young Persons (Care and Protection) Act 1998* s.94.

[255] *Children and Young Persons (Care and Protection) Act 1998* s.93.

[256] *Children and Young Persons (Care and Protection) Act 1998* s.106A(1). See Chapter 23 concerning reviewable deaths.

13.22 Such evidence is deemed to be prima facie evidence that the child or young person the subject of the care proceedings is in need of care and protection.[257] A parent or primary care-giver in relation to whom this evidence has been admitted can rebut the prima facie evidence by satisfying the Children's Court on the balance of probabilities that either:

> *(a) the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist, or*
>
> *(b) the parent or primary care-giver concerned was not involved in causing the relevant reviewable death of the child or young person.*[258]

13.23 All documentary evidence in care proceedings must be in affidavit form unless a Children's Magistrate or Children's Registrar directs otherwise. Affidavits must be written in the first person, must be divided into numbered paragraphs, and any extractions from other documents contained within or annexed to affidavits must be fair extracts.[259]

13.24 The usual procedure in relation to the evidence of witnesses is that the affidavit of the witness is tendered into evidence and is treated as being his or her 'evidence in chief'. The witness can be called to be cross examined on their evidence if the parties desire it. Leave may be granted to a party to supplement the affidavit evidence of a witness with further oral evidence, or to call a witness who has not sworn or affirmed an affidavit in the proceedings, if the Children's Court is satisfied that to do so would promote the interests of justice and the interests of the child or young person the subject of the proceedings.[260]

13.25 The standard of proof in care proceedings is on the balance of probabilities.[261]

Appellate structure

Appeals to the District Court

13.26 A party who is dissatisfied with a care order made by the Children's Court (other than an interim order) can appeal to the District Court against the order.[262] No review lies to the Supreme Court unless the case is one that would attract prerogative relief or invocation of the parens patriae jurisdiction.[263]

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[257] However, it was held in the matter of *SB v Parramatta Children's Court* [2007] NSWSC 1297 that evidence of a previous removal is not in itself a ground for determining whether a child or young person is 'in need of care.'

[258] *Children and Young Persons (Care and Protection) Act 1998* s.106A(3).

[259] Children's Court NSW, *Practice Direction No.28*, *Case Management in the Care Jurisdiction*, paras. 16 and 28.

[260] ibid., paras 17, 17.2, 17.3, 17.14.

[261] *Children and Young Persons (Care and Protection) Act 1998* s.93, see also *Re Sophie* [2008] NSWCA 250.

[262] *Children and Young Persons (Care and Protection) Act 1998* s.91.

[263] *Re Sophie* [2008] NSWCA 250.

13.27 An appeal to the District Court is by way of a new hearing, and fresh evidence (or evidence in addition to or in substitution for the evidence on which the care order was made) can be received. The Court may, instead of taking fresh evidence, admit into evidence the transcript of the Children's Court proceedings and any exhibits tendered.[264]

13.28 Statistics held by the District Court of NSW (the District Court) indicate that just over one per cent of all District Court lodgements were care proceedings appeals in 2005, 2006, and 2007. In 2005 there were 31 such appeals, increasing to 37 in 2006 and to 40 in 2007 with the average disposal time being 7.7 months. However, data provided by DoCS indicate the number of appeals in 2004/05 and in each successive year was 54, 92, 85 and 86. The Inquiry understands that the difference between the figures arise, in part, because DoCS' data concern workload, whereas the District Court's data relate to new matters commenced in that year.

13.29 The District Court was unable to provide the numbers of individual children and young persons involved in the appeals or the numbers of appeals relating to Aboriginal children and young persons.

13.30 Information held by DoCS indicates that between July 2002 and December 2007, 73 per cent of appeals were brought by the parent and 17 per cent by DoCS. The parent was successful in 39 per cent of the parent instituted appeals, and DoCS was successful in 66 per cent of the remaining appeals.

13.31 Of the 35 pending District Court care proceeding appeals as at 30 June 2007, three had been ongoing for at least 12 months, none for longer than 15 months and 18 for more than six months.

The Administrative Decisions Tribunal

13.32 The Administrative Decisions Tribunal's (ADT) Community Services Division has jurisdiction in relation to original decisions and reviewable decisions. In its original decision jurisdiction, applications can be brought by a prohibited person - that is a person convicted of sex offences or offences involving the use of violence against a child. A prohibited person is barred from working with children unless a declaration stating otherwise is made by the ADT. Before making such an order, the ADT must be satisfied that the applicant does not pose a risk to the safety of children.

13.33 Under s.245 of the Care Act, decisions reviewable by the ADT include decisions in relation to:

a. the authorisation of people as authorised carers for children or young persons in OOHC, and the cancellation or suspension of their authorisation

[264] *Children and Young Persons (Care and Protection) Act 1998* s.91(2) and (3).

b. the granting to, or removal from, an authorised carer of the responsibility for the daily care and control of a child or young person

c. the accreditation of agencies in relation to the conduct of OOHC services

d. the disclosure (or non-disclosure) by an agency conducting OOHC of high level identification information concerning the placement of a child of young person

e. the employment of children in the entertainment, exhibition and door-to-door sales industries

f. the transfer of a child protection order to another participating state.

13.34 Most of the decisions reviewed by the ADT concern the removal of children and young persons from foster parents and the cancellation or suspension of a foster parent's authority.

13.35 The number of applications for review of decisions made under the Care Act fell from 18 in 2006/07 to 17 in 2007/08. Twenty applications were filed under the *Commission for Children and Young People Act 1998* (the CCYP Act) in 2007/08, representing no change from the previous year. Approximately two thirds of all applications disposed of in the course of 2007/08 were determined in less than six months from the date of filing.[265]

13.36 Appeals in care matters from a decision of the ADT are heard by an appeal panel. Appeals under the CCYP Act, from a decision of the ADT, are heard by the Supreme Court. In 2006/07, two decisions made under the predecessor to the CCYP Act were appealed to the Supreme Court. Both were dismissed.[266] The Inquiry does not know the number of appeals (if any) from decisions made by the ADT under the CCYP Act in 2007/08.

13.37 The ADT advised the Inquiry that between 2002 and 6 February 2008, 22 matters were listed for mediation. Of these, three were vacated and listed for later in 2008, six settled and 11 did not settle.

The Supreme Court

13.38 The Supreme Court has jurisdiction to conduct a judicial review of administrative decisions made in the course of the management of matters arising in relation to the care and protection of children and young persons. Such jurisdiction is exercised in accordance with usual administrative law principles. Additionally it can intervene in the exercise of its' parens patriae jurisdiction (although subject to the limitations noted in *Re Elizabeth*[267]) as discussed in Chapter 11.

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[265] Correspondence: Administrative Decisions Tribunal, 7 November 2008.

[266] Administrative Decisions Tribunal, *Annual Report 2006/07*, p.21.

[267] *Re Elizabeth* [2007] NSWSC 29.

Legal representation in care proceedings

13.39 The following people have a right of appearance in care proceedings:

a. each child or young person who is the subject of the care proceedings

b. each person who has parental responsibility for the child or young person

c. the Director-General

d. the Minister.[268]

13.40 Each of these people may appear in person (if capable) or be legally represented.[269]

13.41 Other persons who, in the opinion of the Children's Court, have a genuine concern for the safety, welfare and well-being of the child or young person may, with the leave of the Children's Court, appear in care proceedings (in person or through a legal representative).[270]

13.42 Section 99 of the Care Act allows the Court to appoint a legal representative to act for a child or young person who is the subject of proceedings brought under the Care Act (Care Proceedings). There is a rebuttable presumption under the Care Act that a child aged less than 12 years is not capable of giving proper legal instructions.[271]

13.43 A legal practitioner will act as an Independent Legal Representative if the child is younger than 12 years or if a guardian ad litem (see below) has been appointed. Such a representative is often referred to as a 'separate representative.' A practitioner appointed to represent a child or young person 12 years of age or older, for whom a guardian ad litem has not been appointed, will act as a Direct Legal Representative, on the instructions of child or young person.[272] If a guardian ad litem has been appointed the legal representative will act on that person's instructions.[273]

13.44 Appointments of Independent Legal Representatives and Direct Legal Representatives in care proceedings are referred to the LAC and the work is allocated to a practitioner who is either employed by the LAC, or engaged by it on its Care and Protection Panel.[274] The Panel is comprised of private practitioners who have been accepted by the LAC as being eligible to carry out legal work in care proceedings. Generally, they need a demonstrated knowledge and experience in the conduct or preparation of matters under the

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[268] *Children and Young Persons (Care and Protection) Act 1998* s.98(1).

[269] *Children and Young Persons (Care and Protection) Act 1998* ss.98(1) and (2).

[270] *Children and Young Persons (Care and Protection) Act 1998* s.98(3).

[271] See *Children and Young Persons (Care and Protection) Act 1998 (NSW)* ss.99A, 99B and 99C.

[272] See *Children and Young Persons (Care and Protection) Act 1998 (NSW)* ss.99A, 99B and 99C.

[273] *Children and Young Persons (Care and Protection) Act 1998* s.100(4).

[274] Children's Court NSW, *Practice Direction No.28 Case Management in the Care Jurisdiction,* para.10.1.

Care Act. Successful applicants are appointed to the Panel for up to five years.[275]

13.45 The key difference between the two types of representation is that the Direct Legal Representative acts on the instructions of the child or young person, while the Independent Legal Representative acts in the best interests of the child or young person.

13.46 There is currently no requirement that legal practitioners appearing in care proceedings undergo any specialist training or have any specialist accreditation. However, Panel members must complete at least five Continuing Legal Education points (equivalent to five hours of face to face learning, or 10 hours of video or online learning) each year in courses relevant to their practice in care proceedings.[276]

13.47 The absence of a specialist training requirement to be an Independent Legal Representative or Direct Legal Representative, is in contrast to the eligibility to be a children's representative in the family law jurisdiction.

13.48 Eligibility to become a children's representative in the family law jurisdiction requires, *inter alia*, participating in a compulsory two day National Training Program.[277]

13.49 The LAC annually conducts a one day training course in Care and Protection Law, which it offers to its in-house solicitors and current Panel members. DoCS also conducts a single day of training to legal practitioners who are on its panel. Apart from this (and from any Continuing Legal Education courses that might be offered by various institutions from time to time), the Inquiry does not know of any training courses currently available that are specifically targeted at practising in care proceedings. It is noted that the Children's Court facilitates a mentoring program to provide Independent Legal Representatives with advice and assistance in relation to their role.[278]

13.50 The Law Society offers specialist accreditation in various areas of the law. A practitioner wishing to become an accredited specialist must have completed at least five years of full time practice, and at least three years of work in the area of specialisation. In addition, the practitioner must pass exams in communication, problem solving, client service, and the law. The Law Society asserts that the benefits of specialist accreditation include:

a. offering the public and the profession a reliable means to identify a practitioner with proven capability in a specific area of law

b. encouraging improvements in the quality and delivery of legal services

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[275] Legal Aid NSW, *The Panels Process*, www.legalaid.nsw.gov.au.

[276] Legal Aid NSW, *Care and Protection Practice Standards*, November 2007, p.8.

[277] Legal Aid NSW, *Panel for Independent Children's Lawyers, Information for new applicants,* p.2.

[278] Children's Court NSW, *Mentoring Program,* www.lawlink.nsw.gov.au/childrenscourt.

c. providing practitioners with an incentive and opportunity to increase their competency in their chosen area of law.[279]

13.51 Children's Law is one of the areas in which specialist accreditation is periodically offered.[280] However, the Law Society informed the Inquiry that accreditation in Children's Law has not been offered for a number of years, and that when it will next be offered depends on market interest. DoCS has however informed the Inquiry that it understands from the Law Society that specialist accreditation in children's law will be next offered in 2009.

Guardians ad litem

13.52 Under s.99C(2) of the Care Act, the Children's Court can, on the application of a legal representative for a child or young person who is older than 12 years, make a declaration that the child or young person is not capable of giving proper instructions. In such cases, the Children's Court will generally appoint a guardian ad litem for the child or young person under the provisions of s.100 of the Care Act.

13.53 The Children's Court can also appoint a guardian ad litem for a child or young person over the age of 12 years, if the Court is satisfied that there are special circumstances that warrant the appointment of a guardian ad litem, or that the child or young person will benefit from that appointment.[281]

13.54 The Court can appoint a guardian ad litem for the parent of a child or young person the subject of care proceedings if it is satisfied that the parent is incapable of giving proper instructions to his or her legal representative,[282] or request the legal representative to act as *amicus curiae*.

13.55 Where any party seeks to appear in person, the Children's Court can require that person to be legally represented if it is satisfied that he or she is incapable of representing him/herself. If the Court is also satisfied that such a person is incapable of giving proper instructions to his or her legal representative, it can appoint a guardian ad litem to instruct that party's legal representative.[283]

13.56 The Inquiry was informed that a guardian ad litem appointed in care proceedings is entitled to retain a solicitor, who will be funded by the LAC. In situations where a guardian ad litem has been appointed for a child or young person, the legal practitioner representing the child in the proceedings will in fact act on the instructions of the guardian ad litem.[284]

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[279] Law Society of NSW *Specialist Accreditation Scheme*, *Guide to Application and Assessment*, 2008, p.4.
[280] ibid.
[281] *Children and Young Persons (Care and Protection) Act 1998* s.100(2).
[282] *Children and Young Persons (Care and Protection) Act 1998* s.101.
[283] *Children and Young Persons (Care and Protection) Act 1998* s.98 (2) and 98(2A).
[284] *Children and Young Persons (Care and Protection) Act 1998* ss.99D(b)(i) and 100(4).

13.57 The Children's Court may require that a guardian ad litem provide written evidence of their views and of the instructions that they have given to the legal representative acting for the child, young person or parent for whom the guardian ad litem has been appointed. This evidence may be provided by way of affidavit (which would be prepared by the solicitor), or by way of a report prepared by the guardian ad litem.[285]

13.58 All guardians ad litem, upon appointment by the Children's Court, are given access to the Court's file in relation to the care proceedings.

Issues arising

Initiating process and affidavits

13.59 DoCS submitted that the requirement that evidence be submitted by way of affidavit is unduly legalistic, and stated:

> *No other Australian care jurisdiction has this requirement for the submission of all evidence to be included in an affidavit, for example, as part of the innovations within the Family Court, the Magellan Project allows for the information to be supplied by the child welfare agency by way of a report. Similarly, the Family Court's practice in children's matters is to initially ask the parties to identify what is agreed and what is in dispute and then affidavits are only allowed to be filed about issues in dispute.*[286]

13.60 According to DoCS lawyers, the use of affidavits is contrary to a holistic approach to child protection work.

13.61 The LAC submitted that affidavits might not be the best way to ensure that all relevant information is put before the Court. It stated:

> *An alternative might be to consider simpler documentary requirements at first instance (that is, when the care application is first filed), provisions for discovery of the DoCS file, and directions for the filing of affidavits (and the matters to be addressed in those affidavits) when it is clear that the matter is proceeding to a defended hearing.*[287]

13.62 The Children's Court favours the use of affidavits (indeed, it is the Children's Court's Practice Direction that requires that affidavits are used), but stated:

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[285] Children's Court Clinic, *Guardian ad Litem Handbook*, para.3.4.

[286] Submission: DoCS, Operation of courts in the child protection system (abridged), p.12.

[287] Submission: Legal Aid NSW, 20 February 2008, p.44.

It would be very helpful if the Department of Community Services were prepared to be more economical and selective in the matters contained in its affidavits that, from the Court's point of view, frequently are far too long and contain far too much information, a great deal of which is unreliable.[288]

13.63 The combination of ss.61(2) and 68 of the Care Act (which require that DoCS specify the orders that it seeks in its application and that leave be sought before further documentary evidence can be filed) and cl.21 of the Rules (which requires that an application be accompanied by an affidavit supporting the orders sought) has resulted in the general view that DoCS is required to file the entirety of its evidence at the outset of care proceedings. Further, altering the orders sought, and filing further evidence, can only be done with the leave of the Court.[289]

13.64 A representative from the LAC informed the Inquiry that DoCS makes ambit claims, although she conceded that the legislation might be the cause of this.[290] She said that DoCS often sets out "as much as possible of the most damning evidence it has,"[291] and that, especially in matters where DoCS does not ultimately seek long term orders for parental responsibility, this process of making an ambit claim "gets everyone sort of tense and anxious unnecessarily."[292]

13.65 The LAC informed the Inquiry that in many cases DoCS does not specify the actual final orders it will seek until shortly before the final hearing. This statement is to some extent supported by the results of the LAC's own survey of care proceedings in which it was involved that were finalised between 1 January and 31 March 2008. The LAC informed the Inquiry that this survey indicates that it was in only 17 out of the total of 58 cases, that DoCS specified the exact orders it would finally seek at the commencement of the proceedings. In 12 cases, it specified the exact orders it would finally seek either at the preliminary conference or in a Care Plan filed before the preliminary conference. In 29 cases, it specified the exact orders it would finally seek after the Care Plan had been filed (this number includes seven cases in which DoCS did not specify the exact orders it would seek until the commencement of the final hearing).

13.66 The Children's Court, while supporting the continued use of affidavits, stated:

It might be more useful if the Director-General were to present to the Court on that first day only sufficient material to allow the case to be established and to support his application for interim care orders and, thereafter, to make the DoCS file available for inspection by the child representative and the legal

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[288] Submission: Children's Court NSW, 14 January 2008, p.16.

[289] *Children and Young Persons (Care and Protection) Act 1998* ss 61(3) and 68.

[290] Transcript: Inquiry meeting with representatives of Legal Aid NSW, 8 February 2008, p.23.

[291] Submission: Legal Aid NSW, 20 February 2008, p.44.

[292] Transcript: Inquiry meeting with representatives of Legal Aid NSW, 8 February 2008, p.23.

representatives of the parties. Discussions along those lines are underway by 'the working party' made up of representatives of the Department of Community Services, the Attorney General's Department, Legal Aid NSW and the Court.[293]

13.67 DoCS stated:

An alternative approach would be to file a far more limited document that merely addressed the evidence to support a determination that the child is in need of care and protection and interim orders. Detailed material to support final orders could then be filed at a later time in the process allowing greater time for deliberation and consultation over the proposals.

By requiring DoCS to file all material at the commencement of proceedings, DoCS is often unaware at that time as to the final orders which may be sought and will not have received the benefit of hearing from the child or the child's family. This means that DoCS must file comprehensive material to cover all possibilities. In filing any material that might be held, irrespective of whether it is later relied upon, DoCS can antagonise the child's family and induce unnecessary argument and anxiety. This can add to the adversarial nature of the proceedings.[294]

13.68 DoCS recommended:

a. Dispensing with the requirement that DoCS must file all material at the commencement of the proceedings.

b. Simplifying court documentation and recognising the constraints of time in preparing such documents.

c. Simplifying documents required to commence proceedings so that the information provided supports a determination that the child is in need of care and protection and interim orders. Detailed material to support final orders could be filed at a later date.[295]

13.69 A retired Children's Magistrate informed the Inquiry:

A procedure where DoCS only files minimum evidence at the outset and perhaps in (unsworn) report form is something of a return to the processes under the 1939 Act. This often placed the Court in a difficult position when considering making interim orders. Magistrates were faced with conflicting submissions

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[293] Submission: Children's Court NSW, 14 January 2008, p.16.

[294] Submission: DoCS, Operation of courts in the child protection system (abridged), pp.13.

[295] ibid., p.34.

> *from the bar table with little reliable evidence. Sometimes there were requests for officers to be cross-examined on reports.*
>
> *….the notion that there be full disclosure (or discovery) to the parties but only selective evidence to the Court (being only that which is essential for that stage of the hearing process reached), may reduce the volume of the court files but is also a slippery slope towards the Court actually being misled by omission.*[296]

13.70 The Inquiry is persuaded that the requirement for affidavit evidence, and all material relied upon, to be filed at the beginning of the proceedings is ultimately not in the best interests of the children and young persons for whom the system operates.

13.71 The Inquiry is of the view that applications by DoCS should be by way of report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child or young person is in need of care and protection and any interim orders sought. Where further evidence dealing with matters in dispute is necessary the Court can give directions as to how that evidence is to be adduced, once those matters have been identified.

13.72 The Inquiry is keen to see the system move towards a more holistic and less incident based response. Changing the initiating process in this way should reduce the 'legalism' associated with care proceedings, ease the anxiety of caseworkers caused by preparing lengthy affidavits and lessen tension between DoCS and the family by not commencing with an 'ambit' claim.

13.73 In relation to the requirement that DoCS indicates in its application the particular care order sought, the Inquiry is of the view that this provision should remain, as it permits all parties to understand the position taken by DoCS. It should not be onerous on DoCS as it should have formed the requisite opinion by the stage of instituting proceedings.

13.74 The Inquiry is troubled by the use of the 'ambit' claim as asserted by the LAC. It will not enhance any early resolution of the matter and may well alienate the parents, or their lawyers. DoCS should refrain from its use. Where preliminary conferences work as intended (see the previous chapter) the final orders sought by DoCS should be made known to the other parties at least one week prior to the preliminary conference.

13.75 The reliability of some of the material supporting the application will be an issue, regardless of whether it is in the form of an affidavit or a report. The nature of the jurisdiction is such that reports of risk of harm are nothing more than assertions by the reporter. The veracity of the material contained in the report

[296] Submission: John Crawford, 29 February 2008, pp. 2-3.

will still be able to be tested and its form should not impede the Magistrate's decision making.

13.76 There is merit in making the DoCS files available to parties to the proceedings shortly after an application is made. The Inquiry understands that the work involved in masking the identity of reporters before providing access to the file can be considerable. However, to provide the files as a matter of course, obviates the need for subpoenas, gives all parties the opportunity to know the available information and rely on it as necessary, and reduces the likelihood of allegations of skewed affidavits by DoCS (see below).

13.77 Alternatively, DoCS might provide specified documents which may include previous court orders and reasons for decision, minutes of key meetings, any assessment or other expert reports. Whichever solution is adopted should improve the process and relationships.

Evidence in relation to emergency removals

13.78 Many DoCS caseworkers, and the PSA, informed the Inquiry of the difficulties in drafting an affidavit within hours of an emergency removal.

13.79 The Children's Court submitted:

> *The statutory requirement that DoCS file an affidavit within 24 hours of its removal of a child from the care of his/her family…is designed to ensure that the State does not arbitrarily remove children from the care of their parents and that it acts with proper cause. It is submitted, in the circumstances, that the inconvenience to DoCS officers is justified particularly since all that is required to support an Emergency Care and Protection Order is a brief affidavit outlining an immediate risk. The resulting emergency care and protection order will "hold the ring" for a fortnight giving DoCS a further period in which to prepare its affidavit as to the need of care and protection which will ground its s.61 care application.*[297]

13.80 A former Children's Magistrate submitted that amending the legislation to allow for a three working day period in which to file an emergency application could be desirable in that it would allow for better preparation of evidence.[298]

13.81 As the Inquiry understands it, the length of time prior to a court determining the needs of a child, in relation to an emergency removal, varies from jurisdiction to jurisdiction. In some jurisdictions, an application must be made within one

[297] Submission: Children's Court NSW, 21 April 2008, p.2.
[298] Submission: John Crawford, 13 February 2008, p.1.

working day or eight hours[299], 48 hours,[300] in some 72 hours,[301] in some 10 days.[302] A Judge in Manitoba, Canada stated that the timing should:

> *Achieve a constitutional balance between the need for interim measures to protect the child at risk of serious harm and a requirement for an expedited post apprehension hearing process.*[303]

13.82 NSW seems to have one of the shortest timeframes. The Inquiry is aware that Professor Parkinson recommended the provision which now appears in the Care Act, which involved a change from the 1987 provision which permitted an application within 72 hours. While the Inquiry understands the policy underpinning the current provision, it is of the view that the timeframe should be extended to 72 hours, in order to properly put the evidence before the Court, and that such an extension would not infringe the balance set out above.

Expedition

13.83 DoCS informed the Inquiry:

> *The duration of court proceedings is important for a child. Not only is the process stressful for the child and will disrupt other important activities (such as schooling, for those of that age) but pending the making of final orders, it defers the implementation of plans for the long term stability of the child and the formation of new stable, nurturing and loving relationships where these might be necessary.*[304]

13.84 A number of submissions similarly described the deleterious effect that waiting for final orders has on children. The Children's Court agreed.

13.85 Most submissions that referred to the length of care proceedings favoured shortening, to the extent possible, the time taken to complete proceedings and reach a final decision about the child's future care.

13.86 DoCS informed the Inquiry:

> *For the very young child, the best evidence available to this Department is that long term arrangements should be in place within six months.*[305]

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[299] *Children, Youth and Families Act 2005* (Vic) s.242(2) and *Child Protection Act 1999* (Qld) s.18(5) and (7).

[300] *Los Angeles County Department of Child Services v Superior Court* (1988) 200 CalApp3d505 cited in DoCS, Intranet, *Topic 15: Emergency removal of children for their care and protection*, p.17.

[301] *Jordan v Jackson* (1994) 15F3d333.

[302] *State X REL Miller v Locke* (1979) 253SE2d540.

[303] *Winnipeg Child and Family Services v Child and Family Services v W(KAL)* (2000) 191DLR (iv) 1 at [127].

[304] Submission: DoCS, Operation of courts in the child protection system (abridged), p.9.

[305] ibid.

13.87 DoCS stated that the duration of the process might be shortened if the process itself was trying to achieve less, and therefore stated "limiting of the Court's jurisdiction might permit earlier final orders – to the benefit of the child."[306]

13.88 Other submissions pointed to the procedural and practical problems which were thought to prolong proceedings. A legal practitioner who was present at the Public Forum in Wagga Wagga stated that in regional areas, there can be long delays in the court process due to the length of time between sittings. She said:

> *In regional areas where there are circuit courts… courts don't sit every day in that particular location. For example, in the Griffith circuit, where parties have their children removed, they face the disadvantage of either having to wait a longer period of time than anticipated in the legislation to have their matter come back before the court. Alternatively, which is often what is happening, if we seek to have the matter listed within the circuit, then they have to travel numerous hours in regional areas where no public transport is available in order to have that decision reviewed at an earlier stage.*[307]

13.89 Another legal practitioner present at the Wagga Wagga Public Forum said that she has experienced delays in proceedings due to DoCS not filing evidence on time.

13.90 A DoCS officer from a CSC in Southern Region described delays as a result of the actions of parents not attending Court or awaiting legal representation, or the granting of adjournments by the Court. She also said that matters are being delayed on account of legally aided practitioners lengthening the process for financial reasons. She said:

> *One solicitor said to me that if they offer up a draft minute of care then Legal Aid will pay them more money, so they will ask for an extra week's adjournment so that they can offer up a draft minute of care which is nearly identical to the Department's, but maybe has two or three different words in it, so then that means that the case has to take an extra week in court.*[308]

13.91 Another DoCS officer from a Northern Region CSC informed the Inquiry that care matters before the Children's Court are continually adjourned due to parents not filing their evidence.

13.92 The PSA stated:

> *The inefficiency of the court system is a constant frustration for caseworkers. The court expects (caseworkers) to adhere to*

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[306] ibid.

[307] Transcript: Public Forum, Wagga Wagga, 11 March 2008 pp.3 and 4.

[308] Transcript: Inquiry meeting with DoCS staff, CSC Southern Region.

timeframes, but then does not adhere to its own time restrictions, leading to inefficiencies in caseworkers' time. For example, caseworkers report that it is not unusual for there to be five or six caseworkers waiting all day in court for their matters to be heard.[309]

13.93 The Inquiry received a submission from a DoCS caseworker in relation to the difficulty in determining the prospects of restoration within a short timeframe. She stated:

On many occasions, the timelines set by the Children's Court seem to be unrealistic, in my experience. Once a determination is made that the child is in need of care and protection, the Director-General has three weeks in which to file and serve his Care Plan. Where a family has been known to the Department for some time, this deadline is not usually a problem. Where a family has just become known to the Department, the deadline provides no leeway for the parents to demonstrate whether or not there is a realistic possibility of restoration. It is often frustrating for managers and caseworkers to make a well thought out, appropriate recommendation for final orders for the child.[310]

13.94 The Inquiry is of the view that expedition is in the best interests of children and young persons, however, not at the expense of a fair, considered hearing. There should be no changes to the processes solely to reduce the time taken.

Movement of hearing dates

13.95 DoCS stated that listing dates in the Children's Court shift so that court rooms and Magistrates are constantly occupied:

Dates for hearing are often moved between courts and even moved to earlier dates. Consideration is rarely given to the availability of legal representatives, instructing caseworkers or witnesses or to the need to maintain continuity of legal representation. This leads to hearings being conducted by legal representatives with less than 24 hours notice. It is now the full time work of a clerical officer within DoCS Legal Services to do nothing but re-arrange timetables and locate lawyers who may be able to handle matters at the last moment.[311]

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[309] Submission: Public Service Association, 17 March 2008, p.8.

[310] Submission: DoCS current staff member, p.3.

[311] Submission: DoCS, Operation of Courts in the child protection system (abridged), p.11; Transcript: Public Forum, Role of Courts, 22 February 2008, p.18.

13.96 DoCS recommended that the Children's Court adhere to the principles of continuity in judicial and legal representation, given the specialist nature of the jurisdiction and the significant impact court orders will have on the lives of children, young persons and their families.

13.97 The LAC also cited the movement of hearing dates without regard to the availability of children's solicitor. A representative informed the Inquiry:

> *Those children have a relationship with that lawyer; they know that lawyer and that lawyer knows them. To have another lawyer turn up at a hearing because their lawyer isn't available is inappropriate for those children.*[312]

13.98 The LAC also said that the Court's desire to expedite proceedings was leading to listing problems and a lack of predictability.

13.99 A representative from the Aboriginal Legal Service, who had also experienced alterations to court dates and locations, said that this was problematic for Aboriginal people, stating "continuity is particularly important to Aboriginal people."[313]

13.100 As stated earlier in this chapter, expedition is important in this jurisdiction, but not at the expense of a fair hearing in which a party can be represented by a lawyer with whom they have developed a relationship. The Children's Court should reconsider its practice of moving cases to different courts and on different dates at short notice.

13.101 In addition, the Inquiry considers that the Children's Court should reconsider its listing practices in its criminal and care jurisdictions in relation to callover days and mentions, by listing cases in successive time brackets, so as to avoid the need for practitioners, caseworkers and families to remain at the Court for unnecessarily lengthy periods waiting for their cases to be called up for what can be quite brief hearings.

'Adversarial' Proceedings

13.102 The Inquiry received a number of submissions stating that care proceedings are, or are increasingly becoming, 'adversarial', or that legal practitioners and DoCS were behaving in an 'adversarial' manner. It was not always clear what was meant by 'adversarial', and it seems likely that the term means different things to the different people who used it. The definition of the term is likely to cover everything from the mere testing of evidence in court, the presence of a number of legally represented parties, to combative, hostile and point scoring behaviour. It may relate to procedures, processes or the conduct of participants.

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[312] Transcript: Public Forum, Role of Courts, 22 February 2008, p.20.

[313] ibid.

13.103 DoCS characterised an adversarial approach as being akin to a contest between competing interests. DoCS stated that adversarial approaches do not assist families, carers and officers of welfare agencies in building cooperative working relationships, and can make it "almost impossible" in many cases for caseworkers to continue working with the family of the child who is the subject of the proceedings.[314] DoCS further stated:

> *Child protection is not (or should not be) about balancing competing interests. It is about identifying the risk(s) to a child and protecting that child from the risk(s). An adversarial contest is unlikely to be the best way to arrive at a sound decision on such issues.*[315]

13.104 DoCS recommended that the Children's Court adopt 'less adversarial court procedures' as trialled in other courts, such as the Family Court (discussed in the previous chapter).

13.105 The Ombudsman characterised the adversarial approach of lawyers as being "to vigorously represent the interests of their clients"[316] and stated:

> *It must be said that such an approach does not necessarily assist in facilitating the conduct of care proceedings in a way that promotes the best interests of children.*[317]

13.106 During a meeting with the Inquiry, a representative from the LAC stated:

> *The word 'adversarial' has some very difficult connotations. It is put as a very bad thing. But if it means that cases are being run properly, that evidence is being required, that the decisions are being based on appropriate evidence and therefore are in the best interests of those children, I don't see that as being a bad thing.*[318]

13.107 However, the LAC was critical of DoCS appealing Children's Court decisions, an approach it described as adversarial.

13.108 A barrister practising in care proceedings informed the Inquiry that the child protection system would be improved by giving properly trained Magistrates "more inquisitorial powers."[319] The PSA also submitted that the Children's Court should be inquisitorial rather than adversarial. Similarly, Women's Legal Services stated:

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[314] ibid., p.13.

[315] Submission: DoCS, Operation of courts in the child protection system (abridged), p.5.

[316] NSW Ombudsman, *Care Proceedings in the Children's Court: A discussion paper,* July 2006, p.36.

[317] ibid.

[318] Transcript: Legal Aid NSW, 8 February 2008, p.17.

[319] Submission: a barrister, p.1.

> *The Children's Court does not function in the non-adversarial manner legislatively required. This is perhaps inevitable, given…the Act does not substitute an adversarial model by assigning an inquisitorial role to the Court. In the absence of this, it is unsurprising that the Children's Court defaults into an adversarial role.*[320]

13.109 Women's Legal Services also stated that care proceedings are 'legalistic' in that practitioners and the Court use 'jargonistic language,' which can 'disempower' parties to the proceedings.[321]

13.110 The Inquiry was informed by DoCS caseworkers and legal officers in every non-metropolitan region, that care proceedings in those regions are being conducted in an increasingly adversarial manner.

13.111 A DoCS legal officer in a CSC in Western Region stated:

> *Every step of the way sometimes is a big battle. Interim orders go to hearing quite often to establish the child's in need of care goes to hearing…Contact, in particular, is becoming more adversarial in court.*[322]

13.112 DoCS caseworkers in different CSCs in the Southern Region informed the Inquiry that there had been a recent increase in the number of cases in which 'establishment' is contested (that is, there is a contest in relation to whether the relevant child or young person is in need of care or protection).

13.113 There can be little doubt that there is much concern amongst stakeholders about the way in which care proceedings are conducted. However, for reasons already discussed, use of the word 'adversarial' is ultimately not very helpful.

13.114 The Inquiry agrees that the model of a judicial officer balancing competing interests is not an appropriate one in this jurisdiction. However, it is also the case that the consequences of the decisions made in care proceedings on families and children are enormous. There should be testing of evidence, there should be legal representation and it is appropriate that both DoCS and representatives for children and families vigorously seek to obtain an outcome in the best interests of children. However, it is clear that practice and procedure in this area requires change and improvement, and recommendations to this end are made later in this chapter.

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[320] Submission: Women's Legal Services, p.4.

[321] ibid.

[322] Transcript: Inquiry meeting with DoCS staff, CSC Western Region.

Rules of evidence

13.115 Rules of evidence place limits on the information that can be considered by a court, but also assist the court in determining the strength and reliability of the information that is before it.

13.116 The Inquiry received some submissions in relation to some of the consequences of non-application of the rules of evidence in the Children's Court.

13.117 The Children's Court stated:

> *It doesn't matter if material complies or fails to comply with the rules of evidence. What matters is whether, acting protectively, the court can place some reliance on the material. It is a feature of the information provided to the court on behalf of the Director-General that it may include anonymous, and sometimes unreliable and occasionally malicious and/or quite incredible reports which have been made to the Department and then handed on to the Court. It is another feature that many of these reports will never have been closely investigated or examined by departmental offices before handing them on to the court. It is not the approach of the court to ignore those reports simply because they are hearsay or anonymous or vague or deal with 'historical' matters but it is necessary, in order to avoid error and the possibility of making unnecessary or inappropriate care orders to the ultimate disadvantage of the child or young person, to sift the material carefully in order to arrive at the truth.*[323]

13.118 A barrister practising in care proceedings informed the Inquiry:

> *Evidence is almost never excluded because it is not in proper form. The increase in 'paper' may have been at the behest of the Senior Children's Magistrate who has been properly concerned about how he is to find 'facts' when there is no-one with first hand evidence to contradict a parent's denial of neglect or abuse.*[324]

13.119 The PSA stated that the 'standard' and 'level' of evidence expected by the Children's Court in care proceedings is too high.[325]

13.120 The Inquiry agrees with the approach set out above by the Senior Children's Magistrate. From the various transcripts the Inquiry has reviewed, it is satisfied

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[323] Submission: Children's Court NSW, 14 January 2008, p.16.

[324] Submission: a barrister, p.1.

[325] Transcript: Inquiry meeting with representatives of the Public Service Association, 9 January 2008, p.25.

that the Court appropriately applies ss.93(3) and (4) of the Care Act in relation to the rules of evidence and standard of proof.

A model litigant?

13.121 During the course of the Inquiry, it was frequently asserted in submissions and during Public Forums that the affidavits sworn by DoCS caseworkers and tendered in Court did not always contain all relevant material in DoCS possession. In particular, it was asserted that material favourable to the opposing party, and material that was not consistent with DoCS' application was omitted from some DoCS affidavits.

13.122 It is obviously of critical importance to the court system that government agencies with a statutory responsibility to bring applications in relation to care and protection do so fairly and objectively. Accordingly, the Inquiry was concerned to receive evidence supporting these assertions. The assertions were made by lawyers as well as by parties to proceedings.

DoCS affidavits

13.123 Some submissions stated that in some cases, DoCS caseworkers select only the information supporting the DoCS case for inclusion in their affidavit. A solicitor who was present at the Public Forum in Nowra informed the Inquiry that in his experience DoCS was selective about the material it put into its affidavits. He stated:

> *In my experience, they very selectively put material before the court that's prejudicial to the parents. If I subsequently subpoena the DoCS file, I'll find a whole lot of things that are very useful, for instance, that the parents aren't really the parents from hell, but that doesn't go into the DoCS affidavits. It seems to me that they've actually usurped the role of the magistrate. It is up to the magistrate to decide whether or not the children should return home or not. It's actually the department doing all they can to make sure that they decide it by only feeding selected material to the magistrate.*[326]

13.124 The Inquiry sought documents from this solicitor as well as material and a response from DoCS. The Inquiry's examination of the documents from the two sets of proceedings in relation to which the solicitor provided documents, revealed the following:

a. There was information favourable and unfavourable to DoCS application which was omitted from an affidavit tendered by DoCS.

b. One DoCS affidavit selectively quoted from a report, however that report was annexed in full to the affidavit.

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[326] Transcript: Public Forum, Nowra, 13 May 2008, p.19.

c. In the same affidavit, the caseworker inaccurately quoted from a report by an expert. That report was separately tendered to the Court and the caseworker acknowledged to the Court, via the lawyer representing DoCS, the inaccuracy. Unfortunately, however, in the ultimate judgement by the Court the inaccurate reference in the affidavit was relied upon by the Magistrate.

d. In relation to the other matters raised by the solicitor, they were either not supported by the material reviewed by the Inquiry or there was insufficient information available for the Inquiry to form a view.

13.125 However, as illustrated by various submissions to the Inquiry, a lack of attention to detail can be perceived as DoCS selectively presenting a position and, at the least indicate poor practice.

13.126 The LAC informed the Inquiry:

> *DoCS does not always present all the evidence of which it is aware when filing evidence in support of its positions. Affidavits filed by DoCS in support of its position that the child is 'in need of care and protection' and/or in support of the final orders that it is seeking can set out all of the 'bad' and none of the 'good', all of the 'weaknesses' and none of the 'strengths' of the parents. Summaries of other documents that are contained in these affidavits can minimise or even omit altogether evidence that would paint the parents in a better light. These practices mean that DoCS' case often contains only that evidence that supports its own position and omits evidence of which it is aware that might support the parents' or child representatives' positions.*[327]

13.127 The Inquiry spoke with a group of six experienced and well regarded barristers and solicitors who regularly appear in the care jurisdiction (both for DoCS and for other parties). In relation to representing DoCS, one said:

> *It is the approach of the Department, and it's an endemic problem, that we must prove our case; we must only marshall the evidence that will support us; and we must ignore or not produce the evidence against us ….*
>
> *I'm not saying it's deliberate. It is an endemic policy that seems to be within the Department itself. It is not individual officers …*
>
> *That has been my experience. When I act for the Department, I say, "Our position is to provide all relevant information - good, bad or ugly - to assist the Court in reaching the most proper decision." I know my colleagues certainly will do the same, but*

[327] Submission: Legal Aid NSW, 20 February 2008, pp.48-49.

I will disclose information that I know does not advance my case and might be adverse to it because I see an obligation as a representative of the Department to provide all relevant information to the court and to the parties that touches upon the issue to be determined …

They often selectively quote from reports instead of producing the whole report.[328]

13.128 Another, in relation to acting for the child or young person, said:

One of the functions is that really you must subpoena the DoCS file. When you do that and you go through the file, invariably you find that there is a mountain of material plus and minus. Sometimes DoCS says that you should be restoring; then you find a huge amount of material as to why it should not be, or vice versa.[329]

13.129 As part of its investigation, the Inquiry sought the views of a number of caseworkers employed by DoCS throughout the State. The information they provided ranged as set out below, however it emerged that among at least some of those workers, there was a belief that they are required to place before the Court only that material which is favourable to their application.

13.130 At one end of the spectrum caseworkers in CSCs in the Hunter/Central Coast, Western and Southern Regions, and a legal officer from a Hunter/Central Coast CSC, informed the Inquiry that casework managers ensure that caseworkers tell the 'whole story' in their affidavits.

13.131 Other DoCS caseworkers had a different approach. In a Hunter/Central Coast CSC, one caseworker stated that DoCS caseworkers skew the evidence they put into their affidavits in order to support their case:

I believe that we do skew them towards the Department's point of view. And I know there are people sitting in this room that would not agree with me because we have had that discussion about the fact that we do tend to present the Department's case which, as I have been informed, is our job regardless of whether we agree with what we are presenting, that our job is to present it to the Court.[330]

13.132 Another said:

My training was 22 years ago and it was very different then and caseworkers are constantly retraining me on how it's supposed

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[328] Transcript: Inquiry meeting with lawyers specialising in care and protection matters, 12 March 2008, p.36.
[329] ibid.
[330] Transcript: Inquiry meeting with DoCS staff, CSC Hunter/Central Coast Region.

to be done now, but very much for me the basis of an affidavit is to provide evidence to the Court to support the action that the Department has taken. It needs to talk to why the child is in need of care and protection. It doesn't need to provide every single thing we've ever done with the family and in fact if we include that, the legal support officer will take it out because affidavits shouldn't be too long. They're too difficult for the Magistrate and the solicitor's to read if they're 25 pages long.[331]

13.133 The following exchange took place during a meeting with DoCS officers:

Counsel Assisting: If there's material which suggests, by way of a report of other information available to you, that the parents or mother is actually capable and competent to look after the child and there is no need of care and protection, it is clearly a piece of information you've taken into account and in the overall scheme discounted to have come to the view that an application was necessary, but is that the sort of information you would put in your affidavit?

Caseworker: I'm not sure. I can't think of a time when we'd do that. We'd certainly encourage the mother to put that before the Court herself as part of her evidence. We wouldn't discount it, but it probably wouldn't form part of our evidence.[332]

13.134 The following exchange took place during another meeting with DoCS officers:

Caseworker: I think when we first got the solicitors on board, which was only in recent times, initially it became very adversarial and it became very much you had to win your case, so you only put the stuff that backed up our arguments. We fought that and I think we won.

Counsel Assisting: Who did you fight with?

Caseworker: We actually fought with legal branch and we went up to management to the Regional Director. Eventually it came back down that no, we wouldn't do it this way. I think it's working well.[333]

13.135 During another meeting, a caseworker said:

I have been with the Department for 14 years. I haven't done fieldwork for a significant number of years. However, when I was in the field as a caseworker and then also as a casework

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331 Transcript: Inquiry meeting with DoCS staff, CSC Southern Region.
332 ibid.
333 ibid.

specialist, historically that was definitely my training, and my line direction from my managers was that you only focus on the negatives of the situation – so not to risk losing the case.

In all my years, I can't say that I had any training or influence to balance that up. I can definitely say that the focus was to get whatever efforts you could get – in my experience – to demonstrate that the family is not coping and, I guess, to make a very clear statement that that child is at great risk of harm if the court doesn't accept what our recommendations are. But again that's not current; I haven't had any recent experience.[334]

13.136 A more recently trained DoCS caseworker said:

I have been around for two years, so I finished my training just over a year ago. The affidavit training we received was basically that, in a case where we are going for removal, what we are actually putting in is: these are the reasons why we want to remove and this is how the family has engaged with us or how they have not. In cases where they have and where attempts have been made by the family to say "These are the reasons why we shouldn't remove our children," what we are actually doing is we are saying that, but we are trying to use it as a leverage point to say, "Okay, these are the positive things that this family has, but this is why, in our opinion, this is not enough."[335]

13.137 In *Re Liam,* McDougall J commented on the evidence of DoCS. He noted that in an affidavit, a caseworker had included some material about a contact session that was taken out of context and resulted in that part of the affidavit being misleading.[336] His Honour said:

I draw attention to this in the hope that, in future, care will be taken to ensure that when employees of DoCS summarise or extract from documents that are not otherwise in evidence (as the relevant access report was not in evidence before the Children's Court) they do so accurately, fairly and impartially. In my view, any other approach is inconsistent with the paramount consideration specified in s.9(a) of the Act.[337]

13.138 The Inquiry sought further information about the events described above by caseworkers and was advised by DoCS that "at no stage was anything stated by way of policy other than that all relevant information should be included [in

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[334] ibid.

[335] ibid.

[336] *Re Liam* [2005] NSWSC 75 at [60]-[63].

[337] *Re Liam* [2005] NSWSC 75 at [64].

affidavits]."[338] DoCS stated that since 2004, more guidance has been provided to casework staff as to the content of affidavits.

13.139 The Inquiry sought from DoCS the current and historical policies, procedures, transcripts and programs concerned with educating caseworkers and others who regularly swear/affirm affidavits in care and protection proceedings as to the requirements. From that material it appears that between 2000 and 2004 the information contained in relevant policies and procedures was that affidavits should include all relevant information, including evidence of any alternative action attempted.

13.140 A discussion on the types of matters that should be included in the affidavit appears in the policy relevant to the period from 2004 to 2007. There is no reference to the important principle that affidavits should contain all material whether favourable or not favourable, which is relevant to the application.

13.141 Since January 2007 a new policy has been published by DoCS for its staff. In this document there is reference to the affidavit containing truthful material which should not be put in a way that either deliberately misleads the court or is false. There is reference to only stating relevant facts.[339]

13.142 In relation to training caseworkers in the art of preparing affidavits for court, the materials have changed over the years. In the most recent training package there is reference to the fact that DoCS must prove its case in support of an application, which is of course true. There is no reference to ethical requirements in relation to presenting all relevant evidence to a court.

13.143 DoCS also provided the Inquiry with its care and practice standards which are said to apply to both in-house legal officers and external legal practitioners acting in care matters on behalf of DoCS. There is nothing in that document which refers to ethical responsibilities other than a reference to being a 'model litigant.' A Code of Conduct and Ethics dated May 2004 has been provided. It contains little guidance in this area.

13.144 It is clear from the material provided that some effort has been directed at educating caseworkers in the use of affidavits. The introduction of Care Legal Support legal officers in 2006 was designed to ensure that affidavits were improved in quality. In addition, there was a joint project with the LAC and the Children's Court to remove extraneous material from affidavits and instead focus on the applications before the Court and the Inquiry understands that this project is still ongoing.

13.145 DoCS indicated to the Inquiry that:

> *as there are no known cost orders from the 2007 to 2008 period arising from a failure to properly disclose information and very*

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[338] Correspondence: DoCS, 4 June 2008.

[339] DoCS, Intranet, *Casework Practice, Affidavits.*

> *few comments on appeal on this topic it is not possible to further comment other than to point out that if this was a significant issue then either or both of these avenues would be expected to elucidate the issues.*[340]

13.146 The information available to the Inquiry is troubling. The Inquiry concludes that there is a practice in, at least, some CSCs whereby caseworkers routinely do not provide all relevant material which both supports and does not support its application, to the Children's Court. It is unlikely that those caseworkers intend to mislead the Court, rather they are acting on a mistaken belief that this is required of them. Unfortunately, the effect of such actions is that the Children's Court may not always have all the relevant information before it in order to make decisions in the best interests of the children and young persons who are subject to its jurisdiction.

Case study 20

The Inquiry received a submission from the Redfern Legal Centre in relation to statements made by DoCS officers in criminal proceedings against their client (the mother). The criminal proceedings related to the mother's alleged assault of her two daughters, "A" and "B". The following information was provided.

DoCS records indicate that A, B and the mother's son "C" were known to DoCS. DoCS records show a number of risk of harm reports and requests for assistance relating to A and B dating back to 1995 (usually made by either the mother, or her former partner and father of A and B – "the father"), the presence of AVOs protecting the mother and children from the father, and a "system alert" that was sent to Queensland Department of Children and Family Services (after A had run away from the mother and was living with the father in Queensland). DoCS records show that the system alert states:

> *There is a history of severe and ongoing domestic violence perpetrated by [the father] against [the mother] dating back to 1999.*

The mother and the father had been involved in "a long running and acrimonious family law dispute over the custody of their daughters," and that at various times the Family Court had allocated parental responsibility to the mother, and at other times to the father. On three occasions the Family Court had made recovery orders against the father for the return of the children to the mother.

In November 2006, A made allegations that she and B had been assaulted by the mother in 2003. The mother was charged with eight counts of common assault against her daughters. On the day that the mother was

[340] Correspondence: DoCS, 5 June 2008.

arrested and charged by Police, B and C were assumed into care by DoCS.

At the time of making the allegations, A was living with the father, B had recently started having contact with the father and A, and the father was again seeking "custody" of B in the Family Court. DoCS was aware of these circumstances.

A had originally made allegations of assault against her mother in 2003. Police reports and DoCS records demonstrate that this was investigated at the time. The mother had reported to Police that A and B had fought over a jar of Nutella, and that the mother had restrained A to prevent her from harming her sister. When interviewed by DoCS officers, A informed them that she had been fighting with her sister and that she had told her sister that she was going to "smash her face in," and that her mother had restrained her. DoCS and Police took no further action in relation to this incident.

In relation to the complaints made by A in 2006, two DoCS officers (the caseworker with day to day responsibility for the casework in relation to B and C, and the secondary caseworker) provided statements to Police (at the request of Police). Despite extensive knowledge of the family and the context in which A's allegations against the mother were made, DoCS did not provide relevant information to Police. The caseworkers' statements:

> *could be read as inferring that the historical risk of harm reports (dating from 1995) were made only against [the mother]. The statements contain no reference to any report of violence against [the father] or the children, they contain no reference to the earlier Recovery Orders and the involvement of the Australian Federal Police, they contain no reference to the Systems Alert regarding [the father] and they contain no reference to the investigation by DoCS caseworkers into the allegations of assault made by A in 2003, which then became the subject of the Police investigation in 2006.*

The criminal charges made against the mother were dismissed after hearing the prosecution evidence only. The Magistrate noted that the statement of one of the DoCS caseworkers:

> *does appear to give a one sided account of key aspects concerning the DoCS file. It seems to gloss over what appears to have been a number of notifications over the years which, rather than implying they were the result of a concern conducted by the accused they may well have been a concern of conduct by the father of A. But the statement is one sided and doesn't really bring out the full detail there, doesn't go to matters such as more that one AVO being in place for the protection of the accused against [the father] and the children involved. So it does appear to be one sided and unsatisfactory.*

The Inquiry sought a response from DoCS to the submission. DoCS accepted the facts as recounted above and stated:

> *it is acknowledged the witness statements provided to the Police by [caseworker] and [secondary caseworker] did not contain a full overview of the history of reports received by the Department, references to any domestic violence, or previous family law court proceedings involving family members.*

DoCS sought to explain how the one sided statements came to be provided to Police. DoCS stated:

> *[Secondary caseworker] advises that the statements provided were requested by [Constable] of NSW Police. Specifically, [Constable] requested information about any physical abuse of B by [the mother] that the caseworkers were aware of.*
>
> *The caseworkers entered into the formulation of a statement with Police in the context of new advice that [the mother] had been charged with an alleged assault against her daughter. The caseworkers reasonably took this request to be a request for information specifically in relation to these allegations.*
>
> *[Secondary caseworker] advises that at the time she provided her statement she held the view (as did the Department) that Police would subpoena the Department's files to supplement the information that she had given in her statement. Departmental files show that a subpoena was received from NSW Police for the children's files on 10 October 2007.*

DoCS also told the Inquiry that its files show that on 20 December 2006 the caseworker had prepared and filed two detailed affidavits to the Children's Court in relation to this matter, which outlined the history of the reports received by DoCS and its interventions with the family.

> *While it is accepted in hindsight the statements proffered by [caseworker] and [secondary caseworker] were narrow and indeed not reflective of all the information known to the Department at the time, the context in which they provided these statements must be considered. That is, that the Police requested statements about a particular aspect of the caseworkers' knowledge of the family and this request was responded to, thereby giving the mistaken view that the allegation of physical abuse by [the mother] was the key issue in the Department's perspective.*
>
> *Actions have been initiated within the Community Services Centre in order to address the practice issues identified in this complaint by Redfern Legal Centre. For example, the Manger Client Services is arranging for legal services to run a staff training session on providing*

> *statements to the Police and the importance of obtaining legal advice in such matters. A broader practice issue for further consideration is how DoCS and NSW Police can work together to share information more effectively in matters of child abuse.*

13.147 Further education of DoCS caseworkers in relation to the nature of care proceedings and the information that should be included in affidavits is required.

13.148 The LAC informed the Inquiry that it sees a relationship between adversarial behaviour, and the lack of an implemented model litigant policy. It stated:

> *Were DoCS to act as a 'model litigant', whereby it presents a fair and balanced case, makes full disclosure, acts in such a way as to ensure that all of the evidence relevant to the child's best interests (rather than only that evidence which supports its own case) is before the court, shares all information about its case with the other parties and accepts and recognises that it is bound by the decisions of the court, the adversarial nature of the proceedings would be muted rather than enhanced.*[341]

13.149 The Model Litigant Policy for Civil Litigation has recently been approved in NSW. That document describes the nature of the obligation to act as a model litigant as follows:

> *The obligation to act as a model litigant requires more than merely acting honestly and in accordance with the law and court rules. It also goes beyond the requirement for lawyers to act in accordance with their ethical obligations. Essentially it requires that the State and its agencies act with complete propriety, fairly and in accordance with the highest professional standards.*[342]

13.150 The obligation requires that the State and its agencies act honestly and fairly in handling claims and litigation. The details are more appropriate to *inter partes* civil litigation than care proceedings, although the underlying policy is sound.

13.151 The LAC recommended that all agencies responsible for conducting care proceedings be required to act as a model litigant. It stated that "the policies and guidelines that apply to the officers of the DPP are an appropriate model."[343]

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[341] Submission: Legal Aid NSW, 20 February 2008, p.50.

[342] Attorney General's Department NSW, *The Model Litigant Policy for Civil Litigation*, 22 July 2008, para.3.1–3.4.

[343] Submission: Legal Aid NSW, 20 February 2008, p.50.

13.152 A barrister experienced in care proceedings stated that the care jurisdiction is quasi-prosecutorial, and also suggested that a code of conduct needs to be introduced, similar in nature to that followed by prosecutors in the criminal jurisdiction, and reflecting "the ethical duties and responsibilities of the Director-General in cases before the care court."[344]

13.153 The Inquiry agrees that DoCS should do more to install in its staff the principle underpinning the concept of the model litigant. The Inquiry recommends guidelines be developed for DoCS caseworkers based on the guidelines applicable to the DPP.[345]

Appeals

13.154 A number of submissions were made about the nature and timeliness of appeals from the Children's Court to the District Court. Surprisingly, and somewhat alarmingly, the Children's Court holds no information as to the outcomes of appeals from its jurisdiction. This issue was raised at one of the Inquiry's Public Forums and soon thereafter, the Inquiry was informed that the District Court will now provide copies of such decisions. That is clearly necessary for the Children's Magistrates to properly carry out their functions.

13.155 At issue before the Inquiry was whether there should be a change to the appellate procedure including whether appeals should be limited to questions of law, whether there should be a leave requirement and whether a specialist division of the District Court should be established.

13.156 The recommendation made by DoCS that appeals be heard by a full bench of Children's Magistrates to ensure the same level of expertise as in the Children's Court was explored with stakeholders. The LAC stated that if this occurred, the full bench should be made a court of record. The Children's Court however noted that the full bench model would require the appointment of more Children's Magistrates. The Deputy Chief Magistrate stated that she had some "philosophical difficulties" with a review panel being composed of judicial officers who are, in other cases, sitting as the first instance decision maker.[346]

13.157 Alternatively, it was suggested by CCYP that specialist District Court judges hear the appeals. The LAC agreed. Similarly, the Law Society said that it favoured:

> *the creation of a Care and Protection Division in the District Court, with specially nominated judges trained in care and protection matters to increase the efficiency of hearings.*[347]

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[344] Submission: a barrister.

[345] Office of the Director of Public Prosecutions, *ODPP Guidelines,* 1 June 2007. Guidelines 3-7 and 26-27 are of particular relevance.

[346] Transcript: Public Forum, Role of Courts, 22 February 2008, p.63.

[347] Submission: Law Society of NSW, p.8.

13.158 Many submissions were concerned with the 'inexperience' of judicial officers in the District Court in dealing with care proceedings.[348]

13.159 If the District Court continued to hear appeals, the Children's Court and DoCS suggested that such appeals only be allowed with the leave of the Court, and DoCS recommended that they be limited to questions of law. By contrast, the Law Society stated there should be no impediment to an appeal, as did the Foster Care Association and the LAC. The LAC stated:

> *As things currently stand, care decisions can often be made by Local Court magistrates sitting as the Children's Court who have no expertise in the Act or in care matters. Further, even those Magistrates who sit in the Children's Court as specialists do not always agree on the application of the law to cases with similar facts. It is essential that the appeals courts in these matters be able to review not just errors of law but also the merits of these cases. Given that appeals are few and far between,… there does not appear to be any reason, other than the resource problems that appeals cause for DoCS, for any change to the current system.*[349]

13.160 The LAC advised that it applies a means and merits test for grants of legal aid to potential appellants (other than children's representatives) in the District Court, and that this effectively operates as a leave mechanism.

13.161 The Children's Court recommended that appeals should proceed on the basis of the material filed in the Children's Court, and on the transcript of the Children's Court proceedings, rather than as a new hearing.

13.162 The Inquiry also received some submissions in relation to the time taken to complete appeal hearings in the District Court. The Children's Court stated that:

> *an appeal to the District Court is likely to add the best part of a year to the delay in settling a child or young person and this is unfair and unsatisfactory.*[350]

13.163 The Inquiry is not in favour of a full bench comprised of Children's Magistrates. While they undoubtedly have the necessary expertise, they are relatively small in number and the importance of the matters being considered warrants an appeal to higher level court which is a court of record.

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[348] Submission: Legal Aid NSW, 20 February 2008, p.109; Submission: Law Society of NSW, p.8; Submission: Children's Court NSW, 14 January 2008, p.30.

[349] Submission: Legal Aid NSW, 20 February 2008, p.107.

[350] Submission: Children's Court NSW, 14 January 2008, p.31.

13.164 The Inquiry understands that the Chief Judge of the District Court is of the view that it is not possible for a specialist bench of the District Court to be created to deal with the small number of appeals.

13.165 The Inquiry notes that the District Court has established a group of judges who sit on the Medical Tribunal, which, deals with a smaller number of cases on an annual basis, than appeals in the care jurisdiction. Unlike care matters, the Medical Tribunal hears first instance matters as well as appeals, and the District Court judge sits with two medical practitioners and a lay person.

13.166 The Inquiry is persuaded that the relatively few appeals would be best served by being heard by judges with particular expertise in the care jurisdiction. While it may not be necessary to create a separate division, a process whereby the selection of judges to hear such matters takes into account their knowledge, interest and experience, would be useful.

13.167 As about one third of care matters are dealt with by non-specialist Magistrates, the Inquiry is not of the view that appeals should be limited to questions of law alone. The Inquiry has had the benefit of reading a number of transcripts of hearings from specialist and non-specialist Magistrates. It is fair to say that the understanding from the bench of not only the law but the research and learning behind children's development and related matters is variable. Occasionally, non-specialist Magistrates equate matters of contact with access or 'spending time' decisions in the family law jurisdiction. It is clear to the Inquiry that this kind of misconception can have significant effects on families when translated into orders. This matter could be revisited if a circuit of some sort is introduced so that fewer than 10 per cent of care matters are dealt with by non-specialist Magistrates.

13.168 It is also the Inquiry's experience that leave applications can be lengthy and can canvass those matters that would ordinarily be covered in an appeal, and thus it is not of the view that a leave requirement should be required.

13.169 However, the District Court should, as a general rule, hear appeals based on the transcript in the Children's Court particularly when the appeal is from the decision of a specialist Children's Magistrate. Clearly when new facts or issues have emerged since the time of the first decision, there will be a necessity for the evidence below to be supplemented by additional evidence.

Legal representation in care proceedings

13.170 An academic lawyer, in a paper submitted to the Inquiry, said:

> *The effective representation of children is challenging and requires lawyers to develop new skills and knowledge beyond those required when working with adults. Lawyers working in these jurisdictions have to develop skills in communicating with and relating to children and young people as clients. Lawyers also have to develop means of communicating with other non-*

> *legal professionals involved in judicial decision making for children.*[351]

13.171 The Inquiry agrees. A number of recommendations were made to the Inquiry in relation to improving the quality of representation.

Training

13.172 The Inquiry received a number of submissions supporting the introduction of training for practitioners who practice in care proceedings, both those representing children and young persons, and those representing adults.

13.173 This issue is not a recent one, in his 2006 discussion paper on care proceedings in the Children's Court, the Ombudsman stated:

> *Questions have been raised about the inconsistent quality of legal representation in country courts, where there are said to be few practitioners well versed in the legislation and sufficiently experienced in care proceedings.*[352]

13.174 An academic lawyer informed the Inquiry that in the course of her research, she had interviewed 35 lawyers representing children in care proceedings, family law proceedings, and criminal proceedings. She stated:

> *Independent lawyers representing children in child protection matters have been offered significantly less education and support in undertaking their roles compared with those representing children in family proceedings and criminal matters…Some lawyers with significant experience expressed concerns about the way in which new lawyers representing children in care matters were supported and educated in order to be able to perform the role competently.*[353]

13.175 The Inquiry also received oral submissions in relation to some practitioners not spending enough time with their clients prior to hearings, and on occasions not even speaking to the children or young persons involved in the proceedings.

13.176 Compulsory training for Independent Children's Lawyers is a feature of the family law jurisdiction, and its use in care proceedings was cautiously suggested by the LAC.

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[351] N Ross, "Legal Representation of Children," in G Monahan and L Young (eds), *Children and the Law,* 2008, p.552.

[352] NSW Ombudsman, *Care Proceedings in the Children's Court – a Discussion Paper*, 2007, p.42.

[353] Submission: N Ross, p.3.

Code of conduct for legal representatives

13.177 It was also submitted that a code of conduct or best practice standard be developed for all legal representatives in care proceedings.

13.178 The Family Court and the LAC informed the Inquiry that the establishment of training and codes of conduct for Independent Children's Lawyers has worked very well in the family law jurisdiction.

13.179 Practitioners representing children and young persons in care proceedings are subject to the LAC's *Care and Protection Practice Standards*, which set out the practitioner's responsibilities to the child. Compliance with the standards is monitored by the LAC. The obligations include maintaining continuity of representation, maintaining a relationship with the child or young person, interviewing the child or young person, explaining the procedure and possible outcomes, exploring the child or young person's wishes or instructions, obtaining and advising the child or young person of all relevant material, and participating in court proceedings either in the child's or young person's best interests or with a view to advancing the child's or young person's stated position.

13.180 In order to comply with the LAC's practice standards, Independent Legal Representatives and Direct Legal Representatives must observe the Law Society's *Representation Principles for Children's Lawyers*. These principles include matters such as determining whether or not a child or young person is capable of giving instructions, the role of direct and independent representatives and how to determine what is in the best interests of a child or young person.[354]

Legal Aid funding issues

13.181 DoCS submitted that, as a result of the LAC's funding policy, which provides funding in stages, one of which is the hearing, some private practitioners who are being funded by the LAC prolong matters that might otherwise be resolved in order "to gain additional funding under a grant." This view was supported by caseworkers in a Southern Region CSC. The LAC conceded that it was possible that the way in which it funds these cases might encourage practitioners in receipt of Legal Aid funding to proceed to a full hearing of a matter rather than to attempt settlement.

13.182 DoCS has submitted that, in order to avoid this, practitioners should be required to sign a certificate certifying that, after a review of the materials, they are satisfied that there are reasonable prospects of their client obtaining care orders that are substantially different from those proposed by DoCS. DoCS submitted that any finding at the end of the proceedings that there was no reasonable basis for the certification should result in a financial penalty in relation to the funding grant.

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[354] Law Society of NSW, *Representation Principles for Children's Lawyers*, pp.5 and 7.

Guardians ad litem

13.183 The Inquiry was informed that in England, children's guardians (the English equivalent of guardians ad litem) are always interposed between a child who is involved in, or is the subject of, proceedings, and the child's legal representative. The Executive Officer of the Children's Court stated that the advantage of the English system is that:

> *The guardians are very experienced social workers. The first thing that they do when they're appointed is to go to…the Social Services office, and read the file from beginning to end. They can critique the work that has been done, and they can build up a rapport with the child and all of those things which a lawyer doesn't have the time to do, won't be paid to do and won't do. So their decision making is on a par with what DoCS decision making should be, because they're coming from the same discipline… the lawyers just argue the case.*[355]

13.184 DoCS informed the Inquiry that the role of the Independent Legal Representative would be 'clarified' if a guardian ad litem were to be appointed for all children and young persons under 12 years of age for the purpose of providing instructions, and recommended that a guardian ad litem should be appointed in these cases. A group of guardians ad litem to whom the Inquiry spoke, suggested routinely interposing a guardian ad litem between the child and their lawyer.

13.185 DoCS also recommended that there should be a requirement that some of the guardians ad litem appointed to the Guardians ad Litem Panel are Aboriginal "so that decision making might be appropriately crafted to accommodate particular concerns of Aboriginal people."[356] The Senior Children's Magistrate indicated that he believed the system of interposing a guardian ad litem between a child and his or her lawyer is a "better system,"[357] but stated that it is also a very expensive system.[358]

13.186 The coordinator of the Court's guardian ad litem program stated that there is currently no code of conduct, nor any formal complaints procedure, in relation to guardians ad litem. She also informed the Inquiry that there is currently some work being carried within Attorney General's to develop a centrally coordinated guardian ad litem panel to be used by all courts and tribunals in NSW.

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[355] Transcript: Inquiry meeting with representatives of the Children's Court NSW, 29 April 2008, p.11.

[356] Submission: DoCS, Operation of courts in the child protection system (abridged), p.33.

[357] Transcript: Inquiry meeting with representatives of the Children's Court NSW, 29 April 2008, p.12.

[358] ibid., p.11.

Inquiry's view

13.187 The Inquiry supports the development of a coordinated capacity in NSW to appoint guardians ad litem in care and other proceedings, as well as the development of requirements to ensure that they have the relevant qualifications and experience and that they attend relevant and regular training. It also support the development of a code of conduct for their role in legal proceedings, in particular in care proceedings, and arrangements for monitoring compliance with it.

13.188 The requirement that some of the guardians ad litem are Aboriginal is seen by the Inquiry as important given the over representation of Aboriginal children and young persons in the child protection system.

13.189 While the Inquiry accepts the evidence before it that the interposition of a guardian ad litem between a child under 12 years of age and his or her legal representative, may ultimately work in the best interests of the child, it is not persuaded that this is the most effective way of ensuring children are well represented.

13.190 The Inquiry is of the view that a code of conduct should be developed applicable to all legal representatives in care proceedings. Particular attention should be given to the training that they are required to undergo, using the training available in the family law jurisdiction as a guide. Further, specialist accreditation should be available. The LAC and DoCS, in the operation of their respective panels, should establish a mentoring or supervision system to assist inexperienced practitioners to enter the jurisdiction with suitable direction.

13.191 The Inquiry is not persuaded by DoCS' recommendation to introduce a certification of a client's case having reasonable prospects of success. It accepts the contention of the LAC that its processes for granting legal aid should have the same or similar effect. It believes that an appropriately drafted code of conduct should also address the issue.

Magistrates exercising care jurisdiction

13.192 The Inquiry considered a number of matters in relation to the constitution of the Children's Court including, whether it should be headed by a District Court Judge, whether those sitting as Children's Magistrates should be regularly rotated and whether there should be a rural circuit.

A District Court Judge

13.193 The review of the 1987 Act chaired by Professor Parkinson which led to the Care Act and the amendments to the *Children's Court Act 1987* recommended

that, as in Victoria and other jurisdictions, the senior judicial officer in the Children's Court should be of a status equivalent to a District Court Judge.[359]

13.194 This has been supported by DoCS, lawyers who frequently appear in the jurisdiction and by the NSW Law Reform Commission in a 2005 report.[360] The Inquiry agrees. The appointment of a District Court Judge to head the Children's Court would reflect the importance of the care and protection of children or young persons and the complexity of many of the cases heard in the jurisdiction. In other respects that person would take on the responsibilities of the current Senior Children's Magistrate position.

Circuits

13.195 The Local Court informed the Inquiry that in 2006, a total of 4,875 care matters were "dealt with" in NSW.[361] The Local Court said that 2,731 of these matters were heard in designated Children's Courts, that is about 56 per cent, although it may be higher as specialist Magistrates can hear cases in regional areas.

13.196 In its submission, DoCS stated that, based on the statistics it had received from Attorney General's (which, DoCS stated, were flawed due to a change in the counting system and a duplication of some counting), about 65 per cent of care matters are dealt with by specialist courts.

13.197 DoCS stated:

> *It is strongly recommended that an arrangement be put in place so that there … be circuits of specialist Children's Magistrates to cover the State so that hearings of more that 95 per cent of care matters may be dealt with by a specialist Children's Magistrate.*[362]

13.198 DoCS also recommended that the numbers of specialist Children's Magistrates and Children's Registrars be increased, thus "permitting a greater coverage of the State."[363]

13.199 The NSW Law Reform Commission also formed this view as expressed in a 2005 Report on Young Offenders.[364]

13.200 The Children's Court advised that it would "welcome a system which allowed all care cases to be heard by specialist Children's Magistrates."[365] The Children's Court stated that if it was given the resources for the appointment of another

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[359] DoCS, *Review of the Children (Care and Protection) Act 1987, Recommendations for Law Reform*, December 1997.

[360] NSW Law Reform Commission, Report 104, *Young Offenders,* 2005.

[361] Submission: Local Court of NSW, p.2.

[362] Submission: DoCS, Operation of courts in the child protection system, pp.30 and 31.

[363] Submission: DoCS , Operation of courts in the child protection system, p.37.

[364] NSW Law Reform Commission, Report 104, *Young Offenders,* 2005.

[365] Submission: Children's Court NSW, 21 April 2008, p.20.

two Children's Magistrates, then they could assume responsibility for country circuits, and "could make a big dint in all of the non-urban work in the State."[366] The Children's Court said that this number would not include coverage of the big regional centres.[367]

13.201 The Inquiry is of the view that there should be sufficient specialist Children's Magistrates appointed to permit a circuit to be held and that the number of matters presided over by non-specialist Magistrates should be reduced to fewer than 10 per cent. The Inquiry notes that in the event that Children's Registrars assume greater responsibility as set out below, more Magistrates' time may become available to assist in establishing a circuit.

Qualifications and tenure

13.202 DoCS stated:

> *The criteria that the current (or indeed any previous) Chief Magistrate has applied in selecting Magistrates to be appointed to the Children's Court are unknown. It is presumed that the current criteria are restricted to the Magistrate expressing an interest in working in the Court. While the current Senior Children's Magistrate has extensive experience in child and family law, other appointments as Children's Magistrates would not appear to have any experience in a professional capacity in dealing with children or young people or their families or be able to demonstrate a requisite level of knowledge, qualifications or skill.*[368]

13.203 The Women Lawyers' Association of NSW recommended that all judicial officers presiding over care proceedings be specialists in child protection. A barrister practising in care proceedings submitted that the manner in which magistrates are rotated in and out of the Children's Court jurisdiction requires review. He also informed the Inquiry:

> *rarely, if ever, are any persons with any background in both the law and social or behavioural sciences ever appointed to the Children's Court.*[369]

13.204 DoCS caseworkers in the Northern and Western Regions were critical of local Magistrates' knowledge of the jurisdiction. Some lawyers practising in the jurisdiction were also concerned about the expertise of Children's Court Magistrates.

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[366] Transcript: Inquiry meeting with representatives of the Children's Court NSW, 19 December 2007, p.13.
[367] ibid., p.14.
[368] Submission: DoCS, Operation of courts in the child protection system, p.30.
[369] Submission: a barrister.

13.205 A DoCS officer informed the Inquiry that one of the Local Court Magistrates in her area makes contact orders based on standards used in the Family Court. She said:

> *We had one long term order where he gave the mother, who had significantly harmed the child, three days a week contact because that's very similar to the Family Law Court where he had worked. We were looking at the primary responsibility going to the father, but he said, 'Yes, mother's harmed the child, but the Family Law Court would say she could have the children for three days a week so we will do that.'*[370]

13.206 In relation to the selection and term of appointment for Children's Magistrates, the NSW Law Reform Commission recommended an appointment based on Victoria's model, whereby the president of the Children's Court in consultation with the Chief Magistrate determines who is appointed to the Children's Court. It also recommended that appointments should be for a term not exceeding three years (but that reappointments may be made).[371]

13.207 In relation to the rotation of Magistrates, the Local Court informed the Inquiry:

> *As far as practical, Magistrates rotate through the Children's Jurisdiction on a three-year term. This accords with the policy of rotating Magistrates through metropolitan courts. It is considered that approximately three years is the optimal time for a Children's Magistrate to specialise in children's matters and still obtain objectivity and enthusiasm for the position. The rotation policy also increases the number of judicial officers with an in-depth knowledge and experience in this area.*[372]

13.208 DoCS recommended that the current practice of rotating Children's Magistrates generally should end as valuable experience built up in the Children's Court is being eroded.

13.209 A former Children's Magistrate submitted that the position of Children's Magistrate should be advertised, and should invite lawyers or Magistrates to apply for the position, and that the position should be for three years, with an option to extend for a further two years.[373]

13.210 The Ombudsman stated that given the distinctive nature of care proceedings, there are strong grounds for the Magistrates that hear care proceedings having a particular commitment to, and considerable experience in, the jurisdiction. The Ombudsman said:

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[370] Transcript: Inquiry meeting with DoCS staff, CSC Western Region.

[371] NSW Law Reform Commission, Report 104, *Young Offenders,* 2005, p.205.

[372] Submission: Local Court of NSW, p.3.

[373] Submission: B Holborow, p.2.

We are aware that there is currently significant rotation amongst Children's Court Magistrates and believe that 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 Children's 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 Children's Court in Victoria.[374]

13.211 The Local Court advised the Inquiry that in Western Australia, Children's Magistrates are appointed for tenure. The Local Court submitted this is 'not desirable,' and stated:

Anecdotally, Magistrates who spend extended time in the Children's Court find the extended exposure to care matters can have deleterious effect on productivity and their health.[375]

13.212 The Inquiry notes that Family Court Judges deal with an equally demanding workload over an often lengthy period. The Inquiry is of the view that s.7(2) of the *Children's Court Act 1987* provides the appropriate qualifications for a Children's Magistrate. It accepts that rotation is desirable to ensure that Magistrates remain objective, however in order to benefit from the experience gained on the bench, rotation should occur after five years, if desired, rather than three years.

Judicial education

13.213 According to the Judicial Commission of NSW (the Judicial Commission), judicial education and professional development is not mandatory for judicial officers in NSW. However, participation in programs of education and professional development are strongly encouraged by policies of the various courts, and by the existence of the National Standard for Professional Development for Australian Judicial Officers, which recommends five days of judicial education per judicial officer annually (including self-directed professional development).[376]

13.214 However, the Children's Court advised the Inquiry that:

Attendance by Children's Magistrates at the five days judicial education provided each year, the five days live-in orientation

[374] Submission: NSW Ombudsman, Children's Court NSW, p.8.

[375] Submission: Local Court of NSW, p.4.

[376] Judicial Commission of NSW, *Annual Report 2006/07,* pp.18-19.

> *course and the s.16 meetings for Children's Magistrates conducted at least twice per year is compulsory.*[377]

13.215 The Judicial Commission, in conjunction with the Local Court, offers a two day Pre-Bench Workshop for all newly appointed Magistrates. At the Pre-Bench Workshop, new magistrates are provided with the Local Court Bench Book, which contains information on the Care and Protection Jurisdiction.

13.216 The Judicial Commission operates a Magistrates Orientation Program annually which is a five day residential program for all new Magistrates. New Magistrates participate in the program once they have had between four and twelve months experience on the Bench.

13.217 Each year the Magistrates Orientation Program includes one session specifically relating to the care and protection jurisdiction. In relation to the last three Orientation Programs, these sessions were presented by the Senior Children's Magistrate and academic lawyer, Dr Judy Cashmore. A number of sessions have been offered over the last three years relevant to care proceedings presented by the Senior Children's Magistrate, DoCS, Police and various academics.

13.218 The Judicial Commission informed the Inquiry that, relevant to care proceedings, it had published the *Sexual Assault Handbook* and various other papers.

13.219 The Local Court has a policy of attaching Magistrates to the Children's Court in Parramatta for three months prior to those Magistrates taking responsibility for a regional circuit for the first time. The Local Court stated:

> *Each Local Court Magistrate, upon appointment must undertake a period of service on the country circuit for a minimum of two years and a maximum of five years (subject to the discretion of the Chief Magistrate).*[378]
>
> *Prior to appointment to a country circuit, every Magistrate must sit for three months, full time in the Metropolitan Children's Court. This usually occurs at Parramatta Court, where there is a spread of work assistance and guidance from experienced Children's Magistrates, in particular the Senior Children's Magistrate.*[379]

13.220 The Inquiry was advised by the Children's Court that during this three month period, the Magistrates are provided with tuition, consisting of:

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[377] Correspondence: Children's Court NSW, 18 July 2008.

[378] Submission: Local Court of NSW, p.3.

[379] ibid.

> *A number of sessions with the Executive Officer where relevant aspects of the Children and Young Persons (Care and Protection) Act, together with the Standard Directions which apply in the Children's Court, Practice Directions and some of the more significant decisions appearing in Children's Law News, are explained and discussed in detail. The Executive Officer provides an outline of the jurisdiction and some of the practices of other parties to the child protection system including the Department, the agencies and the Children's Court Clinic. Various Care files relating to previous cases are examined and discussed.*[380]

13.221 The Inquiry was advised that during the three month training period, these Magistrates are allocated 'less complex' matters to hear and determine, and are encouraged to discuss these matters with experienced Children's Magistrates.

13.222 DoCS recommended that:

> *Identified and publicly available training is required for those Magistrates sitting in the care jurisdiction for the first time.*[381]

13.223 Section 16(1)(c) of the *Children's Court Act 1987* requires the Senior Children's Magistrate to convene a meeting of Children's Magistrates at least once every six months. The Children's Court informed the Inquiry that the Children's Magistrates meet tri-annually for conferences at which they discuss issues and receive training related to the Children's Court jurisdiction.

13.224 The Inquiry has been provided with the program in relation to three conferences held in 2007. In relation to care proceedings, a large range of topics were discussed including intervening in child neglect, DoCS' parental drug testing pilot and discussions on family group conferencing, care circles, reports pursuant to s.82 of the Care Act and the administration of psychotropic medication to children.

13.225 The training regime appears adequate for specialist Magistrates, however, non-specialist Magistrates appear to receive little by way of formal training in the specialist jurisdiction.

A docket system

13.226 The LAC has suggested that the Children's Court adopt a formal docket system, whereby cases are allocated to a single judicial officer for the duration of proceedings (from the first return date through to the final hearing). The LAC submitted that a docket system would ensure that a consistent approach was adopted throughout the course of proceedings, and that:

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[380] Correspondence: Children's Court NSW, 18 July 2008.

[381] Submission: DoCS, Operation of courts in the child protection system, p.37.

This would avoid the current situation whereby interim orders can be made and changed by different magistrates, where leave for the preparation of expert reports might be granted or refused by one magistrate and then the parties subsequently questioned by another magistrate at final hearing as to why there is no expert report, and where section 82 reports and applications for variation / rescission are heard by magistrates who have no knowledge of the reasons behind the underlying orders.[382]

13.227 The LAC also submitted that the greater degree of judicial management resulting from the docket system might reduce the level of adversarial behaviour. The Children's Court was of the view that it would not be successful, given the number of registries and specialist Magistrates, and because it had not been successful in other jurisdictions.

13.228 While the Inquiry is mindful of the experience recounted by the Local Court in other jurisdictions, it is persuaded of the advantages of consistency in judicial decision making. The Inquiry believes that a trial of a 'docket system' in the Parramatta Children's Court should be undertaken.

Children's Registrars

13.229 DoCS stated that Children's Registrars were originally intended to "work in an arrangement akin to the Magellan model," but that this has not occurred.[383]

13.230 In 2007 there were five specialist Children's Registrars in NSW.[384] The Parkinson review of the 1987 Act recommended that 13 Children's Registrars be appointed, and funding was provided for the appointment of nine. The fact that only five Children's Registrars have been appointed has attracted the criticism of the Ombudsman and DoCS.

13.231 There is currently one Children's Registrar, and two Acting Children's Registrars, who do not have legal qualifications. The Children's Court advised the Inquiry that it would support a requirement for legal qualification for all future appointments to the position of Children's Registrar.

13.232 DoCS stated:

While Children's Registrars were initially all legal practitioners this no longer appears to be the case. If the occupiers of these positions are to conduct ADR or to assume a greater role in

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[382] Submission: Legal Aid NSW, 20 February 2008, p.117.

[383] DoCS, *Discussion paper on alternatives for hearing and making decisions in child protection matters,* February 2008, p.11.

[384] Local Court, *Annual Review 2007,* p.21.

making consent orders and presiding at directions hearings, then legal qualifications should be a pre-requisite.[385]

13.233 The Children's Court stated that, under Attorney General's training budget, Children's Registrars are offered the same training as Local Court Registrars, but are not offered any training in mediation.

13.234 Professor Parkinson, stated:

I do not think that sufficient advantage has been taken of the opportunities created by the 1998 Act [Care Act] for better dispute resolution processes. The Children's Registrars were a significant innovation….They have proved very effective both in terms of getting consent arrangements by negotiation and ensuring that cases are ready to proceed to trial.[386]

13.235 When required, Children's Registrars travel to regional areas to provide assistance in care proceedings. A DoCS officer in a CSC in Northern Region informed the Inquiry that there was a noticeable difference in the way preliminary conferences were run when a Children's Registrar from Sydney had carried out some work in that Region.

There was a period where we did a lot of preliminary conferences, they were run like a mediation, and they were really successful. We actually had matters dealt with expeditiously because there was a skilled and trained and aware Registrar that would come up from Sydney and run it like a mediation… Now our preliminary conferences do not run the same way, there is often no outcome, and it is another delay in the process. A matter can have three, four, five preliminary conferences before it is finalised and often for no real point other than to check on compliance of documents and things like that.[387]

13.236 The Local Court indicated that, when a request is made by a Local Court Magistrate for assistance from a Children's Court Magistrate in care proceedings, "the Senior Children's Magistrate would initially allocate a Registrar to conduct a settlement or directions hearing (or both)."[388]

13.237 The Inquiry is of the view that sufficient legally qualified and experienced Children's Registrars are necessary to ease the burden of Magistrates in procedural and consent matters throughout NSW, and to perform ADR functions.

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[385] Submission: DoCS, Operation of courts in the child protection system, p.32.

[386] Transcript: Inquiry meeting with Patrick Parkinson, p.4.

[387] Transcript: Inquiry meeting with DoCS staff, CSC Northern Region.

[388] Submission: Local Court of NSW, pp.2-3.

Conclusion

13.238 The Inquiry makes the following recommendations in order to simplify proceedings, improve the quality of the evidence adduced by DoCS, ensure that lawyers appearing in the jurisdiction are appropriately skilled and qualified and act professionally, enhance the standing of the Court and the skills of Registrars and have more cases heard by specialist Magistrates.

13.239 While this chapter has not specifically referred to the needs of Aboriginal children and young persons before the Children's Court, the Care Circle project referred to in the previous chapter is an important step in identifying further ways in which the court processes can become less alienating and more meaningful for Aboriginal children, young persons and their families.

Recommendations

Recommendation 13.1

> The *Children's Court Act 1987* should be amended to insert a provision similar to s.27 of the *Local Court Act 2007* and the *Children's Court Rules 2000* should be reviewed to ensure that the Rules are consistent with the *Children's Court Act 1987* and the Care Act, and any practice directions or notes that are issued after amendment of the Act should similarly accord with the legislation.

Recommendation 13.2

> There should be no requirement, by way of legislation or practice, that DoCS is to file all material relied upon in care proceedings at the beginning of the proceedings.

Recommendation 13.3

> Care applications by DoCS under ss.45 and 61 should be made by way of an application filed in the Court supported by a written report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection and any interim orders sought, without any requirement for the filing of any affidavit, unless ordered by the Court in circumstances where establishment is contested. The DoCS file or relevant portion of it should be made available to the parties.

Recommendation 13.4

Section 45 of the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require DoCS to apply to the Children's Court no later than 72 hours after the child or young person has been removed or care assumed.

Recommendation 13.5

The Children's Court should revise its practices in relation to changing hearing dates and moving proceedings between courts, as well as its listing practices for callovers and mentions.

Recommendation 13.6

DoCS caseworkers should be given more specific training and guidance in relation to the nature of care proceedings and in relation to the evidence to be placed before the Court, to ensure its relevance, accuracy and fair balance.

Recommendation 13.7

Guidelines should be developed for DoCS caseworkers based on the Code of Conduct applicable to the Office of the Director of Public Prosecutions.

Recommendation 13.8

A code of conduct should be developed applicable to all legal representatives in care proceedings. Specialist accreditation should be regularly available. Any necessary training or assessment mechanisms should be available on an ongoing or regular basis. A similar regime should also be established for Guardians ad Litem.

Recommendation 13.9

A District Court Judge should be appointed as the senior judicial officer in the Children's Court.

Recommendation 13.10

There should be sufficient specialist Children's Magistrates appointed to permit rural and regional circuits to be held to ensure that the proportion of matters in the care and protection jurisdiction presided over by non-specialist Magistrates is reduced to fewer than 10 per cent.

Recommendation 13.11

A trial of a 'docket system' in the Parramatta Children's Court for matters in the care and protection jurisdiction should be undertaken.

Recommendation 13.12

Registrars of the Children's Court should be legally qualified and alternative dispute resolution trained and sufficient in number to perform alternative dispute resolution and to undertake procedural and consent functions.

14 Interface with family law

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Introduction

14.1 As is evident from Chapter 13, there are mechanisms whereby serious allegations of sexual or physical abuse of children in post-separation parenting matters are brought to the attention of child protection agencies such as DoCS, and whereby reports from that agency about the child or young person can be provided to the Family Court.

14.2 The reforms brought about under Magellan were necessary in part because of the complexities of a system in which the family law courts, created by Commonwealth legislation, adjudicate private disputes within a family, and in which the child protection agencies and the Children's Courts, created by State legislation, determine matters of public concern about the safety, welfare and well-being of children and young persons.

14.3 Formal arrangements between DoCS and the family law courts are in place and consist of an MOU (containing general principles) and a Protocol (containing operational procedures) between DoCS and the Family Court, and a separate MOU and Protocol, in similar terms, between DoCS and the Federal Magistrates Court. Each of the Federal Magistrates Courts and the Family Court exercise jurisdiction under the *Family Law Act 1975*. They are collectively referred to as 'family law courts' in this chapter.

14.4 The most significant ways in which the Federal and State systems intersect, for the purposes of this Inquiry, are as follows.

14.5 First, DoCS may intervene in family law court proceedings for a number of reasons including where serious allegations of sexual or physical abuse of children have been made, either through the Magellan process as discussed in Chapter 13, or otherwise.

14.6 Secondly, an order for contact made by the Children's Court may be registered in the family law courts, and thus become enforceable in accordance with powers exercised by those Courts.

14.7 Thirdly, a child or young person may be cared for by a person by virtue of an order of a family law court, in circumstances where the carer is entitled to a supported care allowance from DoCS.

Intervening in family court proceedings

14.8 The *Family Law Act 1975* (Family Law Act) provides for mandatory and voluntary reporting to a child protection agency, which for the purposes of this report is DoCS.

14.9 If a party to parenting proceedings alleges that a child has been abused or is at risk of being abused, DoCS is notified by a family law court.[389]

14.10 Where an officer or professional in a family law court has reasonable grounds for suspecting that a child has been abused or is at risk of being abused, that person must notify DoCS. Where a person has reasonable grounds to suspect that the child has been or is at risk of being ill treated, or "has been exposed or subjected, or is at risk of being exposed or subjected, to behaviour which psychologically harms the child", that person may notify DoCS.[390]

14.11 To avoid any inconsistency or overlap in decision making, orders made under the Care Act (that is, orders made under the State system), by virtue of a provision in the Family Law Act, prevail over orders made under the Family Law Act (that is, orders made under the Federal system). In addition, the family law courts cannot make an order in relation to children or young persons under the care of a person under the State welfare law, that is the Care Act in NSW, unless the order comes into effect after the child or young person has left care or, in NSW, DoCS consents.[391]

14.12 DoCS may also intervene in proceedings in a family law court, either at the request of the court through the Magellan process as discussed in Chapter 13 or otherwise, or of its own initiative.[392]

14.13 DoCS will normally intervene in family law proceedings where it does not consider that either parent is a suitable carer or where it does not consider that the protective parent is able to place all relevant material before the court for the benefit of the child.

14.14 The Inquiry was informed by the Family Court that in most Magellan cases, DoCS does not intervene. It stated that out of the 82 matters which had been placed in the Magellan program across the two registries in which Magellan had been implemented in NSW (being Sydney and Parramatta) up until May 2008, DoCS had intervened in only nine of these matters. DoCS agrees with these data.

14.15 DoCS has informed the Inquiry that there had been 110 requests for it to intervene since July 2007, pursuant to s.91B of the Family Law Act, that is, other than in Magellan cases, and that it had intervened in 82 of those matters. DoCS informed the Inquiry that its involvement in family law cases has increased from 20 matters per year in 2000/01 to 223 in 2006/07.

14.16 The Inquiry received a number of submissions from agencies and from individuals stating that DoCS was reluctant to become involved with families who were in family law court proceedings. UnitingCare Burnside, for example,

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[389] *Family Law Act 1975* s.67Z.
[390] *Family Law Act 1975* s.67ZA (2) and (3).
[391] *Family Law Act 1975* s.69ZK.
[392] *Family Law Act 1975* ss.91B and 92A.

informed the Inquiry that DoCS caseworkers tend to 'back away' if a child's parents are involved in family law court proceedings, on the assumption that the child is 'under the attention of the law' and will therefore be safe.[393] The Inquiry was informed by a legal practitioner practising in both family law court proceedings and care proceedings:

> *There is a real issue about whether the Department chooses not to intervene in matters. I have had a couple of matters where the experts say that the Department needed to intervene and the Department has said no thanks. We are then left with really dysfunctional parents with kids with absolutely no protective safeguards in place.*[394]

14.17 The Inquiry understands and accepts that notifications arising out of family law disputes are generally reports of concern about the safety of a child in a family setting, and that this does not necessarily mean that DoCS needs to investigate each notification in order to fulfil its statutory function. There are a number of very valid reasons why DoCS may not investigate a notification received from a family law court. First, the report may not be sufficiently serious to justify its intervention. The question in family law proceedings is usually about the competing claims of each parent in relation to where the child will live and with whom they will spend time. These are not the same questions that arise in child protection proceedings.

14.18 Secondly, the information provided by the notifier may not disclose sufficient reason to believe the child is at risk of the abuse alleged. While the notifier may have a belief to that effect, the evidence to support that belief may be insufficient.

14.19 Thirdly, the reported concern may relate to events some time in the past or the child may currently be in a situation where he or she is no longer exposed to the risk disclosed in the report. The Care Act, at least in relation to its reporting requirements, includes the standard of "current concerns." Thus historic matters, while relevant to family law proceedings, are not sufficient to attract the intervention of the child protection system.

14.20 Finally, DoCS necessarily must prioritise the response it makes to reports of risk of harm and, based on the reports under assessment and allocation, the notification from a family law court may not be the subject of an investigation.

14.21 In addition, the Family Law Act requires the reporting of many incidents which are not reportable under the Care Act. Under the Family Law Act, the threshold for making a notification is that the child to whom the proceedings relate has been abused or is at risk of being abused. As indicated above, it does not

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[393] Submission: UnitingCare Burnside, p.28.
[394] Transcript: Inquiry meeting with lawyers specialising in care and protection matters, 12 March 2008, p.48.

require there to be any current concerns about the safety and welfare of the child, as is provided in the Care Act.

14.22 Of particular note is the fact that, in the event that the parents have separated and the child can be protected adequately through orders made in family court proceedings, which deny or restrict contact between the offending parent and the child, there will be no need for DoCS to intervene. In other words, if there is a viable carer and the child is in his or her care, then the child will not be in need of intervention under the Care Act.

14.23 A final matter of consideration is that family law proceedings are essentially private proceedings and can be resolved by consent at any time. There is no requirement that any consent orders be protective of the child. Under the Care Act proceedings must have the safety, welfare and well-being of the child at their centre.

14.24 As can be seen from the discussion above, the issue is not a simple one and must be decided on a case by case basis.

14.25 The Inquiry understands that generally the Family Court has no issue with DoCS not intervening, as in most cases, there is one protective parent. However, there have been two cases where the Inquiry was informed that intervention would have been preferred but did not eventuate.

14.26 The MOU and the Protocol appear to be comprehensive and sensible. The Inquiry is of the view that if DoCS and the family law courts act in accordance with the terms and spirit of those documents, intervention should take place in appropriate cases. DoCS will always have to prioritise its work and thus make decisions as to when it intervenes.

14.27 Pursuant to the Protocol, when the family law court requests that DoCS intervene, DoCS provides the Family Court with a Magellan report. This should be provided whether or not DoCS intends to intervene. Both DoCS and the Family Court are of the view that the provision of reports works well.

14.28 Finally, the Inquiry is aware that a 2002 report by the Family Law Council on Family Law and Child Protection recommended that, in order to avoid duplication of effort between the state and federal systems, a decision should be taken as early as possible whether a matter should proceed under the Family Law Act or under child welfare law, with the consequence that there should be only one court dealing with the matter. The report referred to that as the “One Court principle”. [395] The Inquiry agrees with this approach.

14.29 The following case study demonstrates the complexities of the inter relationship of the powers of the Local Court and the Family Court and the role of DoCS and the Police.

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[395] Family Law and Child Protection, Family Law Council, September 2002.

Case Study 21

The family became known to DoCS in 2005. Between July 2006 and the end of August 2007, the personal history for six year old C records initial assessments of 14 reports to the Helpline, in the context of reports of domestic violence and family law court proceedings. DoCS was told that family law court orders were in place stating that C and her brother B (7) were to reside with their mother, with the father having contact every second weekend and for half of the school holidays.

In March 2007 DoCS received several reports regarding a threat said to have been made by the father of the children. The father was alleged to have told the mother on the telephone, while the children were in his care and able to hear, that “you don’t get much for murder so I’ll put a bullet through each of the children’s heads and then I’ll come and get you.” The father was said to have access to firearms and to have a history of violence toward the mother.

According to Police, a previous AVO taken out by the mother had expired the day before the threat was made. Police told DoCS that the children were “reported to be safe and well in mother’s care,” that the mother was seeking legal advice to amend the family law court orders, and that she had indicated she would not send the children to their next contact visit.

In April 2007, a SAS1 states that the mother rang the allocated caseworker at DoCS, distressed, after the AVO she had sought for herself and the children was not granted. The mother advised the caseworker that the Magistrate in the Local Court refused to grant the AVO because neither Police nor DoCS had investigated the matter. The notes say that the “Magistrate stated that this indicated the threat was not considered serious and thus he decided the AVO was not warranted.”

The caseworker also recorded that the “NM feels helpless now to protect her children as she must allow NF contact as per [family law] orders or risk fine or jail.” The caseworker says that in response to the mother questioning why DoCS did not investigate, she “Advised her that as the children were in her care and that as a result were safe as NF did not have access to them, that there was no risk to them and consequently no investigation took place. Explained further that due to lack of resources, that as she was being a protective parent, that other matters were given priority.”

It appears that DoCS were concerned about the comment attributed to the Magistrate. Email records in the file document efforts by DoCS to confirm that the Magistrate denied the AVO on the grounds stated. One email, which appears to be from a senior manager, states “If the views are as indicated, then there are some other avenues we will need to explore

including judicial review of the decisions being made at that court and for that we'll need [DoCS Director of Legal Services] direction."

The emails record that a caseworker contacted the Court for verification, and was advised that DoCS could, for a fee, apply for either a copy of the transcript or the Magistrate's file, but that there was 'no guarantee' that the information would be in the transcript. The worker asked whether she should pursue the matter further. The file holds no further information about DoCS investigation of the Magistrate's views.

Later reports to DoCS indicate that the matter was referred to the Magellan project and that the father's access was suspended, and that he was also ordered to attend anger management counselling. An initial assessment in August noted that the father was to have no access until further notice.

Enforcement of certain Children's Court orders in the family law courts

14.30 Children's Court orders about residence and contact can be registered under the Family Law Act, in a family law court and then enforced as if they were orders made under that Act.[396]

14.31 Thus, for example, a NSW care order dealing with contact could be registered in a registry of a family law court in NSW or in a different state. Once registered, the order "has the same force and effect as if it were an order made by that court."[397]

14.32 The Family Law Act contains detailed provisions for enforcing orders dealing with matters such as with whom the child should live and have contact ('parenting orders'). In general, because of the lack of any separate enforcement agency,[398] such proceedings are usually brought by a party to the parenting proceedings, who claims that the other party has not complied with the orders.

14.33 It should first be noted, however, that enforcement has proved a difficult and frustrating aspect of family law.[399] Most parenting orders involve continuing

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[396] *Family Law Act 1975* ss.70C and 70D.

[397] *Family Law Act 1975* s.70E.

[398] The Family Law Council has recommended, among other things, "That the Government establish a child orders enforcement agency or in the alternative that the Government provide additional and specified funding to enable the State and Territory Legal Aid Commissions to assist parties to bring applications about serious contraventions of parenting orders before the family courts." Family Law Council, Improving Post-Parenting Order Processes: A report to the Attorney-General, October 2007, www.ag.gov.au/flc.

[399] For a detailed consideration, see the Family Law Council, *Child Contact Orders: Enforcement and Penalties,* 1998 www.ag.gov.au/flc. The present Family Law Act includes provisions based on the Council's recommendations, but the 1998 report remains a valuable discussion of the nature of the problems, many of which persist. See also Australian Law Reform Commission, "For the sake of the kids - Complex contact cases and the Family Court," *Australian Law Reform Commission Report, 73,* 1995.

obligations, and dealing with a particular breach may not ensure compliance in the future. Some of the penalties that might be considered, especially fines and imprisonment, might well have an adverse impact on the children concerned, whose best interests were the basis for the original parenting order. The need for parties to bring enforcement proceedings has also proved a significant difficulty. Parties may be reluctant or unable to undertake further proceedings for enforcement. The Inquiry understands that the lack of enforcement powers in the Care Act is a deliberate recognition of the need to encourage voluntary participation in performing court orders. Thus, enforcement provisions may be unlikely to achieve better long term outcomes for the child.

14.34 The Family Law Act, however, contains a number of enforcement provisions. There is an injunction power, a power of arrest, and powers to make location orders (requiring people to provide information about a child's location) and recovery orders (requiring people to return a child, and authorising the police or others to use force if necessary).[400]

14.35 There are also proceedings for contravention of orders.[401] The provisions distinguish between more serious and less serious contraventions. In relation to the less serious contraventions, the family law courts can direct the person to a post-separation parenting program, make a further parenting order that compensates a person for the time not spent with a child as a result of the contravention, require the person to enter into a bond, or to make monetary compensation, or pay costs.[402] In relation to the more serious contraventions,[403] the possible orders include a community service order, a bond, a fine, and a sentence of imprisonment for up to 12 months.[404] In addition, there is a power to deal with a contravention of an order under the Family Law Act that "involves a flagrant challenge to the authority of the court" as a contempt of court.[405] As well as providing for penalties, the Family Law Act also makes provision for the Court to vary the parenting order that was breached, reflecting the realisation that some contravention proceedings stem from misunderstood or badly drafted orders, or from orders that have become unsuitable for changed situations.[406]

14.36 Once an order from a Children's Court has been registered in a family law court, the enforcement provisions sketched above become available. DoCS can register a Children's Court order, and can apply for an enforcement order, the only special requirement being the necessity under s.69ZK of providing the written consent of a child welfare officer. Thus, it appears that there would be

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[400] *Family Law Act 1975* s.68B. The court may "make such order or grant such injunction as it considers appropriate for the welfare of the child" including various restraining and other orders ss.65Q, 67J-67N, 67Q-67Y, 68C.

[401] *Family Law Act 1975* ss.70NAA–70NFJ.

[402] *Family Law Act 1975* s.70NEB.

[403] Defined, in substance as repeated contraventions and contraventions that show a serious disregard of obligations under the parenting order that was contravened: *Family Law Act 1975* s.70NFA.

[404] *Family Law Act 1975* ss.70NFB-70NFG.

[405] *Family Law Act 1975* s.112AP.

[406] *Family Law Act 1975* ss.70NAE, 70NBA.

no difficulty in DoCS making application for any of these various forms of enforcement of a Children's Court order registered in a family law court.

14.37 The Family Law Act specifies who can bring applications for a recovery or location order, or an injunction, or contravention proceedings. In each case, the requirements are the same as those in relation to applications for parenting orders, the relevant category being "any other person concerned with the care, welfare or development of the child."[407]

14.38 While the representatives of the Family Court with whom the Inquiry had discussions were not aware of these provision being used for care matters, DoCS informed the Inquiry that the procedure has been used by it, particularly in cases where there is risk of interstate flight.

Financial and other assistance from DoCS for non-parent carers who care for children as a result of family law orders

14.39 The Inquiry received submissions from carers who were responsible for children following orders made by a family law court rather than the Children's Court. A number of them said that they had been informed by DoCS, or otherwise understood, that they were not entitled to any financial or other assistance from DoCS, because of the absence of a Children's Court order granting them the care of the relevant children.

14.40 This is not the case. A supported care allowance can be provided for children and young persons who are in the care of relative or kinship carers, even where the Minister or Director-General has no aspect of parental responsibility. This allowance may be payable for placements resulting from a Children's Court Order, a family law court order and even where there is no court order. It is at the discretion of DoCS and depends, in part, on the likelihood of the child entering OOHC if not for the care currently provided by the relative or kinship carer. Other assistance may also be available pursuant to s.22 of the Care Act. The Inquiry does not suggest that there should be any alterations to this practice.

14.41 More needs to be done however to ensure that those carers who may be in need of assistance from DoCS, are aware of DoCS' guidelines, and of its discretion to provide financial support.

Extending the Magellan Project

14.42 NSW became part of Magellan in July 2003 and its reach was limited to a small number of postcodes in the Sydney metropolitan area. The Inquiry understands

[407] Section 67K (location orders); s 67T (recovery orders); and s 69C (all other proceedings under Part VII of the Act, ie the Part dealing with children.

that DoCS imposed this restriction because of other reforms being implemented and because the MOU and Protocol were not yet in place.

14.43 Given its recent positive evaluation, the Inquiry is of the view that Magellan should be extended to a significantly greater area of NSW than is currently covered. The Inquiry understands that DoCS proposes to extend its participation in Magellan to the Metro West Region this year and to rural regions by the end of 2009. The Inquiry agrees with this phased approach. It is also noted that Magellan is only available in the Family Court and not the Federal Magistrate's Court, where a significant majority of family law matters are now heard.

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Introduction

15.1 Research shows that there is a significant correlation between juvenile participation in crime and rates of reported neglect or abuse, as well as a strong relationship between juvenile offending and homelessness.[408]

15.2 Two surveys in this State in relation to juvenile offending have shown that:

a. 28 per cent of male and 39 per cent of female detainees, and 21 per cent of males and 36 per cent of females subject to community orders had a history of being placed in care[409]

b. over 90 per cent of detainees had been suspended from schooling at one time or another, and that three quarters had left school before finishing Year 9.[410]

15.3 In addition, a study carried out in 2002, found the following:

> *Sixty-eight per cent of those who appeared in the Children's Court for the first time in 1995 had reappeared in a NSW criminal court at least once within the next eight years. Forty-three per cent of the cohort reappeared at least once in the Children's Court and 57 per cent had at least one appearance in an adult court over this period. … In other words, 13 per cent of those who appeared for the first time in a Children's Court, in 1995, ended up in an adult prison within eight years. The number of reappearances in court was found to be significantly related to the age at which the juvenile first appeared in court; with youths aged 10 to 14 at their first appearance having significantly more court appearances over eight years than youths who were aged over 14 at their first appearance.*
>
> *Nearly 70 per cent of the 5,476 juveniles examined in the present study reappeared in court within eight years. These results are fairly consistent with the international literature on juvenile offending …. One important policy implication of the current findings is that efforts to reduce the risk of reoffending should not be delayed in the belief that most young people making their first appearance in the Children's Court will never reappear in court again.*[411]

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[408] See for example, the studies cited by the Australian Institute of Health and Welfare in its Feasibility Study, *Linking SAAP, Child Protection and Juvenile Justice Data Collection,* June 2008, p.2; NSW Bureau of Crime Statistics and Research*, Social and Economic Stress Child Neglect and Juvenile Delinquency,* 1997.

[409] Department of Juvenile Justice, Justice Health and University of Sydney, *NSW Young People on Community Orders Health Survey 2003-06: Key Findings Report*, 2006, p.11.

[410] Department of Juvenile Justice, Justice Health and University of Sydney, *NSW Young People in Custody Health Survey: Key Findings Report*, 2003.

[411] S Chen, T Matruglio, D Weatherburn and J Hua, "Crime and Justice Bulletin: 'The transition from juvenile to adult criminal careers,'" *NSW Bureau of Crime Statistics and Research, Contemporary Issues in Crime and Justice,* Number 86, May 2005, pp.10-11.

15.4 The significant correlation between the high level of offending behaviour and the indicators of risk among young offenders, points to the importance of DoCS, Juvenile Justice and Police, and also those agencies such as Education, Health and Housing who have close contact with families, working together to provide support and interventions to address the factors of neglect, abuse, social and economic distress that contribute to offending behaviour.

15.5 Not only is this important for the personal well-being of the adolescents and young persons affected by these negative factors, but it also has ramifications for the community at large, as the following observations of the Bureau of Crime Statistics and Research (BOCSAR) show, in relation to urban areas:

a. The findings indicate that, assuming other factors remain unchanged, an increase of 1,000 additional neglected children would result in additional 256 juveniles involved in crime. Alternatively, and again assuming other factors remained unchanged, an increase of 1,000 additional poor families would result in an additional 141 juveniles involved in crime.

b. The increases in juvenile court appearances resulting from such increases in neglect or poverty would be 466 for each additional 1,000 neglected children or 257 for each additional 1,000 poor families. The increase in criminal offending would be substantially larger given that only a small proportion of offences result in court appearances.[412]

15.6 The recently released NSW Criminal Courts Statistics 2007 show a three per cent increase in the number of persons with matters finalised in Children's Courts for that year (up to 9,141).[413]

15.7 In the first part of this chapter the sentencing of young offenders is examined, including the availability of diversionary options, and the several programs and strategies that exist which are directed towards preventing anti-social and criminal conduct by young offenders. Issues concerning the management of young offenders once they come under the supervision of Juvenile Justice particularly those who are under the parental responsibility of the Minister, and the programs that then become available for their rehabilitation, are also examined. In the second part of the chapter, consideration is given to those aspects of the adult or general justice system that have an impact on keeping children and young persons safe.

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[412] NSW Bureau of Statistics, "Social and Economic Stress Child Neglect and Juvenile Delinquency," 1997, p.viii.

[413] NSW Bureau of Crime Statistics and Research, "NSW Criminal Court Statistics 2007," August 2008, p.iii.

Juvenile Justice

Release on bail or subject to a bond

15.8 One problem which was repeatedly brought to the notice of the Inquiry has been the difficulty in securing accommodation for young people who might otherwise have been released on bail, but cannot be released because they do not have stable accommodation or are unable to return home because of family breakdown or safety or neglect risks.

15.9 In the absence of dedicated bail facilities for young people, many have been held remanded in detention for significant periods, with potentially adverse consequences for their prospects of rehabilitation. Particularly difficult to place are those facing sexual offence charges or who have a history of sexual offending. Similar problems can arise where young offenders who, after conviction, are unable to obtain suitable accommodation where that is the subject of a condition in a bond.

15.10 Recent statistics show that there is a significant increase in the number of detainees in juvenile detention centres.[414]

15.11 Juvenile Justice advised the Inquiry that as at 15 June 2008 there were 272 young people in custody on remand, compared with an average daily total of 164 for 2006/07.

15.12 Juvenile Justice has advised that:

> *On any given day, detainees on remand in juvenile detention make up 55 per cent to 60 per cent of the total juvenile detention centre population. This figure is even higher for young women in detention, with around 65 per cent to 75 per cent being on remand. A recent review of remand cases undertaken by Juvenile Justice over a period of three months (the first quarter of 2006/07) found that 90 per cent of these did not meet bail conditions in the first instance and spent an average of eight days in custody. Ninety-five per cent of those remanded during the review period had court imposed bail conditions to 'reside as directed'.*
>
> *The review also indicates that the 10 – 12 years age group spend an average of 25 days in custody before being able to meet their conditions of bail. Of those young people who were identified as having been involved with DoCS, the average time in custody before meeting their bail conditions was 12 days*

[414] Department of Juvenile Justice, *Annual Report 2006/07*, p.18.

> *compared to seven days for those who had no previous DoCS involvement or where this was unknown.*
>
> *This situation is particularly worrying when it is considered that about 84 per cent of young people remanded to custody do not go onto receive a custodial order after sentencing.*[415]

15.13 It would seem that Juvenile Justice has no legislative obligation or common law duty to provide or to arrange accommodation for people within this group, and no legislative basis to place children under 16 years of age in accommodation other than with their parents or legal guardians or authorised carers (where they are under the parental responsibility of the Minister). It is not funded to provide accommodation services other than within detention centres, although it does from time to time use 'brokerage funds' to purchase accommodation as a step of last resort, where that will assist in preventing those within this group entering custody, in accordance with their bail/case management plan.

15.14 It would also appear that, save in the case of those under the Minister's parental responsibility, DoCS cannot be compelled to find accommodation for those within this group.

15.15 The nature of the problem is illustrated by two cases. First, there is the case of *Minister for Community Services and Anor v Children's Court of NSW*[416] in which DoCS brought proceedings in relation to the validity in law of a condition included in a bond imposed by the Children's Court requiring the child in question to "reside as directed by the Department of Community Services, - not with your mother unless both the mother and [child] agree."[417] This case was one in which DoCS had made it clear to the Court, both earlier in the proceedings when bail was at issue, and at the time of sentencing, that it did not have the facilities to house the child, nor was it in a position to provide any direction as to where she should go. It was held that the condition was within power, although it did not have the effect of requiring DoCS to provide the accommodation or assistance contemplated.

15.16 The second case is that of *Police v Raymond,*[418] which involved a 14 year old boy charged with several offences, but without a prior record. Despite being granted conditional bail in similar terms to that considered in the last mentioned case, his custody continued for some time because of DoCS' inability to find a suitable place of residence for him. Juvenile Justice notified DoCS of his homelessness on several occasions, as did the Magistrate who made a formal declaration that he was homeless. Serious concerns were expressed by the Magistrate concerning the fact of a 14 year old homeless youth being warehoused in a juvenile detention centre. The application of the Department

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[415] Submission: Department of Juvenile Justice, p.14.

[416] *Minister for Community Services and Anor v Children's Court of NSW* [2005] 62 NSWLR 419.

[417] *Minister for Community Services and Anor v Children's Court of NSW* [2005] 62 NSWLR 419 at [16].

[418] *Police v Raymond* [2007] CLN 3.

to revoke the condition, which would have permitted his release, was declined. This left DoCS in the position of endeavouring to find some temporary accommodation, although still without any statutory obligation to do so.

15.17 One of the Inquiry's case studies highlights this issue.

Case Study 22

A was born on 18/4/91. Her mother was 14 years old. She lived with her maternal grandmother and then with her maternal aunt until 2004 when she returned to live with her mother who was getting married and was pregnant. Reports to DoCS commenced on her return to her mother when she was 13 years old. To date there are 95 reports to DoCS. The mother repeatedly reported to DoCS expressing her inability to cope with A's behaviours. She was fearful of A being around her toddler and newborn baby and could not cope with the financial stress of providing A's required ADHD medication. From December 2005 to March 2006 there were a number of incidents of reported assault on the mother by A. In April 2006 A was arrested and held in the custody of the Juvenile Justice. The conditional bail undertaking was that she 'remain in custody until suitable accommodation is found in community eg DoCS/Juvenile Justice.'

The mother stated that A was not able to return home and no placements were able to be located, however a high cost option was available ($3,200 for weekend with a 1:1 carer in a motel). After consultation with the manager, the DoCS caseworker advised Juvenile Justice that no placement options were available and A remained in detention in Juvenile Justice's care. Juvenile Justice urged DoCS to find a placement as this was 'just an AVO matter so A does not deserve to remain in custody over the weekend.'

15.18 Access to bail is of particular significance for young people charged with criminal offences in diverting them from potentially unnecessary contact with a delinquent group, and in limiting the interruption of their education and family connection. The desirability of maintaining members of this group in the community and of involving them in programs and support services while on bail, so as to encourage their successful completion of the bail period, has been recognised by the Youth Justice Board in the UK whose model includes the following standards:

a. Programs should be developed at the initial bail assessment point, and be individually tailored to the needs of the young person.

b. Young persons should have immediate access to programs and support services once they are released on bail. If there is to be an intensive support program, a timely start will improve the young person's retention in the program.

c. Programs should take a more holistic view of the young person and their needs, and interventions should be focused on promoting a more stable lifestyle.

d. Family should be involved when possible.

e. Programs should include court support to help the person to comply with their bail conditions. For example court reminder calls, accompanying the young person to court, organising transport when necessary and providing information and advice about the court and bail process.[419]

15.19 A positive commitment on the part of Juvenile Justice to secure accommodation for young people within the juvenile justice or criminal justice systems who would be allowed their liberty, either pending trial or pursuant to a non-custodial disposition such as a bond or suspended sentence, had they a stable place in which to live, would accord with the requirements of the international instruments to which Australia is signatory.[420]

15.20 It is understood that one such service, 'New Pathways', can provide for a limited amount of accommodation combining residence with treatment but more is obviously needed.[421] It is also understood that a trial of an integrated case management project is to be conducted out of the Parramatta Children's Court commencing in December 2008 and involving DoCS, Juvenile Justice, Justice Health, and DADHC to respond to the needs of young people before the Courts, who have high level and complex needs and who would normally be bailed if they had suitable accommodation or placement options. This, the Inquiry believes, is a commendable initiative which should be expanded, if found upon evaluation to be effective.

15.21 It has, however, been pointed out that the trial will only target a very small number of people (five at any one time), and that it does not immediately address the more systemic issues which are apparent, as a result of the fact that Juvenile Justice clients are often excluded from accessing the limited accommodation services including SAAP funded services (see Chapters 17 and 20) which are available to adolescents and young persons, due to their complex needs and high risk rating. Among those particularly likely to be excluded are those with a history of sexual offending and those charged with property damage and serious behavioural offences, leaving as the only available option, at this stage, a detention centre 'placement'.

15.22 The Inquiry considers that it would be helpful to establish an after hours bail placement service similar to Victoria's Central After Hours and Bail Placement Service, that is available to young people aged 10-18 years, who are at risk of

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[419] G Denning-Cotter, "Bail Support in Australia," *Indigenous Justice Clearinghouse*, April 2008.

[420] The United Nations Convention on the Rights of the Child, 1989, Article 20; and the UN Standard Minimum Rule for the Administration of Juvenile Justice Rule 24.

[421] This program is run by Youth off the Streets and caters for moderate to high risk male adolescents aged 13 to 18 years. It has recently been extended to include young people with an intellectual disability and is to be the subject of an evaluation commissioned by DoCS which is to start by the end of 2009.

being remanded in custody, or who require bail accommodation; or similar to Queensland's Conditional Bail Program and Youth Bail Accommodation Support Service.[422]

15.23 The difficulties in securing the release on bail of young Aboriginals has been particularly problematic. It needs to be addressed, as a matter of urgency, given the disproportionately high number of Aboriginal children and young people who come into contact with the juvenile justice system. The intensive Bail Support Program recently introduced in NSW may prove to be beneficial in this respect if it can be extended to rural areas.[423]

15.24 It is only in its early stages and seemingly the subject of limited funding, but it does have the advantage of using the window between arrest and sentencing to address the factors behind offending and to open up opportunities for diversion.

Sentencing and diversion of juvenile offenders

15.25 HREOC has noted the commitment of Australia to introduce diversionary measures for juvenile offenders in accordance with the provision of the *UN Convention on the Rights of the Child*, as elaborated upon by other United Nations rules and guidelines.[424]

15.26 HREOC noted that:

> *Indigenous juveniles are particularly vulnerable to being trapped in a cycle of contact with the criminal justice process. Yet studies show that Indigenous juveniles are less likely than non-Indigenous youth to benefit from mechanisms, such as conferencing, to divert juveniles from custody... Similarly, there is evidence that Indigenous children have not received the benefit of police cautioning at the same rate as the general youth population.*[425]

15.27 HREOC also drew attention to the recommendations of the Royal Commission into Aboriginal Deaths in Custody concerning the desirability of providing a wide range of non-custodial options for young Aboriginal juvenile offenders.[426]

15.28 This is an area where Police through their Youth Liaison Officers have a role in activating interventions under the *Young Offenders Act 1997* (the Young Offenders Act); in organising programs that can target the behaviour of young offenders to divert them from the criminal justice system or to assist them in not re-offending; in identifying young people whose risk taking behaviour, family

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[422] G Denning-Cotter, 2008, op. cit.

[423] ibid.

[424] The Human Rights and Equal Opportunity Commission, *Human Rights Brief No. 5 Best Practice Principles for the Diversion of Juvenile Offenders*, 2001.

[425] ibid.

[426] ibid., p.6.

situation or previous contact with Police indicate that they are at risk of becoming persistent offenders; and in referring them to relevant services. It is also an area where other agencies, including DoCS, Health and Juvenile Justice have an important role to play, and for which the provision of assured funding for relevant programs is of considerable importance.

The Young Offenders Act

15.29 The Young Offenders Act provides an opportunity for offenders aged 10-18 years who have committed certain categories of offences[427] to be dealt with by Police outside of the court system,[428] in a variety of ways that fall short of the criminal sanctions that might otherwise be attracted, including warnings, cautions and youth justice conferences.

15.30 Under the Young Offenders Act, the level and type of intervention will be determined on the basis of a number of factors, including the seriousness of the offence, the harm to the victim, the degree of violence and any previous offending history.

15.31 The Young Offenders Act has been the subject of evaluation by the NSW Law Reform Commission,[429] by the BOCSAR on three occasions[430] and by the Sydney Institute of Criminology.[431] Generally these evaluations concluded that the Young Offenders Act has introduced a successful scheme for diverting young offenders from court.

15.32 The Ombudsman has been actively involved in encouraging Police in relation to the effective use of diversionary options, including the use of community members to issue cautions, securing access by offenders to legal advice, and developing a Youth Liaison Officer training package. In a submission to the Inquiry the Ombudsman advised:

> *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 [Young Offenders] 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.*[432]

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[427] As specified in s.8 of the *Young Offenders Act 1997.*

[428] *Young Offenders Act 1997* s.3.

[429] NSW Law Reform Commission, Report 104, *Young Offenders,* 2005.

[430] 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).

[431] J Chan (ed), *Reshaping Juvenile Justice: The NSW Young Offenders Act 1997,* Institute of Criminology, Monograph 22, 2005.

[432] Submission: NSW Ombudsman, Young People at Risk, pp.19-20.

15.33 The Inquiry is of the view that this option is an important component of a criminal justice system that can provide an early brake upon an emerging pattern of anti-social activity or criminality, and that can also pave the way for access to relevant programs, particularly at the conferencing stage. It is of the view that the concerns of the Ombudsman need to be addressed.

Youth Conduct Orders

15.34 A trial of the use of youth conduct orders to be made by the Court, as an alternative to dealing with cases under the existing provisions of the Young Offenders Act, has been announced, which is to commence from December 2008, in the New England, Campbelltown and Mt Druitt Local Area Commands. The NSW Attorney General has announced that:

> *Orders can include strict limitations on a juvenile's movement and behaviour, including curfews, school attendance requirements and non-association orders so they don't mix with bad influences or gang members.*
>
> *Offenders will also undergo intensive case management with their families, forcing them to confront issues like drug and alcohol dependence.*
>
> *They can also be referred to treatment for mental health problems and their families may be given extra help with parenting support and housing.*
>
> *The aim is to get young offenders to work with their families in addressing the causes of their anti-social behaviour before they graduate into career criminals.*[433]

15.35 The Inquiry welcomes this initiative, which may provide greater rigour to the diversionary regime already mentioned.

The Youth Drug and Alcohol Court

15.36 Another route for diversion, and for addressing the circumstances that give rise to juvenile offending, involves referral to the Youth Drug and Alcohol Court, an initiative that grew out of the 1999 NSW Drug Summit, that has been trialled in western Sydney since 2000, and is being expanded to central and eastern Sydney. It operates within the legislative framework of the *Children (Criminal Proceedings) Act 1987*.

15.37 Program funding is provided by the NSW Government and by the Commonwealth Government through the National Illicit Drug Diversion Initiative.[434]

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[433] Attorney General's Department of NSW, Media Release, 18 July 2008.

15.38 An evaluation by the Social Policy Research Centre of the University of New South Wales of the first two years of the program suggested that it was having an important positive impact on the lives of many participants and recommended that it:

> *should continue and possibly be expanded to selected other geographical areas subject to a number of issues being addressed.*[435]

Indigenous youth sentencing

15.39 An area requiring particular attention is that of young Aboriginal offenders who represent almost 50 per cent of the juveniles who are in detention pursuant to control orders,[436] and approximately 33 per cent of young offenders subject to community supervision.[437] This group is particularly prone to homelessness and violence or abuse, and its members tend to enter the juvenile justice system in early adolescence and often remain with the criminal justice system into adulthood.

15.40 The Ombudsman has pointed out that:

> *In 2004, the police undertook an analysis of Aboriginal offenders aged 10 and 11 years. 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:*
>
> *a. Every child charged had child/young person at risk reports, and 15 of the 23 had five or more reports of this nature.*
>
> *b. All 23 had been the subject of DoCS referrals, and 16 of the 23 had been the subject of DoCS referrals on five or more occasions.*
>
> *c. At age 10 or 11, every child charged with an offence in the six month review period had previously been charged.*
>
> *d. Every child had faced between two and 53 charges before this six month period.*

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[434] Lawlink NSW: Youth Drug and Alcohol Court, www.lawlink.nsw.gov.au/lawlink/drug_court.

[435] Social Policy Research Centre, University of New South Wales Evaluation of the New South Wales, *Youth Drug Court Pilot Program, Final Report,* December 2003 (Revised March 2004), pp.v-vi.

[436] Department of Juvenile Justice, *Annual Report 2006/07,* p.45; showed that the average daily number of young people in custody for the year was 331, of which 159 were of Aboriginal and/or Torres Strait Islander background: Australian Institute of Health and Welfare, *Juvenile Justice in Australia 2006/07*, p.52.

[437] Australian Institute of Health and Welfare, *Juvenile Justice in Australia 2006/07*, p.32.

e. *In the six month period reviewed, one child accrued a further 23 charges.*[438]

15.41 The Ombudsman has been conducting reviews of the measures that Police Local Area Commands across NSW have introduced to implement the Police's Aboriginal Strategic Directions Policy, the aim of which is to improve criminal justice outcomes for Aboriginal communities and to make positive changes in the relationships between Police and those communities. In particular, it has looked at diversion strategies, and other activities operated through initiatives having a relevance for the broader community, such as those provided through the Police Community Youth Clubs.

15.42 In general, the Ombudsman has reported favourably on the Police response in its more recent reviews during 2006 and 2007, and has noted the replacement of ad hoc activities with properly planned strategies. The Inquiry considers that continuity of implementation of such strategies across all Local Area Commands is important.

15.43 Strategies which improve relations between Police and Aboriginal communities, and the use of the several opportunities that exist for diversion, including those available under the *Young Offenders Act 1997*, are particularly important for Aboriginal youth whose contact with Juvenile Justice is likely to have a long term negative impact. The need for these kinds of responses is only part of the solution. Until the several criminogenic factors, and general background of disadvantage and isolation from mainstream services elsewhere discussed in this report are met, there is likely to continue to be a disproportionate representation of Aboriginal youth in the juvenile justice and care and protection domains.

15.44 The Inquiry notes that in Victoria, the Koori Youth Justice Program established in 1992, has now been expanded to most of the State. It is staffed by custodial Koori workers and community Koori workers employed by community organisations. It has a role that is preventative, as well as responsive in relation to offenders subject to supervision or diversion following their appearance in Court.[439]

15.45 It is the role of Koori Youth Justice workers to develop Aboriginal cultural support plans and to provide support for clients and their families, in addressing and planning suitable goals.[440]

15.46 Associated Programs in Victoria include the Koori Intensive Bail Support Program, the Koori Early School Leavers and Youth Employment Program, and the Koori Pre and Post Release Program, each of which is focused upon diverting young Aboriginal people from the youth justice system, and

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[438] Submission: NSW Ombudsman, Young People at Risk, p.14.

[439] Australian Institute of Health and Welfare, *Juvenile Justice in Australia 2006/07*, p.112.

[440] ibid.

responding to the need to provide rehabilitation opportunities for those who do enter that system.[441]

15.47 The Inquiry is of the view that consideration could usefully be given to the development of a similar model in NSW, involving Juvenile Justice and Aboriginal Affairs. It could take its place within the structure of the Interagency Plan, and build upon those programs and strategies that have currently been introduced for the purpose of reducing the disturbing over representation of Aboriginal Youth in the group of young persons subject to community supervision or detention. It would need to satisfy the principles for a culturally appropriate program identified in Chapter 18 of this report, and an assessment of its viability in this respect would be assisted by a careful study of the Koori Youth Justice Program.

Cooperation between DoCS and Juvenile Justice

15.48 Serious problems can arise in those cases where a child or young person in statutory care comes into conflict with the criminal law and becomes subject to the control or supervision of Juvenile Justice.[442]

15.49 Clearly there is a need for Juvenile Justice and DoCS to have a cooperative framework to ensure that those within this group who are in care, but in detention or under supervision, have their needs met and their prospects of rehabilitation sufficiently addressed.

15.50 The removal by DoCS of the Specialist Adolescent District Officers who had a responsibility to work with this group among others, and to ensure that their needs were met, appears to have been unfortunate, for this reason.

15.51 Juvenile Justice drew attention to the desirability of a shared client database being established, that would permit a better linkage between DoCS and Juvenile Justice, and strategies for interventions for those who are most at risk of being entrenched in the criminal justice system. The provision of a systems interface between the client databases of DoCS and Juvenile Justice would seemingly allow the two agencies to plan their services more effectively, improve case management, allow for a useful exchange of information and permit Juvenile Justice to prepare better informed background reports of the kind that are required for sentencing purposes. It might also enable each agency to provide more meaningful assistance for young people who are appearing before the courts, sometimes at a point where they are not technically a client of either agency. The Inquiry considers that there is considerable force in the submission of Juvenile Justice in support of the introduction of such a capacity.

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[441] ibid.

[442] *HA v Minister for Community Services* [2003] NSW ADT 149. Case determined under the 1987 Act, but illustrative of the challenging issues involved for DoCS, carers and the ADT in these cases.

15.52 An allied suggestion of Juvenile Justice was to the effect that there be an allocated caseworker at the DoCS Helpline to deal with Juvenile Justice calls, or at least that Juvenile Justice be added to the Police and Education on the priority list for a response. This, it suggested, could be of considerable value in relation to those young people who are brought before Bail Courts during the weekends, who present with care and protection issues, but who are not subject to the parental responsibility of the Minister. Currently, it was suggested, DoCS is slow to respond to those involved in those cases, resulting in them being effectively assigned to the responsibility of Juvenile Justice and detained in a Juvenile Justice facility.

15.53 The Inquiry notes that the 2004 MOU between DoCS and Juvenile Justice, which was supported by formal local protocols between the Regional Directors of the two agencies, determines each agency's respective roles and responsibilities for young people aged 10 years or above who are under the parental responsibility of the Minister, and who are subject to the effective control of Juvenile Justice by reason of their offending. The MOU and protocols are due for review but this has not occurred. The Inquiry considers that this requires urgent attention.

15.54 Juvenile Justice also suggested that DoCS and Juvenile Justice work together in addressing those cases where one or other of the agencies becomes involved because of a conflict between a juvenile and his or her family, which may result in proceedings for a breach of an AVO attracting Juvenile Justice's jurisdiction, or a risk of harm notification to DoCS. This could be addressed by the preparation of a Parent Responsibility Contract in which each agency contributes its specialist skills to defusing the conflict and addressing any ongoing issues, or by referral to an external DoCS funded agency similar to the procedure adopted by the Queensland Referral for Action Intervention Service model.

15.55 The Inquiry notes that there is a current project between DoCS and a number of other Departments including Juvenile Justice to address DoCS response to Juvenile Justice calls. DoCS advised the Inquiry, and the Inquiry agrees, that there is a clearly different perspective between the relevant departments as to whether a child is, indeed, in need of care and protection. The Inquiry understands that as part of this project, Juvenile Justice has been party to inquiries which have established that there are less than 20 young people a year who fall into the group who are the subject of these calls. In light of this relatively low number, the Inquiry does not agree with the Juvenile Justice suggestions that there be an allocated caseworker at the Helpline to deal with such calls. This does not, however, mean that the interests of those within this group, can be neglected, or that joint work should not be undertaken.

15.56 Worthy of consideration, is the suggestion of Juvenile Justice that a juvenile offender compact be established, involving in addition to Juvenile Justice, Department of Corrective Services, Education, Health, DoCS, DADHC, Police and Attorney General's, that would better align the policies of each department.

15.57 As envisaged by Juvenile Justice, the compact would establish a set of principles under which agencies would co-operate in servicing and prioritising young offenders. The principles would include recognition that:

a. the reduction of re-offending requires a multi-agency approach

b. the needs of Aboriginal children and young persons require particular attention

c. there is a need to target the group of young offenders at highest risk of future offending namely 10-14 year old Aboriginal males

d. pre-court/detention and post order/detention are areas for the focus of agencies' interventions.

15.58 Juvenile Justice proposes that for each agency, specific services, strategies and target groups would be clearly defined in this compact. These would be developed through consultation with each agency and would be supported by performance measures to assess the ongoing efficacy of the compact.

Reducing the risk of re-offending

15.59 Juvenile Justice has a core responsibility to work with offenders under its supervision in reducing their risk of re-offending and in addressing the underlying issues that contribute to such conduct. It has, however, pointed out, in a submission to the Inquiry, that little headway will be made unless the wider welfare and support needs of this group, whose members predominantly come from backgrounds of neglect and disadvantage, are met.

15.60 Therein lies the challenge. Having regard to the average length of community supervision for juveniles, and the average length of detention pursuant to a control order, of six months, Juvenile Justice has only a short period of time to work with these people. It follows that intensive support from other agencies is essential during this period, which can then lead to ongoing assistance or casework, so as to give those within this group a positive redirection.

15.61 Juvenile Justice has advised that it finds that other agencies, both government and non-government, tend to withdraw their services and to decrease the level of support once young people come under Juvenile Justice supervision, most likely in the belief that Juvenile Justice will be able to provide the necessary support, or otherwise out of a reluctance to take on complex high needs clients who may be difficult to engage, or because of the potential occupational health and safety risks to their staff.

15.62 Juvenile Justice has, however, recognised the need for it to adopt innovative strategies. As noted in its Annual Report for 2006/07 it now has:

> *A range of programs and interventions within both the custodial and community environments that are designed to address the needs of young offenders. These include offending behaviour programs, such as Targets for Effective Change, a program*

from the United Kingdom, that uses strategies that research has shown are effective in reducing reoffending. They also include counselling and group-work programs that focus on young offenders' alcohol and other drug issues, sex offenders and violent offenders and programs specific to Aboriginal young people.[443]

15.63 It added that:

A priority for the Department is addressing the high numbers of Aboriginal young offenders, and young offenders aged between 10-14 years. To address the needs of these groups, the Department is enhancing current strategies and developing new programs to provide effective interventions. Initiatives such as the Intensive Supervision Program will have a clear focus on young Aboriginals in the 10-14 age range.[444]

15.64 Among the services provided from Juvenile Justice Community Offices are specialised programs that deliver interventions such as the Sex Offender Program and Violent Offenders Program, Alcohol and Drug Abuse Counselling, and case management and networking, aimed at linking offenders with community support services.[445] Not all of these programs are available within the eight Juvenile Justice Centres now under the control of Juvenile Justice although specialist and psychological services are available of a generic kind involving educational, vocational, recreational and personal development programs.[446] It is understood that the Sex Offender Program is only available to offenders under supervision in the community. Clearly this limits the capacity of such programs to address the behavioural problems of those who need them.

15.65 Of potential value in this respect is the proposal of Juvenile Justice to introduce an Intensive Supervision Program in two pilot sites (the Hunter area and western Sydney) that will involve intensive work with children and young persons and their families, involving multi-systemic therapy over a period of four to six months. It will deal with a range of issues including substance abuse, re-engagement in education and vocational pursuits, health and welfare issues, housing needs, family conflict and negative peer pressure, for those juveniles with a history of committing serious offences and/or repeat offending, or whose severe anti-social behaviour puts them at risk of incarceration. The interventions are to be delivered both at home or in community settings and address parenting practices, family relationships, substance abuse problems,

[443] Department of Juvenile Justice, *Annual Report 2006/07*, p.34.

[444] ibid.

[445] ibid.

[446] The Kariong Juvenile Correctional Centre for the more serious offenders aged 16 and above and those whose behaviour while in detention has required their transfer to a more secure facility, is now within the responsibility of the Department of Corrective Services.

education, improved group associations and the establishment of a suitable network of support.[447]

15.66 A unit is to be established to oversee the program and to manage the development of similar evidence based programs.[448] It is understood that this program has been successfully used in New Zealand, the USA, Canada and a number of European countries, that up to 70 families will be targeted each year for the four years of its current life, and that it will draw upon the cooperative support of other agencies including DoCS, Police and Health. It is expected to be of particular value for an Aboriginal target group.[449]

15.67 The Inquiry considers this to be a program that should be actively supported and expanded if found, after evaluation, to be successful; and in this respect it notes that particular attention has been given to ensuring that this intervention is appropriate for young Aboriginals with a Juvenile Justice history.

15.68 One further matter of relevance for those leaving juvenile justice custody is the requirement for Juvenile Justice to develop a Post Release Support Plan, in compliance with the requirements of the Department's Post Release Support Program. It includes a structured 12 week program designed to achieve an overall reduction in the number of clients who re-offend after release from a juvenile justice centre.[450] It is further enhanced with a brokerage system that supports clients without ready access to a Post Release Support Provider and, in particular, clients in rural and remote areas. This Program is funded through the Department's Community Funding Program.

15.69 Also funded under the Community Funding Program are the following programs:

a. Accommodation Support Programs that assist young people in securing and maintaining appropriate accommodation, in developing living skills and in providing case management services.

b. Local Offender Programs that assist young persons at risk of offending or reoffending to access educational and vocational pathways.

c. Alcohol and Other Drug Programs that aim to increase the capacity of young persons to effectively manage their lives and achieve a sustained reduction in their levels of substance use. The Department currently funds two types of programs – a Family Counsellor Program in metropolitan Sydney and two eight-bed rural residential drug rehabilitation services at Dubbo and Coffs Harbour managed by the Ted Noffs Foundation. Residential drug rehabilitation services aim to provide an intensive treatment program for substance misusing young persons located close to their homes and families.

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[447] Department of Juvenile Justice, *Annual Report 2006/07*, p.39.

[448] ibid., pp.39–40.

[449] NSW Youth Action Plan, *Progress Report as at 30 June 2007*, pp.19–20.

[450] Department of Juvenile Justice, *Annual Report 2006/07*, p.43.

d. The Employment Skilling Program that assists young people subject to a supervised court order by providing access to relevant education, vocational training and employment pathways, and by helping them to establish and maintain positive links with the community.

e. The Children's Visiting Legal Service (Legal Aid Commission) that provides legal assistance to detainees.[451]

15.70 The Inquiry has been advised that 39 non-government organisations are funded through Juvenile Justice's Community Funding Program. Funding for 2007/08 was $5.7 million and the budget for 2008/09 is $5.9 million.

15.71 An additional program of value is the Juniperina Shared Access Trial negotiated between Housing, Juvenile Justice, DoCS and Justice Health, (see Chapter 7).

Justice Health Program

15.72 Commonly, young offenders have mental health issues, including personality disorders, that need to be addressed before they become entrenched. Juvenile Justice has informed the Inquiry that a significant number of those in detention have significant mental health or personality disorder issues, a circumstance that tends to be aggravated where, as is commonly the case, their parents also have history of criminal offending or of mental illness, or are in custody.

15.73 Justice Health has an important role to play in this area, both in arranging assessments and reports to the court, and in linking these people to mental health services and other agencies as well as services for those exiting juvenile detention through its Community Integration Team. DoCS should also play a role, as part of its responsibility in providing assistance to those under the parental responsibility of the Minister, by engaging Justice Health, in those cases.

15.74 As noted in the NSW Youth Plan Progress Report as at 30 June 2007:

> *Justice Health has received $1.2 million recurrent funding to provide services for clients 10-18 years old who have come in contact with the criminal justice system and have an emerging mental illness and/or drug and alcohol problems.*
>
> *The service comprises four main components: community based assessments and linkage to appropriate community services; court liaison and diversion; discharge planning for young people in custody and for some young people occupying mental health inpatient beds; and case management of a small number of clients. The service has commenced in Western Sydney area and will expand to the Central Sydney area and a regional area yet to be determined. Results from the first four*

[451] ibid., pp.36-37.

> *months of operation of this service indicated that of 44 clients referred to assessment via court diversion 14 cases were diverted into treatment, with all criminal matters dismissed, with a further 11 diverted into treatment with treatment compliance as a condition of their bail.*[452]

Participation of DoCS in cases within the Juvenile Justice system

15.75 Relatively few cases are reported to DoCS by Magistrates sitting in the criminal jurisdiction of the Children's Court.[453]

15.76 The Children's Court, in its submission to the Inquiry, submitted that a power should be conferred on the Court to require the Director-General of DoCS to provide courts with reports on the care and protection issues of a child or young person brought before them in proceedings of this kind, and on the actions which the Department proposes to take concerning them, or to give an explanation of why no action is to be taken.

15.77 While the NSW Ombudsman accepts that there would be merit in the Children's Court receiving timely information from DoCS in relation to those appearing before it, about whom a Magistrate has concerns, it suggests that such referrals should be limited to cases where "a high risk of harm appears to exist."[454]

15.78 The NSW Law Reform Commission considered this point in its 2005 Report on Young Offenders. The Commission noted that:

> *… the relationship between the Children's Court, DoCS and Juvenile Justice in care matters that come before the court seems to be problematic. … it is not always clear who has, or should have, responsibility for the young person before the Court. Nor is it always clear what services and resources are available and who has the authority to utilise these in a particular matter. Benefits would flow to young people caught up in the criminal justice system if the ambiguities in the Court/departmental interrelationships were resolved and if there were greater cooperation between these bodies in matters before the Court. Such cooperation should extend to providing the Court with the information it needs to make the most appropriate orders in respect of the young offender.*[455]

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[452] NSW Youth Action Plan, *Progress Report as at 30 June 2007*, p.16.

[453] Submission: NSW Ombudsman, Young People at Risk, p.20, NSW Ombudsman noted that only 32 cases of this kind were reported in 2005.

[454] ibid.

[455] NSW Law Reform Commission, Report 104, *Young Offenders,* 2005, at 8.141.

15.79 It recommended that:

> *A Protocol should establish which department or departments has responsibility for a young person appearing before the Children's Court in a criminal matter who is in need of care and protection and/or bail or crisis accommodation. The Protocol should promote co-operation in such matters between the Children's Court, the Department of Juvenile Justice and the Department of Community Services, in the child's best interests.*[456]

15.80 The Law Reform Commission noted that the Children's Court currently has the power under s.7 of the *Children (Protection and Parental Responsibility) Act 1997*, when exercising criminal jurisdiction, to require the attendance at court of the young offender's parents.[457] The Children's Court submitted to the Commission that this power should be extended to apply to the Director-General of DoCS or his or her delegate. Currently, s.3 of the *Children (Protection and Parental Responsibility) Act 1997* specifically excludes the Minister and the Director-General of DoCS from the definition of 'parent' under the Act. The Commission's view was as follows:

> *The Commission sees the merit and logic of the Court's submission. However, amendment of the definition of 'parent' in the Children (Protection and Parental Responsibility) Act 1997 (NSW) to include the Minister and the Director-General of DoCS would have consequences in many different areas of parental rights and responsibilities, extending far beyond sentencing. Accordingly, it would not be appropriate for the Commission to recommend this change in this review. This is particularly so given that the submission was made late in the review and we have not had the opportunity to consult widely on it. We do, however, recommend that Parliament consider the issue and the Children's Court's submission, at the least in relation to DoCS' attendance in court in criminal proceedings where the young offender is subject to a care order.*[458]

15.81 The Inquiry does not consider it appropriate for the Children's Court to have an own motion power of the kind suggested, as this would be inconsistent with its role as a court of law charged with the determination of cases brought before it. To confer upon the court an own motion or supervisory role would cross the appropriate boundaries within which the two institutions, one judicial and the other administrative, need to function.

[456] ibid., at Recommendation 8.7.
[457] ibid.
[458] ibid., at 8.144.

15.82 However, the Inquiry does agree that, if requested by the Court, DoCS should provide relevant information within its possession that might assist in the sentencing young people before the Children's Court in relation to a criminal offence which, it might be expected, would identify any ongoing care and protection issues that might need to be taken into account in the exercise of the court's sentencing discretion. It can exercise its s.248 power for that purpose.

Conclusion

15.83 It is recognised that there is a clear distinction between the child protection and criminal justice systems which needs to be maintained. On the other hand, coming within the juvenile justice or criminal justice system should not exclude a young offender from long term services from DoCS and other human service agencies. Nor should a shortage of refuges or other forms of accommodation result in young people, who cannot live safely with their families, being remanded in custody unnecessarily, pending trial.

15.84 There are important strategies and trials that are designed to prevent young people from becoming engaged with the criminal justice system, including the Redfern Waterloo Case Coordination Project, the New Street Adolescent Service, the Anti-Social Behaviour Project, the Project Energy Scheme in the Illawarra Local Area Command, and the Tirkandi Inaburra Project for Aboriginal boys aged between 12 and 15 years, who have potential but are beginning to get into trouble, some of which are discussed elsewhere in this Report.

15.85 These initiatives need to be encouraged. The long term consequences of acquiring a record as a juvenile, or of being detained in a detention centre, in terms of future employability and rehabilitation, are such that every possible alternative should be made available. This has a particular significance for those young people who, through no fault of their own, have suffered that degree of abuse, neglect and poor parenting that might call for care and protection intervention or that might otherwise heighten their risk of drifting into criminal behaviour.

15.86 For those who do become the subject of interest by both DoCS and Juvenile Justice, the case for extensive joint intervention including Health is compelling.

Adult justice system and child protection

Role of NSW Police Force

15.87 Police officers have a substantial role in the area of child protection, arising under the Care Act and the general criminal law, including;

a. the investigation and prosecution of those offenders who are responsible for the infliction of physical harm upon young people, or for their sexual

assault, or for their neglect, as well as those involved in child pornography and child prostitution offences

b. attending domestic violence incidents and investigating drug offences or responding to disturbances involving mentally ill persons, which may leave them with reasonable grounds to suspect that young people who are associated with those involved in such events are at risk of harm from abuse or neglect and with a resulting obligation to notify DoCS

c. delivering or coordinating crime prevention and diversionary/support programs that are aimed at identifying and diverting young people from offending or becoming the victims of crime

d. arranging activities for young people through the Police and Community Youth Club network and similar services

e. assisting DoCS staff in the removal of young people who are suspected of being at risk, and in cases of emergency acting on their own volition to remove such persons, pending DoCS engagement in the case,[459] and to refer them to emergency, interim placements

f. seeking AVOs in the name of the child or young person where that is considered necessary for their protection, and enforcing them when breaches come to notice

g. reporting to DoCS where there are reasonable grounds to suspect that a child or young person is at risk of harm,[460] or is homeless,[461] or where there are concerns for the possibility of future harm to an unborn child[462]

h. assisting with the provision of the information required for working with children checks

i. locating missing young people, including those who have run away from a placement, and responding to abandoned or unsupervised children, as well as those who are left unattended in motor vehicles

j. presenting children believed on reasonable grounds to be in need of care and attention, to a medical practitioner[463]

k. investigating persons suspected of posing a risk to young people, operating the scheme for the registration of certain offenders who pose risks of that kind, and seeking Offender Prohibition Orders concerning persons within this group

l. reporting to the Coroner in relation to child deaths where the death has occurred under any of several defined circumstances, and to carry out investigations into any such death where directed by the Coroner, or upon its own motion

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[459] *Children and Young Persons (Care and Protection) Act 1998* ss.43.

[460] *Children and Young Persons (Care and Protection) Act 1998* ss.24 and 27.

[461] *Children and Young Persons (Care and Protection) Act 1998* ss.120 and 121.

[462] *Children and Young Persons (Care and Protection) Act 1998* s.25.

[463] *Children and Young Persons (Care and Protection) Act 1998* s.173.

m. participating in the work of the Child Death Review Team, including the provision of records required to inform research undertaken by that team.

Child Protection and Sex Crimes Squad

15.88 This is a statewide Specialist Child Protection Squad that includes the Sex Crimes Team and the JIRTs. It is structured to carry out investigations into serious or serial child and adult sex crimes, as well as serious child physical assault cases, child pornography and grooming offences, female genital mutilation and protracted or complex child prostitution cases and to provide support for Local Area Command investigations. It administers the Child Protection Register, and maintains a proactive intelligence and surveillance capacity to support squad and Local Area Command investigations. Its Child Exploitation Unit investigates child sex offender activities on the internet and related computer and telecommunications devices and it is the liaison point for national and international investigations into this area of activity. It also provides forensic examinations of computers and hard drives suspected of being used for the manufacture or distribution of child pornography.

Joint Investigation Response Teams

15.89 JIRTs comprise representatives from Police, DoCS and Health, that investigate cases involving the sexual assault and serious physical abuse and neglect of children and young persons upon referral from DoCS. Their principal concern is with victims aged under 16 years. Their role has been examined in Chapter 8.

Specialist support positions

15.90 The response of these units in relation to child protection issues is supported by the presence of a number of specialist positions.

a. Domestic Violence Liaison Officers are stationed within Local Area Commands, with a responsibility to support and monitor the policing response to family and domestic violence, ensure protection orders are sought for victims including young people, monitor family and domestic violence-related ‘child at risk’ reports made to the DoCS, and support JIRT police officers in applications for AVOs through the courts.

b. The Inquiry was advised that a Domestic and Family Violence Team is to be established under the authority of the Deputy Commissioner, Field Operations, to provide a corporate monitoring role of domestic violence incidents, and their management by Police.

c. Youth Liaison Officers work with young people, their families and community members to reduce and prevent crime, to enhance positive relationships between young people and Police, and to promote a safer shared public environment.

d. Police and Community Youth Club Youth Program Officers are based in 59 Police and Community Youth Clubs across the State, and their task is to

deliver programs and interventions for young offenders, young people at risk of offending, and youth crime hotspots, that are aimed at addressing risk factors, and building protective factors and resilience in those within this group.

e. School Liaison Police Officers implement educational programs and crime prevention workshops at high schools, that are aimed at addressing youth crime, supporting victims of crime, and developing mentoring schemes.

f. Aboriginal Community Liaison Officers assist operational police officers to develop, implement and monitor programs that are designed to establish positive relationships between Aboriginal communities and Police.

g. Ethnic Community Liaison Officers are unsworn officers who assist operational police officers in building closer relationships with local communities from diverse cultural and linguistic backgrounds.

h. Child Protection Regional Liaison Officers have a coordination role and a potential for direct involvement in the Child Protection Watch Team strategy.

15.91 Police in its submission to the Inquiry has argued for retention of the tiered approach mentioned above. The Inquiry does not see any reason to depart from that structure, or to question the establishment of the specialist positions mentioned, each of which has the potential to add value to the contribution provided by Police in protecting children and young people.

Additional protective powers

15.92 In addition to their capacity to charge those who commit offences under the general criminal law against young people, the Police have power to apply for Apprehended Domestic or Personal Violence Orders on their behalf under the *Crimes (Domestic and Personal Violence) Act 2007;* and for Child Protection Prohibition Orders that prohibit persons who are registered under the *Child Protection (Offenders Registration) Act 2000*, and who pose a risk to the lives or sexual safety of children, from engaging in specified conduct, under the *Child Protection (Offenders Prohibition Orders) Act 2004*.

15.93 Specific protection is also provided for young people following the successful prosecution by Police of those who are involved in certain sexual and violence offences, as a result of the registration regime established under the *Child Protection (Offenders Registration) Act 2000,* which requires such offenders to provide Police with personal information, including the details of any children and young persons with whom they reside or have regular unsupervised contact. Compliance with these requirements is now enhanced by the establishment of the Child Protection Watch Team Project which has multi-agency involvement and has been the subject of a positive evaluation.

15.94 Consequences arise in relation to the capacity of those offenders thereafter to work with children and young persons, by reason of the provisions of the CCYP

Act.[464] Additional protection is provided by the power of the Supreme Court, on the application of the State, to order the extended supervision or continuing detention of certain classes of sex offenders.[465]

15.95 Apart from the general criminal law, the Care Act creates the following several specific offences which are designed to protect young people:

a. A person intentionally takes action that has resulted in or appears likely to result in the physical injury or sexual abuse of a child, or young person, or in the child or young person suffering emotional or psychological harm such that their emotional or intellectual development is or is likely to be significantly damaged, or in their physical development or health being significantly harmed.[466]

b. A person without reasonable excuse, neglects to provide adequate and proper food, nursing, clothing, medical aid or lodging for a child or young person in his or her care.[467]

c. A person without lawful excuse removes or causes or procures a child or young person to be removed from the care of the person into whose care and protection or care responsibility they have been placed.[468]

d. A person tattoos any part of the body or a child or young person without the written consent of a parent of that child.[469] The definition of tattooing has now been extended to include other procedures including body piercing.

e. A person leaves a child or young person in the person's care in a motor vehicle without proper supervision for such period or in such circumstances that they are likely to become emotionally distressed and their health becomes or is likely to become permanently or temporarily impaired.[470]

15.96 For each of these offences under the Care Act the maximum penalty is 200 penalty units ($22,000). The need for these offences under the Care Act is obvious. The issue which arises, however, is whether they should be punishable by imprisonment as an addition to, or as an alternative to, a court imposed penalty. The Inquiry notes that in a response to the DoCS Discussion Paper, the Police Ministry proposed an amendment of these provisions so as to allow a term of imprisonment to be imposed for up to six months. The Inquiry does not agree, at least in relation to the prosecution of parents, since imprisonment is only likely to exacerbate any underlying risk issues.

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[464] *Commission for Children and Young People Act 1998* Part 7.

[465] *Crimes (Serious Sex Offenders) Act 2006* Parts 2 and 3.

[466] *Child and Young Persons (Care and Protection) Act 1998* s.227.

[467] *Child and Young Persons (Care and Protection) Act 1998* s.228.

[468] *Child and Young Persons (Care and Protection) Act 1998* s.229.

[469] *Child and Young Persons (Care and Protection) Act 1998* s.230.

[470] *Child and Young Persons (Care and Protection) Act 1998* s.231.

Diversion and crime reduction strategies

Pre-trial diversion of adults charged with child sexual assault

15.97 A critical aspect of law enforcement in relation to the protection of young people from sexual and physical abuse is the provision of diversionary programs which can address the offending behaviour of adults and reduce the risk of its repetition. There are some useful initiatives in this respect, which the Inquiry considers should be encouraged and made more widely available.

15.98 Among their duties Police have a responsibility to provide information to arrested adults concerning the Pre-Trial Diversion of Offenders (Child Sexual Assault) Program, the Cedar Cottage Program, established under the *Pre-Trial Diversion of Offenders Act 1985*.

15.99 The Cedar Cottage Pre-Trial Diversion of Offenders (Child Sexual Assault) Program provides therapy for sexual offenders who plead guilty to abusing a child in their care. Offenders are referred to the program by Police or the courts and receive an eight week intensive assessment to decide if they will be accepted. Participants then attend group and individual therapy sessions for a minimum of two and a maximum of three years. Victims and families are also provided with individual and group therapy sessions.[471]

15.100 An evaluation of the program found a sharp drop in estimated lifetime re-offending rates from 13.2 per cent to 7.5 per cent for sexual offences. Non-sexual offending also declined in the treatment group, although not to the same extent.[472] Those who did not enter the program had an associated lifetime re-offending rate for sexual offences of about 12 per cent, those who participated in the program – even if they did not complete – had an estimated re-offending rate of less than five per cent.[473] The authors conclude that:

> *the remarkably successful outcomes of this diversion program must be viewed in the context of other comparatively costly prison-based and community based offender treatment programs, most of which are unable to demonstrate any effects of treatment.*[474]

15.101 The Inquiry understands that Health, which administers the program intends to give consideration to possible legislative change to broaden the criteria for access, and to the conduct of further research. In the meantime the Inquiry is of the view that the program should be maintained and that additional efforts

[471] J Goodman-Delahunty and J Pratley, *The NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program: An Evaluation of Treatment Outcomes*, July 2008, p.ii.
[472] ibid.
[473] ibid., p.iv.
[474] ibid., p.v.

should be made by Police, the DPP and the defence Bar to make its availability known and understood by potential participants.

15.102 The Inquiry does, however, note that Health has concerns about DoCS ceasing its involvement with a family once an offender has been referred to Cedar Cottage, and that it also has similar concerns about DoCS limiting its involvement in the case of young persons referred to the New Street Program.[475] The Inquiry understands Health's concern, but is also mindful of the prioritisation process which DoCS inevitably must follow.

Other Diversionary Programs Concerning Adults

15.103 There are some additional diversionary programs targeted at adults which have relevance for the safety of young people. Where successful they can reduce or eliminate the circumstances within the home that contributed to abuse and neglect in their several forms. Although any detailed consideration of these programs is beyond the scope of this report, the presence and potential value of the following programs in NSW is briefly noted:

a. The Magistrate's Early Referral into Treatment Program, a Local Court pre-plea diversion program that targets adult defendants with illicit drug abuse problems.[476]

b. The Rural Alcohol Diversion Pilot Program directed at adult defendants with alcohol abuse or dependence problems who are offered the opportunity of rehabilitation as part of the bail process.

c. The participation of offenders in the Circle Sentencing process and in the Adult Drug Court, that also opens up the possibility of diversion and access to rehabilitation programs or services which may reduce the safety risk of children and young persons living in the same household as the offender. This has a particular significance for those cases where substance abuse has been a major factor in the notification of children at risk to DoCS, since its presence can operate as a significant impediment to restoration.

Department of Corrective Services

15.104 The Interagency Guidelines define the child protection role of the Department of Corrective Services (Corrective Services) as the management of offenders in custody (including young offenders held in Kariong Juvenile Correctional Centre) and in the community. The Interagency Guidelines state that one role of Corrective Services is to work with child related offenders to reduce their risk of re-offending, and supervise offenders released into the community on probation or parole. This involves case management of the offender,

[475] This program is discussed in Chapter 7.

[476] NSW Health: The Magistrate Early Referral and Treatment (MERIT) Program, *Health Outcomes*, November 2007.

incorporating strategies to minimise risk of harm to the community, including young people with whom the offender may have contact.

15.105 The Interagency Guidelines also state that Corrective Services has a responsibility to maintain a victims' register responding to requests from registered victims for information concerning an offender's release from custody, escape or participation in external leave programs from a correctional centre.[477] Corrective Services reported that in the 11 years from the establishment of the register to 2007, it had provided a service to 2,200 victims of crime.[478]

15.106 Corrective Services stated that it established the Child Protection Coordination and Support Unit to ensure these child protection responsibilities were met.

15.107 Corrective Services provides or resources a number of programs, projects and interventions to reduce the risk of reoffending and contribute to a safer community.

15.108 Programs for offenders in custody include:

a. drug and alcohol treatment programs
b. programs for violent offenders and sex offenders (including a program for female sex offenders)
c. mental health programs
d. restorative justice conferencing
e. facilitation of visits with family and friends to enhance reintegration after release from custody.[479]

15.109 Programs and services for offenders being managed in the community include:

a. Sex offender risk assessments (140 risk assessments and eight assessments under the *Crimes (Serious Sex Offender) Act 2006* conducted in 2006/07).[480]
b. Aboriginal specific programs in the community. Corrective Services received $3.8 million from July 2004 to June 2008 under the *Two Ways Together* Aboriginal Affairs Policy 2003-2012. This funding has been allocated across the following three project locations:
    i. Lismore and Tabulam – Rekindling the Spirit. Corrective Services reported that:

> *Developed in 1998, Rekindling the Spirit targets Aboriginal males and Aboriginal females and their*

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[477] *NSW Interagency Guidelines for Child Protection Intervention,* 2006, Appendix 2, p.4-5.
[478] Department of Corrective Services, *Annual Report 2006/07,* p.22.
[479] ibid., p.34.
[480] ibid., p.39.

> *families to address the underlying causes of offending behaviour thereby reducing family violence and re-offending. ... In 2006/07, 53 male and 14 female Community Offender Services clients started the program and the Department forged community partnerships to extend the program to Tabulam.*[481]

ii. Dubbo–Yindyama La (Family Violence Project) to develop an inter-agency approach to male perpetrators of violence. Corrective Services reported that in 2006/07, 30 supervised Aboriginal male offenders were referred to the program.[482]

iii. Newtown/Redfern - Walking Together Project. Corrective Services reported that this program addressed problems of loss and lack of cultural identity for urban Aboriginal offenders, and that the program had been revised to more specifically target family violence. It was reported that in 2006/07 Corrective Services developed a parallel program for Aboriginal female offenders to address family violence, emphasising the need to protect children and speaking out against violence towards women and children in the family and in the community, and that during that year, 56 men and 28 women were referred to the programs.[483]

c. Sex offender program maintenance for offenders being released. Corrective Services reported that in 2006/07, 20 additional sex offenders commenced a community based relapse prevention program. It was reported that 14 completed the program, and three were returned to custody and therefore did not complete the program. It was also reported that 47 sex offenders located too remotely to access metropolitan based programs were seen individually.[484]

d. The establishment of community based programs for offenders with dual diagnosis (both mental health and drug and alcohol disorders) in 2006/07.[485]

e. The Community Compliance Group which targets high risk offenders, primarily sex offenders, and work closely with the families of offenders, is an initiative of Corrective Services.

15.110 Corrective Services programs have targeted strategies for Aboriginal people, such as an Aboriginal mentoring program in some facilities. The Aboriginal Support and Planning Unit, established in 1993 after the Royal Commission into Aboriginal Deaths in Custody, was involved in the development of specific policies, resources and programs for Aboriginal inmates, such as the *Aboriginal and Torres Strait Islander Inmate Handbook*.

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[481] ibid., p.42.
[482] ibid., p.42.
[483] ibid., p.43.
[484] ibid., p.44.
[485] ibid., p.45.

15.111 Corrective Services administers a Community Funding Program, which allocated a total of $2,828,171 to 10 organisations in 2006/07.[486] Link-Up (NSW) Aboriginal Cooperative received $74,480 for services to help Aboriginal and Torres Strait Islander Offenders establish and strengthen their family links. SHINE for Kids received $572,865 from Corrective Services for services to support children of offenders.[487] This represented 45 per cent of the total SHINE for Kids income for that financial year.[488]

Recommendations

15.112 The Inquiry has noted the sentencing options and the range of diversionary or rehabilitation programs in place or subject to trials, which seek to advance the objective of keeping young people out of the criminal justice system and of advancing their rehabilitation once they have offended, and of reducing the extent to which adult offenders pose a continuing threat to the safety of children and young persons. The overall structure appears to the Inquiry to be comprehensive and adequate, and it does not see it as necessary to do more than express its general support for the current system.

Recommendation 15.1

> An after hours bail placement service should be established by the Department of Juvenile Justice similar to the Victorian Central After Hours and Bail Placement Service, that is available to young people aged between 10 and 18 years, who are at risk of being remanded in custody, or who require bail accommodation; or similar to the Queensland Conditional Bail and Youth Program Accommodation Support Service.

[486] ibid., p.133.
[487] ibid., pp.45 and 133.
[488] SHINE for Kids, *Annual Report 2006/07,* p.15.

Part 4 Out-of-home care

16 Out-of-home care

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Overview

16.1 Removing children and young persons from their family can only occur where it is necessary to protect them from the risk of serious harm. The safety, welfare and well-being of the child or young person removed is paramount over the rights of the parents.

16.2 While these principles governing the removal of children and young persons are apparently straightforward, their application is not. There is little reliable research that tracks children and young persons through OOHC. Performance assessment of the OOHC system is presently based on process rather than on measured outcomes. As a result little is known of the long term outcomes for children and young persons in OOHC and there is relatively little to guide one when reviewing practices in NSW.

16.3 It is however noted that progress is being made. DoCS is implementing, in conjunction with non-government organisations, an OOHC minimum data set which will collect information on such things as school attendance, suspensions from school and medical assessments.

16.4 A longitudinal study commissioned by DoCS of children and young persons in OOHC is in progress to enable a better understanding of their backgrounds and characteristics, and of how these factors influence outcomes.

16.5 Additionally, in November 2007, DoCS engaged Ernst & Young to undertake an evaluation of the OOHC program.

16.6 The NSW OOHC service system is complex and involves a range of stakeholders including children and young persons, their families/carers and government and non-government agencies. Designated agencies, including DoCS, provide placement, supervision and support services and are responsible for the authorisation of carers who have responsibility for the daily care and control of the child or young person whilst in OOHC.

16.7 The Care Act, the Regulations and the *Adoption Act 2000* set the legislative framework for the provision of OOHC placement and support services in NSW.

16.8 A number of provisions of the Care Act have not been proclaimed and as a result, the foster provisions of the 1987 Act have not been repealed. While there are some exceptions, this means that care orders by the Children's Court are regulated by the Care Act and other arrangements are regulated by the 1987 Act. This is discussed later in this chapter.

16.9 Section 135 of the Care Act defines OOHC as residential care and control of a child or young person at a place other than their usual home, for a period in excess of 14 days, by a person other than a parent or relative[489] where the care

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[489] Except where the Minister has parental responsibility or the Director-General has care responsibility.

and control is provided under an order of the Children's Court or where the child or young person is a protected person as defined by that section.

16.10 Clause 17 of the Regulations and s.135(2) of the Care Act exclude certain arrangements from the definition of OOHC. Otherwise cases answering the description in the preceding paragraph constitute statutory care.

16.11 DoCS provides support to children and young persons placed with relative/kinship carers, or in voluntary care, where there has not been statutory intervention or a related court order. The purpose of its extended 'definition' is to prevent the unnecessary entry of children into statutory OOHC. Section 161(2) of the Care Act provides a broader definition of OOHC for the purpose of allowances than does s.135.

16.12 DoCS both funds and provides OOHC services to children and young persons. The OOHC service system is mixed, with DoCS as the largest service provider delivering services to around 85 per cent of all children and young persons in OOHC, with the remaining 15 per cent comprising those in non-government general foster care, that is care by persons other than relatives or kin, or in residential care. They include the children and young persons with high and complex needs who are catered for in more intensive non-government organisation placements.

16.13 All OOHC systems nationally, including NSW, have experienced a substantial increase in the number of children and young persons entering care in recent years. Not only has the need for these services increased, but many of those entering OOHC are presenting with increasingly complex needs and challenging behaviours.[490] The task of meeting this demand is placing the NSW OOHC system under considerable pressure. All Australian jurisdictions are confronting similar challenges.

16.14 In December 2002, approximately $617 million was allocated in additional funding to increase the number, type and quality of OOHC services for children and young persons as part of the DoCS Reform Package. Approximately 75 per cent of this funding was to be provided in the last three years of the Reform Package. A significant proportion is still subject to the finalisation of the 2007 expression of interest process for new OOHC services. This means that many of the new services identified to meet the demand for placements and supports have yet to commence. DoCS anticipates that these new services will be in 2008/09. It is unclear from the information provided by DoCS how many new places will result from this funding and whether this will be adequate to meet the anticipated demand.

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[490] C Smyth and T Eardley, "Out of home care for children in Australia: A review of literature and policy. Final Report," *Social Policy Research Centre, University of New South Wales,* February 2008, p.3.

Key provisions/concepts

16.15 OOHC is generally regulated by Chapter 8 of the Care Act. Section 134(1)(c) of the Care Act provides that one of the objectives is to clarify the roles and responsibilities of those involved in the provision of OOHC by distinguishing between:

a. care responsibility – the daily care and control of a child or young person

b. supervisory responsibility – the supervision of those who have care responsibility, and

c. parental responsibility – all the duties, powers, responsibilities and authority which by law, parents have in relation to their children.

16.16 These categories are not necessarily exclusive of each other. As outlined below, care decisions may be made by more than one body, such as a person with parental responsibility, the designated agency and the authorised carer.

Entry into care

16.17 The entry of a child or young person into the OOHC system can occur through multiple pathways:

a. a request from a parent to a designated agency, DoCS or DADHC for a voluntary care placement

b. DoCS initiated non-statutory(supported) care (mostly relative/kinship care)

c. DoCS initiated statutory care through an order of the Children's Court that the child or young person is in need of care and protection

d. answering the description of a protected person, as defined by s.135(4) of the Care Act.

Parental responsibility

16.18 Under s.79(1)(b) of the Care Act, if the Children's Court finds that a child or young person is in need of care and protection it may make an order placing the child or young person under the parental responsibility of the Minister. Where such an order is made the Court must determine which aspects of parental responsibility (if any) are to be the responsibility of others or are to be exercised jointly with the Minister pursuant to s.81 of the Care Act.

16.19 The Court may make an order under s.79(1)(a) allocating parental responsibility, or specific aspects of parental responsibility, to either:

a. one parent to the exclusion of the other parent (in which case the child or young person is not in OOHC)

b. one or both parents and the Minister or others jointly

c. another suitable person (for example the Court has to date placed some Aboriginal children under the parental responsibility of the principal officers of specialist Aboriginal designated agencies).

16.20 A parent may retain specific aspects of parental responsibility (for example contact and religious upbringing), while parental responsibility in relation to residence may be allocated to another person. In cases where the parent does not have (at least) parental responsibility for residence, the child or young person will be in OOHC, unless one of the specific exemptions in s.135(2) of the Care Act or clause 17 of the Regulations applies.

16.21 The parental responsibility of the Minister is delegated to the Director-General, with the exception of certain residual powers of guardianship. Aspects of parental responsibility, other than those residual powers may be delegated to the principal officer of a designated agency and then sub-delegated to other authorised carers.[491] The delegate may also, in some situations, arrange for others to perform care tasks while still retaining care responsibility.

16.22 Section 164 of the Care Act provides that the Minister is responsible for the provision of accommodation for any child or young person for whom the Minister has sole parental responsibility or parental responsibility in relation to residence.

Supervisory responsibility

16.23 Section 138 of the Care Act provides that arrangements for the provision of OOHC may only be made by a designated agency or by the Children's Guardian. Section 140 of the Care Act provides that a designated agency is responsible for supervising the placement of a child or young person that the agency has placed in the OOHC of an authorised carer. That responsibility extends, *inter alia*, to giving directions to authorised carers.

16.24 Section 141 of the Care Act requires DoCS to supervise the placement of a child or young person in OOHC if another designated agency ceases to be able to fulfil its responsibilities in relation to the child or young person.

16.25 Section 139 of the Care Act defines a designated agency as a department of the Public Service, or an organisation that arranges the provision of OOHC, if the department or organisation is accredited for the time being in accordance with the regulations.

16.26 Clause 36 of the Regulation provides for accreditation by the Children's Guardian of a department or organisation as a designated agency if the agency satisfies accreditation criteria.

[491] *Children and Young Persons (Care and Protection) Act 1998* s.157.

Care responsibility

16.27 All foster carers and relative/kinship carers (where the Minister has parental responsibility or the child or young person is in the care of the Director-General by order of the Children's Court) must be authorised.

16.28 Sub-sections 157(1)(a)-(d) of the Care Act provide that an authorised carer of a child or young person has authority to consent to certain medical or dental treatments or other activities involving a person in care, while sub-section 157(1)(e) gives the authorised carer general authority "to make other decisions that are required in the day to day care and control of the child or young person."

16.29 Section 157(3) provides that the exercise by authorised carers of these functions is subject to any written direction given by the designated agency that placed the child or young person in the daily care and control of the authorised carer, or given by the Children's Guardian.

16.30 This means that the designated agency with supervisory responsibility can determine the extent to which authorised carers exercise daily care and control of children and young persons in their care. This enables the designated agency to have daily care and control in respect of specified matters, with daily care and control in respect of other matters being left to the authorised carer.[492]

Permanency planning

16.31 A key principle of the Care Act requires that safe and stable permanent placements be secured for children and young persons in OOHC as early as possible[493]. Section 78A specifies the need for permanency planning for those who enter OOHC and requires the making and execution of a plan that aims to provide a child or young person with a stable placement that offers long term security.

16.32 Where an application is made by the Director-General to the Children's Court for a care order, s.83 of the Care Act requires the Director-General to assess whether there is a realistic possibility of the child or young person being restored to his or her parents. Section 84 specifies the matters to be dealt with in a permanency plan that involves restoration.

16.33 If a child or young person cannot be reunited with his or her family, decisions about long term placement, including adoption, must happen as early as possible.[494] If the child or young person cannot be returned to his or her family

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[492] Children's Guardian, *Proposed regulatory amendments for the assessment and authorisation of carers and principal officers of designated agencies*, October 2007, pp.9-10.

[493] *Children and Young Persons (Care and Protection) Act 1998* s.9(f).

[494] DoCS, *Child protection and out-of-home care caseworker policy manual*, p.93.

a permanency plan that identifies other suitable options of caring for the child or young person must be developed.[495]

Review

16.34 Section 150 of the Care Act requires placements of children and young persons in OOHC pursuant to an order of the Children's Court to be reviewed by the designated agency supervising the placement, for the purpose of determining whether the safety, welfare and well-being of the child or young person is being promoted by the placement. The review is to be undertaken within the timeframes respectively specified by s.150(2) (a) and (b) of the Care Act and/or when there are changes in the circumstances of the placement.[496]

Types of care arrangements

16.35 Short to medium term OOHC placements are usually required when a child or young person requires a placement because of a temporary care agreement or pending the outcome of action in the Children's Court. At the time that the placement is arranged the outcome for the child or young person may not be clear.

16.36 Long term foster or relative/kinship care, permanent care, or adoption are considered for children or young persons who are placed in care under an order of the Children's Court for a period longer than 12 months, where restoration is unlikely.

16.37 Children and young persons who enter OOHC may be in voluntary care, temporary care, or supported care placements, in addition to statutory care placements as defined earlier.

16.38 Voluntary care refers to care arrangements when an agency responds to a family's request for assistance by providing a placement away from the usual home of the child or young person. In this instance, there is no Children's Court order to reassign parental responsibility, so the parent keeps the decision making role. The statutory provisions in relation to voluntary care including the unproclaimed provision of the Care Act are dealt with at the end of this chapter.

16.39 DoCS does not arrange these placements and it only becomes involved if there are grounds for making a report that the child in voluntary care is at risk of harm. Currently DoCS stipulates that agencies should supply no more than two per cent of their DoCS funded placements as voluntary care on a care day's basis.

16.40 Temporary care is a voluntary form of OOHC specified under s.151 of the Care Act and is usually provided by a relative, kinship or foster carer. DoCS can

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[495] DoCS, *Permanency Planning Policy*, Executive Summary, p.1.

[496] *Children and Young Persons (Care and Protection) Act 1998* s.150 (2) (c) and (d).

organise temporary care where a child or young person is assessed as in need of care and protection. This occurs when particular circumstances of the placement are part of an approved case plan to support the family to resolve issues of a child's or young person's safety, welfare or well-being. Temporary care of a child or young person may only be arranged either:

a. with the consent of a parent, or

b. without parental consent if the parents of a child or young person cannot be reasonably located.

16.41 These arrangements are for a period of up to three months after which DoCS can renew the arrangement for a further three months if the child or young person is still in need of care and protection. These arrangements cannot be made or renewed if the child or young person has, during the previous 12 months, been in temporary care for a period exceeding six months.[497] A case plan is to be developed as part of these arrangements and should address the restoration of the child or young person upon leaving this form of care. DoCS is required to keep parents or usual carers informed about the whereabouts of a child or young person placed into temporary care.[498]

16.42 Supported care is a voluntary arrangement whereby a child or young person lives with either:

a. a relative or kinship carer, if the carer has parental responsibility via a Children's Court or Family Court order and they receive the Supported Care Allowance

b. a relative or kinship carer, after a child protection intervention but where there is no court order and the carer receives the Supported Care Allowance

c. a non-relative who has parental responsibility via a Family Court order and the carer receives the Supported Care Allowance.

16.43 Statutory care as defined earlier can include relative or kinship care where the Minister has parental responsibility for the child or young person as a result of an order of the Children's Court.

Adoption

16.44 Adoption can become part of the case plan for a child or young person at any time after the decision not to pursue restoration has been made. Casework in relation to adoption involves working with the authorised carers, the child or young person and the birth parents. Adoption orders are granted by the NSW Supreme Court. The important issues for the Supreme Court include whether an adoption order is in the best interests of the child or young person, what attachments have been formed between the child or young person and the

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[497] *Children and Young Persons (Care and Protection) Act 1998* s.152(4).

[498] *Children and Young Persons (Care and Protection) Act 1998* s.154(2)(c), and see also s.51.

proposed adoptive parents and the views of the birth parents of the child or young person regarding consent to the adoption.

16.45 Other types of adoptions, including local, special needs and inter-country adoptions are discussed later in this chapter.

Financial support

16.46 To support these placements, DoCS provides financial support for children and young persons who are unable to live with their parents, by way of allowances and extra financial support payments; that is payments for special expenses not included in the standard allowances.

16.47 Section 161 of the Care Act provides the legislative basis for these payments.

16.48 The type of allowance available for the care of a child or young person depends on the care arrangement and placement category:

a. A statutory care allowance is provided for the care of children and young persons who are in the parental responsibility or care of the Minister or Director-General and are placed with an authorised carer. This allowance may also be payable where the Minister has shared parental responsibility with another person but the Minister has parental responsibility for residency of the child or young person. This allowance may also be payable where a Children's Court Order has allocated parental responsibility to an agency or a non-relative carer, where such person has been authorised.

b. A supported care allowance is provided for the care of children and young persons in the care of relative or kinship carers, where the Minister or Director-General has no aspect of parental responsibility, or where shared parental responsibility is between a relative and the Minister, but where the Minister does not have parental responsibility for the residency of the child or young person. This allowance may be payable in relation to placements subject to a Children's Court Order, a Family Court Order or where there is no court order.

16.49 There is an assessment process to determine the level of allowance paid to a carer, according to the level of care required, which in turn depends on whether the child or young person has high or complex needs.

Data relating to OOHC

Children and young persons in OOHC

Number of children and young persons in OOHC

16.50 There were 14,667 children and young persons in OOHC in NSW as at 30 June 2008, compared with 9,273 at 30 June 2002. Since 30 June 2002, the number of children and young persons in OOHC in NSW has increased by 58.2 per cent. Since 2002, the most significant annual increase in the OOHC population in NSW was 19.7 per cent from 30 June 2006 to 30 June 2007.

16.51 While the total number of children and young persons in OOHC at 30 June 2008 was available and known at the time of compiling the data in this chapter, detailed data on children and young persons in OOHC throughout 2007/08 had not been finalised. Therefore the detailed data provided in this chapter are based on children and young persons in OOHC as at 31 March 2008 rather than 30 June 2008. Similarly, any 2007/08 OOHC data relate to the period 1 April 2007 to 31 March 2008 rather than 1 July 2007 to 30 June 2008.

16.52 The number of Aboriginal children and young persons in OOHC in NSW increased by 90.1 per cent between 30 June 2002 and 31 March 2008. The number of Aboriginal children and young persons in OOHC as a proportion of the OOHC population has also risen from 25.3 per cent as at 30 June 2002 to 31.3 per cent as at 31 March 2008.

Table 16.1 **Children and young persons in OOHC as at 30 June, 2002 to 2007 and 31 March 2008**

	2002	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*
Aboriginal children and young persons in OOHC	2,345	2,706	2,703	2,686	3,033	3,865	4,458
Aboriginal children and young persons in OOHC as a percentage of the OOHC population	25.3%	26.9%	26.1%	26.8%	28.6%	30.4%	31.3%
Non-Aboriginal children and young persons in OOHC	6,576	7,031	7,281	7,271	7,562	8,822	9,761
Not entered	352	322	353	84	28	25	25
Total number of children and young persons in OOHC	9,273	10,059	10,337	10,041	10,623	12,712	14,244
Percentage change from previous year	-	8.5%	2.8%	-2.9%	5.8%	19.7%	12.1%

16.53 The number of children and young persons in OOHC in each age group as a proportion of all children and young persons in OOHC remained relatively

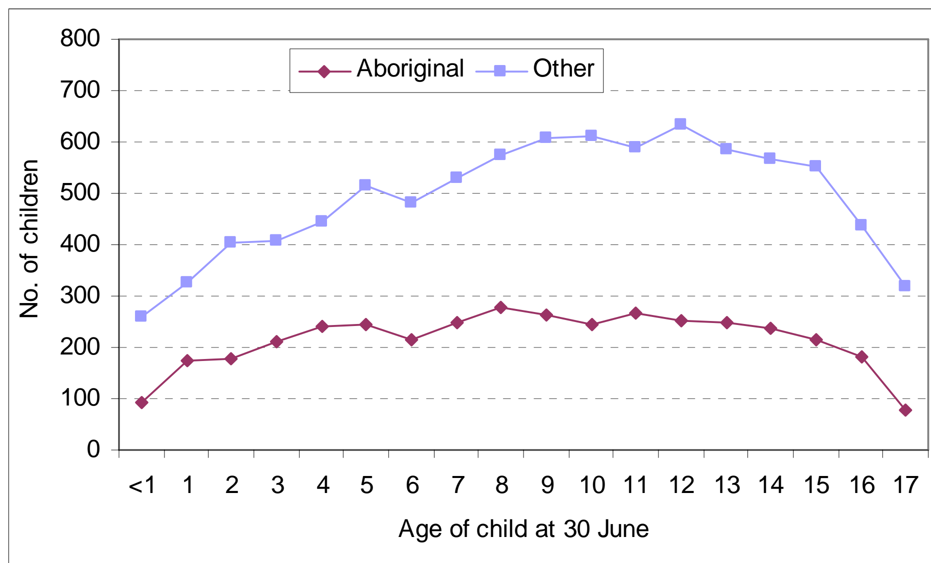
steady from 30 June 2002 to 31 March 2008. There has been a slight increase in children aged less than one year in OOHC as a proportion of all children and young persons in OOHC, rising from 2.6 per cent as at 30 June 2002 to 3.1 per cent as at 31 March 2008.

16.54 While the total number of children and young persons in OOHC increased by 12.1 per cent from 30 June 2007 to 31 March 2008, the number of children in OOHC aged less than one year increased by 23.6 per cent. There was a 15.5 per cent increase over the same period for children aged 1-2 years and 21.3 per cent in young persons aged 16-17 years.

16.55 As at 31 March 2008, 43.4 per cent (6,182) of children in OOHC were aged 5-11 years and 25.7 per cent (3,657) were aged 12-15 years.

16.56 The pattern of children and young persons in care by age does not appear to differ greatly by reference to Aboriginality, as shown in Figure 16.1. The numbers for both Aboriginal and non-Aboriginal children and young persons tend to increase with age until around seven years and then flatten out until around 15 years when a sharp decrease occurs.[499]

Figure 16.1 **Number of children and young persons in OOHC by age and Aboriginality as at 30 June 2007**[500]



Note: 'non-Aboriginal' includes 'not stated'

Rate of children and young persons in OOHC

16.57 The rate of children and young persons in OOHC per 1,000 of the NSW 0-17 years population increased from 5.9 per 1,000 as at 30 June 2002 to 9.1 per 1,000 as at 30 June 2008. During this period the most significant increase was

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[499] DoCS, *What DoCS data tell us about Aboriginal clients*, December 2007.

[500] ibid.

from 30 June 2006 to 30 June 2007 when the rate rose from 6.7 to 8.1 per 1,000.

16.58 The rate of Aboriginal children and young persons in OOHC per 1,000 of the NSW Aboriginal 0-17 year population is significantly higher than for all children and young persons in the State. The rate increased from 41.9 per 1,000 as at 30 June 2002 to 61.4 per 1,000 as at 30 June 2007. During this period the most significant increase was from 30 June 2006 to 30 June 2007 when the rate rose from 48.2 to 61.4 per 1,000.

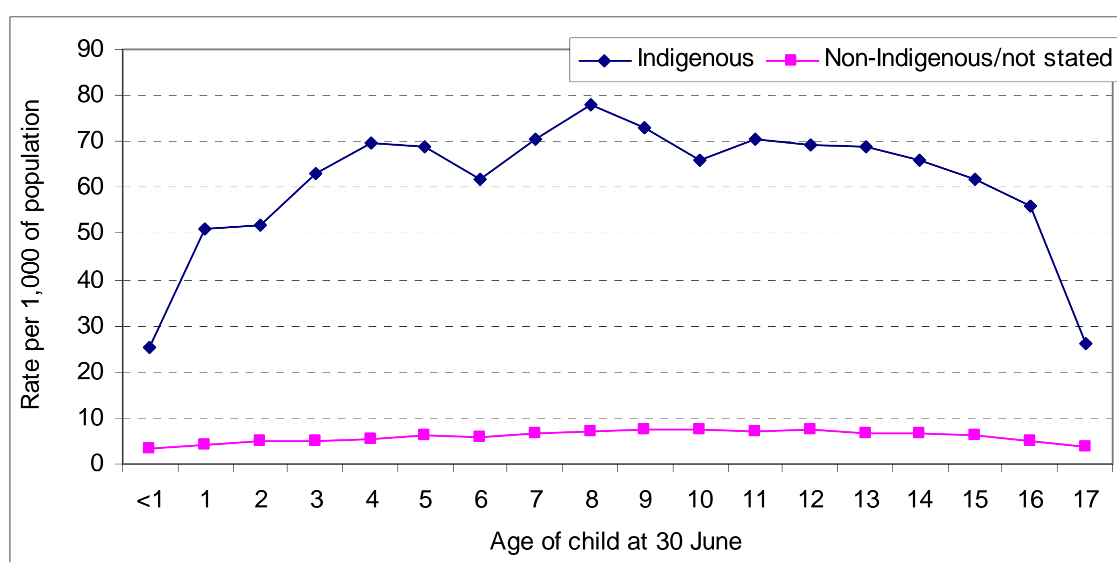
16.59 At 30 June 2007, the rate of Aboriginal children and young persons per 1,000 in OOHC in NSW was almost eight times higher than the rate for all children and young persons in OOHC. It was 10 times higher than for non-Aboriginal children and young persons.

Table 16.2 **Rate of children and young persons in OOHC per 1,000 population as at 30 June, 2002 to 2007**

	30 June 2002	*30 June 2003*	*30 June 2004*	*30 June 2005*	*30 June 2006*	*30 June 2007*
All children and young persons in OOHC	5.9	6.4	6.5	6.3	6.7	8.1
Aboriginal children and young persons in OOHC	41.9	48.3	42.9	42.7	48.2	61.4

16.60 As shown in Figure 16.2, the rates of Aboriginal children and young persons in care as at 30 June 2007 are greater than those for other children across all age groups. The difference in rates of children in care by Aboriginality is generally far greater for those aged from 4-15 years.[501]

Figure 16.2 **Rate of children and young persons in OOHC by age and Aboriginality per 1,000 population, at 30 June 2007**[502]



[501] ibid.

[502] ibid.

Children and young persons entering OOHC

16.61 In the 12 months to 31 March 2008, 4,686 children and young persons entered OOHC in NSW, which was an increase of 0.8 per cent on the 4,648[503] children and young persons who entered OOHC in 2006/07.[504] While there was a 6.9 per cent increase in children and young persons entering care from 2002/03 to 2007/08, the numbers of children and young persons remaining in care longer has significantly increased in this period.

Table 16.3 **Number of children and young persons entering OOHC, 2002/03 to 2007/08**

Year	*Entry into Care*
2002/03	4,382
2003/04	N/A
2004/05	3,479
2005/06	3,681
2006/07	4,648
2007/08 (1 April 2007 to 31 March 2008)	4,686

16.62 Of the children and young persons who entered care in 2006/07, around 30 per cent (1,380) were Aboriginal. For every 1,000 Aboriginal children and young persons in NSW in 2006/07, 22 entered care. This compares with a rate of two per 1,000 for non-Aboriginal children and young persons entering care in 2006/07.

16.63 In 2006/07, of the 4,648 children and young persons who entered OOHC, 70.6 per cent entered care for the first time, while the remaining 29.4 per cent had an OOHC history before re-entering care.

Age at entering OOHC

16.64 In 2006/07, children aged less than one year had the highest rates of entry to care. For every 1,000 children in NSW aged less than one year, around seven entered care. The rate is around 50 per 1000 children for Aboriginal children aged less than one year and around five per thousand for other children aged less than one year.

16.65 While the proportion of children and young persons entering care in 2006/07 generally decreased with age, there was an increase for children at 14 years of age.[505]

16.66 The age distribution of children and young persons entering OOHC for the first time was different from that of children and young persons re-entering care, as

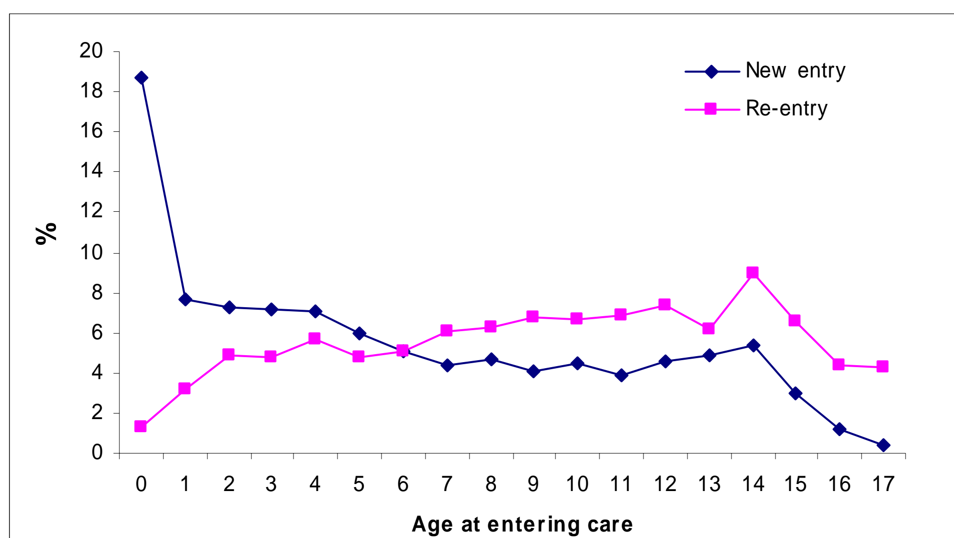
[503] This figure varies slightly from that used in DoCS annual reporting for 2006/07 (4,658) due to a different data source being used for a detailed analysis of entries.

[504] DoCS, *Analysis of children and young persons who entered OOHC in 2006/07,* June 2008.

[505] ibid.

shown in Figure 16.3. 53.9 per cent of new entry children and young persons were aged less than six years compared with 24.5 per cent of re-entry children and young persons. Further, 18.7 per cent of new entry children and young persons were aged less than one year compared with 1.3 per cent of re-entry children and young persons. Re-entry children and young persons were more likely to be aged over six years than new entry children and young persons.[506]

Figure 16.3 **Children entering OOHC in 2006/07 by OOHC history: percentage accounted for by each age group**[507]



16.67 Aboriginal children and young persons accounted for 28.7 per cent (1,346) of all those entering OOHC in the twelve months to 31 March 2008. There were no marked variations across the age groups, although Aboriginal children aged less than one year accounted for 29.8 per cent of all children entering care aged less than one year and Aboriginal children aged 1-5 years accounted for 29.5 per cent of children entering care aged 1-5 years.

Time between first report and first entry to OOHC

16.68 Table 16.4 shows that for children and young persons entering OOHC for the first time in 2006/07, the average number of days from the time of their first report and entering care was 1,284 days, or 3.5 years. Of these, half entered care within 938 days (2.6 years) of their first report. So in 2006/07, the majority of children and young persons entering OOHC had a long child protection history.[508]

16.69 For children aged less than one year at entry to care, the median time that elapsed between the first report and entry into care was 144 days while for children and young persons aged 13-17 years, it was 2,139 days (5.9 years).

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[506] ibid.
[507] ibid.
[508] ibid.

The median time that elapsed for children aged 6-12 years was similar to that of children and young persons aged 13-17 years.[509]

Table 16.4 **Time from first report to entering OOHC 2006/07 based on new entry children and young persons who had a child protection history**

Age at entering care	*No of children and young persons*	*Average waiting time (days)*	*Median waiting time (days)*
<1 year	570	164	144
1-5 years	1,093	916	850
6-12 years	972	1,917	2,004
13-17 years	442	2,246	2,139
Total	3,077	1,284	938

Re-entry to OOHC

16.70 Table 16.5 shows the previous OOHC experience of children and young persons who re-entered care in 2006/07. Older children and young persons were more likely to have had more OOHC episodes and to have stayed longer in OOHC than younger children. Over half of the 13-17 year olds who re-entered OOHC had been in care two or more times previously. This group had spent an average of 1,390 days in care previously.

Table 16.5 **Children and young persons re-entering OOHC in 2006/07, by OOHC history**

Age at entering OOHC	*No of children and young persons*	*% with 1 previous episode in OOHC*	*% with 2+ previous episodes in OOHC*	*Average no. of previous care episodes*	*Average no. of days in previous care*
<1 year	18	100.0	0.0	1.0	68
1-5 years	317	61.8	38.2	2.0	184
6-12 years	617	52.5	47.5	3.3	541
13-17 years	414	43.7	56.3	3.0	1,390
Total	1,366			2.9	709

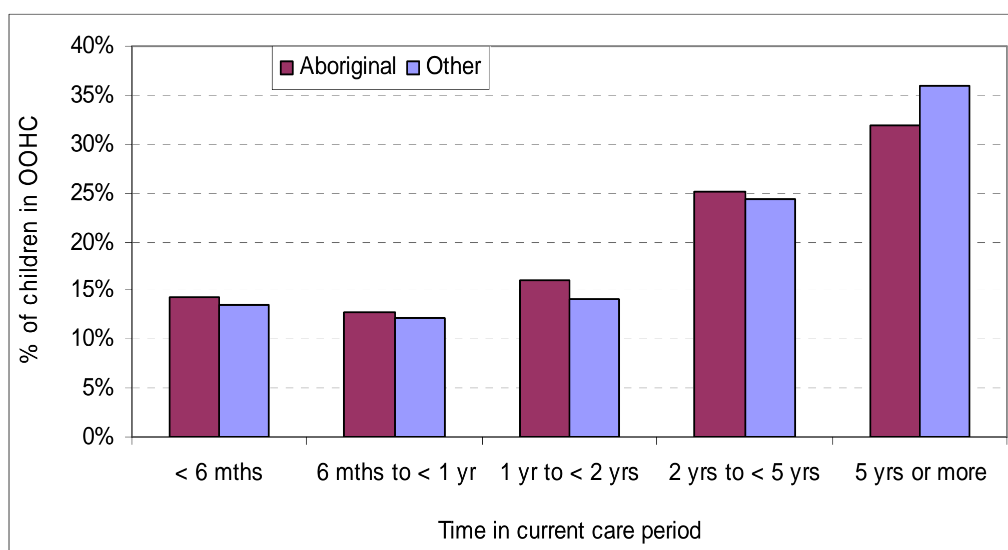
Time spent in OOHC

16.71 Some children and young persons remain in OOHC for short periods of time prior to returning home, while others remain in OOHC for long periods of time, possibly until they reach 18 years. As at 30 June 2007, 32 per cent of Aboriginal children and 36 per cent of the remainder had spent at least five years in their current care period.[510]

[509] ibid.

[510] ibid.

Figure 16.4 **Time spent in care during current care period for children and young persons in care as at 30 June 2007**[511]



Summary

16.72 Of the children and young persons who entered care in 2006/07:

a. 70.6 per cent were entering care for the first time

b. those entering care for the first time were more likely to be aged less than six years than children and young persons who were re-entering care

c. the likelihood of them having been reported before entering OOHC was similar for both new entry and re-entry children and young persons

d. half of the children and young persons who entered care for the first time received their first report when they were aged less than one year

e. older children and young persons were more likely to have been in OOHC previously than younger children and to have had a longer previous period in OOHC before re-entering care.

Care arrangement

The proportion of children and young persons in OOHC under statutory care arrangements increased slightly from 60.3 per cent at 30 June 2005 to 63.4 per cent as at 31 March 2008.

The proportion of children and young persons in relative or kinship care, but under no care order, increased from 10.0 per cent at 30 June 2005 to 16.2 per cent at 31 March 2008. The proportion of these children and young persons whose legal status was parental responsibility to a relative decreased from 21.6 per cent at 30 June 2005 to 15.1 per cent at 31 March 2008.

[511] ibid.

Table 16.6 **Children and young persons in OOHC by care arrangement as at 30 June, 2005-2007 and 31 March 2008**

	30 June 2005		*30 June 2006*		*30 June 2007*		*31 March 2008*	
Care arrangement	*No*	*%*	*No*	*%*	*No*	*%*	*No*	*%*
Statutory care								
Parental responsibility to the Minister	5,723	57.0	6,402	60.3	7,790	61.3	8,843	62.1
Parental responsibility to non-relative	149	1.5	142	1.3	144	1.1	133	0.9
Parental responsibility to agency	83	0.8	84	0.8	69	0.5	33	0.2
Interstate ward no transfer	50	0.5						0.0
Detached Refugee/non-citizen child	33	0.3	36	0.3	31	0.2	15	0.1
Protected person	13	0.1	7	0.1	6	0.0	10	0.1
Statutory care sub-total	6,051	60.3	6,671	62.8	8,040	63.2	9,034	63.4
Supported care								
Parental responsibility to relative	2,164	21.6	2,100	19.8	2,102	16.5	2,156	15.1
Relative/kinship care: no order	1,005	10.0	1,180	11.1	1,927	15.2	2,313	16.2
Temporary care	243	2.4	218	2.1	180	1.4	189	1.3
Care responsibility of DG Removal/Assume	84	0.8	167	1.6	257	2.0	195	1.4
Parents	71	0.7	64	0.6	77	0.6	123	0.9
Emergency care & protection order	10	0.1						
Pre Adoption Care responsibility of DG	2	0.0	4	0.0	4	0.0	3	0.0
Supported care sub total	3,579	35.6	3,733	35.1	4,547	35.8	4,979	35.0
Other voluntary care arrangements	236	2.4	139	1.3	96	0.8	84	0.6
Not specified	175	1.7	80	0.8	29	0.2	147	1.0
Total	10,041	100	10,623	100	12,712	100	14,244	100

The proportion of Aboriginal children and young persons in OOHC who were in statutory care increased from 52.9 per cent (2,044) at 30 June 2007 to 54.8 per cent (2,443) at 31 March 2008. This is significantly lower than for non-Aboriginal children and young persons in OOHC, of whom 67.4 per cent (6,591) were in statutory care at 31 March 2008.

Of the 1,932 Aboriginal children and young persons under supported care arrangements at 31 March 2008, 56.4 per cent (1,090) were in relative or kinship care but under no care order, and for 36.7 per cent (710), parental responsibility was assigned to a relative. This compares to 40.1 per cent (1,223) and 47.5 per cent (1,446) respectively for the 3,047 non-Aboriginal children and young persons under supported care arrangements.

The proportion of children and young persons under finalised care orders decreased from 77.2 per cent at 30 June 2005 to 69.6 per cent at 31 March 2008. Over the same period, the proportion of children and young persons in OOHC under no care and protection orders increased from 12.4 per cent to 18.0 per cent. Over this period, the proportion of children and young persons under no care and protection orders who were Aboriginal remained steady at around 45 per cent.

Service provider

16.73 The proportion of children and young persons in OOHC with a legal status of parental responsibility to the Minister who were placed with an NGO OOHC service provider increased from 17.1 per cent at 30 June 2003 to 21.8 per cent at 31 March 2008. In relation to the OOHC placement provider, there are significant variations between Aboriginal and non-Aboriginal children and young persons. While proportionately more non-Aboriginal children and young persons were in NGO placements at 31 March 2008 compared with 30 June 2003 (22.3 per cent compared with 14.9 per cent), the opposite has occurred for Aboriginal children and young persons. At 31 March 2008, 20.5 per cent of Aboriginal children and young persons in OOHC were in NGO placements compared with 27.1 per cent at 30 June 2003.

Table 16.7 **Number of children and young persons in OOHC with a legal status of parental responsibility to Minister, by placement provider and Aboriginality as at 30 June 2003 and 31 March 2008**

	Aboriginal		*Non-Aboriginal*		*Total*	
	No	*%*	*No*	*%*	*No*	*%*
30 June 2003						
DoCS placement	625	72.9	3,287	85.1	3,912	82.9
NGO placement	232	27.1	576	14.9	808	17.1
Total	857	100	3,863	100	4,720	100
31 March 2008						
DoCS placement	1,870	79.5	5,005	77.7	6,875	78.2
NGO placement	481	20.5	1,440	22.3	1,921	21.8
Total	2,351	100	6,445	100	8,796	100

Note: ‘non-Aboriginal’ includes ‘not stated’

Placement type

16.74 At 31 March 2008, 51.2 per cent of children and young persons in OOHC were placed in relative or kinship care and 37.1 per cent were placed in foster care.

16.75 A relatively small proportion (2.4 per cent) of children and young persons in OOHC were in residential care at 30 June 2007 and 31 March 2008. Proportionately, even less Aboriginal children and young persons were in residential care at those dates (1.4 per cent).

Table 16.8 **All children and young persons in OOHC by placement type as at 30 June 2007 and 31 March 2008**

Placement type	*30 June 2007*		*31 March 2008*	
	No	*%*	*No*	*%*
Parents	611	4.8	802	5.6
Relative & Aboriginal Kinship Care	6,497	51.1	7,290	51.2
Non related person	350	2.8	274	1.9
Foster care	4,741	37.3	5,289	37.1
Supported accommodation	79	0.6	75	0.5
Residential care	309	2.4	344	2.4
Independent living	125	1.0	163	1.1
Not specified	0		7	0.0
Total	12,712	100	14,244	100

16.76 Of the 1,660 children and young persons who entered care in 2006/07 and were placed in relative/kinship care, 29.0 per cent were in statutory care and 62.5 per cent were in supported care. Proportionately, there were fewer children and young persons entering relative/kinship care under care orders in 2006/07 than in 2004/05, when they accounted for 38.3 per cent of children entering relative/kinship care.

16.77 As at 31 March 2008, proportionately more Aboriginal children and young persons in OOHC were placed in relative/kinship care than non-Aboriginal children and young persons in OOHC: 62.8 per cent compared with 45.9 per cent. Proportionately fewer Aboriginal children and young persons in OOHC were placed in foster care than non-Aboriginal children and young persons in OOHC: 28.8 per cent compared with 40.9 per cent.

Table 16.9 **Aboriginal children and young persons in OOHC by placement type as at 30 June 2007 and 31 March 2008**

Placement type	*30 June 2007*		*31 March 2008*	
	No	*%*	*No*	*%*
Parents	133	3.4	195	4.4
Relative & Aboriginal Kinship Care	2,469	63.9	2,799	62.8
Non related person	68	1.8	54	1.2
Foster care	1,102	28.5	1,284	28.8
Supported accommodation	11	0.3	12	0.3
Residential care	53	1.4	64	1.4
Independent living	29	0.8	49	1.1
Not specified	0		1	0.0
Total	3,865	100	4,458	100

16.78 Of the 7,290 children and young persons in relative/kinship care at 31 March 2008, over two thirds (4,980) were under a care order.

High Needs Kids

16.79 As at 30 June 2008, there were 583 children and young persons in OOHC that were classified as High Needs Kids.[512]

16.80 As at 30 June 2008, 38.4 per cent of High Needs Kids were in funded placements. The remaining placements were funded through allowances and extra financial support payments. It would appear that High Needs Kids and young persons in program funded placements cost approximately 35 per cent more than those whose placements were paid through allowances and extra financial support payments.

16.81 Caution should be exercised when comparing the cost of program funded placements with placements paid through allowances and extra financial support payments. The latter are often used where there is a shortage of funded general foster care placements resulting in a broader range of needs in this group, some of which are below the threshold for the high needs funded placements and others above the needs threshold. The costs for High Needs Kids in funded placements include all costs for the child, including allowances and extra financial support payments, and all caseworker operational and management costs. This is not the case for placements paid through allowances and extra financial support payments, which do not include the costs of the DoCS caseworker and management and operating costs.

Table 16.10 **Number and cost of High Needs Kids placements as at 30 June 2007 and 2008**

	30 June 2007			*30 June 2008*		
	Funded placements	Paid through allowances & extra financial support payments	Total	Funded placements	Paid through allowances & extra financial support payments	Total
Number of placements	224	298	522	224	359	583
Average annual cost per placement	$144,220	$89,531		$148,871	$97,119	
Total annual cost	$32.3 million	$26.7 million	$59.0 million	$33.3 million	$34.9 million	$68.2 million

Number of OOHC placements

16.82 The following table outlines the number and percentage of placements for children and young persons in OOHC for the period June 2005 to June 2007. The data have remained fairly steady over the four years, with almost half of all

[512] DoCS commonly refers to children and young persons in OOHC with high and complex needs as 'High Needs Kids'. It is a term the Inquiry uses in this chapter to refer to this cohort of children and young persons.

children and young persons having only one OOHC placement and a further one quarter having had two placements.

Table 16.11 **All children and young persons in OOHC by number of placements as at 30 June, 2005 to 2007 and 31 March 2008**[513]

Number of distinct placements	*2005*		*2006*		*2007*		*2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
1	4,599	45.9	4,996	47.1	6,164	48.6	6,876	48.5
2	2,564	25.6	2,567	24.2	2,996	23.6	3,408	24.0
3	1,300	13.0	1,323	12.5	1,533	12.1	1,698	12.0
4 or more	1,563	15.6	1,718	16.2	2,000	15.8	2,200	15.5
Total	10,026	100	10,604	100	12,693	100	14,182	100

Note: this data does not include children and young persons in a placement of less than 7 days.

16.83 Over the four years from 2005 to 2008, Aboriginal children and young persons were slightly less likely to have multiple placements than other children.

Table 16.12 **Aboriginal children and young persons in OOHC by number of placements as at 30 June, 2005 to 2007 and 31 March 2008**[514]

Number of distinct placements	*2005*		*2006*		*2007*		*2008*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*
1	1,303	48.6	1,542	50.9	2,060	53.4	2,368	52.9
2	655	24.4	695	23.0	839	21.7	960	21.5
3	298	11.1	334	11.0	406	10.5	499	11.2
4 or more	425	15.9	457	15.1	554	14.4	647	14.5
Total	2,681	100	3,028	100	3,859	100	4,474	100

16.84 Table 16.13 shows that the likelihood of multiple placements increases with the length of time a child or young person remains in OOHC. For instance, at 31 March 2008, 21.8 per cent of children and young persons who had been in OOHC for between one and two years had been in three or more placements. By comparison, 41.5 per cent of children and young persons who had been in OOHC for five years or more had been in three or more placements.

[513] The total numbers for each year are slightly different to the data on the number of children in OOHC provided in other data.

[514] The total numbers for each year are slightly different to the data on the number of children in OOHC provided in other data.

Table 16.13 **Children and young persons in OOHC by number of placements and length of time in care, 31 March 2008**

Number of distinct placements	*Length of time in OOHC*					
	<1 month	*1 month to <6 months*	*6 months to <1 year*	*1 year to <2 years*	*2 years to <5 years*	*5 years or more*
1 placement	305	1,153	914	1,328	1,518	1,658
2 placements	13	337	346	683	876	1,153
3 placements	3	71	151	292	468	713
4 or more placements	0	7	70	267	577	1,279
Total	321	1,568	1,481	2,570	3,439	4,803

16.85 As at 30 June 2007, a lower percentage of children and young persons in foster care had been in only one placement compared with children in other types of OOHC placements. The data also indicate that children and young persons placed in DoCS foster care are less likely to have multiple placements than children placed in NGO foster care.

16.86 However DoCS advises caution when examining the data in the table. A child or young person placed with an NGO may have had a prior placement with DoCS in the current care period or vice versa. The table classifies the placement type (that is, DoCS or NGO) according to the current placement in the care period.

Table 16.14 **Children and young persons in OOHC by number of placements and by NGO foster care and DoCS foster care, as at 30 June 2007**

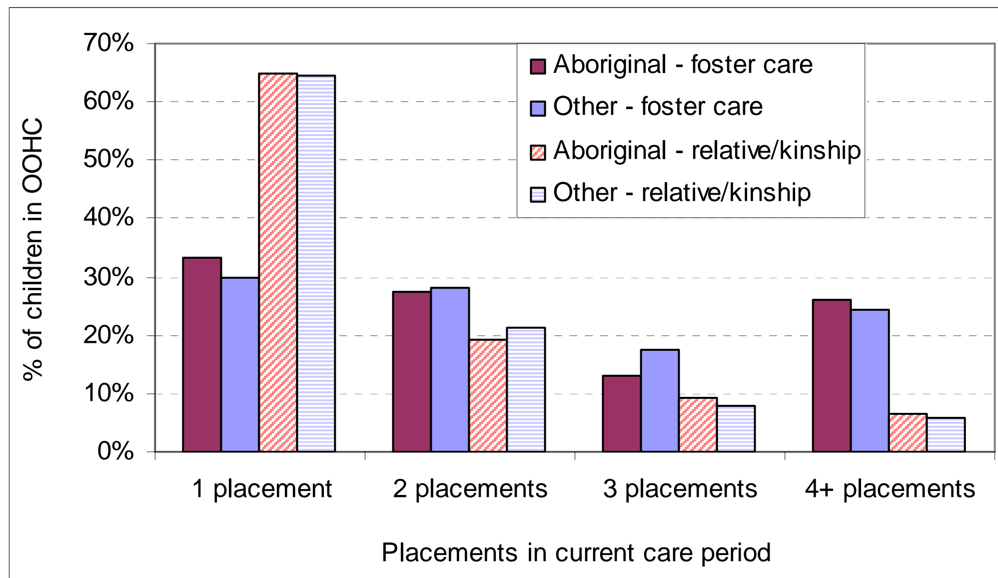
	NGOs foster care		*DoCS foster care*		*Total foster care*		*Other*		*All children*	
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*	*No*	*%*
1 placement	396	26	1,041	33	1,437	31	4,727	59	6,164	49
2 placements	385	25	931	30	1,316	28	1,680	21	2,996	24
3 or more placements	752	49	1,177	37	1,929	41	1,604	20	3,533	28
Total	1,533	100	3,149	100	4,682	100	8,011	100	12,693	100

Note: 'Other' category includes relative and kinship care, residential care, supported accommodation and independent living

16.87 Figure 16.5 shows that the stability of placements is quite different for those children and young persons in foster care when compared with those in relative or kinship care. Children and young persons in relative or kinship care are more likely to have had only one placement, with little difference between Aboriginal and non-Aboriginal relative or kinship care. [515]

[515] DoCS, *What DoCS data tell us about Aboriginal clients*, December 2007.

Figure 16.5 **Number of placements in current care period for children and young persons in OOHC by type of care and Aboriginality as at 30 June 2007**[516]



Allocation of OOHC cases

16.88 As at 31 March 2008, 63.8 per cent of children and young persons in OOHC had an allocated caseworker, 2.7 per cent of OOHC cases had an allocation status of 'unallocated' and 33.4 per cent of cases were categorised by DoCS as being considered for allocation on a 'resubmit' basis.[517] When taking the latter two categories into account, 36.1 per cent of children and young persons in OOHC do not have an allocated caseworker to undertake full case management.

Table 16.15 **Children and young persons in OOHC by allocation as at 31 March 2008**

Allocation status	*Children and young persons*	
	No	*%*
Allocated	9,086	63.8
Resubmit	4,753	33.4
Transfer	23	0.2
Unallocated	381	2.7
Not Stated	1	0.0
Total children and young persons in OOHC	14,244	100

Note: this data is predicated on the assumption that all NGO provided placements have allocated caseworkers.

[516] ibid.

[517] Defined as "a workload management strategy and means that no work is being undertaken in the current period, although the cases may be subsequently allocated to ensure payments are made or if a crisis occurs." DoCS letter to Children's Guardian, 10 March 2008.

16.89 As at 31 March 2008, 78.5 per cent (7,088) of the 9,034 children and young persons in statutory care had an allocated caseworker.[518] Of the 7,044 children and young persons in DoCS statutory care, 72.4 per cent had an allocated caseworker. 93.7 per cent of children in DoCS statutory care aged less than one year and 82.5 per cent of children aged 1-2 years had an allocated caseworker. Allocation rates generally dropped for children older than two years.

16.90 As at 31 March 2008, 35.9 per cent (1,788) of the 4,979 children and young persons in supported care had an allocated caseworker. Of the 4,811 children and young persons in DoCS supported care, 33.7 per cent had an allocated caseworker. 81.6 per cent of children in DoCS supported care aged less than one year, and 59 per cent of children aged 1-2 years had an allocated caseworker. Allocation rates dropped progressively as children got older.

Leaving care

16.91 In 2007/08, children aged 5-11 years represented 29.4 per cent of all children and young persons who left care. This was followed by children aged 12-15 years at 24.2 per cent and young persons aged 16-17 years at 19.6 per cent.

Table 16.16 **Children and young persons exiting care by age and Aboriginality during 2006/07 and 1 April 2007 to 31 March 2008**

	2006/07			*2007/08*		
Age group	*Aboriginal*	*Non-Aboriginal*	*Total*	*Aboriginal*	*Non-Aboriginal*	*Total*
<1 year	38	122	160	38	121	159
1-2 years	77	187	264	77	222	299
3-4 years	68	217	285	69	193	262
5-11 years	200	600	800	180	616	796
12-15 years	174	505	679	198	457	655
16-17 years	94	369	463	121	408	529
Not stated	2	2	4	0	3	3
Total	653	2,002	2,655	683	2,020	2,703

Note: ‘non-Aboriginal’ includes ‘not stated’

[518] The data is based on the assumption that all NGO cases are allocated.

Cost of care

Table 16.17 **Average cost children and young persons in OOHC 2006/07 and 2007/08**

	2006/07	*2007/08*
Average cost per day – supported care allowance	$28.65	$32.98
Average annual extra financial support payments children and young persons in supported care	$1,077	$523
Average cost per day – statutory care allowance	$33.48	$29.75
Average annual extra financial support payments children and young persons in statutory care	$6,554	$9,327

16.92 The average cost for children and young persons in OOHC generally increases with age, whether the child or young person is in statutory or supported care.

Table 16.18 **Average cost per day for care allowances by age, 2007/08**

Age	*Supported Care*		*Statutory Care*	
	Average cost allowance per day per child	*Average cost contingencies per annum per child*	*Average cost allowance per day per child*	*Average cost contingencies per annum per child*
<1	24.59	1,225	25.59	2,732
1	26.42	1,393	26.90	4,495
2	27.04	961	26.62	5,317
3	27.46	786	26.47	5,997
4	27.52	814	27.34	5,722
5	29.13	758	28.52	5,042
6	30.85	405	30.66	6,235
7	31.41	407	31.86	4,491
8	30.61	254	31.12	5,205
9	31.07	528	30.88	6,667
10	31.47	346	31.05	6,669
11	31.35	346	30.87	9,808
12	31.28	401	29.44	15,777
13	30.59	949	29.19	16,239
14	36.23	473	31.30	18,843
15	41.39	385	31.34	21,922
16	41.90	446	33.61	15,056
17	41.34	379	30.47	21,491
Total	32.98	523	29.75	9,327

Data summary

16.93 The number of children and young persons in OOHC and the rate of children and young persons in OOHC has increased each year since 2002, with the most significant increase occurring between 30 June 2006 and 30 June 2007.

16.94 The extent of the increase in the number of Aboriginal children and young persons in OOHC and the rate of their entry into OOHC is greater than for non-Aboriginal children and young persons in OOHC.

16.95 There has been a moderate increase in the number of children and young persons entering care since 2002, however, there has been a significant increase in the numbers of children and young persons in OOHC remaining in care longer.

16.96 Nearly two thirds of all children and young persons in OOHC are under statutory care arrangements and just over half of Aboriginal children and young persons in OOHC are in statutory care arrangements.

16.97 About one half of children and young persons in OOHC were placed in relative or kinship care and over one third in foster care. A small number were in residential care.

16.98 More Aboriginal children and young persons in OOHC were in relative/kinship care than non-Aboriginal children and young persons.

16.99 There has been little change in the number of placements per child over the last four years, with almost half of all children and young persons having only one OOHC placement and a further one quarter having had two placements. Aboriginal children and young persons in OOHC were slightly less likely to have multiple placements.

16.100 Children and young persons in statutory care were about twice as likely to have a caseworker allocated than children and young persons in supported care.

16.101 The average cost of children and young persons in supported care has increased between 2006/07 and 2007/08 while it has decreased for children and young persons in statutory care. Extra financial payments for the former have halved and increased by half for the latter.

Research

16.102 It is well recognised nationally and internationally that children and young persons in OOHC are a vulnerable and at risk group in the population. Research indicates that those entering OOHC have poorer outcomes than the average child or young person. They have been identified as having increased developmental, behavioural, emotional and mental health issues and are less likely to access continuous education, treatment and medical care as a consequence of multiple placements, changes in caseworkers or alternating periods of placement at home and in OOHC.

16.103 The findings of research about the effectiveness of children and young persons in OOHC services, including foster care, compared with children and young persons remaining at home are mixed. Some studies show that children and

young persons who are in stable OOHC are better off remaining in care,[519] while other studies have found that going into care fails to have a remedial effect for many and may in fact have adverse outcomes.[520]

Permanency planning

16.104 Permanency planning is a relatively recent area of development in Australian child protection, having been introduced in 2003. Evidence derived from neuropsychological and attachment research[521] clearly identifies the need for children to have security and continuity of attachment in order to develop optimally.

16.105 A rupture of attachment ties is a traumatic event in a child's life, with major short term and long term consequences such as cognitive problems, psychological and behavioural problems, and delays in development.[522]

16.106 A study from Illinois demonstrated that maintaining family and community links, by placing children with relatives and/or placing siblings together and by maintaining the child in his or her community, leads to increased placement stability.[523] According to this study, a child "placed in such a setting is over 60 per cent less likely to experience a placement move than a child placed with a non-relative caring for at least one other non-related foster child."[524]

16.107 Expert opinion is that for younger children in particular, a decision about restoration should not take longer than six months. Similar timeframes have been recommended and/or implemented in other jurisdictions in Australia, the UK and USA.[525]

16.108 Research undertaken in South Australia to identify factors and strategies which might reduce instability and delay in the care system, found that:

> *children's social and family background factors influenced placement trajectories. Infants entering the care system come from families with multiple difficulties and co-occurring problems. In particular, parental substance misuse and neglect*

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[519] J Barber and P Delfabbro, *Children in foster care,* London, Routledge, 2004, cited in Submission: Cashmore, Scott and Calvert, 26 February 2008, p.19.

[520] J Doyle, "Child protection and child outcomes: measuring the effects of foster care," *American Economic Review, in press,* 2007, C Lawrence, E Carlson and B Egeland, "The impact of foster care on development," *Development psychopathology, 18,* 2006, cited in Submission: Cashmore, Scott and Calvert, p.19.

[521] J Shonkoff and P Phillips, *From neurons to neighbourhoods: the science of early childhood development,* National Academy Press, Washington, 2000.

[522] Fahlberg, *Attachment and Separation,* BAAF, 1982, Gauthier Y, Fortin G & Jeliu G, "Clinical application of attachment theory in permanency planning for children in foster care: the importance of continuity of care," *Infant Mental Health Journal, 25 (4),* 2004, 379-396, cited in DoCS, *Permanency Planning Guidelines Good Practice Guidelines,* May 2007, p.42.

[523] A Zinn, J DeCoursey, R George, M Courtney, "A study of placement stability in Illinois," *Chapin Hall Center for Children, University of Chicago,* 2006, cited in DoCS, *Permanency Planning Guidelines Good Practice Guidelines,* May 2007.

[524] DoCS, *Permanency Planning Guidelines Good Practice Guidelines,* May 2007, p.42.

[525] DoCS, *Permanency Planning Policy,* (undated), p.3.

> *were found to be increasingly more common. These same factors and parental intellectual disability significantly decreased the likelihood of successful reunification.*[526]

16.109 The study also found that almost 40 per cent of children and young persons who had been placed in protective care, who were subsequently placed back home still had at least one social or family risk factor present and approximately one in ten had three or more risk factors present. Subsequent abuse was confirmed in 26 per cent of these cases.[527]

16.110 A supplementary study, *Children with Multiple Care and Protection Orders*' found that multiple 12 month orders appear to be associated with lengthy restoration processes. The study indicated that the restoration process requires good assessment and planning, family compliance with case plans and family readiness to safely reassume the ongoing responsibility for their child(ren). For some families, making the required progress can be slow and may necessitate ongoing service assistance and close monitoring, even after a child's return to the family home.[528]

16.111 The authors state that to ensure a child's stability, to enable them to form secure attachments, and to have their development proceed accordingly, reunification attempts should not go on indefinitely. As such, reunification needs to be targeted, time limited and subject to change if parents do not demonstrate significant progress for their child's developmental and emotional needs.[529]

16.112 The Certainty for Children in Care study highlights that:

> *establishing cause and effect in relation to this placement stability was difficult given that a cluster of inter-related factors are involved… it is unclear to what extent the interaction between child and carer characteristics played a role. The children who had experienced placement stability were generally better adjusted and had fewer conduct problems than other children in care. Thus, while it may seem logical to conclude that stability itself led to these better psychosocial outcomes, it may also be the case that these children were better adjusted or less 'damaged' when they came into care….(and) although carer characteristics were identified as being very important in influencing placement outcomes for*

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[526] P Delfabbro, H Jeffreys, N Rogers, R Wilson and M Borgas, "Certainty for Children in Care: A study into the placement history and social background of infants placed into South Australian Out-of-home Care 2000-2005", *South Australian Department for Families and Communities*, July 2007, p.28.

[527] ibid.

[528] P Delfabbro, H Jeffreys, N Rogers, R Wilson and M Borgas, "Certainty for Children in Care: Children with multiple Care and Protection Orders: Placement History, decision making and psychological outcomes," *South Australian Department for Families and Communities*, July 2007, p.39.

[529] ibid.

> *stable children, it is not clear what aspects of parenting were specifically influential in the cases identified.*[530]

16.113 Several factors are linked with placement disruption. For example, it is more likely that the child is older, that their birth families are from economically and socially marginalised ethnic minorities, that they have health and behavioural problems and that they are separated from their kin. Research suggests that the first six to seven months of a placement is the period of highest vulnerability to placement movement.

16.114 Although the evidence is not yet conclusive, it is generally agreed that maintaining safe contact between children and birth families and/or wider kinship networks is an important step towards continuity. In addition to safety, the research data that exist indicate that the quality of the contact is of equal importance to safety.

16.115 The participation of children and young persons and their representation in decisions that affect their long term welfare and well-being is also crucial. Willingness to join a new family, and the degree to which their wishes are heard and acted upon, are factors logically connected to placement outcomes, particularly the risk of disruption. Bessell and Gal, however, note that the literature reveals the absence of children's participation in decisions made about them, once they enter the care and protection system.[531] Given that children identify their participation in decisions affecting them as one of their central needs, they suggest that workers must find ways which empower children to participate.[532]

16.116 There are no identifiable trends in the research that specify the characteristics of potential good adoptive or foster carers. A more systematic approach to identifying carer suitability and readiness for committed and sensitive care giving relationships may decrease the number of placement disruptions.

16.117 Fernandez states that:

> *placement instability is the outcome of poor initial decisions and lack of support to foster carers. Strengthening professional decision making to ensure children are less likely to move, and investing in the support of carers are important for improving stability.*[533]

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[530] P Delfabbro, H Jeffreys, N Rogers, R Wilson and M Borgas, "Certainty for Children in Care: Children with Stable Placement Histories in out-of-home care," *South Australian Department for Families and Communities*, July 2007, p.45.

[531] S Bessell and T Gal, "Forming Partnerships: The Human Rights of Children in Need of Care and Protection", *Crawford School of Economics and Government, Australian National University*, 2007, p.4.

[532] ibid., pp.12 and 16.

[533] E Fernandez, "Unravelling Emotional, Behavioural and Educational Outcomes in a longitudinal study of children in foster care," *British Journal of Social Work,* April 2007, p.14.

She also adds that planned monitoring as well as services to deal with transitions and disrupted attachments are crucial.

16.118 Thoburn concludes that:

> *for children who cannot be safely brought up by their birth parents, a sense of permanence and confidence in being a full member of the family they are living with are essential to their long-term well being.*[534]

Health

16.119 International studies show that children and young persons entering OOHC have a high prevalence of acute and chronic health problems and developmental disabilities.[535]

16.120 Research also indicates that once in OOHC they have significantly poorer health outcomes in relation to visual defects, dental health, hearing impairments, speech development, completed immunisations, mental, emotional and behavioural health.

16.121 A study undertaken by the Child Protection Unit at Sydney's Children Hospital in 2005, (of the health needs of children living in OOHC in NSW), showed rates of physical, developmental and emotional health problems that are higher than the rates for health problems reported in the general community of Australian children.[536]

16.122 This evaluation of the first 122 children seen by the OOHC health screening clinic at Sydney Children's Hospital Child Protection Unit found that only three per cent of these children were free of health problems; 25 per cent had incomplete immunisation; 30 per cent had an abnormal vision screen; 28 per cent had an abnormal hearing test; 30 per cent had dental problems; 60 per cent needed referral to development assessment following the Australian Developmental Screening Test; 33 per cent showed speech delay (45 per cent of the under fives showed speech delay); and 54 per cent had behavioural or emotional health problems.[537]

16.123 The financial risks in the longer run for state health authorities associated with the provision of identified specialist services are considered to be significantly outweighed by the costs (ethically and financially) of providing appropriate early treatment. Outcomes from research show that young persons with high support

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[534] J Thoburn, 2007, *Routes to permanence for children who have experienced deprivation and family violence, some messages from research,* paper to Centre for Research on Community and Children's Service, International Conference, Overcoming Violence and Poverty, August 2007, p.17.

[535] Royal Australasian College of Physicians Paediatric Policy, "Health of children in 'out-of-home' care," 2006, p.14.

[536] D Nathanson and D Tzioumi, "Health Needs of Australian Children living in out-of-home care", *Journal Paediatrics and Child Health*, Vol 43, pp.695-699.

[537] ibid., p.696.

needs who have left the formal care system are likely to cost governments "on average $2.2 million over the life course from age 16 up to 60, with an overall estimated average cost per annum of $50,000."[538]

Mental health

16.124 Several recently published Australian studies have examined the mental health and well-being of children and adolescents in care.

16.125 Sawyer et al sampled children and adolescents in foster care in Adelaide. They found that 61 per cent of children and adolescents living in foster care scored in the clinical range for behaviour problems on care-giver reports on a standardised checklist. The proportion of children in foster care with problems on the externalising syndrome scales (such as 'attention problems', 'aggressive behaviour' and 'delinquent behaviour') was six to seven times that of children in the community group. Adolescents in foster care also scored significantly higher on a depression scale than those in the community. The difference between groups on depression scores was particularly marked for boys.[539]

16.126 Osborn and Delfabbro conducted a case file study in four Australian States (South Australia, Western Australia, Queensland and Victoria) examining children in OOHC with two or more placement breakdowns.[540] The total sample had experienced a range of 2-55 placements during their time in OOHC. Just under half of the total sample had experienced at least one relative care placement, and more than half had experienced at least one residential/group care placement.[541]

16.127 Results from this study showed that almost three quarters of the children came from households with a history of domestic violence or physical abuse; two thirds had parents with substance abuse problems; and almost three in five had been neglected. Half the sample had parents with mental health problems, significant financial problems, or homelessness. The majority of the children and young persons had suffered physical abuse (73.4 per cent), sexual abuse (65.9 per cent) and neglect (58.2 per cent). Low levels of family contact and poor social functioning were evident in the children across the states. Almost three quarters of the children were attending school or TAFE/apprenticeship

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[538] Morgan Disney and Associates and Applied Economics, *Transition from Care: Avoidable Costs to Governments of Alternative Pathways of Young People Exiting the Formal Child Protection Care System in Australia, Volume 1, Summary Report*, November 2006, cited in Health, Community and Disability Services Ministers' Conference paper, *Medicare benefits schedule item number for health checks of children in out-of-home care*, 23 July 2008, p.4.

[539] M Sawyer, J Carbone, A Searle and P Robinson, "The mental health and well-being of children and adolescents in home based foster care," *NWA,* 2007, 186, p.181-184.

[540] A Osborn and P Delfabbro, "National comparative study of children and young people with high support needs in Australian out-of-home care," *Final Report, Adelaide, South Australia, University of Adelaide*, 2006 cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, September 2006, p.2.

[541] DoCS, *Models of service delivery and interventions for children and young persons with high needs, Literature Review,* September 2006, p.2.

programs, of these 34 per cent had been suspended and 12.7 per cent had been excluded.[542]

16.128 Similar to Sawyer et al, the study by Osborn and Delfabbro found that almost 60 per cent of the children were in the abnormal clinical range for emotional and behavioural functioning.[543]

16.129 The Children in Care Study[544] stated that those in the study had exceptionally poor mental health and social competence, relative to the general population and to other populations of children in care. More than half the boys and girls in the study were reported to have clinically significant mental health difficulties. They presented with complex disturbances, including multiple presentation of conduct problems and defiance, attachment disturbance, attention-deficit/hyperactivity and trauma related anxiety.[545]

16.130 The RANZCP stated that a key finding of this study was that:

> *children who were placed in care before the age of seven months had fewer attachment problems than children entering care at older ages. The risk for attachment and mental health problems rose to moderate in children who entered care between seven and 30 months of age and increased further for those placed after the age of 30 months.*[546]

16.131 Age at entry into care appears to be a strong predictor of children's mental health outcomes. Several studies have new reported that older age entry into OOHC is associated with poorer mental health outcomes. However, further analysis has showed that the poorer mental health of older children in care is largely attributed to later placed children entering care with high levels of pre-existing disturbance. Many children in OOHC have experienced a number of adverse and stressful events prior to care entry.[547]

16.132 This is consistent with attachment theory. By age three, the most critical aspects of attachment development are either successfully negotiated or have led to aberrant development. Attachment theory suggests that children who enter care before the age of six to nine months are likely to develop normal, secure attachments to their foster or kinship carers. The Children in Care Study's findings are consistent with this expectation, that children who entered

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[542] A Osborn and P Delfabbro, 2006, op. cit., cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* p.2.

[543] The Royal Australian and New Zealand College of Psychiatrists, *The Mental Health needs of children in out-of-home care*; A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, Melbourne, 2008, p.10.

[544] M Tarren-Sweeny.and P Hazell, "Mental health of children in foster and kinship care in NSW," *Journal of Paediatrics and Child Health*, *Volume 42*, 2006, pp.89-97.

[545] ibid., p.96.

[546] The Royal Australian and New Zealand College of Psychiatrists, *The Mental Health needs of children in out-of-home care*; A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, Melbourne, 2008, p.9.

[547] DoCS, *Research to Practice Note, 2007, Mental Health of Children in OOHC in NSW*, p.2.

care prior to seven months had significantly better mental health and fewer attachment problems than children entering care at older ages.[548]

16.133 Placement security can influence the development and well-being of children in care. In the study, placement security or longevity was a strong predictor of mental health outcomes for children after controlling for age at entry into care and anticipated placement breakdown. This is consistent with emerging research, which demonstrates a strong relationship between placement instability and high mental health service usage by children in care.[549]

16.134 This study also showed that children living in alternate care, whether placed with relatives or foster parents, are disadvantaged compared with children in the general population in regard to their prior exposure to adversity, subsequent development and mental health problems.

Education

16.135 There is little published Australian data on the educational performance of children and young persons in OOHC.

16.136 Research that has been undertaken into the education experiences of children and young persons in care shows that those in care are less likely than their peers to continue their education beyond the minimum school leaving age. They are likely to attend a large number of different schools and to experience substantial periods of absence from school.[550] Educational disruption was frequently a direct result of children and young persons in care having to change school as a result of a placement change.[551] They also appear to have a significant risk of being suspended or expelled because of behavioural problems or truancy.

16.137 DoCS stated that children and young persons in statutory OOHC "are at significantly higher risk of poor educational achievement, unemployment, homelessness, substance abuse and mental health problems" and that early identification and timely provision of government services, including education intervention programs and services were needed to reduce these risks and ensure positive outcomes.[552]

16.138 Research confirms that the educational outcomes of those in OOHC are poor. This is related to the impact of a poor start in life, low expectations of education

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[548] DoCS, *Children in Care Study, 2005, Mental Health of Children in OOHC in NSW*, p.3.

[549] R Newton, A Litrownik, J Landsverk, "Children and youth in foster care: disentangling the relationship between problem behaviours and number of placements," *Child Abuse and Neglect, 24(10),* 2000, pp.1363-74, D Rubin, E Alessandri, C Feudtner, D Mandell, A Localio, T Hadley, "Placement stability and mental health costs for children in foster care," *Peadiatrics, 113(5),* 2006, pp.1336-41, Fernandez, "Unravelling Emotional, Behavioural and Educational Outcomes in a longitudinal study of children in foster care," *British Journal of Social Work,* April 2007, p.2.

[550] CREATE Foundation*, Education Report Card, 2006,* p.30.

[551] ibid.*,* p.6.

[552] DoCS, *Child protection and out-of-home caseworker policy manual*, p.95.

in birth families, the impact of multiple placements and schools attended and limited additional support provided to them within the school system. While 80 per cent of children and young persons living at home with their families in NSW complete their HSC, less than 36 per cent of children and young persons in care complete this milestone.[553]

16.139 Further, Cashmore et al found that:

> *four to five years after leaving care young people were much less likely than their peers to be in full-time work and/or education. Many had a history of part-time and casual work in poorly paid and low skills jobs, and over half the young women had children. Those who had completed Year 12, however, were more likely to be employed or studying, and to be faring well across a number of areas compared with those that did not complete Year 12. The more stable and secure they had been in care, the more years of schooling they completed, the better they were faring 4-5 years after leaving care.*[554]

16.140 The CREATE Foundation Report Card on the education of children and young persons in OOHC in 2006 found a number of key challenges faced by this group and noted that those in care were:

a. much less likely to continue within mainstream education beyond the period of compulsion

b. much more likely to be older than other children and young persons in their grade

c. on average likely to attend a larger number of primary and high schools than other students

d. likely to miss substantial periods of school through changes of placement.[555]

High needs children and young persons

16.141 Children and young persons in OOHC who have high needs generally present with complex and multiple problems, including significant histories of abuse, serious mental health issues, 'challenging' behaviours, intellectual and learning disabilities, histories of school suspension/expulsion, and difficult familial relationships.[556]

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[553] J Cashmore and M Paxman, "Longitudinal Study of Wards Leaving Care," *Social Policy Research Centre, University of New South Wales*, January 1996, p.116.

[554] J Cashmore M Paxman and M Townsend, "The Educational Outcomes of Young People 4-5 years After Leaving Care: An Australian Perspective," *Adoption and Fostering, Volume 31, Number 1*, 2007, p.50.

[555] CREATE Foundation*, Education Report Card, 2006,* p.30.

[556] DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.iii.

16.142 A recent Australian study of children and young persons with high needs in OOHC found that the majority had suffered physical abuse (73.4 per cent), sexual abuse (65.9 per cent) and neglect (58.2 per cent).[557]

16.143 Osborn and Delfabbro found that most children and young persons with high needs first came into contact with the child welfare system at around the age of three years but usually did not finally enter care until four years later.[558] Their study also showed that children within this high needs population are usually aged around 12-13 years and have typically experienced 10 or more previous placements. On average, these children had been in the care system for five years.

16.144 Children and young persons with high needs are often involved in two or more service systems.[559] Figures from the 1996 US National Adolescent and Child Treatment Study indicate that agency contact was, in order of frequency, mental health (93 per cent), juvenile justice (80 per cent), school based special education (71 per cent) and child welfare (69 per cent).[560] Walrath et al found that re-contact with any agencies or services after six years was high, with four out of 10 adolescents being re-arrested and 75 per cent being readmitted to a mental health placement or juvenile correction facility.[561]

16.145 The frequency, intensity and duration of the behaviours and the complexity of the needs of these children and young persons present difficult challenges for carers and service providers and can lead to multiple, crisis related placement changes that often exacerbate underlying behavioural and emotional issues

16.146 Families of children and young persons with high needs are often characterised by low self-esteem, poor impulse control, aggressiveness, anxiety and depression. Adverse environmental conditions such as poverty, unemployment, poor nutrition and lack of social supports often interact with parent and child factors to increase stress.[562]

16.147 Research has suggested that almost three quarters of this high needs group came from households with domestic violence or physical abuse, two thirds had parents with substance abuse problems and half had parents who had

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[557] A Osborn and P Delfabbro, 2006, op. cit., cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.2.

[558] A Osborn and P Delfabbro, 2006, op. cit., cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006.

[559] A Muscat, A Baron, A M Baron and N Spencer, "The care and health needs of children in residential care in the Maltese Islands," *Child: Care, Health and Development, 27,* 2001, pp.251-262, cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.3.

[560] J Howell, M Kelly, J Palmer, R Mangum, "Integrating child welfare, juvenile justice and other agencies in a continuum of services," *Child Welfare 83(2),* 2004, cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.3.

[561] C Walrath, D Mandell and P Leaf, "Responses of children with different intake profiles to mental health treatment," *Psychiatric Services: A journal of the American Psychiatric Association, 52(2),* 2001, cited in DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.3.

[562] DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.3.

significant mental health issues and/or parents who were unable to provide adequate housing.[563]

16.148 A number of models of service delivery have been developed for children and young persons with high needs. These are typically intensive, multi-faceted interventions involving a network of professionals working in collaboration with the child or young persons and their foster carers and birth families.[564]

Residential care

16.149 The decrease in residential care over the past two decades has resulted in a limited availability of flexible, high quality residential services for children and young persons with high needs. Early research on residential care generally reported poor outcomes for children and young persons, and the experience has been one of a decline in residential facilities throughout the western world with an increase in alternative forms of care. For instance, in Australia in 1983, approximately 40 per cent of those in OOHC lived in some form of residential care. In 2008, less than three per cent of the total care population were residing in this form of care in NSW.

16.150 More recent research findings have however found that some young persons can benefit from an appropriate residential placement, particularly when it is time limited, has a therapeutic component and is part of a plan for transition to a more 'normalised' care environment.[565]

16.151 Delfabbro et al note that many forms of residential and group care options that were previously thought to be very restrictive can actually be less restrictive than home based care environments. The authors conclude that the elements that characterise care (for example, levels of discipline, routine, autonomy and free time), rather than the type of care (foster or residential), determine how restrictive the placement will be for the child or young person. The implication of this research is that greater effort needs to be put into establishing the optimal characteristics of care, rather than the ideal placement type, that will result in the best outcomes for children. Delfabbro and colleagues argue that the care continuum should be re-evaluated and residential care be considered as an option when children first enter care, where they can be assessed and receive appropriate treatment services.[566] As Cashmore and Gilligan note:

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[563] ibid., p.2.

[564] ibid., p.3; L Bromfield and A Osborn, "'Getting the Big Picture': A Synopsis and Critique of Australian Out-of-Home Care Research," *Australian Institute of Family Studies*, *No 26*, 2007, p.29.

[565] DoCS, *Models of service delivery and interventions for children and young persons with high needs*, *Literature Review,* September 2006, p.3.

[566] P Delfabbro, A Osborn, and J Barber, "Models of service for children in out-of-home care with significant emotional and behavioural difficulties," *Developing Practice, 14,* 2005 cited in L Bromfield and A Osborn "'Getting the Big Picture': A Synopsis and Critique of Australian Out-of-Home Care Research," *Australian Institute of Family Studies, No 26*, 2007, p.29.

> *The question is not just about whether certain forms of residential care 'work', but also being able to say why and under what conditions.*[567]

16.152 Underpinning most successful service interventions for high needs children and young persons and indeed others in OOHC are strong case management, integrated multi-agency working, and highly skilled staff and carers who receive expert supervision, ongoing training and support.

Therapeutic foster care

16.153 There is a recognised need for specialised models of therapeutic foster care to address the limited number of placement options for children and young persons with challenging emotional and behavioural difficulties.

16.154 Therapeutic foster care is an intensive, family based therapeutic approach for children and young persons with serious emotional and behavioural disorders and for particular groups of children (like siblings) that require a more complex caring role. Intensive foster carers have specialised training and support requirements and receive a higher level of reimbursement than general foster carers.[568] Based on current evidence, therapeutic foster care is a 'promising' intervention for children and young persons experiencing mental health problems, behavioural problems and problems of delinquency.[569] Therapeutic foster care appears to be most successful for children under the age of 14 years and for boys rather than girls, with previous OOHC placement as the most significant predictor of impairment and change in mental health status over time.[570]

Multi-systemic therapy

16.155 Multi-systemic therapy is an intensive, goal oriented, time limited (typically three to six months) home and family focused treatment approach designed to equip children and young persons and their carer families with the skills to function more successfully in their community environment. Several reviews have classified multi-systemic therapy as a 'probably efficacious' treatment according to the criteria for empirically supported treatments.[571]

16.156 Bor argued, in a submission to the Inquiry, that the case for applying multi-systemic therapy to child abuse and neglect is strengthened because correlates of child abuse and neglect are similar to correlates of antisocial and aggressive

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[567] J Cashmore and R Gilligan, "Residential Care," *International Handbook on Child Research* (unpublished).

[568] DoCS, *Models of service delivery and interventions for children and young persons with high needs, Literature Review,* September 2006, pp.10-17.

[569] G M McDonald and W Turner, "Treatment Foster Care for improving outcomes in children and young persons," *Cochrane Database of Systematic Reviews*, *Vol 1*, 2008, p.38.

[570] DoCS, *Models of service delivery and interventions for children and young persons with high needs, Literature Review,* September 2006, pp.15 and 20.

[571] ibid., p.iv.

behaviours. Queensland Health has proposed a trial of multi-systemic therapy as part of the Department of Child Safety's response to the Report of Crime and Misconduct Commission into Child Protection. Pilot projects are being undertaken in Brisbane. Juvenile Justice is soon to commence a trial of multi-systemic therapy.

Service coordination

16.157 The term 'wraparound services' had its origins in American programs originally developed for children and young persons with significant mental health and behavioural difficulties. These services were characterised by comprehensive, coordinated, community based service delivery programs. The term is used in a broader sense in Australia to refer to the individualised services which address the needs of the child or young person in care, as identified through the assessment and case planning process.[572]

16.158 Major transition points or milestones in the life of a child or young person are likely to provide the clearest signal of the need to consider or reconsider whether additional support services are required. These critical periods may typically include entry into a new placement, commencing school (primary and secondary), the onset of puberty, leaving school, leaving care and commencing employment. Services that have been identified as priority supports needed for children and young persons in care include:

a. respite care

b. psychological and counselling services (including behaviour management support)

c. specialist medical and allied health services

d. educational support services.[573]

16.159 Studies examining outcomes of 'wraparound services' for children and young persons show improvements in school performance and psychological and behavioural functioning. However, 'flexible' and 'individualised' nature and grassroots development of such services makes rigorous evaluation difficult. As such, there is a lack of empirical evidence to show whether 'wraparound services' work any better than regular services such as individualised therapies.[574]

16.160 The Systems-of-Care model developed in the USA represents an attempt to achieve an integrated approach at the broader level of systems and organisations in order to address the multiple service requirements of children and young persons with high needs. This model aims to provide improved

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[572] DoCS, *Out-of-home Care Wraparound Support Services for Children and Young People,* April 2007, p.4.

[573] ibid.

[574] DoCS, *Models of service delivery and interventions for children and young persons with high needs, Literature Review,* September 2006, p.v.

organisational and interagency arrangements as a key component of the program logic for delivering services to this target group.[575]

16.161 There have been several reviews of the empirical status of the Systems-of-Care model. The consensus has been that there is a growing body of evidence suggesting that Systems-of-Care can lead to improved interagency working. However, the gains for the children and adolescents and their families have been modest. As a result, the evidence is mixed regarding the effectiveness of Systems-of-Care on outcomes for children and young persons with high needs.[576]

> *In brief, trends in service provision indicate that residential and specialised models of care are being implemented in Australian States and Territories. However, there is little evidence that these programs are being routinely evaluated … In addition, there is a recognised need for specialised models of residential or group care and treatment foster care to address the limited number of placement options for children and young persons with challenging emotional and behavioural difficulties.*[577]

16.162 Research design limitations have been identified across all services and interventions for children and young persons with high needs. These include limited use of control or comparison groups and lack of valid and reliable outcome measures making evaluation of effectiveness and comparison between studies difficult.[578]

Foster care

16.163 In Australian and overseas jurisdictions:

> *while the need for foster carers has been rising, there have been decreasing numbers of individuals willing to foster. This has been attributed to the greater participation of women in the workforce, the inadequacy of remuneration provided to carers, increasing expectations of carers, and attrition as existing carers age.*[579]

16.164 Bromfield and Osborn state that these and other reasons, such as the challenging behaviours of children in care, and inadequate supports to carers, have also contributed to decreased retention rates for existing carers.

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[575] ibid.

[576] ibid.

[577] L Bromfield and A Osborn "'Getting the Big Picture': A Synopsis and Critique of Australian Out-of-Home Care Research," *Australian Institute of Family Studies, No 26*, 2007, p.30.

[578] DoCS, *Models of service delivery and interventions for children and young persons with high needs, Literature Review,* September 2006, p.v.

[579] L Bromfield and A Osborn, 2007, op. cit., p.2.

16.165 The research indicates that broad based media strategies are effective for awareness raising and stimulating an initial interest in fostering, but are less successful in the conversion of inquiries into actual carers. One of the 'best' recruitment strategies is the use of current and experienced carers to recruit by word of mouth.[580]

16.166 A DoCS research report, *Spotlight on Safety* notes that one in three adults surveyed indicated they might at least consider being a foster carer in the future and almost half said they might consider being a respite carer.[581] Other researchers have found that the majority of carers feel they have 'good' or 'just enough support,' however, carers also reported they were often dissatisfied as they did not feel adequately supported by the relevant state or territory government agency, and often experience difficulty in communicating with caseworkers in obtaining approvals for extra financial support payments, and in complying with contact requirements.[582]

16.167 Further, Bromfield and Osborn stated that most carers cease fostering due to a change in their personal circumstances. However, there also appeared to be a link between support and retention, with participants from several studies reporting that they stopped fostering due to burn out, lack of support, adverse effects on their families, and the foster children being difficult.

16.168 They suggested that carer retention may be improved if carers are better supported through improved reimbursement packages, increased recognition and involvement (for example, input into decisions regarding foster children), better information about the child, and increased levels of support (such as, access to support services and respite).[583]

16.169 In considering the question whether foster carers should receive a salary, McHugh notes:

a. the growing professionalism of foster caring; that is, assessment, training and supervision is more highly regulated and rigorous

b. carers are no longer simply substitute parents

c. fostered children's complex needs and challenging behaviours require highly committed multi-skilled specialist carers

d. carer recruitment and retention has become increasingly problematic here and elsewhere.[584]

16.170 McHugh argues that as:

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[580] ibid., p.12.

[581] Urbis Keys Young and DoCS: *Spotlight on Safety: Community attitudes to child protection, foster care and parenting,* 2006, p.3.

[582] L Bromfield and A Osborn, 2007, op. cit., p.12.

[583] ibid.

[584] M McHugh, "Should Australian foster carers be entitled to receive a fee/salary wage for caring?" *Social Policy Research Centre, University of New South Wales*, Paper presented at the "ACWA 08 Strong, Safe and Sustainable: responding to children, young persons and families in a civil society", August 2008.

> *the older generations of foster carers retire from fostering a wage component may attract a different cohort of younger, qualified persons into fostering, able to meet the challenges of more demanding and difficult placements and, meet their need for an adequate income.*[585]

16.171 Ambivalence on the part of carers towards the merits of being paid for caring, and the current income support arrangements for some carers, however, are complicating factors that may impede support for a carer wage. At the present time many foster carers are reliant on government income support payments and associated benefits (for example, Health Care Card, rental assistance). Currently carer subsidy payments are not regarded as income and are not subject to income tax.

16.172 McHugh notes that the Productivity Commission's estimates of annual real expenditure on residential OOHC per child range from $150,000 to $240,000. This is seven to eight times higher than the annual real expenditure on foster care per child ($21,000–$29,000).[586] In comparison with residential care, foster care is far less expensive to government and provides significant cost savings.

16.173 The limited research into the experiences of the natural children's foster parents showed that foster children do have an impact on natural children. Foster children encourage positive experiences (such as sharing, responsibility, caring and independence), but these are coupled with the contradictory experiences of loss (such as having to share the attention of parents), resentment and a wish to escape.[587]

16.174 Although some carers feel they receive sufficient training, many feel that further training to fully prepare them for the role of caring is a priority. The amount of training undertaken by carers varies, and possibly 20 per cent in a sample surveyed in 2004 had not completed initial training.[588] Some carers reported that they did not receive any training prior to having children placed in their care. Carers want training that is both practically oriented and nationally accredited, as well as specialist training to enable them to provide therapeutic foster care.[589]

16.175 Carer requests for nationally accredited training and specialist training in treatment foster care may be an indication of carers' support for the professionalisation of foster care.[590] Of the 450 NSW carers surveyed in a study by McHugh et al, 54 per cent thought fostering should be semi-

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[585] ibid.

[586] Productivity Commission, 2007, 15.36, cited in M McHugh, 2008, op. cit.

[587] L Bromfield and A Osborn, 2007, op. cit., p.13.

[588] M McHugh, J McNab, C Smyth, J Chalmers, P Siminski, P Saunders, "The availability of foster carers: main report," *DoCS and Social Policy Research Centre,* 2004, p.63.

[589] L Bromfield and A Osborn, 2007, op. cit., p.13.

[590] ibid.

professional, 32 per cent thought it should be professional, and 13 per cent thought it should be voluntary. [591]

16.176 The Victorian Centre for Excellence in Child and Family Welfare developed the Foster Care Communication and Recruitment Strategy to strengthen its approach to carer recruitment and retention, and redress the shortage of foster carers across Victoria.[592] This strategy identifies four points in the life of a carer which can help retain carers:

a. the period from the time a family contacts the agency until they are approved as a foster carer/family

b. the period of time between approval as a foster carer and placement of children with them

c. the period of time after children have been placed in the family

d. the end of placement support and debriefing.

16.177 The Centre's research found that:

a. carers are more likely to continue caring when there is a financial package, which implies they want foster care to be more professionalised

b. 62 per cent of past carers surveyed said they would consider returning to caring if systemic sources of dissatisfaction were addressed

c. carers stay involved because of positive changes and outcomes for the child, and positive feedback from the child, professionals or parents.[593]

16.178 Disincentives to become or remain a foster carer included:

a. lack of information provided about the child

b. the nature of the child

c. lack of worker continuity

d. lack of respite care

e. interference with personal life

f. financial drain

g. perceived lack of trust and respect for the carer role

h. fear of meeting the child's parents

i. assessment processes that are perceived to be lengthy and intrusive. [594]

16.179 A significant initiative of the recruitment strategy will be to implement the Best Practice Engagement Project. The Best Practice Engagement Project is a 12

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[591] M McHugh, J McNab, C Smyth, J Chalmers, P Siminski, P Saunders, 2004, op. cit., p.69.

[592] J Higgins "Foster Care Communication and Recruitment Strategy – Best Practice Engagement Project," *Child Abuse Prevention Newsletter, Vol 16, no. 1*, National Child Protection Clearinghouse, Australian Institute of Family Studies, 2008, pp.12-13.

[593] ibid.

[594] ibid.

month project involving ongoing collaboration and communication between foster care services in Victoria to identify and test potentially good practice ideas in foster care recruitment and retention. The process is being facilitated at both statewide and local levels.[595]

16.180 Another area of potential dissatisfaction and loss of foster carers from the system concerns the process for managing allegations which are made against them. This is examined in more detail in Chapter 23.

Kinship care

16.181 The increase in the use of kinship care for OOHC placements is an international phenomenon that commenced in the late 1980s. The literature suggests this trend is likely to continue and perhaps increase. Despite this, the growth in kinship care is not underpinned by strong outcomes focused evidence. Australian studies have found there is little substantial research on kinship care in Australia.[596] Furthermore, there is no concrete evidence that this type of care produces better outcomes for children and young persons.[597]

16.182 Paxman states that:

> *The research literature is limited by methodological problems such as small samples or the sample being part of larger investigations of other topics, and a lack of baseline measures from which progress comparisons can be drawn.*[598]

16.183 Barth, Green, Guo, McCrave (in Press) state that the differences between children in kinship care and foster care is complicated as a result of the various selection processes which complicates the interpretation of outcomes in child protection cases.[599]

16.184 Listening to children about their experiences and needs is not often reflected in studies, as children tend not to be included as participants.[600] Research however suggests that essential knowledge about positive and less positive experiences that children have, in different care arrangements, can enable a

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[595] ibid.

[596] J Cashmore and F Ainsworth, "Audit of Australian Out-of-home care research," *Child and Family Welfare Association of Australia and Association of Children's Welfare Agencies*, 2004, p.10, L Bromfield and A Osborn, 2007, op. cit., p.31.

[597] L Bromfield and A Osborn, 2007, op. cit., p.32.

[598] M Connolly, "Kinship Care: A selected literature review," *New Zealand: Department of Child, Youth and Family,* 2003 and E Farmer and S Moyers, *Children Placed with Family and Friends: Placement Patterns and Outcomes,* report to the Department of Education and Skills, School for Policy Studies, University of Bristol, 2005 cited in DoCS, *Outcomes for children and young persons in kinship care: an issues paper*, December 2006.

[599] R Barth, R Green, S Guo and J McCrae, *Kinship care and non-kinship foster care: informing the new debate,* cited in R Haskins, F Wulcyzn and M Webb (eds), *Findings from the national survey of child and adolescent well-being,* 2006.

[600] GS Cudderback, "Kinship family foster care: A methodological and substantive synthesis of research," *Children and Youth Services Review 26 (7),* 2004, pp.623-639; J Messing, "From the child's perspective: A qualitative analysis of kinship care placements," *Children and Youth Services Review 28,* pp.1415-1434.

better understanding of the dynamics of kinship care.[601] Messing states that recent evidence from children in kinship care has identified that there is a reduction in stigma compared with foster care, due to the reduced trauma associated with separation from parents, and to preservation of the sense of familial relationships.[602]

16.185 In NSW, relative/kinship care is more common than foster care. It is the only State where there are significantly more children and young persons in relative/kinship care than in foster care.[603] As discussed earlier in this chapter, a higher proportion of Aboriginal than non-Aboriginal children and young persons are placed in kinship care.

16.186 Whilst research into kinship care is in its infancy, it suggests that:

a. there is no conclusive evidence that those in kinship care are more or less well adjusted than those in foster care

b. being placed in kinship care decreases the risk of placement disruption, however, recent longer term studies indicate that stability in kinship care may reduce over time

c. it may depend on who the carer is, for example an older grandmother or younger aunts and uncles

d. children and young persons placed in kinship care, in comparison with those placed in foster care, tend to remain in care longer, are reunified with their birth families at slower rates, and are adopted at lower rates

e. children and young persons placed with relatives are more likely to have contact with birth parents and siblings than their counterparts in foster care

f. kinship care placements require the same entitlements to monitoring and support as non-relative foster care placements. [604]

16.187 While there is little research in Australia on the characteristics of kinship carers, studies overseas indicate that kinship carers are more likely than foster parents to be single older women, and to be poorer and less educated. Factors that may impact on effective caring include economic disadvantage, stress, health issues and limited parenting skills. Conflict with birth family is a feature of many kinship care placements and this adds to the stress that kinship carers face. Further research is needed to understand the impact of kinship care on the lives of carers and on the outcomes for children and young persons.[605]

16.188 Grandparent headed families are increasingly prevalent in Australia and are one of the fastest growing forms of OOHC. Increasingly grandparents are assuming

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[601] S Altshuler and J Gleeson, "Completing the evaluation triangle for the next century: measuring child 'well-being' in family foster care," *Child Welfare, 78(1),* 1999 cited in M Connolly, 2003, op. cit., p.16.

[602] J Messing, op. cit., pp.1415-1434.

[603] As at 31 March 2008, L Bromfield and A Osborn, 2007, op. cit., p.32.

[604] ibid., pp. 31-32; DoCS, *Outcomes for children and young persons in kinship care: an issues paper*, December 2006, p.5.

[605] DoCS, *Outcomes for children and young persons in kinship care: an issues paper*, December 2006, p.iv.

the full time parental care of their grandchildren because of mental illness and drug addiction of the biological parent(s), or because of the effects of child abuse or neglect, family violence, incarceration, HIV/AIDS and/or parental death.[606] However, there is little information regarding the characteristics and experiences of Australian grandparent headed families who assume care through the intervention of child protection services or of those who arrange the care of their grandchildren privately.[607] This "lack of visibility means that there are a substantial number of grandparent headed families who do not receive supervision, support services or financial assistance."[608] Evidence suggests that grandparent headed families that arranged care, without the intervention of child protection sources, are relatively more disadvantaged in terms of financial and social services than all other forms of kinship care families and non-relative foster families.[609]

16.189 Literature from the USA reveals that assuming full time parenting responsibilities for grandchildren is associated with a number of negative outcomes including psychological distress, poorer physical health and lower social supports.[610]

16.190 In Australia, Aboriginal carers tend to have higher rates of poverty and disadvantage and are more likely to be experiencing poorer health than their non-Aboriginal counterparts. A key concern for Aboriginal grandparent carers is overcrowding and birth parents living in or regularly visiting the same house.

16.191 In addition, the level of services and support provided to relative/kinship and foster placements differ. There is strong evidence that relative/kinship carers receive less training, fewer services and less support than foster carers.[611] There is evidence that the assessment of relative/kinship carers often occurs after the child has been placed.

16.192 There is general agreement in the literature that kin are less likely to enrol children in additional services and are less likely to be supervised by a statutory agency. Some research shows relative/kinship carers are keen to receive services to help them care for these children but often they are reluctant to request assistance from statutory agencies.

16.193 There is some evidence that caseworkers do not feel the same level of services is necessary for relative/kinship placements as for foster placements.

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[606] B Horner, J Downie, D Hay and H Wichmann, "Grandparent-headed families in Australia", Family Matters, *Australian Institute of Family Studies*, *No, 76*, 2007, p.77.

[607] ibid., p.79.

[608] C Goodman, M Potts, E Pasztor, D Scrozo, "Grandmothers as kinship caregivers: Private arrangements compared to public child oversight," *Children and Youth Services Review, 26(3),* 2004, cited in B Horner, J Downie, D Hay and H Wichmann, 2007, op. cit., p.78.

[609] B Horner, J Downie, D Hay and H Wichmann, 2007, op. cit., p.79.

[610] ibid.

[611] G Cuddeback, "Kinship family foster care: A methodological and substantive synthesis of research," *Children and Youth Services Review, 26(7),* 2004, pp.623-639, cited in DoCS, *Outcomes for children and young persons in kinship care: an issues paper*, December 2006, p.iv.

16.194 A greater understanding of relative/kinship care requires more methodologically rigorous research that could include longitudinal studies that could take into account: baseline data on entry to care to measure pre-existing differences between foster care and kinship care; the use of standardised measures across a number of domains (such as behaviour, child development, school performances, child and family functioning and outcomes as well as a focus on the child's experience); well designed controlled studies; and a multiple informant approach (children, carers, workers, parents, case files). Given the over representation of Aboriginal children in kinship care placements, studies should also include appropriate and culturally sensitive research methods and should canvas the views of Aboriginal children and young persons in care as well as consulting with their carers.[612]

16.195 The Inquiry notes that DoCS is undertaking primary research on kinship care in NSW. Stage one of this study, the analysis of historical data on all children and young persons in kinship and foster care is complete. Stage two involves an analysis of 120 case files and telephone interviews with caseworkers of a random sample of children and young persons who have been in care for longer than six months in four placement types (supported kinship care, statutory kinship care – Aboriginal and non-Aboriginal and foster care). A draft report is expected by March/April 2009, which will go some of the way to building an evidence based approach.

Accreditation and monitoring of the OOHC service system

16.196 In NSW, the Care Act establishes the Children's Guardian as the agency responsible for the accreditation and monitoring of the designated agencies, that is, the government and non-government organisations that provide OOHC placement and support services to children and young persons. These services include placement, case management, supervision and support. The Children's Guardian reports directly to the Minister for Community Services.[613]

16.197 The NSW OOHC accreditation system, which provides a structured means of providing recognition of an organisation's performance against relevant standards, commenced operating in July 2003. The *NSW Standards for Substitute Care Services,* were developed by and for the OOHC sector as optimum standards. It was considered unlikely that any organisation would meet the standards immediately but would do so in time.

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[612] DoCS, *Outcomes for children and young persons in kinship care: an issues paper*, December 2006, p.iv; N Richardson, L Bromfield and D Higgins "The Recruitment, Retention and Support of Aboriginal and Torres Strait Islander Foster Carers: A Literature Review," *Australian Institute of Family Studies, National Child Protection Clearinghouse,* 2005, pp.66-67.

[613] *Children and Young Persons (Care and Protection) Act 1998* s.181.

16.198 Accreditation is commonly used in Australia in the health, child and aged care sectors. NSW, however, is the only jurisdiction that has established an OOHC accreditation system. The agencies that are accredited by the Children's Guardian essentially have a licence[614] to provide OOHC services. The Children's Guardian also has a number of other powers common to licensing bodies, including powers to impose, vary and revoke conditions of operation, and to remove or suspend an organisation from the OOHC sector. The Regulation, *inter alia*, provides for ADT review of Children's Guardian decisions concerning the imposition of conditions on, and the suspension or cancellation of, accreditation.

16.199 At June 2008, there were 58 government, non-government and private agencies, including DoCS and DADHC, approved as designated agencies to provide foster or residential care to children and young persons in NSW.[615]

16.200 The provisions regulating OOHC in the *Children and Young Persons (Savings and Transitional) Regulation 2000* were not introduced until July 2003. Clause 22A of this Regulation provides for the interim accreditation of service providers operating immediately before the accreditation scheme commenced.

16.201 Designated agencies with interim accreditation were given a choice whether to enter an Accreditation and Quality Improvement Program prior to 30 June 2005 or to apply for immediate full accreditation. The purpose of the Accreditation and Quality Improvement Program is to allow agencies, which were not able to apply for full accreditation, to improve the quality of their OOHC over a period of time. Agencies are issued with a Quality Improvement Certificate and are required to provide a Self-Study Report yearly that demonstrates continuing improvement in the mandatory requirements and core standards, the critical standards and the significant standards.[616] Agencies wishing to remain in the Accreditation and Quality Improvement Program must submit evidence for all mandatory requirements and applicable core standards that have not been met.[617] These agencies must progressively achieve the standard that would entitle them to be accredited as a designated agency by 14 July 2013.

16.202 Of the 58 designated agencies, there are currently 21 designated agencies in the Accreditation and Quality Improvement Program, including DoCS and DADHC.[618]

16.203 Case file audits are conducted to determine whether the agency fulfils its obligations under the Care Act and Regulations. If recommendations are made

[614] A 'licence' is often described as a 'permit to do business which could not be done without the licence' – *Judicial and Statutory Definitions of Words and Phrases, Vol 5,* St Paul, West Publishing, 1904:4138.

[615] Children's Guardian, *Annual Report 2007/08,* p.92.

[616] Children's Guardian, *Out-of-Home Care Accreditation and Quality Improvement Guide for Organisations*, 10 April 2007, p.20.

[617] ibid., p.21.

[618] Office for Children, *Annual Report 2007/08,* p.117.

they must be implemented as a priority.[619] If the case file audits of agencies in the Accreditation and Quality Improvement Program show continued non-compliance or failure to address the recommendations, that agency may be required to apply for accreditation.[620]

16.204 The Children's Guardian has conducted an internal review of the OOHC accreditation and quality improvement system. This report identified the following issues:

a. The requirement that all OOHC agencies be accredited is different from most other accreditation schemes. Generally, accreditation is not a pre-requisite to enter a particular market, while OOHC accreditation in NSW effectively operates as a form of licence.[621] As such, the accreditation scheme currently determines entry to the market based on criteria that are founded on optimum standards.

b. The OOHC Standards were developed for quality improvement purposes, not for regulation purposes.

c. Accreditation systems generally allow for accreditation to be granted where relatively minor performance issues are identified, with conditions imposed to direct further improvement. The system may operate to exclude providers from the market for minor matters that, under most other accreditation schemes, would be addressed within a performance improvement framework.

16.205 The report recommends that the *Children and Young Persons (Savings and Transitional) Regulation 2000* be amended to enable the Children's Guardian to accredit an applicant that substantially satisfies the criteria for accreditation, with conditions to be imposed to drive further necessary performance improvement within 12 months of accreditation.

16.206 Information provided or heard by the Inquiry indicated overall strong support for the role and functions of the Children's Guardian in providing a framework to improve OOHC policies, procedures, practices and services for children and young persons in OOHC in NSW. The proposed changes to the Accreditation and Quality Improvement Program proposed by the Children's Guardian would support a move to outcomes based performance indicators (where possible); place a stronger focus on performance, rather than conformity; lead to a reduction in the overlap and duplication of aspects of the OOHC Standards; and give a stronger recognition of agency innovation and alternative ways of meeting standards. The Children's Guardian informed the Inquiry:

> *Broadly speaking, it is to move the system from a pass/fail system into one that is focused on continuous quality*

[619] Children's Guardian, *Out-of-Home Care Accreditation and Quality Improvement Guide for Organisations*, 10 April 2007, p.23.

[620] ibid., p.24.

[621] Children's Guardian, *Review of Out-of-Home Care Accreditation and Quality Improvement System and Processes*, October 2007, p.6.

> *improvement. It is one that will allow for more flexibility and innovation by services. It will allow the Guardian to take into account other sources of information. At the moment it is a paper-based system. It is our intention that we would undertake site visits and talk to staff and look at requirements ourselves.*[622]

16.207 The Inquiry supports the recommendations of the internal review.

16.208 The Children's Guardian, in exercising the accreditation and monitoring functions may come across information that gives rise to concerns about a community services provider or about the welfare and well-being of a child or young person, or group of children or young persons in care.

16.209 In such instances, the Children's Guardian can refer such matters, or complaints received by that office, to the Ombudsman. Similarly where the Ombudsman has concerns about the complaints handling system of a designated agency or of a non-government adoption service provider, a report containing recommendations regarding its systems may be referred to the Children's Guardian and then taken into account in relation to that Office's accreditation role.[623]

16.210 The Inquiry notes that the Ombudsman and the Children's Guardian have discussed the appropriateness of recognising the Children's Guardian as a relevant agency under Schedule 1A of the *Ombudsman Act 1974* to enable the Ombudsman and Children's Guardian to enter into complaint referral and information sharing arrangements under Part 6 of that Act.

16.211 This would remove any uncertainty as to whether the Care Act or *Adoption Act 2000* may limit the Children's Guardian authority to pass on complaints information to the Ombudsman.

16.212 The Inquiry agrees that these amendments should be made.

OOHC casework by DoCS

16.213 One of the key areas of the DoCS Reform Package was to increase its capacity to allocate caseworkers to children and young persons. This package included the establishment of an additional 300 OOHC caseworker positions,[624] 50 to work with High Needs Kids (known as intensive support services), a further 50 to assess, authorise, recruit, train and support carers for a period of 12 months, and the remaining 200 to work in generalist OOHC positions.

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[622] Transcript: Public Forum, Oversight Agencies, 28 March 2008, p.29.

[623] *Ombudsman Act 1974* s.43.

[624] 150 under the original package and a further 150 announced in the 2006/07 budget.

16.214 When a child or young person becomes the subject of care proceedings, the role of the Child Protection Caseworker (CSC based) includes: assessing the protective intervention required to address the risks to the child or young person; identifying and organising an OOHC placement where required; identifying and assessing relative/kinship carers; and carrying out permanency planning case review and case management until final orders are in place. Once final orders with parental responsibility to the Minister are made, the case is transferred to an OOHC team or identified non-government OOHC service provider.[625]

16.215 The role of OOHC Caseworkers (CSC based) is to support decision making on issues about achieving permanency for the child or young person, to advise and support the Child Protection team to find a long term placement option, to negotiate the handover of case management from the Child Protection team if final orders exceed 12 months, to implement the case plan, to monitor and review it, and to carry out the tasks associated with leaving care.

16.216 The transfer of cases from the Child Protection team to the OOHC team is an area of practice still requiring improvement, according to the Ombudsman. Delays in case transfer can mean that required services are not put in place for children and young persons, or for their carers, in a timely manner thereby affecting outcomes.

16.217 There was evidence in submissions, case files and other information received by the Inquiry to suggest a lack of matching between the child or young person and the carer, a lack of communication between birth parents, carers, and children and young persons, and a lack of participation of children and young persons. Poor practice in this area leads to a range of problems including placement breakdown, poor outcomes for children and young persons in OOHC and difficulty in attracting and retaining carers.

16.218 Submissions, and the Inquiry's case file audit, identified that where DoCS Child Protection staff are attempting to find an OOHC placement for a child or young person there are often a series of inappropriate referrals and placements due to the focus on the crisis rather than on the quality of the placement. The shortage of carers also means that there are less options from which to select. DoCS OOHC staff often become involved in matters too late in the process to get placement matching right in every case.

16.219 Key issues raised particularly by non-government services providing placements for children and young persons in OOHC included:

a. the lack of personal information provided by DoCS caseworkers about a child or young person when placed and the timeliness of this information to ensure their needs and matching with the carer occurred

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[625] DoCS, *Caseworker policy manual child protection and out-of-home care Draft*, March 2008, p.47.

b. the failure to provide critical information and documentation of relevance for children and young persons such as their birth certificates, Medicare cards, health status, allergies and the like

c. lack of review processes by DoCS as the case manager.

16.220 DoCS has also recognised these deficiencies and has informed the Inquiry that it is revising casework practice on care plan reviews to ensure that they specify the issues that should be covered in the review and documented on the file.

16.221 DoCS has also commenced a project to identify the information that should be provided to carers at the time a child is placed with them, including information of the kind outlined earlier in this chapter.

16.222 Findings from the Ombudsman's Review of Children under five years states that there have been improvements since 2002 in the documentation in care plans of how permanency would be achieved. However, concerns still exist concerning the relationship of the DoCS Child Protection team, the OOHC team and in relation to the handover that is necessary to give effect to these plans.[626]

16.223 Many children and young persons are in care for short periods before being restored to their families. A number of submissions to the Inquiry identified that there is, at times, inadequate preparation, assessment or planning, as well as poor support for the family following the child's return home, where restoration has been identified as a goal for that particular child, or young person. This at times has resulted in the child or young person being returned to OOHC, often repeatedly.

16.224 Statistics provided by DoCS indicate that 29.4 per cent (1,366) of children and young persons entering care in 2006/07 had previously been in care.[627] Of these children and young persons, they had an average of between 8-26 previous child protection reports. Further, over half of the 13-17 year olds who were re-entering care had on average been in care three times previously with an average of 1,390 days in care. This suggests that the process for assessing the needs of these children and young persons, as well as the capacity of the family to provide adequate and safe care, and then putting in place appropriate supports to enable effective restoration may not have been adequate, or alternatively that the decision concerning restoration may not have been comprehensive. The circumstances of the family may also have changed, and may not been sufficiently taken into account.

16.225 There were a number of issues raised concerning the need for concurrent planning for children and young persons entering OOHC. Often when children or young persons are removed from their families they can have multiple placements while the matter is before the court. Wesley Community Services advised the Inquiry:

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[626] NSW Ombudsman, *Group Review Report: Children under five,* November 2007, pp.14-18.

[627] DoCS, *Analysis of children who entered OOHC in 2006/07*, June 2008.

Children come into the care system when they're removed from their families. I believe that we need to start looking for long-term placements immediately. At the moment, various CSCs will not do that, because they say that it's pre-empting the decision of the Court.[628]

16.226 Unfortunately, DoCS does not keep data on the number of children and young persons restored to their families and their outcomes. Thus the Inquiry has largely relied on information from other reviews as well as submissions.

16.227 The Inquiry is of the view that the OOHC Caseworker/NGO provider should begin working formally with the child or young person at the time of entry into care to ensure that placement matching and associated functions are progressed. The Child Protection Caseworker should retain case management and responsibility for the development of the care/case plan in conjunction with OOHC Caseworker/NGO/carer/natural family. The discretion permitted by the current DoCS procedure as to whether consultation with the OOHC Caseworker/OOHC provider occurs, should be strengthened to a requirement, where it has been determined there is not a realistic possibility of restoration.

Types of placement and support options for children and young persons in OOHC

16.228 There are a range of service models that have been established, or that are being established for children and young persons in OOHC in NSW. OOHC service models include those relating to relative/kinship care, general and intensive foster care, residential care, wraparound services including respite care, supported independent living services, leaving and after care support, and adoption.

16.229 Many of these service models are in the process of being established as a result of the DoCS OOHC expression of interest process that occurred in 2007, and as such are not yet available as options for all children and young persons across the State.

16.230 There are presently 3,225 relative/kinship carers managed by DoCS, and 7,290 children and young persons were in this type of care as at 31 March 2008.

16.231 As at March 2008 5,289 children and young persons were in general foster care. DoCS has approximately 2,100 active carers, which is an increase of 400 on 2004 figures.

16.232 There are presently 105 intensive foster carer placements across the State.

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[628] Transcript: Public Forum, OOHC, 29 February 2008, p.5.

16.233 Residential care is provided to a small number of children and young persons who have challenging behaviours and high support needs,[629] and continues for as long as is required. This type of care is generally only suitable for those aged 12 years and above. As at March 2008, 2.4 per cent (344) of children and young persons in OOHC were in residential care.

16.234 Supported independent living services are provided for young persons with low to moderate support needs who are in transition to independent living. The client group is young persons aged 16-18 years in the parental responsibility of the Minister. As at March 2008, 238 young persons were in either supported accommodation or independent living.

16.235 Family preservation services are primarily designed to maintain children and young persons aged from 0-15 years with their family and/or extended family, who are engaged sufficiently with appropriate support networks to prevent them from entering OOHC.

16.236 'Wraparound support services' are being introduced by DoCS. These services include respite care, psychological and counselling services, (including behaviour management support) specialist medical and allied health services and educational support services which focus on improving the social, emotional, educational and physical health needs of those in OOHC.[630]

16.237 Information provided to the Inquiry indicates that for a number of children and young persons placement stability remains a significant issue. For children and young persons in OOHC multiple placements, changes in schools, neighbourhoods and communities, irregular contact with their families, loss of friends and multiple changes of workers undermine continuity of care, stability and sense of their security and identity.[631] The present lack of placement options for children and young persons within their own communities reported to the Inquiry means that some are located in other parts of the State away from local networks and supports. A young woman informed the Inquiry:

> *I stayed with some families, rehabs, and I was locked up quite a few times, so a lot of different environments. Because I moved around so much it meant that every time I moved my file would get transferred which meant that sometimes I wouldn't have a DoCS officer for months at a time.*[632]

16.238 A young man informed the Inquiry:

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[629] These children and young persons are likely to fall into the category of High Need Kids.

[630] DoCS, *Out of home care service model: Wraparound support services*, April 2007, p.4.

[631] J Cashmore and M Paxman, "Longitudinal Study of Wards leaving Care: four to five years on," *Social Policy Research Centre,* University of New South Wales, 2007, p.7.

[632] Transcript: Inquiry meeting with representatives of CREATE Foundation, 2 April 2008, pp.6, 15-20.

I have been in care 13 years. I have been in and out of 38 families within that 13, 14 years.[633]

16.239 A small number of children and young persons in OOHC exhibit extremely challenging and risky behaviours, to themselves and to others. These children and young persons typically have a history of multiple placements, complex or high level casework and support needs and/or challenging behaviours. While these 'High Needs Kids' represented approximately four per cent of those in care (522), in 2006/07, they accounted for around 23 per cent of OOHC budget for contracted care, allowances and extra financial support payments.

16.240 In June/July 2002 there were 240 High Needs Kids being cared for through individualised funding arrangements. This number represented 2.6 per cent of the then 9,273 children and young persons in the OOHC system. The management of this high needs group was subject to significant criticism from oversight agencies and other non-government services as many children and young persons were in these placements (often outside their area of origin and thus away from their normal support networks) through Individual Client Agreements, which were both costly, short term, lacked a focus on permanency planning and were not necessarily achieving good outcomes.

16.241 In 2002 the Ombudsman reviewed a number of these individual funding arrangements[634] and identified several systemic weaknesses including:

a. the limited capacity of non-government program funded agencies to provide services for children and young persons with high or complex needs, for reasons including negative experiences with contracting in the past, a lack of growth funds in the program and an out of date funding formula not reflective of the real costs of service provision

b. the absence of a policy framework for residential care

c. the lack of provision of any therapeutic models of care in NSW, whether through residential or foster care/professional care placements.

16.242 Most of the recommendations emanating from this report have since been implemented by DoCS.

16.243 As noted earlier, data on children and young persons entering care show that older members of this group were more likely to have had more OOHC episodes and to have stayed longer in OOHC than those who were younger. This together with a significant child protection history suggests that they become increasingly more complex and require more intensive supports.

16.244 The Inquiry accordingly supports DoCS' direction in providing a greater diversity in types of placements in its current funding reform process including program funding for High Needs Kids. More needs to be done however on reducing

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[633] ibid., pp. 7-8, 20.

[634] NSW Ombudsman, *Inquiry into individual funding arrangements in out-of-home care,* June 2003, p.iii.

unnecessary multiple placements for this group through improved assessment and matching of children and young persons and carers, as well as supporting foster and kinship carers, especially in relation to managing challenging behaviours.

Aboriginal children and young persons in OOHC

16.245 Not only are Aboriginal children and young persons more likely to be placed in OOHC compared with non-Aboriginal children, there is also a shortage of culturally appropriate placements to accommodate these children and young persons.

16.246 The Inquiry was told that a lack of safe accommodation for children and young persons is resulting in an increase in the number of Aboriginal and non-Aboriginal children and young persons being placed on remand in detention centres. There was support for the view that a range of safe accommodation models for this group should be available in NSW. While some of the models suggested to the Inquiry are controversial, they included:

a. boarding school models, including schools managed by small community controlled organisations (not large residentials) to deal with both OOHC and entrenched community issues

b. temporary group home style care for Aboriginal children and young persons, incorporating intensive work with the child or young person and his or her family to enable transition back into the care of their family, such as the Safe Families Program in Alice Springs (refer to Chapter 8 for more details).

c. Aboriginal community controlled and supported foster and kinship care models, which incorporate fluid care arrangements to facilitate placement, retention and fulfilment of the need for proper cultural instruction of Aboriginal children and young persons.

16.247 DoCS informed the Inquiry that a project is currently underway with Juvenile Justice, DADHC, Justice Health, DoCS and Police to examine the issue of a lack of safe accommodation for children and young persons to reduce numbers remanded in juvenile detention. The new approach will be trialled in Parramatta Court.

16.248 The AIFS and SNAICC has noted that there is a diverse and large range of programs and interventions that have been designed to tackle this problem.[635]

16.249 In 2005, the AIFS commenced research into the needs of Aboriginal children in OOHC. SNAICC and AIFS then worked together to identify and profile

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[635] J Higgins and N Butler, "Characteristics of Promising Indigenous Out-Of-Home-Care Programs and Services. Promising Practices in Out-Of-Home Care for Aboriginal and Torres Strait Islander Carers, Children and Young People," Booklet 1, *Australian Institute of Family Studies, 2007*, p.3.

promising programs and services in the OOHC sector for Aboriginal children. They reported that:

> *While a few of the profiled programs had been externally evaluated, the majority had not, and the term 'promising' applies to the collection of programs profiled for this project.*[636]

16.250 SNAICC and AIFS identified eleven promising tools and programs, three of which are found in NSW: *Step by Step* Aboriginal assessment tool – (ACWA, in collaboration with the DoCS), A*boriginal Carers Network* - Carer support group network (AbSec) and *Marungbai* – Leaving and after care service for Indigenous young people (Great Lakes Manning Aboriginal Children's Services, Taree).

16.251 The research found that the common characteristics of these projects were as follows:

a. establishing effective relationships with government departments and NGOs

b. developing strategies for seeking project funding approval

c. building the profile of the organisation or program

d. identifying the organisation's core business

e. establishing a collaborative staffing structure so that staff feel empowered

f. offering a comprehensive service

g. empowering the community, carers and young persons.[637]

16.252 Successful organisations with promising practices for Aboriginal children and young person in OOHC were seen to have had the community on board. They had spent time and effort in consulting and involving community members so that the local community had a sense of ownership over the program. Where this occurred, the local community tended to be more satisfied with the program's services.

16.253 In terms of the management styles of the successful organisations that were profiled in the research, all had strong leadership, were clear on core business, and operated within the boundaries of that core business. Each of these organisations had a collaborative teamwork approach with staff within a flat organisational structure.[638]

16.254 Successful organisations were also characterised by strong relationships with external stakeholders, and a respected and influential profile in the community; and each organisation undertook a role in educating the community and other

[636] ibid., p.4.
[637] ibid., pp.7-18.
[638] ibid., p.17.

organisations about more culturally appropriate ways of addressing child protection and OOHC issues for Aboriginal children and young persons.[639]

16.255 In addition, this Inquiry notes the Ombudsman's submission that the current capacity of the Aboriginal OOHC sector is limited, with these services currently only able to place around 200 of the Aboriginal children and young persons in OOHC. The Inquiry supports further consideration of the Ombudsman's suggestion that a review take place of AbSec's current capacity with the view to considering the role it might play in the future through expanding its activities in this area. This is captured in the recommendation made in Chapter 8 concerning the Lakidjeka program.

Djarragun Foster Care Program

16.256 The Inquiry heard that the Cape York Institute and Djarragun College have developed a proposal for a school based model of care for children from Cape York, Queensland. The model was developed in response to a lack of Aboriginal foster care in Queensland.

16.257 Djarragun College is an Indigenous school located in Gordonvale, Queensland, providing early childhood education for children aged 3-4 years through to post secondary vocational education to students from Cairns, Cape York, Yarrabah and the Torres Strait Islands. School boarding facilities are provided on site for students from Year 8 through to Year 12. Emergency boarding is also provided to primary age students who are not able to live at home. The school has been operating since 2001.[640]

16.258 The program envisaged the establishment of a purpose built facility on a separate campus in partnership with the Queensland Department of Child Safety to provide care for 40-50 Cape York children aged 9-12 years. The facility would act in a manner similar to a primary boarding school but with more intensive support provided. Responsibility for the care of each child would be shared between the school and permanently assigned respite parents in a family based environment. The model would cater for children subject to child protection orders and also children accepted through a voluntary referral mechanism.[641]

16.259 Features of the model include:

a. delivery of high quality education with small class sizes and individual education plans

b. intensive on-campus support including counselling and medical services delivered within a model of 'rigorous health management', which includes

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[639] ibid.

[640] Cape York Institute and Djarragun College Proposal, April 2008, p.23, provided by Secretariat of National Aboriginal and Islander Child Care.

[641] ibid.

an initial health assessment and access to regular ongoing consultation and specialist care as required

c. maintenance of a strong connection with culture through placement in an indigenous environment in the school, involvement of family where appropriate with on-site accommodation available, homeland visits for supervised and structured cultural activities, and video and teleconferencing facilities to enable regular contact between children and family members

d. 24 hour support through consistent boarding parents for school based care with a ratio of at least one carer to 8 children at all times, and permanent 'respite parents' specifically recruited and making a long term commitment to a particular child, providing for care outside the academic year and for regular weekends visits, and participating in the child's school life through academic, cultural and sporting events.[642]

16.260 The exit program would usually involve transition into the secondary boarding program at Djarragun College.[643]

16.261 In July 2008, the Commonwealth Government committed $2 million to the project.[644] In August 2008, ABC media reports quoted the Queensland Minister for Child Safety as supporting the project in principle.[645] The proposed model appears to be consistent with a number of the principles for promising practices identified in the literature.

16.262 The Inquiry agrees that innovative measures are needed for Aboriginal children and young persons to remain connected with their culture while being safe, cared for and educated. Recommendations are made in Chapter 18 on this matter.

Recruitment, training, support and retention of carers

16.263 Recruiting, training, supporting and thus retaining foster carers was a key issue before the Inquiry.

16.264 Continuity of key relationships with caseworkers is integral to effective intervention and support for children and young persons and their carers. Equally important is the skill level of the caseworker in being able to build a relationship with children and young persons and their carers. Information provided by DoCS indicates that just over one half of children and young

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[642] ibid., pp.8-12.

[643] ibid., pp.4-12.

[644] Media Release: Minister for Department of Families, Housing, Community Services and Indigenous Affairs, 22 July 2008, www.fahcsia.gov.au.

[645] *State funding for Indigenous foster care program still in doubt,* 12 August 2008, www.abc.net.au.

persons in DoCS OOHC have an allocated caseworker, which ultimately impacts on its ability to support children and young persons and their carers.

16.265 Further while the number of those in foster care has increased by six per cent in 2007, the number in DoCS foster care has increased by 12 per cent in 2007, resulting in an increase in the proportion of foster care placements effected through DoCS.[646]

16.266 The Inquiry was provided with detail of a raft of changes that DoCS has implemented or proposes to implement, that are designed to increase the numbers of carers and to improve their quality and support.

16.267 DoCS has introduced dedicated positions within each of the seven regions, to work in Carer Support teams. These positions are primarily focused on recruiting, training and providing individual support to carers, primarily new non-related authorised carers.

16.268 In August 2006, DoCS introduced a centralised telephone line for statewide foster care inquiries, which operates beyond the standard hours of a CSC. However, a recent review undertaken by DoCS showed that 77 per cent of applicants authorised in 2007 went directly to the CSC rather than the centralised telephone line.

16.269 Advisory Committees have been established and DoCS intends to provide funds for the provision of peer support services for foster carers in NSW. Standard health care records have been distributed to carers and they also receive newsletters, which are intended to keep them informed of any relevant developments and of any functions which they might wish to attend.

16.270 Some of these strategies are reasonably new and it would not be expected that their value would yet be felt by carers. However, the litany of problems reported to the Inquiry suggests that much more needs to be done, or that what has been done needs to be better explained and brought to the attention of carers. Three broad issues, in particular, were brought to notice.

16.271 First, DoCS and others noted that the current recruitment, assessment and authorisation processes were cumbersome and needed to be streamlined. DoCS said:

> *Delays can be due to DoCS internal processes, screening/probity check timeframes, as well as applicant delays. The current authorisation process is also costly in terms of time and resources because there is a requirement that two trained assessors should be involved in the 'Step by Step' assessment process.*[647]

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[646] DoCS, *Business Process Review: authorisation of foster carers*, March 2008.

[647] Submission: DoCS, OOHC, p.26.

16.272 In a recent review DoCS found that:[648]

a. only four per cent of applicants who express an interest in foster care are finally authorised

b. the average time to complete the authorisation process is 43 weeks

c. there is no single management information system to monitor and control the process

d. the authorisation process is overly staff intensive, repetitive and confusing

e. the current competency based assessment of carers used by DoCS is not well understood by its staff.

16.273 Aboriginal carers raised related but different issues. AbSec informed the Inquiry that:

> *... agencies are able to better recruit foster carers. DoCS can't recruit foster carers because they have still got a bad name in the Aboriginal community. You are working for welfare. If you are a carer for DoCS, the Aboriginal community look down on you - "What are you doing working for the welfare?" When they work for an agency, they have not got that stigma.*[649]

16.274 Higgins and Butler examined a number of programs that successfully recruited, assessed and trained Aboriginal carers as part of the Promising Practices in OOHC series. They concluded that recruitment of Aboriginal carers works best when: training and support programs provide comprehensive, supportive services to carers; recruitment is conducted by Aboriginal persons through Aboriginal organisations; recruiters use community generated opportunities to reach potential carers; and Aboriginal carers are available to speak to prospective foster carers.[650]

16.275 The Ombudsman also reported that word of mouth was arguably the most effective strategy for recruiting Aboriginal carers, and for it to be effective, carers needed to feel well supported and to strongly endorse fostering to others in their community.

16.276 Higgins and Butler found that effective assessment and training of Aboriginal carers occurred when assessment and training programs were carer centred and responsive. The most effective assessment tools used a relaxed, conversational style of gathering information, and incorporated community knowledge about a family when assessing a potential carer. Successful training

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[648] DoCS, *Business Process Review: authorisation of foster carers*, March 2008.

[649] Transcript: Inquiry meeting with representatives of the Aboriginal Child, Family and Community Care State Secretariat, 18 December 2007 p.14.

[650] J Higgins and N Butler, “Characteristics of Promising Indigenous Out-Of-Home-Care Programs and Services. Promising Practices in Out-Of-Home-Care for Aboriginal and Torres Strait Islander Carers” Booklet 2*, Australian Institute of Family Studies,* 2007, p.36.

programs valued the input of carers and acknowledged the skills and knowledge that carers brought to the caring role.[651]

16.277 Successful support of Aboriginal carers was found to involve advocacy on behalf of carers when dealing with child welfare agencies; the provision of access to needs based, comprehensive and responsive support, enabled knowledge sharing and skills building, and opportunities for carer unity through support group meetings or community events.[652]

16.278 A recent report by the Ombudsman *Supporting the Carers of Aboriginal Children*, while based on a small sample of 100 carers, found that NSW carers of Aboriginal children and young persons identified a need for regular and appropriate support from caseworkers, improved access to quality training, consistent consultation in compliance with the principles in the Care Act, better cultural support planning and assessment and intervention for the health and education needs of Aboriginal children in OOHC.[653]

16.279 The consistent statements of the need for further support are at times not specific about the actions required. However, the 2004 study of 450 carers in NSW by McHugh et al found:

> *All stakeholders viewed the provision of casework to children as a critical component of support for carers. The support carers want from caseworkers is casework itself, stated the NSW FCA [Foster Care Association] spokesperson. They want caseworkers to work with carers and to build up ongoing relationships with children to bring about the best outcomes.*[654]

16.280 The Inquiry has three key observations to make about carer recruitment and support. First, DoCS needs to change its processes to reduce the time taken to improve the quality of its screening at each stage, including the entry point, and to train staff in any new processes. DoCS shares this view and is currently progressing the move to an assessment centre approach on similar lines to that employed for caseworker recruitment. If viable in the short term, pending transfer of most OOHC service provisions to the non-government sector (discussed later in this chapter), this strategy should continue. DoCS will also require a short term emergency carer capacity to deal with children and young persons entering temporary OOHC time.

16.281 Secondly, it is clear to the Inquiry that relative/kinship carers have received less training and support than other authorised foster carers. DoCS accepted that:

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[651] ibid., p.38.

[652] J Higgins and N Butler, "Comprehensive support for Indigenous carers and young persons. Promising Practices in Out-Of-Home-Care for Aboriginal and Torres Strait Islander Carers," Booklet 3, *Australian Institute of Family Studies*, 2007, p.6.

[653] NSW Ombudsman, *Supporting the Carers of Aboriginal Children,* 2008.

[654] M McHugh, J McNab, C Smyth, J Chalmers, P Siminski and P Saunders, 2004, op. cit., p.76.

> *the level of assessment, training and support provided to statutory relative/kinship carers should be broadly at an equivalent level to that provided to un-related authorised foster carers, although it is acknowledged that there may be points of difference between the two carer groups. For example, although the training needs of both groups may have many similarities, relative/kinship carers may require additional input and support around managing family contact issues.*[655]

16.282 Thirdly, the Inquiry is concerned that the communication with and engagement of carers by DoCS caseworkers and their direct line managers do not always reflect DoCS policies and procedures. Examples of problems which were raised with the Inquiry on numerous occasions, included:

a. poor communication between caseworkers, casework managers and carers

b. non response to calls or letters

c. information not being provided to carers about children or young persons in their care including a failure to provide, or a delay in the provision of, essential documents such as Medicare cards, or the Blue Book

d. non engagement of carers in case conferences and failure to respect their views about children and young persons in their care

e. months taken to receive payments or approvals for expenses incurred for the child or young person in their care, including the cutting off of allowances where the CSC had overlooked the need for an annual review

f. failure to allocate a caseworker, or to maintain a continuity in the allocated casework

g. failure to provide respite.

16.283 A number of OOHC agencies also identified problems in getting DoCS to acknowledge and listen to carers. The CEO of Barnardos informed the Inquiry:

> *My experience is my agency has to very strongly advocate to have either the agency's point of view heard or, most particularly, the carer's point of view heard and their experience acknowledged.*[656]

16.284 In contrast, the Ombudsman's 2007 review of 49 children in OOHC under five years found that 75 per cent of all carers, even those without an allocated worker, said they felt well supported by DoCS in meeting the identified needs of the children in their care. A number of these carers were very positive about the support they received from carer support caseworkers.[657]

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[655] Submission: DoCS, OOHC, p.28.

[656] Transcript: Public Forum, OOHC, 29 February 2008, Louise Voigt, p.12.

[657] NSW Ombudsman, *Group Review Report: Children Under Five*, November 2007, pp.7-27.

16.285 DoCS acknowledged that its relationship with carers required improvement:

> *The relationship between DoCS and some carers has been difficult. There are two elements. The first is resources. There are simply not enough DoCS' OOHC caseworkers to provide a satisfactory level of service to carers and children. The second is culture, with the Foster Care Association suggesting that DoCS' caseworkers have a poor attitude to carers.*[658]

16.286 Given the increasing numbers of children and young persons in OOHC as well as their placement with relatives or kin, supporting these carers is essential. DoCS cannot do it with its current resources. The recommendations made at the end of this chapter in relation to a gradual transition to NGOs being responsible for more, and ultimately most, children and young persons in OOHC should address this issue in the long term.

16.287 Further research on the needs of relative/kinship carers would be useful to identify the support they need and to reduce placement breakdowns caused by any systemic neglect of carers.

Case Management

16.288 Case management is a process involving assessment, planning, implementation, monitoring and review to strengthen families and decrease risks to children and young persons and to achieve identified case plan goals.[659] Case management is meant to ensure that resources and services are mobilised, and coordinated to meet the needs of a child or young person entering and in OOHC.

Children's Guardian audit

16.289 A recent case file audit undertaken by the Children's Guardian identified significant differences between the case management practices of DoCS and non-government organisations, and found that children and young persons in non-government agency care were likely to benefit from the more informed and comprehensive case support provided by these agencies, than was the case for children and young persons in DoCS care.

> *Non-government agencies with case management responsibility were more likely to have case conferences convened to support case planning and review, consider contact arrangements, invite the child or young person and their mother to attend case reviews, have mental health reports and review behaviour management and the use of psychotropic*

[658] Information provided by DoCS to Government, March 2008.
[659] DoCS, *Case Management Policy.*

medication, and commenced preparation for leaving care. They were also more likely to identify timeframes for reviews and the completion of tasks, and stipulate the responsibilities of each person or agency.[660]

16.290 The results are not particularly surprising, although unsatisfactory. The reality is that the additional caseworkers employed by DoCS under the Reform Package, were faced with a 58.2 per cent increase in the numbers of children and young persons in OOHC by 30 June 2008. As a consequence DoCS data show that just over half of the children and young persons in DoCS OOHC placements had an allocated caseworker. Of these, 72.4 per cent in DoCS statutory care placements and 33.7 per cent in DoCS supported care had an allocated caseworker.

16.291 The caseloads for NGOs are about 1:10, with an upper limit of 1:12, compared with 1:19 for DoCS. It is also the case that DoCS as the ‘provider of last resort,’ cannot turn children and young persons away even if it will provide sub-optimal services.

16.292 While not in response to these findings but of relevance to them, DoCS informed the Inquiry and Cabinet that:

the high volume, demanding nature of the work currently means that DoCS casework effort is primarily directed towards responding to crisis. As a result all children and young persons in care are not able to receive the comprehensive case management required,[661]

and

for many children in OOHC DoCS is not able to meet even the most basic requirements of allocating a caseworker and conducting an annual review of the placement.[662]

16.293 Given the findings of the Children’s Guardian and faced with DoCS data, the Inquiry requested the Children’s Guardian to undertake an analysis of the DoCS allocated and unallocated cases examined in her audit. The purpose of the analysis was to examine whether the existing audit findings, in relation to DoCS statutory care cases, were affected by the allocation status of the cases in the sample.

16.294 The results of that analysis showed that of the 1,356 DoCS case files audited by the Children’s Guardian, 76 per cent were allocated. Further, while allocated files were between twice and three times as likely to have a current plan or

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[660] Submission: Children’s Guardian, p.39

[661] Submission: DoCS, OOHC, p.8.

[662] Information provided by DoCS to Government, March 2008.

review, than unallocated or 'resubmit' files, the allocated files did not meet the standard set by the audit of 80 per cent compliance with the OOHC Standards.

16.295 Further, compliance levels of allocated files progressively declined across the age groups, indicating that young children were being prioritised over adolescents, a similar finding to the April 2008 report, *Australia's Homeless Youth: A Report of the National Youth Commission Inquiry into Youth Homelessness.* Similarly, preparation for leaving care for those aged 15 years and over was non-compliant across all allocation categories, although allocated foster care files were more likely to have information about leaving care when compared with relative/kinship carers.

16.296 Just over 55 per cent of all allocated files showed that formally constituted case conferences had occurred. DoCS allocated files, however, reached compliance levels of over 80 per cent for inviting carers and significant others to case conferences.

16.297 In relation to Aboriginal Placement Principles, all unallocated files documented the explanation for placements while only six in ten allocated files contained this information.

16.298 The Inquiry was surprised that so many of DoCS' cases were allocated in the audit. It was not consistent with the average number allocated, although data provided by DoCS suggest that the allocation rate for those in statutory OOHC is significantly higher than those in supported OOHC. However, when one considers the ratio of caseworkers to children and young persons in OOHC, some of the disparity in the quality of casework with NGOs may be explained.

16.299 As at December 2007, the notional average DoCS caseworker caseload was around 26 when caseworker position vacancies are taken into account. Whilst there is no universally accepted formula for calculating caseload, on average, the literature offers support for a caseload of around 15 OOHC cases per worker.[663] Research evidence broadly identifies a recommended OOHC caseload range of 12-20 'standard/low need' cases/children per caseworker and five to eight 'intensive/high need' cases/children per caseworker at any given time. Actual caseloads at different government and non-government organisations range from 17-32 cases.

16.300 The audit concludes with the Children's Guardian view that serious consideration should be given to gradually transferring the case management of a larger proportion of the OOHC cases to the non-government sector.

[663] Submission: DoCS, OOHC, p.18.

Who should be responsible for children in OOHC?

Introduction

16.301 There are significant debates nationally and internationally about whether the state or non-government services should primarily deliver OOHC services. Currently, different jurisdictions in the Australia have different approaches. In Queensland, South Australia and Victoria, the department is a regulator, funder and provider. In Victoria, the government case manages a very small percentage of children and young persons, and in the other two states mentioned, the government is responsible for fewer that 50 per cent of children and young persons in OOHC.

16.302 The ACT is the only jurisdiction where the government is not an OOHC provider. The ACT department funds OOHC services and monitors these through funding agreements. In Tasmania, the Northern Territory and Western Australia, the department provides OOHC and funds non-government services, monitored through funding or service agreements. In Tasmania and the Northern Territory, contracting of non-government services is limited.

16.303 There have been a number of reviews in NSW of OOHC such as the 1992 Ministerial review of *Substitute Care Services in NSW* (the Usher Review) which recommended the gradual transfer of all OOHC services to NGOs, with DoCS only providing services "where a contract with a non-government agency is impossible."[664] This was not adopted by the Government at the time because previous DoCS attempts at contracting had resulted in poor performance outcomes, costs were seen to be higher in the non-government sector and concerns were held by the government that non-government services would not take the more difficult to place children. Since that time there have been changes in the contracting arrangements including performance management, and a greater experience in the provision of OOHC by the NGO sector, as well as the introduction of accreditation.

Options

16.304 There are a number of possible arrangements for the allocation of decision making responsibility for children and young persons in OOHC.

Scenario A

16.305 DoCS has parental responsibility and is responsible for placement and case management and there is no involvement of a non-government agency, other than the provision of identified support services. This arrangement is presently

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[664] NSW Ministerial Review Committee, *A Report to the Minister for Health and Community Services from the committee established to review Substitute Care Services in NSW (Usher Review),* January 1992.

the most common for children and young persons in DoCS foster and relative care.

Scenario B

16.306 DoCS has parental responsibility and is responsible for case management. The non-government agency provides a placement only service with responsibility for ensuring the day to day care by an authorised carer.

Scenario C

16.307 DoCS has parental responsibility and case management and the non-government organisation provides placement and casework services.

Scenario D

16.308 DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. Under this scenario, the agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of a child with an authorised carer, or the decision to remove a child or young person from a carer. DoCS retains the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change court orders and for providing after care assistance. This arrangement applies to only a few of the children and young persons currently in OOHC.

Scenario E

16.309 DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers). Barnardo is the only agency where this has occurred. DoCS and the NGO are jointly responsible for the initial care plan, court applications, records and providing after care assistance. Approximately 300 children and young persons are currently cared for in this way.

Scenario F

16.310 The Children's Court assigns parental responsibility to an NGO which is responsible for case management. This matter is dealt with in Chapter 9 where reasons are given for not preferring this option.

16.311 DoCS' policy is that case management **will** transfer from DoCS to a non-government agency in circumstances where:

a. DoCS child protection action is complete and DoCS is not undertaking court action

b. final Children's Court orders for sole or shared parental responsibility to the Minister are in place

c. final Children's Court orders for restoration are in place

d. other long term orders such as a supervision order, which places the child or young person under the supervision of the Director-General, are in place. In such cases, prior to the case being transferred, DoCS is to negotiate and agree with the service provider, the initial case plan for the child or young person.

16.312 Also part of DoCS' current policy, case management **will not** transfer in cases where the child or young person:

a. has significantly complex needs

b. is assessed as at high risk of immediate or serious harm

c. case management requires high level collaboration from other government agencies that is unable to be achieved by a non-government organisation.

16.313 Further, agencies with case management are required to:

a. maintain current and comprehensive essential information about children and young persons to inform decision making

b. regularly review placements in accordance with s.150 of the Care Act

c. review all behaviour management plans and use of psychotropic medication

d. develop plans and conduct reviews according to guidelines provided by the Children's Guardian.[665]

16.314 The Inquiry received many submissions addressing the responsibility for children and young persons in OOHC. Most of the non-government service providers' submissions argued that DoCS should not be a provider of OOHC at all. By this, the Inquiry understood that Scenario D or E set out above were preferred. DoCS, on the other hand, was in favour of a mixed service system in which DoCS and non-government services shared the provision of OOHC, in which case management would generally be undertaken by the NGOs, except for a small number of High Needs Kids.

16.315 The difference between these positions essentially lies in the proportion of children and young persons who would be cared for by the State or by NGOs respectively. The State, in the form of the Department, prefers it to be mixed, whereas the NGOs want the greater share of the work.

16.316 A factor which should not be overlooked is s.141(1) of the Care Act which provides that DoCS is obliged to take responsibility as a 'provider of last resort' where a service provider does not meet the needs of a child or young person or withdraws from service provision for other reasons.

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[665] DoCS, *Case Management Policy*.

Arguments in favour of transferring all or much of OOHC responsibility to the non-government sector

16.317 There is an inherent conflict in DoCS being both a provider and a funder of OOHC services.

16.318 Casework for children and young persons both entering and in OOHC who are under the management of DoCS can often be neglected due to prioritisation of crisis driven work.

> *Forensically driven systems are so preoccupied with managing their problematic 'front ends' that precious resources: financial, human and intellectual, are diverted away from the development and maintenance of effective systems of care.*[666]

16.319 This concurs with feedback provided by DoCS staff when the Inquiry met with CSCs. It is also consistent with the findings of the audit recently conducted by the Children's Guardian.

16.320 A transfer of much of the OOHC responsibilities to the non-government sector is not inconsistent with preserving a short term role for DoCS in the delivery of crisis placements. This concurs with findings of the Usher Review which stated:

> *...that the appropriate, long term role for the Department of Community Services should be to assess and review service needs, negotiate contracts with service providers, and to monitor standards, and to ensure programme and financial accountability on the part of service providers. The Department should not continue to operate as a major substitute care provider. Such activity by the state government seriously compromises its proper assessment, contracting, review and monitoring roles in relation to the provision of services for children who are in need of substitute care services.*[667]

16.321 NGOs have smaller and less formalised management structures and often have greater capacity to implement reforms and innovative service models more quickly than government agencies.

16.322 Of significance to many who made submissions was the experience that, in some cases, clients do not want to deal with a government agency, but are happy to deal with an NGO, which is associated in their minds with the broader community and is seen as a non-judgemental agency that is directed towards providing assistance to those in need.

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[666] Submission: Australian Association of Social Workers, p.29.

[667] NSW Ministerial Review Committee, *A Report to the Minister for Health and Community Services from the committee established to review Substitute Care Services in NSW (Usher Review),* January 1992, p.4.

16.323 Effective performance management and performance based contracting, such as has been introduced by DoCS will be capable of addressing any current deficiencies in NGO governance, structures and other aspects of their operations.

16.324 Finally, the functions of the Children's Guardian and those of the Ombudsman provide additional safeguards for monitoring the standards for the delivery of services to children and young persons in OOHC services.

Arguments against transferring all of OOHC responsibility to the non-government sector

16.325 As noted, DoCS has advocated for a mixed service system in which DoCS and non-government services share service provision in OOHC. The advantages of such a system, such as presently exists are that:

a. it ensures flexibility for services being provided in the most effective and efficient manner by the provider best placed to do so

b. it enables DoCS to be an informed purchaser.

16.326 Other arguments have been advanced in favour of maintaining the status quo as follows:

a. to alter the existing system would expose DoCS to higher policy implementation risks if it does not directly manage OOHC

b. NGOs can lack economies of scale, efficient and effective infrastructure, management systems or suitably qualified personnel. The provision of more expensive services by NGOs, even if of better quality, could lead to an increase in DoCS under funding its clients

c. some objectives of NGOs may differ from those of the Government and where it is difficult to monitor outputs or outcomes, an NGO may render different services from those for which it was contracted

d. as they only have responsibility for part of the child protection system, NGOs may not necessarily support policy changes that improve the system as a whole.

e. where the outputs or outcomes from services are difficult to observe or measure this can lead to performance problems.

Other factors

16.327 Several important factors need to be taken into account in addition to these competing contentions.

16.328 First, the OOHC population is projected to increase from the current 14,667 children and young persons to 19,495 by the year 2011/12. Accordingly, NGOs would need sufficient capacity to meet this increased and probably increasing

need. DoCS estimates that once the current OOHC funding reform process is complete, NGO maximum capacity will be 4,063 placements.

16.329 Secondly, comparing the cost to the State of OOHC provided by the Department with that provided by NGOs is not simple. There is little difference in the cost per person in general foster care between the two sectors, and that difference is generally accounted for by the higher salaries paid to government workers. However, when one factors in the lower ratios of children or young persons to caseworkers in the NGO sector (about 1:10), DoCS appears to be the cheaper provider. This, however, is misleading as it does not adequately reflect the number of unallocated cases and the poorer quality of casework which inevitably occurs when a caseworker is faced with a greater number of children and young persons.

16.330 Thirdly, data provided by DoCS suggest that children and young persons in OOHC have multiple placements whether in DoCS foster care or non-government foster care. In 2006/07, 49 per cent of those in non-government foster care had three or more placements, compared with 37 per cent in DoCS foster care. These figures, however, need to be carefully examined as a child or young person placed with non-government organisation may have had a prior placement with DoCS in the current care period or visa versa.

16.331 Fourthly, most OOHC service provision is managed by DoCS and as such the scale of the operation varies significantly between DoCS and NGOs. For example, Barnardos currently provides services to 214 and UnitingCare Burnside to 104 children and young persons. By comparison, as at June 2008 one large DoCS CSC, Campbelltown alone was responsible for 615 children and young persons in OOHC.

16.332 Fifthly, there will always be a cohort of seriously disturbed and high needs children and young persons, particularly those in their later years, which NGOs will have difficulty in placing or may be unable to place unless there have specialised places or carers. In addition, there will always be a need to have carers available for short term crisis situations. Unless there is a body of carers, trained and ready to care for this group on DoCS behalf, it may be prevented from delivering an essential part of its statutory function.

Position of the oversight bodies

16.333 The Ombudsman and the Children's Guardian are more cautious than the NGOs and suggest a more gradual process. The Children's Guardian recommended the progressive delegation of case management responsibility to NGOs according to their capacity as set out in by DoCS case management policy. She further recommended that DoCS consult her before delegating case management or broader parental responsibility to particular NGOs.

16.334 Both the Ombudsman and the Children's Guardian note that when comparing the quality of DoCS casework with non-government service provision,

consideration needs to be taken of caseworker allocation rates. The Ombudsman stated that there may be some merit in DoCS being an informed purchaser of services if it remains a supplier.

> *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 and closely monitored. In particular any rapid expansion of individual services – particularly those without well established practice in this field – may pose a risk to the quality of services provided.*[668]

and

> *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 in the non government sector …. there is the question as to whether DoCS may need to retain responsibility for certain young persons 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.*[669]

Inquiry's view

16.335 Regardless of whether children and young persons are cared for by the State or by the NGO sector, the increase in the size of the group in care and in the length of their stay in care, and the need for acceptable ratios of caseworkers to children and young persons, inevitably mean that the cost of OOHC will increase.

16.336 The Inquiry agrees with the comments of the Usher Review quoted above, and with the caution expressed by the Ombudsman and the Children's Guardian. In its view, there should be a gradual transition to Scenarios D and E with case management for those with complex needs as defined in the policy remaining for the time being with DoCS, along with a close monitoring of the cost benefits of any such progressive devolution of this function. There will always be the need for DoCS to be the provider of last resort.

16.337 As is clear from the data, there is an increasing number of children and young persons entering care with significant child protection histories which suggests that managing the complexity of their needs will require experienced staff. This

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[668] Submission: NSW Ombudsman, pp.1-2.
[669] ibid., p.2.

together with an increasing shift to non-government service provision will need to be accompanied by adoption of a workforce strategy that will attract staff able to support and coordinate services from a range of agencies to meet the needs of those in care.

16.338 The Inquiry is satisfied that the safeguards in place with the delegation of parental responsibility to the Principal Officer of Barnardos are sufficient and should be followed in subsequent delegations. Further, it agrees with the Children's Guardian that she should be consulted by DoCS before the Department determines to delegate parental responsibility to any other person or agency, and be heard on the suitability of such a delegation.

16.339 The Inquiry also agrees with the Children's Guardian that DoCS' Case Management Policy is sound and clearly spells out appropriate roles and responsibilities in relation to case management functions and the need for case management to sit with the agency providing the direct services to children and young persons in OOHC. As she said:

> *The 2007 DoCS Case Management Policy outlines the responsibilities of DoCS and non government agencies under particular parental responsibility, case management, casework and placement arrangements. This is an excellent resource and it is hoped it will resolve some of the uncertainties that have traditionally accompanied arrangements where DoCS and a non-government agency share responsibilities for a child or young person in OOHC.*[670]

Health screening and assessment

DoCS, Health and the Colleges

16.340 DoCS and Health signed a MOU in 2006 aimed at increasing access for children and young persons in OOHC to services provided by Health. The MOU is being implemented at the local level through joint agreements between DoCS Regions and the Area Health Services. The quality of local level working relationships and service capacity varies across the State. An addendum to this MOU is being developed, aimed at meeting the mental health needs of children and young persons in care.

16.341 The types of services covered under the MOU include:

a. identifying referral points in each Area Health Service for community health, drug and alcohol services, and mental health services

b. specialist medical, psychiatric and other health assessment services

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[670] Submission: Children's Guardian, p.39.

c. specialised medical and mental health services, including secure in-patient psychiatric acute care appropriate for children and young persons

d. specialist sexual offender services for children and young persons who sexually offend.

16.342 Health in its submission to the Inquiry stated that referrals of children and young persons in OOHC are prioritised because the serious health and social inequalities experienced by these children and young persons are recognised as an additional dimension beyond the presenting features of any referral. As such, the referral of a child and young person is "considered ahead of any others where a clinical imperative does not require an alternative prioritisation."[671] Health further stated that those in OOHC need to have access to a comprehensive primary health assessment, and need to be subsequently linked into the local services best equipped to meet their needs. Information provided to the Inquiry suggests that while policy supports this, practice can at times be variable depending on capacity within Area Health Services.

16.343 The Royal Australasian College of Physicians (RACP) has issued a paediatric policy relating to the health of children in OOHC. It states that:

> *there are multiple reasons for vulnerability in these children including their high prevalence of abuse and neglect, their greater likelihood of disadvantaged backgrounds, and their increased biological weighting for example, with parents with mental health and drug abuse problems. These factors also contribute to fragmented health care.*[672]

16.344 It stated that there is no unified response or specific policies or recommended standards of health assessment intervention for those in OOHC. RACP has recommended that an assessment of children and young persons should be conducted within 30 days of entering OOHC.[673]

16.345 Other states have acknowledged the need for a health screening process for those who are in OOHC. These states are currently in the process of developing or have implemented a process to undertake health screening for this group with the purpose of identifying any health issues and facilitating appropriate follow up.[674]

16.346 Queensland's Department of Child Safety, with the assistance of Queensland Health, has developed the Child Health Passport to facilitate a baseline health assessment for each person upon entry into care and to provide for annual health checks whilst they remain in OOHC. The process enables health issues

[671] Submission: NSW Health, p.43.

[672] Royal Australian College of Physicians, *Health of children in out-of-home care: Paediatric Policy,* 2006, p.14.

[673] ibid., p.6.

[674] Health, Community and Disability Services Ministers' Conference paper, *Medicare benefits schedule item number for health checks of children in out-of-home care*, 23 July 2008, p.5.

to be identified through the health screening process and where there is a need for follow up, this is undertaken by the caseworker who also ensures that health information is shared with a child's carer to enable them to meet any health needs.[675]

16.347 In Victoria, under the Looking after Children case practice framework, plans are developed to meet the health needs of children and young persons in OOHC. Plans are reviewed six monthly for children under five years of age and annually for children aged five years or over. Victoria is moving to strengthen this approach through a comprehensive health and well-being assessment when children and young persons first enter care. This will be provided by the combination of a general practitioner, a mental health clinician and a paediatrician.[676]

16.348 Western Australia's Departments of Health, Child Protection and Education and Training are working to establish a system that will ensure children and young persons in OOHC have health and education assessments and plans covering physical, mental and dental care. It is envisaged that the assessment model chosen would review physical growth, progress towards developmental milestones and psychological/emotional development.[677]

16.349 South Australia has developed Health Standards for Children and Young People under the Guardianship of the Minister. This involves an agreement between the Department of Families and Communities and the Department of Health that Health will provide a comprehensive paediatric assessment upon entry into care.[678]

16.350 RANZCP, following a recent review of the evidence regarding the mental health of children and young persons in OOHC, has recommended that every person entering care as part of the entry process, has a multi-model mental health assessment. It was also stated that particular attention should be paid to assessment of those with intellectual disabilities entering care, because of the potential for these disabilities to mask their mental health issues. This assessment should occur within 30 days of entering care.[679]

16.351 The RANZCP has concluded that the evidence is 'convincing' that 'chronically' maltreated children can be protected from developing mental health problems if they enter care at a young age. They therefore recommended that in cases where parental incapacity to change makes it clear that reunification is unlikely, permanent care arrangements should be prioritised, especially for children aged under two years.[680]

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[675] ibid.

[676] ibid.

[677] ibid.

[678] ibid.

[679] The Royal Australian and New Zealand College of Psychiatrists, *The Mental Health needs of children in out-of-home care*; A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, Melbourne, 2008, pp.21 and 24.

[680] ibid, p. 18.

16.352 The RANZCP supported the establishment of evidence based parent education and home visiting programs to prevent child abuse and neglect, as well as maternal antenatal assessments, and antenatal and postnatal education to improve parental mental health and parenting skills.[681]

16.353 RANZCP noted that Aboriginal cultural and spiritual factors can impact on how mental health problems develop and may influence how the problems appear and how appropriate and acceptable treatment may be. However, the report also noted that diagnoses based on culturally specific assessments may lead to misdiagnosis with long term consequences. The RANZCP therefore called for development of culturally appropriate tools to assess child development and mental health, and for increased knowledge and understanding of these issues.[682]

16.354 Further, RANZCP stated:

> *Access to competent, comprehensive mental health care needs to be a priority for children in out-of-home care.*[683]

16.355 DoCS' procedures state:

> *All children and young persons should undergo a health, developmental and mental health/behavioural assessment within 60 days of entering care. Their case worker is responsible for arranging these assessments which are carried out by a range of medical and allied health professionals.*
>
> *The physical health/medical component of the assessment should include the following:*
>
> i. *completion of a medical history profile of the child and family to understand the health conditions of parents or siblings which may impact on the child's health, welfare and well-being*
> ii. *immunisation register check*
> iii. *physical examination that checks for growth delay (e.g careful measure of weight, height and head circumference) and signs of malnutrition*
> iv. *screening for visual and hearing deficits*
> v. *screening for signs of pathological conditions that need further investigation (e.g. foetal alcohol syndrome, fragile X syndrome, physical abnormalities that may be related to past abuse)*

[681] ibid., pp. 18 and 19.
[682] ibid., pp. 29 and 30.
[683] ibid., p.23.

vi. dental health screening.

A developmental assessment component should also be done which covers domains such as general cognitive functioning, language and communication, gross and fine motor functioning and socialisation.[684]

16.356 The mental health/behaviour assessment may be deferred until after the initial shock of being removed from family has subsided and the child or young person has settled into an alternative placement.[685]

16.357 DoCS' policy places responsibility on the caseworker to obtain the child or young person's personal health record (Blue Book), from the parents. If this is not possible the caseworker arranges for the carer to obtain a new one from their local child health centre or hospital. It then becomes the responsibility of the carers to update the Blue Book during the time the child or young person is placed with them. If the child or young person leaves a placement the Blue Book should be returned to the caseworker to ensure that it goes to the next placement or to the parents.[686]

Services

16.358 OOHC Assessment Clinics are specialist health and development assessment services for children entering OOHC operating in NSW Health's specialist children's hospitals. The clinics offer medical and psychosocial assessment and referral to allied health assessment (where allied health assessments are not provided at the same time).

16.359 The Children's Hospital Westmead Clinic operates from the Child Protection Unit. Children placed under the care of the Minister for Community Services for a period of two years or more, living in the Sydney West Area aged from 0-12 years, with a priority for children aged 0-8 years, may be referred by DoCS for this service.

16.360 Sydney Children's Hospital Child Protection Unit Out-of-Home Care Screening Clinic provides a similar service for children in the DoCS Metro Central Region. This service is also for children aged 0-12 years, and targets those in care, under temporary or permanent orders, and gives priority to children aged 0-5 years. An evaluation of this service was published in 2007, and the service has been running since 2005.

16.361 The Kaleidoscope Health Screening Clinic for Children in OOHC is the John Hunter Children's Hospital's Out-of-Home Care Screening Clinic, based in the Hunter Child Protection and Family Counselling Service. It is available for

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[684] DoCS, *Child Protection and out-of-home care caseworker policy manual,* p.96.
[685] ibid., p.97.
[686] ibid., p.96.

children placed under the care of the Minister for Community Services who are expected to be in long term care and are children aged from 0-12 years.

16.362 Similar to the Children's Hospital in Westmead, priority is given by the Kaleidoscope Clinic to children aged 0-8 years. The Clinic provides medical and psychosocial assessment with referral to allied health assessment where indicated. Referrals are taken from DoCS or from the foster care non-government organisation responsible for the child. The service is based at Wallsend in Newcastle. Hunter New England Area Health Service advised the Inquiry that the service had been running since November 2006. Statistics, evaluation, funding information, and the cost of the program in 2006/07 were not available.

16.363 KARI Aboriginal Resources is funded by DoCS to deliver foster care services across South West Sydney and to coordinate comprehensive health assessments for Aboriginal children entering OOHC. The KARI Clinic is a partnership between KARI, Sydney South West Area Health Service and DoCS.

16.364 The KARI Clinic operates from three locations: Tharawal Aboriginal Corporation premises in Airds, KARI Aboriginal Resources Inc. site in Liverpool, and at the Liverpool Hospital Rainbow Cottage.

16.365 The KARI Clinic was evaluated in 2005 by the Centre for Health Equity Training Research and Evaluation. The focus of the evaluation was to establish the extent to which the initiatives of the Clinic had achieved its stated aims, and to examine how it evolved and how it has worked with Aboriginal children and young persons entering care.[687]

16.366 It was reported that the KARI Clinic had experienced a range of obstacles. One was that at the time of the evaluation in 2005, the Clinic was said to be "running on goodwill since its establishment ... there was still no formal/written agreement between the partners about the resources to be committed."[688] Whilst an MOU was in place between the agencies there was no specific reference to resources to be committed from the respective agencies.

16.367 Lack of specific funding for this Clinic was said to be a major limitation of the Clinic's operation, as was the fact that it was not seen as an established health service for Aboriginal children, and that it did not have a consistent location or consistent personnel. Lack of specific services such as dental and hearing services was also mentioned by staff as an access barrier for foster carers.[689]

16.368 The time taken for the provision of assessments was seen as a further barrier:

> *The slow response in assessing children was also seen as a result of the limited one a month times allocated for clinical*

[687] Sydney South West Area Health Service, *Final Draft of the 2005 Evaluation Report*, p.ii.
[688] ibid., p.13.
[689] ibid., p.14.

assessments, the transitional nature of Aboriginal families and the clinic not being seen as core business.[690]

16.369 It was also reported that at the time of the evaluation, follow up and treatment for the children assessed had been limited.[691]

16.370 The evaluation noted that the Clinic had experienced difficulties in accessing and maintaining health care data and information for the children assessed, and noted that the management of health care data and information was one of the challenges of this model.[692]

16.371 It was reported that achievements of the KARI Clinic included the fact that it had provided the opportunity for early identification of the health needs of Aboriginal children in OOHC, with children receiving health and developmental assessments. The benefits were believed to have extended beyond the children to their carers, who were said to have experienced improved confidence in caring for foster children, increased knowledge of health behaviours and improved access to health services as a result of their involvement with the Clinic.[693] The KARI Clinic was also said to have improved communication and relationships between the interagency partners KARI, Health and DoCS.[694]

16.372 Despite the obstacles encountered, it was seen that "the future vision of the KARI Clinic is a transferable model of health care not only for Indigenous children but for all children in OOHC."[695] It was acknowledged, however, that the model required further work to achieve this goal. In 2008, the Kari Clinic was a winner of the NSW Aboriginal Health Awards for Strengthening Aboriginal Families and Children.

Issues Arising

16.373 The issues raised with the Inquiry relating to the health needs of children in OOHC fell into three broad categories. First, the need to secure access to comprehensive, multi-disciplinary health and developmental assessments for children entering OOHC; secondly, the need for access to routine and specialised services to improve health and development outcomes for children and young persons in OOHC and to support their carers; and thirdly, problems with agency and government structures and systems that acted as barriers to improving the outcomes for those in OOHC.

16.374 The Inquiry heard that there was a widespread understanding of the importance of comprehensive health and development assessments for children entering

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[690] ibid., p.15.
[691] ibid., p.16.
[692] ibid., p.29.
[693] ibid., p.8.
[694] ibid., p.9.
[695] ibid., p.30.

OOHC, and that the recommendations of the RACP policy were widely supported. The comprehensive assessment clinics run at the three children's hospitals, and the KARI clinic for Aboriginal children were perceived to be good models. However, access to such services was identified as a problem.

16.375 Access to follow up health and developmental interventions was a concern across the State. The Inquiry understands from Health that only an estimated 10 per cent of children entering OOHC had a primary health assessment by NSW Health Services in the period July 2007 to 30 June 2008. This highlights that the MOU has yet to be fully implemented. The Inquiry heard that although health workers were willing, the implementation of the MOU was hampered by a lack of services. A major gap in the availability of speech pathology services was identified. The paucity of services was seen to impact adversely on the children, but also on their carers and their caseworkers. One NGO OOHC service provider said:

> *The impact for us as an agency is for our caseworkers working with foster families with the children in care, because they're the ones still waiting, waiting, waiting, and we can't give them an answer and we don't have access to make the system work better. So when we were looking earlier today at disruption rates and support, I think that that flow on will make a big difference, if we can improve the access and service delivery.*[696]

16.376 The Inquiry heard that one pressing issue that hampered agencies in their efforts to meet the health needs of children entering OOHC was the fragmented information systems and poor access to personal and family health information. The Inquiry understands from Health that, following an audit in September 2008, it was identified that there is no standard or consistent approach to the collection of data for health screening and assessment for children in care by Area Health Services other than in the five clinics set up to conduct multi-disciplinary assessments. Further, health information about a child who moves from one area to another can be problematic as the relevant health provider may not be informed of the relocation and the child's health information does not necessarily follow them. One paediatrician in Wagga Wagga informed the Inquiry that a process was needed to ensure that when a child was removed from his or her parents, essential health information was gathered such as whether the child had a condition requiring regular medication. He gave the example of an epileptic child on anti-convulsant medication.

16.377 The Inquiry was advised that the presence of an accessible, comprehensive medical record or a transferable record (as recommended by the RACP) would be of huge value in the assessment of these children and young persons, and that even the routine information recorded in the Blue Book would assist in providing a comprehensive assessment of the child's needs. The Inquiry heard that currently, the information systems within Health made it difficult to access

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[696] Transcript: Public Forum, OOHC, 29 February 2008, p.51.

health histories especially where children and young persons had moved into a different health area, and that there were additional problems accessing information from other agencies such as DoCS and DADHC to inform the assessment.

16.378 Health informed the Inquiry that there was a national and statewide move toward centralised electronic medical records, but that a functioning centralised record was unlikely to be available for a decade.

16.379 Children and young persons have many needs which cannot always be met by one government department or agency. In an attempt to meet these needs in a coordinated manner a range of MOU have been established between various government departments, notably, Health, DADHC and Education. These MOUs state that children and young persons in OOHC are to be given priority for services delivered by these agencies. Information provided by both DoCS, other non-government agencies and through submissions, however, indicates that there is presently a difficulty across NSW and particularly in rural and remote areas in accessing assessment and intervention services. Barnardos advised the Inquiry:

> *We are sceptical in the implementation. For example an MOU negotiated by DoCS Director-General with his equivalent in Health to achieve prioritised paediatric assessment was well publicised in the media. However 18 months later conversation with staff at the hospital concerned demonstrates very few children referred by DoCS received the paediatric assessment.*[697]

16.380 While the policy and the MOU are clear, presently within the NSW OOHC system there is no guarantee that children and young persons entering OOHC will have their health, developmental and dental needs assessed and followed up in a timely manner. In the 2007 Review of children under five years by the Ombudsman, ongoing concerns were identified about the adequacy of general health and other screening when children enter care. Similar findings were also made in the NSW Ombudsman's 2008 draft report on 35 children aged 10 to 14 years who were in OOHC and who were under parental responsibility of the Minister.[698]

16.381 Health in its submission to the Inquiry stated that while DoCS and Health have agreed on a model for comprehensive health assessments, other contract arrangements have been put in place by DoCS. Health strongly recommended that it should become the primary provider of health assessments to children and young persons in OOHC to prevent service duplication, disjointed care and waste of resources. Health stated that it was able to offer statewide

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[697] Submission: Barnardos, pp.17-18.

[698] NSW Ombudsman, *Review of a group of children aged 10 to 14 in out-of-home care and under the parental responsibility of the Minister for Community Services, Draft,* 12 November 2008, p.8.

assessment services that are linked to treatment services, although it accepted that successful implementation would require additional resources.

16.382 As part of the OOHC expression of interest process, DoCS sought tenders for the provision of health assessments for children and young persons, which would suggest that access to these services is currently not being provided in a systematic manner by Health. DoCS is currently in negotiation with Catholic Healthcare to provide health assessments across the seven DoCS regions. The annual cost of this contract is estimated at approximately $4 million. DoCS advises that this agency will not be contracted for treatment or clinical services. Referrals will be prepared and treatment sought through the usual Health processes or through private practitioners where necessary.

16.383 It is unclear whether or not these services contracted by DoCS will compare favourably with the public health models currently available in some locations in NSW. A concern for the Inquiry is how services that are needed following the assessment of children and young persons will be accessed and delivered and by whom. Many submissions and concerns raised during the Inquiry's Public Forums, meetings with DoCS CSC staff highlighted the current lack of required treatment and health services presently available, despite a plethora of well documented MOUs.

16.384 There was, however, evidence provided to the Inquiry of successful partnership models in place between some Area Health Services and DoCS, which were providing good results. Health has collaborated with DoCS on a potential service model option for health assessments of children and young persons entering care. As such it is unclear to the Inquiry why negotiations with another service provider (Catholic Healthcare) and not Health are being progressed. It would appear that subject to having sufficient funding, Health would be best placed to provide both assessment and ongoing provision of services, where required, subject to being able to deliver consistently across the State through the various Area Health Services. Health informed the Inquiry:

> *NSW Health is the best agency to provide these comprehensive health care assessments as it has the expertise, knowledge and skills, within a tiered health care system, ensuring that there is no duplication of services, disjointed care; delays for children nor waste of resources.*
>
> *Furthermore, the link between the Health assessment process and the referral process to improve access to mental health services for children and young persons in care remains critical given that mental health issues contribute significantly to morbidity in this population.*[699]

16.385 Recommendations are made at the end of this chapter.

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[699]Submission: NSW Health, p.43.

Education

16.386 There is an MOU between DoCS and Education in relation to educational services for children and young persons in OOHC. The objectives of this MOU are to:

a. clarify the roles and responsibilities of the two departments in meeting the needs of children and young persons in OOHC who are attending a NSW government school

b. ensure that children and young persons in OOHC receive appropriate support at those stages, or in those circumstances in their school life, where coordinated service delivery through information sharing, or case planning or management is beneficial

c. promote information sharing about each department's programs, services and other resources, to facilitate better outcomes for children and young persons in OOHC.

16.387 The MOU provides for the development of individual education plans on a case by case basis, as appropriate. It also provides for responding to requests from DoCS, an authorised carer, or a child, or young person in care, for learning support, based on identified need.

16.388 Many submissions to the Inquiry raised concerns about children and young persons not getting access to education because of their challenging behaviours resulted in expulsion and suspension from school. While Education's, *Suspension and Expulsion of School Students Procedures* states that "a work program should be provided for the duration of the suspension" information provided to the Inquiry suggests that this rarely happens. UnitingCare Burnside informed the Inquiry:

> *In 2007 Burnside had 76 children and young persons 5-16 years old in care … Thirteen children and young persons in Burnside services, aged between 10 and 16 years, were expelled or suspended from schools in 2007. This represents approximately 17 per cent or almost one in five children placed in our care were in conflict with the school system at this level. The result was approximately 30 months of lost school between the 13 children…. In about 40 per cent of cases no school work was provided.*[700]

16.389 In the Ombudsman's review of children aged 10-14 years in OOHC, a number of these children had multiple school placements and histories of poor school attendance and school suspension with many performing below average in relation to literacy and numeracy skills. This draft report also noted that some

[700] Submission: Burnside, OOHC, June 2008, Attachment: Briefing Paper: Suspension / expulsion of children and young persons in UnitingCare Burnside Out of Home Care Services, 2007, p.19.

children whose academic performance was below average before they entered long term OOHC had made significant improvements as a result of additional support including in-class support, tutoring, and assistance from school counsellors.[701]

16.390 All Australian jurisdictions have identified the importance of Individual Education Plans. In Victoria, Queensland, South Australia and ACT the intention is for all children in OOHC to have these plans. In NSW, Tasmania, Western Australia and Northern Territory these plans are completed on a needs basis. National and international research confirms that Individual Education Plans are regarded as the best strategy for ensuing an educational focus is maintained throughout the period the child is in care.

16.391 The CREATE Foundation has also been conducting research on the education of children and young persons in care. CREATE identified the fundamental areas of immediate action required to support and improve the educational participation and performance of children and young persons in care that have been reported on since 2002. The areas of action include:

a. ensuring that all children and young persons in care have an individual education plan

b. establishing mechanisms that monitor, evaluate and review achievement of outcomes.[702]

16.392 The Inquiry agrees that these actions are required.

16.393 DoCS is currently funding research into the educational needs of children and young persons in OOHC to identify how these can be better met. The results of this will be available in early 2009.

16.394 DoCS has developed a policy position under which there is a requirement for all children and young persons aged three years and over to have an educational assessment within 90 days of entering care.[703] In addition, children aged 3-12 years who are already in care, who have not had such an assessment, will be required to have one completed. For care leavers, as part of their leaving care plan, the need for an educational assessment will be determined on a case by case basis.[704] The Inquiry supports this policy, subject to education and employment options being examined for all care leavers. DoCS advised that an estimated $2 million would be required to fully implement this policy.

16.395 The implementation of the 'OOHC minimum data set' in NSW will provide information on educational participation, incidences of suspension and expulsion, educational attainment levels and retention rates for children and

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[701] NSW Ombudsman, *Review of a group of children aged 10 to 14 in out-of-home care and under the parental responsibility of the Minister for Community Services, Draft,* 12 November 2008, p.9.

[702] CREATE Foundation, *Report Card on Education 2006,* p.5.

[703] DoCS, *Proposed policy position on educational assessment of children in OOHC*, February 2008, p.2.

[704] ibid., p.3.

young persons in care. The OOHC minimum data set is expected to be implemented by NGOs in March 2009 and in DoCS in July 2009. To date, no data on educational participation and performance are available in NSW. It is unclear from the information provided by DoCS when reporting on this area will commence for both funded and direct OOHC services.

Unproclaimed provisions in the Care Act

16.396 A number of key sections of the Care Act have not been proclaimed. Most of these relate to powers of the Children's Guardian with respect to OOHC.

16.397 The Children's Guardian believes the current unproclaimed provisions would be unworkable in their current form and are not in the best interests of children and young persons in OOHC. This position was generally supported by others, including DoCS. Those provisions concern voluntary OOHC, dispute resolution, case review, delegation to non-government organisations and the exercise of residual powers of guardianship.

16.398 There are however a number of amendments which are sought by the Children's Guardian, which are addressed below.

Voluntary Out-Of-Home Care

16.399 Sections 135(1)(c)(ii) and 135(3)(b) effectively exclude some forms of voluntary care from the OOHC definition. In addition, ss.155 and 156 which provide for the monitoring or review of children and young persons in voluntary OOHC remain unproclaimed.

16.400 A number of submissions were critical of the consequent absence of regulation of those providing care for these children and young persons, including those provided by the Ombudsman and ACWA.

16.401 The Inquiry understands that DoCS has recently consulted extensively on a proposal for a revised scheme for voluntary care. Its purpose is to clearly distinguish between a statutory scheme for OOHC, temporary arrangements which are supported by DoCS, and voluntary care without the involvement of the Courts or DoCS, so as to ensure those in the latter category are not subject to harm. That scheme, which this Inquiry supports, incorporates the following elements:

a. Limiting the definition of OOHC to apply only to children and young persons in court ordered care or who are protected persons.

b. Reclassifying voluntary OOHC into supported care, including short term temporary care arrangements involving and supported by DoCS, and parent initiated and managed voluntary care.

c. Requiring for those in voluntary care, if in care for over 90 days, that care is to be provided or supervised by a designated agency which must prepare

care plans which are reviewed annually. If in care for under 90 days and not by a designated agency then the provider of the care should be registered with the Office of the Children's Guardian.

16.402 This proposal is primarily directed at children and young persons with disabilities and recognises that the current unproclaimed provisions would capture arrangements where state intervention is not warranted. For example, they could apply to a child or young person staying with friends over school holidays, or to a child or young person with a severe disability who is in respite care frequently.

16.403 The Inquiry notes that this proposal has received the support of those most concerned with the voluntary OOHC regulation including DADHC, the Children's Guardian, NCOSS, ACWA and the Ministerial Advisory Council.

16.404 The Inquiry is of the view that consideration should also be given to incorporating a formal mechanism for mediation as part of the voluntary OOHC system, to be accessed in circumstances where care-givers become concerned about a parent's ability to act in the best interests of the child or young person and these concerns fall short of a reportable risk of harm. The Inquiry notes that this mechanism has been supported by DADHC and by the Children's Guardian.

Dispute resolution function

16.405 The unproclaimed s.183 of the Care Act provides that the Children's Guardian may use his or her best endeavours to informally resolve disputes between various parties that may arise in the administration of the Care Act and regulations.

16.406 The Children's Guardian has told the Inquiry that her Office does not have the expertise to resolve disputes concerning the broad administration of the Care Act and Regulations, given its OOHC focus. The Inquiry understands that the intention of the Parkinson review of the 1987 Act was that this function was to be limited to matters arising between carers and DoCS in the context of OOHC.

16.407 The Inquiry is of the view that since these provisions were drafted, a more sophisticated complaint handling framework is in place within DoCS, NGOs and the Ombudsman rendering it unnecessary for the Children's Guardian to undertake this work. In addition, greater use of ADR as set out in Chapter 12 should enable these disputes to be resolved by other means.

Case plan/review function

16.408 The unproclaimed s.181(1)(d) of the Care Act requires the Children's Guardian to examine a copy of the case plan for each child or young person in OOHC and a copy of each report made following the regular review of the case plan.

16.409 The unproclaimed s.150(5) of the Care Act requires copies of each review report to be provided to the Children's Guardian, with reviews to be conducted at least annually. More frequent reviews are required in some circumstances.

16.410 The Children's Guardian submitted that given the numbers of children and young persons in statutory care, proclamation of ss.181(1)(d) and 150(5) would require the Children's Guardian to review well in excess of 10,000 case plans/reviews each year.

16.411 The Children's Guardian is of the view that the broad monitoring provided for under the Case File Audit Program and in the Accreditation and Quality Improvement Program constitute a better vehicle to ensure the review of children and young persons in statutory care.

16.412 Professor Parkinson suggested to the Inquiry that at least annual reviews should be provided to the Children's Guardian:

> *That they be received by the Guardian, that the Guardian has a register, a record of children in out-of-home care, and ticks off that it has been received. That then is an extra tool for her if she has concerns about a particular child or a particular category of case, to at least have the review on file to be able to look at what has been happening in the last couple of years. It is an obvious management tool.*
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> *I would be comfortable if we repealed the provision that they have to examine every report.*[705]

16.413 The Inquiry agrees with Professor Parkinson's suggestion. Requiring review reports to be forwarded to the Children's Guardian would enable a register to be kept by her Office which can then inform the other statutory functions attaching to it. It will also render more transparent this activity in DoCS. There should not be a statutory requirement that the Children's Guardian examine each report. Nor should there be a requirement for the Children's Guardian to examine every case plan for those in OOHC.

Delegating to non-government agencies

16.414 Under s.181(1)(a) the Children's Guardian has the power to exercise, subject to the direction of the Minister, the parental responsibilities of the Minister for a child or young person for the benefit of the child or young person. As this is not proclaimed, DoCS has responsibility for delegating responsibility for decision making to non-government agencies.

16.415 The Children's Guardian advised the Inquiry that to proclaim this provision would interfere with:

[705] Transcript: Inquiry meeting with Professor Parkinson, 27 February 2008, p.5.

> *recently established systems for allocating parental responsibility, case management responsibility and casework responsibility. These systems set out in the 2007 DoCS Case Management Policy are linked with current funding systems and should be given an opportunity to be embedded.*[706]

16.416 However, the Children's Guardian advised the Inquiry that she believes that her Office held sufficient information relevant to agency capacity to take on additional decision making functions, and that DoCS should consult with the Children's Guardian before delegating responsibility (including case management responsibility) to non-government agencies.

16.417 DoCS has agreed with this proposal, although prefers that it be effected otherwise than by legislative amendment.

16.418 The Inquiry agrees that DoCS and the Children's Guardian should develop a process whereby consultation occurs before DoCS delegates the responsibility mentioned. In the absence of agreement between them, the Inquiry recommends that the Care Act be amended to require consultation. Provision should be made for those the subject of adverse comment from the Children's Guardian to respond to that comment.

Residual powers of guardianship

16.419 By virtue of the fact that the powers of the Children's Guardian to act as the name suggests, have largely remained unproclaimed, s.186, which has been proclaimed, is anomalous.

16.420 To grant to the Guardian the non-delegable powers set out in s.186(1)(a) – (f) would not be in keeping with the current role and function of that office. These include:

a. granting consent to the marriage of a child or young person

b. granting permission to remove a child or young person from NSW

c. applying for a passport on behalf of a child or young person

d. granting consent to medical and dental treatment of a kind prescribed by the regulations

16.421 The Children's Guardian submitted to the Inquiry that it would not be in the best interests of children and young persons in OOHC for the Children's Guardian to exercise the non-delegable 'residual powers of guardianship referred to in s.186 of the Care Act.' She recommended that the Care Act be amended to remove the references to the Children's Guardian exercising these residual powers of guardianship. The Inquiry agrees. They are currently exercised by DoCS and by other persons with parental responsibility.

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[706] Submission: Children's Guardian, p.67.

16.422 The Children's Guardian also submitted that non-delegable functions should be set out in the Regulations, and the Children's Guardian should have the:

> a *function of monitoring the systems in place for making such decisions;*
>
> b *power to require the Director-General of DoCS to provide such information to the Children's Guardian on the exercise of 'non-delegable' parental responsibility functions, as the Children's Guardian may require; and*
>
> c *power to report and make recommendations to the Minister on systems for making 'non-delegable' parental responsibility decisions and on particular parental responsibility decisions that should or should not be capable of being delegated.*[707]

16.423 A senior officer from the Office of the Children's Guardian explained the proposal in the following way to the Inquiry:

> *It is appropriate to have an external party involved in that process, but does it respond to an identified crisis or concern? The answer is no. It is a sensible oversight arrangement that really requires some discussion and is likely to have minimum impact on our workloads, but perhaps offer some assurance to the sector that these decisions are not being made unilaterally and are being made in consultation.*[708]

16.424 DoCS did not support this proposal. It noted that if the designated agencies are concerned about decisions made by DoCS, there are existing mechanisms including application to the ADT to have the decisions re-considered. In addition, the Children's Guardian's Case File Audit Program provides it with capacity to deal with matters of this type.

16.425 DoCS is subject to considerable oversight by a number of agencies. The Inquiry is of the view that there are sufficient mechanisms in place, including the various functions of the Ombudsman, to address any concerns about the exercise of the non-delegable functions associated with parental responsibility. It does not support the suggestion of the Children's Guardian in this respect.

A 'safety net'

16.426 The Children's Guardian advised the Inquiry of her experience of individual children and young persons in OOHC who are not receiving appropriate care and where the regulatory framework does not offer them sufficient protection.

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[707] ibid., p.69.

[708] Transcript: Inquiry meeting with representatives of the Office of the Children's Guardian, 1 July 2008, p.22.

16.427 The Children's Guardian also noted in her submission to the Inquiry that the Usher Review, the 1997 Police Royal Commission and the Parkinson review of the 1987 Act all identified the need for a body, independent of DoCS and the Courts, to exercise its powers of guardianship in respect of children and young persons under the parental responsibility of the Minister.

16.428 The Children's Guardian sought:

> *more targeted special guardianship powers so they are focused on vulnerable children and young persons in OOHC who have not had their care concerns addressed by existing mechanisms, or whose life or safety is in such danger that urgent independent decision making is required….This would see the Children's Guardian taking on a 'safety net' role, … the Children's Guardian would be the guardian of last resort.*[709]

16.429 Under this model, the Children's Guardian would have the power to "overrule the decision of a designated agency concerning any aspect of parental responsibility,"[710] with s.140 of the Care Act being amended to provide that a designated agency must comply with any written direction of the Children's Guardian to exercise parental responsibility in a particular way.

16.430 It would be also necessary to proclaim s.182 of the Care Act to allow the Children's Guardian to remove a child or young person from a particular care arrangement if the designated agency did not comply with a proposed written direction under s.140.

16.431 The Children's Guardian would, in exercising such decision making powers, need to be able to apply to the Court for the rescission or variation of a care order under s.90(3) of the Care Act. Section 184 of the Care Act would then need to be proclaimed to ensure that the Children's Guardian may make such an application, notwithstanding the Children's Guardian not having been a party to the original proceedings.

16.432 The Children's Guardian and her staff expanded on her submission in the following way:

> *It is the power to direct an agency, a designated agency, that the Minister's delegated parental responsibility be exercised in a specified way. At the moment, for instance, we would have no power to direct DoCS to find an alternative placement for that child. Once the agency is out of the out-of-home care accreditation system, our formal powers in relation to that agency stop, but because parental responsibility cascades down from the Minister to the Director-General of DoCS and is*

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[709] Submission: Children's Guardian, p.64.
[710] ibid., p.70.

> *then subdelegated on to delegated agencies, if you had the power to direct the Minister's parental responsibility with respect to accommodation be exercised in a particular way, if it had not, after you'd discussed it, managed the issue appropriately, you would be able to issue a legally enforceable direction.*
>
> *. . .*
>
> *If an agency is applying inappropriate restraint practices in respect of one child but is providing good care for the majority of its clients, but they have one child who has special needs who is not being cared for well, you would ask the agency to address those concerns. If the agency did not address those concerns, you would have a power to direct that care be provided in a particular way. If that care were not provided in a particular way, you would have the power to direct the removal of that child and have them placed with a more appropriate agency.*[711]

16.433 The Children's Guardian gave a series of examples. The first example was in relation to monitoring the transition of children and young persons from agencies which no longer intend to provide OOHC or are deemed inappropriate to provide that care. She pointed to delays in transitioning particular children and young persons and advised that using her existing power to require information about those children and young persons from DoCS, pursuant to s.185, was not effecting positive change.

16.434 Secondly, an example was given in relation to the Children's Guardian receiving information during its case file audits or through the accreditation process of defective management. She made reference to a case of a child who was in short term crisis accommodation for 14 months, without a behaviour management plan, without consent for psychotropic medication, and without case reviews or immunisation records or school reports. She sought reports from DoCS through s.185, which did not result in any appropriate change to the child's situation.

16.435 Finally, the Children's Guardian provided an example of the cessation of funding for a service for Aboriginal children and young persons in circumstances where, had she the power, she would have intervened at a much earlier time to protect the children.

16.436 DoCS disagreed and advanced two reasons for not adopting the Children's Guardian's suggestion. First, the Children's Guardian accredits agencies and can place conditions on their accreditation. If the placement is in accordance with that accreditation, that should be the end of the Children's Guardian

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[711] Transcript: Inquiry meeting with representatives of the Office of the Children's Guardian, 1 July 2008, pp.7-8.

involvement. Otherwise, new criteria are being brought into play and added complexity results. Secondly, such a role would permit the Children's Guardian to make decisions without being obliged to consider the budgetary and practical implications for DoCS or for the designated agencies which its funds.

16.437 The Inquiry is aware that there are undoubtedly cases where children and young persons in care 'drift;' that is, they are not the subject to active intervention by the Department or designated agency. Their emotional, educational and medical needs may go largely unmet. The current oversight arrangements to ensure the safety, welfare and well-being of the child or young person include: a court order following a hearing (in most cases); being placed in care with an agency which has been accredited and/or is being monitored, or with the Department, each of which would owe statutory obligations; appeal rights in some cases to a Tribunal; and the existence of an external and internal complaint handling body. The existence of these remedies or oversight arrangements tends to dilute the need for the establishment of an independent body with a general authority to exercise a power of guardianship in relation to individual children and young persons under the parental responsibility of the Minister.

16.438 While the Inquiry is acutely conscious that the current system does not always result in quality care for all children and young persons who have been removed from their home, it is not persuaded that increasing the oversight in the manner suggested by the Children's Guardian is the solution. The Children's Guardian can and does use s.185 to bring the deficiencies she finds to the attention of DoCS, and/or the Ombudsman.

16.439 The Inquiry is of the view that the preferable approach is to equip DoCS and other designated agencies better so that they can respond to the children and young persons in their care, and to the Children's Guardian, when she draws attention to concerns. The Inquiry is particularly concerned that the Children's Guardian should not be empowered to make decisions, with a legislative mandate, which have budgetary implications for DoCS, and which might interfere with the most effective allocation of its resources.

Other proclaimed functions of the Children's Guardian

16.440 The Children's Guardian submitted that several other sections of the Care Act are no longer appropriate and should be repealed or amended.

16.441 Section 105(3)(b)(iii) of the Care Act if proclaimed would permit the Children's Guardian to consent to the publication or broadcasting of identifying information about children and young persons under the parental responsibility of the Minister, where the Guardian was of the opinion that the publication or broadcasting could be seen to be of benefit to the child or young person.

16.442 The Children's Guardian is not a party to care or other court proceedings and has not been involved in case management or case planning for children and young persons under the parental responsibility of the Minister.

16.443 The Children's Guardian has accordingly delegated this function to the Director-General of DoCS since it is DoCS that appears in Children's Court proceedings and has a relationship with the Court.

16.444 Notwithstanding, the Children's Guardian is still occasionally approached to approve the publication or broadcasting of identifying information concerning children and young persons under the parental responsibility of the Minister.

16.445 The Children's Guardian suggests that s.105(3)(b)(iii) should be amended to delete her role in this respect and to authorise the Director-General to consent to such publication or broadcasting. The Inquiry agrees, since the Children's Guardian will not be sufficiently informed to make assessments under s.105(3)(b)(iii).

16.446 The Children's Guardian also suggests that s.90(3A) of the Care Act should be amended to remove the requirement that the Children's Guardian be notified of certain rescission and variation proceedings concerning the assignment of parental responsibility. The Inquiry agrees.

16.447 Finally, the Children's Guardian submitted that s.141(2) should be amended to require that DoCS be advised, and that it then advise the Children's Guardian, when a designated agency ceases to be able to fulfil its responsibilities in relation to a child of young person, in addition to making an application to the Children's Court to vary the OOHC arrangements. DoCS opposed that submission. The Inquiry understands that s.141 applies in a very few cases where the Minister has delegated parental responsibility to a designated agency. In the event of the application being made to the Children's Court, each interested party would have an opportunity to adduce evidence and make submissions. In light of the Children's Guardian relatively limited role with respect to parental responsibility, the Inquiry sees little reason to amend the section.

The Register

16.448 Section 159 of the Care Act has not been proclaimed. It was intended to place an obligation on the Director-General to maintain a register in which there are entered particulars of every child or young person who has been in OOHC for a continuous period of 28 days or more.

16.449 In line with the amended definitions of OOHC to statutory care, supported care and voluntary care, the Inquiry can see no reason why a record in the form contemplated by s.159 cannot be kept for at least those children and young persons in statutory OOHC.

Adoption

16.450 The Care Act, the Regulation and the *Adoption Act 2000* set the legislative framework for the provision of OOHC placement and support services in NSW, including the process for adoption of a child. Adoption orders in NSW are granted by the Supreme Court.

16.451 In other Australian jurisdictions, different courts are responsible for granting an adoption order.

a. In the ACT, the Supreme Court makes adoption orders.[712]

b. In the Northern Territory, the Local Court grants adoption orders.[713]

c. In Queensland, the Children's Court grants adoption orders.[714]

d. In South Australia, adoption matters are handled by the Youth Court of South Australia.[715]

e. In Tasmania, adoption orders are granted by the Magistrates Court (Children's Division).[716]

f. In Victoria, the primary responsibility for adoption lies with the County Court.[717]

g. In Western Australia, the Family Court of Western Australia handles matters relating to children, including adoption.[718]

16.452 Adoption is the legal process which permanently transfers all the legal rights and responsibilities of being a parent from the child's birth parents to the adoptive parents. It is one of the range of options to be considered in placement planning for children who cannot live with their birth families, that can help to ensure that such children have the stability and continuity of a relationship that is necessary for their well-being and development.

16.453 Adoption of children is not a common practice in Australia. According to the AIHW, in 2006/07 there were a total of 568 adoptions of children in Australia. Of these, 71 per cent, were inter-country adoptions. A further 18 per cent were 'known child' adoptions, which were generally adoptions by a step parent to incorporate children into a new family. The remaining 10 per cent were local adoptions.[719] Of the 568 children adopted in Australia in 2006/07, 164 were in

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[712] *Adoption Act 1993* (ACT), p.72 Dictionary.

[713] *Adoption of Children Act 1994* (NT) s.3 and see: www.nt.gov.au/health/comm_svs/facs/adoption/adopting_child_in_nt.pdf

[714] *Adoption of Children Act 1964* (Qld) s.6.

[715] *Adoption Act 1988* (SA) s.4.

[716] *Adoption Act 1988* (Tas) s.3.

[717] *Adoption Act 1984 (*Vic*)* s.5, covers the role of County Court, concurrent Supreme Court jurisdiction, and that matters may be referred to the Supreme Court by the County Court see also www.cyf.vic.gov.au/adoption-permanent-care/adoption.

[718] *Adoption Act 1994* (WA) s.4. See also www.familycourt.wa.gov.au.

[719] Australian Institute of Health and Welfare, *Adoptions Australia 2006/07,* February 2008, p.8.

NSW.[720] In 2007/08 in NSW there a total of 125 adoption orders made. Of these, 73 were inter-country adoptions, 22 were adoptions of children by carers, 15 were local adoptions, 10 were step-parent adoptions, three were relative adoptions and two were special case adoptions.[721]

16.454 According to Cashmore the main reasons why children in long term OOHC are not being adopted more often include the financial disincentives to adoption for carers, and overloaded caseworkers not having the time and skills or the necessary supervision to ensure that they follow through on developing the necessary plan and preparing the paper work. Also many children in care are living with relatives and adoption is generally not considered a useful or appropriate option. The issue of adoption for Aboriginal children is particularly problematic given the history of the 'stolen generation' and because, as HREOC's *Bringing them Home* report states, the concept of adoption is "incompatible with the basic tenets of Aboriginal society."[722]

16.455 Following a recent review of the *Adoption Act 2000*, the Inquiry understands that NSW Cabinet has approved reforms to adoption law and practice, which include:

a. streamlining the processing of inter-country, step parent and relative adoptions with applications being submitted directly to the Supreme Court without the involvement of DoCS

b. reforms to adult adoptions

c. less prescriptive eligibility criteria (to be included in the *Adoption Regulation 2003*) including removal of a prohibition on accepting applications from persons pursuing fertility treatments and a focus on factors that affect parenting capacity

d. greater involvement of Aboriginal agencies in the adoption of Aboriginal children

e. reforms to the right to access adoption information, and to the publication of the names of parties to adoption proceedings

f. streamlining the processes for children aged 12-16 years who wish to consent to their own, or their child's adoption

g. agreement by Cabinet that statutory foster carers should continue to receive the statutory care allowance for children and young persons that have been in their care for a minimum of two years, after the making of an adoption order.

16.456 Perhaps reflecting the low numbers of children and young persons adopted in NSW, the Inquiry received few submissions on this issue. From the material

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[720] ibid., p.9.

[721] DoCS, *Annual Report 2007/08,* p.259.

[722] J Cashmore, "Lessons from the US on Permanency Planning," *Social Policy Research Centre, University of New South Wales,* undated.

reviewed doing the course of the Inquiry, there is nothing in the reforms approved by Cabinet which would give rise to any concern by the Inquiry.

16.457 However, mindful of the importance of stable relationships for children and young persons unable to live with their families and the emphasis on permanency planning, the Inquiry has considered whether the Supreme Court remains the appropriate forum for adoption applications and orders.

16.458 It believes that consideration should be given to transferring jurisdiction to the Children's Court in circumstances where current child protection concerns exist. That would be consistent with the practice in other States and may result in adoption being given more consideration at an earlier stage. The jurisdiction would otherwise remain with the Supreme Court. Any appeal against an order by the Children's Court in relation to adoption should lie to the Supreme Court.

Inter-country adoption

16.459 In June 2008, NSW became a signatory to a revised Commonwealth-State Agreement on Inter-country Adoptions. Under this Agreement, the Commonwealth has assumed responsibility for the management and negotiation of inter-country adoption programs. The States and Territories continue to be responsible for day to day approval and processing of these applications including training and assessment of applicants, placement arrangements and post-placement reporting to the child's country of origin.

16.460 DoCS reported that the review of the *Adoption Act 2000* had provided an opportunity to examine the Department's ongoing involvement in inter-country adoption court processes.

16.461 DoCS informed the Inquiry that in 2005, it conducted a comprehensive internal review of its adoption functions and practices:

> *The review concluded that the first order priority role for a State level child protection agency ought to be securing stable and/or permanent placements for children who are in out-of-home care.*[723]

16.462 As a consequence, DoCS has been investigating ways to reduce the commitment of its resources to adoptions where there are not child protection concerns that fall within NSW jurisdiction.

16.463 The Inquiry supports DoCS endeavours in this regard.

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[723] Submission: DoCS, OOHC, p.21.

Conclusion

16.464 This section collects the principles which the Inquiry believes should underpin OOHC in NSW, the goals to be reached and what needs to be done to achieve these goals. The Inquiry has not costed the recommendations contained in this chapter, however, where DoCS has provided the Inquiry with an estimate of costs, that estimate has been included.

Principles

16.465 Children and young persons both entering and in care should be heard and should participate in decisions affecting them.

16.466 Decisions and actions should be based on an understanding of how they will affect the children and young persons, particularly in relation to their safety, well-being and development.

16.467 Children and young persons require a stable foundation from which their relationships, identity, values, and cultural awareness can develop.

16.468 Continuity of attachment ties is essential for the overall development of a young child, and when children and young persons are separated from their birth families, stable foundations must be re-established as soon as possible either with their birth family or with an alternative long term carer or family.

16.469 Early decision making about permanency planning, including restoration to family, results in better outcomes for children and young persons, both in immediate terms and for life after care.

16.470 All Aboriginal children and young persons in OOHC should be connected to their family and their community, while addressing their social, emotional and cultural needs.

16.471 Children and young persons should be assisted to gain regular access to education, health and other services to meet their changing needs and to enable them to grow and develop.

16.472 Carers should actively participate in decision making in relation to children and young persons in their care.

Goals

16.473 Restoration decisions should not take longer than six months, particularly for younger children.

16.474 A continuum of services should be in place that listens to children and young persons, that responds to their changing needs and that minimises changes in

the people who are critical to caring for and working with them, such as carers and caseworkers.

16.475 Greater in-depth assessment of children and young persons coming into care through more comprehensive assessment and interventions in the crucial early stages of placements should be part of agency placement and planning processes.

16.476 Care arrangements for children and young persons should be based on their assessed needs, and the assessed capacity of carers to meet these needs.

16.477 Carers should be provided with timely information about those in their care, their needs, and the type of support they need to flourish in their care.

16.478 Children and young persons where possible should be placed with relatives and/or with siblings, and generally should be placed as close as possible to where their family/kinship and support networks are located.

16.479 There should be sufficient health and specialist services including dental, psychological, counselling, speech therapy, mental health and drug and alcohol services available to meet the needs of children and young persons in OOHC.

16.480 Assistance and supports should be provided to children and young persons in OOHC and to their carers at critical life transition points, such as entering care, moving from primary to secondary school and leaving care.

16.481 There should a system common to all agencies delivering services to children and young persons in OOHC that collects essential health information and monitors their health and educational outcomes. This should include an accessible, comprehensive medical record or a transferable record for children and young persons in care.

16.482 Foster, kinship and relative carers should be supported in caring for children and young persons, including managing those with challenging behaviours, to improve the stability of placements. This should include access to regular and planned respite care, behavioural management support, and other evidence based specialist services.

16.483 Interventions for high needs children and young persons in OOHC should include strong case management, integrated multi-agency work, and highly skilled staff and carers who receive expert supervision, ongoing training and support.

16.484 Young persons should be assisted when leaving care to transition effectively to stable accommodation and to receive further education and/or training and/or employment, so as to maximise their potential for independent living.

16.485 NGOs in partnership with other relevant government agencies such as Health, Education and DADHC should deliver OOHC services.

16.486 Outcome measures of the performance of the agencies engaged in OOHC work at the local, regional and state level, should be compatible and outcome based, in addition to process focused. These should be available to all agencies delivering OOHC services.

16.487 Safe housing for children in care is critical. There should be a mix of low, medium and high intensity accommodation and support services that are flexible in meeting the changing needs of children and young persons in care, including, where appropriate, residential accommodation. Resorting to SAAP services should be avoided for children in care.

Future Demand

16.488 As noted in Chapter 5, the data show that the number of children and young persons in OOHC has substantially increased and suggest that without modification of the current care and protection system this pattern will continue. Further, as a result of increasing cases being investigated by an expanded child protection workforce and children and young persons staying in care longer, the number of children and young persons in OOHC is projected to continue to increase. In the longer term strategies to intervene much earlier to help families will reduce the numbers of children and young persons entering OOHC. These strategies are outlined in Chapter 10.

16.489 DoCS has developed a funding model which estimates the future OOHC population using past and expected rates of entry into care and length of time of stay patterns in OOHC.

16.490 Regardless of whether children and young persons are cared for by the State or by the NGO sector, the increase in the size of the group in care and in the length of their stay in care, and the need for acceptable ratios of caseworkers to children and young persons, inevitably mean that the cost of OOHC will increase

16.491 The caseworker ratio to support the placements of children and young persons in care should be between 1:12 and 1:15. DoCS has provided estimated costing to achieve an average of 1:15.

Table 16.19 **Projected OOHC population and additional caseworkers (cumulative) required to attain caseloads of 15 and expenditure on care allowances and contingencies for children and young persons in OOHC**

	2007/08	*2008/09*	*2009/10*	*2010/11*	*2011/12*	*2012/13*	*2013/14*	*Total*
Total	14,667	15,605	16,993	18,295	19,495	20,332	21,197	
1:15 Caseload: Additional Caseworkers required	-	300	400	490	550	600	650	650
Extra Caseworkers $m	-	53	70	86	96	105	114	524
Estimated increase in allowances for additional children in OOHC $m	-	23	37	56	70	82	94	362

16.492 DoCS informed the Inquiry that additional funding over the next six years will be required to make payments to authorised carers (allowances) for every day costs of caring for a child (such as, school clothes, food) as well as extra activities to support a child in OOHC, such as contact with birth parents. This is a result of the increased number of children and young persons in OOHC.

Recommendations

Recommendation 16.1

DoCS OOHC/NGO OOHC caseworkers should become involved with children and young persons in OOHC at an earlier stage than final orders and have a responsibility to identify and support the placement of the children or young people, where it has been determined that there is not a realistic possibility of restoration.

Recommendation 16.2

Over the next three to five years, there should be a gradual transition in the provision of OOHC for children and young persons as follows:

a. Most children and young persons in OOHC should be supported by one of the two following models:

   i. DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. The agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of a child or young person with an authorised carer, and for any decision to remove a child or young person from a carer. DoCS retains

the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change Court orders and for providing after care assistance.

ii. DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers) subject to consultation with the Children's Guardian (see Recommendation 16.15).

iii. Children and young persons with significantly complex needs or who are assessed as at high risk of immediate or serious harm or whose case management requires high level collaboration with other government agencies will remain case managed by DoCS.

b. At an early stage, DoCS should progressively commence the transfer of long term kinship/relative carers to NGOs so as to allow the NGOs to carry out any necessary training and to provide ongoing support for these carers.

c. At an early stage, DoCS should progressively reduce its role in the recruitment of foster carers and transfer current long term foster carers to NGOs.

Recommendation 16.3

Within 30 days of entering OOHC, all children and young persons should receive a comprehensive multi-disciplinary health and developmental assessment. For children under the age of five years at the time of entering OOHC, that assessment should be repeated at six monthly intervals. For older children and young persons, assessments should be undertaken annually. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by NSW Health and DoCS.

Recommendation 16.4

NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead.

Recommendation 16.5

The Department of Education and Training should appoint an OOHC coordinator in each Region.

Recommendation 16.6

The NSW Government has a responsibility to ensure that all children and young persons removed from their parents and placed in its care receive adequate health treatment. Thus, there should be sufficient health services including speech therapy, mental health and dental services available to treat, as a matter of priority, children and young persons in OOHC.

Recommendation 16.7

The introduction of centralised electronic health records should be a priority for NSW Health. Given that this is likely to take some time, an interim strategy should be developed to examine a comprehensive medical record or a transferable record for children and young persons in OOHC, which should be accessible to those who require it in order to promote or ensure the safety, welfare and well-being of the child or young person.

Recommendation 16.8

Within 30 days of entering OOHC, all preschool and school aged children and young persons should have an individual education plan prepared for them which is reviewed annually by the Department of Education and Training and by the responsible caseworker. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by the Department of Education and Training and DoCS.

Recommendation 16.9

Carer allowances should be reviewed periodically by an independent body and should more closely reflect the actual costs to the carer of providing care, according to the varying categories of need.

Recommendation 16.10

The Memoranda of Understanding between DoCS and respectively, the Department of Ageing, Disability and Home Care, NSW Health and the Department of Education and Training should be revised to reflect the increasing responsibilities of NGOs for the provision of OOHC.

Recommendation 16.11

A common case management framework for children and young people in OOHC across all OOHC providers, should be developed, following a feasibility study on potential models including the Looking After Children system.

Recommendation 16.12

Due to the large numbers of Aboriginal children and young persons in OOHC, priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.

Recommendation 16.13

There should be sufficient numbers of care options for children and young persons with challenging behaviours that include specialised models of therapeutic foster care.

Recommendation 16.14

DoCS and/or relevant NGOs should receive sufficient funding to service the actual and projected OOHC population to enable an average ratio of one caseworker to 12 children and young persons.

Recommendation 16.15

DoCS should consult with the Children's Guardian before delegating parental responsibility to any person, except in circumstances where DoCS has shared parental responsibility and is delegating to the person with whom it shares parental responsibility. In the event that a mechanism for that to occur has not been introduced to the satisfaction of DoCS and the Children's Guardian within 12 months of the publication of this report, the *Children and Young Persons (Care and Protection) Act 1998* should be amended to require that consultation.

Recommendation 16.16

With respect to the *Children and Young Persons (Care and Protection) Act 1998:*

i. the proposal set out in the draft Cabinet Minute to introduce a revised scheme for voluntary care should be implemented and the Children's Guardian should receive the additional resources necessary to perform the functions of that office that would apply to those within that scheme

ii. section 183 should be repealed

iii. section 181(1)(d) should be repealed

iv. section 181(1)(a) should be repealed

v. section 186 should be repealed

vi. section 105(3)(b)(iii) should be amended to delete reference to the Children's Guardian and to replace it with the Director-General of DoCS

vii. section 90(3)(b) should be repealed

viii. section 159 should be proclaimed

Part 5 Specific issues

17 Domestic and family violence and child protection

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Introduction

17.1 The report thus far has considered the nature of reports to, and response of, the child protection system to risks of harm in children and young persons. Detailed data about the system appear in Chapter 5 as does research about child protection practices in Chapter 4. Directions for a way forward are suggested in Chapter 10 to address the need for an integrated response to child abuse and neglect from all agencies, in particular Health, Education and Police.

17.2 Improvement to case management and case practices are addressed in Chapter 9 which is designed to address the response of DoCS to its increasingly complex client base.

17.3 The Inquiry notes that in service provision, research, legislation and policy the terms 'domestic violence', 'family violence' and 'domestic and family violence' are sometimes used differently and at other times interchangeably. The Inquiry recognises that 'family violence' is the term preferred by many Indigenous communities. 'Family' covers a diverse range of ties of mutual obligation and support, and perpetrators and victims of family violence can include, for example, aunts, uncles, cousins and children of previous relationships[724].

17.4 For the purposes of this report, the broader term, 'domestic and family' violence will generally be used. However, when referring specifically to risk of harm reports 'domestic violence' will be used as this reflects the terminology used by DoCS and the Police.

17.5 Domestic and family violence is taken to occur when one partner in an intimate relationship attempts by physical or psychological means to dominate and control the other. It is generally understood as 'gendered violence,' and is an abuse of power within a relationship or after separation.

17.6 Definitions of domestic and family violence are "multiple and shifting."[725] Narrow definitions of domestic and family violence typically refer only to physical and sexual violence but broader definitions encompass threats of abuse (harassment), stalking or psychological or emotional abuse.[726]

17.7 Domestic and family violence "is typically not about one-off incidents of actual violence but a sustained pattern of abusive behaviours and attitudes that may escalate over time,"[727] although it is usually an incident that triggers the mandatory report which is made to DoCS.

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[724] Australian Government's Green Paper on Homelessness, *Which Way Home?* May 2008, p.89; Violence in Indigenous Communities, National Crime Prevention, 2001, p.1.

[725] J Irwin, F Waugh and M Wilkinson, "Domestic Violence and Child Protection: A Research Report," *University of Sydney*, August 2002, p.19.

[726] ibid.

[727] A Mullender, "What children tell us 'He said he was going to kill our mum'" in C Humphreys and N Stanley (eds), *Domestic Violence and Child Protection Directions for Good Practice,* 2006, p.56, cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.13,

17.8 For a woman, ongoing domestic and family violence may:

a. mean that her decisions are constantly undermined (by the man)

b. make it difficult to access medical care (for bruises, fractures, cuts)

c. mean little opportunity for normal social contact for her children and herself

d. prevent her from providing her children with strong positive and reliable relationships which are necessary to helping them manage the stress and trauma in their lives

e. cause trauma, lessening her capacity to help her children make sense of what is happening during or after a violent incident, than would be the case in other frightening situations

f. mean that she experiences hyper-anxiety and alertness.[728]

17.9 As is clear from Chapter 5, domestic violence in the family is the most commonly reported issue in child protection reports. Those reports will usually be made by Police after they have been called to the victim's home. The children and young persons who are the subject of these reports may or may not have been home at the time of the incident, and may or may not have been sighted by Police prior to making the report to DoCS. Upon the basis of existing data, these reports from Police are very unlikely to be treated by DoCS as urgent and are unlikely to be the subject of a detailed investigation. Many of these children and young persons probably do not need statutory intervention but most will benefit from some service offered by the government or non-government sector. How they can best be directed to that service is dealt with in Chapter 10.

17.10 In Australia, only three of the eight child protection systems incorporate consideration of child exposure to domestic and family violence within child protection legislation – NSW, Western Australia and Tasmania.[729]

17.11 Domestic and family violence poses a number of challenges for the child protection system as well as for other human services and justice systems. First, while academic commentators caution against the assumption that domestic and family violence is always damaging to children and young persons, they tend to represent a significant minority of commentators. The general weight of the research is that witnessing domestic and family violence is in all cases a form of psychological child abuse.

17.12 Secondly, the mother is more likely to be a victim of domestic and family violence rather than a perpetrator, however, it is usually to her protective conduct or lack thereof that the child protection scrutiny is directed.

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[728] DoCS: *Brighter Futures Practice Resource: Domestic and Family Violence Vulnerability,* August 2008, pp.5-6.

[729] KL Nixon, LM Tutty, G Weaver-Dunlop and CA Walsh, "Do Good Intentions Beget Good Policy? A Review of Child Protection Policies to Address Intimate Partner Violence," *Children and Youth Services Review*, 29, 2007, p.1476.

Caseworkers need to have sufficient training and access to resources to navigate an appropriate response in these circumstances.

17.13 Thirdly, any effective response to children and young persons residing in a home where domestic and family violence is present, needs to consider that frequently such violence will coincide with drug and alcohol use by one or more carers and, on occasions will also coincide with the presence of mental health issues for one or more carers. Thus, an integrated response involving health expertise and services as well as the potential need for Police to apply for an AVO, is needed. This is addressed in Chapters 9 and 10.

17.14 Finally, significant resources are expended by DoCS and Police systems in making and processing reports about domestic violence, even though few of those reports end in interventions designed to reduce the risk of harm to children or young people.

17.15 This chapter is concerned with understanding the research base and data on domestic and family violence, and suggesting ways in which reports about domestic violence to DoCS can better be made to increase the likelihood of a positive response for those subject to it.

Statistics

17.16 Over the last three years, namely 2005/06 to 2007/08 (preliminary figures) domestic violence has consistently accounted for about a quarter of all reports made to DoCS. Similarly, the Police have consistently made almost three quarters of all domestic violence reports to DoCS over that period of time.

17.17 Just under one third of all child protection reports over the last three years have had domestic violence listed as at least one of the reported issues. In numbers alone, over 94,000 reports were received which included domestic violence as a factor in 2007/08 (preliminary).

17.18 The most frequently recorded child protection risk factors in reports concerning 55 per cent of all children, known to DoCS, who died in 2007 were domestic violence and parental substance abuse. Further, in 39 per cent of all families, domestic violence and parental substance abuse were the most commonly recorded co-existing risk factors, while in 24 per cent of all families neglect and domestic violence were co-existing risk factors.

17.19 As is known from Chapter 5, multiple reports about the same child or young person have significantly increased over the last five years. However, re-reporting by Police within seven days about the same issue is relatively low and, therefore not surprisingly, such short term re-reporting about domestic violence incidents is also relatively low, even though such behaviour tends to be repetitive to the point of becoming an endemic feature of these relationships.

17.20 Domestic violence was the primary reported issue in over one quarter of all reports that were referred to a CSC/JIRT for further assessment in 2006/07. However, only 2.5 per cent of these reports were assigned a response time of the less than 24 hours, with the majority (61.1 per cent) being assigned a response time of less than 10 days. Accordingly, domestic violence reports are less likely to be considered urgent by DoCS, perhaps because the information in domestic violence reports is low level and does not warrant a higher priority unless associated with other risk factors.

17.21 Further, domestic violence reports by Police were less likely again to be considered urgent by DoCS, with 1.7 per cent being assigned a response time of less than 24 hours and the majority (65.8 per cent) being assigned a response time of less than 10 days.

17.22 In both 2006/07 and April 07/ March 08, domestic violence reports were slightly less likely to be referred to a CSC/JIRT for further assessment when compared with all reports so referred in those years.

17.23 For the period 1 April 2007 to 31 March 2008, over one quarter of all domestic violence reports were closed and the CSC/JIRT before any secondary assessment. In 2006/07, over one third were so closed.

17.24 For the period 1 April 2007 to 31 March 2008, almost one third of all domestic violence reports were closed after a SAS1 was completed and 6.9 per cent were the subject of a completed SAS2. Of those reports that were substantiated, 14.2 per cent had domestic violence as the primary reported issue.

17.25 What can be seen from this data is that domestic violence reports were less likely to result in intervention by DoCS. Of the more than 76,000 reports made in April 07/ March 08 about a risk of harm from domestic violence as the primary reported issue, just over 5,000 were substantiated.

Research

17.26 It is difficult to accurately estimate the true incidence of domestic and family violence in the community as victims are often reluctant to report such violence to Police or to Health or to seek assistance. However, the Ombudsman's 2006 report, *Domestic Violence: Improving Police Practice,* states that only 14 per cent of women who experienced violence from an intimate partner reported the most recent incident to Police.[730] In addition, as noted earlier, there are differing definitions of domestic and family violence, and data collection methods are

[730] Australian Institute of Criminology, *Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence against Women Survey*, 2004 cited in NSW Ombudsman, *Domestic Violence: Improving Police Practice,* December 2006, p.4.

inconsistent.[731] However, Access Economics has estimated that approximately 1.6 million women in Australia have experienced domestic and family violence in some form since the age of 15 years.[732]

17.27 Many women are subject to domestic and family violence while they are pregnant, although prevalence estimates vary. Abused women are also at greater risk of experiencing health problems during pregnancy and postnatally. The period leading up to, and just after, birth is one of the most vulnerable periods in human development.[733]

17.28 Aboriginal women experience domestic and family violence at a considerably higher rate than non-Aboriginal women.[734] As with non-Aboriginal women, Aboriginal women under report incidents.[735] In NSW, Aboriginal women are four times more likely than the average NSW woman to be a victim of domestic and family violence.[736] In NSW in 2002, Aboriginal women reported experiencing domestic and family violence related assault at six times the State average.[737] There is also evidence that Aboriginal women are more likely than non-Aboriginal women to suffer serious injury as a result of domestic and family violence.[738] Reflecting this research has been the recent requirement to make prenatal reports[739] and the introduction by Health of domestic violence screening referred to in Chapter 7.

17.29 Research consistently shows that domestic and family violence is nearly always associated with other risk factors as well.[740] Poverty, substance abuse, child sexual and physical abuse, parental anti-social personality syndrome and other mental conditions including and maternal depression may all co-occur. Learned behaviour and de-sensitisation to the presence of abuse within a family, during childhood, can lead to distorted perceptions of its acceptability and of appropriate response mechanisms.

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[731] J People, "Trends and patterns in domestic violence assaults," *Crime and Justice Bulletin, Number 89*, NSW Bureau of Crime Statistics and Research, October 2005, p.2.

[732] Access Economics, *The cost of domestic violence to the Australian economy,* October 2004, p.16, cited in T Drabsch, "Domestic Violence in NSW," *NSW Parliamentary Library Research Service*, Briefing Paper 07/2007, June 2007, p.1.

[733] DoCS, *Responding to Pre-Natal Reports Policy*, August 2007, p.7.

[734] T Szirom, D Chung and R Jaffe, *Indigenous Family Violence Phase 1 Meta-evaluation Report,* 2003 cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review,* Draft, March 2008, p.7.

[735] P Memmott, R Stacy, C Chambers, C Keys, *Violence in Aboriginal Communities*, 2001, Commonwealth Attorney-General's Department (National Crime Prevention) pp.7, 38, 41.

[736] J Fitzgerald and D Weatherburn, "Aboriginal Victimisation and Offending: The Picture from Police Records," *NSW Bureau of Crime Statistics and research*, December 2001, p.2.

[737] NSW Department of Aboriginal Affairs, *Two Ways Together Report Indicators Report 2005,* p.61.

[738] Aboriginal and Torres Strait Islander Women's Task Force, "Aboriginal and Torres Strait Islander Women's Task Force on Violence report," *Queensland Government*, 1999; H Blagg, "Crisis Intervention in Aboriginal Family Violence: Summary Report," *Commonwealth of Australia*, 2000, p.8.

[739] *Children and Young Persons (Care and Protection) Act 1998* s.25.

[740] DoCS, "Domestic Violence and its Impact on Children's Development," presentation delivered at the DoCS Fourth Domestic Violence Forum, 24 September 2002, p.2.

17.30 The Australian Bureau of Statistics Personal Safety Survey 2005[741] found that 57 per cent of women who experienced violence by a current partner reported that they had children in their care at some time during the relationship, and 34 per cent said that these children had witnessed the violence. The survey also found that nearly 40 per cent of women who experienced violence by a previous partner said that children in their care had witnessed the violence.

17.31 Research has also found that the inclusion of women's predictions of 'dangerousness' improves the accuracy of predictions of further assault.[742] Assessment tools, such as actuarial tools used for domestic and family violence have limited scope for inclusion of individual vulnerabilities and personal circumstances whereas women's assessments do.[743]

17.32 A growing body of international research confirms that domestic and family violence and child abuse frequently co-occur within the same families.[744] Recent research has shown that rates of co-occurrence of child abuse with domestic and family violence can range from 22-67 per cent.[745] This is supported by the data analysis in Chapter 5 and highlights the complex environment within which child protection and health workers operate.

17.33 Child abuse and neglect in the context of domestic and family violence can occur in a variety of ways: the same perpetrator may be abusing both mother and children, the children may be injured when 'caught in the crossfire' during incidents of adult violence; children may experience neglect because of the impact of the violence and controlling behaviours on the mother's physical and mental health; or children may be abused by a mother who is herself being abused.[746]

17.34 Evidence is emerging that cases where both domestic and family violence and child abuse occur represent the greatest risk to children's safety and that large numbers of cases in which children are killed have histories of domestic and family violence.[747] Of the 114 reviewable child deaths in 2006 in NSW where the children and young persons or their sibling were known to DoCS:

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[741] Australian Bureau of Statistics, Personal Safety, Australia, 2005 (Reissue), p.40.

[742] A Weisz, R Tolman and D Saunders, "Assessing the risk of severe domestic violence. The importance of survivor's predictions," *Journal of Interpersonal Violence, 15(1)*, 2000, pp.75-90 cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.49.

[743] L Laing, "Risk assessment in domestic violence," *Australian Domestic and Family Violence Clearinghouse Topic Paper,* 2004; A Weisz, R Tolman and D Saunders, 2000, op. cit., pp.75-90 cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.49.

[744] L Laing, "Domestic Violence in the Context of Child Abuse and Neglect," *Australian Domestic Violence Clearinghouse*, 2003, p.1; DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review,* Draft, March 2008, pp.16-17.

[745] L Knickerbocker, R E Heyman, A M Smith Slep, E N Jouriks and R McDonald, "Co-occurrence of child and partner maltreatment: Definitions, prevalence, theory and implications for assessment," 2007, *European Psychologist*, pp.36-44.

[746] L Laing, 2003, op. cit., pp.1-2.

[747] ibid., p.2.

at least one risk of harm report was made in relation to 85 children and/or their sibling(s) in the 12 months prior to the death. In just under half of the reports made (41), domestic violence was the main issue reported.[748]

17.35 Research about domestic and family violence and its effect on parenting has found that children living in households with domestic and family violence have an increased risk of physical abuse.[749] DoCS has advised that 24 per cent of children who died in 2007 were reported as being at risk from both domestic violence and physical abuse.

17.36 Laing cautions against stigmatising children and young persons who have been exposed to violence. Raising their experience of violence as a social issue "inevitably constructs a socially deviant identity for these young people."[750] Potentially one of the most damaging aspects of this 'deviant' identity, it is suggested, is the belief that these children and young persons will inevitably go on to either perpetrate or suffer violence themselves. Laing, accordingly, challenges the "unthinking acceptance of the cycle of violence"[751] and refers to evidence that abused children do not necessarily become 'abusers.'

17.37 Humphreys argues that statutory child protection agencies have been slow to recognise the contribution of domestic and family violence to many situations of child abuse and neglect.[752] Historically, child protection intervention has tended to focus on women (mothers), despite the fact that men are estimated to be responsible for around half of the incidents of physical abuse of children and young persons and for the majority of the most serious incidents of physical abuse. Interventions have focused on women, even when their violent male partners are known to have committed the abuse of children and young persons.[753]

17.38 Several reviews undertaken by DoCS in 2007 found that there was little or no contact with the perpetrator following reports of serious domestic violence. In these cases DoCS found that casework in response to domestic violence focused on supports for the victim or encouraging the victim to seek protection through legal orders.

17.39 This has led to the proposition that there is often 'gender bias' in child protection intervention. It is argued that this gender bias can result in women being held accountable for 'failing to protect' their children from the actions of men who use

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[748] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths,* December 2007, p.27.

[749] G Margolin, EB Gordis, AM Medina and PH Oliver, "The co-occurrence of husband to wife aggression, family of origin aggression and child abuse potential in a community sample: implications for parenting," 2003.

[750] L Laing, "Children, Young People and Domestic Violence" Issues Paper 2, *Australian Domestic and Family Violence Clearinghouse,* 2000, pp. 21 and 22.

[751] ibid., p.22.

[752] C Humphreys, "Avoidance and confrontation: social work practice in relation to domestic violence and child abuse," *Child and Family Social Work, Vol 4,* 1999, pp.77-87 cited in L Laing, 2003, op. cit., p.3.

[753] L Laing, 2003, op. cit., p.3.

violence against them, and in a failure to hold men accountable for the effects of their violence on women and children and young persons.[754]

17.40 The use of language when recording information concerning domestic violence in child protection cases was also highlighted as a casework practice issue by DoCS. Common ways of recording domestic violence in files included 'violence between the parents' and 'a violent relationship.' These terms were used even when the father was violent towards the mother. Lamb describes such labelling as "acts without agents" and argues that the way violence is described can minimise the seriousness of this violence.[755]

17.41 In fact, Nixon et al, note that:

> *women's perceived inadequacies, including a perceived lack of parenting skills, an inability to protect their children, a lack of awareness of the impact of abuse on children, and an inability to choose non-violent partners, frequently become the focus of child protection intervention.*[756]

Further:

> *By making abused women the focus of child welfare intervention, the actual perpetrators are ignored.*[757]

17.42 'Gender blind' child protection intervention may place pressure on a woman to leave a relationship in which she is being abused on the threat of removing her children. However, appropriate support may not be provided nor the complexities with which she is struggling recognised.[758] Humphries notes that separation, where there has been a history of domestic and family violence, is one of the highest risk factors for homicide and serious sexual and physical assault.[759] The goal, however, of much child protection intervention is often to insist on separation as the only way to ensure the safety of the children and young persons. As Nixon et al state, this is because support of the non-offending parent falls outside the mandate of child protection agencies as their paramount consideration is for the welfare of the child protection agencies.[760] Balancing the needs of child protection with interventions sensitive to the de-powered position of the abused woman poses challenging dilemmas for statutory child protection services.[761] This highlights the need for good

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[754] ibid.

[755] S Lamb, "Acts without agents: an analysis of linguistic avoidance in journal articles on men who batter women," 1991.

[756] KL Nixon, LM Tutty, G Weaver-Dunlop and CA Walsh, 2007, op. cit., p.1473.

[757] ibid.

[758] L Laing, 2003, op. cit., p.3.

[759] C Humphreys, "Domestic Violence and Child Protection: exploring the role of perpetrator risk assessments," *Child and Family Social Work, Vol. 12*, 2007, p.365.

[760] KL Nixon, LM Tutty, G Weaver-Dunlop and CA Walsh, 2007, op. cit., p.1479.

[761] L Laing, 2003, op. cit., p.4.

casework and effective supervision, quality training and real interagency collaboration.

17.43 Professor Reg Graycar, Associate Dean (Postgraduate Research), University of Sydney and Professor Julie Stubbs, Deputy Director, Institute of Criminology, University of Sydney advised the Inquiry that there has been a 'pendulum shift' from a failure to pay attention to domestic and family violence as an issue with respect to children, to a heavy handed over reaction in some cases.

17.44 They argued that domestic and family violence cases cannot be dealt with uniformly as a single category and that cases need to be approached on a case by case basis. They cautioned against the presumption that domestic and family violence is always damaging to children. Further the research literature does not provide an adequate definition of exposure to violence and provides little consensus as to the impact of particular forms, types and frequencies of violence on children. This, Nixon et al state, means that the assessment as to whether violence is ongoing and of a serious nature is left to the discretion of individual workers."[762]

17.45 In a submission to the Inquiry, Professor Graycar and Professor Stubbs, cited international research that indicates a wide variation in the responses of children who have been exposed to domestic and family violence. They said that Bragg found that children's responses ranged "on a continuum where some children demonstrate enormous resiliency while others show signs of significant maladaptive adjustment."[763] They also cited Edelson's argument:

> *against assuming that childhood exposure to violence is automatically a form of child maltreatment and suggests the need to modify child protection services and the expansion of primarily voluntary community-based responses to these children and their families.*[764]

Mills, Huntsman and Schmied also note that whilst there is evidence that supports the conclusion that domestic and family violence has a detrimental effect on children "the fact remains that many children have not been found to be suffering significantly adverse effects."[765]

17.46 Some argue that witnessing domestic and family violence is in all cases a form of psychological child abuse, while others argue against automatically defining all child witnesses as victims of child abuse.[766] Those who caution against

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[762] K L Nixon, L M Tutty, G Weaver-Dunlop and C A Walsh, 2007, op. cit., p.1481.

[763] H Bragg, *Child Protection in families experiencing domestic violence,* US Department of Health and Human Services Administration for Children and Families , Office on Child Abuse and Neglect, 2004, cited in Submission: Graycar and Stubbs, 11 February 2008, pp.6-7.

[764] J Edelson, "Should childhood exposure to adult domestic violence be defined as child maltreatment under the law?" in P Jaffe, L Baker and A Cunningham (Eds), *Protecting Children from Domestic Violence, Strategies for Community Intervention,* 2004 cited in Submission: Graycar and Stubbs, 11 February 2008, p.7.

[765] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families*, *Literature Review*, Draft, March 2008, p.8.

[766] L Laing, 2000, op. cit., p.15.

automatically defining exposure to violence as child abuse argue that this fails to take into account the efforts which women are making to protect their children and to deal with the violence in their lives, and that insensitive child protection intervention may place the woman and her children at greater risk.[767]

17.47 Edleson identifies a need for a standardised measure of children's behaviour that addresses the unique problem of children exposed to domestic and family violence (including a measure of perceived safety).[768] Other research also suggests the need to develop appropriate diagnostic criteria to measure traumatic symptoms and to accurately assess their impact on preschool aged children.[769] The Inquiry sees merit in exploring the use of such tools.

17.48 Research indicates that victims of domestic and family violence can continue to be effective parents.

> *The majority of victims of domestic violence are not bad, ineffective, or abusive parents, but researchers note that domestic violence is one of a multitude of stressors that can negatively influence parenting. However, many victims, despite ongoing abuse, are supportive, nurturing parents who mediate the impact of their children's exposure to domestic violence. Given the impact of violence on parenting behaviours, it is beneficial that victims receive services that alleviate their distress so they can support and benefit the children.*[770]

17.49 Best practice guidelines typically support maintaining the children in the care of their 'non-offending parent' if possible. For instance, practice guidelines for "Effective intervention in domestic violence and child maltreatment cases" developed on behalf of the US National Council of Juvenile and Family Court Judges have endorsed three core principles:

a. To ensure stability and permanency, children should remain in the care of their non-offending parent (or parents), whenever possible.

b. A community service system should have many points of entry, should minimise the need for victims to respond to multiple and changing service providers, have adequate resources to allow service providers to meet family needs and avoid out-of-home placements.

c. Responses should differ according to the experience and needs of particular families: "Families with less serious cases of child maltreatment

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[767] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families*, *Literature Review*, Draft, March 2008.

[768] J Edleson, *The overlap between childhood maltreatment and woman abuse,* 1999, cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, A Literature Review*, Draft, March 2008, p.27.

[769] AA Levendosky, A Huth-Bocks, M Semel and DA Shapiro, 2002 "Trauma symptoms in preschool aged children exposed to domestic violence," *Journal of Interpersonal Violence, 17,* pp.150-164, cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.27.

[770] H Bragg, 2004, op. cit., cited in Submission: Graycar and Stubbs, 11 February 2008, pp.6-7.

and domestic violence should be able to gain access to help without the initiation of a child protection investigation or the substantiation of a finding of maltreatment."[771]

17.50 It is difficult to argue with the appropriateness of any of these principles.

17.51 Australian research suggests that some women victims of domestic and family violence choose not to call the Police because of their concerns about the mandatory child protection reporting provisions.[772] This may be a particular concern for Aboriginal women. The Office of the Status of Women estimated that only six per cent of families where domestic and family violence is present have contact with statutory services.[773] The need for a non-coercive response to domestic and family violence which, where appropriate, is not linked to child protection reporting was raised in the Inquiry's Public Forum on Assessment Model and Process as it was acknowledged that this kind of link can prevent women from reporting. Munro also confirmed to the Inquiry that there is fear among victims of domestic and family violence that if they report they will get caught up in the child protection system. The system needs to deal with these perceptions because they can indeed be accurate.

17.52 Child welfare interventions have been criticised for potentially exacerbating violent situations. Abused women who are already under tremendous stress because of the abuse may be further traumatised by child welfare involvement thus compromising their parenting abilities and reducing their capacity to meet their children's emotional needs. Children in turn may also experience "severe and long lasting effects" if they are removed from the non-abusive parent.[774]

17.53 Other reasons for not reporting domestic and family violence to Police relate to concern about the consequences for their children, the desire to avoid involvement in the criminal justice system and fear of reprisals.[775]

17.54 There is therefore debate about whether all children and young persons who are exposed to domestic and family violence should be considered 'abused' and hence the possible subject of statutory child protection intervention.

17.55 In their international comparative analysis of how the issue of child exposure to intimate partner violence has been addressed within a child protection policy context Nixon et al conclude that legislation or policy decisions that broadly define any children who are exposed to violence in the home as maltreated can

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[771] S Schechter and J Edelson, *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice,* 1999, cited in Submission: Graycar and Stubbs, 11 February 2008, p.7.

[772] C Humphreys, "Domestic Violence and Child Protection: Challenging Direction for Practice," *Australian Domestic and Family Violence Clearinghouse*, Issues Paper 13, May 2007, p.5.

[773] Office of the Status of Women, 1998, cited in DoCS, "Domestic Violence and its Impact on Children's Development," presentation delivered at the DoCS Fourth Domestic Violence Forum, 24 September 2002, p.2.

[774] K L Nixon, L M Tutty, G Weaver-Dunlop, and C A Walsh, 2007, op. cit., p.1473.

[775] N Taylor and J Mouzos, "Community Attitudes to Violence Against Women Survey 2006: A full technical report," *Australian Institute of Criminology*, November 2006, p.94; S Trally, D Faulkner, C Cutler and M Slatter, "Women, Domestic and Family Violence and Homelessness: A synthesis report," *Department of Families, Housing, Community Services and Indigenous Affairs*, Commonwealth of Australia, August 2008, p.21.

be problematic as they may further victimise abused women and their children, deter women from seeking help or disclosing abuse for fear of their children being removed, and overwhelm already overburdened child protection systems.[776]

17.56 This appears to hold true in NSW. The decision to include exposure to domestic and family violence as a form of child abuse has had significant implications for child protection services. A 2002 study by Irwin, Waugh and Wilkinson found that, consistent with current trends, domestic violence was the most common reason for reporting a child to DoCS but that domestic violence referrals were less likely to undergo an investigative assessment.[777]

17.57 Further, Irwin et al's research found that many child protection workers felt ill-equipped to respond to cases involving domestic violence and the inclusion of "exposure to domestic violence as a category of child abuse did not translate into changed practices for many child protection workers."[778] The need to support better practice and quality training remains relevant today.

17.58 This also points to a need for those reporting to exercise their professional judgement about the presence of a significant risk of harm within the terms of the legislation. This is addressed later in this chapter.

17.59 At the Public Forum on Assessment Model and Process, DoCS expressed concern that children and families experiencing domestic and family violence who are reported to DoCS "do not yet have the pathways to get effective help … they get locked in the DoCS system, and to no value to them."[779]

17.60 Given the necessity of safety and security as a primary means of helping women and children living with domestic and family violence, a number of practitioners and researchers in this field have given attention to developing and determining the effectiveness of programs for perpetrators of violence. Laing and Bobic, however, emphasise that this is a contentious area.[780] To date the evidence for the effectiveness of perpetrators programs is weak and some argue that scarce resources are better devoted to supporting women and their children. The National Crime Prevention report *Ending Domestic Violence? Programs for Perpetrators* reviewed programs specifically for male perpetrators of domestic and family violence and concluded that:

> *Concerns about program effectiveness, and particularly about the capacity of programs to stop men continuing to abuse their partners or ex-partners and their children, have contributed in*

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[776] K L Nixon, L M Tutty, G Weaver-Dunlop, and C A Walsh, 2007, op. cit., pp.1469-1470.

[777] J Irwin, F Waugh and M Wilkinson, 2002, op.cit., p.9.

[778] ibid., p.10.

[779] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.29.

[780] L Laing and N Bobic "Economic Costs of Domestic Violence: Literature review," *Australian Domestic and Family Violence Clearinghouse,* April 2002.

> *part to the reluctance of many governments to fund perpetrator programs.*[781]

17.61 This highlights the importance of ensuring that programs for perpetrators work in parallel with programs that engage and support women. It is also imperative that while men are participating in programs women's safety is ensured.[782]

17.62 Little attention seems to be given in perpetrators programs to their relationship with their children and their role as a parent, even though men who perpetrate domestic and family violence are often very limited in their ability to parent effectively.[783]

17.63 Domestic and family violence behaviour change programs in NSW are funded primarily through Corrective Services and partnerships with non-government services. The Inquiry understands that the NSW Government has concerns about the effectiveness and applications of these programs and is currently developing guidelines to ensure that they are consistent with best practice standards and are effective in reducing re-offending and do not place victims at risk. A report is to be provided to the Government by an interagency working group by December 2008.[784]

17.64 Evidence does however, exist which shows that integrated domestic and family violence systems are necessary to reduce the rates of violence.[785] Most research examined by the Inquiry identifies that the best way to protect children subject to domestic and family violence is to support and protect the adult victim, while holding the perpetrator accountable.

The need for an integrated response

17.65 The recognition that child abuse and domestic and family violence frequently co-exist, together with that body of evidence that accepts the harmful effects of exposure to domestic and family violence on children, have led to calls for improved collaboration between statutory child protection services and domestic and family violence services. The complexity involved in the 'causes' or risk factors for domestic and family violence and child abuse indicates that there can be no single, simplistic solution: models need to draw on multiple perspectives with a view towards integrating services and intervention approaches as

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[781] National Crime Prevention, "Ending Domestic Violence? Programs for Perpetrators," *Attorney General's Department,* Canberra, 1999, p.199.

[782] EW Gondolf, "Evaluating batterer counselling programs: a difficult task showing some effects and implications," *Aggression and violent behaviour, 9(6),* 2004, pp.605-631, cited in DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.73.

[783] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families*, *Literature Review*, Draft, March 2008, p.73.

[784] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence,* p.24.

[785] L McFerran, "Taking back the castle: how Australia is making the home safer for women and children," *Issue paper 14, Australian Domestic and Family Violence Clearinghouse,* July 2007, p.22.

necessary.[786] Health care workers, police, teachers, domestic and family violence and child protection workers all play overlapping roles in the prevention and intervention of cases of harmful domestic and family violence.

17.66 Leading researchers and policy makers in Australia, the USA and the UK have argued for a more collaborative approach between domestic and family violence and child protection agencies which has as an objective better support for both children and victims.[787]

17.67 Laing, however, states that such collaboration faces considerable challenges, given the very different histories, philosophies and structures of these two services.[788]

17.68 On one hand, domestic and family violence services:

a. are community-based, offering services on a voluntary basis to women and children escaping violence

b. are 'woman-centred' and stress the empowerment of women through respecting their choices and providing information and support.

17.69 In contrast, child protection services:

a. have a statutory base and deal largely with involuntary clients

b. focus on children

c. deal with women who may be at a very different stage in recognising and dealing with the violence than the women who contact domestic and family violence services.

17.70 Laing notes that these differences result in a number of barriers to collaboration:

a. tensions between the 'child-centred' and 'woman-centred' philosophies of child protection and domestic and family violence services

b. tensions about how best to hold violent men accountable. Child protection services often have little leverage with abusive men. As a result, threats to remove children may not be a concern to the perpetrator of violence, while at the same time, a woman's fear of losing her children can be utilised by the abusive man as part of his tactics of coercive control.[789]

17.71 The Inquiry supports the strategies for building collaboration that have been found to be effective including:

a. establishing 'common ground,' that is, agreement on a common goal of intervention

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[786] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families*, *Literature Review*, Draft, March 2008, p.60.

[787] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008, p.74; C Humphreys, May 2007, op.cit., p.16.

[788] L Laing, "Evaluation of the Green Valley Domestic Violence Service," *University of Sydney*, 2005, p.71.

[789] L Laing, 2003, op. cit., p.6.

b. understanding the roles of each service system, including the constraints and pressures under which they operate

c. cross training to bring together two bodies of expertise

d. arranging ongoing consultation between child protection and domestic and family violence workers on a case by case basis to combine the knowledge and experience of each system, and in this way, develop practice knowledge with complex cases.[790]

17.72 Chapters 10 and 24 further expand on the Inquiry's views about building the better practice and stronger interagency responses, which are of relevance in particular for the cohort of high risks families which tend to become repeat clients of more than one agency.

17.73 A recent literature review undertaken by DoCS provides an overview of strategies and interventions that address both domestic and family violence and child protection concerns.[791]

17.74 Interventions may include individual counselling, group programs and interventions for mothers and children. The length of interventions also varies considerably, lasting anywhere from six weeks for some group programs to two years for individual counselling.[792]

17.75 Overall fewer interventions designed for children and young persons experiencing domestic and family violence exist than for women experiencing domestic and family violence. Many of those that do target children in the 4-13 year age group. There appears to be a gap in services for programs specifically targeting adolescents.[793]

17.76 Child abuse prevention programs, such as home nurse visitation, have been found to be less effective when domestic violence is present.[794] Olds found that the presence of such violence had a negative impact on the ability of home visitation schemes to achieve their targeted outcome, noting that "the program had no impact on the incidence of domestic violence, but domestic violence did moderate the impact of the program on child abuse and neglect."[795]

17.77 In terms of effectiveness, while many programs undertake before and after client satisfaction surveys, comprehensive program evaluations, including measuring long term impact, are uncommon. Furthermore, due to small sample sizes, the scarcity of control groups and variability in programs, evaluation

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[790] ibid., pp.8-9.

[791] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008.

[792] ibid.

[793] ibid.

[794] L Laing, 2003, op. cit., p.2.

[795] D Olds, L Sadler and H Kitzman, "Programs for parents of infants and toddlers: recent evidence from randomised trials," *Journal of Child Psychology and Psychiatry, Vol 48(3)*, 2007, p.378.

results are not only difficult to compare they often lack the rigour to provide conclusive outcomes.[796]

17.78 The recent DoCS review of selected studies provides the following synthesis of ideas about what works in intervention programs for women and children:

a. The greatest benefits for children and their mothers come from programs that run for both women and children concurrently.

b. Timing of the programs is important, intervention is of the greatest benefit once child/family are living free of violence.

c. Follow up indicates that ongoing support provides significant benefits for women and children.

d. Irrespective of the particular program the act of intervention, with its associated support, expression of care and concern and reduction of family isolation, appear to have an impact on improving the quality of life for many of these families.

e. Evidence supports the notion that well planned and appropriately intense interventions, along with inclusion of parenting support to mothers, can help lead to a reduction in children's and women's distress following exposure to intimate partner violence.

f. Research has yet to identify which particular program components have the greatest benefit for specific treatment needs. [797]

17.79 Much of the recent literature reviewing models of practice explores and/or evaluates ‘integrated' or ‘coordinated community response' models, as opposed to individual interventions or programs. These models involve the collaboration of a range of services involved in various aspects of supporting women and children experiencing domestic and family violence. “Underpinning these models is the realisation that no single program has the capacity to develop or provide the resources or services required by families experiencing domestic violence.”[798]

17.80 Integrated models may, for example, may involve any or all of the following: domestic and family violence services; child protection agencies; housing services, Police, correctional services, community, women and child support agencies, and schools. Domestic and family violence is also often just one ‘problem' in the lives of these families who may require the resources of multiple services. An integrated model would, as the name suggests, help families access the necessary services in a coordinated and managed way. It has been noted that until recently integrated services have focused mainly on services for

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[796] DoCS, *Domestic Violence: Strategies and Interventions to Support Children and Families, Literature Review*, Draft, March 2008.

[797] ibid.

[798] ibid.

women experiencing violence and have to some extent neglected the needs of children.[799]

17.81 UnitingCare Burnside in particular advocated for agencies to provide family based support for families who experience domestic and family violence, rather than referral between agencies that separately provide services for parents, children, young people and perpetrators.

17.82 McFerran examines a range of models that allow women and children victims of domestic and family violence to stay in their homes and states:

> *the evidence from the ACT, Tasmania and Victoria and the NSW pilots, is that governments and community services now recognise that a state-wide, integrated response ensures the most consistent, accountable and durable outcomes for the greatest numbers of women and children.*[800]

17.83 The Australian Domestic and Family Violence Clearinghouse states:

> *good practice domestic and family violence integrated systems across states and territories can reduce homelessness by supporting women to stay in their homes, enhancing victim safety, reducing secondary victimisation and holding abusers accountable for their violence.*

17.84 The Clearinghouse further states that "the evidence that integrated programs can provide safety for women experiencing family violence to remain in their homes is compelling."[801] It is difficult to argue with the proposition that when domestic and family violence forces a woman to leave home this fact is of itself a form of secondary harm that should not be visited on her or her children.

17.85 The Inquiry concludes that integrated services which are built on evidence based casework, clear guidelines for intervention, quality training and supervision and effective interagency collaboration form the basis of the appropriate response to domestic and family violence in the child protection context.

NSW response

17.86 Priority R1 of the NSW State Plan, reduced rates of crime, particularly violent crime, states that:

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[799] ibid.

[800] L McFerran, "Taking back the castle: how Australia is making the home safer for women and children," *Issue paper 14, Australian Domestic and Family Violence Clearinghouse,* July 2007, p.22.

[801] Australian Domestic and Family Violence Clearinghouse response to: Australian Government's Green Paper on Homelessness, *Which Way Home?* May 2008, p.2.

> *Domestic and family violence is a crime and is a priority area for Government. Our responses need to support the victim, ensure the legal processes are timely, and respond to the causes of domestic and family violence. To achieve this, we will develop and implement a State-wide strategy to deal with the causes and consequences of domestic violence.*
>
> *The strategy will include programs to facilitate early intervention in high risk situations, provide more options for victims and their children to escape domestic violence, and coordinate services so victims receive integrated police, legal and social assistance. Families at risk of, or suffering from, domestic violence will be able to seek help earlier and be supported through fast-tracked legal proceedings and other support services.*[802]

17.87 The State Plan has set a target of reducing the incidence of violent crime against individuals by 10 per cent by 2016.

17.88 The achievement of these results is closely linked to a number of other State Plan priorities, including reducing re-offending (R2), increasing participation and integration in community activities (R4), prevention and early intervention (F4) and reducing avoidable hospital admissions (F6).

Whole of government response

17.89 Premier and Cabinet have estimated that the cost of domestic and family violence to the NSW economy is approximately $2.8 billion. This figure includes the cost of support services, police intervention, court services and the pain and suffering of victims. The largest part is spent on mainstream services or core agency business, such as the DoCS Helpline or emergency health services. Only a small proportion is spent on targeted domestic and family violence services, such as the DoCS Domestic Violence Line or Domestic Violence Liaison Officers provided by Police.[803]

17.90 In August 2007, the Government commissioned a review of existing structures for coordinating NSW Government action to address domestic and family violence and violence against women.[804]

17.91 As a result of the review the Government is now implementing a new approach to preventing violence against women to enable coordination of strategic policy development, service provision and training.

17.92 The new approach involves the following:

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[802] NSW Government: *A New Direction for NSW – State Plan*, November 2006, p.28.

[803] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence,* p.11.

[804] ARTD Consultants, *Coordinating NSW Action Against Domestic and Family Violence,* 8 November 2007.

a. The establishment of a Violence Prevention Coordination Unit in the Office for Women's Policy, Premier and Cabinet, which will take a leadership role in the development of policy aimed at reducing domestic and family violence. The initial task of this unit will be the development of a statewide strategic framework to ensure that linkages between agencies and programs are strengthened and services are integrated.

b. The engagement of five statewide project officers in addition to two existing positions to deliver major Government projects in key service delivery agencies. Three of these projects have already been trialled and evaluated, and the Government has committed to either expanding, or making these projects permanent under the new approach. Two of these coordinators are located with DoCS to work on the Staying Home Leaving Violence and the Integrated Case Management projects. Two coordinators are based with Health to work on the Intersectoral Domestic and Family Violence Education and Training project and the Risk Assessment Tool and one coordinator is located with Attorney General's to work on the Domestic Violence Intervention Court Model.

c. The appointment of nine regional coordinators within Police who are to focus on ensuring the integrated delivery of human services and criminal justice responses. These positions will be expected to establish and maintain a regional coordination network to ensure links between local domestic and family violence service delivery agencies within the region. Regional coordinators will be located at the Police Regional Command Offices in Parramatta, Surry Hills, Bankstown, Newcastle, Coffs Harbour, Wollongong, Wagga Wagga, Dubbo and Tamworth. In addition to the nine regional coordinator positions, Police is establishing 40 additional Domestic Violence Liaison Officers (previously 123 positions)[805] to be located within Local Area Commands.

d. The establishment of a new Premier's Council for Preventing Violence Against Women to advise the Premier and facilitate more formal and direct engagement between the non-government sector and the Government.

17.93 The NSW Government has committed the following amounts to specific domestic and family violence projects over four years (2007 to 2011):

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[805] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence*, November 2008, p.18.

Table 17.1 **NSW Government domestic and family violence projects**

Domestic Violence Court Intervention Model	$8.4m
Integrated Case Management	$12.0m
Non-government Sector Grants	$8.0m
Staying Home Leaving Violence	$5.1m
Court Assistance Scheme	$2.6m
Indigenous Programs (to be announced)	$3.6m
Police Equipment	$0.5m
Total	$40.2m

17.94 In addition, $8 million will be spent on remote witness facilities that are expected to assist victims of domestic and family violence when giving evidence in prosecutions of perpetrators.

17.95 A number of NSW Government agencies have been involved in providing training for practitioners in domestic and family violence, both within their agency and with partner government and non-government agencies. For example, Health funds the Education Centre Against Violence, administered by Sydney West Area Health Service. The centre provides statewide specialised training, consultancy and resource development for Health and interagency workers who provide services to children and adults who have experienced sexual assault, domestic and family violence and/or physical and emotional abuse and neglect. Police and DoCS also provide specialist training for officers and caseworkers in recognising and responding to domestic and family violence.

17.96 While work has been done by NSW Government agencies and the non-government sector to improve responses to domestic and family violence, there is not yet an effective coordinated and comprehensive response to this problem in NSW. These responses and services are primarily provided by mainstream services, which largely operate independently of each other.

17.97 The Inquiry has been informed that Premier and Cabinet is developing a strategic framework to underpin statewide responses to domestic and family violence. As part of this process, Premier and Cabinet has developed a discussion paper on domestic and family violence which will form the basis for feedback and consultation in 2009. General issues identified by the NSW Government in responding to domestic and family violence include:

a. the complex array of service providers across multiple sectors and disciplines

b. concern that domestic and family violence victims must compete for priority with other demands on each of those service systems

c. the difficulty involved in achieving coordination across agencies as a result of limited availability of resources, different information systems and territorial issues

d. concern that the sector is often specifically interested in parts of the problem or service responses rather than engaged in taking a holistic view of domestic and family violence

e. there is no statewide approach to providing targeted support for high demand clients to reduce their disproportionate impact across the service spectrum.[806]

17.98 The former Director-General of DoCS has been engaged to assist in the development of the Domestic and Family Violence Strategic Framework, and as part of that work is considering the extent to which high demand clients of human services and justice agencies are among those families experiencing domestic and family violence.

17.99 It is evident from the Inquiry's work that there is substantial anecdotal evidence indicating that a relatively small proportion of families in NSW take up a substantial amount of the human services and justice services provided and that these families have experienced domestic and family violence. The extent of the problem and possible systemic improvements in dealing with it at both agency and interagency level are under consideration.

17.100 A number of concerns and questions were raised about the Government's new approach to domestic and family violence in various Public Forums and meetings held by the Inquiry around the State. There were concerns in relation to gaps in services but also in relation to the increasing focus on a criminal justice and police response to domestic and family violence rather than other needed responses such as community capacity building.

Apprehended Violence Orders

17.101 On 10 March 2008 Part 15A of the *Crimes Act 1900* was repealed and the *Crimes (Domestic and Personal Violence) Act 2007* commenced. For the purposes of the Act a 'domestic violence offence' is defined as a personal violence offence committed by a person against another person with whom the person who commits the offence has or has had a domestic relationship, an expression which is given an extended definition.[807]

17.102 In passing this Act, Parliament recognised, *inter alia,* that: domestic violence, in all its forms, is unacceptable behaviour; domestic violence is predominantly perpetrated by men against women and children; children who are exposed to domestic violence as victims and witnesses are in a particularly vulnerable position; and such exposure can have an impact on their current and future physical, psychological and emotional well-being.[808]

17.103 Significant changes made by the new Act include requirements that:

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[806] ibid.

[807] *Crimes (Domestic and Personal Violence) Act 2007* ss.*5 and 11.*

[808] *Crimes (Domestic and Personal Violence) Act 2007* s.9(3)(f).

a. where a person has been found guilty of a domestic violence offence, a recording is to be made in the person's criminal record that the offence was a domestic violence offence and similar recordings may be made in relation to domestic violence offences previously committed by the person[809]

b. when making an apprehended domestic violence order or interim apprehended domestic violence order for an adult, there is to be included as a protected person, under the order, any child with whom the adult has a domestic relationship unless there are good reasons for not doing so.[810]

17.104 Previously, when a victim took out an AVO, the children were not necessarily included on the order. The Ombudsman found that it was unusual for Police to initiate separate AVOs for children and questioned whether police officers had received adequate procedural guidance to determine the circumstances that warranted an application for an AVO on behalf of a child.[811]

17.105 It is anticipated that the new Act will remedy this by requiring the Magistrate to consider the safety of the protected person and any child directly or indirectly affected by the conduct of the defendant.[812] It will be critical to monitor the impact of these provisions.

17.106 Section 43 of the Care Act requires DoCS and Police to consider whether an AVO would provide sufficient protection to a child or young person who is believed to be at risk before making the decision to remove the child from his or her family. The note to section 40 of the Care Act states that:

> *The intention of the Act is to ensure that children and young persons are protected by using the least intrusive option. Removal of children and young persons should be a last resort. The option of an apprehended violence order to protect a child or young person should be considered. In cases where there is an immediate danger of abuse, an apprehended violence order against the alleged abuser, requiring him or her, for example, to leave the house, may be sufficient to ensure the protection of the child or young person while investigations and assessments continue. The order could be made to cover the child or young person and, if appropriate, the child or young person's primary care-giver and other members of their household.*
>
> *These orders are available under the Crimes (Domestic and Personal Violence) Act 2007.*
>
> *If a child or young person is removed in an emergency situation, the Director-General should also consider whether an*

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[809] *Crimes (Domestic and Personal Violence) Act 2007* Part 3, section 12.

[810] *Crimes (Domestic and Personal Violence) Act 2007* Part 9, section 38.

[811] NSW Ombudsman, *Domestic Violence: Improving Police Practice*, December 2006, p.42.

[812] *Crimes (Domestic and Personal Violence) Act 2007* s.17(1).

application for an apprehended violence order may still be the most effective way of ensuring the immediate and safe return of the child or young person to the home.

17.107 These requirements recognise the strong association between domestic and family violence and child protection concerns,[813] and the desirability of maintaining the victim and children or young people in their home.

Specific NSW Government domestic and family violence projects

17.108 The Domestic Violence Intervention Court Model was developed to improve the efficiency and quality of the criminal justice response to domestic and family violence, through agreed protocols and services for:

a. improved policing

b. improved court assistance support

c. improved management of local court activities

d. reduced incidence of re-offending

e. linking victims with other sources of support, including housing and counselling.

17.109 Attorney General's is the lead agency for this project. A two year trial began in Wagga Wagga and Campbelltown in September 2005. The Government has now committed recurrent funding of $2.1 million per year for four years to continue the model at both locations. This funding commenced at the start of the 2007/08 financial year.

17.110 Attorney General's is currently investigating the options and implications of mainstreaming the protocols and services developed as part of the model as part of the core business of partner agencies.

17.111 An evaluation of the model found mixed results with Police and local court outcomes, however, victims were very satisfied with the Police response in both of the trial local area commands and with the support they received. Most victims reported that they felt safe at the time of interview and most victims said they would report a similar incident to the Police in the future.[814]

17.112 The majority of stakeholders also believed the trial was successful and should be continued in Campbelltown and Wagga Wagga and should be considered for implementation in other locations.

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[813] Standing Committee on Social Issues, *Care and Support. Final Report on Child Protection Services*, December 2002, p.130.

[814] L Rodwell and N Smith, "An Evaluation of the NSW Domestic Violence Intervention Court Model," *NSW Bureau of Crime Statistics and Research, Attorney General's Department of NSW*, 2008.

17.113 However whilst the evaluation reports positive results with respect to the experience of victims, it is silent in relation to the impact of the model on women with children and any associated child protection issues. Given that DoCS is one of the interagency partners in this model the Inquiry suggests that future evaluations factor this into their analysis and subsequent recommendations.

17.114 The Domestic Violence Intervention Court Model has been identified as an effective integrated crisis response and short term criminal justice and community social welfare response to domestic and family violence. Following a further evaluation and the completion of the business model, consideration will be given to expanding this program.

Staying Home Leaving Violence

17.115 DoCS and Housing are the lead agencies for this project. Staying Home Leaving Violence is an approach that helps women and children stay safely in their homes without their violent partner. The support of the Police, Magistrates and Local Courts is an important aspect of the project as an exclusion order is negotiated as a part of an AVO. The framework entails:

a. the removal of the violent partner from the home

b. keeping the violent partner out of the home over time

c. addressing the immediate and longer term safety issues for the woman and her children

d. providing longer term support for the woman and her children, and the prevention of future violence.

17.116 The framework is based on research funded in 2004 by DoCS, to find out from women who had left a violent relationship what would enable them and other women to remain in their homes.[815] The study found that remaining in their own home brought considerable benefits to the woman and her children including stability of accommodation, stability and security for the children, less disruption to their lives and a sense of empowerment. The study also noted the broader social and economic benefits including reducing women's homelessness and financial disadvantage and placing accountability for violence and its consequences with the perpetrator.

17.117 The specific practices that underpin the framework are:

a. protocols between key agencies to ensure a coordinated response for the removal of the violent partner, and the addressing of safety issues for the woman and her children

b. a local community campaign to increase awareness of, and support for the option of staying home safely

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[815] R Edwards, "Staying Home Leaving Violence; Promoting Choices for Women Leaving Abusive Partners," *Australian Domestic and Family Violence Clearinghouse*, 2004.

c. the provision of outreach support by all agencies

d. safety plans for the women and children which may include enhanced home security: the changing of locks, installation of a phone alarm linked to key agencies, and security doors.

17.118 Pilots have been established to put the key elements of the framework into practice, and to test and evaluate different service approaches to implementing the framework.

17.119 Evaluations for both Bega and South Eastern Sydney Staying Home Leaving Violence projects have been conducted. The evaluation of the Bega project found that the pilot had been successful in developing a robust, holistic model for providing a service to assist to keep women and children in a stable home environment while excluding a violent perpetrator.[816] While the Bega evaluation recorded that two thirds of clients reported positive outcomes, there was also significant reporting of inadequate or unsupportive police and court responses, which identified the need for formal MOUs or agreements, which have subsequently been developed.[817]

17.120 The evaluation of the Eastern Sydney Staying Home Leaving Violence pilot reports that the pilot reached a broad range of women in terms of those who had not previously used welfare services and in terms of their age, housing tenure and cultural identity but noted that "although there is a high incidence of family violence in Aboriginal communities, there is under representation of this group in the project."[818] Nearly two thirds of the project's clients were able to remain living in their own homes with the perpetrator of violence excluded. Women who had been employed, were able to stay in employment and the majority of children maintained stability in education and child care arrangements. The pilot found that the project developed strong and well managed linkages with other service providers, leading to appropriate referrals to the project, joint case management and linking of clients to other support.

17.121 Both pilots involved the negotiation of an MOU with Police.

17.122 The NSW Government has committed an additional $5.1 million to expand the project to an additional 16 locations from 2009/10 onwards. The locations of these programs will be determined on the basis of Police reporting data. Planning for this expansion commenced in July 2008.

17.123 Housing is currently investigating options under the Housing and Human Services Accord, whereby other government agencies and their NGO partners could have nomination rights for public housing properties for domestic and

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[816] Bega Women's Refuge, Purple Kangaroo Consultants, *Final report of the Staying Home Leaving Violence project*, April 2007, p.26.

[817] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence,* November 2008, p.6.

[818] "Evaluation of Staying Home Leaving Violence Eastern Sydney Pilot Final Report," August 2007, p.5.

family violence clients where support arrangements were in place (see Chapter 7).[819]

Risk assessment and information sharing

17.124 A priority identified by workers in domestic and family violence has been the development of an approach that can appropriately identify the full range of domestic and family violence risk factors and the consequent intervention that might be required to break the cycle of violence.[820]

17.125 In March 2006 the Government commenced the development of a cross agency approach. Health is the lead agency for this project. The cross agency risk assessment approach is intended to be used by service providers in Health, Police, DoCS, Attorney General's and other agencies in order to:

a. assess the needs of the victims, including children

b. identify existing interventions and service options designed to reduce the risk of violence and address the needs of victims

c. provide appropriate referrals and/or reports

d. liaise with other agencies to develop a clearer picture of the risks (including documentation of decision making processes, sharing information between agencies and a standard format for data).

17.126 A trial of the approach is scheduled for the end of 2008 in two locations (one metropolitan, one rural). An evaluation report of the trial is anticipated by April 2009.

17.127 As of 1 July 2008, Health had also recruited a statewide coordinator for Intersectoral Domestic and Family Violence Education and Training. This position will be responsible for scoping, coordinating and delivering specialist domestic and family violence training and resource development across government agencies. The position is based at the Education Centre Against Violence. It is the Inquiry's view that it is of critical importance that DoCS establishes strong links with this initiative.

17.128 Overall the literature supports routine screening for domestic and family violence but notes that for successful implementation there needs to be comprehensive training of healthcare and support workers, workers within the judicial system, and the availability of a multi-agency referral network.[821]

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[819] ARTD Consultants, "Coordinating NSW Government Action against Domestic and family Violence" 8 November 2007, p.20.

[820] ibid., p.21.

[821] Department of Premier and Cabinet: *Domestic Violence Rapid Review Draft Report*, September 2008, p.10; M Hester and N Westmarland, "Tackling Domestic Violence: Effective Interventions and Approaches: Home Office," *Communities and Development Unit*, London, 2005; R Braaf and G Ganguly, "Cultural Challenges for violence prevention: working towards an ethical practices of sustainable interventions. Expanding on Horizons," *University of Sydney*, 2002.

Integrated Case Management

17.129 Integrated Case Management aims to deliver coordinated services to clients through a multi-disciplinary team based on clear referral protocols between agencies. The need for such a model arises because no single government agency is structured to provide the complex mix of services needed to respond to domestic and family violence. The lead agency for this project is DoCS.

17.130 The Government provides funding of around $3 million per annum for Integrated Case Management projects targeting high risk groups and communities experiencing domestic and family violence, at nine locations across NSW (Green Valley, Wyong, Canterbury/ Bankstown, Bourke, Mt Druitt, Wollongong/ Shellharbour, Brisbane Waters, Manning/ Great Lakes and Bellambi/ Corrimal).

17.131 Different approaches have been adopted to integrated case management reflecting regional partnership arrangements and local service systems.

17.132 DoCS advised that under priority R1 of the NSW State Plan, it has commenced work on the development of the consistent framework for the Integrated Domestic and Family Violence Services Programs. The purpose is to consolidate the project and support alignment with statewide directions.

17.133 A number of the projects have been evaluated, and while each vary in terms of operation, process and staffing, evaluation results consistently report the following:

a. There has been an increase in the number of victims pursuing AVOs as well as a reduction in the reporting of high risk families, systemic improvements in sharing of knowledge and information between Police and child protection services, and a significant reduction in the numbers of chronic high risk offender families.[822]

b. There has been a sustained decrease in the number of dismissals of AVO and other proceedings because of non-attendance by the parties, a reduction in the percentage of repeat offenders and repeat victims, and a reduction in the percentage of AVO breaches, along with the provision of information, emotional and practical support resulting in women feeling safe during the court process.[823]

c. There have been improved interagency responses to domestic and family violence, strengthened relationships with Police and the adoption of practice that addresses the safety of both women and children.[824]

d. There has been an increase in the rate at which AVOs are granted in domestic violence cases, compared with domestic violence cases that do not involve integrated case management, along with a significant reduction

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[822] D Atkins, AandK Consulting Pty Ltd, *DART Review Report*, December, 2004, p.27.

[823] Evaluation of the Central Coast Domestic Violence Intervention Response Team Project, February 2006, p.4.

[824] L Laing, 2005, op. cit.

in the rate of repeat domestic violence incidents as well as an improvement in relationships between Aboriginal women and Police, with Aboriginal women becoming more willing to report domestic violence.[825]

e. Clients reported feeling safer and helped with a reduced incidence of domestic and family violence.[826]

Department of Community Services

17.134 DoCS allocates significant funding to deal with the consequences of domestic and family violence for children and families. The major program responses cover service delivery through its CSCs and JIRTs, its Domestic Violence Line, CSGP and SAAP.

17.135 There are also a range of early intervention and prevention strategies to address the causes and consequences of domestic and family violence. For example, DoCS has partnered with local organisations to deliver the Tamworth Children and Domestic Violence Group Work Program for mothers and children.

17.136 The Department also allocates funding to a range of targeted domestic and family violence services, including training and education campaigns and projects funded respectively under the Area Assistance Scheme, and the CSGP and Intensive Family Based Services.[827]

17.137 Delivery of the youth component of the Aboriginal family violence partnership projects has begun in five separate locations in rural and remote areas of NSW. Aboriginal family violence partnership projects are being developed in partnership with Aboriginal communities, local agencies and the Commonwealth Government. They aim to prevent domestic and family violence by promoting messages about healthy and non-violent relationships and by improving access to the legal system for Aboriginal women experiencing violence.[828]

17.138 In addition DoCS early intervention program, Brighter Futures, involves a partnership between DoCS and non-government agencies that offers intensive support to vulnerable families, focusing on their needs and addressing the wide range of factors that can contribute to poor outcomes for children and young persons, including domestic and family violence. Almost half of the families who have entered the program to date have been affected by domestic and family violence.[829]

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[825] H Armstrong and P Melser, "Evaluation of the Police/Women's Refuge Partnership against Domestic Violence Project," February 2005.

[826] DoCS, *Evaluation Report: Canterbury-Bankstown Domestic Violence Team*, 19 December 2005, p.28.

[827] An evaluation of the Intensive Family Based Services demonstrated that the program significantly reduced reports involving domestic violence, physical and psychological abuse, Intensive Family Based Services, *Evaluation Report*, Draft, March 2008, p.6.

[828] DoCS, *Annual Report 2006/07*, p.28.

[829] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence*, November 2008, p.22.

Domestic Violence Line

17.139 DoCS statewide Domestic Violence Line is a toll free 24 hour, seven days a week telephone counselling and referral service. Caseworkers help people work towards stopping domestic and family violence through appropriate referrals thereby minimising the risk and increasing their safety. Domestic Violence Line staff work with DoCS Helpline where children are in danger or at risk of harm in violent family situations.

17.140 It is a centralised access point for all women's refuges across NSW and links with other crisis support services in NSW and interstate.

17.141 The Domestic Violence Line received more than 23,000 calls in 2007/08. The majority of these involved incidents of verbal, psychological and physical violence. More than 7,200 calls involved nearly 15,000 children in the affected households, an increase of 2,800 children from 2006/07.[830] From information provided by DoCS to the Inquiry, it appears that staffing has remained relatively stable at about 32 staff.

17.142 As can be seen from Chapter 10, the Inquiry is of the view that if a report does not meet the statutory threshold, this resource should be used more frequently. Other state agencies, including the Police and NGOs should refer the family, or the reporters, themselves should contact the Line to obtain further assistance for the family. This may require additional resources at the Domestic Violence Line.

Supported Accommodation Assistance Program

17.143 SAAP provides accommodation and support services to help people who are homeless or at risk of becoming homeless. This can include families in crisis, single adults, young people, and women and children affected by domestic and family violence. Domestic and family violence was cited as the main reason for seeking support in 54 per cent of SAAP support periods for women with children.[831] SAAP is jointly funded by the Commonwealth and the NSW Governments. NSW contributes 50.4 per cent of funds and the Commonwealth 49.6 per cent. In 2007/08, the program provided around $120 million in funding to 390 NGOs in NSW to deliver support, outreach, advocacy, living skills development and supported accommodation services, as well as linkages to other specialist services such as health, housing and aged care. It provides a major crisis response for people affected by domestic and family violence whose personal safety is threatened and who have acute needs and require immediate support.[832]

17.144 The different service models that are funded under SAAP include:

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[830] DoCS*, Annual Report 2007/08*, p.22.

[831] Australian Government's Green Paper on Homelessness, *Which Way Home?* May 2008, p.20.

[832] DoCS, *Annual Report 2006/07*, p.20.

a. women's refuges/safe houses and domestic and family violence outreach services

b. domestic and family violence support services

c. supported accommodation for families

d. supported accommodation for young people

e. crisis support groups

17.145 In 2007/08, DoCS provided funding under SAAP to 82 women's refuges. In 2008/09 these services will receive more than $32 million in SAAP funding.

17.146 According to a 2004 national report, approximately 10,500 women pass through NSW refuges each year.[833] Concerns were raised with the Inquiry about the levels of funding for some safe houses, which meant that the needs of the community could not be met.

17.147 Humphries reported that national research showed that only 14 per cent of children accompanying women using SAAP services were provided with counselling, child care, kindergarten and/or assistance with access arrangements. Similarly, an audit of 1,244 agencies across Australia showed that only three per cent of organisations operated individual programs for children exposed to domestic and family violence.[834]

17.148 The Commonwealth Government's recent Green Paper on Homelessness suggests that there is a need to align homelessness responses to domestic and family violence with law and justice services. This could mean, for example:

a. changing laws to require the removal of perpetrators of violence from the family home

b. creating alternative accommodation, custodial and treatment options for perpetrators

c. co-locating support and accommodation services with other services such as child care centres, health clinics or recreational facilities

d. providing flexible assistance packages that help people move back into safe and permanent housing in a timely manner

e. changing laws and procedures to encourage courts and police to work more closely with domestic and family violence service providers

f. counting children as SAAP clients and providing brokerage funds to pay for counselling, school books and uniforms so that children can go to school

g. forming partnerships between schools and family health services to identify children at risk and to respond early, to minimise the disruption to children's

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[833] WESNET, "Women's Refuges, Shelters, Outreach and Support Services in Australia," *Office for Women, Department of Families, Housing, Community Services and Indigenous Affairs,* 2004, p.60.

[834] C Humphreys, May 2007, op. cit., pp.16-17.

schooling and to address the effects of homelessness on their ability to learn.[835]

Orana Far West Child and Family Partnership Development Project

17.149 The Orana Far West Child and Family Partnership Development Project is considered an example of a best practice homelessness response for families experiencing violence. The project, led by DoCS, provides emergency accommodation for women and children escaping domestic and family violence. The project includes assisting the transition of families from the safe houses into longer term affordable housing. Safe houses are also 'drop-in' centres where women can support each other. The project is a partnership between the Commonwealth and NSW Governments and brings together the following key service elements:

a. promoting strong, functional well supported families, healthy development of children and to reduce and prevent child abuse and neglect in participating families through the Brighter Futures program

b. enhanced SAAP funding and support – to improve the capacity of safe houses in Bourke, Brewarrina, Lightning Ridge, Walgett and Wilcannia to respond to women and children experiencing, or at risk of, family violence

c. establishing Child and Family Linkage workers in each of the five safe houses

d. linking with Housing to assist safe house clients to receive the support services they need to live independently and maintain their tenancies

e. investigating options for the crisis accommodation program to support the work of the five safe houses

f. working with the Aboriginal Housing Office to improve housing options for clients and children in safe houses.

Other DoCS initiatives

17.150 In addition to the funding it provides, DoCS has developed a number of resources to provide guidance to caseworkers on working with domestic and family violence. One of these is the Brighter Futures Practice Resource: Domestic and Family Violence Vulnerability, which is evidenced based and provides practical guidance for caseworkers in this Program.

17.151 The Caseworker Development Course has a module which focuses exclusively on domestic and family violence. Staff involved in early intervention casework receive extra training in domestic and family violence via the Safe Homes, Safer

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[835] Australian Government's Green Paper on Homelessness, *Which Way Home?* May 2008, p.66.

Futures Training Program. This training reflects and operates from the following principles:

a. responsibility for abuse remains with the perpetrator of abuse

b. responsibility for changing abusive behaviour remains with the perpetrator of abusive behaviour

c. children's and women's safety is prioritised at all times

d. working with interagency partners to access more in depth and specialised intervention.

17.152 In addition, Research to Practice seminars are held which included a seminar on domestic and family violence. Relevant research papers are also available on the intranet.

17.153 There is a need for a more nuanced assessment and intervention approach by DoCS Child Protection Caseworkers to the impacts of domestic and family violence on children and women. The Inquiry is of the view that this group of staff also need access to specific training and expertise such as that provided to Early Intervention Caseworkers. Further, casework practice guidelines need to highlight the importance of offering support and protection and identifying strategies and resources that can assist child protection workers in better supporting the non-offending partner and children.

Other key agencies

17.154 Health predominately delivers domestic and family services through mainstream health services (emergency departments, drug and alcohol, maternity, mental health and other community and hospital services). Health policy and procedures mandate routine screening for domestic violence for women attending antenatal and early childhood health services and for women aged over 16 years attending mental health and drug and alcohol services.

17.155 There is no specialist service stream for domestic violence counselling across Health as there is for sexual assault. Victims are referred to other services, where these are available, however, the Inquiry understands that some Area Health Services have developed specialised centres.[836]

17.156 Appropriate accommodation is a key issue in domestic and family violence. Housing is working with other agencies in seven priority locations covering 18 public housing areas, where a component of this work may support families experiencing violence and increase their capacity to access mainstream services and supports.[837]

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[836] Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence*, November 2008, p.12.

[837] ibid., p.13.

17.157 Homelessness NSW has reported that the number of women and children becoming homeless as a result of domestic and family violence in NSW is not decreasing under current strategies.[838] The most significant problem identified with the current response is the lack of exit points from crisis and transitioned accommodation.[839]

17.158 While there are some initiatives as noted earlier in this chapter, these need to be complemented by a range of accommodation and support options to meet the varying needs of children and women.

NSW Police and domestic violence risk of harm reports

17.159 Police has a policy titled *The Investigation and Management of Domestic and Family Violence* which requires its officers to report to DoCS when a child is present at a domestic violence incident, or is known to be living in a domestic violence situation. This is in contrast to paragraph (d) of s.23 of the Care Act which is in the following terms:

> *the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm.*

17.160 As a consequence of this policy, Police make many reports to DoCS, the precise number being unknown, where they attend a single incident of domestic violence occurring at premises in which a child usually lives, but who was not present at the time, without harbouring any suspicion of risk of serious physical or psychological harm. Police officers have informed the Inquiry that they report to DoCS about half of the domestic violence incidents they attend. Presumably, the other half have no children in attendance or ordinarily present.

17.161 From the work done by the Ombudsman in 2007 in reviewing the deaths of certain children between January 2005 and April 2007, 29 events involving 18 families are identified in which he had concerns about Police compliance with its policy for reporting children at risk of harm in relation to domestic violence.[840]

17.162 In nine events, a mandatory risk of harm report and/or a report under the policy may have been warranted, however the Police records do not indicate that one was made. In 10 events, a mandatory risk of harm report and/or a report under the policy may have been warranted, and Police records indicate that a report

[838] ibid., section 4.8, p.8.

[839] D Tually, C Cutler and M Slater, "Women, Domestic and Family Violence and Homelessness: a Synthesis Report", *Flinders Institute for Housing, Urban and Regional Research*, 2008, cited in Department of Premier and Cabinet, *Discussion Paper on Domestic and Family Violence*, November 2008, section 4.58, p.17.

[840] NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.36.

was made but there was no evidence that it was received by DoCS. In 10 events, in which neither a mandatory risk of harm report nor a report under the policy may have been warranted, a report was recorded as having been made by Police yet there was no evidence that it was received by DoCS.

17.163 The Ombudsman dealt with these matters by convening meetings with DoCS and the Police. No resolution had been achieved by the time of the writing of this report.

17.164 Domestic and family violence warrants serious and timely attention by all authorities. Possible models are discussed in this chapter. However, the response by Police as set out in its reporting policy is resulting in resources being spent unproductively.

17.165 It is clear from Chapter 6 that health and education workers acknowledge and accept that the legislation requires of them the exercise of judgement as to whether a risk of harm exists. Those with whom the Inquiry spoke, believed that their knowledge of the child and family and their professional skills well place them to form the judgement required by the Care Act.

17.166 The Inquiry has questioned those representing the Police on a number of occasions during the Inquiry about the breadth of its notification policy. Assistant Commissioner Kaldas informed the Inquiry:

> *if we were to move towards filtering more and not sending things on, we feel that all we would be doing is simply shifting the risk.*[841]

17.167 By which, he clarified, he meant shifting the risk from DoCS to the Police. Detective Superintendent Begg stated:

> *I think most Police officers are probably not in a position to judge whether a child is going to have any sort of long term effects of domestic violence.*[842]

17.168 In its submission to the Inquiry Police said:

> *A significant proportion of children reported to the Helpline by police officers attending a domestic violence incident require no child protection intervention based solely on the incident. However, the information gathered by police officers from a domestic violence (or any other) incident adds to any information that may already be held by DoCS on the child or the family and should be important in assisting DoCS caseworkers assess any increase in the risk to the children. If it is the first such police report, it could assist DoCS in*

[841] Transcript: Inquiry meeting with NSW Police Force senior executives, 25 June 2008, p.2.
[842] ibid., p.4.

determining risk of harm if future reports are made by any agency about the children.

The Australian Domestic Violence and Family Violence Clearinghouse and the Australian Institute of Criminology have a wealth of literature linking the deleterious impact that witnessing domestic violence has on children. Even if children are not the direct victims of domestic violence, the ability of women victims to provide appropriate quality of care to their children is affected by their violent experiences. There is strong evidence of the coexistence between domestic violence and child protection/child abuse. It is not reasonable to assume that exposure to a 'verbal argument' is any less traumatic than the actual physical abuse of another when witnessed by a child, especially if there is frequent and ongoing patterns of similar family behaviour. The content and context of the verbal argument may determine the impact of the argument upon a child. For example, if there is threatening behaviour by an adult to another, or to the child, this is significant. Context is an important consideration for police officers including whether the incident forms a pattern of abuse or represents the escalation of abuse. This is not for attending police officers to judge. Such matters should always be referred to DoCS caseworkers for appropriate assessment.[843]

17.169 Taking a different view, a police officer at one interagency meeting indicated that "we are, as police officers, well able to apply an objective risk assessed view of the world in terms of the need to provide a child at risk assessment"[844] so that not as many unnecessary reports go to DoCS. It was suggested that a commissioned officer in each command could have the report referred to them and then make an assessment based on relevant criteria.

17.170 In relation to DoCS having all available information, DoCS KiDS system is obviously an important resource to child protection work. However, Police holdings are available and can be accessed by the use of the s.248 Direction Power.

17.171 Police urged the Inquiry not to increase the threshold for reporting domestic violence incidents. However, the key concern for the Inquiry has not been the circumstances prescribed by the Care Act as to when domestic violence incidents should be reported, but that Police are directed by policy to report matters which fall short of that specified in s.23(d). In its submission, Police appear to be supporting an amendment to s.23 to align it with the policy. No other person has submitted to the Inquiry that s.23(d) should be amended to that end.

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[843] Submission: NSW Police Force, May 2008, pp.13-14.
[844] Transcript: Interagency meeting, Southern Region.

17.172 Concerns about the 'noise' generated in the system by the volume of domestic violence reports were recorded in a number of submissions received by the Inquiry. The consequence of over reporting means that "when you get all of those reports coming in and the vast majority are trivial, you swamp the system so much you don't notice the really serious ones."[845] Humphries states that "inundating the statutory child care agency with referrals may actually increase the risk of harm, as those children in greatest danger may become lost in the 'debris of referrals' and not receive a service."[846] The Benevolent Society also noted that we "have a system whereby an incident of domestic violence is counted as a child being at risk of harm." This means "you have this massive reporting with no action taking place."[847]

17.173 As discussed in Chapter 6, 16,426 reports made by Police in 2006/07 did not meet the statutory test. It is likely that most of these were domestic violence incidents.

17.174 In a meeting with the Inquiry, Dr Eileen Munro, Reader in Social Policy, the London School of Economics and Political Science, suggested that if Police used a simple grading of seriousness from one to five, it would be much more useful for DoCS workers. NCOSS similarly suggested that there be a filter applied by mandatory reporters before reporting to DoCS to reduce 'crowding' of the system.

17.175 Humphries cites work by different Police authorities in the UK that are using or developing tools to assess the risks posed by the perpetrator of domestic and family violence to assist them to prioritise their work. Most of the tools are based on the factors that have been associated with lethality and serious assaults including sexual assault, stalking, perpetrator substance misuse and mental health problems, separation, pregnancy and child abuse.[848] The evaluation of Police risk assessment showed that officers appreciated having a systematic approach to risk assessment that also provided a basis for safety planning.[849]

17.176 Police raised with the Inquiry the inadequacy of COPS[850] in identifying repeat victims of domestic violence: "There is a great anomaly between the numbers of repeat victims on our COPS system."[851]

17.177 Police referred to a domestic violence checklist that is completed by every officer at the scene of a domestic violence incident, however this is not

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[845] Transcript: Inquiry meeting with Dr Eileen Munro, 10 March 2008, p.4.

[846] C Humphries, "Domestic violence and child protection: exploring the role of perpetrator risk assessments," *Child and Family Social Work, Vol 12*, 2007, p.361.

[847] Transcript: Inquiry meeting with senior representatives from the Benevolent Society, 12 December 2007, p.30.

[848] C Humphreys, 2007, op. cit., p.362.

[849] ibid., p.366.

[850] 'COPS' is the Computerised Operational Policing System which records all police activities by NSW Police.

[851] Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.18.

analysed statistically on a state basis, so that one of the questions a police officer has to ask is whether the incident has happened before.

17.178 DoCS raised the issue of the quality and timeliness of reports received from Police. In some instances the information was insufficient to make an adequate assessment. DoCS told the Inquiry that Police:

> *are interested in criminality and prosecution and evidence; we are just into the softer things that the police may not actually record on their system……Such as how a child was presenting when the police turned up to a domestic violence incident. Totally irrelevant really, unless the child has been assaulted, to police purposes, but really critical to us.*[852]

17.179 The Ombudsman has also noted the variable quality in information provided by Police to DoCS in child at risk reports. Police reports do not necessarily contain contextual information that may assist DoCS to make an appropriate assessment.[853]

17.180 DoCS reported that they would like to get more information from Police, for example, if it is the first offence, the severity of domestic violence cases, so that DoCS can use this intelligence in assessing the relative priority of the reports for investigation.

17.181 Police and DoCS have recently completed a project, following from a recommendation made by the Ombudsman to improve the risk assessment of matters reported by Police. It has resulted in a one page tool being developed to collect key information relevant to assessing risk of harm in domestic and family violence situations. The type of information sought includes whether the incident was a repeat, whether children were present and currently safe and whether there are signs of drug or alcohol use by carers or of mental health issues. The Inquiry understands that some concerns about privacy are being dealt with through legal advice and urges those concerns to be resolved quickly by agreement or amendment of the relevant instrument or law.

17.182 It is a very sensible document and should be implemented and shared, after suitable amendments, with other mandatory reporters.

Conclusion

17.183 The Inquiry supports the findings of the recent Premier and Cabinet 2008 Literature Review of domestic violence that there is agreement in peer reviewed literature that outcomes of programs designed to prevent the recurrence of domestic violence and to improve the long term safety and well-being of those

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[852] Transcript: Inquiry meeting with DoCS senior executives, 30 November 2007, p.38.

[853] NSW Ombudsman, *Domestic Violence: Improving Police Practice,* December 2006, p.43.

who have experienced domestic violence have been inconsistently and poorly evaluated, thus reducing a reliable evidence base about what works.

17.184 Notwithstanding this, considerable work has been and is being done in the area of domestic and family violence and child protection. However, challenges remain to ensure that caseworkers and other key professionals such as police have available to them, understand and apply the developing evidence based approaches to intervening in families where domestic violence gives rise to child protection concerns. They need to work with other agencies and NGOs, and with their domestic violence workers, to determine the right service or response. Preferably, caseworkers should support the non-offending parent, usually the mother, to stay in the home with her children, having sufficiently reduced the risk of harm. This may require collaboration with Housing, Police and the courts.

17.185 The fathers should not be forgotten; they should be encouraged to take responsibility for their violence or other abusive behaviours and increase their awareness of the impact of their violence on the children. This requires access to Health or other perpetrator programs and/or the involvement of Police and the courts.

17.186 Legal protections should be used, including AVOs and criminal charges, and active public awareness campaigns conducted that will emphasise this unacceptability of this form of conduct and publicise the resources available to victims.

17.187 In addition to the features identified by DoCS and set out earlier in this chapter of interventions which work, the following principles should be the benchmarks against which proposed interventions are tested:

a. interventions should occur at universal, secondary and tertiary levels
b. the response should be integrated and coordinated and involve, at least Police, Housing and Health and relevant non-government services
c. where possible services should be co-located or operated from a ‘hub’
d. cross agency assessment tools should be used
e. cross agency training should by undertaken
f. women and children should be supported to stay in their homes.

17.188 Where possible, and to assist the Government in determining where best to allocate funds, projects designed to reduce domestic violence or to assist those living with it, should have compatible measures for success. In addition, evaluations of these projects should be undertaken using consistent methodology to enable more useful comparisons to be made than those which have occurred to date.

17.189 The nature of the research on the effects of exposure to domestic violence on children and the potential for 'gender blindness' in child protection work[854] suggest that more should be done to equip caseworkers with the knowledge and skills to assess risk of harm reports and determine interventions when domestic violence is the cause of risk. The use of Structured Decision Making as recommended elsewhere in this report may also assist in this regard.

17.190 Equally, joint training between child protection workers and workers with other agencies concerning children and domestic violence should occur. The Education Centre Against Violence would appear to be an appropriate vehicle to facilitate such training.

17.191 Otherwise, the Inquiry supports the current Government initiative to develop a comprehensive cross agency response to the problem, be driven from within Premier and Cabinet, focusing on the core group that take up a substantial amount of the time and resources of the human services and justice agencies. Effective intervention in that area could have a significant impact on the costs of those agencies in not having to deal with these families in the future. Equally it could provide an example and incentive for those on the periphery of this care group to seek out assistance.

Recommendations

Recommendation 17.1

> The NSW Police Force should amend its policies in respect of reporting domestic violence incidents to DoCS to align with the requirements of s.23(d) of the *Children and Young Persons (Care and Protection) Act 1998* and should provide the necessary training to its officers to enable them to comply with the amended legislation.

Recommendation 17.2

> DoCS and NSW Police should agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made.

Recommendation 17.3

> DoCS caseworkers should receive domestic violence specific training, jointly with other relevant agencies and NGO workers.

[854] KL Nixon, LM Tutty, G Weaver-Dunlop and CA Walsh, 2007, op. cit., p.1482.

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Introduction

18.1 Aboriginal children and young persons are significantly over represented in the child protection system, as well as in juvenile justice institutions. The reason for this state of affairs is likely to be the cumulative effects of poor health, drug and alcohol and drug abuse, gambling, pornography, unemployment, discrimination, poor education, housing and the general disempowerment of their parents and communities which has led to family and other violence and then on to sexual abuse of men and women and, finally, of children.[855]

18.2 Much has been said and written about this inequity, and this chapter refers to most of it. Sound principles have been expressed by reviews, more recently and notably, the inquiry which led to significant intervention in the lives of Aboriginal families in the Northern Territory.

18.3 For a child protection system, the enormity and long standing nature of the causes of child abuse and neglect in Aboriginal communities can be overwhelming. This chapter seeks to document the words and work of others, to examine in some detail the response of NSW to child sexual abuse and to express some views about possible ways forward in NSW.

18.4 The purpose of this chapter is to provide a considered basis for intervention, drawing upon other recent inquiries and academic research, that underpins the general recommendations made in this chapter, but more importantly, those individual recommendations which the Inquiry has made in the other chapters, which focus on the individual components or aspects of the care and protection system. The reasons for those recommendations are set out in those chapters, and are not repeated in this chapter, save, an occasions, in passing.

The history of removal of Aboriginal children from their families in Australia

18.5 In 1997, HREOC delivered the Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, *Bringing them home*.

18.6 *Bringing them home* has since been a key reference point for policy development and further inquiries regarding Aboriginal children and families. In the introduction to the report, the authors note that:

> *The histories we trace are complex and pervasive. Most significantly the actions of the past resonate in the present and will continue to do so in the future. The laws, policies and*

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[855] Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'", *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.6.

> *practices which separated Indigenous children from their families have contributed directly to the alienation of Indigenous societies today.*
>
> *For individuals, their removal as children and the abuse they experienced at the hands of the authorities or their delegates have permanently scarred their lives. The harm continues in later generations, affecting their children and grandchildren.*[856]

18.7 *Bringing them home* details ongoing negative effects for many survivors of the separation. Main areas of functioning discussed were parenting skills (including high anxiety about parenting that can manifest as a lack of discipline), reluctance to use mainstream services due to a fear that those services will take their children away, and a higher incidence of behavioural problems in the children of those who were removed.[857]

18.8 Those removed as children were reported to experience high rates of self harm and suicide, high rates of domestic violence, and unresolved grief and trauma that was passed on to their children as anxiety and distress.[858] The report also commented on the poor mental health of those removed as children, and the effect on their parenting capacity and therefore the life outcomes of their children.[859]

18.9 The ongoing and generational negative effects of such policies and practices have been noted in other countries with a similar history of colonisation, and of policies that attempted to control or assimilate Indigenous populations into mainstream culture. The literature notes particular parallels between the experiences of Australia and Canada, the USA and New Zealand.[860]

History of removal of Aboriginal children in NSW

18.10 The findings of *Bringing them home* at a national level are also true of the experience of people in NSW. A Protector of Aborigines was first appointed in NSW in 1881, and a Board of Protection established in 1883. The Board was granted statutory authority with the passing of the *Aborigines Protection Act 1909.* Under this Act, an Aboriginal child no longer had to be considered

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[856] Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, 1997, p.4.

[857] ibid., pp.193-196.

[858] ibid., p.197.

[859] ibid., pp.198-202.

[860] For example, D Valentine and M Gray, 2006, op. cit, pp.537-545; T Bell and T Libesman, "Aboriginal and Torres Strait Islander Child Protection Outcomes Project Report, From Aboriginal child welfare to Aboriginal children's well-being," Commissioned by Secretariat of National Aboriginal and Islander Child Care and the Department of Human Services Victoria, unpublished, October 2007; T Libesman, "Child welfare approaches for Indigenous communities: International perspectives," 2004 *Child Abuse Prevention Issues* no. 20, Australian Institute of Family Studies; Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'", *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.274.

neglected before the Board had the power to remove the child from his or her family.[861]

18.11 Missions and institutions to accommodate Aboriginal children removed from their parents were established at a number of sites across NSW, including missions at Bomaderry, Bowraville, Erambie, Lake Macquarie, Maloga School, Parramatta, Warrangesda and Wellington Valley, and institutions at Kinchela and Cootamundra.[862]

18.12 NSW claims to be the first Australian jurisdiction to stop the indiscriminate removal of 'part Aboriginal children' in 1940 and also to be the first Australian government to apologise to the Aboriginal people in the wake of *Bringing them home*.[863]

18.13 DoCS has acknowledged the history of removal of Aboriginal children by child welfare authorities in NSW. The DoCS intranet has the following statement:

> *DoCS and its predecessor organisations have a long history of involvement with Aboriginal and Torres Strait Islander communities. It is estimated that between 1883 and 1969 nearly 6,000 Aboriginal children were removed from their families in NSW, amounting to one in six or seven children compared to one in 300 for non-Aboriginal children.*[864]

18.14 DoCS, through its former and current Director-General, has also apologised to the Aboriginal people for the effects of past policies.

Legislative provisions

18.15 The Care Act contains specific provisions regarding needs of Aboriginal children and young persons.

18.16 'Aboriginal and Torres Strait Islander' means a person who:

(a) is a member of the Aboriginal or Torres Strait Islander race of Australia, and

(b) identifies as an Aboriginal person, or Torres Strait Islander race of Australia, and

(c) is accepted by the Aboriginal community or Torres Strait Islander race of Australia, as an Aboriginal person or Torres Strait Islander race of Australia.[865]

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[861] T Drabsch, "Indigenous Issues in NSW: NSW Parliamentary Research Service Background Paper 2004", *NSW Parliamentary Library, no. 2/04*, pp.52-53.

[862] ibid., p.54.

[863] ibid., pp. 54 and 56.

[864] DoCS, Intranet, Aboriginal Welfare History.

[865] *Children and Young Persons (Care and Protection) Act 1998* s.5 and *Aboriginal Land Rights Act 1983* s.4.

18.17 If the Children's Court is satisfied that a child or young person is of Aboriginal or Torres Strait Islander descent it may determine that they are an Aboriginal or Torres Strait Islander for the purposes of the Care Act.[866] The Director-General is to make reasonable enquiries as to the Aboriginality of a child or young person who is the subject of a report.[867]

18.18 The objects, principles and responsibilities contained in Part 1 of Chapter 2 of the Care Act[868] apply equally to Aboriginal and non-Aboriginal children and young persons.

18.19 The Care Act also contains Aboriginal specific principles the first of which is that Aboriginal people are to participate in the care and protection of their children and young persons "with as much self-determination as is possible" and the Minister may negotiate and agree with Aboriginal people to the implementation of programs and strategies that promote self-determination.[869]

18.20 The second Aboriginal specific principle recognises Aboriginal participation in decision making and states that Aboriginal families, kinship groups, organisations and communities are to be given opportunities to participate in decisions made about the placement of their children and young persons, and in other significant decisions made under the Care Act, "by means approved by the Minister."[870]

18.21 The Care Act also contains the Aboriginal Child Placement Principles, including the general order for placement, the relevance of the child's self-identification and wishes, and guidance for cases where a child or young person has parents from different Aboriginal communities or one Aboriginal and one non-Aboriginal parent.[871] These principles have been discussed in detail in Chapter 11. The Care Act requires that a permanency plan for an Aboriginal child or young person must address how the plan has complied with the Aboriginal and Torres Strait Islander Child and Young Person Placement Principles in s.13.[872]

18.22 The Care Act contains specific provisions for the keeping of records by DoCS and designated agencies relating to Aboriginal children and young persons placed in OOHC.[873]

18.23 The *Adoption Act 2000* sets out the Aboriginal Placement Principles and their application to adoptions of Aboriginal children. Provision is made for Aboriginal participation in decision making, and to ensure that alternatives to adoption are considered for Aboriginal children.[874] It also includes specific requirements for

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[866] *Children and Young Persons (Care and Protection) Act 1998* s.5(2) and (3).
[867] *Children and Young Persons (Care and Protection) Act 1998* s.32.
[868] *Children and Young Persons (Care and Protection) Act 1998* Part 1 of Chapter 2.
[869] *Children and Young Persons (Care and Protection) Act 1998* s.11.
[870] *Children and Young Persons (Care and Protection) Act 1998* s.12
[871] *Children and Young Persons (Care and Protection) Act 1998* s.13.
[872] *Children and Young Persons (Care and Protection) Act 1998* s.78A(3).
[873] *Children and Young Persons (Care and Protection) Act 1998* ss.14 and 167.
[874] *Adoption Act 2000* ss.33-39.

counselling and information to be supplied prior to the giving of consent for the adoption of an Aboriginal child.[875] The court must not grant an adoption order for a child unless it is satisfied that the Aboriginal Placement Principles have been properly applied.[876]

18.24 An adoption plan for an Aboriginal child to be adopted by non-Aboriginal parents must set out the ways in which the child is to be assisted to develop a healthy and positive cultural identity and for links with that heritage to be fostered.[877]

Data

18.25 The literature reveals the disadvantage experienced by the Aboriginal population compared with the non-Aboriginal population. HREOC has noted that:

> *It is a tragic fact that an Aboriginal or Torres Strait Islander child born today does not have the same life chances as other Australian children.*
>
> *This is something that should not exist in 21st century Australia. And it is the defining challenge for our nation.*[878]

18.26 One of the problems with data collection regarding Aboriginal status is that information collected by the census and by government agencies regarding Aboriginality is self reported. This means that if, for any reason, an Aboriginal person does not wish to disclose his or her Aboriginal identity, the statistics will not record him or her as an Aboriginal person.

18.27 There are powerful historical and current reasons why Aboriginal people may wish to avoid being identified by government authorities. This means that most of the statistics gathered about Aboriginal people for official purposes are likely to underestimate the true numbers of Aboriginal people using a service. Even with this qualification, the available statistics still clearly demonstrate the over representation of Aboriginal children and young persons among the more disadvantaged people in Australian society, and in the child protection and justice systems. Chapters 5 and 16 set out in detail the available data on Aboriginal people in the child protection system.

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[875] *Adoption Act 2000* ss.64-65.

[876] *Adoption Act 2000* s.90 (e).

[877] *Adoption Act 2000* s.46 (3).

[878] Human Rights and Equal Opportunity Commission, *Social Justice Report Commonwealth of Australia,* Canberra, 2007, p.6.

Aboriginal families

18.28 The rate of involvement of Aboriginal children and young persons in the child protection system occurs within a broader context of disadvantage and vulnerability experienced by Aboriginal families.

18.29 2.1 per cent of the NSW population identify as Aboriginal.[879] Aboriginal children account for approximately four per cent of the total NSW 0-17 years population.[880]

18.30 13 per cent of Aboriginal families have four or more children compared with five per cent for the total population of families in Australia.[881]

18.31 The Aboriginal population has a younger age structure than the non-Aboriginal population. 40 per cent of the Aboriginal population in Australia is aged less than 14 years – more than twice the rate for the total population.[882] 45 per cent of the Aboriginal population of NSW are aged 0-17 years.

18.32 In 2004/05 the life expectancy for Aboriginal men in Australia was 59 years and for Aboriginal women 65 years, compared with 77 years for all males and 82 years for all females.[883] This impacts on the structure of the extended family, the availability of grandparents and other key relatives to support parents and form relationships with children.[884]

18.33 Aboriginal children have poorer health and a higher mortality rate than non-Aboriginal children. For example:

a. Since 2001, over 10 per cent of NSW Aboriginal babies have had low birth weight (less than 2,500 grams) and prematurity (less than 37 weeks gestation). These rates are one and a half to two times higher than the rates for NSW babies overall.[885]

b. The perinatal mortality rate among babies born to Aboriginal mothers in NSW was 15.2 per 1,000 in 2005, higher than the rate of 8.6 per 1,000 experienced by babies born to non-Aboriginal mothers.[886]

c. In 2007, the NSW Child Death Review Team reported that 56 of the children who died in NSW in the reporting period identified as Aboriginal. This was 9.3 per cent of the deaths in that period, and represents a death

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[879] Australian Bureau of Statistics, *2006 Population Census*, 26 September 2008.

[880] DoCS, *What DoCS data tell us about Aboriginal clients,* December 2007.

[881] Department of Families, Housing, Community Services and Indigenous Affairs, "Longitudinal Study of Australian Children," *Fact Sheet No. 5 Indigenous Families are Different,* 2006.

[882] ibid.

[883] Australian Bureau of Statistics and Australian Institute of Health and Welfare, *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, *Vol 4704.0*, 2008, p. xxii.

[884] F Stanley, S Richardson and M Prior "Children of the Lucky Country? How Australian society has turned its back on children and why children matter?" *Macmillan*, 2005, p. 52.

[885] NSW Health, "Mothers and Babies Report," 2005, p.10.

[886] ibid.

rate of 99.8 deaths per 100,000 for Aboriginal children, compared with 35.37 deaths per 100,000 for the overall child population for 2007.[887]

d. Of the 54 infants who died suddenly and unexpectedly in NSW in 2006, 13 (24.1 per cent) were Aboriginal.[888] Aboriginal infants in Australia are up to six times more likely to die from sudden infant death syndrome than non-Aboriginal children. Nationally, between 1991-2000, the Aboriginal rate was 4.49 per 1,000 live births compared with the non-Aboriginal rate of 0.73.[889]

e. Suicide by Aboriginal people is concentrated in the younger age groups for both males and females. The suicide risk for Aboriginal males aged 15–19 years has been identified as four times that of the general population.[890]

18.34 In 2006/07 Aboriginal children and young persons represented 27.2 per cent of those attending a Youth Justice Conference, 39.5 per cent of those under community supervision, 37.8 per cent of those remanded in custody, and 54.7 per cent of those sentenced to detention.[891]

18.35 In June 2007, Aboriginal men comprised 20 per cent of the total male offender population in custody. Aboriginal women comprised 31.3 per cent of the total female offender population in custody.[892]

18.36 Aboriginal children and young persons are less likely than non-Aboriginal children to finish their high school education, reach minimum standards of literacy and numeracy, or to leave school with the educational levels they need to undertake further education or to enter employment.[893]

18.37 In 2005/06, Aboriginal people accounted for 16 per cent of all SAAP clients in NSW (4,300 Aboriginal clients, including 2,750 accompanying children).

Care and protection of Aboriginal children in NSW

18.38 As can be seen from Chapter 5 of this report, Aboriginal children and young persons are far more likely to be reported to DoCS than non-Aboriginal children and young persons. For children aged under one year, Aboriginal children are almost five times more likely to be reported than non-Aboriginal children. Aboriginal children are also more likely to be the subject of multiple reports.

18.39 There has been a slowing trend in the number of child protection reports in the period 2006/07 to 2007/08 (preliminary) compared with 2005/06 to 2006/07.

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[887] NSW Child Death Review Team, *Annual Report 2007*, p.9.

[888] ibid.

[889] SIDS and Kids, "2004 Report on First Australian SIDS Pathology Workshop," p.8: www.sidsandkids.org.

[890] B Nielsen, E Katrakis and B Raphael "Males And Mental Health: A Public Health Approach," *NSW Public Health Bulletin, 12(12),* 2001, pp.330-332.

[891] Department of Juvenile Justice, *Annual Report 2006/07*, p.21.

[892] Department of Corrective Services, *Annual Report 2006/07*, p.42.

[893] Department of Families, Housing, Community Services and Indigenous Affairs, "Longitudinal Study of Indigenous Children" *Fact Sheet No. 5*, 2006.

For reports involving non-Aboriginal children and young persons, the percentage increase over these two periods fell from 16.7 per cent between 2005/06 to 2006/07 to 4.7 per cent between 2006/07 to 2007/08. For reports involving Aboriginal children and young persons, there was also a fall in the percentage increase of reports, but it was not as marked. The percentage increase fell from 29.1 per cent to 11.9 per cent.

18.40 In the period April 07/March 08, Aboriginal children and young persons were less likely to be the subject of reports that were designated as 'information only' or that were closed at the Helpline. The Aboriginal children and young persons in these categories, however, had about twice the number of reports per person compared with non-Aboriginal children and young persons in this group.

18.41 Therefore, reports on Aboriginal children and young persons were slightly more likely to be referred for further assessment than non-Aboriginal children and young persons. Of the reports referred to a CSC or JIRT for further assessment in the period April 07/March 08, those concerning Aboriginal children and young persons are less likely to be closed without further assessment.

18.42 If the percentage of reports made about Aboriginal children and young persons is taken as a benchmark, the statistics show that a slightly higher proportion of the reports that received a SAS1 and were subsequently closed in April 07/March 08 concerned Aboriginal children and young persons. The proportion of reports concerning Aboriginal children and young persons that received a SAS2 over the same period was also higher than for non-Aboriginal children and young persons. Of the reports that received a SAS2 and were substantiated, the proportion that concerned Aboriginal children and young persons was also higher.

18.43 It would appear from the data that Aboriginal children and young persons involved in reports are more likely to be the subject of a completed secondary assessment. Further the subsequent statutory response by DoCS is more likely to result in Aboriginal children and young persons entering care. As is shown in Chapter 16, Aboriginal children and young persons, who accounted for about one seventh of all people reported to DoCS in 2007/08, accounted for almost a third of the children and young persons in OOHC.

18.44 In 2006/07 and 2007/08, the proportions of Aboriginal children and young persons reported with specific issues differed from the proportions of non-Aboriginal children and young persons reported with those issues. The proportions of Aboriginal children and young persons with reported issues of carer drug and/or alcohol abuse or neglect were higher than those for non-Aboriginal children and young persons. The difference between the two groups was not as pronounced in the case of domestic violence.

18.45 The number of Aboriginal children and young persons in care, and the proportion of Aboriginal children and young persons in the OOHC population, has steadily increased since 2005. Based on the rates per 1,000, Aboriginal

children and young persons are more than ten times more likely than other children and young persons to be in OOHC.[894]

18.46 Of the children and young persons in OOHC in 2008, Aboriginal children and young persons were less likely to be in statutory care than non-Aboriginal children and young persons, were less likely to be in an NGO placement, and were more likely than other children and young persons to be in relative/kinship care. Those in relative/kinship care tended to have a lower number of placements, and this may contribute to the fact that Aboriginal children and young persons are slightly less likely to have multiple placements.

18.47 Aboriginal children and young persons also continue to be over represented in reviewable deaths, and more broadly, they also feature disproportionately in the deaths of all children in NSW.[895] In 2006, the deaths of 123 children were reviewable. Twenty-five were Aboriginal children.

18.48 From 2003 to 2006, 19 per cent of all child deaths in NSW were reviewable. In the same period, 42 per cent of the deaths of Aboriginal children were reviewable.[896]

Previous reports and their recommendations

18.49 The experience of Aboriginal people in the child protection system has been discussed in a number of reports and issues papers.

18.50 In the years since the release of *Bringing them home*, South Australia, the Northern Territory, NSW, Queensland, Victoria and Western Australia have released reports which considered at least some aspects of the involvement of Aboriginal children and young persons in child protection systems in Australia.

18.51 These key reports are discussed below.

Bringing them home

Findings of the *Bringing them home* report

18.52 The report concluded that although legislation and the language used in the child welfare field had changed, paternalistic attitudes towards Aboriginal children and families persisted in child welfare departments in Australia. The experience of Aboriginal children and families with child welfare agencies was still reported to be "overwhelmingly one of cultural domination and inappropriate

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[894] DoCS, *What DoCS data tell us about Aboriginal clients,* December 2007, p.3.
[895] NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths*, December 2007, p.16.
[896] ibid., p.ii.

and ineffective servicing, despite attempts by departments to provide accessible services."[897]

18.53 Thus, it was concluded, a complete overhaul of welfare services for Aboriginal children, families and communities was required, resulting in a very different model of service in which Aboriginal communities would be involved as true partners in negotiating the services and models most appropriate for their particular community or region.[898]

18.54 It was noted that the involvement of extended kin networks, close supervision of very young children, a high level of autonomy among older children, and an emphasis on providing comfort and affection rather than discipline, are features of Aboriginal child rearing widely recognised in communities in different geographic locations and living different lifestyles. Such practices contrast with the view in Western societies, where a child's regular absence from the nuclear family or absence over a period of time is considered abnormal and indicative of a problem within the family.[899]

18.55 This contrast demonstrates one aspect of the conflict of values between Western and Aboriginal perspectives regarding children and families. Where there is a lack of understanding and lack of acceptance of extended Aboriginal family relations, the functioning of the extended family within an Aboriginal cultural context is seen as pathological or dysfunctional, and what is 'normal' Aboriginal practice signals a problem to many welfare workers.[900]

18.56 Many of the recommendations of *Bringing them home* dealt with providing appropriate mechanisms to record and recognise the experiences of individuals, families and communities affected by the forcible removal of Aboriginal children, and the need for a formal apology by government and church groups who were historically involved in the forcible removal of Aboriginal children from their families.

18.57 Some of the recommendations had specific relevance for the care and protection of Aboriginal children in NSW. These were about mental health, substance abuse, and parenting and well-being programs, addressing the social and economic disadvantages that underlie the contemporary removal of Aboriginal children and young persons, developing a legislative framework for self-determination, minimum standards of treatment for all Aboriginal children, and amendments to family law.

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[897] Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families,* 1997, p.400.

[898] ibid., p.401.

[899] ibid., p.392-393.

[900] ibid., p.392-393.

Responses to *Bringing them home*

18.58 In December 1999, in response to the report, the Commonwealth allocated funding of $63 million over four years for "practical assistance for those affected by the former practice of separating Aboriginal and Torres Strait Islander children from their families."[901] The funding included a number of history and archiving initiatives to assist Aboriginal people to record and protect their heritage. It also included funding for four program areas:

a. almost $6 million for further development of Indigenous family support and parenting program

b. $11.25 million to establish a national network of family link-up services to assist individuals

c. $16 million for 50 new counsellors to assist those affected by past policies and for those going through the reunion process

d. $17 million to expand the network of regional centres for emotional and social well-being, giving counsellors professional support and assistance.[902]

18.59 In addition, in 2001/02 the Commonwealth allocated $53.8 million over four years (to June 2006) to continue the Link-Up services, the education and training, and the counselling and parenting elements of the original package of measures. This brought the total expenditure to $116.65 million for the period to June 2006.[903]

18.60 In 2003, the Ministerial Council of Aboriginal and Torres Strait Islander Affairs evaluated the implementation of the recommendations of the *Bringing them home* report.

18.61 The 2003 evaluation noted that the overall response by all states and territories to issues regarding the contemporary separation of Aboriginal children and young persons from their families and communities focused almost exclusively on the impact of children's and young person's legislation and the requirement for compliance with Aboriginal Child Placement Principles. The evaluation stated:

> *The removal of children from Indigenous families for child protection reasons still occurs much more frequently than it does for non-Indigenous families. While action to implement the Indigenous Child Placement Principle has been taken in every jurisdiction, some children are still being placed in non-*

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[901] The Senate Standing Committee on Legal and Constitutional Affairs, *Stolen Generation Compensation Bill 2008,* June 2008.

[902] J Herron, Press Release, Bringing them home: Commonwealth Initiatives, 1997, parlinfoweb.aph.gov.au.

[903] Office for Aboriginal and Torres Strait Islander Health, "Evaluation of the Bringing them home report and Indigenous Mental Health Programs," Commonwealth of Australia, Canberra, 2007, p.2.

Indigenous care because of a shortage of Indigenous foster carers.[904]

18.62 A Commonwealth funded evaluation published in 2007 found that there were four main achievements of the programs funded in response to *Bringing them home.* First, the link-up and counselling programs had provided services to a large number of Aboriginal clients nationally. Secondly, along with the mental health and well-being programs, these programs had provided services to many Aboriginal people who are unlikely to have received services otherwise. Thirdly, the programs had generally provided services in a culturally appropriate manner. Finally, there were generally high levels of client satisfaction and positive outcomes for clients in relation to most programs, with the exception of a number of social and emotional well-being regional centre programs.

18.63 The evaluation also found four main limitations of the programs. It said there was a lack of focus on the first generation Stolen Generation members, and a significant and undesirable level of variation in the skills and qualifications of staff in many of the programs.[905] As a result of these and other factors, it was found that staff burnout and turnover were significant problems for the programs.[906] A lack of national consistency in service delivery, and limited geographical coverage were found to be the other limitations in all four program areas.[907]

Critiques of the Government response to *Bringing them home*

18.64 In a speech to mark the tenth anniversary of *Bringing them home* on 24 May 2007, Professor Lowitja O'Donoghue said:

Of the 54 recommendations made in the Bringing them home report, 35 have been ignored – that is two thirds.

Where there has been a response – for example, Link-Up services – the funding is drastically inadequate to meet the need.[908]

18.65 On Wednesday 13 February 2008, Prime Minister Kevin Rudd delivered a national apology to the Stolen Generations on behalf of the new Commonwealth Government sworn in on 3 December 2007. In a response to the Government's

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[904] Ministerial Council of Aboriginal and Torres Strait Islander Affairs, "Evaluation of Responses to Bringing Them Home Report: Final Report," December 2003, p.49.

[905] Office for Aboriginal and Torres Strait Islander Health, "Evaluation of the Bringing them home report and Indigenous Mental Health Programs," Commonwealth of Australia, Canberra, 2007, p.iii.

[906] ibid.

[907] ibid.

[908] L O'Donoghue, "Tenth Anniversary of the Bringing them home report," hosted by *Stolen Generations Alliance: Australians for Healing, Truth and Justice,* Great Hall, Parliament House, Canberra, Speech, 24 May 2007.

national apology to the Stolen Generations, Tom Calma, the Aboriginal and Torres Strait Islander Social Justice Commissioner with HREOC said:

> *The Stolen Generations have needs that have yet to be met, mainly due to under-funding of Link Ups and other support organisations. There remains a pressing need for specific assistance tailored to the particular circumstances of those forcibly removed from their families…*
>
> *And there are many recommendations of the 'Bringing them home' report that have not been implemented…*
>
> *In fact, there has been little attempt to even consider many of these recommendations at the federal or state level in recent years, or for them to be implemented systematically across all jurisdictions.*[909]

18.66 The Inquiry was unable to locate any comprehensive evaluation of the progress in implementing each of the recommendations of the *Bringing them home* report that would provide sufficient detail to assess these current claims that the majority of recommendations have not been implemented.

18.67 It did, however, seek information from DoCS about the actions it had taken in response to the report. DoCS advised that it had formally apologised as set out earlier in this chapter, sought and achieved legislative amendment in accordance with nine of the report's recommendations, including maintaining and granting access to records, self-determination and the Aboriginal Child Placement Principle. In addition, it has improved the availability of and access to records, developed a relative and kinship care policy, devised the Aboriginal Strategic Commitment set out later in this chapter, reviewed the Interagency Guidelines in light of the report and begun targeted recruitment of Aboriginal carers.

18.68 Further reference to actions by DoCS is made later in this chapter.

Ampe Akelyernemane Meke Mekarle "Little Children Are Sacred" the Northern Territory inquiry

18.69 In 2007, *Ampe Akelyernemane Meke Mekarle "Little Children Are Sacred"*, the Report of the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (the NT Inquiry), was provided to the Northern Territory Government. Chaired by Rex Wild QC and Patricia Anderson, the NT Inquiry was asked to examine, among other matters, the extent, nature and factors

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[909] T Calma, "Let the healing begin: Response to government to the national apology to the Stolen Generations" Speech delivered at Parliament House, Canberra, 13 February 2008 at www.hreoc.gov.au.

contributing to sexual abuse of Aboriginal children, with a particular focus on unreported incidents of such abuse, and to identify barriers and issues associated with the provision of effective responses to, and protection against, sexual abuse for Aboriginal children.[910]

18.70 In the report, the co-chairs note that:

> *Our terms of reference required us to enquire into the protection of Aboriginal children from sexual abuse. We will, no doubt, receive some criticism for appearing to stray well beyond that limited brief. However, we quickly became aware – as all the inquiries before us and the experts in the field already knew - that the incidence of child sexual abuse, whether in Aboriginal or so-called mainstream communities, is often directly related to other breakdowns in society. Put simply, the cumulative effects of poor health, alcohol, drug abuse, gambling, pornography, unemployment, poor education and housing and general disempowerment lead inexorably to family and other violence and then on to sexual abuse of men and women and, finally, of children.*[911]

18.71 As a result of this widening of the investigation from the limited brief given to the NT Inquiry, the report effectively provides a recent review of national and international work related to the protection of children of the Indigenous peoples of Australia, North America and New Zealand.

Findings of the NT Inquiry

18.72 The NT Inquiry found that the sexual assault of Aboriginal children was associated with the broader indicators of Aboriginal disadvantage.

18.73 Asserting that sexual assault is no more acceptable in Aboriginal culture than it is in European or mainstream society, the report summarised the underlying causes of the present situation in both urban and remote Aboriginal communities.

18.74 The excessive consumption of alcohol and other drugs, including petrol sniffing, was described as a major factor, and as either the cause or result of poverty, unemployment, lack of education, boredom and overcrowded and inadequate housing. Together these factors lead to excessive violence, and in the worst case to sexual abuse of children. The NT Inquiry was convinced that neglect led to physical and emotional abuse and thence, in the worst case, to sexual abuse.

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[910] Northern Territory Government, “Ampe Akelyernemane Meke Mekarle ‘Little Children are Sacred’”, *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.4.

[911] ibid., p.6.

18.75 The NT Inquiry found that the problems underlying the sexual abuse of Aboriginal children have been well documented and that many of the solutions were also well documented. While it found that there were no 'quick fixes,' and that a conservative estimate is that it would take at least 15 years (or one Aboriginal generation) to begin to make the necessary difference, it also found that there were some actions that can be taken relatively quickly and easily.

18.76 The inquiry's report noted that vast resources were allocated to crisis responses, when it seemed desirable to prevent the problem from occurring in the first place. Despite the expressed abhorrence of Aboriginal communities for the sexual abuse of children, the same communities appeared to find it difficult to accept responsibility for the behaviour of those community members who committed such abuse. The NT Inquiry found that attitude change was required.

18.77 Education was a key strategy in changing the problem attitudes and in rehabilitating Aboriginal communities.

> *We are utterly convinced that education (that properly addresses the needs of the local community) provides the path to success. We have been dismayed at the miserable school attendance rates for Aboriginal children and the apparent complacency here (and elsewhere in Australia) with that situation.*[912]

18.78 Along with education, the report noted that addressing alcoholism was a major priority. The effect of alcoholism on the Aboriginal community was seen as so significant, that it was useless to try to implement any other proposals unless alcoholism was addressed.

Recommendations from the NT Inquiry

18.79 All the recommendations of the report of the NT Inquiry are seated within a context of working in partnership with Aboriginal people, families and communities. Within the 97 recommendations a number have wider applicability than the Northern Territory.

18.80 The recommendations included a call for the Commonwealth to work with the Northern Territory to "develop long term funding programs that do not depend upon election cycles nor are limited by short-term outcomes or overly bureaucratic reporting conditions and strictures."[913]

18.81 A whole of government approach to child sexual abuse, and enhanced information sharing between agencies, was recommended. Consultation with Aboriginal people and communities regarding investigations and decision

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[912] ibid., p.18.
[913] ibid., p.22.

making about Aboriginal children was specifically addressed, and consultation with Aboriginal communities in the development of strategies and programs was also a feature.

18.82 The report described gaps in the interagency response to sexual assault, and noted that regional and remote services are not adequately resourced to meet the needs, and that victims of sexual assault require a coordinated and integrated response from investigative and support agencies.[914]

18.83 For statutory child protection services the recommendations covered the need for greater government investment in child protection system reform and in the recruitment, training and retention of a greater number of child protection workers, greater access to cultural advice and expertise for child protection workers, and more strategic, planned investment in local community workforces.

18.84 The report found that while hospitals may contribute to the forensic investigation of child sexual abuse and the treatment of injuries and infections, it is primary health care services that play the largest role in the response to child sexual abuse.[915] Particular reference was made to: mental health; the implications and impacts of sexually transmitted infections in young persons; the development of comprehensive child and adolescent mental health services; and the provision of increased services for those children whose behaviour indicates significant trauma and distress resulting from abuse.

18.85 The development or expansion of health services such as maternal and child health home visitation, increased services for prenatal care and children aged 0-5 years and their families, increased access to health and welfare services through primary health care centres as ‘service hubs’, and the collaborative development and implementation with Aboriginal communities of services and programs to address ‘inter-generational’ trauma and to improve the emotional and mental well-being of community members, was also part of the preventive and early intervention response recommended.

18.86 For investigative and justice agencies, themes relevant to most states including NSW included:

a. better integration of police and statutory child protection

b. development of a repository of specialist knowledge and skills in interviewing child victims and Aboriginal child victims

c. active recruitment of Aboriginal police officers and associated roles with an emphasis on recruitment of female staff

d. more effective consultation with Aboriginal communities

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[914] ibid., pp 104-105.

[915] ibid., p.106.

e. improved knowledge and skills of staff through better education on child abuse and neglect and improved procedures for reporting abuse and for offering support to people affected by abuse

f. consideration of the needs of possible child victims when determining bail where a sexual offence is alleged to have been committed against a child

g. provision of more sex offender rehabilitation programs, including culturally appropriate community based programs for convicted offenders deemed suitable for such programs, as well as for those at risk of offending

h. provision of youth specific culturally appropriate rehabilitation programs for juvenile sex offenders in detention, on parole or subject to community based orders.

18.87 Family support services were recommended by the report as an integral aspect of prevention. The need for specific services and groups for men to address their counselling, healing, education and treatment needs and the provision of short term accommodation in crisis was addressed, including a recommendation that the government actively support Aboriginal men to discuss and address child sexual abuse and other violence in communities.[916]

18.88 The key role of education was addressed in two parts: school education and community education and awareness.

18.89 The suggested school education strategies included:

a. ensuring that all children of school age attend school on a daily basis in accordance with the government's responsibility to provide compulsory education for all school age children, to be supported by the employment of additional home school liaison officers and school counsellors

b. ensuring that all three year olds and above attend a preschool program

c. ensuring that every child attends a full time transition to school program prior to commencing school.

18.90 There were also strategies suggested to reform the education system to provide Aboriginal students with the same outcomes as other students, within a culturally appropriate context. Fostering ownership of the education system by local communities through strategies such as a universal meals program for Aboriginal students with parents to provide financial and in-kind support, and utilisation of schools after hours for purposes such as community centres, supervised homework rooms and adult education venues, were also recommended.

18.91 The report urged that consideration be given to the provision of additional residential schools for Aboriginal students, designed to be located near their country, that would enable maintenance of family and cultural ties.

[916] ibid., pp.26-28.

18.92 The report proposed a community and parent education campaign on the value of schooling that would encourage community and parental commitment to sending children to school, and also proposed a major attitude change and awareness raising campaign.

18.93 Several recommendations in the report specifically focused on addressing the threat posed by alcohol abuse and intoxication in Aboriginal families and communities. The recommended approach included a policy framework to guide actions to reduce overall alcohol consumption and intoxication. Other strategies provided for reduced access to takeaway liquor in the Northern Territory, and reforms to licensing and liquor legislation to increase the consideration of social impacts when granting or refusing liquor licences.

18.94 Media and education campaigns were also part of the recommended response to alcoholism, pornography and gambling.

18.95 Implicit in the recommendations about the role of communities was the responsibility of government to support and resource Aboriginal communities actively to develop community based and community owned strategies that fit within their cultural context to meet the needs of children.

18.96 Finally, the recommendations about compulsory cross cultural practice training for government workers addressed the lack of understanding of Aboriginal perspectives and the conflict of values between Western and Aboriginal perspectives regarding children and families, which was identified as a root cause of the failure of the welfare system to address the needs of Aboriginal children in the *Bringing them home* report and other material reviewed by the NT Inquiry.

18.97 All the recommendations made in the report were intended to be implemented according to nine ‘rules of engagement’ or principles. The report provided detailed interpretation and explanation of each principle to assist service providers. The principles may be summarised as:

a. improving government service provision to Aboriginal people
b. taking language and cultural ‘world view’ seriously
c. ensuring effective and ongoing consultation and engagement
d. involving a local focus and recognition of diversity
e. encouraging community based and community owned initiatives
f. encouraging recognition and respect of Aboriginal law and empowerment and respect of Aboriginal people
g. ensuring balanced gender and family, social or skin group representation
h. providing adequate and ongoing support and resources
i. providing ongoing monitoring and evaluation.

Responses to the NT Inquiry report

18.98 On 21 June 2007, the Australian Government announced a national emergency response to protect Aboriginal children in the Northern Territory from sexual abuse and family violence. This response became known as the 'Northern Territory intervention' or Northern Territory Emergency Response (NTER).

18.99 The NTER was originally designed with three phases:

a. stabilisation–the introduction of emergency measures to protect children and make communities safe (year one)

b. normalisation of services and infrastructure (years two to five)

c. longer term support based on the same norms and choices that other Australians enjoy (year five onward).[917]

Progress on the NTER

18.100 On 21 June 2008, the NTER Taskforce final report to Government was released (the Taskforce Report). A further update was posted on the FaHCSIA website documenting progress to 22 October 2008.[918]

18.101 The October operational update noted that income management measures were in place in 70 communities, associated outstations and town camp regions with a total of 15,554 people being subject to income management as at 22 October 2008. Income management provisions involved half of all income support and family assistance payments being held back to be spent only on food, school, nutrition, rent and other essential items. The measures were applied to all members of a target community who received welfare payments.

18.102 Additional positions had been created as part of employment reform measures as well as police deployed and more custodial facilities put in place. New liquor laws have been in force since 15 September 2007, with the intent to ban the sale, possession, transportation and consumption of alcohol on Aboriginal land and to monitor takeaway sales across the Territory. Additional activities included interventions to help address the need for alcohol and other drug withdrawal, treatment and rehabilitation services. Changes to Territory legislation to extend 'dry' areas and to support communities in the development of Alcohol Management Plans and permit systems were also noted.

18.103 The supply and possession of pornographic material have been banned in prescribed areas since 14 September 2007.

18.104 The activity to enhance education reportedly included the provision of funding to the Northern Territory Government to recruit an extra 200 teachers over four

[917] Northern Territory Emergency Response Taskforce, "Final Report to Government," June 2008, www.facsia.gov.au.

[918] ibid., p.8.

years and to establish additional classrooms. Provision of breakfast and lunch to school aged children through the School Nutrition Program has been put in place in 68 communities as at 22 October 2008.

18.105 The supporting families element of NTER was reported to include the recruitment of child protection and community workers. Health checks have been carried out with follow up specialist treatment where necessary and new property and tenancy management arrangements are being introduced for public housing.

18.106 The Taskforce Report acknowledged the critical role of both early childhood intervention and education in achieving better outcomes for Aboriginal people. It supported a range of investments, from greater support for pregnant women, early parenting skills development and preschool for all four year olds, through to ensuring that there is a primary school in each community, compulsory parental contribution to school nutrition programs, universal access to secondary education for all secondary school aged students, and provision of adult literacy and numeracy programs in remote communities.

18.107 The Taskforce Report noted the positive impact of income management strategies for women with children, and the protection it provided from ‘humbugging’ or being coerced into giving money to others.

18.108 In relation to alcohol, the Taskforce Report stated supported the expansion of rehabilitation services, and recommended:

> *Consideration should be given to consulting with each community to replace alcohol bans with community-specific Alcohol Management Plans.*[919]

Report of the NTER Review Board

18.109 On 13 October 2008, the NTER Review Board, which was appointed by the Commonwealth Government to conduct an independent review of the first 12 months of the NTER to assess its progress in improving the safety and well-being of children and in laying the basis for a sustainable and better future for residents of remote communities in the Northern Territory, reported.[920]

18.110 The report however also described a mixed response to NTER, in particular, a “deep belief that the measures introduced by the Australian Government under the NTER were a collective imposition based on race.”[921] It referred to a “strong sense of injustice that Aboriginal people and their culture have been seen as exclusively responsible for problems within their communities.”[922] The report

[919] ibid., p.21.

[920] Report of the Northern Territory Emergency Response Review Board, October 2008. www.nterreview.gov.au.

[921] ibid., p.9.

[922] ibid.

found that the effectiveness of the intervention was diminished through its failure to engage constructively with the Aboriginal people.

18.111 The report identified gains and noted that there was support for the additional police stations, and the measures designed to reduce alcohol related violence, to increase the quality and availability of housing and to advance early learning and education.

18.112 It recommended that while the benefits of income management were being increasingly experienced, it should be imposed only as a part of child protection measures.

18.113 It recommended that laws prohibiting the possession and transportation of alcohol on prescribed lands be maintained and that alcohol supply, demand and harm reduction strategies be implemented and comprehensive alcohol management plans finalised. It was recommended that illicit drug use should also be addressed.

18.114 Recommendations in relation to capacity building were also made as well as various other recommendations of particular relevance to conditions specific to the Northern Territory.

The Inquiry's experience

18.115 The Inquiry travelled throughout NSW and visited a number of towns either with, or located near, significant Aboriginal communities, including Bourke, Coonamble, Broken Hill, Wagga Wagga, Dubbo, Lismore, Moree, Inverell, Ballina and Nowra. The Inquiry visited metropolitan CSCs and held a Public Forum on issues facing Aboriginal communities. It also visited Toomelah and Boggabilla and held meetings with the local communities and with the agencies working with those communities. The Inquiry met with a number of representatives of Aboriginal organisations including the AbSec, the Tharawal Aboriginal Corporation, the Aboriginal Legal Service and the Victorian Aboriginal Child Care Agency Cooperative. SNAICC made valuable contributions to the Public Forum. In addition, the Inquiry met with the Ministerial Advisory Panel on Aboriginal child sexual assault and Aboriginal Affairs.

18.116 During these visits and meetings, the Inquiry heard similar stories to those recounted by the reports referred to above. Its experience in relation to the Toomelah and Boggabilla communities is set out in more detail in Chapter 19 of this report.

18.117 The Inquiry was particularly impressed by staff of the Ourgunya Women's Safehouse in Brewarrina, a service for Aboriginal women and children with seven beds in the Western Region. Similar to many other rural areas, the Inquiry was informed of insufficient services in this area and of relationships of

variable quality between DoCS workers and Aboriginal communities and workers.

18.118 Positive messages were also provided. In the Southern Region, an Aboriginal lawyer from a community legal centre said:

> *There is a negative perception of DoCS within the Aboriginal community, obviously, given the history of the Stolen Generation, and there is much fear and mistrust of DoCS. Despite this, I have seen some improvement. I think this is a flow on from the community engagement that DoCS is doing. Also, their efforts in communicating with the community about the early intervention programs and their employment of Aboriginal people as liaison officers, et cetera, have gone a long way towards bringing about a slow change in the perception of DoCS. The perception is still there, most community members would agree that DoCS is seen as a place that takes children away, but that is slowly changing and I believe that people are starting to see that DoCS can also provide support for families in need.*[923]

18.119 Summing up working with DoCS staff, one Brighter Futures Aboriginal program manager informed the Inquiry:

> *Some are excellent. It's like every department … you get the odd one that doesn't know anything about Aboriginal issues.*[924]

18.120 Improvements in relationships with DoCS were also noted in the Northern Region, where the Inquiry was advised that since the commencement of the Brighter Futures program, Aboriginal families had started to specifically request DoCS involvement in preference to that of the Lead Agency.

18.121 While still concerned at the lack of Aboriginal agency representation in the evaluation of expressions of interest for OOHC service provision, in its final submission to the Inquiry, AbSec noted that there had been a "significant improvement in the Department's willingness to engage at a meaningful level with AbSec and its member agencies" resulting in the funding of, and participation in, specific projects and in regular meetings between the agencies.[925]

Work being done by the Commonwealth

18.122 The Commonwealth Government has specific initiatives responding to the needs of Aboriginal children, including their over representation in the child

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[923] Transcript: Public Forum, Nowra, 13 March 2008, p.6.

[924] Transcript: Inquiry meeting with representatives of Tharawal Aboriginal Corporation, 8 March 2008, p.20.

[925] Submission: Aboriginal Child, Family & Community Care State Secretariat, 10 October 2008, p.2.

protection system. The Federal ALP policy released before the 2007 Federal election *New Directions: An equal start in life for Indigenous children* makes the following commitment:

> *Within a generation, Indigenous and non-Indigenous children should be able to expect the same healthy life outcomes.*[926]

18.123 The Commonwealth Government has a responsibility for funding Aboriginal-specific primary health services, and it also funds Aboriginal child health checks under the Medicare system. The *New Directions* policy made a commitment of $112 million over four years to child and maternal health services, including enhancements to health care for Aboriginal mothers and children, $37.4 million for sustained nurse-led home visiting, and additional capital funding for accommodation facilities for Aboriginal women who need to leave their communities to give birth.

18.124 The policy also includes commitments to parent-child services to improve parenting skills, as well as the development, learning and well-being of Aboriginal children, and to the provision of 15 hours per week of early learning programs for Aboriginal four year olds, and of funds for further implementation of the Australian Early Development Index, and for intensive literacy and numeracy programs.

18.125 Finally, the policy proposes the establishment, where practicable, of 'Indigenous Child and Family hubs' to co-locate parent-child services to "allow greater continuity of care and attention to the individual needs of Indigenous children."

18.126 In the May 2008 discussion paper *Australia's Children: safe and well,* the Commonwealth Government described the establishment in December 2007 of a specific Working Group on Indigenous Reform under the authority of COAG, with a work program that includes protection from violence for Aboriginal parents and children, early childhood development interventions, safe home environment, access to primary health services, and supporting school attendance.[927]

18.127 The paper listed existing government strategies including the review of the NTER and the National Indigenous Violence and Child Abuse Intelligence Task Force, jointly funded by the Commonwealth and the States and Territories with a focus on understanding violence, child abuse, substance abuse, pornography and fraud in Aboriginal communities.

18.128 Strategies proposed in the discussion paper included the development of a specific set of principles and approaches to guide child protection interventions with Aboriginal children, and the development of specific service models for the

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[926] Australian Labor Party Policy, "New Directions: An equal start in life for Indigenous children," www.alp.org.au, p.11.

[927] Department of Families, Housing, Community Services and Indigenous Affairs, *Australia's Children: safe and well, Discussion Paper*, 2008, p.24.

urban, rural and remote protection of Aboriginal children. The discussion paper suggests a strategy to improve the responsiveness of mainstream interventions to the needs of Aboriginal children, and a specific action to support compliance with the Aboriginal Child Placement Principle. An Aboriginal child protection workforce strategy is also proposed.

18.129 The 2008/09 Commonwealth Government budget included additional Aboriginal specific strategies, such as the provision of:

a. $1.6 billion over four years for remote Aboriginal housing, to be delivered through bilateral agreements with the States and Territories

b. $19 million over three years to strengthen the Aboriginal health workforce, which was additional to $49.3 million over four years allocated as part of the COAG commitment to address drug and alcohol use in Aboriginal communities

c. $323.8 million for 2008/09 for the NTER mentioned earlier in this chapter

d. $1.7 million over two years to contribute to evidence based policy.[928]

18.130 Some Commonwealth Government strategies include Aboriginal specific aspects. For example, FaHCSIA reported that the Indigenous Children's Program, part of the Stronger Families and Communities Strategy, funded 33 services in Australia at a cost of $5.72 million which expired on 30 June 2008. The implementation of the Australian Early Development Index now includes an Aboriginal specific version of the Index.

18.131 The NSW and Commonwealth Governments are signatories to the bilateral agreement: Framework Document Overarching Agreement on Aboriginal Affairs between the Commonwealth of Australia and the State of NSW 2005-2010, which includes an agreement on working together through *Two Ways Together* (discussed later in this chapter) and the development of Shared Responsibility Agreements. The Murdi Paaki COAG Trial which commenced in 2002 was implemented under this Agreement.

18.132 Shared Responsibility Agreements are voluntary agreements between governments and Aboriginal communities developed where Aboriginal people and communities decide that they want to address specific priorities. These agreements set out what families, communities, governments and other partners will contribute to address the priorities and to achieve the outcomes in the agreement.[929]

18.133 The 2006 evaluation of the COAG Murdi Paaki trial by Urbis Keys Young stated that people consulted in the course of the evaluation raised issues regarding Shared Responsibility Agreements, and gave the following example:

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[928] Commonwealth Budget Statement: Closing the Gap between Indigenous and non-Indigenous Australians, May 2008. www.ato.gov.au/budget/2008-09.

[929] Framework Document Overarching Agreement on Aboriginal Affairs between the Commonwealth of Australia and the State of NSW 2005-2010: www.daa.nsw.gov.au.

While the Australian Government has made it very clear that SRAs have no relevance to core government responsibilities and services in health, education and training, law enforcement, employment services and the like, there can in practice be disagreement about what matters can and cannot be appropriately included in an SRA.[930]

COAG Murdi Paaki Trial

18.134 The Murdi Paaki COAG Trial is one of eight COAG trials that were established in 2002 and referred to as the 'Shared Responsibility Trials'. The purpose of the trials was twofold. First, for governments to work better together at all levels and across all agencies. Secondly, for Aboriginal communities and governments to work in partnership to improve life outcomes and to build the capacity of people in those communities to manage their own affairs.[931]

18.135 In the Murdi Paaki region, which covers sixteen communities in the far western district of NSW, it was reported that there were six regional Shared Responsibility Agreements signed by the Murdi Paaki Regional Assembly (or its predecessor, the Regional Council) and 11 local agreements with six of the local communities at the time of the evaluation, with further local agreements under negotiation.[932]

18.136 The evaluation stated that among stakeholders familiar with the COAG trials, Murdi Paaki was seen as the most advanced trial in terms of community capacity and governance. Further, the findings of the evaluation were positive with regard to the strong commitment to the trial, demonstrated by the key government departments involved, and with regard to the relationships those agencies had developed in the communities. The evaluation also found "the governance capacity of communities has improved, and many communities appear better able to articulate their priorities to government in constructive fashion."[933]

18.137 The evaluation stated that DoCS was noted positively by stakeholders among the agencies and perceived as having embraced the trial.[934]

18.138 Bromfield and Holzer found that the separate funding of individual services by the Commonwealth and State Governments provided some examples of local collaboration which included Aboriginal health services, Aboriginal targeted programs and family violence programs.[935] The Inquiry notes that the Aboriginal Maternal and Infant Health Strategy (AMIHS) in NSW has incorporated the

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[930] Urbis Keys Young, *Evaluation of the Murdi Paaki COAG Trial Final Report,* 2006, p.17.

[931] Morgan Disney and Associates, *Synopsis Review of the COAG Trial Evaluations*, November 2006, p.12.

[932] Urbis Keys Young, *Evaluation of the Murdi Paaki COAG Trial Final Report*, 2006, p.18.

[933] ibid., p.ii.

[934] ibid., p.27.

[935] L Bromfield and P Holzer, "A national approach for child protection: Project report," *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008, Melbourne. p.50.

Commonwealth funded Alternative Birthing Services Program sites, provided additional funding to those services to enhance them to the level of the State funded programs and aligned the performance indicators to produce a single successful strategy now being implemented statewide.

Work being done in NSW

18.139 NSW is addressing the disadvantage experienced by Aboriginal people in a number of ways. The NSW State Plan includes an Aboriginal specific priority which is to improve health, education and social outcomes for Aboriginal people (priority F1). In addition, *Two Ways Together* is the NSW Government 10 year whole of government Aboriginal Affairs Plan. The Inquiry notes that the Standing Committee on Social Issues on Overcoming Indigenous Disadvantage will consider the issue of responsibility for performance indicators and delivering priorities under these two plans in its final report.[936]

18.140 In 2008 an indicator's report was published on *Two Ways Together* which showed a wide gap in outcomes for Aboriginal people compared with the general population of NSW, and acknowledged that there was a need to develop more comprehensive information about many of the services provided for Aboriginal people. It noted that many of the initiatives aimed at reducing Aboriginal disadvantage were targeted at specific locations, in recognition of the need to avoid the 'one size fits all' approach. The report noted that data quality remained an issue.[937]

18.141 The Aboriginal Family Health strategy and the extension of New Street, an adolescent early intervention program for adolescents who display sexually abusive behaviours to Aboriginal adolescents are discussed in Chapter 7. Reference is made to the Education Centre against Violence initiative *Weaving the Net* which has been developed for Aboriginal communities in Chapter 8.

The NSW Aboriginal Child Sexual Assault Taskforce report

18.142 The 2006 report of the NSW Aboriginal Child Sexual Assault Taskforce (ACSAT) *Breaking the Silence: Creating the Future. Addressing child sexual assault in Aboriginal communities in NSW*[938] was among the reports considered by the NT Inquiry, and the broad findings of both reports are similar. The ACSAT report found that the sexual assault of Aboriginal children was widespread and under reported, that the incidence of sexual abuse and other

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[936] Overcoming Indigenous Disadvantage in NSW, Interim Report of the Standing Committee on Social Issues, June 2008, p.xix. www.parliament.nsw.gov.au/socialissues.

[937] Department of Aboriginal Affairs, *Two Ways Together Report on Indicators 2007*, p.1. www.daa.nsw.gov.au.

[938] NSW Aboriginal Child Sexual Assault Taskforce, "Breaking the Silence: Creating the Future, Addressing child sexual assault in Aboriginal communities in NSW," *Attorney General's Department of NSW,* Sydney, 2006.

forms of child abuse and neglect in Aboriginal communities was associated with the broader indicators of Aboriginal disadvantage, and that they were symptoms of a breakdown of Aboriginal culture and society.

18.143 Similar to previous reports and the report of the NT Inquiry, ACSAT identified a number of factors that influenced the incidence of child sexual assault. These included:

> *Substance abuse; social and economic disadvantage; exposure to pornography and a sexualised society; the 'normalisation' of violence (or intergenerational cycle of violence); the presence of family violence; unresolved trauma and grief; breakdown of family and community structures; lack of community engagement with the issue; lack of support for community-driven solutions; and inadequate responses from service providers.*[939]

18.144 ACSAT found that child sexual assault was not well understood in Aboriginal communities, and was therefore often undetected. While the research specifically considering a link between child sexual assault and family violence required further development, the report noted that the work which had been done, suggested that the presence of family violence in Aboriginal communities had an influence on the incidence of child sexual assault.

18.145 ACSAT found that Commonwealth and State Government responses to child sexual abuse in Aboriginal communities lacked coordination and suffered from limited government leadership. It found that child sexual assault in Aboriginal communities was not explicitly addressed in *Two Ways Together* and that service responses to child sexual assault were not being provided in a holistic way.

18.146 In relation to data collection across NSW government agencies that impacted on the data used to plan responses to child sexual assault in Aboriginal communities, it found inconsistent recording of Aboriginality, the use of different key definitions across agencies, and the use of different data collection periods, making data correlation and comparison difficult.

18.147 ACSAT made specific findings about DoCS. These included the following:

a. While there was some understanding of the pressures on DoCS and some communities expressed the view that DoCS workers in their area were doing a good job, many Aboriginal people continued to fear and mistrust DoCS as a consequence of past practices towards Aboriginal people. This was compounded by a lack of understanding of the supportive role DoCS could take. Fear and mistrust increased every time DoCS responded inappropriately or inconsistently to a report of child sexual assault, failed to keep families informed or failed to make appropriate referrals for support.

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[939] ibid., p.4.

b. There were few stable OOHC placements available for Aboriginal children and young persons. Instances where children were not safe in out-of-home kinship care were cited, as was the need to undertake thorough assessments prior to placing a child in an OOHC placement, and to continue to monitor children's safety. ACSAT also found that DoCS needed to provide adequate financial and practical supports to ensure stability in kinship care placements.

c. While DoCS had made attempts to employ more Aboriginal workers, recruitment and retention of Aboriginal staff was still hampered because the Aboriginal people they did employ felt overwhelmed, overworked and not well supported.

d. Young persons aged 16 – 18 years were falling through a service gap, and many communities were not aware that DoCS was supposed to provide services to this group.[940]

18.148 The need for an improved understanding of Aboriginal culture and improved engagement with Aboriginal communities was identified for staff in DoCS, Police, the DPP Witness Assistance Service, and the Judiciary. ACSAT found that a number of agencies, including Police, the DPP and Education should employ additional Aboriginal staff.

18.149 It also found that more culturally specific services and programs needed to be developed and implemented across Corrective Services and Juvenile Justice. These agencies were identified as having an important role in supporting the healing of survivors of child sexual assault, and in preventing further assaults, *inter alia*, by identifying and offering culturally appropriate and effective programs for those people in contact with their services who displayed sexually offending behaviour.

18.150 Overall, ACSAT reported that Aboriginal communities were positive about the quality of services provided by Health. However, ACSAT also found that there were barriers to effective service provision for Aboriginal people who had experienced child sexual assault. It was found that Aboriginal people were often confused about the roles of different health workers, and were frequently not aware of sexual assault services or of what they could provide. Some of the services provided by Health, such as child sexual assault telephone counselling, were reported to be culturally inappropriate.

18.151 Other health services, such as drug and alcohol services, it was suggested did not respond adequately to the likelihood that their clients may have experienced child sexual assault. ACSAT found that: there were not enough forensic medical services available, especially in rural and regional NSW; there were not enough counsellors or support workers to respond to Aboriginal communities; referral requirements and delays reduced access to services; and it was not clear what types of counselling models worked well for Aboriginal people.

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[940] ibid., pp.6-7.

18.152 Communities reported to ACSAT that many Aboriginal people had difficulty accessing JIRT, and did not feel supported by JIRT. Co-location of Police and DoCS together was identified as an effective model, and the suggestion was made that a Health worker should also be co-located with JIRT officers. It found that Health should be more involved in the JIRT model, and that where the transport of Aboriginal people was required, they were most comfortable with it being provided by Health.[941]

18.153 JIRT interviewing and communication styles were not seen to accommodate Aboriginal cultural practices, and were ineffective for Aboriginal children and young persons. Families who had had involvement with JIRT reported that a lack of information about the JIRT investigation, and the absence of Aboriginal people as staff or community partners in JIRT, made it a difficult experience.

18.154 ACSAT found that an incomplete understanding of child sexual assault, and a lack of understanding of the dynamics and impacts of child sexual assault in Aboriginal communities, impacted on the quality of services provided in a number of contexts. These included support provided by the Witness Assistance Service, responses provided by Juvenile Justice, and education and protective behaviours training in schools.

18.155 The lack of community awareness of available services for families who had experienced child sexual assault was not found to be limited to Health or DoCS services. ACSAT also found that Aboriginal communities were often not aware of resources in the broader service system such as emergency and alternative accommodation for families in crisis available through Housing, counselling and compensation available through Victims Services, for which Attorney General's has responsibility.

18.156 ACSAT examined the response of NGOs. NGO services were well perceived by Aboriginal people and for many Aboriginal people it was the only service type of service they would use. However, many NGOs reported feeling unsupported by government agencies, insufficiently funded to meet community needs for the services they provided, and hampered by the prevalence of one-off project funding which tended to lead to ad hoc service delivery. ACSAT expressed concern about the access of NGO staff to training, about the dynamics of child sexual assault in Aboriginal communities, and about NGO staff awareness of their reporting obligations.

18.157 Alternative models for addressing child sexual assault considered by ACSAT included specialist sexual offences courts in South Africa, a Queensland local community model known as the Cherbourg Critical Incident Group and the Community Holistic Circle Healing Model from Hollow Water in Canada. From its examination of alternative models, ACSAT concluded that further research was required.

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[941] ibid., p.9.

18.158 ACSAT considered the discussion of alternative models to be introductory rather than definitive, and commented that the complexity of theories and principles underpinning the alternative models, and the appropriateness of the various responses to child sexual assault in Aboriginal communities required careful consideration. It suggested that research and development of a new model for responding to child sexual assault in Aboriginal communities needed to occur, at the same time as the recommendations of the report were implemented.

The Interagency Plan

18.159 In January 2007 the NSW Government released its public response to the ACSAT report, the *New South Wales Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011*[942] (the Interagency Plan). The Interagency Plan contains 88 actions, focused on four strategic directions: law enforcement; child protection; prevention and early intervention; and community leadership. Several actions are to be implemented statewide, while others are to occur in specific locations. The Interagency Plan is linked to existing policy frameworks such as *Two Ways Together* and the NSW State Plan.

18.160 There are nine lead agencies involved in implementing this plan: Aboriginal Affairs, Attorney General's, DoCS, Corrective Services, Education, Health, Police, Juvenile Justice and Premier and Cabinet.

18.161 The Inquiry reviewed the Interagency Plan and the ACSAT report. It found that more than one third of the 119 recommendations of the ACSAT report were not addressed by the Interagency Plan.[943] It is noted that the NSW Government did not accept all recommendations which partially accounts for this figure. For example, the role of the Ombudsman as, in effect, auditor of its implementation was not accepted. This matter is discussed later in this chapter.

18.162 Those not addressed included some important recommendations or parts of recommendations for child protection services:

a. Recommendation 11: establishing an Aboriginal child sexual assault coordination unit

b. Recommendation 17: concerning the way in which the government provides funding for regional and local initiatives to address child sexual assault issues

c. Recommendation 21: proposing a formal review by the Ombudsman of how the ACSAT report recommendations are implemented

d. Recommendation 26: providing more prevention and early intervention services

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[942] NSW Government, *New South Wales Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011*.

[943] Examples are actions 7, 12.1, 25, 27, 33, 51, 56, 58, 64, 66, 72, 77, 80, 81, 82, 88.

e. Recommendation 34a: relating to the conduct of annual reviews of all DoCS supported placements for Aboriginal children.

f. Recommendation 65: relating to the development of community based offender treatment programs for adults, that can be available for self referral and are not dependant for access on involvement in the criminal justice system.

Adequate funding?

18.163 The release of the Interagency Plan was not accompanied by any additional funding.

18.164 The Inquiry understands that a funding proposal for the Interagency Plan was submitted in late 2006, however, the relevant committee of Cabinet determined that all initiatives would need to be funded within existing agency resources.

18.165 However, it appears from a response from the Minister for Aboriginal Affairs to a question asked of him in the Budget Estimates Committee on 13 October 2008, that the Interagency Plan is costed at $52.9 million and, of that, $26.9 million was new money allocated in last year's budget.[944]

18.166 The Inquiry understands that the 2008/09 budget allocated $22.9 million over four years for the Safe Families Program, which aims to tackle the incidence and consequences of child sexual abuse in Orana Far West. This is to be achieved by providing community engagement, child protection, early intervention and prevention, law enforcement and individual and family support services.

18.167 The Inquiry agrees with the comments of Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, HREOC:

> *While the plan is a step in the right direction on the part of the New South Wales Government, it also highlights the limitations of addressing such an issue of such scale and seriousness without the commensurate level of responses and resources.*[945]

18.168 Various agencies also commented to the Inquiry on the resource implications of some of the actions required under the Interagency Plan. Attorney General's noted that there had been no funds provided to recruit additional Witness Assistance Service officers. The cost of training was noted as a barrier for agencies seeking to train more staff to Certificate IV Aboriginal Cultural Education Program. Health noted that the statewide expansion of the AMIHS was to be met from within existing resources, and noted that the lack of additional funding was a barrier to implementation of the forensic services review. Many of the strategies implemented by Police, Juvenile Justice and

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[944] The Inquiry understands that $22.9 million rather than $26.9 million has been allocated.

[945] Speech by Tom Calma, NAIDOC Week, NSW Department of Premier and Cabinet, 10 July 2008.

Corrective Services are also dependent on funding from within existing resources.

18.169 There were some references to funded actions, such as Education's Kids Excel and Youth Excel programs and the installation by Police of digital recording equipment for JIRT units, however the funds referred to do not appear connected to the Interagency Plan. For example, the funds for Education appear to have been announced in 2005, prior to the Interagency Plan.

18.170 The recently released Interim report by the NSW Standing Committee on Social Issues, *Overcoming Indigenous disadvantage in NSW,* states that government funding allocated to reduce the incidence of child sexual assault has been inadequate, that the indicators to monitor the programs and implementation of the Interagency Plan have not yet been developed and that the reporting processes vague at best.[946]

Progress

18.171 In January 2008 the Inquiry requested that Aboriginal Affairs provide a progress report on implementation of the Interagency Plan. When it proved difficult to access a coordinated analysis of progress, the Inquiry requested copies of the reports provided to Aboriginal Affairs by each agency. These were provided up to October 2007.

18.172 Further, in March 2008, the Inquiry requested that all agencies involved provide a progress report on their implementation of the Interagency Plan, along with the milestones and performance measures and information about any funding required, sought and received for implementation.

18.173 The Inquiry has reviewed the draft milestones and performance measures proposed for the actions of the Interagency Plan. In the majority of cases the performance measures proposed show a direct link to the action, and logically would indicate whether the action has been successfully achieved.

18.174 However, it appears to the Inquiry that the performance indicators are often designed to measure a process (such as a review of legislation, revision of policy or procedures, development of an education package or of a plan for delivery of annual training, or preparation of a research paper or options paper). This means that they measure how well the process has been undertaken, rather than giving a measure of a tangible or practical outcomes for Aboriginal children and young persons or their families. Even where the action relates to a specific service, such as Intensive Family Based Services, current performance indicators are about the completion of a service evaluation, rather than whether there has been a greater availability of services or any improvement in outcomes for Aboriginal children and young persons.

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[946] Overcoming Indigenous Disadvantage in NSW, Interim Report of the Standing Committee on Social Issues, June 2008, p.132. www.parliament.nsw.gov.au/socialissues.

18.175 With regard to Action 33, which deals with the application of the Aboriginal Child Placement Principles, DoCS has set performance measures such as “per cent of placements meeting Aboriginal Child Placement Principle requirements.” This matter has been addressed at some length in Chapter 11. In short, it is likely that the data are not of sufficient quality to adequately measure compliance.

18.176 The ACSAT report found that the problems facing Aboriginal communities in reducing child abuse and neglect and family violence required coordination of services, more community awareness, better cultural awareness for agency staff, changes in policy and more research to inform practice. The Interagency Plan includes actions to address these needs.

18.177 However, the ACSAT report also found that Aboriginal people needed more prevention and early intervention services, more services to respond to child sexual abuse, more services to effectively work with adults and young persons who abused children, and more support and counselling for people who report abuse and proceed to court. The Interagency Plan has limited actions to meet these needs.

18.178 The Interagency Plan has an emphasis on the development of agency capacity to:

a. improve staff awareness of Aboriginal culture and increase their capacity to work in a culturally respectful way with Aboriginal people

b. increase the proportion of the workforce in human services and justice agencies that identify as Aboriginal

c. increase awareness of the incidence and dynamics of child sexual assault, and the flags or markers that can assist in recognising that child sexual assault is occurring, with an emphasis on recognition of risk to Aboriginal children.

18.179 At this stage, the human services and justice agencies involved in implementation have reported progress in a number of areas including the development of policies, training packages and programs and negotiations/strategies to improve the recruitment and retention of Aboriginal staff. A number of reviews have been conducted, which contribute a further raft of recommendations to the activities outlined in the Interagency Plan. The reviews that have contributed to implementation of this plan include the JIRT review, and the Review of Forensic Medical Services, the implementation of which is still to occur, even through it is of vital importance for the provision of forensic support for Police investigations and prosecutions.

18.180 Additional services have been announced – such as the establishment of four Health Aboriginal child sexual assault counselling positions, with another two funded and about to be established, and a new treatment service for adolescent offenders who are not eligible for Juvenile Justice programs (for the Hunter New England region) which is expected to start taking referrals in late 2008. AMIHS

is also included in service delivery strategies; as are the delivery of the Schools In Partnership (with $65 million over four years granted by Treasury in 2005 and 2006), the Kids Excel ($7 million over four years) and Youth Excel ($4.6 million over four years) programs by Education. Additionally, the newly introduced Health Youth Alcohol Action Plan 2008-2012 includes a special focus on alcohol use in Aboriginal communities.

18.181 While the Interagency Plan appears to have generated significant activity levels within each of the agencies since its release in 2006, the nature of the draft performance measures makes it difficult to assess the actual impact on Aboriginal people and communities, or on those Aboriginal children and young persons who are experiencing or at risk of sexual assault.

18.182 The lack of independent oversight of implementation by the Ombudsman recommended in the ACSAT report (Recommendation 21) is of particular concern. The Inquiry could not access a report measuring success against the Interagency Plan and this task is not being undertaken by Aboriginal Affairs. The Ombudsman met with Aboriginal Affairs in January 2008 and received advice that the Department was in the process of developing performance indicators to measure the success of these strategies. It was agreed that the Ombudsman would develop a localised audit strategy that complemented the Aboriginal Affairs' coordinating role.[947] In the Inquiry's view it would be appropriate for the Ombudsman to monitor and report to government on progress with implementation of the ACSAT report, on an ongoing basis.

18.183 The NSW Ministerial Advisory Panel on child sexual assault in Aboriginal communities (the Advisory Panel) provided information to the Inquiry on recommendations and actions that had not progressed.

18.184 At the Inquiry's invitation, the Advisory Panel provided the Inquiry with a list of areas which it believes require further and particular action on the part of NSW Government in addressing Aboriginal child sexual assault in NSW. Those areas were academic research, restorative justice, workforce development, comprehensive cultural awareness and OOHC. Each of these matters was either the subject of a recommendation or an action in Interagency Plan. The Advisory Panel informed the Inquiry that, in its view, any initiatives should receive additional funding from the NSW Government and that responsible agencies should not be required to implement strategies from existing budgets.

18.185 A recommendation about the ACSAT report and the Interagency Plan appears at the end of this chapter.

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[947] NSW Ombudsman, *Submission to the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission*, February 2008, p.25.

Department of Community Services

18.186 DoCS has submitted to the Inquiry that key elements of reform in the child protection system in relation to Aboriginal and Torres Strait Islander children and families are as follows:

a. establishing a localised response at the community level that will engage Aboriginal people in driving change and in planning service delivery

b. continuing efforts to recruit and retain Aboriginal staff and to improve the knowledge and capacity of non-Aboriginal staff to work with Aboriginal families (discussed in Chapter 3)

c. continuing work to build the information and research base to inform effective evidence based services

d. introducing changes to the Children's Court procedure and practices to make it more appropriate for Aboriginal people

e. delivering programs such as Brighter Futures linked with the Aboriginal Infant and Maternal Health Strategy to deliver more holistic and intensive programs over a longer and sustained period

f. investigating the merits of family conferencing (discussed in Chapter 12)

g. investigating the development of an Aboriginal parenting strategy

h. developing further models of care that are appropriate for Aboriginal children and young persons at risk of harm, such as IFBS, accompanied by a pathway into post intervention support services (discussed in Chapters 7 and 8)

i. working with Aboriginal NGOs to build the capacity of that sector (discussed in Chapter 3)

j. recruiting and retaining Aboriginal foster carers and providing better support for Aboriginal kinship care (discussed in Chapter 16).

18.187 The Inquiry agrees with this assessment.

18.188 Of particular note, DoCS has published an Aboriginal Strategic Commitment 2006/2011 which has projected results over a five year period, including an increase in the capacity of DoCS funded Aboriginal and non-Aboriginal NGOs, particularly in relation to: early intervention and prevention; the provision of cultural support to Aboriginal children and young persons in child protection and OOHC; a consistent application of the Aboriginal and Torres Strait Islander placement principles, support, development and retention of Aboriginal staff; and increased collaboration across all tiers of government and with Aboriginal communities.

18.189 A key area in which DoCS has had some success is in relation to the numbers of Aboriginal caseworkers and other staff that it employs, which is discussed in Chapter 3. Further, it has increased the capacity of its Aboriginal Services Branch, which provides policy and program advice, from two positions in 2001

to 16 positions in 2008 and is taking steps to increase the number of Aboriginal legal officers. It has introduced a number of measures to increase the skills, qualification and career paths of Aboriginal staff, to compensate for the lesser entry qualifications that apply this group, which are discussed in Chapter 3.

18.190 DoCS notes that there has been limited research in understanding the issues facing Aboriginal children, young persons, families and communities. Research is now being undertaken by it to examine early childhood education within Aboriginal communities and a senior research officer (Aboriginal) was appointed to the Centre for Parenting and Research in 2007. A literature review on early intervention strategies for Aboriginal children is also being undertaken, while the evaluations which have now been completed in relation to IFBS and Brighter Futures have had some regard to Aboriginal families.

18.191 DoCS is carrying out a longitudinal study of children and young persons in OOHC, one sub-component of which will focus on Aboriginal children. In addition, its recent review of the Interagency Guidelines included an evaluation of the effectiveness of the tools for working with Aboriginal communities. This review found that there was a need either to expand the content of the Interagency Guidelines to address the cultural and practical issues or to provide more information and support to workers. Almost 30 per cent of Aboriginal respondents to that study disagreed that the guidelines were useful for Aboriginal people and suggested that the provisions in the Interagency Guidelines for addressing sexual assault could not be effectively applied to Aboriginal children and young persons.[948] This needs to be addressed.

18.192 A further area of work includes the development of a Cultural Support Case Plan to be incorporated into the existing care plans which are presented to the Court.

18.193 There are several DoCS initiatives in relation to OOHC which are dealt with in Chapter 16. In particular, DoCS is implementing a training package for Aboriginal foster carers, is preparing a step by step Aboriginal assessment tool for foster carers, and is developing an Aboriginal Life Story Book to support children in care. It has been engaged in consultation and in work directed towards extending the Permanency Planning Project to include Aboriginal children and young persons. Additionally it has been working with seven Aboriginal OOHC service providers to build on existing service provision so as to assist them to become strong and sustainable providers of OOHC to Aboriginal children and young persons.

18.194 In August 2007 DoCS commenced the Aboriginal Child Deaths Project to analyse and identify systemic or practice issues arsing from the deaths of Aboriginal children from 2005 to 2007.

[948] DoCS, *Evaluation of NSW Interagency Guidelines for Child Protection Intervention 2006*, Final Report, Volume 1, 24 September 2008, p.19.

18.195 It is also noted that DoCS is working with Police and Health to enhance the JIRT program. This includes developing a culturally appropriate JIRT model and working on an Aboriginal child sexual assault project in Nowra to lead practice improvement and better service delivery within DoCS. These matters are discussed in Chapter 8.

18.196 In response to recommendations made in the Ombudsman's *Report of Reviewable Deaths in 2006*, DoCS is developing a uniform consultation framework for staff in CSCs, and has established Local Commitment of Service Plans, with Aboriginal advisory groups in each region, to provide a mechanism for the identification of key issues and priorities for Aboriginal families and communities. These can serve as a means of embedding the commitment of service to Aboriginal people within the systems and culture of the organisations, and of reinforcing the role expected of DoCS staff at a local level to give effect to that commitment.

18.197 A case study highlighting the importance of understanding Aboriginal family relationships appears in Chapter 9.

18.198 DoCS has funded a position to assist Aboriginal agencies through the accreditation process required by the Children's Guardian, to be included on a number of panels of review and to attend regular meetings with senior DoCS officers.

18.199 In addition, in August 2008, SNAICC, AbSec and ACWA signed a Service Development, Cultural Respect and Service Access Policy which seeks to develop more culturally appropriate partnership and service delivery models when the non-Aboriginal NGO sector in NSW is working with Aboriginal communities. The policy is in line with AbSec's service delivery model which has been developed to establish new Aboriginal OOHC services under the DoCS capacity building project.

18.200 Both these events are welcomed by the Inquiry.

Justice agencies

18.201 The initiatives which Police advise have been implemented or are in the process of implementation include the following:

a. enhancing evidence gathering on paedophile activity in rural and remote communities and working with other agencies when required

b. reviewing the effectiveness of AVOs

c. providing funding for Aboriginal specific crime prevention and for improved responses to domestic and family violence strategies, with improved data collection and analysis

d. improving relationships with Aboriginal communities, to be brokered by the Aboriginal Community Liaison Officers with the active participation of police officers at 12 Local Area Command Aboriginal Consultative Committees,

inter alia through the preparation of a guidelines package, workforce recruitment and retention policies and practices to target Aboriginal employment

e. recruiting an Aboriginal Family Violence Officer, as a member of the Aboriginal Coordination team, to work with Local Area Commands and specialist areas, to raise awareness of Aboriginal specific issues, including awareness training for Aboriginal Community Liaison Officers in sexual assault, and to develop Aboriginal Sexual Assault Standard Operating Procedures.

18.202 The disproportionate involvement of Aboriginal juvenile offenders in the juvenile justice system has been mentioned in Chapter 15, and is a matter that calls for specific attention.

18.203 In this regard several initiatives were noted in the NSW Youth Action Plan Progress Report as at 30 June 2007, which appear to hold promise, although some exist on a trial basis and await evaluation. They include the following programs or pilots within the responsibility of Juvenile Justice.

18.204 A trial of the Intensive Court Supervision Program was completed at the end of June 2007 in Bourke and Brewarrina as a partnership between the Court, and community and human service agencies. It aims to reduce recidivism and incarceration among young people in these towns, through offering an opportunity to demonstrate a capacity for rehabilitation to young offenders prior to sentencing. Juvenile Justice is to support the program through its Intensive Bail Support Program.[949]

18.205 Our Journey to Respect Program is an inter-generational Violence Prevention Program for young Aboriginal men who have been charged, or are at risk of being charged with an offence of violence. Training has been conducted under this program in each of the Juvenile Detention Centres and in the western and other regions of the State, and has included Aboriginal young persons under community supervision. It is supplemented by associated programs such as Black on Track and Step out from the Shadows, as well as by programs focused on alcohol and other drugs which Juvenile Justice has developed or is in the course of developing.[950]

18.206 One further initiative worthy of mention is the Tirkandi Inaburra Cultural and Development Centre, which began operations in 2005 and is funded by the NSW Government principally through Attorney General's. It is situated on a rural property near Coleambally in the Riverina region and provides a residence for Aboriginal youths, aged 12-16 years, who demonstrate potential but are showing signs of being involved in the criminal justice system. It is managed by the local Aboriginal community in partnership with the NSW Government and

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[949] NSW Youth Action Plan Progress Report, as at 30 June 2007, p.16. www.youth.nsw.gov.au/minister_and_policy.

[950] ibid., p.22.

provides educational, vocational, and cultural programs, using teachers provided by the Coleambally Central school, and Aboriginal elders, as well as mentoring programs following the return of participants to their communities.[951] It is the subject of ongoing evaluation with a report due in December 2008.[952]

18.207 It may be noted that the Circle Sentencing initiative that was established in February 2002 initially at Nowra Local Court and subsequently extended to other parts of the State[953] is only available in relation to adult offenders. In this respect it differs from the Murri Court in Queensland which also operates in association with the Children's Court.

18.208 Circle Sentencing has been the subject of recent evaluation by the Cultural and Indigenous Research Centre Australia,[954] prepared with the assistance of the statistical analysis conducted by the BOCSAR of its reoffenders database to assess whether participants have lower rates of recidivism (the Circle Sentencing Evaluation). The BOCSAR analysis found that Circle Sentencing had not influenced the rate of re-offending, or the seriousness of the offences of those who had re-offended. However, the report noted that Circle Sentencing has had a positive impact on community members, particularly elders.

18.209 Subject to ongoing evaluation of the Circle Sentencing strategy, an increase in the experience of those involved, and attention to the suggestions made in the Circle Sentencing Evaluation concerning the ways in which the effectiveness and cost efficiency of the system could be improved, consideration could be given to its use for juvenile Aboriginal offenders, or for adopting a Murri Court model within the Children's Court.

18.210 Elsewhere in this report, we have noted, with concern, that young Aboriginal offenders have been less likely to be involved in diversionary programs than their counterparts in the broader community. The Inquiry is of the view that this is a matter that needs to be addressed since the acquisition of a criminal record and exposure to detention is commonly the beginning of a lengthy involvement in the criminal justice system for this section of the community.

Capacity building

18.211 The Inquiry has identified capacity building in Aboriginal communities as critical to building more culturally appropriate models for supporting Aboriginal children.

18.212 A Commonwealth Inquiry into capacity building and service delivery in Aboriginal communities in 2004 defined capacity to include "activities which seek to empower individuals and whole communities while building the

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[951] Attorney General's Department of NSW, *TIRKANDI INABURRA Factsheet.*

[952] NSW Youth Action Plan Progress Report as at 30 June 2007, p.15. www.youth.nsw.gov.au/minister_and_policy.

[953] Armidale, Bourke, Brewarrina, Dubbo, Kempsey, Lismore, Mt Druitt and Walgett Local Courts.

[954] Attorney General's Department of NSW, *Evaluation of Circle Sentencing Program Report*, May 2008.

operational and management capacity of both organisations and governments to better deliver and utilise services."[955]

18.213 In relation to building the capacity of government agencies to deliver effective services to address Aboriginal people's needs, the Inquiry found the evidence fell into four areas of need: enhancing integration and cooperation; enhancing government service delivery; enhancing funding delivery; and enhancing Aboriginal-government partnerships.[956]

18.214 The Inquiry supported the argument that Aboriginal people need to be more involved in the design and delivery of services, and need to be supported or resourced to implement initiatives in a sustainable way, as they often know the solutions to the problems they face.

18.215 Further, it was found that inequities in the funding provided to Aboriginal and non-Aboriginal organisations providing similar services needed to be addressed. Education and health equity was seen as critical to improving Aboriginal capacity as literacy, numeracy and an acceptable level of health were key requirements to enabling people to participate and function in society.

18.216 The Inquiry identified a need to build the capacity of government agencies to understand and work with Aboriginal people and communities, and a need to build the capacity of Aboriginal people and communities to participate in decision making processes. However, the Capacity Building Inquiry stated that "until basic issues of dysfunction and disadvantage in Indigenous communities are addressed, greater capacity building efforts will remain largely ineffective".[957]

18.217 In conclusion, the Capacity Building Inquiry noted that:

> *This inquiry has largely been about service delivery, and about building the capacity of stakeholders. At the first level, this involves building the capacity of governments to be more responsive and effective in addressing the service delivery needs of Indigenous Australians. The second layer, which meshes and overlaps with that, is about building the capacity of Indigenous people and organisations so that they can then deliver or influence the delivery of services more effectively. The third layer is about building capacity so that the need for service delivery is reduced, and the way to do that is work together to improve Indigenous people's quality of life.*[958]

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[955] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, "Many Ways Forward: Report of the inquiry into capacity building and service delivery in Indigenous communities," *The Parliament of the Commonwealth of Australia,* Canberra, June 2004, p.13.

[956] ibid., p.57.

[957] ibid., p.170.

[958] ibid., p.251.

18.218 DoCS efforts at building Aboriginal capacity in its workforce have been discussed elsewhere in this report, and compare favourably with the results achieved by other NSW government agencies. The OOHC capacity building project with non-government organisations involves DoCS, "working with seven Aboriginal OOHC service providers to build on existing service provision and help them to become strong and sustainable providers of OOHC for Aboriginal children and young people."[959]

18.219 The concept of the DoCS project was applauded by AbSec, but was seen as being too small. AbSec stated that the project aimed to increase the capacity of Aboriginal OOHC services from 170 to only approximately 320 places, in the context of there being about 3,200 Aboriginal children and young persons in care. DoCS, on the other hand, advised that the project would increase the capacity of Aboriginal OOHC services by 426 places.

18.220 Significant further work is required across the State to build sufficient system capacity to meet needs, as DoCS stated:

> *Notwithstanding this valuable work at an individual NGO level, NSW lacks a network of agencies that can work across the issues confronting Aboriginal families in a holistic and locally responsive way. DoCS' relationship with AbSec has the potential to create such a model by drawing on its networks. In addition, further investigation is needed as to the most effective structures to inform policy and program development at a strategic level, given the diversity of Aboriginal representative groups.*[960]

A recommendation in relation to increasing capacity building in Aboriginal communities is made in Chapter 10.

Lessons from the literature

Characteristics of Aboriginal family structures and child rearing practices

18.221 While the terms 'kinship' and 'culture' have become part of the language of the child protection system in NSW in relation to the care and protection of Aboriginal children, research with Aboriginal communities has demonstrated that "kinship terminology is not purely a matter of language."[961] A kinship system is a cultural construct.

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[959] Submission: DoCS, Aboriginal Communities, p.12.

[960] ibid., p.13.

[961] F Morphy, "Lost in translation? Remote Indigenous households and definitions of the family," *Family Matters, no. 73, Australian Institute of Family Studies*, Melbourne, 2006, p.24.

18.222 The differences in the concepts of 'family' and 'kin' have implications for more than the accurate collection of meaningful data about families. It could be difficult for caseworkers and others, with an understanding that values the nuclear family above other conceptualisations of 'family,' to have any insight into the different kind of information that may be required for them to assess the safety of an Aboriginal child, or the appropriateness of the potential options available within the family and community to meet the care and protection needs of the child.

18.223 There are also implications for the efforts of caseworkers to correctly assess the context of the child, the meaningful and supportive relationships they have with their family and kin, and to identify the best potential kinship placements for children. Caseworkers raised in Anglo-Celtic society may find it difficult to understand and reflect in casework, and in file notes, the complexity of Aboriginal family and kinship relationships that are important for a child, and for making decisions about where the child should live, if he or she cannot live with parents.

> *An individualistic approach that focuses on the child's needs without proper consideration of their parent/s' and communities' circumstances has been criticized by Indigenous groups in Canada, New Zealand and Australia as failing to take into account Indigenous understandings of family and children.*[962]

18.224 It has also been said that the implications for the child protection system, of having a system based on one set of concepts trying to provide services to children and families who operate on a very different set of concepts, cannot be resolved by making simple modifications to a system designed for non-Aboriginal children. The 2004 Victorian report, *Protecting children: ten priorities for children's well-being and safety in Victoria,* noted that:

> *It will not be sufficient to add an Indigenous element to, for example, the assessment and investigation procedure or to make modifications to the out-of-home care processes for Aboriginal children without considering whether the system as a whole is inclusive of Indigenous cultures and values.*[963]

What constitutes evidence for what works in Aboriginal contexts?

18.225 The literature is consistent in stating or implying that the trauma experienced by Aboriginal people is not only historic but is current and continuing. Responses to trauma and early removal from family and community include antisocial activity, violence and depression, which in turn lead to continuing social

[962] T Bell and T Libesman, 2007, op. cit., p.18.

[963] Victorian Government Department of Human Services, "Protecting Children: Ten priorities for children's well-being and safety in Victoria" cited in T Bell and T Libesman, 2007, op. cit., p.64.

isolation and dislocation. One study of note from Western Sydney[964] examined two adjoining, demographically similar, economically depressed neighbourhoods with contrasting rates of reported child maltreatment. The outstanding difference between the two neighbourhoods was the structure of social networks. The locality with the higher rate of abuse suffered from a relative lack of connection in the social network.

18.226 The cumulative effect of these factors is seen to provide some explanation for the continuing poor health and welfare of Aboriginal people, and their extreme disadvantage compared with non-Aboriginal people.

18.227 Libesman notes that it has been recognised that an individualised, case based approach to dealing with the issues, looking at each child's issues in isolation from the broader community issues, has not been successful for Aboriginal children and families.[965]

18.228 According to Stanley et al:

> *There is a common call in the literature that effective intervention into family violence needs to address both the past traumas and present situational problems and health disadvantages of Indigenous communities. Almost without exception the literature notes the need for inclusion/participation of the local community.*[966]

18.229 Any discussion of 'what works?' begs the question 'how do we know?' Pressures over the last decade or more to adopt 'evidence based' programs, approaches and practices have led to a demand for more rigorous justification of practices.

18.230 Tomison and Poole, in their 2004 audit of prevention programs, note that:

> *... the difficulties of conducting research in applied settings, a lack of agency resources and staff research expertise has meant that despite the vast number of program evaluations that have been performed on a variety of child abuse prevention programs, very few rigorous evaluations have been done in Australia or internationally. The majority of program evaluations are modest, internally focused studies that assess client satisfaction, document the services delivered, describe program*

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[964] T Vinson, E Baldry and J Hargreaves, 1996, cited in J Stanley, AM Tomison and J Pocock, "Child abuse and neglect in Indigenous Australian Communities," Child Abuse Prevention Issues Paper no. 19 *National Child Protection Clearinghouse*, Australian Institute of Family Studies, 2003 Melbourne, p.8.

[965] T Libesman, "Indigenising Indigenous Child Welfare," *Indigenous Law Bulletin, Vol 6 Issue 24*, 2007, p.17

[966] J Stanley, K Kovacs, AM Tomison and K Cripps, "Child Abuse and Family Violence in Aboriginal Communities – Exploring Child Sexual Abuse in Western Australia," *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2002, p.56.

implementation (for replication) and, if possible, the immediate effects of service provision.[967]

18.231 The quality of the information available about the short and long term outcomes of interventions is therefore unlikely to be available at the level of empirical trials, particularly in Aboriginal contexts where it is difficult to implement such trials even where it may be ethical to provide a service or program to an experimental group and to deny it to a control group.

18.232 Stanley et al state that:

> *Best practice responses and solutions to Indigenous violence are difficult to find due to both what would seem to be a dearth of programs and the lack of documented evaluations about the effectiveness of programs. The many reports on the problems within Indigenous communities conclude that the general failure to find solutions is exacerbated by a significant lack of resources, an on-going paternalistic approach towards Indigenous people and a reluctance to address the problem.*[968]

18.233 However, they also note that a number of principles are repeatedly identified in the literature.[969] These can be useful in guiding the development and dissemination of programs to address violence and neglect in Aboriginal communities. This dissemination must be undertaken, however, in the context of local acceptance and adaptation of programs. In the conclusion of her review of international literature, Libesman states:

> *While some of the issues and ideas may be useful and relevant in the Australian context, a key finding in the research is that a 'one size fits all approach' does not work. Research and programs for children's well-being need to be developed, implemented and evaluated locally.*[970]

18.234 It should also be acknowledged that Aboriginal ways of understanding may place greater value on forms of evidence that are not as highly regarded in scientific frameworks. For example, Stanley, Tomison and Pocock note that:

> *... an Indigenous perspective is rarely recorded in the academic literature.*
>
> *Further, much Indigenous knowledge is based on personal accounts and stories, a method which has Indigenous cultural integrity ... Indeed, Indigenous perspectives can be seen as*

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[967] AM Tomison and L Poole, "Preventing Child Abuse and Neglect: Findings from an Australian audit of prevention programs," *National Child Protection Clearinghouse*, *Australian Institute of Family Studies*, 2000, p.6.

[968] J Stanley, K Kovacs, AM Tomison and K Cripps, 2002, op. cit., p.4.

[969] ibid.

[970] T Libesman, 2004, op. cit., p.34.

> *similar to the qualitative methodologies increasingly being used by some non-Indigenous researchers.*[971]

18.235 The Aboriginal and Torres Strait Islander Social Justice Commissioner, has advised caution about proclaiming 'best practice' for working with Aboriginal communities. He has said:

> *I have deliberately chosen the term 'promising practice' over 'best practice'. Best practice is a term from the business world and states that best practice approaches need to be 'replicable, transferable and adaptable'*
>
> *Indigenous communities are diverse. This means that we need to be very careful about proclaiming best practice, transplanting it to another community and then just expecting it to work. 'Promising practice' is a slightly more tentative term, but still allows us to recognise and develop strengths.*[972]

18.236 The term 'promising practices' was also used in a review of OOHC programs and services for Aboriginal children in 2007, undertaken by Higgins and Butler for the AIFS. They state:

> *… the term 'promising' describes programs that have been successful in meeting their goals and objectives, but which have not necessarily been externally evaluated.*[973]

18.237 In 2007, the Office for Aboriginal and Torres Strait Islander Health, within the Commonwealth Department of Health and Ageing, published a review that evaluated the available evidence of effective programs to address selected social and environmental factors relevant to Aboriginal and Torres Strait Islander people and communities.[974]

18.238 The review highlighted the limited quality and quantity of programs addressing these factors in Aboriginal communities in Australia, which makes formulation of specific recommendations difficult. However, the review did identify a number of features of successful programs. These included:

a. involvement of local Aboriginal people in the design and implementation of programs

[971] J Stanley, AM Tomison and J Pocock, "Child abuse and neglect in Indigenous Australian Communities," Child Abuse Prevention Issues Paper no. 19, *National Child Protection Clearinghouse*, *Australian Institute of Family Studies*, 2003, p.1.

[972] Human Rights and Equal Opportunity Commission, *Social Justice Report 2007, Commonwealth of Australia,* Canberra, p.21.

[973] J Higgins and N Butler, 2007, op. cit., p.4.

[974] A Black, "Evidence of effective interventions to improve the social and environmental factors impacting on health: Informing the development of Indigenous Community Agreements," *Office for Aboriginal and Torres Strait Islander Health,* Australian Government, 2007.

b. effective partnerships between community members and the organisations involved, which resulted in community capacity building and employment for local Aboriginal people

c. cultural understanding

d. mechanisms for effective feedback to individuals and families.

18.239 The conclusion that can be drawn from this information is that the best evidence for what works in addressing the issues in Aboriginal communities is likely to be drawn from the Aboriginal people themselves, through consultations, drawing on their ideas, experiences and opinions, respecting their knowledge drawn from their own individual and community experiences, and drawing on case reports of individual Aboriginal people and specific programs.

Findings of the literature

18.240 The literature supports an approach which addresses both the past traumas and history of colonialism and the present situational problems and health disadvantages of Aboriginal communities. The concept of culturally appropriate or culturally competent service provision requires that Aboriginal ways of understanding are incorporated into and respected within models of service delivery.

18.241 A number of principles for the way forward have been proposed and reiterated in the literature. Favoured models of intervention:

a. are tailored to meet the needs of specific localities

b. are based on community development principles of empowerment

c. are linked to initiatives that deal with poor health, alcohol abuse and similar problems in a holistic manner

d. employ local people where feasible

e. respect traditional law and customs where appropriate

f. employ a multidisciplinary approach

g. focus on partnership between agencies and community groups

h. add value to existing community structures where possible

i. place greater stress on the need to work with men

j. place more emphasis on intervention that maintains family relationships and healing.

18.242 Based on these principles the report of the NT Inquiry advocates for the integration of health and family support services in community ‘hubs’ or ‘one stop shops’, and for the trial of joint teams, in a co-located permanent

multidisciplinary structure for both investigation and subsequent professional intervention.[975]

18.243 The HREOC 2007 Social Justice Report provides a similar view:

> *There is no 'magic bullet' to solve the problems of family violence and abuse in Indigenous communities. However, we know that there are a range of program areas that must be addressed holistically to promote change. These program areas include:*
>
> *a. support programs*
>
> *b. identity programs*
>
> *c. behavioural change*
>
> *d. night patrols*
>
> *e. refuges and shelters*
>
> *f. justice programs*
>
> *g. dispute resolution*
>
> *h. education and awareness raising*
>
> *i. holistic composite programs.*[976]

Identifying 'promising' practices

18.244 A number of programs, services or strategies were recommended to the Inquiry. Examples of programs were selected for further discussion by the Inquiry based on the level of 'promise' they exhibited, as well as their potential for broader application in NSW. Some of these are discussed in this Chapter while others appear in Chapters 7, 8 and 16.

18.245 For the purposes of the Inquiry, the approaches examined can be broadly categorised as follows:

a. Prevention or early intervention strategies that aim to address multiple factors that are associated with disadvantage and with higher incidence of child abuse and neglect for individuals, families and communities. They include interventions that aim to influence the behaviour of children, parents and communities so that children have improved social and physical environments in which to grow up, and so that risk is reduced.

b. Child protection interventions, which respond to the presence of reported or suspected child abuse and neglect. Such interventions generally have a

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[975] Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'," *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.278.

[976] Human Rights and Equal Opportunity Commission, *Social Justice Report 2007, Commonwealth of Australia,* Canberra, p.18.

focus on improving the situation so that children can remain with their family of origin. For Aboriginal children, this will also mean programs that ensure culturally relevant responses to child protection issues.[977] The IFBS program is outlined in Chapter 8 of this report.

c. Interventions to improve the outcomes for children in OOHC, which apply to those children who have (usually) been placed in the care of someone other than a parent after a concern has been raised about their safety and/or welfare.

18.246 Some programs cross the continuum of early intervention and child protection.

18.247 The level of 'promise' shown by any particular intervention or program that was assessed was based on:

a. any available formal evaluation of the program and its outcomes

b. annual reports or other service data to show the utilisation and/or effectiveness of the service or program

c. less formal 'evidence' such as expert opinion (including recommendation of the program by an agency with expertise in the field), consumer satisfaction surveys or qualitative impressions of program staff on the outcomes achieved by the service

d. the extent to which the intervention is consistent with the principles found in the literature, including the extent to which it complies with the principles in practice, as well as the extent to which the principles were incorporated in program design and development.

18.248 Where the literature contained an analysis of the factors that contributed to a program or intervention being 'promising' for broader application to Aboriginal communities, the analysis was included rather than detailed discussion of the individual programs. This was the case with OOHC services.

Promising practices

Canada

Manitoba Model

18.249 Similar to Aboriginal people in Australia, Aboriginal people in Manitoba experience significantly worse health and welfare than the non-Aboriginal population. The Aboriginal population is very young, Aboriginal people have an unemployment rate four times that of non-Aboriginal people, and have hospital utilisation rates two or three times the rates for other Manitobans. Aboriginal

[977] J Higgins and N Butler, 2007, op. cit., p.4.

children are more likely to live in poverty and are more likely to be in the child welfare system.

18.250 In 2002, after significant joint work between government and Aboriginal groups, legislation was enacted creating four new child and family services authorities, one for each Indigenous group. All four authorities have the responsibility to develop policy, practices and procedures that are culturally appropriate. All are responsible for the delivery of services, coordination of services and the funding of community based agencies.[978]

18.251 There has been both positive and negative commentary on the Manitoba system.[979]

18.252 The Manitoba system may offer options for Australia to move toward a child protection model that will allow Aboriginal communities self-determination, and the autonomy and adaptability that is said to be required for such communities to find ways of delivering child and family services to protect their children, and that will give them an environment that can support their growth and development free from abuse and neglect.

Vancouver

18.253 In 2005, the Ministry of Children and Family Development transferred child protection services for Aboriginal children, youth and families in Vancouver to the not for profit agency, the Vancouver Aboriginal Child and Family Services Society. The functions transferred include:

a. reviewing, assessing and investigating reports of child abuse and neglect of children

b. providing services to the parents or others who are responsible for the care of such children

c. providing services that will help strengthen Aboriginal children and their families.[980]

18.254 The Inquiry considers that the current environment would not be appropriate for a sudden move to such a model. It is something to which the system could move carefully and by degrees, that is by a progressive increase in the involvement of the Aboriginal communities in the decision making and delivery of services.

[978] T Bell and T Libesman, 2007, op. cit., p.94.

[979] ibid., p.101.

[980] www.vacfss.com/index.php

Indigenous Triple P – the Positive Parenting Program

18.255 Triple P is a parenting and family support strategy with a number of levels that aims to prevent severe behavioural, emotional and developmental problems in children.

18.256 The program aims to do this by enhancing the knowledge, skills and confidence of parents. Triple P is available at a number of levels depending on the needs of parents and families. This ranges from population based media material, through to fact sheets, structured groups and individual parenting programs. An Indigenous version of Triple P was developed and evaluated in two trials, the first with a small sample in Queensland, and the second in twelve communities across Australia.[981]

18.257 The report on the first clinical trial noted that:

> *These results provide the first outcome evidence from a randomised controlled trial of a parenting intervention for Australian Indigenous families conducted by Child Health and Indigenous Health workers in a community setting. This study adds to a series of controlled outcome studies exploring the efficacy and effectiveness of Triple P interventions. The outcomes of this initial trial are a significant step forward in increasing appropriate service provision for Indigenous families and reducing barriers to accessing available services in the community. These trial results are sufficiently encouraging to warrant wider scale implementation and evaluation of the programme with other Indigenous groups in rural and regional areas.*[982]

18.258 Indigenous parents who had completed the Triple P group program reported significantly lower levels of behavioural and emotional problems in their children, and less reliance on dysfunctional parenting practices than was the case for parents who were still on the waitlist for a group. It was reported that the positive effects of the program were still being maintained six months after the program.[983]

18.259 The evaluation examined the cultural acceptability of the program and reported consistently positive feedback from participants on that issue.[984]

18.260 The second trial, in twelve diverse urban, rural and remote sites across Australia, displayed similar outcomes to the first trial, including:

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[981] K Turner, "Supporting Indigenous Health Professionals: Key issues and supports for the adoption of evidence-based behavioural family intervention in Indigenous communities" Paper prepared for the *Australian Research Alliance for Children and Youth*, 2007, pp.5-6.

[982] K Turner, M Richards and M Sanders, "Randomised clinical trial of a group parent education programme for Australian Indigenous families," *Journal of Paediatrics and Child Health* vol 43, 2007, p.436.

[983] ibid., p.429.

[984] ibid., p.435

> *Significant decreases in problem child behaviour and dysfunctional parenting practices (particularly authoritarian discipline, displays of anger and irritability), and high rates of consumer satisfaction. In addition, there were significant decreases in parental depression and stress, and a significant increase in parenting confidence.*[985]

18.261 This trial, however, also included data collected from practitioners which revealed some barriers to delivery of the program:

> *Practitioners reported finding the program useful and appropriate, but many interested sites faced obstacles to program implementation, such as community perception of the priority of parenting support, lack of availability of trained professionals and lack of opportunities for supervision and skill rehearsal, difficulties in rearranging workload to allow for group sessions, engagement issues, and perceived reluctance for completion of questionnaires and data collection.*[986]

Alcohol Supply Reduction Programs

18.262 Until recently, alcohol supply reduction programs have been trialled in various Aboriginal communities particularly in the Northern Territory and in Western Australia, with a minimum six month trial. Black examined six trials and found that four of these demonstrated significant reduction in alcohol consumption and related harm.[987] The analysis concluded that Indigenous communities are increasingly engaged in addressing the problem of alcohol misuse. The evidence remains inconclusive. Of the studies that have been done, most are too small to be generalised to the greater Aboriginal population, and others are of poor quality and have yielded inconclusive results. Nevertheless, the results indicate the importance of community support for successful supply reduction interventions.[988]

18.263 Black notes that expert opinion has indicated that sustained success is unlikely, unless programs also address the underlying reasons for alcohol misuse.[989] These include the lack of meaningful employment, lack of engagement in the education system, poverty, and lack of opportunity to accumulate lifelong assets. Unless addressed there is a risk that alcohol reduction strategies will see users turn to potentially more harmful practices involving drug abuse and petrol sniffing and to a greater extent than presently occurs.

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[985] K Turner, 2007, op. cit., p.6.

[986] ibid.

[987] A Black, “Evidence of effective interventions to improve the social and environmental factors impacting on health: Informing the development of Indigenous Community Agreements,” *Office for Aboriginal and Torres Strait Islander Health,* Australian Government, 2007, pp.53, 55-56.

[988] ibid., p.53.

[989] ibid.

18.264 In terms of applicability to NSW, the programs and studies reviewed were in remote locations such as Halls Creek, Curtin Springs Roadhouse, Tennant Creek, Derby and Alice Springs. The alcohol reduction programs operating in the Northern Territory under the NTER have not yet been fully evaluated.

18.265 New liquor laws came into effect in NSW on 1 July 2008, to provide, *inter alia*, for greater protections for local communities from alcohol related crime. The new legislation includes Aboriginal specific harm reduction measures which permit the declaration of restricted alcohol areas within which the sale, supply, possession or consumption of liquor can be restricted. The declaration of a restricted alcohol zone may only be done at the behest of the community and in consultation with local community members as well as the Minister for Aboriginal Affairs.[990]

18.266 In addition, under the *Local Government Act 1993,* councils can prohibit the consumption of alcohol and create alcohol free zones.[991] The Inquiry understands that Bourke has made its town an alcohol free zone with the consensus of the community.

The NSW Aboriginal Maternal and Infant Health Strategy

18.267 AMIHS was developed by Health in 2000, in response to research into Aboriginal perinatal health in NSW (this research was later published in 2003 as the NSW Aboriginal Perinatal Health Report). The research showed that Aboriginal babies were far more likely than non-Aboriginal babies to die in the first four weeks after birth, were more likely to be born prematurely, and that the rate of Aboriginal babies born with low birth weight was almost double that of non-Aboriginal babies. Low birth weight and prematurity are associated with higher risk of death and illness in the first month after birth.[992]

18.268 Health stated that the research recommended a specific model of service provision, which included a team approach to community maternity services including midwifery, Aboriginal health workers, specialists and general practice, a flexible and non-judgemental approach to service delivery, and a sensitive approach to the underlying social and economic factors impacting on the lives of Aboriginal people. Health states that this model has become the core of the AMIHS service delivery approach. Additionally, the model includes a specific Training and Support Unit which provides support to the staff developing and implementing AMIHS services.[993]

18.269 Initially AMIHS operated from Broken Hill, Wilcannia, Coffs Harbour, Taree, Dubbo, Moree, and Newcastle. In 2007, DoCS entered into a partnership with Health to fund the expansion of the service to the remainder of NSW. As part of

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[990] *Liquor Act 2007 (NSW)* ss.115-116.
[991] *Local Government Act 1993 (NSW)* ss.642-649.
[992] NSW Health, "Aboriginal Maternal and Infant Health Strategy," Newsletter 1, *NSW Department of Health,* October 2007.
[993] ibid.

this expansion, the seven alternative birthing service programs funded by the Commonwealth will receive additional funding to bring them to the level of AMIHS programs.[994]

18.270 With the existing AMIHS services, the enhanced alternative birthing services programs, and additional services to be set up, there will be the equivalent of 31.5 full time equivalent midwife and Aboriginal health worker teams providing specific services to Aboriginal parents across NSW. The cost of providing these services will be approximately $7.3 million per annum.[995]

18.271 The AMIHS model was evaluated after three years of operation, and the results published in 2005.[996] Outcomes included the following:

a. significantly more women attended their first antenatal visit before 20 weeks of pregnancy

b. there was a significant reduction in the numbers of babies born preterm

c. more women initiated breast feeding, and more maintained breast feeding to six weeks

d. Aboriginal women were very satisfied with the services provided by the program.

18.272 As part of the expansion of services under an MOU between DoCS and Health the program will continue to be externally evaluated.

18.273 Although programs exist across Australia with similar goals to the AMIHS, the evaluation of this program has generally demonstrated better outcomes than some other programs.[997]

18.274 Health informed the Inquiry that the 2008/09 State Budget included the provision of an additional $19.1 million to extend the services already provided under the AMIHS model to ensure that Aboriginal families with young children in NSW have quality access to universal early childhood health services. The amount is to be provided over four years. Health further advised that the precise service model was still being developed. Any impact of extending services to early childhood will need to be evaluated and monitored, but the model continues to be promising. In particular an early antenatal visit can be a useful entry point for addressing issues such as alcohol and other drug abuse,

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[994] NSW Health and DoCS, "Memorandum of Understanding between the Minister for Community Services and the Minister for Health regarding joint funding of the Aboriginal Maternal and Infant Health Strategy," 2007.

[995] ibid.

[996] NSW Health "NSW Aboriginal Maternal and Infant Health Strategy Evaluation: Final Report," 2005, www.health.nsw.gov.au.

[997] See for example A Rumbold, and J Cunningham, "A Review of the Impact of Antenatal Care for Australian Indigenous Women and Attempts to Strengthen these Services," *Journal of Maternal and Child Health* 12, 2008, p.83-100. This paper compares the results of ten antenatal care programs developed for Indigenous women, concluding that the impact of the antenatal care programs evaluated and published to date remains inconclusive. The study involved a search of databases of peer reviewed publications and Commonwealth Government websites. Possibly because State department websites were not included in the search strategy, the researchers did not review the AMIHS evaluation, and this program did not inform their analysis.

thereby reducing the incidence of babies born with foetal drug syndrome, and for reducing the risk of domestic violence.

Conclusion

18.275 From the several reports which emanated from the Inquiries referred to in this chapter, and from its own investigations, the Inquiry considers that there are a number of key challenges to be taken into account, when existing programs are implemented or when new strategies are introduced. In order to place its recommendations in context, it is convenient to note these challenges, each of which was recognised by DoCS in its submission.

18.276 The proportion of children and young persons within the Aboriginal population is in excess of that for the non-Aboriginal population, and is growing. A strong community and family structure to support their development is necessary.

18.277 Each Aboriginal community in NSW is different, with the result that any intervention needs to focus on local circumstances including the composition of that community, the strength and capacity of local Aboriginal leadership and the physical availability of government and non-government resources.

18.278 There has been limited research, and hence limited understanding, concerning the critical issues facing Aboriginal communities in NSW. These include the circumstances leading to the occurrence and concealment of sexual abuse, the normalisation of violence, the breakdown of family and community structures, and the long term impacts of kinship care.

18.279 The problems facing Aboriginal families and their children involve a wide range of causes of disadvantage, such that a holistic response involving the full complement of human services and justice agencies is needed.

18.280 An effective integrated network of government agencies and sufficiently supported and funded non-government agencies is needed at a local level to address issues confronting Aboriginal families in the more remote communities, in a holistic way.

18.281 The risk of problems of high levels of violence, particularly domestic and family violence, sexual abuse, substance abuse, poverty, mental illness, unemployment, and poor housing becoming entrenched, and of positive parenting being unavailable, increases significantly where Aboriginal families are living in small towns or in isolated communities without the services and social infrastructure that support families elsewhere.

18.282 The existing services for responding to substance abuse, family violence and neglect in NSW are fragmented, poorly linked and do not reach the more high risk, remote communities. This problem is then compounded by the difficulties faced by caseworkers based in the larger communities, such as Broken Hill, in reaching the at risk families.

18.283 Challenges remain in securing the level of training, support and supervision of the Aboriginal caseworkers who are needed to maximise engagement with Aboriginal communities.

18.284 Difficulties persist in maintaining a suitable pool of Aboriginal foster carers, a significant proportion of the current cohort being grandmothers or aunts who are ageing and in poor health, and also in assessing the capacity and suitability of potential kinship carers to whom the care responsibility is progressively being passed.

18.285 There has been a lack of differential approaches adopted by or available to the Court that would take into account, and that would be more conducive to, kin and community participation in decision making concerning the future of Aboriginal children and young persons.

18.286 Those young Aboriginal people caught up in the juvenile justice system have not been well served in relation to bail, diversionary options, or Aboriginal specific rehabilitation options, with the result that they have been left at risk of joining a cycle of re-offending with limited opportunities for establishing sound family relationships.

18.287 There is remarkable unanimity in the published reports and literature about the problems facing Aboriginal communities, (particularly those in remote areas), the causes of those problems and the principles which should underpin any intervention in their lives of Aboriginal people.

18.288 Notwithstanding this mutual understanding, Aboriginal children and their families remain over represented in the child protection and criminal justice systems. This Inquiry, like many of those that have preceded it, has not identified any universal solution, but has in relation to each of the relevant aspects of child protection, given attention to ways that they may be severally addressed.

18.289 Recommendations have been made in Chapter 10 concerning the general principles which the Inquiry believes should underpin the child protection system in NSW, the goals to be reached and what needs to be done to achieve such these goals. Matters specific to Aboriginal children, young persons and their families have also been addressed in those recommendations. In addition, in Chapter 8, a recommendation is made concerning building capacity in Aboriginal organisations to enable one or more of them to take on a role similar to Lakidjeka. Recommendations concerning Aboriginal children and young persons in OOHC are dealt with in Chapter 16.

18.290 In addition, the Inquiry supports the nine rules of engagement devised by the NT Inquiry and agrees that they should be applied in responding to child protection issues in Aboriginal communities.

18.291 One strategy identified by Premier and Cabinet was the development of co-located family centres servicing Aboriginal communities, involving health and

education, given the importance of success in these domains to interrupt the inter-generational transmission of family and child vulnerability. These along with other strategies such as improved housing supply, the regulation of alcohol supply and access to alcohol and other drug treatment services are currently being considered by the COAG Working Group on Indigenous Disadvantage. The Ombudsman stated that such a strategy, if effectively implemented, has the potential to give Aboriginal communities much easier access to a suite of services aimed at a continuum of care. The Inquiry agrees and has made a recommendation to that effect in Chapter 10.

18.292 As noted earlier, the recommendations made in this chapter are of a broader nature and should be read in conjunction with the more specific recommendations developed elsewhere in this report.

Recommendations

Recommendation 18.1

The NSW Ombudsman should be given authority to audit the implementation of the Aboriginal Child Sexual Assault Taskforce recommendations as described in Recommendation 21 of the Taskforce's report.

Recommendation 18.2

The NSW Government should consider the following:

a. Assisting Aboriginal communities to consider and develop procedures for the reduction of the sale, delivery and use of alcohol to Aboriginal communities.

b. Working with the Commonwealth to income manage Commonwealth and State payments to all families, not only Aboriginal families, in circumstances where serious and persistent child protection concerns are held and there is reliable information available that income is not being spent in the interests of the safety, welfare and well-being of the relevant child or young person.

c. Introducing measures to ensure greater attendance at school, preferably by means other than incarceration, including the provision of transport and of meals.

d. In smaller and more remote communities, introducing the greater use of night patrols to ensure that children are not wandering the streets at night in circumstances where they might be at risk of assault, or alternatively of involvement in criminal activities.

e. Providing accommodation to Aboriginal children and young people at risk of harm of a boarding nature type where the children are cared for and educated.

Recommendation 18.3

The NSW Government should take steps to ensure that the recommendations of the Aboriginal Child Sexual Assault Taskforce report, and the actions in the Interagency Plan, which relate to provision of direct services to Aboriginal children, young persons, families and perpetrators, are carried into effect within the lifetime of the plan.

Recommendation 18.4

The NSW Government should work actively with the Commonwealth in securing the delivery, in NSW, of the services identified in the New Directions Policy and in the 2008/09 Commonwealth Budget that were earmarked for the benefit of Aboriginal people.

19 A case study: the communities of Toomelah and Boggabilla

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The communities

19.1 Toomelah is an Aboriginal community located just south of the McIntyre River, which forms the border between NSW and Queensland. It has a primary school, a health service with visiting general practitioner, a preschool, a family support service and a shop. It is about 21 kilometres south of Goondiwindi in Queensland and 125 kilometres north of Moree in NSW.

19.2 According to the 2006 census there were 337 persons usually resident in Toomelah, 247 (or 73 per cent) of whom identify as Aboriginal. Of the residents, 51 per cent were male and 49 per cent female.

19.3 As at the census date the median age of the Aboriginal population in Toomelah was 20 years, compared with 37 years across the whole Australian population. Ninety-seven (39 per cent) of Toomelah's Aboriginal residents were children aged 0-14 years and most Aboriginal people over the age of 15 years were not in the labour force. About 20 per cent of Aboriginal persons aged 15 years and over had completed Year 10 or equivalent as their highest qualification, and 36 per cent had a qualification. About eight per cent had completed Year 12 and two per cent aged 15-19 years were in full time education.

19.4 There were 48 total dwellings, over 90 per cent of which were rented.

19.5 The median individual weekly income for Aboriginal persons aged 15 years and over was $210, compared with $466 across Australia and the median household income was $619, compared with $1,027 across Australia. The average household size was 5.1 persons and the average number of persons per bedroom was 1.5. The median weekly rent was $50, compared with $190 across Australia.

19.6 Boggabilla is another small community located half way between Toomelah and Goondiwindi, also on the NSW side of the river. It has a central school (primary and secondary), a post office, a police station and court, a health service without a general practitioner, a play group, a TAFE, the Wobbly Boot Hotel, the Town & Country Club, a butcher shop, a service station, a general store and a paper manufacturing business.

19.7 According to the 2006 census there were 647 persons usually resident in Boggabilla. Of the residents, 53.5 per cent were male, 46.5 per cent female, 56 per cent were Aboriginal. The median age was 27 years. About 36 per cent were children aged from 0-14 years. Eighteen per cent were unemployed. The median weekly individual income was $245, while median household income was $560. One parent families accounted for 42.5 per cent of the town's population. The median weekly rent was $100.

19.8 Aboriginal Affairs informed the Inquiry that the Toomelah and Boggabilla communities experience various socio-economic problems associated with isolated Aboriginal communities including poverty, poor housing, limited

infrastructure, and high incidence of domestic violence, alcoholism and diabetes.

19.9 There have been a number of inquiries and reports describing the two communities and recommending action by Commonwealth, state and local agencies over the past two decades.

1988 HREOC report

19.10 In January 1987, racial violence occurred between Aboriginal and non-Aboriginal communities in Boggabilla, Toomelah and Goondiwindi.

19.11 In response, the then Race Discrimination Commissioner, Irene Moss, visited the area and found wide disparities between the living standards and socio-economic expectations of Aboriginals and non-Aboriginals. In particular, she found that the living conditions of Toomelah were unacceptably poor and considerably worse than those in Goondiwindi and Boggabilla.

19.12 In Toomelah, Commissioner Moss found that the water supply was rationed and dispensed twice a day for fifteen minutes at a time, the sewerage system was completely inadequate, the roads were unsealed dirt tracks and there was no drainage or street lighting. She concluded that the poverty and neglect that made up the fabric of the lives of Aboriginal people in Toomelah and to a lesser extent in Boggabilla needed to be further investigated.

19.13 An inquiry was then undertaken by HREOC which resulted in the publication in June 1988 of the *Toomelah Report: Report on the Problems and Needs of Aborigines Living on the New South Wales/Queensland Border* (the HREOC Report). The HREOC Report recorded the history of Toomelah as follows:

> *Toomelah's five hundred residents live on what was originally part of the traditional land of Gamiliraay people. Present knowledge suggests a connection of Aboriginal people with land in this area stretching back fifty thousand years. Toomelah has been an Aboriginal reserve since 1937... In 1975 the land ceased to be a reserve and the freehold title was transferred to the New South Wales Aboriginal Lands Trust pursuant to the Aborigines Act 1969...*
>
> *In 1984 the freehold (184.9 hectares on which stood forty houses, health clinic, primary school and sheds) was transferred to the Boggabilla – Toomelah Local Aboriginal Land Council… established under the Aboriginal Land Rights Act 1983. Generally speaking, all Aboriginal residents of Boggabilla and Toomelah are eligible for membership of the Local Aboriginal Land Council. Members elect their own office bearers. Funding support for the Land Council comes from an annual allocation from the New South Wales Government under*

the Aboriginal Land Rights Act. The Co-operative continues to operate and to receive Federal funding. It holds a ninety-nine year lease over the entire original area…

In the decade since [the reserve era ended] the community has had come to terms with a vast array of new rights and responsibilities. They have had to learn to deal with numerous government departments and other bodies with respect to the provision of a wide range of services and goods, including housing, enterprise funding and other matters. This period has been attended by many difficulties forged by the reserve experience… As Mrs Madeline McGrady told the Inquiry, "No training was given to help people make the transition"…[998]

19.14 The HREOC Report further stated:

The Inquiry was struck by the fact that even after numerous State and Federal government inquiries into Aboriginal and Torres Strait Islander needs, the awarding of joint responsibility for Aboriginal affairs to the Commonwealth Government by a constitutional amendment in 1967, the conclusion of the Commonwealth – State Arrangement with respect to funding for Aboriginal affairs in 1976, and the passage of the Aboriginal Land Rights Act by the New South Wales Parliament in 1983, the people of Toomelah still suffered living standards far below those experienced by the vast majority of non-Aboriginal residents of New South Wales and for that matter by the vast majority of Australians. Words, intention and goodwill are simply not sufficient.[999]

19.15 The HREOC Report recorded that there were 40 dwellings at Toomelah, generally of poor standard, accommodating on average more than 12 people each; which was four times the State average of three persons per household. Water was being rationed.

19.16 The HREOC Report referred to a 1986 Health Department survey of children under six years which found:

over 20% suffering from recurrent chest infections and almost 50% had chronic ear disease... Other health problems identified include diabetes, alcoholism and sexually transmitted diseases… Although a community of five hundred people; Toomelah residents have inadequate access to medical services. The community health worker… has a diploma in Aboriginal Health and services the entire community on her own

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[998] Human Rights and Equal Opportunities Commission, *Toomelah Report: Report on the Problems and Needs of Aborigines Living on the New South Wales/Queensland Border,* June 1988, pp.2-4.

[999] ibid., p.4.

> *most of the time. At times over the past few years a registered nurse has worked full-time at Toomelah. However, there has been no nursing service there since shortly before this Inquiry commenced. A Health Department doctor visits about ten times each year but only to immunise the children… the people must travel to Goondiwindi for most medical treatment… For dental treatment they must often travel to Moree…*[1000]

19.17 The HREOC Report summarised the condition of the community as consisting of sub-standard, overcrowded housing, without an adequate water supply or a properly functioning sewerage system, higher than average rates of a range of debilitating diseases for which members of the community could not get adequate treatment, lack of adequate education and chronic unemployment.

Child protection project

19.18 In 2005, with the assistance of a consultant, the then elders identified key issues in the Toomelah community as health, child sexual abuse and relations with police. As part of a whole of government project to address these issues in both of the communities, the Child Protection Project was initiated in December 2005, led by DoCS. The DoCS Project Team (the Team) began work in June 2006 with the intention that the Team of three caseworkers and a manager, all Aboriginal, would be assisted by two health workers, employed by Hunter New England Area Health Service (HNEAHS).

19.19 The objectives of the project were stated as follows:

a. co-ordination of the planning and implementation of government responses, interventions and prevention programs regarding child sexual abuse issues based on close collaboration with community elders, leaders and agencies and the development of outcomes which would be externally evaluated

b. engagement of the local people in learning necessary skills

c. oversight of capacity building

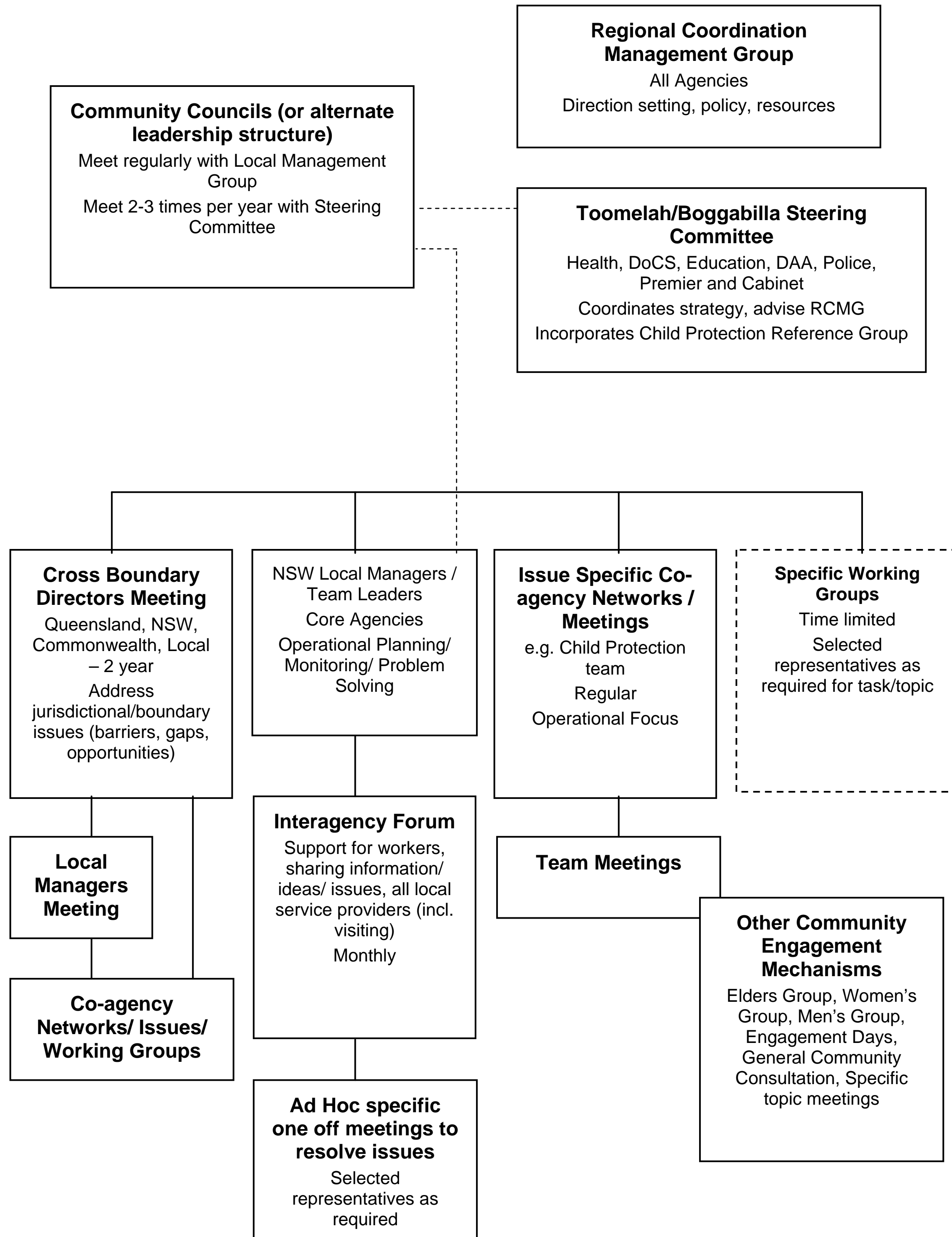
d. development of a program with Education.

19.20 The primary focus was to be on community prevention combined with counselling and healing to address past abuse.

19.21 It was anticipated that the desired outcomes would take at least five to 10 years to achieve. It was estimated in 2006 that the costs would be around $650,000 in 2006/07, $688,000 in 2007/08 and $638,000 in 2008/09.

19.22 The governance structure is as set out in the diagram below.

[1000] ibid., p.53.



Progress

June 2006

19.23 One of the first tasks undertaken by the Team was to analyse child protection data from the two communities for the period 2003 to 2005. The following matters were identified:

a. the reporting trends were consistent

b. 20 per cent of reports were from non-mandatory reporters of whom 16 per cent were family or community members

c. neglect was the most reported issue

d. 21 per cent indicated that carer alcohol or other drug use was an issue

e. almost a third of reports related to concerns about children being exposed to sexual harm and most of these reports came from mandatory reporters who appeared to be relaying concerns on behalf of community members

f. four individuals were identified as perpetrators as well as a number of members of one particular named family

g. an estimated 15 per cent of all the children in the two communities had been reported for sexual harm or risk of sexual harm in 2004/05

h. only 17 per cent of these sexual abuse reports received a less than 24 hours response, notwithstanding that in many cases the perpetrator was clearly identified and named

i. the great majority of alleged perpetrators referred to in reports of specific incidents of sexual abuse or immediate risk of harm were outsiders or community members not closely related to the children

j. few children were interviewed and only one perpetrator out of the 50 was interviewed; he made a confession and was placed on a bond.

November 2006

19.24 By November 2006, most of the 92 children who had been reported for harm or risk of harm from sexual abuse since January 2004 had received some attention from the Team. Thirty-eight children had been assessed, of whom nine were identified as being at serious risk of harm. More than 20, nearly one quarter, were being dealt with by other child protection agencies and another 20 did not warrant further attention by the Team because of, generally, an assessment of low risk of harm.

19.25 In relation to perpetrators, some suspected men and adolescents had left the community and a non-Aboriginal alleged perpetrator was charged with numerous sex offences following a JIRT investigation. Disclosures from two 13 year old girls were being investigated by JIRT, however, ultimately no prosecution occurred as they did not wish to give evidence.

19.26 The plans for 2007/08 were to develop a comprehensive community education program, further develop partnerships, consider international models, evaluate data and outcomes, employ two trainees and establish a transition plan.

19.27 Regular interagency meetings and cross border collaboration meetings were being held. However, one caseworker had resigned and would not be replaced until October 2007.

February 2008

19.28 By February 2008, the communities had suffered the death of three key elders, one of whom was identified as having been the key player in persuading the elders group to request government help. The Team manager had been off work for some five months following an injury. These events were to hinder the Team in attaining its objectives.

19.29 Two administrative positions within the team had been recently created. Community engagement activities had been organised and apparently were well attended. Men's and women's groups were operating with variable attendances and success. The Inquiry was told that about 50 per cent of the Team's time was spent on education and community awareness and support activities.

19.30 Also by this time, risk assessments had been initiated on all children reported for child sexual abuse since 2005 who had remained in the communities. One couple had been assessed as foster carers.

19.31 Thirteen children and young persons had disclosed abuse since July 2006, as a result of which charges were laid against four men and an AVO was granted. Most of the victims were girls aged between 14 and 16 years. It was recorded at this time by the Team that:

> *They [the victims] are without exception unable to confront alleged perpetrators who live close by, who are related or living with someone related to them and who may be in positions of power and influence in the community.*[1001]

19.32 Clearly, there were considerable challenges in encouraging reporting and in following through with giving evidence in any prosecution of the perpetrator.

19.33 A survey of the community was undertaken by the Team, and based on the findings from that survey, a Community Education Plan was drafted. It covered broad and targeted education using the resources of Health, Education and Corrective Services. Elders, men's and women's groups were identified, as were preschool, primary and secondary school children and young persons.

19.34 In terms of the progress made by other agencies, after November 2006, experiences were mixed.

19.35 Significant improvements at the Toomelah Public School were reported including breakfast being provided to children and activities being arranged during breaks and after school. 'Beats', a program to ensure primary school children were attending school, had been instituted, which had resulted in a

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[1001] DoCS, Briefing Note, *Update of Toomelah / Boggabilla Child Protection Project*, 6 July 2007, p.5.

doubling in attendance rates to 80 per cent. Caseworkers were involved in one or two personal development classes at the Boggabilla Central School.

19.36 Relationships with Police suffered when, following a domestic violence incident at Toomelah, a number of community members withdrew the existing MOU with Police to enable Police to enter onto Aboriginal land.

19.37 HNEAHS had created new positions in 2006 in response to community requests, comprising a community development facilitator and a child and family health worker. Both of these positions had been vacant, one since August/September 2007 and, the other since January 2008. However, more positively, Health was funding a new offender treatment program, based on the New Street Service (see Chapter 7), which would operate in Tamworth and target young offenders from the Toomelah and Boggabilla communities.

19.38 The laying of a sewerage system in Boggabilla was apparently complete and repairs to houses were underway.

19.39 During the preceding months, community attention had been diverted by concerns with governance and management at the Land Council, which resulted in the contracting of Land Council management of the community to a private provider. This ultimately affected management of infrastructure, in particular the maintenance of houses.

June 2008

19.40 By June 2008, there had been little further progress recorded. Sixty-nine children were under scrutiny of the Team. While the Toomelah Women's Group was apparently working well, Boggabilla groups were not.

19.41 A deal of publicity had been generated when claims were made to ABC's Lateline program about children prostituting themselves at the Boggabilla Roadhouse. The Inquiry had discussions with Police and DoCS about these claims and was advised that each had been unsuccessful in obtaining sufficient and reliable information from the community to take any further action.

19.42 The Team assisted the Youth Group to develop activities for Youth Week. The HNEAHS positions remained vacant. The Child Protection Reference Group continued to meet bi-monthly.

19.43 Concerns about one of the project Team interviewing a child about allegations against a person to whom the caseworker was related were raised by Police and resolved, apparently to everyone's satisfaction. This highlights the particular challenges when those from within small communities are carrying out difficult and sensitive work, such as child protection.

19.44 The proposed young mothers group, an important initiative given the numbers of pregnant young women and mothers and their reported reluctance to engage with doctors, had commenced.

Data

19.45 Understanding the progress made by the Team is important to know the challenges being faced. In order to gauge the nature of the child protection work being undertaken in the Toomelah and Boggabilla communities, the Inquiry sought various statistics and other data from DoCS. The data collected for the financial year 2006/07 and for July 2007 to March 2008 show the following:[1002]

Reporters and assessment

19.46 In 2006/07, 59 reports involving 31 children and young persons were allocated to a member of the Team. Twenty-two of those reports received a SAS2, 33 reports received a SAS1 only and for four reports there was no record of a risk assessment.

19.47 In this period, 54 reports were made by mandatory reporters with 22 from police and 21 from school/child care reporters. Five reports were by non mandatory reporters comprising three relatives and two from the community.

19.48 For the period July 2007 to March 2008, 106 reports made about 62 children and young persons were allocated to the Team of which, 34 reports received a SAS2, 36 reports received a SAS1 only and for a further 36 reports there was no record of a risk assessment.

19.49 In this period, 84 reports were by mandatory reporters, of whom 32 were police officers, 27 worked in education and 14 in health. There were 22 non-mandatory reporters of whom 11 were from the community, eight were relatives and three were others.

19.50 Thus, the number of reports almost doubled while the percentage that received a SAS1 and SAS2 had reduced, assuming all appropriate records were kept.

[1002] Unallocated reports or reports allocated to the Moree CSC are not included in this data.

Table 19.1 **Reports involving alleged child sexual abuse allocated to the Toomelah Boggabilla DoCS case workers by reporter type**

Source of report	2006-07	July 2007-March 2008
Mandatory reporters		
Police	22	32
Probation and parole	1	0
Corrective services	3	0
Interstate welfare	3	0
Juvenile Justice	1	6
Education	21	28
Health	2	14
NGO	1	4
Non-mandatory reporters		
Relative	3	8
Community	2	11
Other	0	3
Total	59	106

Issues reported

Table 19.2 **Child protection reported referred to the Toomelah Boggabilla DoCS caseworkers by primary reported issue**

Primary Reported Issue	*2006 to 2007*	*July 2007 to March 2008*
Sexual abuse	20	43
Drug and alcohol use by child or young person or carer	6	4
Domestic violence	14	18
Neglect	11	12
Physical abuse	2	9
Inappropriate sexual behaviour by a child or young person	2	10
Psychological abuse	3	6
Carer mental health issues	1	2
Suicide risk	0	2

19.51 The reporting of sexual abuse, physical abuse and inappropriate sexual behaviour by a child have clearly increased.

Multiple reports

19.52 In 2006/07, 15 children and young persons received between two and five reports with the majority receiving two reports. The average number of reports per child or young person was 1.9.

19.53 From July 2007 to March 2008, 29 children and young persons received between two and four reports with the average number of reports per child or young person being 1.7.

Seriousness of reports

19.54 In 2006/07 two reports requiring a response time of less than 24 hours were received, 30 requiring a within 72 hours response and 27 requiring a response within 10 days.

19.55 Of the reports received from July 2007 to March 2008, seven were assigned a required response time of within 24 hours, 49 within 72 hours and 50 within 10 days.

19.56 Four cases have been referred to the Brighter Futures Lead Agency, one through the community pathway and three through the Helpline. The Brighter Futures program began in July 2007. Of the four cases, two are in the assessment phase, one is in the case management phase and the remaining family has exited the program.

Removal of children

19.57 Between July 2006 and June 2007:

a. 10 children had been removed from their families, three of whom were Aboriginal children. Two of those were siblings who were in care and later removed from their carer by Moree CSC and returned to a kinship placement. The third child was removed at her own request and returned to her grandmother/carer, at her own request. The return was subject to undertakings which were not made under the Care Act. The seven remaining children are from a non-Aboriginal sibling group

b. six children were placed under the parental responsibility of the Minister or under shared responsibility

c. 12 children were living in OOHC within the communities of Toomelah or Boggabilla.

19.58 During the period July 2007 to March 2008:

a. one child living in Toomelah or Boggabilla had been found by the Court to be in need of care and protection, and one child was removed from the family

b. one child was placed under parental responsibility of the Minister or under shared parental responsibility

c. 11 children were living in OOHC within the communities of Toomelah or Boggabilla

d. there had been no children restored to families in that period.

19.59 In the period July 2006 to March 2008, there had been one order accepting undertakings and no orders for the provision of support, to attend therapeutic or treatment programs or for supervision.

Prosecutions

19.60 Police informed the Inquiry that, as at March 2008, there had been six prosecutions, some of which were continuing, some dealt with and some found not guilty. A small number of AVOs had been granted.

DoCS responses to children

19.61 To understand the nature of the intervention for some of the children and young persons who received SAS2 assessments, the Inquiry sought and was provided with the following response.

19.62 Between April 2007 and March 2008, 38 children, the subject of 24 reports, had a SAS2 completed. DoCS took the following action concerning these children:

a. Nine reports were referred to JIRT:

   i. three of the reports were in relation to sexual abuse of a non-Aboriginal child; these were assessed by the Moree CSC and in each case the matter was investigated by JIRT

   ii. six were referred to JIRT by the Team; one case concerned domestic violence and the remaining five concerned sexual abuse.

b. Services, usually in the form of referrals for drug and alcohol counselling or to the adolescent mental health services were provided in eight cases. The Inquiry is unaware of the outcome of those referrals.

c. The child and/or the family relocated in six instances, generally in response to issues of neglect and sexual abuse.

d. A care application was brought in two cases; both concerned sexual abuse, and each child was placed with a relative.

e. In relation to two matters the young person involved was not willing to pursue charges.

f. In two cases the perpetrator was charged; one in relation to domestic violence and the other, sexual abuse. In a number of other cases the perpetrator was in jail on unrelated matters.

g. In one case a placement was arranged by the family.

The Inquiry's visits

19.63 The Inquiry travelled to Toomelah and Boggabilla on two occasions. On the first occasion, in March 2008, the Team arranged for the Inquiry to meet with a number of elders from the Toomelah community at Toomelah. In addition, the Team arranged a meeting with interested members of the Boggabilla community in Boggabilla.

19.64 During that visit, the Inquiry also met with caseworkers and their managers from Moree CSC and representatives of agencies working in the region.

19.65 On the second occasion, in June 2008, the Inquiry held a Public Forum to discuss concerns within the two communities. At the request of members of the communities, a portion of that forum was held in private to enable them to express their views without the presence of the representatives of various agencies who also attended.

19.66 At the meeting with elders on 18 March 2008 the issues raised with the Inquiry were similar to those identified in 1988. They included inadequate transport, poor maintenance of houses and overcrowding, continued problems with the water supply, inadequate street lighting and limited employment opportunities. The elders identified a lack of activities for children, a concern about safety of children at communal areas such as the playground, the cost of the contract to build new houses, the failure to transfer skills to the community after those houses had been constructed and the reluctance of young mothers to seek early medical assistance.

19.67 Positively, they noted that there had been improved school retentions since the new principal had commenced at the Toomelah Public School.

19.68 They also identified an issue of particular concern to the Inquiry, which is the reduced ability of the current generation of mothers to assist their daughters in looking after their children, because of substance abuse and similar problems which have blighted some within that generational group. This has led to an increased dependence on ageing elders, and it raises a serious issue for the safety of future generations unless there is a change within the communities.

19.69 The elders identified the need for improved security at the school in relation to the safety of children, drug and alcohol programs and training and linked employment programs. The elders advised the Inquiry that there had been a discussion about whether Toomelah should become a dry community but no agreement had been reached.

19.70 The Inquiry gained the impression that the elders who attended the meeting had little understanding of the presence of the Team or, more broadly, that a concerted effort was being made by various government agencies to assist the community and that additional services and programs were now available.

19.71 This was supported by one of the Team members who advised us that, in her experience, the members of the community did not connect the work that the Team was doing, in relation to establishing and running groups and community education activities, with child protection work. She informed the Inquiry that the members of the community continually asked the Team to tell them again why they were there.

19.72 At Boggabilla, those attending the meeting also raised concerns with the lack of public transport, the need for more services such as mental health, medical and

dental services, problems with housing including overcrowding, and the costs and maintenance and the closure of a local community centre. Additionally there was a degree of scepticism about external intervention and the Inquiry was informed that people from the Government made repeated visits, talk a lot, but nothing ever changes.

19.73 While in the region, the Inquiry also met with representatives of Aboriginal Affairs, DoCS, Police (including JIRT), Health, Housing, Education, Juvenile Justice and DADHC.

19.74 The Inquiry notes that many of the issues raised by the community are under consideration on a statewide basis by the Legislative Council's Standing Committee on Social Issues, in particular the effective provision of essential services including water and transport and improving educational outcomes.[1003]

The Team's experiences

19.75 On the second occasion the Inquiry visited, the members of the Team informed the Inquiry of the challenges they had experienced in engaging with the community.

19.76 For example, one caseworker advised the Inquiry that to have the community attend various events, encouragement by way of a supply of food was often necessary and that any overt mention of child sexual abuse tended to keep people away. Door knocking the communities has been done to encourage people to attend meetings.

19.77 The Team manager described their work as dealing with people who have been disempowered and disenfranchised, and who looked to others to identify for them what was needed to address the many problems faced by the community. This accords with the sentiment expressed at the Public Forum in Boggabilla that the past abuses that had led to these communities becoming dysfunctional, had not yet been addressed, and that there needed to be a more effective healing process and a mutual understanding of the history of these communities.

19.78 An example of the complexity of the task of tackling child sexual assault in the communities arose recently. The Inquiry heard that a 11 year old girl told her family she had witnessed a sexual assault by a 15 year old boy on a nine year old girl. Police were informed, as was DoCS, and JIRT investigated the claim. However, the 15 and nine year old denied that it had occurred, the community became divided between support for the witness and the two supposedly involved. The 11 year old was harassed at school, and tensions developed between the two families.

[1003] NSW Parliament Legislative Council, Standing Committee on Social Issues, *Overcoming Indigenous Disadvantage, Interim Report,* June 2008, pp.xix-xx.

19.79 JIRT could not take the matter much further in the absence of a disclosure by the nine year old and the events were too old to result in useful forensic evidence. A further compounding factor was described as follows:

> *There is an underlying attitude within the community as well to what they'd call marrying up or relationships between children and young people and in some people's eyes this nine-year-old girl has been in a relationship with this 15-year-old boy.*[1004]

19.80 However, gains have been made. The Team manager told the Inquiry of a man who had lived in the community all of his life who had mental health problems and who had sexually assaulted different people at different times. Following intervention by a caseworker, reports were made to DoCS and, as a result, the man was charged and jailed.

19.81 The Inquiry was also told of a 16 year old young woman who had been in a violent and abusive relationship and who, with the support of a caseworker, obtained an AVO and took action which resulted in the young man being charged.

19.82 Another caseworker described collecting a girl to take her to school every day and after 12 months, she gained her trust and the child made disclosures to her.

The communities' experience

19.83 In the part of Public Forum where only members of the communities were present, similar issues were raised to those when the Inquiry first visited. In addition, the Inquiry's attention was drawn to limited counselling for sexual assault victims, lack of knowledge about how to respond to disclosures of sexual abuse, problems with school attendance, the need for a TAFE Certificate Course in Indigenous Therapies and the closure of a community centre funded by the Land Council.

19.84 A Toomelah resident said that the presence of the DoCS worker made a great deal of difference in terms of "people taking responsibility for their kids and making sure that they're safer and getting people to look at the issue."[1005]

19.85 The Inquiry was informed:

> *This has been going on since I was a child. I'm nearly 50. It happened to me and there's nothing different, nothing has changed out there. It's hopeless, they think it's hopeless, there's hopelessness in this town and in Toomelah. As a child growing up in Toomelah, being sexually assaulted by family members, non-family members, you know, it's hard for a child,*

[1004] Transcript: Inquiry meeting with members of the DoCS Project Team at Boggabilla, 10 June 2008, p.6.

[1005] Transcript: Public Forum, Communities of Toomelah and Boggabilla, 11 June 2008, p.15.

especially a young girl, and for a boy it's even harder. They feel disgraced, they feel dishonoured, they feel disrespected and you wonder why they grow up with all this anger, all this tension. They just want to rage at people. I can identify with them.

It is actually the elders that keep all this hidden. It's not the young people, it's the elders. They don't want it to be leaked out because it will disgrace them, it will disgrace the family and speaking from experience and from this place, when things are being opened up, there's lot that's going to shut it down.[1006]

19.86 By contrast, the Inquiry was informed of the following event, as illustrative of positive change which was occurring in the communities:

There was a recent situation … where, you know, the big boys were at the toilet and the little fellow was there. He knew that those big boys were there for something, and I'm talking about a little fellow about five. He knew what to do. He called out for help. Then he went back to the class and he was congratulated and everybody supported him. That's the sort of stuff that has been happening out there. The bigger boys are now identifying some of the men who have been perpetrators in the community. That's the sort of stuff I'm talking about. But the most important one I think is that the kids are getting it, but a lot of our women are not. I think that's where it lies too, that we need to get some more education there.[1007]

19.87 However, there was frustration expressed about the slow pace of change:

The fact is that we had a human rights inquiry some 20 years ago. I don't know if people have noticed much change. They came out and addressed some of the infrastructure stuff, but in terms of the social issues, nothing: our education, economic development, no. We're still going to be sitting down there below the poverty line until our community gets up and says, "Yes, we're going to have a go," but we also need greater assistance from the government and from people within the community as well.[1008]

[1006] Transcript: Interagency meeting, Communities of Toomelah and Boggabilla, 10 June 2008, p.61.
[1007] Transcript: Public Forum, Communities of Toomelah and Boggabilla, 11 June 2008, p.9.
[1008] ibid., p.16.

Responses of other government agencies

19.88 The Inquiry also benefited from the views of other agencies involved in supporting the communities as part of the whole of government response.

Interagency response

19.89 A number of structures have been put in place to enhance interagency work. A Regional Coordination Management Group meets a number of times a year and is coordinated by Premier and Cabinet. There is also a Toomelah-Boggabilla Strategy Steering Group.

19.90 Remote Community Critical Incident Response Standard Operating Procedures For Child Protection in Toomelah and Boggabilla Communities have been formulated to define the joint responsibilities and responses to be taken by NSW Government agencies for serious cases. A critical incident of child abuse is defined as a JIRT referral or other child abuse incident where there is, or is likely to be, significant community impact. They essentially require each relevant agency to respond quickly and appropriately.

19.91 From all accounts, the cooperation achieved has been significant. The representative from Health informed the Inquiry:

> *...when we first started as a group having discussions… in 2005, we agreed that the issues that we were working on within this community required a long term approach and we said between ourselves right back then, "This is at least a 10 year commitment that we're making," so we're now two and a half to three years into that 10 year commitment. I think at this stage I wouldn't claim necessarily big health achievements. I can't say to you that we're seeing major improvements in the health status of the local communities yet, but I think what we have done is laid the foundations and …I think that's largely around the agencies getting their acts together and working much more closely together… We are in the process of doing some extensions and refurbishments to the clinic building in Toomelah to enable us to house the additional services that we're providing there…. I think the fact that we have had a few social emergencies, which is a very broad term, particularly some around child protection, but also some others where we have initiated a very rapid response between the agencies, that has I think worked quite effectively and that's something that might not have happened previously.*[1009]

[1009] Transcript: Interagency meeting, Communities of Toomelah and Boggabilla, 10 June 2008, pp.34-35.

19.92 The Police gave an example of recent interagency response to an event in the community:

> *That was a situation, …a Saturday…, where a young fellow had gone in the river and drowned and been taken out of the river by one of the locals and revived and that caused a lot of trauma in the community. The child had to be airlifted to Brisbane. The family had no money. We were quickly able to make contact with the relevant agencies. I know we contacted DoCS and Health and the next day… the Sunday morning, Health were able to put counsellors on the ground in the community and were able to service that on a Sunday morning, which was remarkable considering that's a big feat generally in the real world. That was a really good outcome and we worked very well together and we were able to ring the right people and get the response we needed.*[1010]

19.93 Key issues identified by those attending the Inquiry's interagency meeting have been the engagement and retention of qualified staff, obstacles to sharing information, some practical problems in obtaining access to cross border services, the insufficiency of specialist services, inadequate transport, absence of sexual assault counselling and the closure of a centre in Boggabilla funded by the Council. The cross border and information sharing issues are dealt with in Chapter 24 of this Report.

19.94 In addition to their combined effort, each agency has particular responsibilities.

Aboriginal Affairs

19.95 The Inquiry was informed that Aboriginal Affairs is undertaking a number of projects in the area. One, in conjunction with the Department of Climate Change is exploring community engagement structures and others concern how to better manage housing infrastructure, water and sewerage.

19.96 The Toomelah water supply comes from an artesian bore and, according to Aboriginal Affairs, there has been a long held community view that the water is unsafe due to its relatively high salt and mineral content. Prolonged testing has been undertaken and a major water supply infrastructure upgrade amounting to $600,000 has been commissioned.

19.97 The HNEAHS advised the Inquiry that between January 2007 and June 2008 there have been seven occasions where samples of water have not complied with Australian drinking water guidelines for E.coli. Three of those failures were in 2008 with one continuing for a week in March 2008.

[1010] ibid., p.35.

19.98 On each occasion of the Inquiry's visits on 18 March 2008 and on 11 June 2008, Toomelah was without water. The Inquiry was told on the second occasion that the pump had broken down and the back up could not be found. Water was being shipped into the communities. Not surprisingly, many in the community were angry at the failure to provide adequate water supplies.

Housing

19.99 Housing has been a vexed issue for decades. It appears from data provided by Housing that there has been considerable expenditure in the area.

19.100 Between 2000 and 2006 Toomelah/Boggabilla benefited from an Aboriginal Community Development Program with a budget of $11 million to provide new and improved housing and infrastructure. The program was hampered and delayed for some years due to compliance and capacity issues with the Land Council. To date the program has delivered 20 new houses, 13 house refurbishments, three house acquisitions and an eight block sub-division (including all services, extension, earth works and roads), a waste transfer station, storm water drainage works, upgraded street lighting, traffic calming, playground equipment and various miscellaneous works. In addition 10 local Aboriginal people have been employed by a private building company as trainee apprentices.

19.101 The management of Toomelah housing has been outsourced by the Land Council to a private Aboriginal management company. The Inquiry understands that there are disputes about the payment of rent and what has been described as the 'poor maintenance' of the properties. Aboriginal Affairs described the Land Council as having "really, really struggled" with housing issues.[1011]

19.102 The 2006 census and the view of the community members with whom we spoke suggest that overcrowding persists.

Education

19.103 The Toomelah and Boggabilla schools each receive additional funding as result of their location and the disadvantage suffered by many of their students.

19.104 For example, since the start of the 2007 school year, Education has funded a non-teaching school principal at Toomelah Public School to strengthen the schools relationship with the community. Education describes Toomelah and Boggabilla as "focus support schools" which means they have attracted additional funding (respectively $180,000 and $150,000 a year) for matters such as literacy, numeracy and attendance.[1012] The child protection syllabus is taught weekly.

[1011] ibid., pp. 11 and 12.
[1012] ibid., p.48.

19.105 Boggabilla Central School has a Families NSW funded playgroup operating three days per week. Year 11 and 12 studies are offered as part of the Northern Border Senior Access Program. The school receives additional funding from the Country Area Program, the Priority Schools Program and the Targeted Schools Initiative.

19.106 Toomelah Public School receives additional financial and staffing support from a similar range of programs.

19.107 That funding has allowed both schools to reduce class sizes. Boggabilla Central School has also focused on attendance, which the principal said is worse from Year 7. Its Principal said:

> *We have what's called a "You can do it" program. That deals with anti-bullying, violence, child protection, and I suppose to the basic, good touch, bad touch. We work with and it is done just about every day in schools. We initiated last year with DoCS to bring in the DoCS workers to have them come into our secondary department. That sort of fell over and we are putting it together again this year… So as we are building up this resilience and ways of the children looking after themselves and how they go about reporting, they will also know the faces of the DoCS workers so that there is a bit of a relationship developed between them that they will report. We have had issues of sexual assault where, when it comes to interviewing, the children just will not disclose, and it can go nowhere unless the children tell their story. I think [that is] the biggest.*[1013]

19.108 The reporting rate for the school is promising. Sixteen reports, the majority of which were of a sexual nature, were made to DoCS in the first six months of 2008 compared with 12 for 2007 and a similar number for 2006. These were made as a result of greater number of disclosures by children at Toomelah Public School.

19.109 Recently conducted evaluations of Boggabilla Central School and Toomelah Public School reveal attendance and performance are significantly below regional and state levels.

19.110 However, the most recent Basic Skill Test figures for Boggabilla Central School show an improvement in the growth recorded by matched students moving from Year 3 to Year 5.

Health

19.111 As at June 2008, the Inquiry was informed that HNEAHS operates the Toomelah Clinic which is staffed by one registered nurse and one Aboriginal

[1013] ibid., p.52.

health worker. In addition, the Aboriginal Medical Service of the Pius X Aboriginal Corporation had recently recruited two health workers, including a nurse, who are also located at the Toomelah Clinic. General Practitioner clinics are held in Toomelah twice weekly and a specialist physician visits monthly.

19.112 A clinic is also situated in Boggabilla staffed by two registered nurses. There is no doctor in Boggabilla. The closest hospital is in Goondiwindi, in Queensland and dentists are located in Moree and in Goondiwindi. There are challenges in using the Queensland health system, for example the mental health services in that State are not available to NSW residents.

19.113 AMIHS has a team in Moree which services Toomelah and Boggabilla.

> *… we are having some difficulty recruiting a midwife to that team at the moment. One of the RNs in Boggabilla, who was recently appointed in a relieving role but likely to be taking on a more permanent role, is actually a midwife and so is doing a lot of that work at the moment as well. We are responding using those strategies. I think the maternal and infant health strategy is probably the most significant strategy that we use, not only in Toomelah-Boggabilla because it's not the only community that has those issues, yes.*[1014]

19.114 Funding has been received to establish a New Street program for juvenile offenders based in Tamworth and the Toomelah/Boggabilla community is the first priority community for that program.

19.115 HNEAHS said that it was difficult to obtain detailed health status data at a level of a small community. It said that over 200 Aboriginal people aged over 30 years had been offered screening and as a result 26 new diabetics had been diagnosed along with 29 new cases of heart disease. Half of those screened had been diagnosed as having diabetes and or heart disease or were considered at high risk of developing such conditions. Sixty per cent had accepted and attended referrals to other services.

19.116 The clinical services offered include immunisations, blood pressure, blood glucose, and child and adult health checks. A weekly antenatal program is available through Goondiwindi Hospital. Eye and vision clinics are provided through the Walgett Aboriginal Medical Service and there is a monthly visit by a renal Aboriginal health education officer. Various health promotions are run. Toomelah and Boggabilla preschools have been screened for Otitis Media throughout 2008.

19.117 Of particular interest, is an MOU which was entered into on 18 February 2008 between HNEAHS, Pius X Aboriginal Corporation and the Toomelah Community Council.

[1014] ibid., p.34.

19.118 The MOU acknowledges that the Commonwealth Department of Health and Ageing has funded Pius X Aboriginal Corporation to deliver primary health care services in Toomelah and Boggabilla. If that MOU is satisfied, there will be a considerably increased array of services available to the two communities. It is worth setting out in full.

19.119 Under the MOU, Pius X Aboriginal Corporation is to provide a senior Aboriginal health worker, an Aboriginal health worker and a vehicle, as well as a fortnightly substance abuse worker and weekly mental health worker. HNEAHS is to provide an Aboriginal health worker, registered nurses at Toomelah and Boggabilla, a community development facilitator, a general practitioner twice a week, an occupational therapist on request and by referral, a diabetes educator fortnightly, a drug and alcohol counsellor fortnightly, a mental health worker fortnightly, a dietitian monthly, an immunisation clinic and well baby clinic weekly, an Aboriginal midwifery service fortnightly, a child and family health worker, a sexual assault counsellor weekly, a PANOC counsellor by referral, a substance abuse project worker weekly, a renal health education officer weekly, a physician half day a week, palliative care by referral, cancer care social worker by referral, Families NSW worker (pending recruitment), Aboriginal family violence support worker, Aboriginal health coordinator, environmental health officer as required, asthma educator by referral and audiometrist.

19.120 According to a worker at the Pius X Aboriginal Medical Service:

> *It's a humungous problem and it needs a humungous amount of work in there to get anywhere because of the shame factor and of course it's shameful, but it is coming down from the generations. As I said, the kids think that's the norm until they get the idea that there's another way of life and this is a very, very sad thing.*[1015]

Police

19.121 Police resources in the area are as follows: there is no Domestic Violence Liaison Officer, there are six police officers at Boggabilla and one of three Aboriginal Community Liaison Officers in the Local Area Command covers Toomelah and Boggabilla. There are three JIRT positions at Inverell which covers Toomelah and Boggabilla while the Health worker for JIRT comes from Tamworth or Glen Innes. Forensic medical services are provided in Armidale or Tamworth.

19.122 Police informed the Inquiry that disclosures of child sexual assault were being made through their usual channels, Education and the community, rather than from the Team. Further, there has not been an increased willingness by people in Toomelah or Boggabilla to speak with Police about child sexual assault matters over the last couple of years.

[1015] ibid., p.59.

19.123 The Police expressed the challenges in obtaining evidence to support charges:

> *I know that JIRT have a great deal of difficulty trying to obtain the relevant evidence that they need to progress things. That is a very frustrating thing. It is very frustrating for the community because I think at times they don't understand the level of evidence we need to progress things, but it is very frustrating for the Police on the ground who are trying to contain the situation at the same time.*[1016]

19.124 The Team Manager's view was as follows:

> *I suppose, first and foremost, we have to accept, whether we like it or not, that it is not always the desire of the community for members of their group to actually be incarcerated: that's one point. Another point is that because of the nature of the environment in which these children are living, that it's not always going to be in their best interests either to disclose or to see something through. That is also dependent upon the supports that they have around them and the possibility that, for instance, their supports, as in their immediate family, if the family member is not the perpetrator, to withstand some of the pressures that can come. It is very different for a child in a Toomelah or even in a Boggabilla to deal with the ramifications of speaking out than it is for a child in a Blacktown or Dubbo or somewhere else.*[1017]

19.125 In discussions with members of the Australian Crime Commission, the Inquiry learned of the less formal methods which staff were using in engaging with local communities in the Northern Territory and which were achieving a greater level of disclosure. The lessons of this experience may be of assistance to JIRT officers.

Identifying gaps

19.126 As is clear from the introduction to this chapter, there has been considerable interest taken in these communities since 1988. Various plans, strategies and approaches have been developed over the decades.

19.127 Sensibly, in 2007, Aboriginal Affairs engaged a consultant to examine these various initiatives and to reduce them to specific actions.

[1016] ibid., p.25.
[1017] ibid., p.42.

19.128 Most of the actions identified derive from the Interagency Plan to Tackle Child Sexual Assault which is dealt with in the previous chapter. In addition, other strategies which are either in place or needed are described as including:

a. establishment of a preschool and occasional child care centre

b. the proposed appointment by Queensland Health of a health education/community liaison position

c. an upgrade of the sub-standard housing and water supply

d. an audit and assessment of assets

e. development of sporting programs

f. revival of the language

g. support for the Toomelah Family and Youth Support Service

h. provision of a bus service

i. vocational education for youth at risk and young offenders.

19.129 The consultant identified gaps including:

a. alternative accommodation for offenders

b. an assessment of the community capacity for the application of the Aboriginal Placement Principles for Aboriginal children and young persons in OOHC

c. wider use of the TAFE Certificate IV course in Aboriginal Cultural Education Program

d. cultural camps

e. employment related strategies

f. improved street lighting in Toomelah

g. night patrols

h. a service agreement with Moree Plains Shire Council.

Is the project working?

19.130 An evaluation of the Child Protection Project was proposed in October 2007. An expression of interest for that evaluation anticipated that a number of measures would be considered. Ultimately, for reasons associated with the anticipated ending of the project in December 2008, an evaluation of a different kind was conducted and a report prepared in October 2008. Those conducting the evaluation had access to similar written information to this Inquiry. In addition, they had a series of face to face meetings with groups and individual stakeholders during a three day visit to the communities.

19.131 Under the categories of child protection reports and responses, community engagement, capacity building, coordination and improvement in support

services and community education, the evaluation made the following observations or conclusions:

a. There had been a significant increase in reporting by the community, although the nature of the reports did not generally result in sufficient information being available for a prosecution.

b. New reports were being appropriately followed up and risk assessments undertaken.

c. Systemic failures including non-reporting by the schools and JIRT criteria had been addressed.

d. While building community engagement has been a core activity for DoCS, feedback was mixed about the work of the Team with the Boggabilla community being least satisfied.

e. Attracting and retaining staff was an ongoing difficulty for Health and DoCS.

f. While Police were generally positive about the effects of the project, the evaluation noted poor relations between the two schools and the Team.

g. Strong senior governance structures were in place, although at the local level this was not as evident.

h. No referrals had been made by DoCS of Toomelah or Boggabilla families to the Brighter Futures Lead Agency, notwithstanding the fact that there was capacity in that Agency (DoCS advised the Inquiry that referrals for Brighter Futures are made from Moree CSC, of which there have been five for Toomelah and Boggabilla).

i. A lack of services targeting youth was identified as well as the adverse impact of the closure of the community centre.

j. Service coordination was hampered by the absence of co-location and the lack of feedback by DoCS.

k. Community education was also been hampered by the delay in providing an education plan, the draft of which has not yet been accepted by other agencies and the communities, although some work of an educative nature had occurred.

l. The evaluation concluded that the project had “achieved quite a lot, but still had a way to go.”

19.132 The Inquiry reviewed the success of the project by reference to the measures which were set out in the initial expression of interest document. They appear below in bold. The data available to the Inquiry is discussed beneath each measure.

Frequency and severity of reports and number of further reports after DoCS (appropriate) action. The criteria for success are stated to be decreasing reports

19.133 Between January 2003 and November 2005, 61 children and young persons were the subject of a child protection report, of whom 60 per cent received no assessment and five per cent received a SAS2. In 2006/07, 31 children and young persons the subject of a child protection report which was allocated to the Team and in the following nine months, the number of children and young persons involved in reports doubled as did the number allocated. This may be due to an increase in reporting overall, an increased capacity in the team, or it may indicate a lack of success by the team or, conversely, success in raising the awareness of child sexual assault.

19.134 There has been a decrease in the number of reports requiring a less than 24 hours response and an increase in the number of reports requiring responses within 72 hours and within 10 days. This may suggest that the presence of the Team in the community has enabled them to address risks earlier. Of the 38 children and young persons who received a SAS2 and for whom information was available in relation to DoCS follow up, it appears that most received some sort of referral, although its outcome is unknown.

19.135 There has been no significant change in the number of children and young persons reported more than once, although the rate of multiple reports is lower than that which occurs on average across the State.

19.136 Of the 11 children and young persons reported more than once in 2007/08, for whom the Inquiry had information about the action taken by DoCS, two were being dealt with by Moree CSC and had been referred to JIRT, three had been referred to JIRT by the Team, one had relocated and the remainder had received support in one form or another from DoCS, as described earlier in the chapter. The dates of the relevant response and their results are not known, so no real conclusions can be drawn.

19.137 There has been increased reporting of sexual abuse, physical abuse and inappropriate sexual behaviour by a child.

19.138 Fewer children and young persons have been removed.

Number of prosecutions and convictions initiated

19.139 Overall, there have been few criminal charges laid, which although disappointing, is hardly surprising.

Number of children and young persons counselled, number of children and young persons and families where DoCS provides follow up and support and nature and type of preventative measure implemented.

19.140 The data provided to the Inquiry are set out earlier. There has been an increase in the number of children who received a SAS2, although whether or not that resulted in the provision of any particular services and whether they were successful is not known.

Improved school attendance, health measures and changes in parental supervision, neglect, domestic violence and drug and alcohol abuse

19.141 Improved school attendance has been reported at Toomelah Public School and there have been reduced class sizes in each school. There is some indication of improvement in performance at Boggabilla Central School.

19.142 There is not sufficient information about changes to health status. HNEAHS told the Inquiry that it is difficult to obtain detailed health status data at the level of a small community.

Communication protocols approved and distributed

19.143 The protocols are in place and the comments made to the Inquiry by the relevant agencies were generally positive. It is noted however that the evaluation reported some dissatisfaction with DoCS, in particular concerning feedback.

Change in community awareness

19.144 There has been an increase in reports from non-mandatory reporters from nine per cent in the first year the Team operated to 20 per cent in the following year.

19.145 There has been an increase in reports from Health from 0 to 17 per cent of all reports by mandatory reporters.

19.146 There has been a decrease in the proportion of reports from Education from about 39 to 32 per cent.

Meetings held with elders, men’s and women’s groups and other community members

19.147 The success of these groups has been patchy although a young women’s group has been recently established. There is evidence from the interagency meetings organised by the Inquiry that a range of meetings have been held by DoCS and other agencies.

Number of services that have improved capacity to deliver services

19.148 There appears to have been an enhanced capacity by Health to deliver some services, although gaps, as set out earlier, remain. Similarly, the funding available to Education suggests an improved capacity.

Project costs sustainable

19.149 According to DoCS, the Team cost just under $1 million in the year 2007/08 and it expects to spend about $700,000 in the second half of 2008. The source of funding has been existing consolidated revenue. The key costs have been staffing.

19.150 In addition to these funds, the CSGP has funded $130,000 for the Toomelah Family and Youth Support Service. The Children's Services Program has funded a preschool and occasional care centre with an annual cost of about $115,000 providing 35 places. The Alcohol and Other Drugs Program for the year 2008/09 will fund about $170,000 for the Toomelah/Boggabilla Getting it Together Program.

19.151 Those figures contrast with the projected costs in 2006, when it was estimated that the costs would be around $650,000 in 2006/07, $688,000 in 2007/08 and $638,000 in 2008/09.

19.152 It is clearly very resource intensive and more so than anticipated.

Other measures

19.153 The Inquiry does not have sufficient information to comment on the remaining indicators, that is the:

a. number of local persons appointed to community development, counselling, youth work and family support roles

b. percentage of case plans which are collaborative

c. percentage of documented collaborative efforts

d. percentage of children and young persons who have received services in line with their case plan

e. nature, type and attendance levels for training for:

   i. government and non-government staff

   ii. children and young persons

   iii. parents and other adults

f. children and young persons who view services as responsible and culturally sensitive

g. perceived increases in safety and reduced vulnerability in the community.

19.154 The Inquiry has not viewed individual files and, in particular, care plans to determine their adequacy and whether they have been implemented. A different story may emerge from that material.

19.155 The Inquiry also reviewed the progress being made against the recommendations of the ACSAT report and considered the issues arising from the evaluation of the project.

19.156 The report contained 119 recommendations for implementation across Government. A detailed analysis of the Interagency Plan appears in the previous chapter.

19.157 The plan contains a number of recommendations which relate to priority locations, Toomelah/Boggabilla being one of them. The Inquiry has applied the work being done by the Team and the Government, about which the Inquiry has sufficient information, against those measures which have been identified as necessary to address child sexual assault in Aboriginal communities.

19.158 Generally, the work being done is in line with the recommendations and indicates that progress is being made. First, in relation to the work which is consistent with the Plan, the following has occurred:

a. In relation to options for removing impediments to reporting child sexual abuse and family violence, there has been increased reporting, particularly from Health, and education sessions with mandatory reporters have been conducted including school principals and the Queensland Department of Child Safety (actions 36 and 37).

b. Truancy is being addressed in a number of ways (action 61 and 62).

c. Community placements have ultimately been found for all young children who could not remain with their parents/carers (action 40).

d. Community events have been held including a child protection summit in September 2007, a community education plan has been developed, personal development classes have been delivered at school and there has been interaction with schools, police and NGOs (action 81).

e. A treatment program for children who sexually offend is being established in Tamworth and will take clients from Toomelah/Boggabilla (action 56).

f. AMIHS has been implemented in Moree and covers Toomelah/Boggabilla (action 64).

g. Experienced Aboriginal staff have been recruited, one of whom is JIRT trained (actions 38, 63 and 66).

h. Cross border meetings are held (action 65).

19.159 Secondly, in relation to those areas where progress is not as stipulated in the Plan:

a. No research on safe houses for Aboriginal women has been carried out (action 41).

b. There is no ongoing coordinated program for school holiday activities or sport and recreational facilities and transport remains a key issue for the communities (action 62).

c. The sexual assault counselling position and the community development worker position exists but neither is filled and both have been vacant for some time (action 44).

Conclusion

19.160 The Child Protection Project was established with an expectation that results would be unlikely to be seen for five to 10 years. Two years in, it is fair to say that there have been modest gains.

19.161 Knowledge in the professional community of child protection issues seems to have improved as seen through the indicator of increased reporting by those mandated to do so, in particular health workers. While a high level of awareness of child protection issues among those living in the communities of Toomelah and Boggabilla was not demonstrated to the Inquiry, the Inquiry accepts that there may be little connection made in the communities between the activities encouraged by the Team and child protection.

19.162 There is available to the Inquiry little information about outcomes for children and young persons reported in the communities. Although, that is true for much of NSW, the numbers of children involved are relatively small.

19.163 There is a deal of information about the costs of the Child Protection Project and some information about the expenditure by Education. Health appears to have committed to make available significantly more resources than were previously available in the community. The Project is without doubt resource intensive and more so than was originally envisaged.

19.164 The complexities and challenges are significant and the interplay with other events such as the death of key community members and the performance of the Land Council, cannot be predicted.

19.165 What is clear to the Inquiry is that no intervention will be successful until many, and particularly leaders within the community, want their lives, and the lives of their children, to change and subsequently begin to participate actively in causing that change. It is not only the responsibility of government and non-government agencies. It has struck the Inquiry that it is the young persons who need to be engaged, along with those young mothers and fathers whose own parents have been unable to help them. The young mothers' group may assist.

19.166 A key issue is the planned finalisation of the Child Protection Project at the end of this year. Most agencies expressed concern to the Inquiry that it would be detrimental to the community for it not to continue. The importance of DoCS presence should not be understated, the Inquiry was informed, it seems

because of the pivotal role played by the Team manager and the Team's consistent and visible role, at least, so far as the professional community is concerned.

19.167 The Inquiry is of the view that it is too early to wind the project up and to refer case management back to Moree CSC. It should continue for up to 18 months on the basis that more comprehensive data are kept, particularly on outcomes, that there is closer collaboration with the new health workers, with whom the Team is preferably co-located, and that there are more referrals to the Brighter Futures Lead Agency.

19.168 DoCS has recently informed the Inquiry that it has made a commitment to the Toomelah/Boggabilla project for a further two years and noted that it had not been funded to do so. The costs of the Project are estimated to be about $773,000 in 2008/09 and about $795,000 in 2009/10.

19.169 Whether this project, or aspects of it, is an appropriate model for child protection work in other Aboriginal communities, is not yet known. While it began at the invitation of some of the elders, it has not continued in that vein, which may be partly because of their deaths, or because their vision was not necessarily shared by other members of the community. It is the case that it incorporates many of the features identified in the literature as contributing to a good model. That literature is discussed in the previous chapter.

19.170 An area which does seem to require more attention, and which was addressed at the Public Forum, was the need for the local community and the broader community, particularly those delivering services in the area, to acquire a better understanding of the history that led to these communities becoming dysfunctional, and of the differences in culture that might lead to a better understanding and partnership.

Report of the Special Commission of Inquiry into Child Protection Services in NSW

Volume 3

The Hon James Wood AO QC

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Acronyms

Acronyms	*Phrase/meaning*
1987 Act	*Children (Care and Protection) Act 1987*
AAE	Allegations Against Employees
AAS	Area Assistance Scheme
Aboriginal Affairs	Department of Aboriginal Affairs
Aboriginal Placement Principles	Aboriginal Child Placement Principles
ABS	Australian Bureau of Statistics
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACSAT	Aboriginal Child Sexual Assault Taskforce
ACWA	Association of Children's Welfare Agencies
ACYFS	Aboriginal, Child, Youth and Family Strategy
ADR	alternative dispute resolution
ADT	Administrative Decisions Tribunal
AHS	Area Health Service
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMIHS	Aboriginal Maternal and Infant Health Strategy
AODP	Alcohol and Other Drugs Program
Attorney General's	Attorney General's Department
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
CALD	culturally and linguistically diverse
Care Act	*Children and Young Persons (Care and Protection) Act 1998*
CCYP	Commission for Children and Young People
CCYP Act	*Commission for Children and Young People Act 1998*
CCYP Act	*Commission for Children and Young People Act 1998*
CDC	Caseworker Development Course
CDCRU	Child Deaths and Critical Reports Unit (DoCS)
CDRT	Child Death Review Team
CEC	Chief Executives Committee
CEO	Chief Executive Officer
CIW	Corporate Information Warehouse
Clinic	Children's Court Clinic
COAG	Council of Australian Governments
Community Welfare Act	*Community Welfare Act 1987*
Corrective Services	Department of Corrective Services
CRC	Children's Research Center
CS CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993*
CSC	Community Services Centre
CSGP	Community Services Grants Program
CYP	Children and young persons
DADHC	Department of Ageing, Disability and Home Care
Discussion Paper	DoCS Discussion Paper, *Statutory child protection in NSW: issues and options for reform,* October 2006
Displan	NSW State Disaster Plan

Acronyms	*Phrase/meaning*
District Court	District Court of NSW
DoCS	Department of Community Services
DPP	Office of the Director of Public Prosecutions
Education	Department of Education and Training
EOI	expression of interest
ESD	Enhanced Service Delivery
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
Family Court	Family Court of Australia
Family Law Act	*Family Law Act 1975*
FGC	family group conferencing
FTE	full time equivalent
Health	NSW Health
HNEAHS	Hunter New England Area Health Service
Housing	Housing NSW
HREOC	Human Rights and Equal Opportunity Commission
HRIP Act	*Health Records and Information Privacy Act 2002*
IFBS	Intensive Family Based Services
Interagency Guidelines	*Interagency Guidelines for Child Protection Intervention 2006*
Interagency Plan	Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011
JIRT	Joint Investigation Response Team
JRU	JIRT Referral Unit
Juvenile Justice	Department of Juvenile Justice
KiDS	Key Information and Directory System
LAC	Legal Aid Commission NSW
LAC proposal	Draft Proposal for a Care and Protection Mediation Pilot (Legal Aid NSW)
LAT	Less Adversarial Trial
Law Society	Law Society of NSW
Magellan	Magellan Case Management Model
MOU	Memorandum of Understanding
NCOSS	Council of Social Services of NSW
New Street	New Street Adolescent Service
NGO	non-government organisation
NTER	Northern Territory Emergency Response
OHS	Occupational Health and Safety
Ombudsman	NSW Ombudsman
Ombudsman Act	*Ombudsman Act 1974*
OOHC	out-of-home care
PANOC	Physical Abuse and Neglect of Children
Police	NSW Police Force
PPIP Act	*Privacy and Personal Information Protection Act 1998*
PPR	Personal Planning and Review
Premier and Cabinet	Department of Premier and Cabinet
PSA	Public Service Association
RACP	Royal Australian College of Physicans
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCMG	Regional Coordination Management Group

Acronyms	*Phrase/meaning*
Regulations	*Children and Young Persons (Care and Protection) Regulation 2000*
Rules	*Children's Court Rule 2000*
SAAP	Supported Accommodation Assistance Program
SACS Award	Social and Community Services Award
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment State 2
SCAN	Suspected Child Abuse and Neglect
SCI	Special Commission of Inquiry
SDM	Structured Decision Making
SDRC	State Disaster Recovery Centre
SERM Act	*State Emergency and Rescue Management Act 1989*
SNAICC	Secretariat of National Aboriginal and Islander Child Care
Treasury	NSW Treasury
Triple P	Positive Parenting Program
Usher Review	Review of Substitute Care Services in NSW 1992
Young Offenders Act	*Young Offenders Act 1997*

20 Young people, leaving care and homelessness

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Introduction

20.1 This chapter is concerned with the problems that are likely to be experienced by adolescents and young persons while in statutory care, and when leaving care. For the purposes of this chapter 'adolescents' are taken to be children within the age group of 12–15 years, and 'young persons' are those who are aged 16 years or above and under the age of 18 years.[1] Collectively the two groups are referred in this chapter to as 'young people.'

20.2 Some young people will have had multiple placements in statutory OOHC or in supported care before reaching the age of 12 years. They are particularly likely to experience breakdown in their placements during their teenage years, this being a period of intense and rapid development, and they are likely to face substantial challenges in making the transition to independent living. Often the experience of transition will be one of inadequate accommodation, emotional vulnerability, difficulty in securing employment, early parenthood, homelessness, substance abuse, mental health problems, lack of support, relationship difficulties and poverty. Save where they have had the benefit of high quality and enduring foster care, most will have limited education and vocational training as well as unaddressed physical, mental and dental health problems.[2] Homelessness and involvement with Juvenile Justice, both while in care and after leaving care, will not be unusual.[3] Reluctance to accept guidance and counselling will be common.

20.3 The lower priority given to young people has been recognised by the NSW Ombudsman who noted the observations of the National Youth Commission in its 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.*[4]
>
> …
>
> *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*

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[1] *Children and Young Persons (Care and Protection) Act 1998* s.3.

[2] J Cashmore and M Paxman, "Longitudinal Study of Wards Leaving Care: four to five years on," *Social Policy Research Centre*, University of New South Wales, January 2007; C Smyth and T Eardley, "Out-of-Home Care for Children in Australia," *Social Policy Research Centre*, University of New South Wales, February 2008, p.4.

[3] C Smyth and T Eardley, "Out of home care for children in Australia: A review of literature and policy. Final Report," *Social Policy Research Centre, University of New South Wales,* February 2008, p.7.

[4] A Report of the National Youth Commission Inquiry into Youth Homelessness, *Australia's Homeless Youth*, 2008, p.125.

> *being prioritised at the expense of support for older children who are being regarded as 'less vulnerable'. In another practical sense, they are 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 reliance 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.*[5]

20.4 The priority which DoCS gives in responding to younger children at risk of harm, and the eligibility criteria for services under the Brighter Futures program,[6] have meant that less attention has been given to young people.

20.5 In this chapter, the inadequacies of the current system so far as it impacts upon young people are identified, and recommendations for reform are developed. In order to place that analysis into perspective, it is helpful to note the following statistical profile.

What the data tell us about young people

20.6 Reports, involving adolescents (12-15 year olds) comprised 24.2 per cent of all reports to DoCS in 2007/08 (preliminary) which is slightly higher than in 2001/02, when such reports accounted for 23.3 per cent of all reports.

20.7 Reports involving young persons (16-17 years old) comprised 4.2 per cent of all reports to DoCS in 2007/08, which, like reports involving adolescents, is slightly higher than in 2001/02 when such reports accounted for 3.8 per cent of all reports.

20.8 As discussed in Chapter 5, there has been an 89.8 per cent increase in the total number of reports between 2001/02 and 2007/08. Over the same period, reports involving adolescents have increased by 96.4 per cent and reports involving young persons have increased by 112.5 per cent. Therefore the number of reports involving adolescents and young persons have increased at a greater rate than for reports across all age groups.

20.9 Adolescents comprised 22.6 per cent of all children and young persons involved in reports to DoCS in 2007/08. This is slightly higher than in 2001/02 when adolescents accounted for 21.5 per cent of all children and young persons involved in reports.

---

[5] ibid., p.136.

[6] That program is reserved for families with at least one child aged eight years or younger or who are expecting a child.

20.10 Young persons comprised 5.1 per cent of all children and young persons involved in reports to DoCS in 2007/08. This is slightly higher than in 2001/02 when young persons accounted for 4.4 per cent of all children and young persons involved in reports.

20.11 There has been a 54.0 per cent increase in the number of children and young persons reported between 2001/02 and 2007/08. Over the same period, there was a 61.5 per cent increase in the number of adolescents and a 77.2 per cent increase in the number of young persons who were reported to DoCS.

20.12 After children aged less than one year, the percentage increase in reports since 2001/02 was greatest among adolescents and young persons.

20.13 In both 2006/07 and 2007/08 (preliminary) the average number of reports for each child or young person reported was 2.3. For every adolescent the average number of reports in both years was 2.5 and for every young person the average was 1.9 reports. Based on this data, adolescents are likely to be the subject of a slightly higher than average number of reports per year and young persons are likely to be the subject of a slightly lower than average number of reports per year.

20.14 The highest average number of reports per child or young person in 2006/07 were for children aged less than one year, and adolescents aged 13 years and 14 years. Not only do people of these ages receive the highest number of reports about them, the rates of reporting per 1,000 population for these ages are also relatively high.[7]

20.15 While adolescents accounted for 22.6 per cent of all children and young persons involved in reports in 2006/07, they accounted for:

a. 22.8 per cent of all children and young persons reported to DoCS between one and three times

b. 22.2 per cent of all children and young persons reported to DoCS between four and 10 times

c. 25.4 per cent of all children and young persons reported to DoCS between 11 and 20 times

d. 56.8 per cent of all children and young persons reported to DoCS over 20 times.

20.16 Of most significance is the number of adolescents who were the subject of more than 20 reports as a proportion of all children and young persons.

20.17 In 2006/07, 43.2 per cent of all children and young persons who were the subject of a report to DoCS were reported for the first time ever. In the same year, 9,892 adolescents were reported for the first time in 2006/07, which accounted for 35 per cent of all adolescents who were the subject of a report in

[7] DoCS, *A closer look: Recent trends in child protection reports to DoCS*, December 2007.

2006/07. There were 2,174 young persons reported for the first time in 2006/07, which accounts for 34.9 per cent of all young persons reported.

20.18 Therefore, compared with the children and young persons who were the subject of reports across all age groups, a higher proportion of adolescents and young persons who were reported to DoCS already had a child protection history. However, this finding is to be expected.

20.19 10.3 per cent of all children and young persons reported in the period 1 April 2007 to 31 March 2008 received at least one secondary assessment that determined harm or risk of harm. 9.8 per cent of all adolescents reported and 4.8 per cent of all young persons reported received at least one secondary assessment that resulted in a determination of harm or risk of harm. Therefore adolescents were slightly less likely than children and young persons across all age groups to be the subject of a report that proceeded to SAS2 and resulted in a determination of harm or risk of harm. Young persons who were the subject of a report were significantly less likely to be the subject of a completed SAS2 that resulted in a determination of harm or risk of harm.

20.20 As at 31 March 2008, adolescents accounted for 25.7 per cent and young persons accounted for 8.7 per cent of all children and young persons in OOHC.

20.21 Of the 4,686 children and young persons who entered OOHC from 1 April 2007 to 31 March 2008, 18.7 per cent were aged 13-17 years. Of this group 28.1 per cent were Aboriginal, which is slightly lower than the 31.3 per cent of children and young persons in OOHC in the same period who were Aboriginal.

20.22 Over half (56.3 per cent) of the 13-17 year olds who re-entered OOHC in 2006/07 had been in care two or more times previously (with an average of three times). This group had spent an average of 1,390 days in care previously (total of all their OOHC episodes).[8]

20.23 As at 31 March 2008, 63.4 per cent of children and young persons in OOHC were in statutory care and 35 per cent were in supported care.[9] The percentage of young persons in supported and statutory care is similar to the average across all age groups, but for adolescents, a higher proportion (42.2 per cent) were in supported care.

20.24 As at 31 March 2008, 66.7 per cent of young people in DoCS statutory care had an allocated caseworker compared with 74.5 per cent for younger children. Similarly, young people in DoCS supported care were less likely to have an allocated caseworker when compared with younger children (26.7 per cent compared with 38.0 per cent).

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[8] DoCS, *Analysis of children and young people who entered OOHC in 2006/07*.

[9] The remaining 1.6 per cent of children and young persons in OOHC were either in other voluntary care arrangements or their care arrangements were not stated.

20.25 This is largely because the allocation rates for children two years and younger are significantly higher than for all other age groups. Across statutory and supported care, the allocation rates for children aged 5-11 years are only slightly higher than for young people.

Funding for youth projects

20.26 DoCS funds a range of youth specific services through the CSGP. It also provides funding for adolescent counsellors, child sexual assault services, youth support services, drop in and social support networks. Through SAAP, funding is provided for accommodation, case management and brokerage to support homeless young people and young people at imminent risk of homelessness. Better Futures is a program for 9-18 year olds which focuses on youth participation, keeping older children and young people at school and helping them make a safer transition to adulthood.

20.27 The Inquiry notes that additional service models have been developed in other states with a particular focus on young people, and which depend on a 'wraparound' process or interagency coordination.

20.28 Several submissions to this Inquiry made the point that key programs, such as Better Futures and the CSGP, have been unable to provide sufficient interventions for young people with at risk behaviours or high support needs, in part due to the lack of sufficient funding and in part due to a lack of any clear focus on this group. The point has also been made that Families NSW is primarily focused on those cases where there are children up to eight years of age, and that there is no matching strategy for adolescents and young persons.[10]

20.29 The Inquiry favours the development of models that will advance interagency cooperation and collaborative responses for young people, together with an increase in funding that would permit greater attention to be given to the provision of early intervention services particularly for the 9-14 years of age group, as discussed earlier in this report.

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[10] The current Inquiry by the Parliamentary Joint Committee for Children and Young People into Children and Young People aged 9–14 years should provide additional insight into the sufficiency of the current system to address the needs of this group.

Casework practice with young people in statutory care

Casework skills relating to young people

20.30 The Inquiry has the benefit of a limited study that was undertaken in 2007 by DoCS in relation to the perceptions of its staff in relation to casework practices with young people. The resulting report noted:

> *…that it is common for workers to be overwhelmed by the complexity of presenting problems and the limited time that is available.*[11]

20.31 Caseworkers reported that they did not really have time to engage young people with the crisis nature of their work and that:

> *we may have a conversation in the car and then refer them to a worker at the end of a phone … our intention is to set up a relationship with them to establish boundaries and to follow that through, but in terms of following through we are not so good.*[12]

20.32 The study identified the limited extent to which effective casework practice with young people had been the subject of study or research, that could provide guidance to staff in working with this group.[13]

20.33 Significantly, it would suggest that special skills training and experience are required for caseworkers working with young people, and that a delicate balance needs to be established in:

a. working with young people while respecting the interests of their family

b. establishing an ongoing relationship of support without taking over the life of those within this group

c. establishing boundaries without being too authoritarian.

20.34 Caseworkers in this study also identified the almost chronic lack of services to meet the needs of young people as a factor determining poor outcomes. They pointed to the waiting lists for many services, such as mental health services and reported spending hours and days on the phone trying to secure an OOHC placement for these young people.[14]

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[11] DoCS, *Effective casework practice with adolescents: perceptions and practice of DoCS staff*, December 2007, p.1. Although that report employs the term 'adolescents' that is defined as including people within the age range of 12-18 years.

[12] ibid., p.19.

[13] ibid., p.1.

[14] ibid., p.19.

20.35 Notwithstanding these difficulties, effective interagency work was seen as crucial to assisting positive outcomes,[15] as was the need for reciprocal sharing of information.

20.36 One of the Inquiry's case studies highlighted the difficulty in finding stable and suitable accommodation for an adolescent.

Case Study 23

Due to difficulties living at home a series of Temporary Care Orders were signed for A, a 15 year old girl, with the mother's consent. DoCS tried to find appropriate placements for A. Initially A stayed with her maternal aunt but after it was alleged that A sexually assaulted the maternal aunt's daughter another placement was required.

In December 2006 A's mother consented to a care application for A. Further reports on A continued to be received by DoCS concerning A's ongoing conflict and risk taking behaviour. On 23 March 2007 the Court expressed 'very serious concerns' about the level of supervision provided to A while she was in the refuge.

A then had 3 foster care placements all of which broke down due to her escalating violent behaviours. After another short term placement A was placed in crisis refuge accommodation in February 2007 until a stable long term placement could be found.

A number of crises, and an allegation of sexual assault, occurred whilst A was in the refuge, particularly in regard to one of the other residents. A was no longer attending school.

During her time at the refuge over 40 reports were made about her violent outbursts, ongoing conflict with residents, self harm, risk taking behaviours. DoCS continued to seek appropriate alternatives but none were available for A as she had high and complex needs.

In July 2007 A made an allegation of sexual assault by her (former) foster carer.

A's placement continued until August 2007 when she self placed with her boyfriend. DoCS raised concerns about A while she was with the boyfriend as he had a significant criminal history, was violent towards her and had mental health issues.

A DoCS funded placement for high needs children became available in December 2007 which was appropriate for A's needs. A moved into new placement but stayed only one night and left to be with her boyfriend.

[15] ibid., p.16.

> A absconded from the placement repeatedly. When A became pregnant significant support and information was provided to her regarding her options and available services, including a number of discussions regarding the possibility that DoCS may remove the child. Significant supports were also provided when she terminated her pregnancy.
>
> In January 2008 the specialist accommodation service was advised that the bed was no longer required for A and that it could be allocated to another client. DoCS arranged two emergency placements on a crisis basis should the need arise and A would need to leave her boyfriend.
>
> A's boyfriend was charged with assault of A in February 2008 and arrested. DoCS and the Domestic Violence Liaison Officer provided support and assistance to A. A self placed with 'friends' (referred to as drug users/dealers) but was found and taken back to her former placement at the refuge on. She stated to her caseworker that she was having problems in the placement and wanted to move. DoCS tried to find alternate accommodation but she absconded again.

20.37 Included in the study referred to earlier were some caseworkers who worked in one of the three now defunct adolescent casework teams which DoCS had in place at the time of the study. Their experience, the need for specialist skills in this area, the absence of any specific practice directions concerning young people, and the reported difficulties which new caseworkers have in coping with this age group, suggest that more needs to be done by DoCS and others to cope with a sector that is now a significant part of its client base.

20.38 The Inquiry notes that the Department of Human Resources in Victoria has specialist adolescent care workers located within each region. Their special skills and experience in dealing with high needs and difficult adolescents has been seen as critical to successful casework practice. This Inquiry is of the view that similar positions should be considered in NSW initially in the regions and eventually at the CSCs, with equivalent status of a casework specialist.

20.39 So far as the Inquiry has been able to ascertain the members of DoCS staff with a specific focus on young people have been the caseworkers attached to street teams, for example, at Kings Cross and at Cabramatta, the 50 intensive support service caseworkers dealing with the high needs client group (which includes a high proportion of adolescents) and the caseworkers forming the Hunter Youth Support Team, who work exclusively with adolescents and provide a consultancy service to other community service centres. While these caseworkers can provide expert assistance for the young people who they can reach, there would seem to be a potentially larger group who could benefit from similar assistance.

20.40 Equally needing additional training and support following authorisation as a carer are the foster carers and kinship and relative carers responsible for the day to day care of young people in care.

Interagency cooperation

20.41 The need for close interagency cooperation in responding to the needs and vulnerabilities of young people in care cannot be understated, as has been indicated by the work of the Ombudsman and the CCYP in the reviews of the deaths of those within this group,[16] which revealed numerous system deficiencies.

20.42 It is understood that DoCS and Health have identified a number of strategies and have taken several initiatives to address these concerns as follows:

a. A DoCS research project looked at practice issues in engaging with young people and aimed to identify serious suicide and self harm patterns in vulnerable young people and to promote models for successfully delivering services to young people in care.

b. A DoCS panel was established to meet on a quarterly basis to focus on suicide/risk taking deaths of young people known to it.

c. DoCS has worked with the Child and Adolescent Mental Health Services Network with the aim of developing a draft framework for ensuring that appropriate mental health services were provided to children and young people.

d. DoCS and Health have an MOU in place which provides for priority access to health services by people under the parental or care responsibility of the Director-General, DoCS or the Minister,

e. An addendum to the MOU has been developed to improve linkages between the two Departments in relation to the care of young people, with a key consideration being risk management and suicide prevention with the aim of providing effective interagency coordination and establishing a system that could meet the needs of those within this age group, in terms of their mental health and risk of self harm or suicide.

20.43 These initiatives are positive and their implementation will need to be monitored. As DoCS informed the Inquiry, mental health, disability and drug and alcohol issues generally emerge during adolescence. There is a risk that these issues will progress unless addressed. As a result, the Inquiry is of the view that attention needs to be given to making the services necessary to deal with these problems more available, and to facilitate their coordination and ease of access.

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[16] For example: NSW Commission for Children & Young People, "Suicide and Risk-Taking Deaths of Children and Young People," *National Centre for Classification in Health*, 2003; NSW Ombudsman, *Causes of death of reviewable children in NSW, 2003-2006*, June 2007; NSW Ombudsman, *Reports of Reviewable Deaths, 2004, 2005, 2006*.

Leaving statutory OOHC

Leaving care statistics

20.44 In the period 1 April 2007 to 31 March 2008, 2,703 children and young persons exited care. Of these 24.2 per cent (655) were adolescents and 19.6 per cent (529) were young persons. Of the 1,184 young people exiting OOHC, 26.9 per cent (319) were Aboriginal.

Outcomes for young people leaving care

20.45 Those leaving care have uniformly been recognised as one of the most disadvantaged and vulnerable groups in society, yet they do not always receive the support they need to settle their lives and to find accommodation and employment.[17]

20.46 Longitudinal studies on young people leaving care, for example that of Cashmore and Paxman, provide evidence that as a group, they:

> *fare more poorly than other young people their age in the general population. They are less likely to have completed school and to have somewhere safe, stable and secure to live; and they are more likely to rely on government income support, to be in marginal employment, and to have difficulties in 'making ends meet'.*
>
> *Most cannot call upon the level of support from their families and the wider networks, which are usually available to young people in the general population.* [18]

20.47 The assumption that like other young people they will access welfare benefits for support is not necessarily well founded. Nor is the assumption that by the time they leave care they will have become 'street smart' and able to care for themselves.

20.48 In addition to their adverse circumstances, including the complicating factors that may intrude while in care such as placement instability, and the limited support available to them, young people leaving care will also have to cope with a number of major changes in their lives in a shorter period of time and at a younger age than many of their more advantaged peers.

20.49 The findings from the Cashmore and Paxman study of wards leaving care indicate that how well this group were faring four to five years after leaving care is a result of what happened to them in care (as well as their experiences before

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[17] Australian Senate Community Affairs Committee, *Protecting vulnerable children: A national challenge. Second report on the Inquiry into children in institutional or out-of-home care,* March 2005.

[18] J Cashmore and M Paxman, 2007, op. cit., p.135.

coming into care), the timing and circumstances of leaving care, and the amount of support they had around them after leaving care.

20.50 Cashmore and Paxman found that within the first 12 months of leaving care:

a. care leavers had moved on average three times
b. almost half were unemployed
c. nearly one third of young women were pregnant or had a child soon after transition
d. just over half had completed only year 10 or less schooling
e. over half had thought of or attempted suicide.

20.51 Maunders et al found from their national overview that:

a. 42 per cent of their sample had been discharged from care before the age of 18 years
b. half had experienced a period of homelessness
c. almost half had committed criminal offences since leaving care.[19]

20.52 The most significant in-care factors identified by Cashmore and Paxman were stability and, more importantly, a sense of security in care.[20] Stability is important because it allows young people to 'put down roots' and develop a network of relationships. Clark similarly found that:

> *the single most important ingredient of effective service provision with these young people is the quality of the direct care staff and their capacity to either offer caring and connectedness to these young people or to foster this kind of relationship between the young person and some other nurturing adult.*[21]

20.53 Given the number of transitions these young people face, one approach suggested has been to stagger the timing of these transitions.[22] One example is to delay the transition from care for those young people still in secondary school until after they have completed their schooling. This is likely to improve their chances of completing their secondary education significantly, and to give them better employment prospects and the possibility of going on to further education. It also provides them with some continuity of connection and relationships, together with continuing practical and emotional support.

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[19] D Maunders, M Liddell, M Liddell and S Green, *Young People Leaving Care & Protection: A report to the National Youth Affairs Research Scheme*, 1999, cited in CREATE Foundation, "Report Card: Transitioning from Care," March 2008, p.16.

[20] J Cashmore and M Paxman, 2007, op. cit., p. 124.

[21] R Clark, "It has to be more than a job; A search for exceptional practice with troubled adolescents," *Melbourne: Deakin University – Policy and Practice Research Unit.*

[22] J Cashmore and M Paxman, 2007, op. cit., p.128.

20.54 For most young people the transition to adulthood is gradual, yet most jurisdictions relinquish their parental responsibilities for young people in care once they reach 18 years of age. This is in contrast to the experience of many other young people of this age who continue to receive financial and emotional support from their families. The Midwest Evaluation of the Adult Functioning of Former Foster Youth is a prospective study following a sample of young people in Iowa, Wisconsin, and Illinois as they make the transition from foster care to early adulthood. The Midwest study presents an opportunity to compare the outcomes of young people who 'aged out' of care in states with different policies (that is, at 18 years of age, 21 years of age, and with differing types of entitlements). Data from the Midwest study suggest that allowing foster youth to remain in care past age 18 years increases their likelihood of attending college and their likelihood of receiving independent living services after age 19. It may also increase their earnings and delay pregnancy.[23]

20.55 DoCS Economics, Statistics and Research Directorate, at the request of the Inquiry, completed an estimate of the costs of implementing the following two scenarios in NSW:

a. Scenario A: 15 per cent of young people exit at age 18 years, a further 10 per cent exit at age 19 years, a further 15 per cent exit at age 20 years, and remaining 60 per cent exit on their 21st birthday, with after care support provided to eligible exited young people up to age 25 years.

b. Scenario B: 100 per cent of young people exit on their 21st birthday with the same after care supports as for scenario A.

20.56 DoCS analysis included estimating the number of young people in each scenario, assuming it was not retrospective. If the policy allowed OOHC young people to remain in care (statutory and relative/kinship care) up to age 21 years in NSW, then the incremental costs would be as follows:

a. policy scenario A: $42 million per annum

b. policy scenario B: $55 million per annum.

20.57 The trend in most jurisdictions, which this Inquiry supports as an alternative to extending the date for leaving care, is to start preparing young people for their change of status well before the transition occurs. If this preparation occurs while they are in care they should be given the life skills to manage greater independence for example, through the funding of driving lessons and through encouraging them to earn their own income through part time work. However, care needs to be taken that those in stable placements do not become destabilised by the process.

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[23] ME Courtney, A Dworsky, and H Pollack, "When Should the State Cease Parenting? Evidence from the Midwest Study," *Chapin Hall Centre for Children*, Issue Brief 115, December 2007, p.8.

20.58 Morgan Disney's study on the transition from care provides information about the current alternative pathways for young people after they leave care and the comparative cost of these pathways to governments. The study aimed to:

> *establish the extent of potential savings if a proportion of young people were successfully diverted, through better support at the point of transition, to lower usage service pathways and to pathways, which are economically and socially more productive.*[24]

20.59 The study estimated that:

> *costs to government of this cohort*[25] *over the life course from age 16 to 60, is just over $2 billion…..This is equivalent per annum to an estimated cost of approximately $46 million for a cohort of 1150 persons and to an average estimated cost of approximately $40,000 per person per annum.*[26]

20.60 This compares with the estimated costs of government services to 1,150 persons in the general population of approximately $3.3 million, or an estimated $3,000 per person per annum.[27]

20.61 In the 16-24 year age group estimated costs are highest in family services. These costs are incurred mainly in the child protection system. There are also high costs in income support and housing support. In the 25-60 year age group, mental health is estimated as the highest cost service system, however income support and housing are also high cost services.[28]

20.62 Morgan Disney's study concluded that:

> *there would be significant economic and social benefits if more young people leaving care were better supported in ways which reduced the likelihood of their progression into prolonged use of high cost services…….This raises the importance of transition services for young people and the role such services might play in supporting people into productive and supportive environments, before their life challenges are profoundly complex and entrenched.*[29]

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[24] Morgan Disney and Associates and Applied Economics, *Transition from Care: Avoidable Costs to Governments of Alternative Pathways of Young People Exiting the Formal Child Protection Care System in Australia*, *Volume 1, Summary Report*, November 2006, p.8.

[25] The cohort refers to 1,150 young people who have been subject to a formal care order within the child protection legislative frameworks across all jurisdictions, post care and who leave care between the ages of 15 and 17 years.

[26] Morgan Disney and Associates and Applied Economics, 2006, op. cit., p.25.

[27] ibid., p.26.

[28] ibid., p.26.

[29] ibid., p.10.

20.63 Bromfield and Osborn's summary of the Australian research and literature on leaving OOHC showed strong support in the literature for minimum leaving care standards, and an integrated model of leaving care support up to 25 years of age.[30] A Commonwealth OOHC Inquiry that reported in 2005 recommended the introduction of national standards for transition planning, particularly when leaving care, as a matter of priority.[31] The same Inquiry in its earlier 2004 report commented unfavourably on the lack of a gradual and functional transition from dependence for care leavers.[32]

Preparation for leaving statutory OOHC

20.64 The designated agency having supervisory responsibility for any person in care is required to prepare a plan, in consultation with him or her, before the time arrives to leave OOHC, and then to implement the plan.[33]

20.65 The plan must include reasonable steps that will prepare that person and, if necessary, his or her parents, the authorised carer and others who are significant to him or her, for leaving care.[34]

20.66 Most jurisdictions stipulate the development of a leaving care plan when the person in care reaches the age of 15 years. Current practice in NSW requires that planning commence at least 12 months before departure from care.

20.67 As a result of the MOU between DADHC and DoCS, however, DoCS is required to notify DADHC at least two years prior to expiration of a care order in any case where a person with a disability is likely to have significant support needs upon leaving statutory OOHC. DoCS and DADHC then commence joint casework and planning. DoCS maintains case management until expiry of the care order, after which DADHC assumes responsibility for the well-being and welfare of the care leaver as an adult.

Entitlements to support and financial assistance

20.68 The Minister is directed by the Care Act to provide or arrange such assistance for those above the age of 15 years who leave OOHC until they reach the age of 25 years, as the Minister considers necessary, having regard to their safety, welfare and well-being.[35] Such assistance may include:

a. the provision of information about available resources and services

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[30] L Bromfield and A Osborn, "'Getting the Big Picture': A Synopsis and Critique of Australian Out-of-Home Care Research". *Australian Institute of Family Studies, No 26,* 2007, p.22.

[31] Australian Senate Community Affairs Committee, 2005, op. cit., p.110.

[32] Australian Senate Community Affairs Committee Inquiry, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children,* 2004, p.124.

[33] *Children and Young Persons (Care and Protection) Act 1998* s.166(1) and (3).

[34] *Children and Young Persons (Care and Protection) Act 1998* s.166(2).

[35] *Children and Young Persons (Care and Protection) Act 1998* s.165(1).

b. assistance based on an assessment of their needs, including financial assistance and assistance for obtaining accommodation, setting up house, education and training, finding employment, legal advice and accessing health services

c. counselling and support.[36]

20.69 Ministerial guidelines for the provision of assistance after leaving care were issued in May 2008. These guidelines now stipulate that all young people leaving care must have a leaving care plan. The guidelines state that whenever available young people should be assisted to access mainstream services. The purpose is to encourage them in their move towards independence. According to these guidelines specific provision of further assistance, including financial support, is to be based on assessment of need and is not an automatic entitlement. Financial assistance can be provided in the form of fortnightly after care payment and/ or one off payments and must be approved by the Regional Director. Further a time limited fortnightly payment up to a maximum $200 may be paid by DoCS to assist a care leaver to secure accommodation where he or she is undertaking full time training or education and would be at risk of homelessness if such assistance was not provided.

20.70 The Minister has a discretion to provide or arrange appropriate assistance for OOHC leavers after they reach the age of 25 years.[37] The provision of assistance also extends to children and young persons who were in care but were subsequently adopted.

20.71 The expenditure by DoCS in relation to after care support and assistance for the year ended 30 June 2007 was approximately $1.2 million for brokerage funds; for the last six months of that year just over $200,000 was paid through allowances and contingencies.

20.72 In 2007/08, brokerage payments decreased slightly to just over $1 million and allowances and contingencies were nearly $700,000 for the full year.

20.73 The Inquiry understands that DoCS has had discussions with Education with a view to obtaining an TAFE fee exemption for care leavers. The Inquiry supports DoCS' attempt to achieve this exemption given the importance for care leavers to gain qualifications that will equip them to enter employment.

Access to records and personal information

20.74 On leaving, or after leaving OOHC, young people have an entitlement to have access, free of charge, to personal information directly relating to themselves, in any records held by the designated agency that had supervisory responsibility for them, or their authorised carer, or the Director-General where such person

[36] *Children and Young Persons (Care and Protection) Act 1998* s.165(2).
[37] *Children and Young Persons (Care and Protection) Act 1998* s.165(3).

was under the parental responsibility of the Minister and the Department was not the designated agency entrusted with their supervisory responsibility.[38]

20.75 Such persons are also entitled to possession, free of charge, of the originals of documents held in a file of personal information by the designated agency, or authorised carer, or by the Director-General respectively, including their birth certificates, school reports, medical reports and personal photographs.[39]

20.76 To facilitate this access, and in order to ensure the preservation of the records, designated agencies are required to keep the records of children and young persons placed with them for seven years after cessation of their responsibility for any such placement, and thereafter to deliver those records to the Director-General.[40]

20.77 Additional provision is made in relation to the records concerning Aboriginal and Torres Strait Islander children and young persons, requiring the Director-General of each designated agency, that supervises the placement of such people in OOHC, to make a record of the date of their entry into OOHC, the period of time spent in such care, and the plan for leaving OOHC.[41]

20.78 The 1996 Cashmore and Paxman study noted that participants reported not being properly informed about their current situation, their history or their entitlements.[42] A substantial minority of those in the study did not know that they could access their files or even that such files existed. Furthermore, when some members of this group did approach the Department to look at their files, they encountered various difficulties including delays associated with the need to find a suitable time when a worker could be with them, being asked to pay a fee ($30 for an FOI request), and a lack of privacy in having someone else with them or controlling what they were allowed to see in the file.

20.79 DoCS informed the Inquiry that many care leavers choose to apply under FOI, particularly those represented by solicitors as:

a. it is quick and statutory time limits apply

b. they obtain a photocopy of all releasable documents whereas when CSCs manage the release of information, they limit the number of pages they copy

c. there are clear appeal paths – Ombudsman, ADT and Supreme Court.

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[38] *Children and Young Persons (Care and Protection) Act 1998* s.168.

[39] *Children and Young Persons (Care and Protection) Act 1998* s.169.

[40] *Children and Young Persons (Care and Protection) Act 1998* s.170.

[41] *Children and Young Persons (Care and Protection) Act 1998* s.167.

[42] J Cashmore and M Paxman, "Longitudinal Study of Wards Leaving Care," *Social Policy Research Centre, University of New South Wales*, 1996, p.142.

Issues arising for those leaving care

Planning for exit from care – casework practice

20.80 Of immediate concern is the question whether sufficient attention is given to the statutory requirement to prepare those in OOHC for independent living.

20.81 One of the key NGO providers of after care has advised the Inquiry of its experience, and of that of SAAP services within its umbrella, that those leaving care often seem to be unaware that they are entitled to after care support, that after care plans are often not well developed, that the provision of funds by DoCS for assistance is patchy at best, that care plans are commonly not implemented or are undermined by local CSCs, and that the compliance with DoCS administrative procedures can operate as a barrier to receiving assistance.

20.82 This would accord with information received from CREATE that, despite the requirements of the Care Act, those about to leave care do not seem to be sufficiently involved in the planning process.

20.83 Current casework practice does recognise the desirability of authorised carers playing an earlier role in preparing people for leaving care. In this respect it notes that caseworkers should discuss with carers the basic skills that young people need to develop towards achieving independence, and the means of imparting these skills to them. This is a matter addressed in the Ministerial guidelines which were published in 2008 and which now provide comprehensive guidance in relation to this topic, in place of the several practice and policy documents that previously existed.

20.84 CREATE, in its submission to the Inquiry identified, as a result of its annual reviews, the following areas as deserving of attention:

a. the provision of departmental caseworkers who have time and resources for after care support, the delivery of which is not as readily provided by departmental caseworkers who often carry larger caseloads and lack the time and resources to engage effectively with young people after leaving care, than is the case with the NGOs

b. the provision of improved communication in casework with young people that informs them of their leaving care and after care entitlements and procedures for making a submission for assistance

c. the adoption of a consistent approach to leaving care and after care provisions across the State

d. an increase in the funding for after care to meet the rapidly increasing demand for after care support services and the increasing cost of living for young people

e. the establishment of arrangements for priority access to all services (in particular health, dental and educational services) for young people leaving care

f. the development of leaving care plans for all young people 12 months prior to independence, even where they are not assigned a caseworker.

20.85 In a meeting with the Inquiry, CREATE also drew attention to the desirability of a systematic study of those leaving care. The Inquiry notes the two Cashmore and Paxman studies which have undertaken this form of analysis. It sees benefit in the continuation of longitudinal studies that can address outcomes and that would also seek to isolate those strategies that have and have not worked.

20.86 DoCS informed the Inquiry that it had agreed to be an industry partner in an Australian Research Council Linkage projects grant being submitted in the November 2008 round on a national evaluation of leaving care services. Most of the other state departments are also partners. This was initiated and approved through the Community and Disability Services Minister's Advisory Council and the outcome of the application will be known in June 2009. If approved it should be a source of valuable information that could lead to improvements in the support needed by care leavers, and in the planning for their exit from care.

Provision of support and assistance

20.87 Eligibility for after care assistance, beyond the provision of information as to available services and referral to those services, currently depends on the care leaver being assessed as at risk of not making a successful transition to independent living based on a number of indicators.

20.88 Under the current practice, however, there are several limitations upon the eligibility of care leavers to receive NSW Government funded assistance, and upon the extent of that assistance, including the age of the care leaver. Assistance is not an automatic entitlement and the process of seeking it and awaiting approval can be an occasion for frustration and possible disengagement.

20.89 A significant barrier identified by the Inquiry has been the likely difficulty experienced by those leaving care in negotiating their way through the available referral points for support and assistance, having regard to their multiplicity, and to the fact that, for some services, they will need to seek assistance from DoCS, while for others they may need to approach one or another of DADHC, Housing, Education, Health, FaHCSIA, Centrelink, a relevant NGO or after care service. The extent to which the NGOs and after care services can provide assistance also varies considerably between the metropolitan area, larger regional cities, and the more remote locations. Those living in rural and remote areas of the State, where NGOs for example have less of a presence, are at a potential disadvantage.

20.90 As noted earlier the funding for after care assistance is very limited. Although it is a laudable objective of DoCS to ensure that any financial support that is given will encourage a growing independence rather than the care leaver remaining in a continuing state of dependence,[43] the order of expenditure involved seems to border on the insignificant, given the number of care leavers aged 15-25 years who could benefit from assistance. While the Commonwealth Transition to Independent Living allowance (a one off payment of $1,000) for the purchase of goods or services may supplement the DoCS allowance, it too is of limited value, and may not be known to some care leavers.

20.91 The Inquiry is satisfied that greater attention needs to be given to ensuring that care leavers are given adequate assistance and information concerning their entitlements to after care assistance from DoCS or via one or other of the several Commonwealth sources for benefits available to young people generally, and that sufficient funding be available to provide the assistance needed.

Safe housing

20.92 Secure safe housing for care leavers, is obviously important, and in this respect Housing is likely to be the most obvious first port of call.

20.93 The Supported Independent Living program provides an integrated accommodation and support program that is designed to assist the transition from care to independent living, through the provision of public or private rental accommodation, case management and support services for up to 24 months. The target group for this program comprises those within the 16-18 years age group at the time of entry into the program who, among other things, are in the parental responsibility of the Minister.

20.94 The ‘lead tenant’ programs, under which a volunteer tenant lives rent free with a household of young people and helps them develop independent living skills would also seem to be of value and to be consistent with other initiatives that would encourage the use of mentors to guide young people through the transition.

20.95 Another option is the shared access model for young people leaving care which is being trialled by Housing and DoCS in the Hunter area and is discussed in Chapter 7.

20.96 Worthy of further research is the ‘foyer’ model of combined accommodation, employment, education and support for disadvantaged young people leaving care, which was originally developed in France and has been adopted with some success in other jurisdictions, most particularly in the UK. The interim evaluation of the pilot model Live ‘N’ Learn Campus, that was established at the Miller Campus in Sydney in 2002, has been reported as providing support for

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[43] DoCS, *Financial Support for Children and Young People in OOHC, Policies & Guidelines*, December 2006.

expansion of this model, in that it has helped to stop young people aged 16–25 years (including care leavers) dropping out of education and becoming homeless, and encourages their entry into employment.[44] Further development of this model was advocated by the National Youth Commission in its report on Youth Homelessness.[45]

Interagency involvement

20.97 It is clear from the foregoing that given the varying needs of young people leaving care, an interagency approach is critical. Young people leaving care need priority access to affordable and stable housing, income support, assistance with the costs of education and further training, dental treatment, physical and mental health care, and general guidance towards achieving independence. No one agency is able to meet all these needs. This provides further support for the proposal elsewhere developed in this report to ensure, wherever practicable, the co-location of state agencies, and the compilation of a comprehensive local index of after care services and resources that is kept up to date and readily accessible.

20.98 The problems in this area will be compounded if there is limited amount of up to date information available to the staff of the individual agencies as to the type and range of services available. The tendency of some government agencies to wait for DoCS to become involved rather than offering their services also does not help.

20.99 In relation to the desirability of an integrated model, CREATE observed:

> *The transition phase, where the impact of support services is maximum, requires more attention to its integration so that young people are informed appropriately of what support is available and how they might go about accessing it.*
>
> *After-Care has been the most neglected area largely because it can be confusing where responsibility lies for maintaining the assistance. Is after-care support a right that should be available to all eligible young people and provided to those assessed as in need, or must the young people seek out particular services and actively ask for help? This question lies at the heart of how after-care support is managed.*[46]

20.100 CREATE noted that a critical factor that needed to be addressed was ensuring that those who need a service after leaving care know the range of possibilities available and how they might be accessed.[47]

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[44] C Smyth and T Eardley, 2008, op. cit., pp.16-17.

[45] A Report of the National Youth Commission Inquiry into Youth Homelessness, *Australian Homeless Youth*, 2008, p.4.

[46] CREATE Foundation, “Report Card: Transitioning from Care,” March 2008, p.49.

[47] ibid., p.27.

20.101 This it saw as a major issue confronting care leavers that needed to be addressed by a number of mechanisms including information on the agency's website dealing with the topic along with the issue of hard copy pamphlets and leaving care kits.[48] The Inquiry agrees that attention needs to be given to this.

Follow up and monitoring

20.102 Practice guidelines call for follow up by the agency responsible for supervising the last placement of a care leaver, within three months of leaving care, and then at half yearly intervals for the next two years where that person wishes to have such follow up. The extent to which there is meaningful follow up, or any concerted effort to maintain contact is not known, although it is accepted that a number of young people who have left care do attend CSCs from time to time with requests for limited monetary assistance which are usually met. Casual crisis visits of this kind are however a poor substitute for a systematic approach to providing ongoing follow up.[49]

20.103 The question of monitoring outcomes and ensuring appropriate follow up was also seen as important by CREATE. It noted:

> *Monitoring of outcomes is the only way the effectiveness and efficiency of the programs can be determined. It is essential to determine (a) the adequacy of the initial Leaving Care Plan, (b) whether or not the necessary support is available, (c) if the necessary services are accessible to those who require them, (d) if the services are being delivered in appropriate ways, (e) if the services are meeting the needs of care leavers, and (f) what are the realistic costs of the services.*[50]

20.104 It is CREATE's view that the outsourcing of OOHC functions make it important to establish guidelines for monitoring the authorised agencies and to develop key performance indicators to assess the support performance and outcomes of these agencies.[51] The Inquiry agrees with this assessment and considers it important that there be effective follow up of care leavers, so far as that is possible, given the reluctance of some members of this group to cooperate and also given their mobility. At the least they should be given positive encouragement, through the availability of ongoing support to participate in a systematic follow up.

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[48] ibid., p.35.

[49] One agency which does provide a two to three year follow-up of some intensity is Youth off the Streets, although it is subject to the request or wishes of the young person leaving care. Phoenix Rising for Children also makes provision for extended formal and informal contact, and for supplying them with emergency contact details.

[50] CREATE Foundation, 2008, op. cit., p.32.

[51] ibid., p.40.

People with disabilities leaving care

20.105 The Ombudsman concluded in his 2004 report, *Group Review of Young People with Disabilities Leaving Statutory Care*, that those within this group needed additional support to that currently provided.

20.106 The recommendations from this report were that DoCS should:

a. take proactive steps to ensure that leaving care planning occurs in accordance with the Department's practice guidelines

b. provide clearer guidance to its caseworkers about the Department's expectations concerning the documentation of leaving care plans

c. 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.[52]

20.107 In May 2006, DADHC's strategic plan, Stronger Together, was released which, *inter alia*, identified the need for new approaches for young people leaving care at the age of 18 years with a disability, as well as additional supports for those exiting the criminal justice system.

20.108 DADHC has advised the Inquiry that it now has four 'supported accommodation options' available for young people leaving care. In response to the Ombudsman's Report, DoCS advised that it had also developed an after care policy for this group, which was completed in May 2008. Each initiative is laudable.

20.109 The sufficiency of these arrangements to cater for young people with disabilities leaving care and their implementation will require ongoing monitoring.

20.110 This is an area where the potential involvement of the Guardianship Tribunal will need to be addressed, by either DoCS or DADHC, for those young people who will lack the capacity to make significant life decisions or to manage their financial affairs.

Access to records

20.111 The Inquiry also notes that approximately 300 applications are made each year by care leavers to access their departmental records, and that current practice requires such access to be had in the presence of a Senior Caseworker or intake officer, at a CSC who is able to respond to any questions or requests for support.

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[52] NSW Ombudsman, *Group Review of Young People with Disabilities Leaving Statutory Care,* December 2004.

20.112 In some instances this can be an exceedingly time consuming process, for example where there are multiple files or where the files contain materials about third parties to which access needs to be restricted because of the requirements of the *Privacy and Personal Information Protection Act 1998*.

20.113 The Inquiry notes the suggestion made by DoCS that resources be made available and funding provided to allow the preparation of records for release to be undertaken centrally, followed by delivery of the records to the applicant by a member of a specialist leaving care team. It has indicated that this could lead to an improvement in response times and service levels.

20.114 The Inquiry supports DoCS examining more effective and efficient ways to undertake this function.

Potential savings

20.115 The provision of more effective services and preparations for leaving care, and of additional support upon leaving care could result in considerable economic savings as well as better outcomes. CREATE in its 2008 Report Card noted a Victorian study in 2006 which attempted to measure the total cost of leaving care in Victoria by matching the life outcomes of care leavers with their peers in the general population (on factors such as child protection, GST revenue loss, health, drug and alcohol abuse, policing, justice, corrections and housing). The differences in the lifetime cost to the state for each person leaving care was found to be $738,741, of which 55 per cent was attributable to policing and justice.[53]

20.116 In 2004, the Senate Community Affairs Reference Committee noted that:

> *As adults, care leavers face relationship problems; drug and alcohol abuse; loss of educational and work opportunities; long term physical and mental health problems; and antisocial and criminal behaviour. This is a significant cost to the individual and a massive long-term social and economic cost for society which may be compounded when badly harmed adults in turn create another generation of harmed children.*[54]

20.117 The Inquiry is unaware of any similar cost benefit analysis having been made in NSW but it would be surprising if comparable savings were not identified. Even if that were not so, any improvement in the lives of a group whose members have been removed from their families by the state can only be regarded as a worthwhile objective.

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[53] CREATE Foundation, 2008, op. cit., p.18; C Forbes, B Inder and S Raman, "Measuring the cost of leaving care in Victoria," *Monash University,* 2006; and see also the estimate of the lifetime cost to Government of those leaving care attributable to their poorer outcomes on all life trajectories by Morgan Disney and Associates and Applied Economics, 2006, op. cit., p.10.

[54] Australian Senate Community Affairs Committee, 2004, op. cit., p.166.

Homelessness of young people

20.118 The incidence of homelessness of young people is of concern. The inadequacy of the existing systems to deal with this problem, and the lack of refuges and safe alternative accommodation for this group was a theme which was repeated in Public Forums across the State, as well as in the Sydney Public Forums and the submissions.

Issues arising

Reporting homelessness

20.119 The Care Act makes provision for the reporting to the Director-General of children who are homeless[55] and, subject to their consent, of young persons (that is 16-17 year olds) who are homeless.[56] A person who provides residential accommodation for a child who, he or she suspects is living away from home without parental permission, must make a report.[57]

20.120 There is an obligation to conduct such investigation and assessment concerning the person who is the subject of such a report as the Director-General considers necessary.[58]

20.121 The Department may provide or facilitate the provision of accommodation, in the exercise of its statutory power to provide assistance, but it is under no compulsion to do so unless the subject of the report is already in care.

20.122 The Inquiry's attention was brought to the fact that homelessness is not expressly included in the list of circumstances that can be taken into account in determining whether a child or young person is "at risk of harm."[59] This, it was suggested, may have been one of the factors behind the response, which was said to be sometimes encountered in individual cases, that "homelessness is not a child protection issue," or that "it is not an issue that DoCS can deal with."[60]

20.123 While the Inquiry acknowledges that homelessness is not included as an 'at risk' circumstance in its own right, it would seem to be encompassed as a fact falling within the general criteria applicable where the 'basic physical or psychological needs' of the child or young person are 'not being met or at risk of not being met.' As such the Inquiry does not consider legislative amendment to be necessary. It does however emphasise that casework practice should

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[55] *Children and Young Persons (Care and Protection) Act 1998* ss.120 and 122.
[56] *Children and Young Persons (Care and Protection) Act 1998* s.121.
[57] *Children and Young Persons (Care and Protection) Act 1998* s.122.
[58] *Children and Young Persons (Care and Protection) Act 1998* s.120.
[59] Within the meaning of the *Children and Young Persons (Care and Protection) Act 1998* s.23.
[60] Submission: Homeless Persons Information Centre, p.2.

recognise the significance of homelessness as a risk factor, that needs to be taken into account and addressed by DoCS. Other agencies, including Health, Attorney General's and Housing should additionally ensure that mental health and domestic violence services, together with crime prevention activities, are available to address and support the underlying factors associated with youth homelessness.

Use of SAAP services

20.124 As has been observed, where a child or young person is one for whom the Minister has sole parental responsibility or parental responsibility in relation to residence, then a statutory responsibility requires the Minister to provide that person with accommodation.[61]

20.125 Of importance in this area are SAAP services (see Chapter 17). An issue has arisen in the past as to whether the responsibility for administering SAAP should fall within the Housing portfolio which maintains the Homelessness Unit, rather than remain a DoCS responsibility. It is understood that NSW, Western Australia and the Northern Territory child protection agencies have this responsibility. In addition in Victoria and South Australia, SAAP lies in a Department of Human Services which includes both the child protection agency and housing responsibility. Although this was not a matter addressed to any extent in the submissions, a transfer of Ministerial responsibility would seem to run the risk of moving the primary focus of SAAP funding towards the provision of accommodation, at the expense of its associated role in delivering allied support services for the most disadvantaged members of the community who depend on SAAP services, including families with children and young persons at potential risk, a significant proportion of whom become involved with DoCS.

20.126 The Inquiry does not consider that there is, at present, a sufficient case for the SAAP responsibility to be transferred to Housing, although it recognises the potential importance of this issue, and the extent to which such a transfer would depend upon comprehensive interagency cooperation, not only between DoCS and Housing, but with all other human service agencies as part of an effective early intervention strategy.

20.127 More pressing issues are the appropriateness of the use of SAAP services for young people in care and the sufficiency of SAAP services to meet the demand.

20.128 In his Report, *Assisting Homeless People: The need to improve their access to accommodation and support services,* the Ombudsman noted that, of the total number of SAAP clients who were provided with support periods during 2001/02, 34.6 per cent were aged under 25 years and that 44.7 per cent of the

[61] *Children and Young Persons (Care and Protection) Act 1998* s.164.

services that were funded targeted young people.[62] The Ombudsman observed:

> *We acknowledge that there are gaps and inadequacies in other service systems, such as drug and alcohol detoxification and rehabilitation services and community-based mental health services. We accept that it is not the core business of SAAP to provide primary health services to people who are acutely ill and who require health, mental health or drug and alcohol services in the first instance. It is also not SAAP core business to provide disability accommodation for those people with disabilities who require specialised assistance as a result of their disability.*
>
> *However, it is not sufficient for SAAP to consider every person within these groups to be outside its responsibility. It is the role of SAAP, in conjunction with other service systems, to cater to a diversity of individuals who are homeless, including people with mental illness, disabilities and/or substance abuse issues.*[63]

20.129 This is an assessment with which the Inquiry agrees. It has considerable significance for those who are at risk but not subject to the parental responsibility of the Minister, and also for those who are transitioning from care.

20.130 In response to the report some of those concerns were addressed. The Ombudsman, however, has advised, as a result of its further work and feedback, that more is needed to improve the links between SAAP services and those provided by other agencies, for example, in relation to substance abuse and health issues. This Inquiry confirms that its own investigations support this conclusion.

20.131 The Ombudsman has, since the inquiries mentioned, conducted a review of the situation of children under the parental responsibility of the Minister who are placed in SAAP services.[64]

20.132 The Ombudsman noted that while DoCS had undertaken in 2004 to clarify policy and practices in this area and to develop protocols between DoCS and youth SAAP services, both in relation to children and young people in SAAP where there is no parental involvement and no court order, and in relation to those where there is a court order in relation to parental responsibility, the draft policy which it had released in 2006 was still under review.

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[62] NSW Ombudsman, *Assisting Homeless People: The need to improve their access to accommodation and support services, Final Report arising from an Inquiry into access to, and exiting from, the Supported Accommodation Assistance Program*, May 2004.

[63] ibid., p.12.

[64] NSW Ombudsman, *Children under the parental responsibility of the Minister who are placed in SAAP services and aged 15 years or under, Final Group Review Report*, February 2008.

20.133 The Ombudsman's inquiry was confined to a relatively small group of children in SAAP services, some of whom were in crisis accommodation, but others of whom were in long term SAAP accommodation as part of a departmental case plan.

20.134 Some of the problems identified in relation to the use of SAAP services, at least on a long term basis, include the fact that these services are exempt from the statutory provisions concerning the provision of regulation of OOHC,[65] are not accredited by the Children's Guardian and are not subject to the standards required for the provision of OOHC.

20.135 The SAAP system is clearly not a care system; it has a lower level of funding and staff supervision than that required for those who should be subject to a properly established placement within the OOHC system. Whatever else it might be, it is not appropriate as a long term accommodation solution for young people in care. Rather its proper role in this context is a transitional or crisis response service *inter alia* for young people. It should, in the view of the Inquiry, be funded on that basis leaving the primary responsibility for providing permanency and support in OOHC for this group with DoCS or with authorised OOHC agencies.

20.136 In this regard DoCS has itself acknowledged that SAAP services are not equipped to meet the long terms needs of children and young persons, particularly those in statutory care, although they are capable of providing crisis support. It noted that its policy review would take into account the opportunities that may exist for closer alignment with the policies of the other states that could support good practice. It also noted that the current expression of interest process for the provision of OOHC services statewide was expected to reduce the need for DoCS to rely on SAAP services.

Recommendations

Recommendation 20.1

DoCS should train and appoint to each DoCS Region, specialist caseworkers to assist in the case management of young people.

Recommendation 20.2

DoCS should fund a training package to assist foster carers and kinship and relative carers in preparing young people for leaving care.

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[65] Clause 17 of the *Children and Young Persons (Care and Protection) Regulation 2000* lists SAAP arrangements as one of the exceptions to OOHC falling within the *Children and Young Persons (Care and Protection) Act 1998* s.135(2).

Recommendation 20.3

DoCS should fund the provision of detailed information to care leavers as to the assistance which is available to them through State and Commonwealth sources after they leave care, and as to the means by which they can access that assistance.

21 Children and young persons and parents with disabilities

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Children and young persons with disabilities

21.1 Children and young persons with a disability are particularly vulnerable and at increased risk of harm, abuse or neglect.[66] Issues of social exclusion, additional care stresses or interrupted bonding within families, bullying by peers and communication difficulties can create added risks for them. Socio-economic factors such as limited income, social isolation, poor carer health and parental concerns about the impact of the disability on other siblings, can tax family resources, time and skills.

21.2 As in cases involving children without disabilities, the majority of those who have abused or neglected children and young persons within this group tend to be family members. Children and young persons with a disability are also at greater risk of abuse by others outside the home.[67] These children and young persons are often involved in multiple care contexts, and they may have difficulty in getting away from abusers or in acquiring protective behaviours or in understanding or recognising potential risk situations. They can lack oral and written communication skills and they may be unable to communicate when abuse is occurring.

21.3 A child's medical condition or disability can 'overshadow' specific child protection risks as part of the assessment of allegations. For example, particular behaviours may be interpreted as related to the child's impairment and not as indicators of forms of abuse or neglect. Evidence in the UK found a child's lack of communication and/or cognitive impairment was often cited as the reason for failing to proceed with an investigation. Other difficulties cited were:[68]

a. problems in identifying the perpetrator of abuse or risk of harm where children were exposed to multiple carers

b. a greater reliance on medical reports and advice rather than on the perspectives of people in frequent contact with a child (such as teachers, support providers and foster carers providing respite)

c. allegations being treated as 'one-off incidents', without understanding the ongoing vulnerabilities and risks for children and young persons with a disability

d. assumptions being made about a parent's quality of care, particularly where forms of neglect were less visible, resulting in some children being left in abusive family relationships.

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[66] L Chenoworth, "Children with Disabilities: What evidence do we have for better practice?" Paper presented to the Association of Children's Welfare Agencies Conference, 2000, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.8.

[67] R Sobsey, "Violence in the lives of people with disabilities: the end of silent acceptance?" *Brooks Baltimore,* 1999, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.9.

[68] National Society for the Prevention of Cruelty to Children "It doesn't happen to disabled children," 2003 and "Child protection and disabled children, Report of the National Working Group on Child Protection and Disability, London, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.9.

21.4 Given the particular difficulties facing children and young persons with disabilities, it is unfortunate that DoCS is unable to provide data on the number of those with a disability who are in care and known to DoCS.

21.5 The capacity to collect data of that kind is available in KiDS, however DoCS notes that when reporters make a call to the Helpline they may not be aware of the disability, or may not be confident to make that assessment. Notwithstanding, the KiDS data that is available shows that for 2006/07, 4.6 per cent of reports contained disability data, and that 8.2 per cent of records of children and young persons in OOHC, at 30 June 2007 contained disability data.

21.6 DoCS advises that the AIHW undertook a pilot collection of disability data earlier this year. All jurisdictions involved in that exercise had similar concerns with regard to the quality of the data. DoCS has also advised that improving the disability database and making the necessary changes to KiDS would involve costs for which budget provision has not been made.

21.7 DADHC informed the Inquiry that its services made 252 mandatory reports in 2006/07, over double the number it made in the previous year (112). It was unable to inform the Inquiry of the primary issue reported or the outcome of the report without accessing individual files. It undertook that task for the Inquiry in relation to the number of reports made as a result of a child or young person not leaving respite. The data provided is not at all clear, but it appears that 37 children and young persons were involved, the majority of whom were reported when they did not exit respite and their parents remained involved.

21.8 According to a 2008 independent evaluation of the MOU between DoCS and DADHC on Children and Young Persons with a Disability 2003, there were an estimated 481 children and young persons who came within its scope in 2006/07. The three principal groups comprised 155 young persons with a disability leaving OOHC, 161 children and young persons the subject of 224 reports made by DADHC to DoCS, and 165 referrals to DADHC from DoCS for services.[69] Just under one third of the cases where DADHC made a report to DoCS resulted in DoCS assessing the child or young person to be in need of care and protection.[70]

21.9 The evaluation report identified that the inability to source comprehensive data on joint cases means that effective monitoring of the MOU is problematic.[71] The Inquiry supports the recommendation of the evaluation report that a data management system in both agencies be developed and implemented so that joint clients are identified. DoCS has informed the Inquiry that such a system will require extensive changes to KiDS as well as operational changes to collect better information earlier.

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[69] *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability,* 1 September 2008, pp.13-15.

[70] ibid., p.25.

[71] ibid., p.15.

21.10 The actual numbers of children and young persons within this grouping, who need assistance and may not be receiving it, is a matter of considerable concern. Their needs and particularly their health needs can be exceedingly complex, and they can substantially affect their quality of life as well as that of their parents and siblings. Moreover their difficulties and the stress on their families is only likely to increase as they grow older.

21.11 In terms of the projected incidence of disability, at the Public Forum on Health and Disability, Dr Matthews from Health cautioned that:

> *We need to acknowledge and respond to the fact that disability is a rapidly changing world. The traditional model was around intellectual disability syndromes, such as Down's. We now have a very large and growing cohort of children with very significant and complex needs, who are surviving, who previously may not have survived. Ventilator-dependent neonates were unknown in recent memory, and we are now in the position of placing and supporting them to live at home with their parents. We now test at birth for over 30 genetic conditions, as we've said in our submission. Because of the expert interventions of some of the people sitting at this table, we have this increasing cohort of children like the one we're talking about, with extremely complex needs, to which I think we all have to acknowledge we have a responsibility collectively to respond. In fairness to us and Government, the size, the volume and the complexity of the problem has caught people a little bit by surprise, and I think it is fair to say that we all need to respond to it.*[72]

21.12 Similarly, the submission received from the Public Schools Principals Forum stated that:

> *More children are enrolling in schools with undiagnosed or unidentified disabilities and have missed the opportunities provided by early intervention services, support groups and specialised pre schools.*[73]

Parents with disabilities

21.13 The Inquiry was informed that the precise number of parents with intellectual disability in Australia is unknown. However, it has been variously estimated that parents with intellectual disability constitute less than one per cent of the general population of parents, that one to two per cent of Australian families with children and young persons aged 0-17 years include at least one parent with a

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[72] Transcript: Public Forum, Health and Disability, 11 April 2008, pp.46-49.

[73] Submission: Public Schools Principals Forum, 15 January 2008, p.18.

learning difficulty (that is, those with a diagnosed or self-identified intellectual disability) and that around 40,000 Australian children under five years have a parent with a learning difficulty.

21.14 Despite representing a modest number of all parents, parents with intellectual disability are significantly involved in the NSW care and protection system. Disability "is constructed as a risk factor for abuse and neglect rather than as an indicator of possible support needs."[74] It is more likely that parents with disability will have at least one child, if not more, removed early in life, and approximately one in six children and young persons in OOHC will have a parent who has a disability.[75] However, evidence provided to the NSW Legislative Council Inquiry into Disability Services and to this Inquiry demonstrates that when family support programs are provided to parents with a disability the outcomes for their children are not significantly different from those for other children.[76]

21.15 One study found that parents with intellectual disability are over represented in the NSW Children's Court's care jurisdiction and have their children removed by order of that Court at a higher rate than children of parents without an intellectual disability. This study found that 8.8 per cent of all cases initiated by DoCS involved parents with intellectual disability. Moreover, of all of the care applications filed by DoCS in this study, a disproportionately large number of children and young persons of parents with intellectual disability were removed from the care of their parents.[77]

Issues arising

21.16 From the information provided to the Inquiry, it seems that not all children and young persons who may be at risk of harm because of their, or their parent's, disability are well served by the current system.

'Passing the buck'

21.17 The Inquiry was informed repeatedly of issues between DoCS and DADHC regarding responsibility for relevant aspects of service provision. For example a Regional Director with DADHC stated that:

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[74] Legislative Council Standing Committee on Social Issues, *Care and Support – Final Report on Child Protection Services*, December 2002, p.145; Legislative Council Standing Committee on Social Issues, *Making it Happen: Final Report on Disability Services*, November 2002, p.128; cited in Submission: People with Disability, p.4.

[75] Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.126; cited in Submission: People with Disability, p.4.

[76] Legislative Council Standing Committee on Social Issues, December 2002, op. cit., p.147; Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.126; cited in Submission: People with Disability, p.5.

[77] D McConnell, G Llewellyn and L Ferronato, "Parents with a Disability and the NSW Children's Court," 2000, cited in Submission: Intellectual Disability Rights Services, 5 March 2008, p.3.

I think sometimes there's tensions around Is this a child protection matter? Is this a parent protection matter? Is this really about disabilities? Is this about an uncontrolled person who needs to be before the court?[78]

21.18 An area of contention is:

whether child protection concerns co-exist with disability issues and assessment of whether any diminished parental capacity pre-existed or is a result of parental stress directly arising from the child's disability. Several cases that have required escalation have involved divergent views about this issue.[79]

21.19 Submissions and representations to the Inquiry identified that there has been a lack of sufficient knowledge or understanding by DADHC caseworkers when assessing child protection risk issues; and a similar deficiency in understanding by DoCS caseworkers of the effects of disabilities.

21.20 It is not the case that there has been an absence of guidelines or protocols to direct caseworkers when dealing with children and young persons at risk because of their or their parent's disability. A key objective of the MOU is to assist staff of both departments to engage in a collaborative approach to assessment, planning and service delivery in relation to children and young persons with a disability and their families. The implementation of the MOU is through regional protocols which address specific communication processes at a local level and includes joint training initiatives.

21.21 Clause 5.4 of the MOU outlines the mechanism whereby issues that cannot be addressed at the regional level are escalated:

Where issues of funding and casework responsibilities cannot be resolved at a regional level within four weeks of the initial communication between the agencies, these cases are to be referred for determination by the Directors-General. No child or young person is to be left without adequate support while interagency issues are being resolved under this clause.

21.22 The MOU specifically identifies that DoCS is required to address risk of harm reports made by DADHC:

DoCS will respond to a risk of harm report made by DADHC in relation to a child/young person with a disability. DoCS will implement a process to identify DADHC referrals to the Helpline and ensure that (a) an appropriate response occurs and (b) that, where circumstances permit, DoCS will make prior contact

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[78] Transcript: Interagency meeting, Dubbo, 3 March 2008, p.38.
[79] Submission: DoCS, Health and Disability, p.14.

with nominated DADHC staff before the response occurs, so as to minimise the risk of placement breakdown.[80]

21.23 The MOU provides that if a need for statutory intervention arises from the child's or young person's exposure to risk of harm, then DoCS will provide all supports other than those directly related to the child's or young person's disability. Supports related to the child's or young person's disability will be provided by DADHC. The exception to this is where a child or young person cannot continue to live at home and the disability is so significant that relative or foster care placements are not a viable option.[81] In such cases DADHC will provide all supports, including placement, other than those associated with the legal status of the child or young person.

21.24 A key part of the MOU with DADHC involves planning for young persons with a disability who are likely to have significant support needs upon leaving OOHC. Under the MOU joint agency case planning for those within this group is required to start at least two years prior to leaving care.[82]

21.25 The purpose of the 2008 independent evaluation of the MOU was to assess the extent to which agency roles and responsibilities were sufficiently clarified, and whether the arrangements supported collaborative approaches to the provision of care, protection and support for children and young persons with a disability. Most staff reported that they had good working relationships with local colleagues and that the understanding of their different roles had improved since the MOU commenced. However, the evaluation found that only 55 per cent of DoCS staff and 42 per cent of DADHC staff think that the agreement about key definitions in the MOU is now good or excellent.

21.26 Three key issues were identified as part of the evaluation. First, it was said that DoCS and DADHC have different definitions or interpretations of when a child or young person is abandoned, when it is possible or not possible to place a child or young person with high needs in foster care, and whether circumstances of concern are due to a child's disability or due to a matter giving rise to child protection concerns. Secondly, it was said that insufficient emphasis on joint assessment and planning is given in the MOU. Finally, it was said that the MOU precipitates a focus on who pays for the support for a family too early in the assessment of needs process.[83]

21.27 As to the first of these issues, staff of both agencies provided examples of a case where a child or young person was residing temporarily in a respite service or other facility, in circumstances where the parents were still the legal guardians and wished to continue to be the decision makers for the child, yet

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[80] Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on *Children and Young Persons with a Disability 2003,* Clause 4.1.2

[81] ibid., Clause 4.2.8.

[82] ibid., Clause 5.5.

[83] *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability,* 1 September 2008, p.39.

indicated that it was no longer possible for them to care for the child or young person in the family home.[84]

21.28 The DoCS view is that a case of this kind does not constitute abandonment because the child is not at immediate risk, partly because the child is in some form of care. It suggested additionally that a court is unlikely to make an order for care and protection where the parents continue to be responsible for the child.

21.29 DADHC, however, believes that what has occurred in such a case does constitute abandonment. Further, DADHC staff were concerned that a child or young person may be deemed 'not fosterable,' due to a lack of available foster carers who have the necessary skills to provide the high level of care required.[85]

21.30 The evaluation also found that the extent to which structures and protocols have been developed and communicated in both agencies to support the MOU has varied and that the process is not complete, noting that:[86]

a. the metropolitan protocol is the most substantially developed
b. reviews of protocols have been inconsistent
c. 45 per cent of DADHC staff and 25 per cent of DoCS staff have read the MOU and know it well, while 35 per cent of DADHC staff and 58 per cent of DoCS staff have read it once or twice and 17 per cent of staff in both agencies know about it but have never seen it or read it[87]
d. DoCS staff perceive that the MOU and protocols provide greater clarity than DADHC staff
e. staff of both agencies agree that the MOU provides effective guidance in managing cases where a child is assessed to be at risk of harm
f. only around half of DADHC staff feel the MOU provides clear guidance in circumstances where:
    i. a family may be withdrawing or relinquishing care of a child or young person with a disability
    ii. foster care is deemed to be not viable
    iii. in response to a report of risk of harm, the DoCS assessment is that there is not a risk of harm
    iv. DoCS determines that the issues for the family arises from the child's or young person's disability rather than a child protection issue[88]
g. local level meetings only occur formally in parts of the State, and otherwise occur on an 'as needs' basis.

[84] ibid., p.19.
[85] ibid.
[86] ibid., p.20.
[87] ibid., p.17.
[88] ibid., p.20.

h. only seven cases have been escalated to the Steering Committee for resolution over the last two years.[89]

21.31 The MOU provides for the establishment of a steering committee comprising relevant senior Head Office executives of both agencies. A number of issues have been raised, considered and resolved at this level but, according to the evaluation, the relevant actions have not been recorded.[90]

21.32 The design and implementation of the Leaving Care Program has been a major focus of this group and has reportedly been effective. As part of the evaluation however a number of cases were reviewed to determine whether young persons exiting care had been notified to DADHC two years prior, as required by the MOU. Seventy-six per cent (31) of cases nominated by DoCS indicated that notification was timely compared with 40 per cent (23) of cases nominated by DADHC.[91] It is of concern that joint training has not occurred in the last two years in any of the regions,[92] nor has joint work occurred in any of the regions on joint recruitment and training of foster carers.[93]

21.33 The cases reviewed as part of the evaluation indicated that joint processes for case management have generally been followed for only about three quarters of the cases.

21.34 Most staff in both agencies (DADHC 77 per cent and DoCS 80 per cent) reported that they knew who to contact when there was a need to escalate a contentious case that required more senior legal advice.[94] However only around half (DADHC 40 per cent and DoCS 60 per cent) thought that ambiguous or contentious cases were able to be satisfactorily resolved.[95]

21.35 Overall there was mixed evidence that implementation of the MOU had resulted in organisational changes to practice and increased understanding that can lead to better care and protection work and disability support, for children and young persons with a disability.

21.36 The evaluation report recommended that the MOU be clarified in a number of ways including the operational definitions for the kinds of matter set out earlier, the approach to joint assessment and planning, governance matters and early intervention initiatives. A joint approach to staff training and recruitment and training of foster carers was also recommended. DADHC has advised the Inquiry that it and DoCS have accepted all of the recommendations of the report and have commenced implementation of the agreed joint action plan.

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[89] Although it has been suggested by DoCS subsequently that this is an under-estimation.

[90] *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability*, 1 September 2008, p.22.

[91] ibid., p.22.

[92] ibid., pp.22-23.

[93] ibid.

[94] ibid., p.25.

[95] ibid.

21.37 The Inquiry was informed that, while previously meetings between the two agencies had been irregular, meetings between senior officers have been convened, in more recent times, approximately quarterly, to identify trends, to assess data and resolve any issues identified through ‘contentious cases’. While this is a positive development it clearly needs to be sustained if the two agencies are to work cooperatively together in implementation of the MOU.

21.38 The Inquiry, while supporting the actions identified in response to this evaluation by both agencies, still has significant concerns about children and young persons with disabilities, and their families, not receiving adequate support services which could address the kinds of issues which if left unaddressed could escalate to the point where the risk level was such as to require entry into the child protection system. Similar concerns relate to the entry of children into that system by reason of the unaddressed intellectual disability of their parents. Early and effective intervention in these cases that left the child or young person properly supported at home would be far preferable to their removal into OOHC.

21.39 The Inquiry received a number of submissions and information which support many of the findings of the evaluation.

21.40 A non-government agency that works with both DoCS and DADHC informed the Inquiry:

> *…there seems to be at times quite a lot of toing-and-froing, confusion, perhaps disagreement between the two agencies as to who is actually responsible for this particular child. There is a tendency by DoCS with any child that has a disability to just want to move that responsibility across to DADHC when it is not necessarily appropriate.*[96]

21.41 Another NGO stated that:

> *We currently have a client who is under 12 years of age with high support needs who is in blocked respite and cannot return home because his safety would be at risk. Our advocate reports that DoCS and DADHC are each refusing to accept responsibility for finding an out of home placement. DoCS say DADHC is responsible and vice versa.*[97]

21.42 From a carer’s perspective:

> *I am the carer of five children with disabilities and that memo is still a mystery to me. Nobody at DADHC or DoCS seems to be able to explain it to me. I would like more information about it. I*

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[96] Transcript: Public Forum, Wollongong, 14 May 2008, pp.9-10.

[97] Submission: Multicultural Disability Advocacy Association, 4 March 2008, p.26.

don't think I am the only carer of a child with a disability who is in that boat.[98]

21.43 A DoCS worker from a CSC in the Northern Region advised the Inquiry that:

It just seems that the memorandums of understanding, although we have them, that trying to initiate a service to a child who clearly has high disability needs is very protracted and very difficult and actually stops a child getting the service that it is clear that they require.[99]

21.44 However, not all workers agreed that the MOU was problematic. A DoCS Regional Director stated that the MOU between DoCS and DADHC:

…. has been particularly strong. It was borne out of a group of eight kids. About two or so years ago both agencies were really struggling as to roles and responsibilities for those eight kids, very complex kids, so we used those kids as a bit of a platform to work through a set of issues and to resolve the issues for those kids, which were incredibly well resolved, and to build on that relationship for other kids.

So there have been a couple of instances now where we have avoided bringing children into out-of-home care because they [DADHC] have come to the party with a family choices package. Otherwise we had no option but to get long-term orders for those kids and to have found alternative long-term carers, so there has been some incredibly good outcomes from that perspective.[100]

21.45 The issue for many was one of inconsistency, as advised by People with Disability Australia Incorporated:

there are great policies in place and memoranda of understanding, et cetera, but what we find as an advocacy organisation working with children with disability and their families ……is that there is an inconsistency in how policies are applied; sometimes, ignorance across the regions around policies and what they actually mean.[101]

Case Study 24

In an investigation into the death of a child, the Ombudsman noted that both the MOU between DoCS and DADHC and the Interagency Guidelines

[98] Transcript: Public Forum, Lismore, 27 March 2008, p.18.

[99] Transcript: Inquiry meeting with DoCS staff Northern Region, p.52.

[100] Transcript: Interagency meeting, Ballina, 26 March 2008, pp.20-21.

[101] Transcript: Public Forum, Health and Disability, 11 April 2008, p.44.

are clear regarding case management responsibilities for children with disabilities who are reported to DoCS. However, in his preliminary observations and findings the Ombudsman stated:

> *Although concerns for the … children's safety and welfare had been identified by both DADHC and [another agency], and the need for a collaborative interagency response to these concerns had been identified by both agencies, in DoCS absence, neither agency pursued such a course. On the contrary, after discussing the need for interagency collaboration to address A's situation, DADHC closed its file for A knowing that DoCS had not allocated her case for risk assessment.*

In relation to A's non-attendance at the special school that was arranged for her, the Ombudsman stated:

> *In our view, the reported arrangement between the school and DADHC effectively abrogated DADHC's responsibility to provide the child with a case management service when this service was demonstrably required.*

DADHC made a risk of harm report to DoCS about A however DoCS closed the report without further assessment a month or so later. When DADHC was advised that the report would not be allocated, DADHC advised that they would request a combined meeting between [another agency] DADHC and DoCS, however "DADHC did nothing to pursue this option."

DADHC later closed the matter. The Ombudsman was critical that:

> *the department closed the matter when it had case management responsibility…..DADHC's failure to meet its responsibilities to A was unreasonable.*[102]

In response to the Ombudsman's preliminary observations, DADHC identified deficiencies in its documentation and supervision in this case.

21.46 The Ombudsman has taken an interest in this area for some time. Following a critical 2004 report focusing on DADHC support for families at risk of giving up the care of their child, DADHC made changes to its policies and practices. The Ombudsman revisited the issue in 2006 and concluded as follows:

a. there has been progress in relation to the issues of collaboration between DoCS and DADHC concerning children with a disability who are at risk of being placed in care but significant work is yet to be completed

[102] NSW Ombudsman, *Investigation into the Death of a Child, Provisional Statement,* 2008, pp.119-130.

b. DADHC has implemented a range of training programs to improve the understanding of working with young children and their families and in responding to risk of harm but all staff should complete relevant training and the training should be evaluated

c. more needs to be done in the area of collaboration between DoCS and DADHC, for example, in individual planning for children and young persons when the MOU is invoked

d. more needs to be done to build on existing initiatives to improve coordination between DADHC and Health, local area health services and Education.

e. DADHC needs to ensure that it has a policy and implementation strategy for individual planning for children living at home and supported by services. This is important for identifying what supports a child and their family need and for making it clear who is responsible for providing that support

f. more needs to be done to ensure that appropriate long term placements are available for children with disabilities entering care on a permanent basis

g. DADHC needs 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.

h. services provided by DADHC should receive the same level of monitoring as that required for services funded by DoCS. While this is planned for the future, currently there are no such monitoring arrangements

i. it is not clear how DoCS and DADHC are collaborating to use existing mainstream foster care services.

21.47 Whilst acknowledging the progress DADHC had made since its first review in 2004, the Ombudsman concluded that:

> *We know through our ongoing work that considerable work still needs to be done. Children and young persons continue to be left in respite beds for extended periods because they cannot go home and there is no alternative care for them. The development of suitable arrangements for children with very complex medical issues remains a priority. For very young children and adolescents with complex behavioural problems—for example with autism—the adequacy of current supports remains a concern.*[103]

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[103] NSW Ombudsman, *Services for Children with a Disability and their Families, Department of Ageing, Disability and Home Care: Progress and Future Challenges*, May 2006, p.12.

21.48 The 2008 evaluation suggests that while there has been some progress between the two agencies many of the issues raised by the Ombudsman still remain. They should be addressed.

Lack of services

21.49 The Inquiry was consistently told that there are not sufficient services in place, primarily, therapy, residential care, foster care, and particularly respite care for those parents who are trying their best to maintain a disabled child or young person at home and with their birth family. The Inquiry notes DADHC's advice to it that it provides in excess of 17,000 services annually to children and young persons with a disability and that just under three per cent of those come under the scope or responsibility of both agencies.

21.50 While this appears on its face to be a substantial response, it does not indicate the nature or duration of the services delivered; nor does it answer the question whether there is an unmet need for services by young people with a disability and if so, the extent of it.

21.51 DoCS identified in its submission to the Inquiry the following common issues with the provision of DADHC services:

a. it is difficult to access therapeutic services such as physiotherapy, speech, and occupational therapy

b. there are few supported independent living options for young persons transitioning from statutory care

c. there are limitations on the capacity to implement Behaviour Management Plans

d. it is difficult to get approvals for home modifications to meet the needs of those in OOHC through the Home and Community Care program

e. there are shortages in respite and other short term care options.

21.52 In 2002, the NSW Legislative Council stated that:

> *Evidence throughout this inquiry has highlighted the current crisis orientation of the disability service system. Families and advocates have widely reported that they are unable to access supports until they reach crisis point, and programs … have reinforced a perception that 'creating' a crisis will produce a response.*[104]

21.53 Little seems to have changed. DoCS informed the Inquiry:

> *At times children with a disability can be reported to DoCS as being at risk of harm, or parents of a child with a disability make*

[104] Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.115.

> *a Request for Assistance to gain access to support services to alleviate stress in the family. These reports or requests to DoCS appear to be initiated as a way of gaining access to the limited number of services available within the current disability services system.*[105]

21.54 In particular, the shortage of respite and other short term care options can push some families into crisis:

> *When the pressure on parents who have been actively seeking respite services reaches crisis level, parents request that their child be taken into OOHC as they can no longer cope. Cases have been identified where families have felt that relinquishing parental responsibility was the only option to enable their child access to services. Sometimes parents do not understand that this extinguishes their rights to make most decisions about their child. It is of concern to DoCS that there is a cohort of children with disabilities who enter the OOHC system due to lack of available disability services.*[106]

21.55 The Inquiry heard of instances where families desperate for assistance found it necessary to refuse to pick up children or young persons who had been admitted to hospital or placed in respite care, in order to attract the attention of DADHC or DoCS. Relinquishment of parental responsibility where that is considered to be the only option for parents to obtain services for their children, should never be necessary in any acceptable health and welfare system. This is an area where DoCS, Health and DADHC should actively work together with parents who have reached this crisis point, in a way that can also maintain their right to participate in decisions involving their children.

21.56 The Inquiry has been informed of a growth in the availability of respite care since July 2006, of over 1,000 new places, with more projected, however DADHC did not, when asked by the Inquiry, provide data on current and projected demand for respite care. DADHC did advise that no application for respite is refused, although that response does not sit comfortably with the experiences reported to the Inquiry of those who had found it difficult, and sometimes, impossible to obtain respite care.

21.57 This is evident from other information provided by DADHC to the effect that "on average up to 8 families statewide lose access to respite for each respite bed that becomes unavailable due to an overstay."[107] DADHC has also made it clear that it does not suggest that every request is met. It pointed out that a service request register is maintained, and that families on the register are invited, on a quarterly basis to indicate what respite they would like to be

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[105] Submission: DoCS, Health and Disability, p.13.

[106] ibid.

[107] Correspondence: Department of Ageing, Disability and Home Care, 10 October 2008, p.6.

considered by the Regional Application Committee. It acknowledged that its attempt to allocate respite may not always match these requests.

21.58 DADHC advised the Inquiry that between 1 July 2005 and 30 June 2008, 29 children and eight young persons overstayed their allocated period of respite.[108] The average length of stay for a child was one year, 11 months and 26 days, and for a young person was seven months and 12 days. The significance of this data, however, is limited as DADHC does not maintain data on the period of respite which is booked for each client. Nine of these children and four of the young persons are reportedly still in respite.[109] The Deputy Director-General, Service Development from DADHC advised that:

> *The issue for us then becomes one of parental responsibility, because for a small number of those children, the parents rightly retain a parental role in their care, but they are reluctant and often refuse consent to allow DADHC to move those children into more permanent accommodation, so some of those children then end up staying in a block respite bed for a long time….*
>
> *They're abandoned in our sense in that they have been left with us and the parents are saying, 'We're not going to take them home,' but in a DoCS sense they're not abandoned, because they're in a DADHC facility and they're getting care.*[110]

21.59 From information provided to the Children's Guardian by DADHC and in turn given to the Inquiry, between 2005-2007, there were 32 children under the age of 16 years living in DADHC respite care placements. The average period of stay was estimated as 501 days. A similar pattern was observed in the older age group, 16 – 17 years, with the average stay for the 22 people in this age group, being 502 days.

21.60 The Inquiry is aware that DADHC has consulted on a new policy to address this issue. It has been advised that following considerable feedback from families, advocacy groups and disability organisations, significant changes have been made to the draft of this policy.

21.61 In his 2006/07 Annual Report, the Ombudsman also noted that a number of beds in respite centres have been 'blocked,' further restricting the availability of services. Beds in respite centres become blocked when they are used to house someone for long periods of time, usually because the person does not have alternative accommodation.

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[108] Department of Ageing, Disability and Home Care does not have data for persons who overstayed in respite prior to July 2005; ibid. p.4.

[109] ibid., p.5.

[110] Transcript: Public Forum, Health and Disability, 11 April 2008, p.50.

21.62 The Ombudsman has received complaints on this matter that raise significant issues such as the adequacy of care provided to residents living in blocked respite beds (that is, in relation to individual planning, health care planning and behaviour management), the adequacy of plans to move some residents into permanent accommodation, the assessment of risk and management of incidents for residents in respite services, and a lack of respite for other families due to blocked beds.[111]

21.63 Not surprisingly, there is a significant over representation of children and young persons with a disability in the high and complex needs group. Residential care for high and complex needs children and young persons is generally not a preferred option as those with a disability are extremely vulnerable in that form of care. DoCS stated:

> *The provision of adequate resources for DADHC to provide accommodation options for this group of children and young persons is therefore of significant interest to DoCS.*[112]

21.64 A parent recounted her experience for the Inquiry:

> *I have a child who has complex medical needs and who is profoundly disabled. He, in November 2006, was put into care for eight weeks through child protection issues. During that time, he had five different placements, and the last placement he had was in a residential place which was a place for 36 kids. In that place, in his room, there were six children, all with very high medical needs - physical disabilities and intellectual disabilities – and they told me that this was the only place there was for him. They said that, because of the level of his need, there was no foster care situation, no other situation for him to be in.*
>
> *He returned to my care-and he needed 24-hour care, turning at night, had epilepsy and needed tube feeds and everything else-eight weeks later, and since he has been returned to my care DADHC provides minimal help with my son in the home-they come to shower him twice a day, which was put on me, I didn't actually ask for that-but there is such a gap.*
>
> *My son was 11 at the time, but if I was to drop dead tomorrow, then there isn't anywhere, really. People say, 'Oh, yes, there is this and there is this and there are family places and this and that', but the reality was that there wasn't anything, in a crisis situation, for my son.*

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[111] NSW Ombudsman, *Annual Report, 2006/07*, p.90.

[112] Submission: DoCS, Health and Disability, p.15.

> *So if I drop dead - my son is a little boy first, with emotional needs and physical needs of being needed to be loved and cared for, first and foremost. How can one carer, in a room full of six kids with multiple disabilities and medical needs, have that connection? You can't. It is a real gap.*[113]

21.65 A paediatrician from Sydney Children's Hospital informed the Inquiry that DADHC does not provide holistic services:

> *So often the service that is provided by DADHC is a goal-orientated service that deals with one issue. When that issue has been dealt with, the case is effectively closed and they are told that they must ring the intake line again…In a six week input in behaviour management, the behaviour for that child and the disability for that child is not going to go away; it is there for life. There seems to be a lack of recognition that these children actually need a lifetime service from somebody.*[114]

21.66 It was suggested that DADHC's eligibility criteria can also pose difficulty. For example, a paediatrician from the Sydney Children's Hospital stated that:

> *We frequently find that, particularly with children with autism, they are unable to get a service from DADHC because they don't meet the eligibility criteria of having an intellectual disability that is in the moderate or severe range. So children who have very significant behaviour problems, being frequently suspended from school, causing major challenging behaviour issues in the home and school environment, may not be able to get a service ……because they do not meet the eligibility criteria. They meet the broad definitions of a disability, their functioning is very much disordered and the functioning of the family is very much disordered, but they are unable to access services because they don't actually have an intellectual disability.*[115]

21.67 Other case studies were brought to the Inquiry's attention which support the comments made above.

Case Study 25

A child with autism was killed in circumstances that resulted in his mother being convicted for his manslaughter. The Deputy State Coroner's findings reveal that the child and his family lived in regional NSW. By the time he was 18 months old, his parents were actively seeking to access early

[113] Transcript: Public Forum, Health and Disability, 11 April 2008, pp.65-66.
[114] Transcript: Public Forum, Health and Disability, 11 April 2008, pp.40-41.
[115] Transcript: Public Forum, Health and Disability, 11 April 2008, p.41.

intervention services, but were told there were no vacancies at the service in their area. As a result, the child did not receive any early intervention services until he was five years old, and even then, only after his parents threatened the service provider with legal action. The child was only provided with a one hour service once per week, and made little progress in the ensuing 12 months. Once the child reached school age, his parents struggled to find a school with the appropriate resources to deal with his behavioural problems. He eventually attended a special autism class with three other students (after his family moved to Sydney).

The child's family faced a range of crises during the child's lifetime, some probably relating to the stress of caring for a severely disabled child, including marital breakdown and mental health problems. DoCS received a risk of harm report concerning the reporter's fears that the child's father had suffered a mental breakdown and might harm himself and his family.

The child was killed when he was about 10 years old, following an apparent disagreement between his parents in relation to the child's needs. The Deputy State Coroner's recommendations, handed down in October 2006, included:

> *That DADHC and DoCS establish a high level working party to consider how relevant interagency information can be shared in a timely manner and that such a working party consider the Ombudsman's report of May 2006 "Services for Children with a Disability and their Families," as well as the report of DoCS' Child Deaths and Critical Reports Unit in relation to another child.*

That DADHC consider "ear-marking" funding specifically for the provision of early intervention services to severely disabled children (particularly for children with an early diagnosis of autism), and respite and support services for the families of those children.

That DADHC consider implementing a system whereby severely disabled children being cared for by their parents have their needs assessed, and where appropriate, be allocated a caseworker to assist in accessing services.

21.68 The Inquiry sought and received a response from DADHC as to the measures which it had taken following the recommendations made in this case.

21.69 The Inquiry was informed that DoCS, DADHC and other human service agencies, in the period since the death of the subject child, had made "considerable progress"[116] in addressing the need for improved interagency communication, including reconvening the Child Protection Senior Officers

[116] DoCS: Letter to Deputy State Coroner, 5 January 2007.

Group and developing the MOU between DoCS and DADHC (signed in November 2003). Additional funds have been made available for children with disabilities generally, including autism, and additional caseworkers were employed in 2006 to coach and mentor staff. The program Stronger Together was also introduced in 2006. DADHC has advised that there has been an $11.7 million enhancement to the existing investment of $92 million under this program, but has also flagged that it would require significant additional resources to improve the outcomes for all children and young persons with a disability and to meet community expectations. It has not however provided the Inquiry with any estimate of the additional funding which it considers would be necessary to achieve these objectives, either in full or substantially.

Inquiry's view

21.70 The Inquiry acknowledges that the intersection between children and young persons with a disability and their families, and child protection issues can be a fraught and troubled area.

21.71 The submissions received and the views expressed to the Inquiry at its many Public Forums, and interagency meetings, attest to the desperation and frustration experienced by families, in getting the right services at the right time and, at times, any services for their children with disabilities.

21.72 Families spoke of their frustration in negotiating complex issues within a fragmented service system in which individual agencies were inclined to look to others to take responsibility for an individual matter. Staff echoed many of these difficulties and tensions.

21.73 The Inquiry is aware that in some areas and regions the MOU between DoCS and DADHC works better than in others. Some staff from DADHC and DoCS described the existence of goodwill and genuine efforts to make interagency approaches work. This highlighted to the Inquiry the importance of relationships and the difference that particular staff members can and do make. The Inquiry is disturbed, however, to observe a system that may rest on the good fortune of the presence of particular personalities within a local DoCS or DADHC office.

21.74 The Inquiry is aware that DADHC was formed in 2001 by bringing together into a new department, the former Ageing and Disability Department, the disability services formerly provided by DoCS, and the Home Care Service of NSW. At that time the Government stated that the creation of DADHC "will help leverage better outcomes for people with disabilities."[117]

21.75 The Inquiry does not advocate a return to the former position of disability services being part of DoCS, however, the need for an improved system for

[117] *NSW Government response to the NSW Parliament Legislative Council Standing Committee on Social Issues Second Report: A Matter of Priority: Report on Disability Services,* 2001.

children and young persons with disabilities who may be at risk of harm, and their families, is clear. There is a need for a whole of government approach to meet the expectation of the community that mainstream agencies will provide the first level of support to people with a disability and to their families or carers.

21.76 In 2006 the Ombudsman stated that:

> *many families who care for children and young persons with disabilities may face significant stress, and that this stress can be unduly aggravated by ineffective implementation of key policies and difficulties in accessing essential services.* [118]

This observation remains strongly relevant today.

21.77 While the Inquiry is mindful that the Ombudsman's report is now two years old, the representations made to the Inquiry suggest that many of these issues are still current in 2008. Further, the Ombudsman's recent investigation into a child death also demonstrated that many of the systemic problems detailed in his 2004 and 2006 reports still exist.[119] The 2008 evaluation report also provides evidence that significant tensions and problems remain.

21.78 The Inquiry supports the recommendations made by the MOU evaluation. More, however, is required.

21.79 First, the establishment of a senior position in DADHC, and the development of a common assessment framework as set out in Chapter 10 should improve the joint planning and assessment of children and young persons who need assistance from both DoCS and DADHC, but only if their staff are uniformly or unreservedly committed to participation in that process.

21.80 DoCS acknowledged that its staff are not specialists in disability. DADHC also acknowledged that its staff's core skills are not in assessing risk of harm. The consequences of these respective deficiencies can lead to decisions which are inappropriate and which risk exacerbating the situation for a child or young person with a disability and their family. This means that effective cross agency framing must be provided, and maintained for the benefit of new staff.

21.81 Secondly, the 20 Specialist Casework Consultant positions for children and young persons within DADHC that were established to provide expert advice on casework practice to DADHC staff as well as to agencies such as DoCS, should be used in conjunction with the position referred to above. Similarly, the DoCS Director, Practice Standards positions should work in conjunction with these Specialists Casework Consultant positions to investigate mechanisms for joint training and professional development.

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[118] NSW Ombudsman, *Services for Children with a Disability and their Families, Department of Ageing, Disability and Home Care: Progress and Future Challenges*, May 2006, Foreword.

[119] NSW Ombudsman, *Investigation into the Death of a Child, Provisional Statement,* 2008.

21.82 Thirdly, DADHC's concern that there are currently no satisfactory options for formally resolving placement and other key life decisions for children and young persons with a disability, where it is concerned that the parent is no longer acting in the best interests of the child or young person is a legitimate concern. As a consequence, it suggests that it is limited in its ability to respond to the needs of those within this group and that while any such conflict remains unresolved it is also difficult to find suitable placement options.

21.83 DADHC stated that it would welcome the introduction of a formal mechanism which would permit mediation in such cases. This could include the development of a legal framework for the appointment of a third party, with authority to make any necessary decision and/or with authority to mediate a resolution which is in the best interest of the child or young person. Without such a framework children and young persons with a disability will continue to be afforded less protection in the OOHC system than other children and young persons. The Inquiry supports this proposal. It may be that the Guardianship Tribunal is an appropriate body with which to discuss such a mechanism.

21.84 The recommendations made later in this report concerning a statutory scheme to regulate voluntary OOHC, which would provide a scheme of intensive regulation and services for children and young persons with disabilities who are placed into care voluntarily by their parents, would address this issue in part.

21.85 Finally, it is apparent that there are not enough services for children and young persons with a disability and their families or for parents with intellectual disabilities who have children or young persons in their care.

21.86 The Inquiry is also aware of Commonwealth-State reforms that should provide additional resources. It agrees that:

> *Current arrangements for the delivery of disability services by Commonwealth, State and Territory Governments are inconsistent, do not meet existing demand, do not have consistent, enforceable quality standards and have no nationally consistent assessment processes. While other service systems such as aged care and child care have undergone substantial reform over the past 20 years, the disability services system has not had such a broad national reform.*[120]

21.87 That broad national reform is necessary.

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[120] Briefing Paper, Community And Disability Services Ministers' Conference, Agenda Item 1.2, "Disability Agreement – Policy and Reform Directions" (issued 18 July 2008), 23 July 2008.

Recommendations

Recommendation 21.1

A data management system should be developed in DoCS and the Department of Ageing, Disability and Home Care to identify joint clients.

Recommendation 21.2

The Memorandum of Understanding between DoCS and the Department of Ageing, Disability and Home Care should be revised to provide the operational definitions set out in the 2008 Memorandum of Understanding evaluation and to specify the manner in which joint assessment and planning will occur.

Recommendation 21.3

Joint training should be carried out for DoCS and Department of Ageing, Disability and Home Care staff, in relation to the care and protection of children and young persons with a disability, and in relation to the individual and mutual responsibilities of the two agencies.

Recommendation 21.4

The recruitment and training of foster carers who care for children and young persons with a disability in voluntary and statutory OOHC should occur jointly by DoCS and the Department of Ageing, Disability and Home Care.

Recommendation 21.5

> The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community Services, or for those whose disabilities are such that they are unable to continue to reside in their homes.

Recommendation 21.6

> Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services.

22 Disaster recovery

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Introduction

22.1 In this chapter the role of DoCS in relation to the coordination of the provision of community welfare services to victims of disasters is examined as well as the question of whether this responsibility should rest partially or wholly with some other department or departments of the Government.

22.2 Several agencies have a potential responsibility for responding to a disaster. Apart from the agency specific legislation concerning these bodies, which include the Police, NSW Fire Brigades, NSW Rural Fire Service, the Ambulance Service of NSW, the NSW State Emergency Service, Health and DoCS, the nature of the response and the relevant powers of these agencies are governed by the following legislation:

a. *State Emergency Service Act 1989*

b. *State Emergency and Rescue Management Act 1989* (SERM Act)

c. *Community Welfare Act 1987* (the Community Welfare Act).

22.3 There is a complex list of obligations, responsibilities and governance.

22.4 In relation to DoCS, it is assigned statutory responsibility under the Community Welfare Act to provide a coordinating role for the provision of community welfare services for the victims of those disasters that are declared, by the Minister for Community Services, for the purpose of the application of s.37A of the Act. The Minister is not to make such a declaration unless satisfied that it is of such a nature as to warrant its treatment as such.[121]

22.5 Although the definition of a 'disaster' is in different terms from that given to 'emergency' under the legislation previously mentioned, it is in sufficiently broad terms to capture substantially the same events, at least once they have occurred.

22.6 'Emergency' under the SERM Act contemplates actual and imminent occurrences, and to that extent it may have a wider application than the expression 'disaster' which is defined in the Community Welfare Act to mean an occurrence, whether or not due to natural causes, that causes loss of life, injury, distress or danger to persons or loss of, or damage to, property; while a 'disaster victim' means a person who is in need or distress, or whose property is lost or damaged, as a result of a disaster.[122]

22.7 The Community Welfare Act provides for the coordination of welfare services for victims of declared disasters and financial and other assistance to disaster victims.

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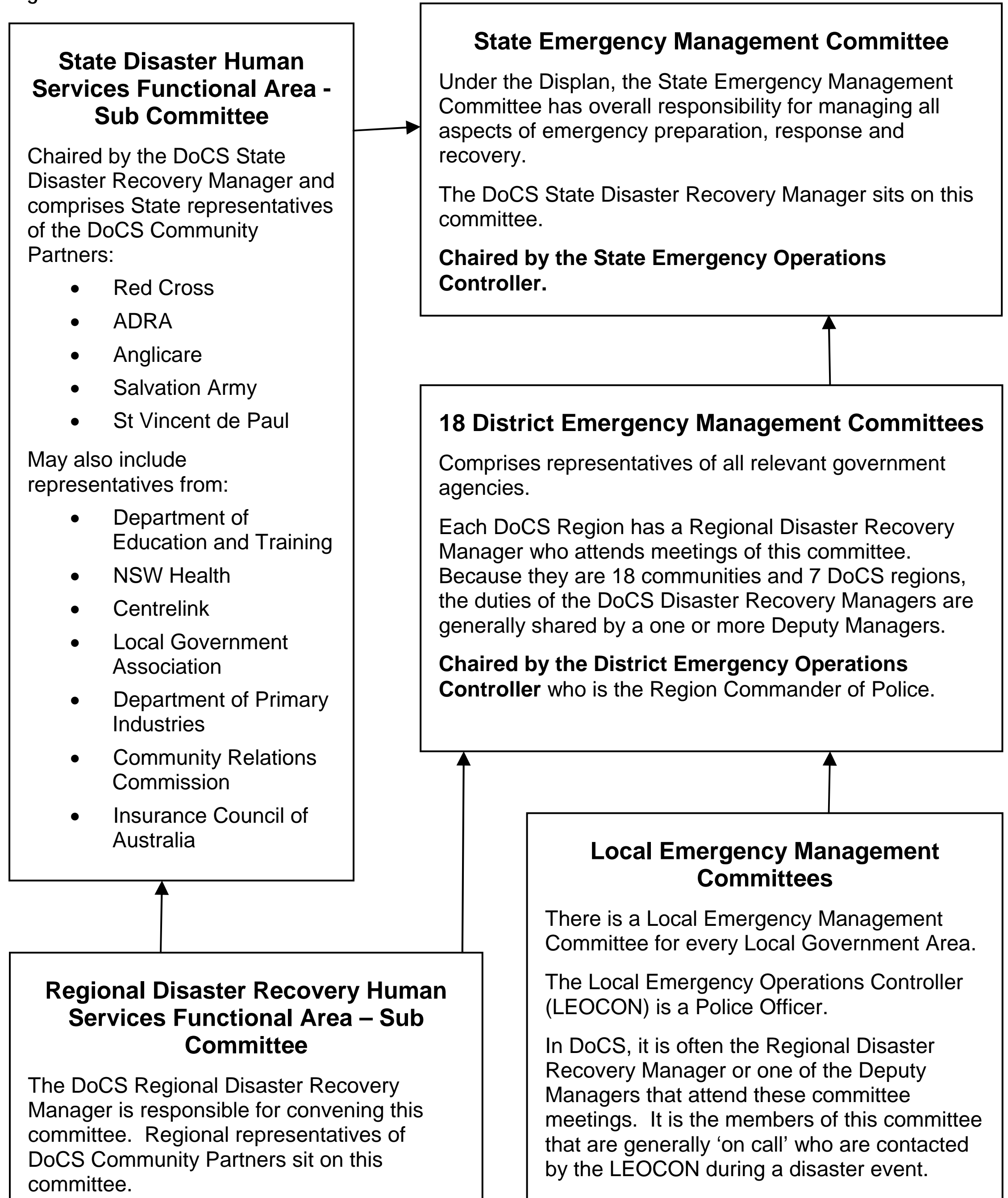
[121] *Community Welfare Act 1987* s.37A(2).

[122] *Community Welfare Act 1987* s.37(1).

22.8 The governance structure for disaster recover operations in NSW is illustrated in the following flow chart:

Figure 22.1 **Governance structure for disaster**



DoCS responsibilities under the Displan

22.9 Section 12 of the SERM Act provides for the development of a NSW State Disaster Plan (Displan). The Displan can be activated in the event of an emergency whether or not a state of emergency has been declared by the

Premier.[123] As an agency responsible for community welfare services under the Community Welfare Act, DoCS is identified in the Displan as the Functional Area Co-ordinator of welfare services during the response and recovery stages of an emergency.

22.10 As such DoCS' role is to manage and coordinate the welfare services component of recovery services of the State to assist those in need. *The Disaster Recovery-Human Services Functional Area Supporting Plan* (Human Services Plan) outlines the management and governance arrangements that DoCS is required to have in place to coordinate human services (that is, disaster welfare services) in the event of an emergency.

22.11 During those operations, one of the five volunteer agencies later mentioned provides welfare services to victims of incidents and emergencies and perform other functions, including the:

a. establishment of Evacuation Centres and Recovery Centres to manage the provision of emergency accommodation and essential material needs of victims

b. provision of personal welfare support, referral and advisory services to victims

c. provision of financial assistance to victims

d. management of donations (the Inquiry understands that new arrangements are being made so as to remove this responsibility from DoCS)

e. coordination of catering facilities and services to provide meals for victims of emergencies and personnel engaged in emergency response and recovery operations.

DoCS State Disaster Recovery Centre

22.12 The State Disaster Recovery Centre (SDRC) is located in Parramatta. It has a small staffing establishment headed by the State Disaster Recovery Manager. Its current staffing consists of three permanent positions and eight temporary positions. Currently 2.5 of the eight temporary positions are vacant.

22.13 The SDRC is responsible for:

a. supporting all regional disaster recovery staff and ensuring that disaster management plans are in place across the State

b. training regional staff who have volunteered to work as Disaster Recovery Officers, Team Leaders or Centre Managers

c. administering the NSW Disaster Relief Scheme and the Community Disaster Relief Fund, and preparing the necessary paper work to seek reimbursement from Treasury for the cost of responding to a disaster event

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[123] *State Emergency and Rescue Management Act 1989* s.13(2).

d. representing DoCS in statewide cross agency planning against the possibility of future major disaster events. This includes planning for emergencies and participation in emergency management exercises such as those potentially involving:

   i. a terrorist attack (especially in the Sydney CBD)

   ii. a radiation leak at Lucas Heights

   iii. an outbreak of the (avian) influenza pandemic

   iv. the activation of safety sites for the Sydney CBD Emergency Subplan.

Role of DoCS community partners

22.14 To fulfil its responsibilities under the Displan, DoCS works in partnership with five community partners to deliver disaster recovery services to affected communities, and in particular to meet the immediate needs of people who are evacuated due to an emergency, or who are unable to complete their journey due to an emergency. Each agency's role is defined in an MOU between DoCS and the agencies. The community partner responsibilities are outlined in the table below.

Table 22.1 **Disaster welfare responsibilities of DoCS' community partners**

Agency	*Responsibility*	*Service*
Adventist Development and Relief Agency (ADRA)	Emergency accommodation	ADRA provides temporary accommodation assistance to victims of disasters.
Anglicare	General support	Anglicare provides assistance with specific tasks or services as identified by DoCS.
Australian Red Cross	Personal support	The Australian Red Cross provides care and comfort to those affected by disasters and assistance to victims needing information.
Salvation Army	Catering	The Salvation Army arranges food and refreshments for disaster victims, volunteer rescue and recovery workers and, on occasion, for paid emergency workers.
St Vincent de Paul Society	Material and personal requisites	The St Vincent de Paul Society assists evacuees by providing basic necessities such as blankets, toiletries, mattresses and clothing.

22.15 Upon activation of the Human Services Plan, DoCS is required by its MOU with community partners to provide:

a. financial support to the community partners to assist in the discharge of their responsibilities under the MOU during operations

b. coordination with other Functional Area Coordinators

c. Disaster Recovery Centres as operationally necessary, staffed and equipped as approved by the State Disaster Recovery Manager

d. administrative support services as negotiated

e. a directory of key personnel appointed to the State and Regional Disaster Recovery Committees

f. meetings of the State and/or Regional Disaster Recovery Human Services Committee.[124]

DoCS' response to an emergency or disaster

22.16 Obviously DoCS' response will vary according to the nature or the seriousness of the event. A number of possible responses may be required. So far as DoCS is concerned, its assistance or involvement is considered by the Regional Disaster Recovery Manager in consultation with the State Disaster Recovery Manager and the DoCS Regional Director, along with one or other of the Local Emergency Operations Controller, or District Emergency Operations Controller, or State Emergency Operations Controller, depending on the magnitude of the event.

22.17 DoCS' involvement may then range from assisting with evacuation and recovery measures to providing financial and other support, which may be immediate or for a longer term, and which in some instances may be means tested.

Evacuation Centres

22.18 Evacuation Centres are established by DoCS to meet the immediate needs of victims following an emergency situation. They may include travellers (commuters and tourists) who are unable to complete their journey. DoCS works with its community partners to establish the Evacuation Centres and to provide immediate assistance during the first 48 hours following a disaster event. This involves the provision of food, clothing, temporary accommodation, transport and emergency health and safety.

22.19 If the services are not available within the Evacuation Centre the preferred option is to provide enough cash assistance to meet the immediate needs of the disaster affected person(s). When assessing a person's needs, staff are guided by DoCS Disaster Recovery-Immediate Assistance Policy.

Recovery Centres

22.20 In the case of larger or more protracted disaster events, it may be necessary to establish a Recovery Centre. Recovery Centres operate on a 'one stop shop' model which removes the necessity for victims to seek services at several venues and eliminates the duplication of services provided to individuals and

[124] Memorandum of Understanding, *Disaster Recovery Services*, July 2005, p.2.

families. Generally, DoCS casework staff are redeployed to work as Disaster Recovery Officers in the Recovery Centres, to take advantage of their training in working with people under stress.

22.21 The duties of a Disaster Recovery Officer are to:

a. assess the needs of the victim and provide referrals to appropriate services as required

b. provide information to the victim on the assistance available to alleviate personal hardship and distress, which includes emergency food, clothing, accommodation and if, eligible, the provision of longer term assistance to recover from the effects of a disaster event

c. assist the victim in completing the required applications for financial assistance, under various relief schemes, assess the eligibility of victims based on the information gathered against the eligibility criteria and make a recommendation to the Recovery Centre Manager

d. provide ongoing personal support services including interpersonal help, active listening and psychological first aid

e. maintain case files for all victims including maintaining file notes, undertaking appropriate verification of information supplied by the victim and maintaining a database.[125]

Operations Centres

22.22 Depending on the scale of the disaster event, the SDRC may also establish a State or Regional Operations Centre for the purpose of the overall coordination of disaster relief across a wider area. An Operations Centre may be established for instance during a particularly active bushfire season when there are a number of bushfires burning around the State.

NSW Disaster Relief Scheme

22.23 The NSW Disaster Relief Scheme allows for the distribution of immediate and longer term assistance to disaster affected victims. People can apply for assistance at Evacuation or Recovery Centres. It is the role of the Disaster Recovery Officer to assess the eligibility and needs of the applicant against a standard set of criteria. The Disaster Recovery Officer makes a recommendation about the application, and it is then either approved or declined by the delegated officer (usually the Centre Manager).

22.24 Disaster Recovery Officers are required to inspect the disaster affected premises before making any recommendations, and to comply with the Departmental Guidelines when handling such applications.

[125] This database is separate from the KIDS database.

Community Disaster Relief Fund

22.25 The Director-General of DoCS has responsibility for establishing and administering the Community Disaster Relief Fund for which provision is made in the Community Welfare Act.[126] This fund is made up of both private donations and public funding.

22.26 Assistance available through the Community Disaster Relief Fund is separate from the government assistance provided through the NSW Disaster Relief Scheme. Grants are made on the basis of criteria recommended by the Community Disaster Relief Fund Standing Committee and are not means tested.

Delivery of services and funding

Funding

22.27 Disaster recovery expenditure varies from year to year. In the incident involving the floods, in the Hunter for example, it required the services of up to 390 DoCS staff for varying periods over 11 weeks. As the former Director-General observed to the Inquiry:

> *You can pretty much guarantee that you will get something in a year, but some years the disaster budget will be very small, and other years you may have raging bushfires across half of NSW and you need a substantial number of staff.*[127]

22.28 The annual expenditure, the Inquiry was advised, can be up to up to $7 or 8 million.

22.29 In purely budgetary terms, DoCS is not required to absorb the cost of providing disaster recovery services from within existing resources. Rather, it receives a corresponding increase in revenue to offset these costs, including the costs of backfilling the positions of staff diverted to recovery work, including any overtime worked to cover for their absence or to respond to the disaster, as well as the costs of community partners who have provided assistance at DoCS' request.

22.30 Around Australia, the cost of disaster recovery is not solely borne by state governments. Under its *Natural Disaster Relief and Recovery Arrangements Determination 2007*, the Commonwealth "may make payments to a State in partial reimbursement for State expenditure in relation to a natural disaster."[128]

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[126] *Community Welfare Act 1987* ss.38-40.

[127] Transcript: Inquiry meeting with DoCS senior executives, 11 February 2008, p.73.

[128] Commonwealth Department of Transport and Regional Services, *Natural Disaster Relief and Recovery Arrangements. Determination 2007*, p.1.

Essentially, the Commonwealth reimburses the states for relief or recovery operations and the provision of assistance to disaster victims, such as emergency food, clothing, temporary accommodation, repair or replacement of furniture and personal effects, removal of debris and repairs to housing.[129]

22.31 Under a cost sharing formula with the Commonwealth, NSW pays for the first $98.9 million of natural disaster costs each year and can claim from the Commonwealth for half of all eligible Personal Hardship and Distress costs within this first threshold. The Commonwealth then matches NSW expenditure for costs between $98.9 million and $173.1 million and beyond that covers three quarters of all costs.[130]

22.32 NSW Treasury is responsible for seeking reimbursement from the Commonwealth. However, DoCS is required to provide Treasury with appropriate documentation regarding the cost of providing material assistance and of redeploying staff to disaster recovery operations.

22.33 In 2007/08 DoCS provided almost $3 million in financial and material assistance to individuals affected by disaster events, including some cases that carried over from previous years.[131]

22.34 During 2007/08 DoCS also provided almost $200,000 for drought-affected families and individuals. More than half of the affected households that received drought assistance lived in DoCS Western Region.[132]

Delivery of services

22.35 The Annual Report for 2007/08 reports that DoCS responded to 27 natural or other disasters across NSW.[133]

Table 22.2 **List of events where assistance was provided 2007/08**

Location	*Event Type*	*Date*
Auburn	Wall collapse	July 2007
Rosehill	Burst water main	July 2007
Mount Kembla	Bushfire	October 2007
Cowan	Bushfire	October 2007
Lismore	Hailstorm	October 2007
Dunoon	Severe storm	October 2007
Stanmore	Boarding house fire	October 2007
St Marys	Siege	October 2007
Port Stephens	Bushfire	October 2007
Werris Creek	Silo fire	November 2007

[129] ibid., p.2.
[130] NSW Office of Emergency Services: www.emergency.nsw.gov.au.
[131] DoCS, *Annual Report 2007/08*, p.18.
[132] ibid.
[133] ibid.

Location	*Event Type*	*Date*
Blacktown	Hailstorm	December 2007
Toowoon Bay	Potential gas cylinder explosion	December 2007
Lake Cargelligo	Storm and flooding	December 2007
Wallerawang	Fireworks explosion	December 2007
Grenfell	Tyre factory fire	January 2008
Northern Rivers	Flood	January 2008
Tenterfield	Flood	January 2008
Wollondilly	Windstorm	January 2008
Cooma	Storm	January 2008
Shoalhaven	Storm	January 2008
Ultimo	Shop explosion	February 2008
Port Stephens	Storm	February 2008
Merrylands	Apartment block fire	February 2008
Muswellbrook	Storm	February 2008
Waterloo	Burst water main	March 2008
Mid North Coast	Flood	April 2008
Wyong	Flood	April 2008

22.36 Significant events noted in the 2007/08 Annual Report included the following:

a. The severe weather on 8 June 2007 resulted in strong winds, and heavy rains in the Mid North Coast, Hunter and Sydney metropolitan regions. Recovery activities for the Hunter and Central Coast continued through most of 2007. Recovery Centres operated in Newcastle, Wyong, Cessnock and Singleton. By mid-August, all had closed except the centre in Newcastle, which operated until late October 2007. More than 3,000 people visited these centres. DoCS conducted more than 1,960 home visits and received more than 1,000 applications for assistance with repair or replacement of household contents, or structural repairs.

b. Flooding was caused by heavy rain on the North and Mid North Coast in early January 2008. To assist flood affected communities, DoCS set up five Evacuation Centres. The Kyogle Recovery Centre had 560 people visit over an eight week period.[134]

Should DoCS continue to be responsible for disaster recovery?

22.37 The first of the issues that concerns DoCS and that has led to earlier submissions to Government to move this responsibility to Premier and Cabinet, is the impact that the diversion of frontline staff to work on disaster recovery has on its core care and protection activities.

[134] ibid., pp.18-19.

22.38 While DoCS is reimbursed for the cost of redeploying staff to work on disaster recovery, this is of little assistance given the difficulty of backfilling any casework positions while the incumbents are redeployed for disaster recovery work. It is the fact that some CSCs are able to call on a pool of caseworkers for temporary assistance, but this is by no means universally available, particularly in country regions.

22.39 Prior to 2002, the DoCS workforce included staff who worked in disability services and in human resources (payroll and recruitment). This changed when Businesslink was established and disability services staff were reassigned to DADHC. A significant number of these officers had previously been involved in disaster recovery work.

22.40 To ensure that DoCS was still able to call on these officers (and any other interested officers in DADHC and Businesslink), formal agreements were made between the two agencies and DoCS. However, in practice, very few non-DoCS staff have been redeployed during an emergency/disaster, and the formal agreements have now lapsed. The Inquiry understands that the SDRC is currently working to renew the MOU with DADHC and to establish a new MOU with Housing.

22.41 Current efforts by the SDRC aside, since 2002, the pool of workers available to work in disaster recovery has shrunk and it is even more likely that disaster recovery staff will be frontline child protection workers.

22.42 The problem has been exacerbated by the fact that, through the SDRC, DoCS has been required to extend its involvement in disasters and emergencies beyond the natural disasters which have traditionally required its attention. As noted it is now expected to have a role in the event of terrorist attacks, outbreaks of human pandemics, the equine flu outbreak, the repatriation of residents caught in war zones, accidents at the Australian Nuclear Science and Technology Organisation, Lucas Heights, and serious disturbances of the kind that were contemplated for public events such as the APEC forum, (for which it conducted some preparatory planning even though it was not assigned any specific obligations other than performing its usual functions under the Displan).

22.43 Additionally it has been necessary for DoCS to engage in planning and training of its staff, and of its community partners, in responding to the wider variety of circumstances that might potentially fall within its responsibility under the Displan.

22.44 The second issue concerns the fact that placing reliance on one agency to coordinate the provision of disaster recovery services leaves the State vulnerable in the event of a large scale emergency or disaster affecting more than one region (as might be the case with multiple valley flooding or widespread bushfires).

22.45 It is recognised that disaster recovery has been seen across Australia as a responsibility within the purview of community service agencies. For example,

the Community and Disability Services Ministers' Conference that reports through COAG has a Disaster Recovery Sub-Committee. In the two states that have divided the community services and child protection functions between separate departments, Queensland and Western Australia, responsibility for disaster recovery rests with the Department of (or for) Communities, with the consequence that community service workers, rather than child protection workers, are redeployed to provide disaster recovery assistance in those states. In Tasmania and Victoria, the relevant departments tasked with disaster recovery have broader responsibilities than DoCS, including health, disability, community and child protection services, and it is understood that in the event of a disaster, the recovery staff would be drawn from a wider pool than in NSW. It is only the South Australian Department for Families and Communities that has a similar structure to DoCS, that is more likely to use care and protection staff for its disaster recovery responsibility.

22.46 DoCS has in the past sought a formal transfer of the responsibility for disaster recovery to Premier and Cabinet on the premise that:

a. disaster recovery needs a whole of government approach and is therefore better handled by the central agency
b. the central agency would have greater ability to 'direct' other agencies to contribute to the disaster recovery process
c. DoCS would not lose the services of its child protection caseworkers who are already fully committed to frontline activities.

22.47 This approach was unsuccessful, but has been renewed in DoCS' submission to this Inquiry, which noted that while it can rely upon the voluntary efforts of the five community partners, "there are no formal arrangements with other Government agencies that will guarantee that their staff will attend"[135] emergencies. The Inquiry understands that the Government has asked that the review of the NSW *Public Sector Employment and Management Act 2002* include a power to deploy human service agency staff to a major disaster response.

22.48 The contrary response to DoCS' submission, which was put to the Inquiry at meetings with DoCS staff, was to the effect that engagement in this form of work is likely to be productive of job satisfaction for its staff whose assistance will be appreciated and who will value a change from the more confronting tasks of responding to care and protection issues. It was also suggested that this kind of work is likely to present a better image for DoCS as a whole, that could help to counter the negative reception which it receives in many quarters. Additionally it has been suggested that it is important to involve an agency that has a statewide presence, although it is by no means unique in that front.

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[135] Submission: DoCS, Interagency Cooperation, p.18.

22.49 On the other hand, the Inquiry was informed at one of the regional Public Forums by a member of an agency that was involved in disaster recovery work on behalf of DoCS during the June 2007 storms, of the experience that some victims of that disaster declined offers of monetary assistance because of an expressed fear that DoCS would then become involved in their lives.

22.50 The Inquiry recognises the force of the argument that DoCS involvement in this form of work can be beneficial for its staff and for the Department as a whole. However, this is not the only area in which the Department, and its workers, provide community assistance, and in overall financial terms it is relatively insignificant, and likely, in most instances, to be of a short duration. Moreover, the extent to which traumatised victims will identify the source of the assistance as DoCS is questionable, particularly in circumstances where the actual assistance is delivered by the community partners.

22.51 The alternative to a transfer of the full responsibility for disaster recovery to Premier and Cabinet that was noted by the former Director-General of DoCS is:

> *To have a bigger group of people and a training program within other agencies so that you can call on the key staff from other agencies who are trained to deal with disasters …… We now have an expired MOU with DADHC where DADHC supplied staff and they still do, MOU or not, but getting other agencies to play ball on this has been exceedingly difficult.*[136]

22.52 Clearly this option would not justify a diversion of staff from other agencies who have specific responsibilities during an emergency such as Police or frontline Health workers involved in acute and emergency care. However it was suggested that there are several agencies that could share the burden if their staff had the necessary training, including, for example, DADHC, Housing, Education, Community Health Organisations, Primary Industries, Fair Trading and Transport, in addition to DoCS.

22.53 There would be sense in maintaining a role for DoCS in those cases where the skills of its workers were required in responding to families in crisis. However much of the work of a purely administrative nature does not call upon their skills and could just as well be provided by staff from other government departments having a human services or client focus.

22.54 The Inquiry understands that within Premier and Cabinet, the Office of Strategic Operations has been established, comprising the Counter-Terrorism, Disaster Recovery Directorate and the Strategic Projects Division that supports and provides strategic advice to the Director-General and Premier in coordinating the NSW Government's response to the threat of terrorism and recovery from major disasters. Premier and Cabinet also has Regional Coordinators located in major regional centres.

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[136] Transcript: DoCS, 11 February 2008, Dr Neil Shephard, p.73.

22.55 This Office could form an appropriate nucleus of an expanded disaster recovery team that could call upon the services of relevant government agencies, including DoCS, to provide, under its coordination and direction, assistance appropriate for the event. In particular this could spare DoCS from having to divert its staff and resources to respond to events that would seem to have little to do with its area of interest, such as the repatriation of citizens caught in war zones overseas, or the payment of horse trainers whose stables were closed because of equine flu, or an outbreak of illness on a school bus.

22.56 An alternative to a transfer of this responsibility to Premier and Cabinet, and specifically to the Office of Strategic Operations, would be a transfer to the State Emergency Service, and the Minister for Emergency Services, leaving it to them to coordinate the full disaster recovery operation, with the authority to call on individual agencies, including DoCS, to provide specific assistance as required. This would reflect the wide powers and functions reserved to the Minister and the Service, although it is acknowledged that the primary role of the State Emergency Service is that of a 'combat agency'.

22.57 If the responsibility for coordination of the disaster recovery is to remain with DoCS then the Inquiry considers it essential to:

a. increase the SDRC staff

b. establish full time and mobile Disaster Recovery Manager positions within DoCS to coordinate and deliver services and to arrange training

c. implement a whole of government approach, including establishing, training and maintaining a pool of skilled staff within other human services agencies who can be called upon in an emergency, and establishing via an appropriate MOU a commitment by these other agencies to provide services and staff appropriate to their special area of operation

d. implement strategies for full cost recovery from the State and Commonwealth Governments

e. ensure that the additional positions referred to above as well as the operations of DoCS in fulfilling the disaster recovery function are fully funded

f. ensure that DoCS is not required to provide its staff and services save where it is necessary to call on its experience and expertise.

22.58 In this respect the Inquiry notes that the current staffing of the SDRC is below establishment, and that as a result training has to some extent been neglected in recent years. Unless the SDRC is properly staffed with sufficient permanent positions, including those who are able to operate on a mobile basis, the capacity of the organisation to respond to any major event or series of events and even to prepare adequately for them is likely to be compromised to an unacceptable degree.

22.59 It may also be noted that in the course of an internal audit, Ernst & Young considered DoCS' preparedness to perform its welfare service requirements

under the Displan, had it been called upon to respond to a disaster incident occurring during the APEC Summit. Some issues were identified in that audit which it was suggested could justify a broader review of DoCS welfare and recovery services operations at some future time, including greater documentation of the processes and practices involved, and the establishment of greater clarity as to the division of responsibilities and tasks between state and regional levels.[137]

Drought relief

22.60 In past years there has been a response from both the Commonwealth and the State in providing assistance to those affected by the long standing drought in NSW.

Commonwealth assistance

22.61 So far as the Commonwealth is concerned an Exceptional Circumstance Declaration can be made where it considers that an event has occurred that has a severe and prolonged impact on a particular area, such as drought.

The NSW Drought Household Assistance Scheme

22.62 The Drought Household Assistance Scheme (the Scheme) was established in late 2002. It is a NSW funded scheme that is administered through the DoCS SDRC, to provide financial assistance to rural families suffering financial distress as a direct result of a drought, and in particular to help them with the payment of household expenses. The original aim of the Scheme was to provide support for farm and rural households directly dependent on primary production, or indirectly dependent on a drought affected rural economy, who were living in areas that were NSW drought declared, but not Exceptional Circumstance declared by the Commonwealth.

22.63 Payments are in the form of grants, not income support. A maximum of $2,000 can be paid to eligible applicants, or $400 for low income rural households needing to purchase household water.

Funding

22.64 The table below summarises the funding and allocation of grants for each financial year since the Scheme was established.

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[137] DoCS, Ernst & Young, *APEC Disaster Recovery Readiness Final Internal Audit Report,* August 2007.

Table 22.3 **Summary of Drought Household Assistance Scheme funding and allocation of grants**

Financial Year	*Treasury Allocation $*	*Total Grant $$ provided to eligible applicants*	*Number of Applications Received*	*Number of individual payments made*
2002/03	4,060,000	4,511,849	3,376	3,025
2003/04	5,300,000	2,789,402	2,512	1,962
2004/05	2,200,000	933,060	1,052	598
2005/06	800,000	422,949	572	260
2006/07	Nil	613,008	834	372
2007/08	Nil	194,613	281	123
2008/09 YTD	Nil	16,168	30	12

22.65 A total of almost $9.5 million has been expended in grants to drought affected families under the Scheme (as at August 2008).

22.66 For the financial years 2002/03 to 2005/06 DoCS received a special consolidated revenue allocation from Treasury to administer the Scheme. The total amount received was just over $12.3 million.

22.67 Since July 2006 however Treasury has not provided any funding for the Scheme and DoCS has been required to cover the total costs of this form of relief from within its general operating budget. This shortfall in funding amounts to more than $820,000 in grant expenditure, as well as associated administrative costs.

22.68 In April 2007, DoCS was advised by Treasury that it would not support funding for the Scheme in the 2007/08 budget. This decision was based on an assumption that the Department had the capacity to fund the Scheme in the short term. In response, DoCS advised Treasury that the Scheme was not a core departmental function and as such it would not have the capacity to provide funding in subsequent years.

22.69 Similarly in May 2008, DoCS was advised that additional funding would not be provided by Treasury for the Scheme. The Cabinet Standing Committee approved the continuation of departmental funding (that is from its existing budget allocation) for the 2008/09 financial year.

22.70 The administration of the Scheme (including the assessment of applications, liaison with applicants and clerical administration) are additional costs that are also met by the Department. These costs vary from year to year depending on the demand for the Scheme.

22.71 A significant question arises as to why DoCS should have any role to play in the provision of this form of assistance, and particularly why it should be a direct cost to its budget. If the Government decides that it is appropriate to complement the Commonwealth assistance in relation to areas of the State that are in fact in drought, although not included in a current Exceptional Circumstance declaration, then it would seem that the funding should be

provided by Treasury, and managed within the Primary Industries portfolio by the NSW Rural Assistance Authority, established under the *Rural Assistance Act 1989*, which already has a statutory function of providing natural disaster relief assistance to the rural sector.

22.72 The Inquiry does not consider it appropriate for DoCS to take on the role of distributing drought relief. That is not a role that calls on any special skills, and it can require considerable time and effort in the administration and processing of applications, for relatively little return to individual households. Moreover, if combined with the assistance otherwise available through the NSW Rural Assistance Authority,[138] a more comprehensive package should be capable of delivery using this agency as a single entry point.

Recommendations

Recommendation 22.1

DoCS responsibilities under the *Community Welfare Act 1987* should be transferred to the Department of Premier and Cabinet or to such other government department as is entrusted with the principal responsibilities for planning for and responding to disasters or emergencies, with DoCS staff being available to be called upon to provide, under the coordination and direction of the Department of Premier and Cabinet or of such other department, assistance appropriate to the event.

Recommendation 22.2

In the event that DoCS retains responsibility under the *Community Welfare Act 1987*, it should be resourced sufficiently to adequately perform that role, without frontline child protection caseworkers being deployed.

Recommendation 22.3

The NSW Government should assign responsibility for distributing drought relief to an agency other than DoCS, and such relief as is provided should not be a cost to the DoCS budget.

[138] In 2006/07 assistance through the NSW Rural Assistance Authority involved $253 million in Commonwealth Exceptional Circumstance assistance, extraordinary funding assistance for Irrigators in the Murray and Murrumbidgee Valleys in the order of $19m, and Natural Disaster Relief Assistance in the order of $3 million, *NSW Rural Assistance Annual Report 2006/07.*

Part 6 Oversight and interagency cooperation

23 Oversight

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Introduction

23.1 DoCS is accountable for its actions pursuant to a range of central and external oversight arrangements, some of which are similar to other government departments and others of which are unique to it.

23.2 Premier and Cabinet coordinates NSW Government policy with all agencies including DoCS. NSW Treasury enters into an agreement each year with DoCS as to the services that DoCS will deliver according to the resources the Government allocates to it, and as to the way in which results will be measured. As with other agencies, the Audit Office of NSW performs an audit on DoCS annual financial statements for the year ended 30 June. The Independent Commission Against Corruption can investigate allegations of corrupt conduct in public sector agencies including DoCS. In addition, there are oversight bodies with more limited areas of interest such as the NSW Privacy Commission and the Public Guardian.

23.3 The NSW Ombudsman deals with complaints made by the public against NSW Government agencies, including DoCS. In addition, his Office has significant oversight functions specific to DoCS, including its management of allegations against staff, and its involvement with children and young persons whose deaths it reviews.

23.4 Unique to DoCS is its relationship to the work of the Children's Guardian, the NSW Child Death Review Team and aspects of the CCYP. The latter two, while not being agencies to which DoCS is accountable, work in related areas. Each of these, and the role of the Ombudsman will be addressed further in this chapter.

23.5 The Inquiry accepts, as the starting point for a consideration of the effectiveness of oversight arrangements in relation to child protection services in NSW, their purpose, as enunciated by the Ombudsman in 2005:

> *The aim of external oversight is to maintain the integrity of government agencies and public officials by holding them accountable for actions and decisions they will make while carrying out their duties. Accountability is a keystone of representative government, as it enhances public confidence in the government sector and, conversely, helps ensure that government is responsive to the interests of the public.*[139]

[139] NSW Ombudsman, *Public Sector Agencies fact sheet, No. 15: Oversight of public administration,* December 2005, p.1.

NSW Ombudsman

23.6 The role and responsibilities of the Ombudsman in relation to child protection services are prescribed by the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) and the *Ombudsman Act 1974* (the Ombudsman Act).

23.7 In December 2002, the Community Services Commission was amalgamated into the Office of the Ombudsman. CS CRAMA was amended to provide the legislative framework for the amalgamation. The responsibilities which are conferred upon the Ombudsman by that Act and which relate to child protection are to:

a. review the deaths of certain children[140] including children or their siblings 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

b. review the situation of a child in care, or of a group of children in care

c. receive and consider complaints about the provision of, or failure to provide, a community service or about the withdrawal, variation or administration of a community service

d. review the complaint handling systems of service providers

e. coordinate and oversight Official Community Visitors, visiting OOHC services

f. monitor and review the delivery of community services and inquire into matters affecting service providers and consumers

g. provide information, education and training in relation to standards for community services and in relation to complaint handling in community services, and to promote access to advocacy to enable consumer participation in decisions about the services they receive.

23.8 The Ombudsman Act confers in the Ombudsman certain powers and obligations, which apply to the exercise and functions under CS CRAMA, including the capacity to make preliminary inquiries and to conduct investigations, to compel statements of information and to interview witnesses.

23.9 Since 2003, the Community Services Division of the Office of the Ombudsman has initiated 90 investigations into 59 matters involving DoCS, the majority of which have concerned child protection issues and have arisen from child death reviews. Those of particular interest to the Inquiry are addressed below.

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[140] Under s.25A of the *Ombudsman Act 1974,* s.13AB of the *Coroners Act 1980* and s.35 of the *Community Services (Complaints Review and Monitoring) Act 1993*, a 'child' is a person under the age of 18 years. This definition is used throughout this chapter.

Reviewing child deaths

23.10 There is some history to the current arrangements whereby child deaths are reviewed. In 2001, NSW was described as having the most complex oversight arrangements for community service providers for any jurisdiction in Australia. In late 2001 the Premier's Department and The Cabinet Office conducted a review of that system. The initial review concluded that it would be considerably enhanced by the amalgamation of the Office of the Ombudsman and the Community Services Commission, the strengthening of the role of the Coroner and the clarification of various objects and functions under CS CRAMA.

23.11 The key principles behind the amalgamation were said to be that none of the then current protections in the review and monitoring system of community services should be weakened, the independence of oversight agencies should be strengthened, and client access and complaint handling should be improved.

23.12 The key benefits were said to include creating a single responsible organisation with sufficient powers, skills and resources, reducing the chance of gaps in the investigation and handling of complaints, providing clients with better access through a single entry point and increasing the credibility of investigations and reports.

23.13 One of the changes effected related to a specific class of child deaths which, until 2003 were reviewed by the Child Death Review Team (CDRT). In the second reading speech for the *Commission for Children and Young People (Child Death Review Team) Bill 2003* the then Minister for Community Services said:

> *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.*[141]

23.14 Thus, from August 2003, the Ombudsman assumed responsibility for reviewing the class of child deaths which became known as 'reviewable deaths.' The Coroner's jurisdiction was extended to cover the same deaths, except those in residential care or detention. In addition, since early 2004, DoCS has established its own child death review function.

23.15 The Ombudsman is required to review the deaths of:

a. a child in care

b. a child in respect of whom a report was made under Part 2 of Chapter 3 of the Care Act within the period of three years immediately preceding the child's death

[141] Legislative Council, Hansard, 25 June 2008, 2048.

c. a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the Care Act within the period of three years immediately preceding the child's death

d. a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances

e. a child who, at the time of the child's 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)

f. 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 and authorised or funded under the *Disability Services Act* 1993 or a residential centre for handicapped persons (in this Part referred to as a person in residential care)

g. a person (other than a child in care) who is in a target group within the meaning of the *Disability Services Act* 1993 who receives from a service provider assistance (of a kind prescribed by the regulations) to enable the person to live independently in the community.[142]

23.16 An MOU exists between DoCS and the Ombudsman in which DoCS undertakes to cooperate with and assist the Ombudsman to access in a timely manner all information held by DoCS of relevance for such cases. This includes information about DoCS funded service providers.

23.17 The Ombudsman described his function in the following way:

> *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.*[143]

23.18 This is achieved by establishing facts, including errors relating to professional practice, and by identifying systemic issues. Usually the reviews are paper based, although interviews can be and are conducted in more complex cases.

Research

23.19 The deaths of children generally are reviewed in order to understand their causes, to hold individuals accountable criminally where the evidence permits and where possible, to devise changes to systems and practices to reduce the instances of preventable deaths.

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[142] *Community Services (Complaints, Reviews and Monitoring) Act 1993*, s.35(1)

[143] Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, p.11.

23.20 More particularly, the scrutiny of deaths of children from abuse or neglect or in suspicious circumstances is important to learn what state agencies charged with their protection can or should do.

23.21 The starting point is the research on fatal child abuse. DoCS has distilled the following issues about fatal child abuse from a literature review it carried out in late 2005:

a. International and local data reporting the rates of fatal child abuse indicate that it is a rare event, but it is likely that official figures for child homicides underestimate the incidence of fatal child abuse.

b. Child homicides are not considered a likely outcome in most cases of child maltreatment with less than one in every 2,000 cases of children reported for abuse resulting in death in the USA. In many studies, most children who were fatally abused were not known to child protection services.

c. Current approaches to risk assessment in child protection services are subject to a high level of inaccuracy in their ability to classify families as being at high, medium or low risk. The small numbers of child abuse cases that occur within the population (less than one in every 100) and the even smaller number of fatal child abuse cases (around one in every 100,000) make it almost impossible to generate accurate risk assessment tools.

d. Risk factors present in cases of fatal child abuse are generally similar to those present in many thousands of other child protection cases. There are many variables that contribute to child maltreatment and these factors tend to be extensive, broad, and at times even inconsistent.

e. Infants and very young children are at greatest risk.

f. Research from the USA suggests that domestic violence is the single major precursor to child assault and neglect in families in that country.[144]

23.22 Many child abuse inquiries have identified organisational issues as significant contributory factors to child deaths. The CDRT 2003 report, *Fatal Assault and Neglect of Children and Young People,* concluded that the three most common errors made by agencies and practitioners were:

i. not recognising and reporting serious and unstable conditions

ii. inadequate risk assessment

iii. poor interagency collaboration and coordination.[145]

23.23 In 2008, the CDRT published a report *Trends in the Fatal Assault of Children in NSW: 1996-2005,* which contained the following messages:

a. There is no evidence of an increase in the likelihood of deaths of children from assault in recent years.

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[144] DoCS, *Fatal Child Maltreatment, Key messages from the research*, November 2005.

[145] NSW Child Death Review Team, *Fatal Assault and Neglect of Children and Young People,* 2003, p.xii.

b. The deaths of children from assault are relatively rare.

c. Nearly 60 per cent of children who died came from families with a child who had been the subject of a report to DoCS within three years prior to the death. Thus, more than one assault death in three occurred in a family with no contact with that system.

d. The greatest difference found in incident rates was for age and Aboriginality.[146]

23.24 In 2008, the CDRT reported on trends in child deaths in NSW between 1996-2005. It found that, after adjusting for age and sex, the likelihood of child deaths from:

a. all causes declined by 37.98 per cent

b. external causes declined by 47.24 per cent

c. diseases and morbid conditions declined by 34.91 per cent.

This report also identified continuing and, in some cases, growing inequities in health outcomes for Aboriginal children and young persons for those from disadvantaged socio-economic locations and for those living in remote parts of NSW.[147]

23.25 From data collected in 2007, the CDRT established that:

a. there was a decrease in the overall death rate (as compared with 2006)

b. there was a slight decrease in the number of infant deaths (as compared with 2006) with infants comprising 62.7 per cent of all child deaths in 2007.

c. the rates of death for 1-17 year olds had remained steady (as compared with 2006)

d. amongst those who died from external causes, vulnerable children were over represented

e. amongst the total number of child deaths, Aboriginal and Torres Strait Islander children and young persons were over represented

f. the number of fatal assaults had declined (as compared with 2006)

g. remote areas had higher rates of child death

h. amongst the total number of child deaths, children in areas of greatest socio-economic disadvantage were over represented

i. the distribution of child deaths varied across NSW

j. age and gender patterns were evident.[148]

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[146] NSW Child Death Review Team, *Trends in the fatal assault of children in NSW: 1996-2005*, 2008, p.3.
[147] NSW Child Death Review Team, *Trends in Child Deaths in NSW: 1996-2005,* 2008, p.xxxi.
[148] NSW Child Death Review Team, *Annual Report 2007,* November 2008.

23.26 The work done by the Inquiry, including its case file audit, its consideration of the various reviews and audits conducted by others, including DoCS and examination of the case studies and the reviewable death reports undertaken or published by the Ombudsman, supports this research.

23.27 In particular, while the two children who died shortly before the Inquiry was established did so in awful and tragic circumstances, the characteristics of their lives were not significantly different from thousands of other children and young persons reported to DoCS who did not die. It is known that: one child was aged seven years at the time of her death and the other child was two and a half years of age, each being older than that generally observed in the research; domestic violence was reported in both families, although other factors existed; one child was Aboriginal; and both families were socio-economically disadvantaged. Their deaths could not have been predicted by DoCS, although the reviews following their deaths have identified a number of deficiencies in the operations of more than one government and non-government agency, who had contact with the families.

23.28 The deaths of each of these children are subject to criminal proceedings and they are not identified in this report. The Inquiry, however, has had the benefit of reviewing the material from all agencies in relation to their deaths and, in particular the reviews undertaken by the Ombudsman and by DoCS. The findings and lessons from these reviews have informed the considerations and recommendations of this Inquiry.

Reviewable Deaths occurring in 2003-2006

23.29 The following table is taken from the Ombudsman's *Report of Reviewable Deaths in 2006*:[149]

Reason for reviewable status	*Number of children, per cent and additional information*			
	2003 deaths	*2004 deaths*	*2005 deaths*	*2006 deaths*
Death resulted from abuse	17 (13%)	7 (7%)	11 (9%)	12 (10%)
Death resulted from neglect	18 (14%)	6 (6%)	12 (10%)	9 (7%)
Death occurred in circumstances suspicious of abuse or neglect	8 (6%)	11 (11%)	10 (9%)	19 (15%)

[149] NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths,* December 2007, p.14.

Reason for reviewable status	*Number of children, per cent and additional information*			
	2003 deaths	*2004 deaths*	*2005 deaths*	*2006 deaths*
The child, or the child's sibling, was reported to DoCS in the three years prior to the child's death	103 (80%): 84 of the children were themselves reported to DoCS. These children were the subject of a total of 286 reports to DoCS. 19 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 143 reports of risk of harm	96 (92%): 72 of the children were themselves reported to DoCS. These children were the subject of a total of 310 reports of risk of harm. 24 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 96 reports of risk of harm.	109 (93%): 69 of the children were themselves reported to DoCS. These children were the subject of a total of 246 reports of risk of harm. 40 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 194 reports of risk of harm.	114 (93%): 81 of these children were themselves reported to DoCS. These children were the subject of a total of 296 reports of risk of harm. 33 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 201 reports of risk of harm.
The child died while in statutory care	10 (8%)	8 (8%)	4 (3%)	4 (3%)
The child died in a detention or correctional facility	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total number of reviewable deaths	128	104	117	123

Note: because a child's death may be reviewable for more than one reason, percentages for any one year will not total 100 per cent.

23.30 Almost 90 per cent of the child deaths reviewed in this period were reviewable because the child or a sibling had been notified to DoCS. Over this period, twenty per cent of all child deaths in NSW were reviewable and 42 per cent of the deaths of Aboriginal children were reviewable.[150]

23.31 All of the Ombudsman's 68 final recommendations which have been directed to DoCS, and which have arisen from its reviewable deaths function, have been accepted or accepted in part and have been implemented or implemented in part. A key issue between the agencies has been the view of the Ombudsman that DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention. This matter has been dealt with in Chapter 9.

23.32 The following is a summary of issues raised by the Ombudsman as reflected by his recommendations in the period 2003 to 2006 and the response of DoCS to those matters.[151]

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[150] ibid., p.ii.

[151] ibid., pp.11-12.

Concerns underlying recommendations	Relevant agency developments and achievements
Improving the quality of DoCS child protection work	DoCS has implemented a quality assurance project that will include an audit of each of its local offices over a four-year period to 2010.
Improving initial risk assessment	DoCS reviews the quality of work done at the central intake Helpline.
Improving secondary risk of harm assessment	DoCS has implemented a revised policy on secondary risk of harm assessment and provided relevant training to staff.
Improving responses to risk arising from neglect	DoCS has implemented a new neglect policy and provided relevant training to staff.
Decreasing numbers of cases closed without comprehensive assessment due to competing priorities	DoCS has endorsed intake assessment guidelines that require the prioritising of high risk cases for secondary assessment.
Improving responses to child protection reports from police	Police are reviewing operating procedures for responding to domestic violence and child protection. DoCS and Police are working on a joint project to improve risk assessment procedures.
Improving responses to cases involving parental substance abuse	Child protection legislation has been amended to include Parent Responsibility Contracts. These are being used in selected DoCS offices that are also piloting a Parental Drug Testing policy. DoCS is revising training to improve staff expertise on carer substance abuse. NSW Health is working to improve services to women who use drugs during pregnancy. DoCS and NSW Health have established a protocol on information exchange regarding DoCS clients on opioid treatment. The agencies are jointly reviewing methadone-related child deaths. NSW Health has upgraded its systemic response to children presenting with methadone poisoning.
Better response to prenatal reports	Child protection legislation has been amended to allow exchange of information regarding an unborn child, and to expand the definition of a child at risk to include prenatal reports in certain circumstances. DoCS has consulted NSW Health and developed a draft policy on responding to prenatal reports.
Improving responses to Aboriginal children and young persons	DoCS has published its *Aboriginal Strategic Commitment 2006-2011* outlining plans to provide better services to Aboriginal clients.
Improving responses to adolescents	DoCS is establishing an internal panel to review the suicide and risk taking deaths of young people known to DoCS.
Better interagency child protection responses	A new edition of the *Interagency Guidelines for Child Protection Intervention* was published in 2006. The effectiveness of interagency practice under the guidelines is to be evaluated during 2007 and 2008. DoCS, Police and Health have reviewed the work of JIRTs and revised criteria for reports of physical abuse. DoCS has memoranda of understanding with agencies including Police, Health and Education. An Anti Social Behaviour Case Coordination Framework is being rolled out as part of an Anti Social Behaviour Pilot Strategy, with a focus on partnerships for improving and coordinating strategies to “reduce risks to, and anti social behaviours of, children and young persons requiring multi agency intervention.”
Improving DoCS data collection and reporting	DoCS resumed quarterly data reporting in 2005.

23.33 These issues have been dealt with throughout this report. It is fair to say that each remains a challenge, the first mentioned primarily because of opposition by the PSA.

Reviewable Deaths occurring in 2006

23.34 The Ombudsman observed in relation to the deaths of the 123 children who died in 2006 (20 per cent of all deaths of children[152]) and were included in the review that: "In most cases, the circumstances of the child's death had no connection to reported child protection concerns."[153]

23.35 Of the deaths in that year of the of 114 children known to DoCS, in 81 cases (71 per cent) reports had been made in the preceding 12 months in relation either to them or their siblings.

23.36 Of the group of 40 children who died as a result of abuse or neglect, or whose deaths occurred in suspicious circumstances, the following is known:

a. 31 children had been reported to DoCS within three years of their deaths

b. almost one quarter (9) were not known to DoCS. Three of these children died of abuse, and two died of neglect. This number is consistent with the proportion of children not known to DoCS in previous years

c. there were twice as many male (21) as female children (10)

d. 15 per cent (6) of the children were identified as Aboriginal

e. criminal charges have been laid in relation to 10 of the deaths.

23.37 Most of the children whose deaths were reviewable in 2006 and who were the subject of a report had two or more reports to DoCS in the three years prior to their death, with the average number of reports being 2.4. This, in fact, is lower than the average ratio of child protection reports for children and young persons reported to DoCS in any one year period. In both 2006/07 and 2007/08 there was an average of 2.3 reports for every child or young person reported.

Reviewable Deaths occurring in 2007

23.38 The Ombudsman provided the Inquiry with preliminary information about reviewable deaths in 2007. The number of deaths reviewed that year increased to 169, equivalent to 28 per cent of all deaths of children. However, the percentage of reviewable deaths which occurred due to abuse, neglect or in suspicious circumstances showed little change from 31 per cent in 2006 to 30 per cent in 2007, although the numbers rose from 39 to 51. The percentage of abuse cases decreased from 11 per cent in 2006 to five per cent in 2007, neglect rose slightly from nine per cent to 11 per cent as did deaths from suspicious circumstances, rising from 11 per cent to 15 per cent.

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[152] ibid., p.3.

[153] ibid.

23.39 The percentage of children or their siblings reported to DoCS in the three years prior to their death remained the same over the two years at 91 per cent of reviewable deaths. In 2006, 71 per cent of this subset of children had been the subject of a report and 29 per cent had a sibling who was the subject of a report. In 2007, the proportions changed slightly with 67 per cent of the children being the subject of a report and 33 per cent having a sibling who was the subject of a report.

23.40 The number of children who died in care rose slightly from three per cent in 2006 to four per cent in 2007.

23.41 Consistent with previous years, most of the 169 children who died in 2007 and whose deaths were reviewable, were very young, with almost two thirds (110) of these deaths being children aged 0-4 years. Twenty per cent (34) of these deaths were of children aged 13-17 years, which is higher than that reported in the previous two years.

23.42 In 2007, there were slightly more male (56 per cent) than female deaths and this is consistent with data from previous years and with child deaths in general.[154]

23.43 The deaths of Aboriginal children represented approximately 21 per cent of all reviewable deaths in 2007. Twenty-eight per cent of all child deaths in NSW were reviewable in 2007. In contrast, almost two thirds of the deaths of Aboriginal children were reviewable (36 of 58 deaths). This represents an increase, in both number and proportion, from 2006.

23.44 The deaths of infants made up the majority of reviewable Aboriginal deaths in 2007. The families of all Aboriginal children whose deaths were reviewable were known to DoCS either through a report in the previous three years in relation to the child themselves (24), or through a report about the child's sibling (12). Two Aboriginal children died in circumstances of abuse and two as a result of neglect. In a further five cases, the deaths occurred in suspicious circumstances.

23.45 Of the group of 51 children who died as a result of abuse or neglect, or in suspicious circumstances in 2007, the following is known:

a. 29 children had been reported to DoCS within three years of their deaths

b. almost one third (16) were not known to DoCS. Two of these children died of abuse, and ten died of neglect

c. almost two thirds of the children were male

d. 18 per cent (nine) of the children were identified as Aboriginal

e. criminal charges have been laid in relation to nine of the deaths.

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[154] Australian Bureau of Statistics, 1998 cited in Correspondence: NSW Ombudsman, September 2008.

23.46 For the 103 children who were themselves known to DoCS, the status of their DoCS case at the time of their death was:

a. open and allocated to DoCS caseworker (32 children)

b. open and unallocated (five children). This means that a report or case plan may have been open at a CSC, but was not allocated to a caseworker for active casework

c. open but unable to ascertain its allocation status from available records (one child)

d. closed (65 children).

23.47 For the 50 siblings of children whose deaths were reviewable and reported to DoCS, the status of the siblings' involvement with DoCS at the time of the child's death was:

a. open and allocated to a DoCS caseworker (27 children)

b. open and unallocated (eight children)

c. closed (15 children).

23.48 Information was also provided by DoCS about its review of children who died in 2007 in circumstances where they, or a sibling, had been reported to DoCS within three years of their death. That information revealed that the most common possible cause of death for these children was illness or natural causes (31 per cent). Four per cent were killed by alleged abuse, seven per cent of the deaths were indicative of neglect, most of which were supervisory neglect and 11.46 per cent died while co-sleeping.

23.49 The most frequently recorded child protection risk factors were domestic violence, parental substance abuse, poor parenting skills and parental mental health concerns. The majority of children and young persons who died had been exposed to more than one risk factor, with neglect being the most frequently recorded abuse type.

Coroner

23.50 Under the *Coroners Act 1980*, the State Coroner and Deputy State Coroner (but not other Coroners) have jurisdiction to hold an inquest in relation to a person who at the time of their death met the same criteria as for the Ombudsman's reviewable deaths jurisdiction.[155] In 2006, 210 such deaths were reported to the State Coroner.[156]

23.51 While reporting an examinable death is mandatory, there is no general obligation on a Coroner to conduct an inquest. The Coroner ultimately decides

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[155] *Coroners Act 1980* ss.13A(1)(c) and 13AB.

[156] Local Courts of NSW, *Annual Review 2006*, p.23.

whether to hold or dispense with an inquest. If the Coroner is able to consider all available evidence, such as the statements of witnesses and medical reports, and is satisfied that there are no outstanding matters to be determined, the Coroner can dispense with an Inquest. An inquest into the death of a child must however be held where:

a. it appears that the child died or might have died as the result of homicide

b. the child died while in custody, while in or temporarily absent from a detention centre, while in the process of attempting to escape custody, or during the course of a police operation

c. there has not been sufficient disclosure as to whether the child has died (for example, in missing person cases), or as to the child's identity and the date and place of death

d. there has not been sufficient disclosure of the manner and cause of the child's death

e. the Minister or the State Coroner directs an inquest to be held.[157]

23.52 If (either before the commencement of an inquest or during the course of an inquest) it becomes apparent to the Coroner that the circumstances of the death may have involved the commission of an indictable offence by a known person, the Coroner may commence or continue the inquest only for the purpose of establishing the death, the identity of the deceased and the date and place of death.[158]

23.53 At the conclusion or suspension of an inquest, a Coroner must record his or her finding, as to whether the person died, the person's identity, the date and place of the person's death, and (in the case of an inquest that has been concluded as opposed to suspended) the manner and cause of the person's death.[159]

23.54 A Coroner can make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the inquest was concerned.[160]

23.55 The State Coroner must notify the Ombudsman of any reviewable death notified to the State Coroner not later than 30 days after receiving the notification.[161] The State Coroner must also provide the Ombudsman with access to records held by the Coroner in relation to these deaths.[162]

23.56 The Inquiry sought from the Coroner's Court a copy of the formal findings in relation to all inquests resulting from the death of a child in NSW since

[157] *Coroners Act 1980* (NSW) ss.14A and 14B.
[158] *Coroners Act 1980* (NSW) s.19.
[159] *Coroners Act 1980* (NSW) s.22(1).
[160] *Coroners Act 1980* (NSW) s.22A(1).
[161] *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.37(3).
[162] *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.38. See also *Coroners Act 1980* s.12A(3A).

December 2002. The Coroner provided 141 findings which were made between 2001 and early 2008.

23.57 Of these, the Coroner has made findings in respect of the deaths of 18 children in circumstances where the Inquiry has identified child protection issues. The issues raised in relation to those deaths are similar to those which the Ombudsman has sought to have addressed by DoCS. They include: criticism of the incident based approach taken by the Helpline; lack of interagency cooperation in relation to children with a severe disability; lack of information sharing between DoCS, Health and Police; the adequacy of recording and assessing reports at the Helpline; assessment of kinship carers; and methadone toxicity.

Child Death Review Team

23.58 The CDRT was established in 1995 and since 1999 has been constituted under Part 7A of the *Commission for Children and Young People Act 1998*. The object of this Part of the Act is to prevent and reduce the deaths of children in NSW through the constitution of the CDRT, which is to exercise the functions contained within the Act.[163] The CDRT considers deaths of children from birth to 17 years of age, excluding still births. The CCYP provides research and secretariat support to the CDRT. It is convened by the Commissioner for Children and Young People and its members include medical practitioners, academics, representatives of Police, DoCS, Health, the Coroner, Education and an Aboriginal representative.

23.59 The functions of the CDRT are as follows:[164]

a. to maintain a Child Death Register

b. to classify 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 research that aims to help prevent or reduce the likelihood of child deaths

e. to make recommendations 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

f. to identify areas requiring further research by the CDRT or other agencies.

23.60 Pursuant to s.45N(2) of the Act, the CDRT cannot undertake a review of a 'reviewable death'[165] but may include such deaths in any research that examines a sample population of child deaths.

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[163] *Commission for Children and Young People Act 1998* s.45A.

[164] *Commission for Children and Young People Act 1998 s.*45N.

23.61 Section 45T of the Act imposes a duty on departments, agencies and individuals to provide the team with full and unrestricted access to records for the purposes of CDRT functions.

23.62 Section 45P(2)(b) of the Act requires the CDRT to provide details in its Annual Report on the extent to which its previous recommendations have been accepted. Sustained home visiting, reporting and research are the main areas about which recommendations have been made by it which are outstanding.

Child Deaths and Critical Reports Unit, DoCS

23.63 The Child Deaths and Critical Reports Unit (CDCRU) is the DoCS internal unit responsible for providing a centralised response to deaths of children known to it and also to cases where there are serious, although non-fatal outcomes for children. It was established in early 2004 as part of the Reform Package. The CDCRU analyses the deaths of all children where they or a sibling have been reported to DoCS within the three years prior their deaths. The CDCRU uses a systems approach to reviewing child deaths. Its focus is broad with the aim of casework being assessed in the context within which decisions are made and actions are taken. The CDCRU facilitates practice review forums in CSCs in response to cases where children have died. This provides staff with an opportunity to reflect on critical practice and decision making issues.

23.64 In September 2007 and in September 2008, the CDCRU compiled a report on the deaths of children known to DoCS which occurred in 2006 and 2007.[166] On each occasion, the CDCRU identified similar practice issues and themes to those identified by the Ombudsman and by the Inquiry. Each issue and theme is addressed in Chapter 9.

Other jurisdictions

23.65 As with other aspects of child protection, there are differing mechanisms for reviewing child deaths in each state and territory. Generally, the main purpose for reviewing child deaths in each jurisdiction is to recommend strategies and initiatives to prevent or reduce the number of deaths of children occurring, and to provide annual reports on the deaths.

23.66 In Victoria, the Office of the Child Safety Commissioner inquires into those children who were clients of child protection at the time of their death or within three months of their death. Those inquiries are reviewed by a multidisciplinary advisory committee, which reports to Parliament annually. The committee's

[165] As defined in the *Community Services (Complaints, Reviews and Monitoring) Act 1993* and referred to above.

[166] Not all of these child deaths were the subject of a full Child Deaths and Critical Response Unit investigation and report.

reports provide quantitative and demographic data and analysis about these deaths in order to identify common themes, issues and opportunities for learning that can influence future policy and practice in relevant service systems.

23.67 In Queensland, the death of any child known to its Department of Child Safety within the three years prior to his or her death is subject to a child death case review under the *Child Protection Act 1999*. The Department commissions an independent reviewer to complete child death case review reports. Those reviews do not investigate cause of death, but focus on the adequacy and appropriateness of the Department's interventions, policies, procedures and interactions with other agencies as they related to the child who died. The Department has six months from the time it learns about the death of a child known to it to provide the Child Death Case Review Committee with its report on the original child death review.

23.68 The Queensland committee is a multi-disciplinary committee chaired by the Commissioner for Children and Young People and Child Guardian. It acts independently, but the Commission for Children and Young People provides secretariat support. The committee reports on its review of each case to the Department of Child Safety within three months of receiving the report from the Department.

23.69 In Western Australia, the Child Death Review Committee reviews deaths which meet one or more of the following criteria:

a. The deceased child or young person or other children in the deceased child's family had been the subject of an allegation of a child concern report or a child maltreatment allegation recorded by the Department for Child Protection within the past 24 months.

b. The family of the deceased child or young person had a number of contacts with the Department for Child Protection within the past 24 months and an emerging pattern was indicated.

c. The deceased child or young person was in the care of the Department for Child Protection or a request for Departmental involvement in an OOHC placement for the child or young person had been made within the past 24 months.

23.70 One of the recommendations from a review of the former Western Australian Department of Community Development, was that the child death review function be transferred from the ministerial Child Death Review Committee to the Ombudsman. This recommendation was endorsed by the State Government and funding has been approved for 2008/09.[167]

23.71 In addition, the Inquiry understands from its website that Western Australia has an Advisory Council on the Prevention of Deaths of Children and Young People

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[167] Western Australian Ombudsman, *Annual Report 2007/08,* p.58.

which is tasked with reducing or preventing the deaths of children aged from 0-17 years, promoting the health, safety and well-being of children through the review and analysis of relevant information and research and through the making of recommendations. The Council is independent and reports to the Cabinet Standing Committee on Social Policy, through the Minister for Community Development.

23.72 In South Australia, the Child Death and Serious Injury Review Committee is an independent statutory body. It reviews cases where there are indications of abuse or neglect, or where a child or family has been known to child protection service within a three year period or is in care.

23.73 The Inquiry understands that in the ACT, the criteria for review by the ACT Child Death Review Team relate to the existence of reports on the child, a sibling or family two years before the death. The Inquiry also understands that the Northern Territory is in the process of establishing a reviewable deaths function which will include the deaths of all children.

23.74 Notwithstanding the different approaches among the jurisdictions, the Inquiry understands, from a seminar conducted in June 2008 on Australasian Child Death Inquiries and Reviews, that the co-existence of domestic violence, mental health, drug and alcohol issues and concerns about interagency collaboration are common to the equivalent of “reviewable deaths” in all jurisdictions.

23.75 It is beyond the Inquiry’s terms of reference to achieve a national approach to child protection or even to the review of child deaths. However, it should be said that the Inquiry supports a move towards a national system of data collection and review on child deaths.

Issues arising

23.76 A number of issues arise from the way in which child deaths are scrutinised in NSW. First is the question of whether it remains appropriate for each of the four bodies who are obliged to, or have assumed responsibility for investigating or reviewing these deaths to continue to do so, or whether wasteful duplication exists. Secondly, it needs to be established whether the categories of deaths which are reviewable are appropriate to achieve the desired purpose. Finally, the interval at which reports about these deaths are made public needs to be examined.

Four agencies

23.77 DoCS, via the CDCRU, the Coroner and the Ombudsman each inquire into and report on deaths of children. The latter two generally inquire or report in public and by reference to similar criteria. DoCS investigates privately and by reference to broader criteria. In addition, research work into deaths is undertaken and published by a fourth body, the CDRT. Two registers are

effectively kept, one by the Ombudsman and one by the CDRT. Other sources of information include the NSW Midwives Data Collection and Australian Bureau of Statistics data.

23.78 At first blush and with reference to other jurisdictions, this appears to be a cumbersome and potentially resource intensive system. DoCS was particularly critical of it.

DoCS view

23.79 DoCS carried out an analysis of the recommendations made by the Ombudsman to DoCS between June 2004 and November 2006 and the work carried out by the CDCRU. DoCS concluded, from that analysis, that about 78 per cent of the Ombudsman's recommendations arising from child death investigations, and about 86 per cent of the Ombudsman's recommendations in the three annual reports were either consistent with work DoCS had already undertaken, or related to reporting back to the Ombudsman on work being done. Only five per cent of the recommendations arising from child death investigations, and 13 per cent of the recommendations from the annual reports offered new directions or initiatives, which DoCS had not identified for itself. When fresh recommendations were made, DoCS stated that they did not generally take into account the operating context or limitations, for example, those relating to staffing levels.

23.80 As a result of its analysis, DoCS identified what it described as opportunities to improve the future operation of the oversight system. It offered three areas for consideration:

a. developing a standard approach to individual child death reviews to satisfy both agencies thereby reducing the duplication of effort

b. replacing recommendations that either reflect existing work or confirm existing practices, with confirmatory statements

c. providing an opportunity to respond to recommendations in the annual reports prior to publication.

23.81 In its submission to the Inquiry, DoCS supported one key external review body, rather than several:

> *One possible model would be a framework similar to that operating in Queensland for the review of child deaths. Under this option a panel would be responsible for the independent oversight of child death reviews. Tapping into superior levels of expertise available via the panel will help ensure that the response to a child death is driven by best evidence in child protection practice. It also provides much clearer lines of accountability… DoCS would be obligated to review its involvement in every case in which a child or sibling was 'known to DoCS' in the previous 12 months. Child death reviews would*

be required to be completed within a strict time frame (six months). The extent and nature of the review would reflect the nature of the death - where there is a preliminary finding that the death was related to child protection issues, a detailed review would be necessary.

Findings of the child death review and recommendations for reform or remedial action would be considered by the DoCS senior executive. Every child death review report would be referred to the panel. Where the death related to matters of abuse and neglect, or suspected abuse or neglect the report would be referred to the Coroner as well.

The panel would review the DoCS report, any 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 would also be empowered to independently report directly to the Minister on the child death if it considered it necessary and desirable to promote improvements to child protection practices. The panel would also carry out a broader function in relation to all child deaths. Its report would include a report on reviewable deaths and only one deaths register (as opposed to the current two) would have to be maintained.[168]

Ombudsman's view

23.82 In relation to DoCS' suggested model, the Ombudsman noted that:

a. DoCS should not have the power to access the necessary information from all the parties who may have had relevant dealings with a child or young person and or their family in the period leading up to their death

b. the model would not adhere to the principles underpinning the granting of the jurisdiction to the Ombudsman and in particular, those concerning the transparency and independence of the review process.

23.83 In his submission, the Ombudsman stated:

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 to monitor the adequacy of the subsequent response. From our many years of oversight, we are acutely aware that agencies often

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[168] Submission: DoCS, Role of Oversight Agencies, p.13.

have good capacity to identify problems, but may fail to effect change.[169]

23.84 Not surprisingly, the Ombudsman also has taken a different view in relation to the value of his work and believes that it has directly resulted in positive changes. The Ombudsman referred to legislative changes in late 2006 in response to issues that he had raised, including the introduction of Parent Responsibility Contracts, prenatal reports, information exchange relating to unborn children, and the admissibility of evidence in care proceedings about a child previously removed and not restored as *prima facie* proof that a sibling is in need of care and protection. In addition, the Ombudsman stated that the revised secondary assessment procedure, and the neglect policy, address issues that had been identified in his reviews.

23.85 He said, in relation to the 13 per cent of the recommendations which concerned 'new initiatives', that they included a proposal that DoCS give priority to risk assessments on children whose siblings had been removed as well as a recommendation for there to be a systematic performance audit of every CSC.

23.86 He also noted that other agencies, notably Health and Police who are subject to his oversight through the reviewable deaths function, speak positively of his role in this area.

23.87 In relation to the role of the CDRCU, the Ombudsman sees its focus as a 'considerable strength' and has advised that it is his preferred approach that, where his office is aware that the CDRCU is conducting a review, to await the outcome of that review. He noted however that timeliness was an issue with its work.

23.88 In the view of the Ombudsman, the system of child death reviews which involve his office and the CDRT has worked well and is effective. He has advised that the functions are complementary and that the legislation provides for procedures that minimise overlap in the conduct of research. For example, the CDRT may not undertake a review of a reviewable death or conduct research about reviewable deaths unless approved by the Minister. In addition he suggested that, the annual reports produced by each agency on child deaths are distinct and complementary.

Other views

23.89 The CCYP has stated that there is currently little or no duplication in the roles of the CDRT and the Ombudsman. In relation to child deaths, the CCYP recommended that the Ombudsman be required to seek and consider the view of the CDRT before undertaking research into child deaths, except in relation to his Annual Report into reviewable deaths.

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[169] Submission: NSW Ombudsman, Oversight Agencies, p.7.

23.90 The Commissioner for Children and Young People who is the convenor of the CDRT expressed the following view at the Public Forum, when asked why the CDRT would not fit functionally well within the Ombudsman's Office:

> *Because the Ombudsman's purpose is to oversight public administration, if you like, and that is not the purpose of the Child Death Review Team. The purpose of the Child Death Review Team is to look at all deaths, not just those covered by public sector agencies….*
>
> *…when you are focused on reviewing deaths of a particular group, it tends to absorb the resources, it tends to be the focus of the report, whereas what the Child Death Review Team is focussed on currently and, as a result of the separation, is in fact the epidemiological issues and surveillance and trying to identify patterns that might prevent children's deaths.*[170]

23.91 Police submitted that there was duplication in the review of child deaths, in particular, between the Ombudsman and the CDRT. The Police are of the view that the role of the Coroner remains appropriate.[171]

Inquiry's view

23.92 There is an overlap between the recommendations function of the Coroner and the systemic work undertaken by the Ombudsman. However, the former's primary focus is on determining the manner and cause of death, a finding not made by the Ombudsman. The Coroner usually has the benefit of the DoCS internal review before holding an inquest and, on more than one occasion, has not made any recommendations because of his or her satisfaction with the internal review and DoCS response to it. In addition, the Coroner undertakes relatively few inquests into reviewable deaths. The Coroner also benefits from oral evidence, has public hearings and is subject to appellate review. The Ombudsman frequently relies on the written record, which, from the Inquiry's experience with DoCS files, is often a poor indicator of whether action was or was not taken. The Coronial Inquest also serves the important function of forming a view whether there is evidence that is capable of establishing that an indictable offence has been committed by a known person and, if so, of referring the matter to the Director of Public Prosecutions.

23.93 The Inquiry is satisfied that there are sufficient differences and benefits from the work of the Coroner such that no change to the jurisdiction arising under the *Coroners Act 1980* is warranted.

23.94 The Inquiry believes, however, that there is a duplication of effort arising from the fact that the CDRT is located in the CCYP. Two primary registers are kept,

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[170] Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, p.7.

[171] Submission: NSW Police Force, p.43.

and there is clearly some tension in who undertakes research functions and for what purpose, hence the Commissioner for Children and Young People's views set out above. There are also issues in relation to information sharing which were identified in the statutory review of the CS CRAMA.[172]

23.95 It is evident to the Inquiry that in considering reviewable child deaths it is critical to examine and compare the contexts in which the deaths occur. This can be enhanced through an integrated function that examines all child deaths in NSW to enable the making of more systemic recommendations to prevent child deaths. Given this fact, and the experience gained by the Ombudsman because of his role in reviewable deaths, it is the Inquiry's opinion that the CDRT should be convened, chaired and supported by the Ombudsman, although with the Commissioner for Children and Young People, or her delegate, continuing to be a member. This would require changes to the *Commission for Children and Young People Act 1998*, and to the Ombudsman Act, to reconstitute the Team and to provide for the processes and powers necessary for its continued operation. It would also require a transfer to the Office of the Ombudsman of the associated research and secretarial support functions and staff. In other respects its operation should remain unchanged, save for the requirement that as between the CDRT and the Ombudsman only one register of child deaths should be kept.

23.96 Because of its statutory responsibility for vulnerable children, and because deaths of children and young persons can involve action or inaction by multiple agencies, there must be oversight by an agency external to DoCS. The Inquiry sees no need to establish a separate panel as suggested by DoCS. The Inquiry is also persuaded that the Ombudsman's power to require the production of documents from other agencies is an important aid to reviewing deaths, and is not a power that should reside in DoCS. Independent and transparent review remains important in this respect.

23.97 The Inquiry has been impressed by the quality and content of the reports produced by each of the CDCRU and the Ombudsman. They are systemic in focus and contribute significantly to an understanding of the events surrounding deaths of children and young persons. A recent report by the CDCRU noted that it relied on the Ombudsman's investigation summary document as providing the factual basis for the report. While, in that case, its findings were similar to the Ombudsman, specific practice themes were also identified, as was recent research into child protection practices. The Ombudsman informed the Inquiry that it is now rare for his office to conduct single agency investigations involving DoCS, given the review processes of the latter.

23.98 It has been raised with the Inquiry that there could be a potential cause for concern in the event that the reviews conducted by the Ombudsman and DoCS

[172] The Committee on the Office of the Ombudsman and Police Integrity Commission recommended that the *Community Services (Complaints, Reviews and Monitoring) Act 1993* be amended to put beyond doubt that members of the Child Death Review Team have a duty to provide the Ombudsman with information and assistance.

resulted in inconsistent messages being delivered to or received by staff. Inevitably and usually properly, there will be different lessons highlighted by DoCS and by the Ombudsman in their reviews. In the Inquiry's review of reports about the same death, differences in approach are evident but not such as to detract from the overall value of the work of each. The staffing context provided by the DoCS report is beneficial and necessary while the scrutiny of the actions of other agencies delivered by the Ombudsman is equally beneficial and necessary.

23.99 The Inquiry is satisfied that neither the Ombudsman nor DoCS should cease reviewing and preparing reports into child deaths. In the interests of transparency and public accountability it is important to preserve the oversight role of the Ombudsman. It is equally important that DoCS should retain a responsibility for ensuring that its casework is effective and that it accepts responsibility for systemic failure.

23.100 There is, however, merit in the DoCS submission that a standard approach to individual child death reviews be developed and that recommendations that either duplicate existing work or confirm existing practices are replaced with confirmatory statements accepting their approach. The Inquiry understands that DoCS is currently provided with an opportunity to respond to recommendations in the annual reports prior to publication, and can make its views known as to whether draft recommendations should retain that character or be the subject of confirmatory statements.

23.101 There is an issue with the timeliness of the DoCS reviews. The Inquiry considers it important that DoCS should complete its reports within six months.

23.102 The Inquiry notes that DoCS is currently considering trialling a root cause analysis approach to its internal reviews. That approach has been successful in Health and the Inquiry would encourage DoCS to trial such an approach.

What should be reviewable and when should it be reported?

23.103 Assuming that the CDRT function is transferred to the office of the NSW Ombudsman, the question arises whether there remains a need for a separate function in relation to reviewable deaths. The Inquiry firmly believes that the reviewable death function should continue, as its particular focus is necessary and is likely to be enhanced by undertaking research into all child deaths. However, the criteria by which certain deaths are reviewed requires further analysis.

23.104 In this latter regard, DoCS made the following recommendation:

> *The NSW definition of 'reviewable death' should be made more meaningful in two ways: a child's death should be reviewable if the cause of death was, or may have been due to abuse or neglect or occurred in suspicious circumstances AND the child*

> *was 'known to DoCS' based on reports about the child or a sibling in the same household in the 12 months prior to the death (rather than three years, as is currently the case).*[173]

23.105 This recommendation was made in the context of a concern that the current system operates punitively by virtue of its emphasis on reports to DoCS and the effect of media reporting of the annual reports produced by the Ombudsman. DoCS quoted Dr Munro who argues that a punitive system of oversight can have a detrimental effect on worker morale and system performance by resulting in an over reliance on procedures, diversion of resources, and difficulty in attracting and retaining staff.

23.106 The Commissioner for Children and Young People and convenor of the CDRT expressed the following view at the Public Forum held by the Inquiry:

> *In … the joint submission that I did with Dr Cashmore and Professor Scott we do make a recommendation that the focus of reporting be on child abuse and death or death in suspicious circumstances, and that the [Ombudsman's] reporting period be extended from one year to three years. The reasons for that is that we think that there is insufficient time for change to occur within one year, and if you extend the reporting time frame, then you do allow for change to occur and for the Ombudsman to then more meaningfully comment on the impact of the work of whatever agency it is implementing the recommendation. The reason we have suggested that the reporting should focus on child abuse and neglect is because of the misunderstanding that has continued for 10 years now about the meaning of 'known to DoCS' or, if you like, 'vulnerable children'.*[174]

23.107 The Deputy Ombudsman's response in the Public Forum was:

> *So if, for example, it is limited to abuse and neglect, suspicious circumstances, then we'd probably look at between 30 and 40 matters per year. In those circumstances the question would have to be asked as to whether we would actually be well placed to make judgments about the child protection system.*[175]

23.108 In his written submission, and in response to DoCS' submission the Ombudsman noted that:

a. the current system is well structured and able to identify causal links

b. only 27 of the 114 (known to DoCS) deaths in 2006 would meet the revised criteria proposed by DoCS

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[173] Submission: DoCS, Role of Oversight Agencies, p.12.

[174] Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, pp.8-9.

[175] ibid., p.12.

c. of the 620 deaths reviewed between 2003 and 2008, only 180 would be reviewable

d. risk factors in the child protection system of many children who die from abuse or neglect are not substantially different from the histories of children who die in other circumstances

e. observations such as an over representation of Aboriginal children, the effect of maternal substance abuse, adolescent deaths arising from suicide and motor vehicle accidents and police reporting of domestic violence would not have been able to be made under the DoCS proposal

f. his office has an 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

g. the response of the media to his Annual Reports is not considered a sufficient ground for extending the time frame, although it was acknowledged that producing an annual report is resource intensive.[176]

23.109 The representative of the Coroner supported limiting the jurisdiction to deaths due to abuse and neglect and to those arising in suspicious circumstances.[177]

23.110 It is necessary to first identify the purpose of any investigation into the death of a child in NSW by an agency other than the Police. The Inquiry is conscious of the academic literature which is critical of the bureaucratic response to child deaths. Scott notes that child death inquiries often make matters worse by concentrating on the last link in the chain of events, rather than the structure and role of child protection services generally and their place as part of a wider government and community response.[178]

23.111 Under CS CRAMA, the Ombudsman is to formulate recommendations for the prevention or reduction of deaths which are reviewable. His Office does so by identifying shortcomings in agency systems or practice that may have contributed to the death or to children being exposed to risk in the future.

23.112 DoCS submitted the following to the Inquiry:

> *The objective of a reviewable deaths framework is to ensure that where a child who had some close connection with the child protection system dies, there is a timely and effective review of the circumstances of that death. It must operate on two levels. Firstly it must investigate the individual death in a way to determine whether the cause of death was related to child protection concerns for the child and make*

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[176] Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, pp.14-18.

[177] Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, p.15.

[178] D Scott, *Sowing the Seeds of Innovation in Child Protection,* Paper presented to the 10th Australasian Child Abuse and Neglect Conference, Wellington, New Zealand, February 2006, p.10.

> *recommendations aimed at the prevention or reduction of such deaths. Secondly it must identify general casework or overall system reform matters that warrant attention or remediation, if they exist.*[179]

23.113 Put another way, if the purpose of a review mechanism for child deaths known to DoCS is to improve the child protection system and there is no proper causal connection between the deaths and that system, then it is not achieving its purpose.

23.114 The Inquiry takes a broader view. Deaths of children and young persons should be reviewed to determine, among other matters, whether the child protection system, at its broadest, should have known about and responded to their circumstances. Much can be learned about the involvement of other agencies in the lives of children who have died from abuse or neglect or in suspicious circumstances when no report has been made to DoCS. The emphasis should be on the circumstances of their death and messages for the child protection system as a whole, not just confined to an examination of what DoCS might have done or did do, in relation to that child.

23.115 Equally, the process should focus on systemic matters and acknowledge that predicting the death of child from reports to a child protection agency is not a science attended by certainty. It involves human reasoning and judgement based on available information, in relation to conduct which is not necessarily predictable.

23.116 The research informs us that child deaths are not considered a likely outcome in most cases of child abuse; most who die are not known to child protection services and the risk factors that are present in cases of fatal child abuse are generally similar to those present in many thousands of other child protection cases which do not have a fatal outcome.

23.117 Consistent with this research, in his report of reviewable deaths in 2006, the Ombudsman said that in most cases, the circumstances of the child's death had no connection to reported child protection concerns. Obviously in some cases a child will die of natural causes or as a result of the actions of a third party for which the carer will have no responsibility or capacity to control.

23.118 Accordingly, the Inquiry takes the view that the criteria of 'known to DoCS' is not useful and can be harmful by escalating in the mind of the public, deaths where a report has been made, which would not have justified an intervention, to deaths which could have been prevented by action from DoCS.

23.119 A report signifies concerns by the reporter, who is more likely than not to be a mandatory reporter. It may or may not meet the threshold of risk of harm,

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[179] Submission: DoCS, Role of Oversight Agencies, p.11.

indeed in excess of 10 per cent of cases it will not do so.[180] Those concerns may or may not be based on factually accurate material. They are not a reliable indicator of whether the child protection system should have known about and, if so, intervened positively in the life of the child.

23.120 In 2006 and 2007, 101 deaths were reviewable on the criteria of abuse, neglect, suspicious circumstances or being in statutory care. That is about a third of all deaths reviewable under the current regime. In the likely event that many of these were known to one or more of the agencies which form part of the child protection system, this role can be closely scrutinised by the Ombudsman. Thus causal links can be explored, if they exist.

23.121 Further, those deaths which do not meet the revised criteria will still be the subject of scrutiny by the CDRT. By transferring the role of convenor to the Ombudsman, information from those deaths can inform child protection work. For example, the presence of drugs in children is identified in the work of the CDRT as are deaths by suicide or resulting from risk taking behaviours.[181]

23.122 The role of the Ombudsman in commenting on the child protection system is a valuable and necessary one, however, the vehicle of child deaths is not the only, nor the most reliable, basis for enlivening that role. First, since 2003 the Ombudsman has initiated 73 investigations into child protection issues, 66 of which have arisen from child death reviews, thus indicating other sources of information. The Ombudsman has used its 'own motion' power in a number of these cases. Secondly, the Ombudsman's complaint handling function is a role which can be used to identify and comment on child protection matters. Finally, its broad monitoring and review functions have permitted it to inquire into other child protection issues including services for children with disabilities, individual funding arrangements in OOHC and support for Aboriginal foster carers.

23.123 The Ombudsman has submitted to the Inquiry that in order to ensure that his office retains an "ongoing and well-informed understanding of child protection practice" a power should be conferred on him to keep under scrutiny the systems for handling and responding to risk of harm reports.

23.124 The Inquiry is of the view that the Ombudsman has a sufficient current ability to scrutinise the systems for handling reports without amending the legislation. His powers under s.11 of the CS CRAMA, particularly to monitor and review the delivery of community services and to inquire into matters affecting service providers and consumers, would amply enable him to scrutinise the response of DoCS to risk of harm reports. The Inquiry agrees that it is important that he continue to do so.

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[180] See Chapter 6.

[181] NSW Child Death Review Team, *Trends in the fatal assault of children in NSW: 1996-2005,* 2008, p.3.

23.125 This approach should not affect the work of the CDCRU which should review the deaths of all children where a report has been made in the preceding three years, either in respect of those children or their siblings.

23.126 The final question concerns the timing of the reporting cycle. An annual reporting cycle is resource intensive for the Ombudsman and, as pointed out by Ms Calvert, Dr Cashmore and Professor Scott, does not permit much meaningful comment about improvements which may have been made since the previous report. Reporting at two yearly intervals should assist in each of these respects. From the data mentioned above, it is anticipated that the deaths of around 100 children would be reported, a sufficient number to draw useful conclusions, as to any systemic or other issues that need to be addressed.

23.127 In conclusion the Inquiry considers that the reviewable death provisions should be amended so as to delete the 'known to DoCS' criterion. This would leave the remaining criteria intact. Although it might still require a review to be made where a child in care dies from natural causes or accident outside the control of a carer or DoCS, the lack of any need for any detailed inquiry, except where the Coroner's jurisdiction was involved, would be obvious. In addition, the Inquiry favours replacing the annual reporting in exercise of the reviewable death function with a bi-annual requirement.

Reviews of children in care

23.128 Since 2003, the Ombudsman has conducted five group reviews of individuals in care: two reviews of children under five years of age, a review of young people with disabilities leaving care, a review of children under the parental responsibility of the Minister placed in SAAP services and a review of a group of children aged 10-14 years in OOHC and under the parental responsibility of the Minister.

23.129 Eight service based reviews have also been conducted. The issues from each of these reviews have been considered in Chapters 16 and 18.

23.130 The Ombudsman and the Children's Guardian each have roles and responsibilities in relation to children in OOHC. The Inquiry has been informed and agrees that the legislative provisions for these roles and responsibilities ensures that the work of both agencies is complementary rather than duplicative. It accordingly does not suggest any change in these arrangements.

Complaints

23.131 In 2007/08 the Ombudsman received 839 formal complaints about agencies providing child and family services, of which 755 were about DoCS. This is a sharp increase from 560 formal complaints in 2006/07 and 595 in 2005/06. It is

unclear whether this increase is attributable to changes that have been made in the presentation and classification of this information.[182]

23.132 In 2007/08, about half of the formal complaints received by the Ombudsman about DoCS concerned its child protection services and about half were about OOHC services provided or funded by DoCS.[183]

23.133 For child protection services, the most common complaints were about the adequacy of DoCS' casework, in response to risk of harm reports about children and young persons:

> *These concerns primarily relate to DoCS' decisions about whether or not to intervene following a risk of harm report, and the adequacy of DoCS' investigation, assessment of, and decisions in response to allegations that a child or young person has been abused or neglected. Other issues that were the subject of complaint included DoCS' handling of complaints about its activities and the professional conduct of staff.*[184]

23.134 Regarding OOHC, the most common complaints were about the adequacy of assessment, planning and provision of services. For example,

> *the appropriateness of placements for children and young people; the supports provided to children in care and their carers; decisions to move children between care placements; and arrangements for contact between children in care and their families. …the quality of 'customer' service provided by service staff, the responses of services to complaints about children in care, and payment of allowances and fees to foster parents to support children in care.*[185]

23.135 The Ombudsman resolved and/or made recommendations for improvements to services in 42.3 per cent of the formal complaints finalised during 2007/08.[186] The Ombudsman acknowledges that many of the complaints are difficult to resolve because of the nature of the subject matter.

23.136 The subject matter of most of the complaints were also raised in submissions made to the Inquiry and are addressed in appropriate chapters of this report.

23.137 The Inquiry has dealt with the complaints management system, so far as DoCS is concerned, in Chapter 2.

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[182] See Figure 35, NSW Ombudsman, *Annual Report 2006/07*, p.80 and Figure 20, NSW Ombudsman, *Annual Report 2007/08*, p.70.

[183] NSW Ombudsman, *Annual Report 2007/08*, p.70.

[184] ibid., p.68.

[185] ibid., p.70.

[186] ibid., p.69.

Official Community Visitors

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

23.139 Official Community Visitors are independent of the Ombudsman although the Ombudsman has a general oversight and coordination role including determining priorities and allocating visiting hours. Official Community Visitors made 307 visits to services accommodating children and young persons and 137 visits to services for children and young persons with a disability in 2007/08.

23.140 The focus of the Visitors is to facilitate and monitor the resolution of issues by services at the local level. Visitors may resolve the issues themselves or refer them to the Ombudsman. In 2007/08, 427 issues were reported to the Ombudsman by Visitors in relation to services for children and young persons, and 204 issues in relation to services for children with a disability. Most were resolved.

23.141 The Inquiry regards this process as a valuable adjunct to the complaints system in that it allows the recipients of services to have a voice, and also in that it provides an opportunity for concerns to be addressed before they develop into serious problems as well as an opportunity to monitor the response of the relevant Services to respond to issues that are identified as being of concern.

23.142 Additionally, it provides the Ombudsman with a further source of referral for investigation, particularly in relation to the kind of concerns that may have an institutional or systemic origin, and that may have an impact on the relatively small group of children and young persons who are placed in the various forms of residential OOHC services.

23.143 The Inquiry is satisfied that the work of the Official Community Visitors is not unduly duplicative of the functions of other oversight bodies, in particular, the accreditation work of the Children's Guardian.

23.144 The Children's Guardian submitted that to assist the OOHC accreditation process, the CS CRAMA should be amended to allow her to have access to reports by the Official Community Visitors.

23.145 This matter was recently before the Legislative Council's Committee on the Office of the Ombudsman and the Police Integrity Commission during its consideration of the review of CS CRAMA. That Committee took the view that legislative amendments may be counter productive and have the effect of making the work of Official Community Visitors more difficult. It expressed the view that because Official Community Visitors report directly to the Minister there is already an avenue through which serious concerns can be raised. It

seems that the Committee's view was influenced by the evidence of one Official Community Visitor who thought if reports were to go back to funding bodies the role of the Official Community Visitors would be confused. That witness also noted that there were occasions when she wished to share information with such bodies as accrediting agencies.

23.146 The Inquiry agrees with the submission of the Children's Guardian. Information obtained by persons appointed by the Minister should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards. Section 8 of CS CRAMA and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* would need to be amended to achieve this outcome.

Reportable allegations

23.147 The Director-General of DoCS and the heads of designated agencies are required to notify the Ombudsman of any reportable allegation made against an employee, and of any reportable conviction, within 30 days of becoming aware of it, and of the action which the relevant agency proposes to take in relation to the employee.[187]

23.148 These obligations arise in the context of Part 3A of the Ombudsman Act, pursuant to which the Ombudsman must scrutinise the systems put in place by designated agencies and other public authorities for preventing reportable conduct by employees and the way in which those agencies handle and respond to allegations of reportable conduct or convictions.[188] In the performance of these obligations, the Ombudsman:

a. receives and assesses notifications concerning reportable allegations or convictions against an employee

b. monitors investigations of reportable allegations and convictions against employees

c. conducts investigations concerning reportable allegations or convictions, or concerning any inappropriate handling, of or, response to, a reportable notification or conviction

d. conducts audits and engages in education and training activities to improve the understanding of, and responses to, reportable allegations.

23.149 In addition to reporting allegations of reportable conduct of employees which arise in the course of their employment, DoCS is also required to notify allegations where they arise from conduct which takes place outside of their employment.

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[187] *Ombudsman Act* 1974 s.25C(1).
[188] *Ombudsman Act* 1974 s.25B.

23.150 'Reportable conduct' means:

a. any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offences), or

b. any assault, ill-treatment or neglect of a child, or

c. any behaviour that causes psychological harm to a child,

whether or not, in any case, with the consent of the child.[189]

23.151 Reportable conduct does not extend to:

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 is recorded under workplace employment procedures, or

c. conduct of a class or kind exempted from being reportable conduct by the Ombudsman under s.25CA.[190]

23.152 The note to this definition in the Ombudsman Act states that examples of conduct that would not constitute reportable conduct include (without limitation) touching a child in order to attract a child's attention, guiding a child or comforting a distressed child; and conduct that is established to be accidental.

23.153 A 'reportable allegation' is defined to mean an allegation of reportable conduct, or an allegation of misconduct that may involve reportable conduct, while a 'reportable conviction' means a conviction (including a finding of guilt without the court proceeding to a conviction), in NSW or elsewhere, for an offence involving reportable conduct.[191]

23.154 Designated agencies include, *inter alia*, DoCS, those agencies that arrange the provision of OOHC and that are accredited for those purposes, and those agencies that provide substitute residential care for children.[192]

23.155 For the purposes of these provisions an 'employee' includes DoCS salaried staff and anyone who is engaged by a designated agency to provide services to children.[193] DoCS authorised carers, including authorised relative carers are also covered.[194]

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[189] *Ombudsman Act* 1974 s.25A(1).

[190] *Ombudsman Act 1974* s.25A.

[191] *Ombudsman Act 1974* s.25A(1).

[192] *Ombudsman Act 1974* s.25A(1); *Children and Young Persons (Care and Protection) Act 1998* s.139.

[193] *Ombudsman Act 1974* s.25A(1).

[194] DoCS 'authorised carers' are considered employees for the purpose of employment screening and allegations of reportable conduct. Recently DoCS made the decision to include relative carers as authorised carers. As a result they are now also considered employees for the purposes of screening and allegations.

23.156 Carers who have kinship placements as a result of an order by the Family Court are not considered authorised relative carers and are therefore not 'DoCS employees.'

23.157 In 2007/08 the Ombudsman received 1,850 notifications of reportable allegations and finalised 1,921. Notifications decreased from 1,995 in 2006/07. The most significant decrease (30 per cent) came from the largest notifier, Education. Education attributes this decrease to the class or kind determination and to training initiatives with its staff and students.[195] However the percentage of reportable allegations from DoCS rose from 23.5 per cent in 2006/07 to 31.1 per cent in 2007/08.[196]

23.158 The most frequently notified issue from all notifiers was physical assault (59 per cent), followed by neglect (10 per cent), sexual offences (nine per cent), sexual misconduct (seven per cent), and behaviour causing psychological harm (four per cent).[197]

23.159 There is a category of misconduct allegations concerning DoCS salaried staff that DoCS will need to investigate, but that may not need to be notified to the Ombudsman. Essentially this category comprises conduct that breaches the DoCS code of conduct or Public Service guidelines, such as not declaring a conflict of interest, breaching confidentiality requirements, or accepting gifts of more than a token nature. In general, they may be dealt with pursuant to the provisions of the *Public Sector Employment and Management Act 2002*, although, if any allegation involves conduct possibly amounting to corrupt conduct within the meaning of the *Independent Commission Against Corruption Act 1988,*[198] then an obligation will arise for it to be reported to that Commission.

23.160 As noted above the staff of accredited non-government agencies, who will normally be employed under the Social and Community Services (SACS) Award, and their authorised foster carers, fall within the definition of 'employee' for the purposes of the reporting and investigation procedures outlined above. Additionally these agencies are required, by virtue of the funding framework, to have adequate human resource management systems in place.[199] They are similarly required by the funding framework to provide an appropriate response to allegations of fraud involving their staff or carers.[200]

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[195] NSW Ombudsman, *Annual Report 2007/08*, p.74.

[196] ibid., p.75.

[197] ibid., p.81.

[198] *Independent Commission Against Corruption Act 1988* ss.7–9.

[199] DoCS, *Performance Monitoring Framework for Funded Services 2006/07* and DoCS, *Good Practice Guidelines for DoCS Funded Services 2006*.

[200] DoCS, *Policy for Responding to Fraud in DoCS Funded Services*, June 2007. See also the Fraud Risk Assessment for Service Providers tool, September 2005 and the Practice Notes on Internal Fraud which were prepared by DoCS to assist funded service providers in addressing the risk of fraud within their organisations.

Investigation of allegations by DoCS

23.161 Under the Care Act the Director-General of DoCS is required to arrange for any report, alleging the abuse of a child or young person by a person employed within the Department, to be investigated in accordance with arrangements made between the Director-General and the Ombudsman.[201] Casework Practice in this regard is guided by the DoCS practice document, Responding to allegations against DoCS.

23.162 DoCS coordinates its response to allegations against employees through the Allegations Against Employees (AAE) Unit which is located centrally within the Complaints Assessment and Review Branch in the Strategy, Communication and Governance Division of the Department.

23.163 When allegations are received by the Helpline, they are referred to the AAE. The determination of whether an allegation of reportable conduct so received will be investigated by the central AAE Unit or within a Region is made on a case by case basis, depending on the potential seriousness of the conduct involved.

23.164 Irrespective of where the allegation is investigated, the procedure is the same, being undertaken in accordance with the DoCS policy and procedures manual, Managing Allegations against Employees.

23.165 Caseworkers at CSCs and at Regions, who have been trained by the AAE Unit in relation to these procedures, conduct the investigation in addition to their ordinary duties.[202] The AAE Unit will, however, provide ongoing support and will review the supporting documentation and outcome report prepared by these investigators, to determine what, if any, action is required.

23.166 If, as a result of the allegation, it appears that a child or young person may be in need of care and protection, a child protection secondary assessment will be undertaken separately from the investigation into the allegation of reportable conduct. If the matter fits within the JIRT criteria it will be referred to an appropriate JIRT for investigation, in addition to the AAE Unit investigation.

23.167 The investigative process involves collecting evidence via interviews and locating relevant documents, providing the employee with an opportunity to respond to the allegation, and completing an outcome report. Findings are made in relation to each component of the allegation if more than one matter is raised. The standard of proof is on the balance of probabilities although to the Briginshaw Standard, where the allegation is serious.[203] The findings available are:

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[201] *Children and Young Persons (Care and Protection) Act* 1998 s.33.

[202] DoCS advised the Inquiry that over 600 field staff have received this training.

[203] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

a. sustained (on balance of probabilities, there is sufficient evidence that the alleged conduct did occur)

b. not sustained – insufficient evidence (that is, insufficient evidence available to establish whether the alleged conduct did or did not occur)

c. not sustained – false (conduct did not occur)

d. not sustained – vexatious (without substance and with the intention of causing distress to the employee)

e. not sustained – misconceived (the allegation was made in good faith, but it was based on a misunderstanding of what actually occurred)

f. unable to determine (not possible to complete an investigation)

g. not reportable conduct.

23.168 Upon the basis of these findings the AAE Unit or the CSC or Region can make recommendations. In the case of a salaried DoCS officer these recommendations could include, but are not limited to, dismissal, caution, warning or other disciplinary or remedial action, and are referred to the Corporate Human Resources Branch in DoCS Head Office. In the case of an authorised carer (including an authorised relative carer), the recommendations could include de-authorisation.

23.169 Once an investigation has been concluded, the Director-General of DoCS, or the head of the designated agency, is required to send a copy of any report made as well as a copy of any statements taken or other documents on which the report is based, to the Ombudsman, and to advise of the action taken or proposed, to allow the Ombudsman to determine whether the matter has been appropriately investigated, and whether appropriate action was taken.[204] The Ombudsman has an 'own initiative' right to conduct an investigation into any matter that has been notified, or into any inappropriate handling or response by DoCS, or by a designated agency, concerning a reportable allegation or reportable conviction, and may exercise a conciliation power in connection with such an investigation.[205]

23.170 Since the NGOs who provide services for DoCS are also required to respond to allegations of misconduct on the part of their staff or carers, the situation can arise where both DoCS and the NGO need to conduct an investigation, which can extend the process and run into problems with the exchange or sharing of information.

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[204] *Ombudsman Act 1974* ss.25F(2) and 25F(3).

[205] *Ombudsman Act 1974* s.25G.

Statistics

23.171 In 2007/08, approximately 31 per cent of all reportable conduct matters notified to the Ombudsman were from DoCS.[206]

23.172 DoCS has advised of an increase in the number of reportable conduct matters involving allegations against employees, which are referred to its AAE Unit.

23.173 DoCS reported that there were 389 reportable conduct matters that it dealt with in 2006/07.[207] In 2007/08 there were 474 cases of reportable conduct investigated by DoCS.

23.174 In 2007/08, DoCS responded to over 800 requests from the Ombudsman for information relating to allegations against employees. DoCS explained that there had been a marked increase in Ombudsman requests which was due to a change in process allowing the capture of a greater number of Ombudsman requests.

23.175 In 2007/08, 97 per cent of the reportable conduct matters investigated related to foster carers.

23.176 Of the investigations finalised in 2007/08, the outcomes reported by DoCS were as follows:

a. sustained – 40 per cent

b. not sustained – 54 per cent

c. other – six per cent.

23.177 Of 1,411 finalised investigations in the period 1 January 2000 to 31 December 2007, only 132 (or just under ten per cent) resulted in action to de-authorise a carer. In 2007, only three per cent of finalised investigations resulted in action to de-authorise.

23.178 The information supplied to the Inquiry by DoCS would suggest that there has been a considerable increase in the number of reports including allegations of reportable conduct against the employees received since 2001/02, although this has not necessarily met with a corresponding increase of notifications to the Ombudsman.[208] DoCS advised that this is because not all reports met the threshold of reportable conduct. They did however require an assessment by DoCS to determine whether they met the threshold.

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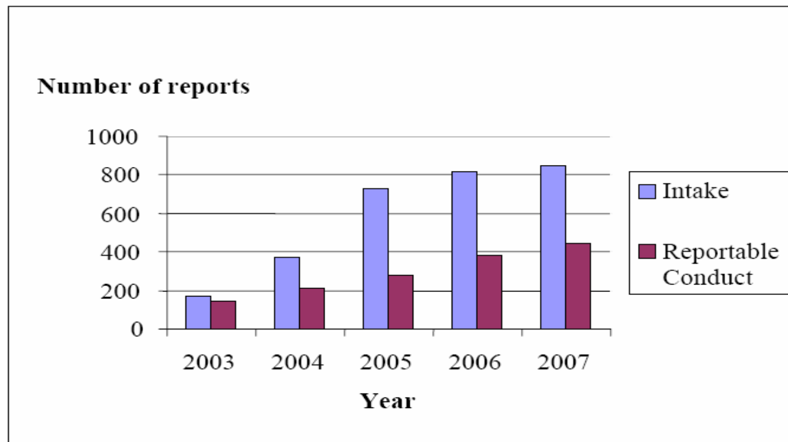
[206] NSW Ombudsman, *Annual Report 2007/08,* p.75.

[207] DoCS, *Annual Report 2006/07,* p.90.

[208] Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, p.5 notes that 352 notifications were made in 2004/05 and that 469 notifications were made in 2006/07 – an increase in the order of 33 per cent.

Figure 23.1 **Reports to AAE**



23.179 While there is some disagreement between DoCS and the Ombudsman as to the precise extent of any increase in notifications, or in the number of requests made of DoCS by the Ombudsman for further information, there is a consensus that there has been an increase in allegations and reportable conduct notifications, which would seem to be attributable to:

a. previous under reporting[209]

b. a greater awareness of child protection issues and of the requirement to report allegations

c. the increase in the number of children entering statutory care or receiving services.

23.180 DoCS advised the Inquiry that it takes about 247 days for an investigation to be completed at the CSC or Regional level, and about 300 days for matters to be finalised by the AAE Unit.

Review of decisions in response to allegations of misconduct

23.181 As discussed in Chapter 13, for authorised carers, there is a right to seek an internal review of a relevant decision by DoCS or by a designated agency, and thereafter, by application, a review in the ADT.[210] The latter right is subject to a request being first made for an internal review, the need for which may be excused,[211] and also to the encouragement of the parties to seek resolution at a local level.

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[209] A fact identified in an internal audit.

[210] By reason of the combined operation of *Children and Young Persons (Care and Protection) Act* 1998 s.245(1)(c), *Administrative Decisions Tribunal Act 1997* ss.36 and 38 and *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.28.

[211] *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.31, *Administrative Decisions Tribunal Act 1997* ss.53 and 55, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

23.182 In any such review the ADT stands in the shoes of the decision maker and reaches a decision on the basis of the material that was relevant at the time of the initial decision, as well as any further material that was relevant at the time of the hearing.[212]

23.183 The Inquiry examined a number of decisions of the Tribunal concerning applications for the review of decisions to revoke the authorisation of carers, or to remove children from the care and control responsibility of carers.[213] The correctness of those decisions cannot properly be the subject of any comment by the Inquiry. However, the Inquiry's review does leave it satisfied that the ADT approaches its task appropriately and with considerable attention to the evidence and to the best interests of the child principles, such that there is no occasion to propose any alternative model for the review of decisions of the relevant kind.

23.184 The decisions reviewed by the ADT are likely to have been instructive for the Department in so far as they disclosed shortcomings in its case management concerning, for example:

a. the insufficiency of caseworker support for carers responsible for the care and control of children with challenging behaviours[214]

b. the giving of instructions to an expert that identified the opinion or the conclusion that the Department wished – contrary to the Expert Witness Code of Conduct and the ADT Practice Note 14, Expert Evidence and Reports[215]

c. a misinterpretation of the Aboriginal Placement Principles[216]

d. a failure to advise the carer of the right to seek an internal review in compliance with the Act[217]

e. inappropriately placing unrelated children with a carer, in circumstances where the children concerned had troubled histories and serious behavioural problems,[218] or placing children with a carer outside that carer's authority[219]

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[212] *YG & G G v Minister for Community Services* (2002) NSW CA 246 at [25]; and *A v Minister for Community Services* (2007) NSW ADT 208.

[213] For example, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16, *QW & QX v Minister for Community Services* (2005) NSWADT 287, *BP v Minister for Community Services* (2007) NSW ADT 184*, A v Minister for Community Services* (2007) NSW ADT 208, *TF v Barnardos* (2005) NSW ADT 259, *SL v Minister for Community Services* (2005) NSW ADT 228, *QB v Minister for Community Services* (2005) NSW ADT 89.

[214] For example, *A v Minister for Community Services* (2007) NSW ADT 208, *BP v Minister for Community Services* (2007) NSW ADT 184.

[215] For example, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

[216] For example, *A v Minister for Community Services* (2007) NSW ADT 208.

[217] *Administrative Decisions Tribunal Act 1997,* s.48(1), *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

[218] For example, *TF v Barnardos* (2005) NSW ADT 259, *QW & QX v Minister for Community Services* (2005) NSWADT 287.

[219] For example, *QB v Minister for Community Services* (2005) NSW ADT 89.

f. unfair or insufficient assessment by DoCS of the matters raised leading to a removal from care.[220]

Commission for Children and Young People

Historical context

23.185 In 1997, the Royal Commission into the NSW Police Service: Paedophile Inquiry recommended:

> *the creation of a Children's Commission to take over the responsibilities in relation to children currently vested in the Child Protection Council and the Community Services Commission*[221]

with

> *appropriate powers and capacity to oversee and coordinate the delivery of service for the protection of children from abuse (including sexual, physical and emotional abuse and neglect). It should be set up in the context of a rationalisation of roles of existing agencies and should have more than a mere advisory role.*[222]

23.186 The Royal Commission also proposed that the Children's Commissioner have authority to perform the role of a special guardian for children in OOHC and have responsibility for collecting information relevant to the suitability of people working in child related employment.

23.187 The Inquiry was informed that just prior to the release of the Royal Commission's report, two other reports were released that also called for the creation of a central organisation to address concerns relating to the welfare of children in NSW.[223]

23.188 The Commission for Children and Young People (CCYP) commenced operation in June 1999, replacing the Child Protection Council. While the organisation itself notes that the Royal Commission "was a major catalyst for establishing the Commission,"[224] its role differed from that envisaged by the Royal Commission. The CCYP's advocacy role was to relate to all children and young persons, and rather than having an oversight role, it was assigned an 'enabling' role to promote the interests of children and young persons in NSW. While given

[220] ibid.

[221] Royal Commission into the Police Service: *Volume V: the Paedophile Inquiry*, May 1997, p.1314.

[222] ibid., p.1293.

[223] Legislative Council Standing Committee on Social Issues, *Inquiry into Children's Advocacy (1996),* and the NSW Community Services Commission, *Who cares? Protecting people in Residential Care,* 1996.

[224] Commission for Children and Young People, *Annual Report 2007/08,* p.47.

responsibility for employment screening of people involved in child related employment, CCYP was not given specific responsibilities in relation to children in OOHC. In its submission to the Inquiry, CCYP noted that "the enabling role fitted with the inclusion of employment screening responsibilities."[225]

23.189 OOHC responsibilities were ultimately given to the Children's Guardian. This role has been addressed in Chapter 16.

23.190 The CCYP is established as a statutory corporation under the *Commission for Children and Young People Act 1998* (the CCYP Act) and has a range of responsibilities including acting as:

a. an advocate for children and young persons

b. a research body inquiring into issues that affect children and young persons

c. a body that both undertakes and monitors background checking of people being considered for child related employment

d. a body that supports the CDRT in carrying out its functions.

23.191 The CCYP is required to report annually to the NSW Parliament.[226] In addition a Joint Parliamentary Committee of Children and Young People oversees its work.[227]

23.192 The Office for Children was established in April 2006 to provide common administrative and financial support to the CCYP and the Office of the Children's Guardian. While the roles and responsibilities of these two bodies remain separate, the Office is headed by the Director-General of Premier and Cabinet.[228]

23.193 As at 30 June 2008, the CCYP employed a full time equivalent of 38.8 positions,[229] against a staff establishment of 41.9.

Background checking

23.194 Under s.36 (1) (c) of the CCYP Act, CCYP can agree to conduct background checking on behalf of employers. CCYP has an agreement with DoCS to undertake Working With Children Checks on all prospective DoCS employees. This agreement has been in place since March 2004. Prior to this, DoCS was also an approved screening agency. When this responsibility was transferred to CCYP, the corresponding Treasury allocation for this task was also transferred to it.

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[225] Submission: Commission for Children and Young People, p.2.

[226] *Commission for Children and Young People Act 1998* s.23.

[227] *Commission for Children and Young People Act 1998* s.28.

[228] Office for Children*, Annual Report 2007/08,* p.4.

[229] Commission for Children and Young People, *Annual Report 2007/08,* p.49.

23.195 CCYP also undertakes background checking on behalf of Police, other government agencies and employers in the non-government child related employment sector. This includes background checks on behalf of non-government welfare and OOHC agencies, child care centres, and religious organisations.[230]

Notifying CCYP of relevant employment proceedings

23.196 DoCS and other relevant employers, including designated agencies[231] that supervise the placement of children and young persons in OOHC, are required to notify the CCYP where employment proceedings concerning allegations of reportable conduct, or the commission of acts of violence, have been completed.[232] This is in addition to notifying the Ombudsman of allegations of reportable conduct. The only exceptions are those cases where the finding is one that the reportable conduct or alleged act of violence did not occur, or that the allegation was vexatious or misconceived.[233]

23.197 The purpose of notification is to facilitate the work of the CCYP in administering the Working With Children Checks. The Working With Children Check involves a check of any relevant criminal records, AVOs, and child protection prohibition orders, and is supplemented by probity checks as appropriate and by a check on the outcome of any relevant employment proceedings.[234]

23.198 CCYP then undertakes a risk assessment based on anything disclosed by these checks. This risk assessment provides potential employers with information to assist in selecting staff for child related employment. Child related employment is defined extensively in the CCYP Act and includes any employment that primarily involves direct contact with children.[235]

23.199 The performance of the duties of a foster carer engaged by DoCS or by any foster care agency, constitutes employment for the purpose of these provisions.[236]

23.200 Although there is not a class or kind agreement in existence between DoCS and the CCYP specifying or limiting what needs to be notified, a two tier system has been established pursuant to which DoCS and other agencies are required to categorise employment proceedings as giving rise to either a Category One or Category Two outcome.

23.201 Category One matters trigger an estimate of risk where the investigation has found either:

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[230] *Working with Children Check Employer Guidelines February 2008*, pp.21-22.
[231] *Children and Young Persons (Care and Protection) Act 1998* s.139.
[232] *Commission for Children and Young People Act 1998* s.39.
[233] *Commission for Children and Young People Act 1998* s.39(1)(a) and (b).
[234] *Commission for Children and Young People Act 1998* s.34.
[235] *Commission for Children and Young People Act 1998* s.33(1)(a).
[236] *Commission for Children and Young People Act 1998* s.33(3).

a. reportable conduct

b. that an act of violence took place

c. some evidence that reportable conduct or an act of violence occurred, however the finding is inconclusive and there is concern that the conduct should be considered in an estimate of risk assessment when the person next seeks child related employment.

23.202 Category Two matters are those where the investigation has found some evidence of reportable conduct or an act of violence, but the finding is inconclusive. By themselves they do not trigger an estimate of risk, if the person has a Working With Children Check. A Category Two matter may however be considered in an estimate of risk, if there has been more than one notification, or if there are other relevant records for the person.

23.203 The risk assessment level that is arrived at by CCYP is provided to prospective employers who have the right to determine whether to employ the person or not. DoCS has advised of the following breakdown of notifications it has made to CCYP by category:

Table 23.4 **Notifications to CCYP by DoCS**

Year	*Category 1*	*Category 2*	*Total Notifications*
2000	1	2	3
2001	20	28	48
2002	68	33	101
2003	71	19	90
2004	112	33	145
2005	94	50	144
2006	153	68	221
2007	169	67	236

23.204 When an allegation of reportable conduct is sustained, the communication of that fact to CCYP can obviously have considerable ramifications for the person the subject of the allegation. The nature of those ramifications is such that there is a need for sufficient safeguards in relation to the handling and investigation of such an allegation, including a right to be heard and a right of review, particularly in relation to authorised carers.

Issues arising

Reporting to the Ombudsman

23.205 The low threshold for reportable conduct and the requirements of the Code of Conduct governing carers,[237] catch what may be considered reasonable responses to sometimes challenging behaviour by children and young persons.

23.206 DoCS has advised that the current class or kind agreement with the Ombudsman which exempts some allegations of reportable conduct from the notification requirements has not resulted in any lessening of its reportable conduct workload, as it applies to only five per cent of the allegations received.

23.207 DoCS has argued for a higher threshold in relation to the kind or degree of physical abuse allegations that are to be reported to Ombudsman. In addition, in the case of a DoCS employee, it suggested that it should not extend to matters that would more properly fall within the exercise of that employee's professional capacity. One instance of that kind has been the subject of debate between the Ombudsman and DoCS, in which it was asserted that the conduct of a caseworker was reportable where, it was alleged, the worker had failed to initiate protective action even though aware of a physical assault by a carer which had left a child with serious physical injuries.

23.208 The Ombudsman has acknowledged that where caseworkers make professional decisions based on approved departmental procedures, then the fact that the child is subsequently harmed should not give rise to a notification to that Office in relation to the employee. The Inquiry agrees with that as a general proposition.

23.209 At the Inquiry's Public Forum concerned with oversight arrangements, both parties accepted the need for some revision of the class or kind agreement, although the Ombudsman would expect, as a condition of any revision, an improvement in DoCS' ability to complete its investigations quickly.

23.210 The Inquiry agrees with the Ombudsman that if there is to be any change in relation to the allegations that should be reported, it should be effected by an amendment of the class or kind agreement, rather than by an amendment of the Ombudsman Act which would have a flow on effect for over 7,000 government and non-government services. The Inquiry notes from the Ombudsman's 2007/08 Annual Report that it records an improved performance in DoCS in relation to delays and finalising investigations.[238]

23.211 The Inquiry has been provided with a copy of the class or kind determination which is in place with the Education, and also with the Catholic Education

[237] *Children & Young Persons (Care & Protection) Regulations 2000*, Schedule 2: Code of Conduct for Authorised Carers.

[238] NSW Ombudsman, *Annual Report 2007/08,* p.80.

Commission of NSW, which confines the notification requirement to serious allegations of reportable conduct. Assuming that DoCS management of these allegations can be improved, for example by acceptance of the recommendations contained in this report, and by providing timely determinations, there would not seem to be any reason why the current class or kind determination should not be similarly extended. The Inquiry accordingly favours the adoption of a class or kind agreement which would elevate the reporting requirements to an equivalent level to that adopted for the Education authorities

DoCS responses to allegations – centralised unit

23.212 Several issues have been identified to the Inquiry in relation to the way in which DoCS handles reportable conduct allegations including:

a. the consistency and adequacy of the investigation being undertaken in regions

b. the Department's tendency to undertake full blown child protection secondary assessments in cases that raise relatively low level allegations

c. delays in the completion of these investigations by regions due to caseworkers having other priority work to complete

d. a general lack of expertise in the regions concerning the management of investigations.

23.213 DoCS has advised that between January 2006 and December 2007, of the reportable allegations against foster carers which were finalised, 48 per cent had case outcomes of sustained – but in 15 per cent of these cases the recommendation was no further action, while in about a quarter the recommendation was for informal action. In 11 per cent of investigations, the recommendation was for removal of authorisation.

23.214 In these circumstances the case for a timely investigation is compelling; as is that for the conduct of a sound risk assessment including a consideration of whether any risk can be satisfactorily managed, before any decision is made to remove a child pending that investigation. Clearly the safety of the child involved remains a paramount consideration in any investigation.

23.215 The Inquiry heard from a number of carers, either through written submissions or at Public Forums, who had faced the experience of children being removed from their care following allegations. A review by the Ombudsman of 91 notifications received between 1 April 2007 and 1 April 2008 showed that 16 of the children were removed (17 per cent of the total notifications), in circumstances where the removal was directly related to the fact of the notification.

Case Study 26

Ms W made a submission dated 7 February 2008, which included the following relevant information. In September 2006 she and her partner were approached by DoCS to take two small children for a fortnight. They did so and for various reasons the children were still in her care until 26 May 2007 when the children went into respite care because Ms W was going on holidays. She returned on 12 July 2007 and after attempting to contact DoCS without success in relation to the return of the children, was ultimately told the children would not be returned to her. She was informed that there had been allegations of abuse that were being investigated against her in relation to the two children, one of whom was 20 months old and the other was 37 months old.

Ms W and her partner were interviewed on 4 January 2008 and received a letter from DoCS dated 24 April 2008 advising of the results of the investigation.

It appears there were 13 allegations, four of which had a finding of not sustained, insufficient evidence and each concerned smacking one of the children. An allegation of smacking on the hand was sustained but found to be trivial or negligible. It appears that Ms W admitted that allegation. The sixth allegation was found to be not sustained on the basis that it was false in relation to smacking one of the children.

An additional seven allegations were made, four of which had a finding of not reportable conduct and concerned behaviour such as forcing a child to sit at the table for two hours, serving the previous night's dinner, causing confusion and referring to the children as naughty. Three allegations were found to be not sustained and false in relation to smacking one or other, and locking the children in the room as a form of punishment.

DoCS informed Ms W that a notification had been made to the CCYP as a Category 2 Relevant Employment Proceedings.

DoCS' response to this case study was that workloads and staff shortages contributed to the delays in dealing with these allegations.

23.216 One option which has been canvassed as a means of improving the timeliness and sufficiency of these investigations is to centralise the investigative process at Head Office in the AAE Unit, and to remove the responsibility for this function from the regions and operational units.

23.217 Of relevance for the adoption of this option is DoCS advice that there is a significant difference in the cost of conducting an investigation centrally and in the regions. The approximate cost of the former is said to be in the order of $1,500 to $4,500 per investigation, while that of the latter is of the order of

$5,500 to $10,500. The difference is said to lie in the greater experience of AAE staff and in avoiding the need for double handling.

23.218 This option is the preferred approach of DoCS, and it has the support of the PSA. The Inquiry agrees that the operations of the AAE unit should be centralised.

23.219 It is accepted however that to be effective, a centralised unit with this responsibility would need to have:

a. adequate staffing and resources

b. the capacity to manage reportable allegations that were formerly handled at CSC or regional level

c. the capacity to conduct a prompt investigation of both high and low level allegations.

23.220 Such a change should lead to more timely investigations, help to contain the costs involved, and encourage a uniform investigation strategy that matches the type and depth of the investigation with the level of risk suggested by the allegation.

23.221 This reorganisation would require some increase in the staffing of the AAE Unit, which currently has a staffing of only 9.6 persons, since it would need to assume responsibility for the 85 per cent of the investigations that are currently carried out in the regions. DoCS has placed an estimate of the cost of this restructure as being in the vicinity of $2.2 million.

23.222 A report following an internal audit of one region in 2006, drew attention to the fact that AAE policy did not provide clear guidelines on how to de-authorise a carer following a decision that an allegation was sustained, or whom should have responsibility for effecting that decision. Also, the report noted that there was a lack of timely follow up by the CSC to reports provided by the AAE Unit. Some confusion was also identified as to the status of carers who were to be de-authorised. Recommendations were made for the implementation of standard procedures to ensure prompt execution of AAE Unit actions, and for de-authorised carers to be recorded as 'do not use' in KiDS.[239]

23.223 Other concerns were identified in this audit *inter alia* in relation to:

a. the non-reporting of reportable conduct

b. the existence of inconsistent practices regarding the retention of documentation generated during the investigation of allegations

c. delays in reporting allegations to the AAE Unit, in conducting the initial investigation planning meetings between the AAE Unit and CSCs and in preparing outcome reports.

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[239] DoCS, Ernst & Young, *Internal Audit Report Regional Operations – Northern*, June 2006, p.42.

23.224 Recommendations were made to address these shortcomings involving additional training and planning,[240] which would be addressed to some extent if the investigative responsibility was centralised in the AAE Unit.

23.225 Another concern that has been raised relates to the provision of information to carers concerning the allegation process, the implications of an investigation, and the level of support available. It has been suggested that insufficient information or guidance has been provided in this respect, and that carers are sometimes denied the assistance of a support person when providing a response to an allegation.

23.226 As a matter of procedural fairness, and in order to maintain the goodwill of carers, this is a matter that clearly needs to be addressed.

Notifying the CCYP

23.227 DoCS has reported that the requirement of notifying the CCYP of concluded employment proceedings, and the absence of a class or kind agreement, results in an over reporting of matters that are relatively trivial, which can then have adverse consequences for authorised carers, and can also lead to unnecessary administrative work for both agencies.

23.228 It argued for the creation of a class or kind agreement, which would exclude, *inter alia*, the need to notify the CCYP of Category Two matters, by reason of the punitive and unnecessarily stringent effect that this can have on carers.

23.229 However, the CCYP has informed the Inquiry that as workers in this sector are quite mobile, there may be more than one agency with a Category 2 issue about the same worker. Thus, if these were not reported, a pattern of conduct might be missed. DoCS was primarily concerned with foster carers, as they are the group mainly the subject of these allegations. As the Inquiry understands that most foster carers can and do move between NGOs and DoCS, the point raised by the CCYP remains valid. However, the Inquiry is concerned that there are matters which are notified which are less serious and do not warrant the attention of the CCYP. DoCS and the CCYP should have discussions with a view to these matters being properly identified and made the subject of a class or kind agreement.

Not sustained findings

23.230 The 'not sustained - insufficient evidence' and 'unable to determine' findings can leave foster carers in a limbo both so far as working as a carer is concerned, but also potentially for other child related work. While these findings will not lead to de-authorisation, the uncertainty that persists is likely, in a practical sense, to mean that their services will not be utilised.

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[240] ibid., pp.43-46.

23.231 Additionally, where children in their care were removed pending the investigation, it is unlikely that they will be returned. For all practical purposes they are regarded as 'inactive carers', a circumstance that is detrimental for the maintenance of a proper working relationship with this group, as well as for the preservation of a much needed resource.

23.232 The Inquiry is of the view that these findings do not serve any useful purpose, and that the available formal findings should be confined to "sustained", "not sustained" and "not reportable conduct". Decisions formulated in terms of "insufficient evidence" or "unable to determine" are in effect, non decisions, which do not have any legitimate precedent elsewhere. Having regard to the balance of proof, in most, if not all, instances a decision should be capable of being made that will also take into account the best interests of the child principle.

23.233 The reasons for the finding should be formally recorded in the outcome report which should be made available to the complainant and to the persons subject to the complaint.

23.234 It is noted that it has been held that the ADT has no jurisdiction to review a decision by a designated agency to notify the CCYP of an allegation of reportable conduct.[241]

23.235 Additionally it would appear that the ADT has no power to review a case where there had been a finding to the effect that the allegation was 'not sustained – insufficient evidence', or a finding 'unable to determine', where that had not led to a decision by DoCS, or by a designated agency, to remove a child or young person from the responsibility of the carer for the daily care and control of a child or young person, or to suspend or to revoke that person's status as an authorised carer.

23.236 There are several examples of cases where decisions to revoke the authority of carers were in fact made and then affirmed by the ADT, where the Tribunal could not be satisfied on the balance of probabilities that the allegations were true, but could also not be satisfied that there was no truth in them.[242] In those circumstances, the best interests of the children in removing what was seen to be a possibility of an unacceptable risk prevailed.

23.237 The approach which the Tribunal takes in relation to such cases is perhaps explained by the following passage in its judgment in *QB v Minister for Community Services*,

> *It is almost trite to observe that cases such as this present very difficult evidentiary issues and that applicants in such matters have heavy evidentiary burdens to discharge, even on the*

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[241] *CS & Anor v Life Without Barriers* [2007] NSW ADT 249.

[242] *HB v Director General DoCS* (2008) NSW ADT 207, *QW & EX v The Minister for Community Services* (2005) NSW ADT 287.

balance of probabilities. This is because the principles to be applied require decision-makers – the Director-General in this case – to give 'paramount consideration' to the safety, welfare and well-being of children in the care of foster parents. As a simple matter of policy, the Director-General, and this Tribunal when reviewing the Director General's decisions are required, where there is a conflict, to place the interests of children involved in such proceedings above those of any carer or foster parent.[243]

Background checks

23.238 DoCS has advised the Inquiry that over the last two years, the CCYP has raised concerns about the increasing number of screening requests from DoCS and as a result, has at times questioned the statutory basis for undertaking screening for some employee categories. DoCS advised that CCYP has argued that not all positions within DoCS have direct and unauthorised access to children and therefore these positions do not require screening.

23.239 Further, DoCS has advised that it has received correspondence from the NSW Family Day Care Association stating that CCYP will not conduct checks on adult household members because there is no legislative basis for it. While not currently required to undertake such checking under the relevant legislation, DoCS has advised that these checks are regarded by children's services licensees as critical.

23.240 DoCS argued that a legislative amendment is required to clarify CCYP's obligations regarding background checking. Specifically, DoCS recommended:

that the CCYP Act be amended to require working with children checks for the following positions:

a. *all new DoCS staff positions (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)*

b. *any contractors engaged by the department to undertake work which involves direct unsupervised contact to children, or access to the KiDS system or file records on DoCS clients (eg IT contractors)*

c. *students working with DoCS officers*

d. *children's services licensees*

e. *authorised supervisors of children's services*

f. *adoptive parents*

[243] *QB v Minister for Community Services* (2005) NSW ADT 89.

> g. *adult household members of foster carers, family day carers and licensed home based carers.*[244]

23.241 While not addressing these concerns specifically, the CCYP submission to the Inquiry has raised the issue of extending background checking to volunteers in identified risk groups. Included in the CCYP definition of volunteers are adult household members of family day carers and authorised carers.

23.242 Background checking of volunteers is also an issue of importance for both the government and non-government sector. Currently, volunteers involved in child related activities are required to complete a Prohibited Employment Declaration, but are not required to undergo a full background check. Health, Police and Education have all recommended that background checking be extended to certain groups of volunteers. Health recommended the implementation of legislation allowing background checks, including national criminal records checks for volunteers in high risk positions. Police noted that clubs, sporting associations and volunteers are exempt from background checks and recommended an examination of the current gaps in the working with children background checking system with a view to making improvements to assist community based organisations to develop procedures and practices to protect children and young persons.

23.243 Education is concerned about volunteers coming into unsupervised contact with students, and also raised concerns about other groups of people such as contracted cleaners and tradesmen that come onto school grounds. Specifically:

> *Education considers that any person who comes onto a school site or accompanies children on an excursion or overnight camp in circumstances where that person may have unsupervised contact with children should be subject to a screening process similar to the Working With Children Background Check.*[245]

23.244 The views of the Catholic Commission for Employment Relations, one of the State's approved screening agencies, are similar to those stated by Education regarding background checking for volunteers and people working on school grounds. The Catholic Commission has advised the Inquiry that for many organisations, volunteers are their greatest area of exposure particularly given that the:

> *sole requirement of a Prohibited Employment Declaration for all voluntary positions is not satisfactory as research indicates that Statutory Declarations have been used both nationally and*

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[244] Submission: DoCS, The Role of Oversight Agencies, p.20.

[245] Submission: Department of Education and Training, p.18.

internationally and in both cases have been found to have been abused by perpetrators.[246]

23.245 Other organisations including Centacare Sydney, the Anglican Church of Australia and Life Without Barriers have also raised concerns about the lack of background screening of volunteers.

23.246 The CCYP submission to the Inquiry advised that in 2006, a survey was undertaken to determine whether there was support for extending background checking to volunteers. CCYP advised that the survey results were mixed. CCYP further advised that these results were in line with the findings of a pilot program undertaken by the CCYP from 2002 to 2004, where three-quarters of the participant organisations found it challenging to set up the administrative systems needed to start doing volunteer checks. CCYP stated:

> *It is clear from these findings that the issues we need to consider for the volunteer community are complex. We do not want to impose unrealistic administrative burdens on volunteer organisations that may already be struggling with regulatory requirements.*[247]

23.247 It is not however clear from the survey whether those who opposed an extension of the checking regime did so on principled grounds, or because of matters going to their administrative convenience.

23.248 CCYP cautioned against a system of checking that may discourage volunteers from joining organisations that provide services for children. The final point made by CCYP on this issue was "we don't want background checks to encourage a false sense of security; we want volunteer organisations to keep working towards being child-safe and child-friendly."[248]

23.249 While there are obvious challenges to extending background checking to volunteers, CCYP accepts that there is merit in undertaking the following actions:

a. extending background checking to volunteers in high risk groups, such as mentoring and adult household members of authorised carer and family day carers

b. auditing the Prohibited Employment Declarations made by volunteers

c. increasing support for organisations through CCYP's child-safe and child-friendly program.

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[246] H Edwards and J Myers, "Safeguarding: another buzzword or a concrete way of ensuring protection of Children?" 2003: www.nspcc.org.uk/inform/Info_Briefing/Safeguarding.pdf cited in Submission: Catholic Commission for Employment Relations, p.2.

[247] Submission: Commission for Children and Young People, p.13.

[248] ibid.

23.250 The Inquiry is of the view that the checking system should extend to those who work directly or have regular access to children and young people in all human service agencies and to volunteers in clearly identified high risk groups. Guidelines would need to be developed to provide greater specificity as to the identity of those who should be subject to checking, following consultation with agencies of the kind mentioned above that are dependent on volunteers.

23.251 The above actions have resource implications for CCYP, which are reflected in its recommendations to the Inquiry that its funding be increased.

Oversight tension

23.252 It became very apparent in the early days of the Inquiry that significant tensions existed between DoCS and the Ombudsman in relation to the extent of oversight by the latter. DoCS had specific concerns about the Ombudsman's child death review function and reportable conduct powers, each of which is dealt with in this chapter.

23.253 More broadly, however, DoCS submitted to the Inquiry that the cost of responding to oversight agencies was a significant impost on DoCS. Further, it argued that responsibilities were blurred in the current oversight arrangements and that the proper role delineation between Government/the Parliament and oversight agencies was not always clear.

23.254 In relation to costs, an analysis commissioned by DoCS of the direct costs of the oversight function by the Children's Guardian, the Ombudsman and the reporting to CCYP concluded that they amount to the equivalent of 43.4 full time equivalent positions per annum. The Inquiry has made recommendations elsewhere designed to reduce those costs through the increased use of class or kind agreements.

23.255 The view of DoCS is that the Ombudsman strays into areas of policy and resource allocation, matters properly left to the Department, its Minister, and when appropriate Cabinet and Parliament. The key examples given were in the area of reviews of child deaths and, in particular, the Ombudsman's recommendation to establish a risk of harm threshold below which no case would be unallocated.

23.256 The Inquiry has found the work of the Ombudsman to be very valuable in carrying out its investigations and in considering reforms to the child protection system. His reports are invariably detailed, comprehensive and sound. It is however the case that his recommendations can concern matters of policy and, if implemented some could have considerable resource and budgetary implications, the precise extent of which may not be obvious to anyone other than DoCS.

23.257 While the Ombudsman has no power to enforce his recommendations, the publication of his reports can have and are undoubtedly designed to have the effect of encouraging compliance. In addition, a person aggrieved by a decision

made by DoCS not to take an action recommended by the Ombudsman or to implement only part of the recommended action can apply to the ADT for a review of the decision by DoCS made in response to the recommendation. The ADT must then decide what the correct and preferable decision is and has the power to affirm, vary, set aside or remit the decision to DoCS.[249]

23.258 DoCS contended that the Ombudsman should be bound by or, at least give effect to the spirit of s.5(1) of CS CRAMA which is in the following terms.

> *(1) The determination of an issue under this Act, and any decision or recommendation on a matter arising from the operation of this Act, must not be made in a way that is (or that requires the taking of action that is):*
>
> *(a) beyond the resources appropriated by Parliament for the delivery of community services, or*
>
> *(b) inconsistent with the way in which those resources have been allocated by the Minister for Community Services, the Minister for Aged Services, the Minister for Disability Services, the Director-General of the Department of Community Services or the Director-General of the Ageing and Disability Department in accordance with Government policy, or*
>
> *(c) inconsistent with Government policy, as certified in writing by the Minister for Community Services, the Minister for Aged Services or the Minister for Disability Services and notified to the Tribunal, Commission or other person or body making the determination.*
>
> *(2) This section does not apply to the exercise of any function of the Ombudsman under this Act.*

23.259 The Inquiry disagrees with DoCS. The independence of the Ombudsman is a key cornerstone of public accountability in NSW. That is reflected is subsection (2) set out above. DoCS is given an opportunity to comment on recommendations proposed by the Ombudsman prior to publication, and should do so with respect to those that it considers trespasses into areas with resource allocation implications. Further, the three areas of reform suggested by DoCS and set out earlier should achieve some beneficial change in the relationship between DoCS and the Ombudsman.

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[249] *Miller v Director-General, Department of Community Services* (No2) [2007] NSWADT 140.

23.260 In any event it is noted that the recommendations of the Ombudsman are just that: they are not binding upon DoCS. Nor does the jurisdiction of the ADT rise above requiring DoCS to reconsider its response to the recommendations. DoCS retains its administrative independence to act within its budget and policy as set by the Minister. If it is subject to adverse comment by the Ombudsman in any published report, it has the capacity to respond and to set the record straight from its point of view, in its annual report.

Recommendations

Recommendation 23.1

The relevant legislation including Part 7A of the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that Team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Recommendation 23.2

DoCS should review the death of any child or young person about whom a report was made within three years of that death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.

Recommendation 23.3

The Community Services (Complaints, Reviews and Monitoring) Act 1993 should be amended by:

i. repealing s.35(1)(b) and (c)

ii. replacing the requirement for an annual report, in s.43 with a requirement that a report be made every two years.

Recommendation 23.4

Information obtained by persons appointed by the Minister as official visitors should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards and s.8 of *Community Services (Complaints, Reviews and Monitoring) Act 1993* and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* should be amended to achieve this outcome.

Recommendation 23.5

The class or kind agreement between the NSW Ombudsman and DoCS should be revised to require DoCS to notify only serious allegations of reportable conduct and to impose timeframes within which DoCS will investigate those allegations.

Recommendation 23.6

DoCS should centralise its Allegations Against Employees Unit and receive sufficient funding to enable this restructure, and to resource it to enable it to respond to allegations in a timely fashion.

Recommendation 23.7

DoCS should revise the findings available following an investigation into an allegation against an employee so as to and permit one of the following findings to be made but no other: sustained, not sustained, not reportable conduct. Adequate reasons should be recorded, and kept on file, which should note not only why an allegation was sustained, but also the reasons why an allegation was not reportable or not sustained.

Recommendation 23.8

The *Commission for Children and Young People Act 1998* should be amended to require background checks as follows:

a. in respect of DoCS and other key human service agencies all new appointments to staff positions that work directly or have regular contact with children and young persons (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)

b. any contractors engaged by those agencies to undertake work which involves direct unsupervised contact to children and young persons, and, in the case of DoCS, access to the KiDS system or file records on DoCS clients

c. students working with DoCS officers

d. children's services licensees

e. authorised supervisors of children's services

f. principal officers of designated agencies providing OOHC or adoption agencies

g. adult household members, aged 16 years and above of foster carers, family day carers and licensed home based carers

h. volunteers in high risk groups, namely those having extended unsupervised contact with children and young persons.

24 Interagency cooperation

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Introduction

24.1 Data on child protection reports, as recorded in Chapter 5, indicate the multi-dimensional nature of the risks facing vulnerable children and families in NSW. Key risk factors reflect trends in other child welfare jurisdictions, both in Australia and internationally, where factors such as domestic violence, drug and alcohol use or mental health and neglect feature in child protection reporting, none of which can be satisfactorily addressed by any one agency working alone.

24.2 Few of DoCS' clients present with only one child protection issue. Most families have a range of unmet needs, and working to improve the safety, welfare and well-being of children and young persons involves advocating for services from other agencies. When DoCS is constrained by the lack of immediate access to services of other agencies, this can compromise its capacity to facilitate engagement with the family and to ensure timely and effective responses to their issues.

24.3 Effective interagency collaboration has the potential to enhance effective child protection services. It can deliver better assessments of need, improve the delivery of holistic services by minimising gaps and discontinuities in services, achieve greater efficiency in resource use and provide more support for workers.[250]

24.4 In its submission to the Inquiry, DoCS referred to research conducted by Buckley[251] and Hallet and Birchall[252] who state that simply mandating collaboration cannot guarantee its success. DoCS advised that, despite the rhetoric, the responsibility for child protection is not usually shared and ultimately, responsibility remains with the caseworker within the system. Further, child protection interagency work tends to drop off once the initial crisis has passed, suggesting that although interagency collaboration is lauded as a desirable policy goal, there is always the danger of 'collaboration inertia' where efforts are focused on processes rather than on outcomes for service users.[253] There was evidence of this before the Inquiry as well as evidence that DoCS casework practices contribute to the lack of engagement by other agencies. This is addressed in Chapter 9.

24.5 The promotion of effective interagency cooperation is consistent with the NSW State Plan, and with the several Plans and strategies that have been developed

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[250] A Tomison, "Current Issues in child protection policy and practice: Informing the Northern Territory Department of Health and Community Services child protection review," *National Child Protection Clearinghouse, Australian Institute of Family Studies,* 2004.

[251] H Buckley, "Child Protection: an unreflective practice," *Social Work Education, Vol. 19 No. 3,* 2000, cited in Submission: DoCS, Interagency Cooperation, p.6.

[252] C Hallett and E Birchall, "Coordination and Child Protection: a review of the literature," *HMSO,* Edinburg, 1992, cited in Submission: DoCS, Interagency Cooperation, p.6.

[253] M Atkinson, "The development of an evaluation framework for partnership working: a review of the literature," *Electronic Journal of Business Research Methods, Vol.3, Issue 1*, Southern Health and Social Services Board, Northern Ireland, 2005 pp.1-10, cited in Submission: DoCS, Interagency, p.7.

in recent years to address domestic violence, anti-social behaviour, and sexual assault and family violence within Aboriginal communities, by project teams whose members are drawn from the key human services and justice agencies.

24.6 On a more general basis, interagency cooperation has been guided by the 2006 NSW *Interagency Guidelines for Child Protection Intervention*, (the Interagency Guidelines) by some area specific interagency guidelines and by a series of individual MOUs and protocols that provide more specific direction concerning their implementation at local level. The resulting structure is complex and a serious question arises as to whether that structure provides a sound basis for the kind of cross government and non-government approach to child protection that is necessary, particularly given the non-congruent nature of the regional boundaries of the agencies, discussed later in this chapter.

The Care Act

24.7 The Care Act specifies the mechanisms that the Director-General (DoCS) can use to foster interagency coordination in providing services to children and young persons and to families who request services or are reported to DoCS.

24.8 Section 16 (2) and (3) of the Care Act provides:

> *(2) Interagency procedures and protocols.*
>
> *The Director-General is to promote the development of procedures and protocols with government departments and agencies and the community sector that promote the care and protection of children and young persons and to ensure that these procedures and protocols are implemented and regularly reviewed.*
>
> *(3) The objects of the procedures and protocols referred to in subsection (2) are:*
>
> *(a) to promote the development of co-ordinated strategies for the care and protection of children and young persons and for the provision of support services directed towards strengthening and supporting families, and*
>
> *(b) to co-ordinate the provision of services for assisting young persons leaving out-of-home care.*

24.9 Sections 17 and 18 of the Care Act, make specific provision in relation to requests by DoCS for services from other non-government and government agencies, as follows:

> *17 Director-General's request for services from other agencies.*
>
> *In deciding what action should be taken to promote and safeguard the safety, welfare and well-being of a child or young*

person, the Director-General may request a government department or agency, or a non-government agency in receipt of government funding, to provide services to the child or young person or to his or her family.

18 Obligation to co-operate.

The government department or agency must use its best endeavours to comply with a request made to it under section if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its functions.

24.10 Sections 20 and 21 of the Care Act make provision respectively for children and young persons, and for parents of children or young persons, to seek assistance from the Director-General. Under s.22, the Care Act further provides:

22 Director-General's response to requests for assistance and reports

If a person seeks assistance from the Director-General under this Part (whether or not a child or young person is suspected of being in need of care and protection), the Director-General must:

(a) provide whatever advice or material assistance, or make such referral as, the Director-General considers necessary, or

(b) take whatever other action the Director-General considers necessary,

to safeguard or promote the safety, welfare and well-being of the child or young person.

Note. After assessing the request for assistance, the Director-General need not take any further action.

The Director-General, in responding to a request for assistance or a report, can provide services or arrange for other government departments and agencies, or community organisations, to provide services to assist children, young persons and their families. Some of the services that may be available include:

- *assessment of risk or need*
- *service co-ordination*
- *emergency financial assistance*

> - *mediation*
> - *counselling for children, young persons and their families*
> - *services for people with disabilities*
> - *parenting education*
> - *out-of-home placement*
> - *drug and alcohol counselling*
> - *early childhood health services*
> - *counselling and support for sexual assault or domestic violence*
> - *respite care*
> - *children's services*
> - *family support*
> - *youth support programs*
> - *accommodation for the homeless*
> - *adoption assistance*
>
> *The Department may also play a role in referring people to services provided under Commonwealth legislation, such as Family Court counselling and access to maintenance entitlements or other benefits.*

24.11 Section 29A of the Care Act makes provision in relation to the ongoing assistance of a child or young person, on the part of persons who make risk of harm reports to DoCS, as follows:

> *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 person's employment or otherwise.*

Focus of this chapter

24.12 Specific areas where interagency collaboration has taken place, or is in the course of development, have been examined in detail earlier in this Report. The focus of this chapter is, accordingly, upon the broader framework for cross

agency cooperation, in particular in relation to the extent to which the Interagency Guidelines and MOUs achieve their purpose, and in relation to the problems likely to be caused by the imperfect boundary alignment of the agencies.

24.13 Additionally, consideration is given to the impediments to efficient cross agency work attributable to the current privacy and information exchange structure, and to certain aspects of alternative models in place in other jurisdictions that might possibly be adapted for application in NSW.

24.14 The need for a substantial revision of the current structure, and in the practices of individual agencies, has received general support in the Public Forums and in the submissions received from the key human service agencies, many of which have drawn attention to the undesirable 'silo' approach which has developed. Although this chapter addresses this issue in the broad, it is recognised that interagency practice occurs at three distinct levels, namely at policy level, program level and direct service level, and that to be successful it must deal with each. The context in which agencies cooperate in establishing a uniform policy approach and goals differs from that in which they coordinate the availability of the individual programs or services within their respective charters, and in turn from that in which they work together on individual cases.

24.15 The Inquiry does not underestimate the difficulty in ensuring effective interagency cooperation, and in overcoming the problems which DoCS noted were:

> *… well documented in the literature and include issues such as lack of ownership by either senior management or front line staff, inflexible organisational structures, conflicting professional ideologies, lack of budget control, communication problems, and poor understanding of roles and responsibilities.*[254]

24.16 Additionally there is the problem of overcoming collaboration inertia where efforts are focused on the presence of service providers rather than on the outcomes for clients.

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[254] Submission: DoCS, Interagency Cooperation, p.6.

Interagency Guidelines

24.17 The introduction to the Interagency Guidelines notes:

> *The Guidelines are a resource to promote effective collaboration, cooperation and coordinated effort across all responsible service providers under the Children and Young Persons (Care and Protection) Act 1998 and ultimately to improve the safety, welfare and well-being of children and young people in NSW.*
>
> *Individual agencies have different responsibilities relating to strengthening families and preventing child abuse, but the best results will occur where agencies are working together and in a complementary way, to deliver the often complex range of responses and supports that are required by children, young people and families.*[255]

24.18 With some exceptions[256] the Interagency Guidelines do not purport to regulate interagency coordination. Rather they appear, on their face, to provide a general explanation of the elements of the child protection process, and of the roles of the agencies with a heavy emphasis on the role and responsibilities of DoCS.

24.19 An evaluation of the Interagency Guidelines, including consultation across the sector, has recently been undertaken by the Child Protection Senior Officers' Group in line with the Ombudsman's *Report of Reviewable Deaths in 2004*. The report recommended that the evaluation should focus on the assessment of agency take up and the effectiveness of the Guidelines.[257]

24.20 A report on the key findings of the evaluation's survey of staff from across the state noted the following:

a. The Interagency Guidelines are fairly well known across the 12 human services agencies, particularly amongst staff whose position means they are likely to be involved in a child protection matter; agencies where take up has been relatively less successful are Police, Juvenile Justice and Housing.

b. All respondents, including non-government respondents, reported being well informed about two key facts: knowledge of the circumstances for reporting a child to DoCS and the indicators of child abuse or neglect.

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[255] *NSW Interagency Guidelines for Child Protection Intervention*, 2006, p.7.

[256] For example, the sections dealing with responsibilities of agencies at case meetings, Chapter 3, p.20; the information-seeking powers of DoCS, Chapter 4, p.3; and managing a best endeavour request, Chapter 6, pp.8-9.

[257] NSW Ombudsman, *Report of Reviewable Deaths in 2004,* December 2005, p.97.

c. Two topics covered by the Interagency Guidelines where there appears to be a lack of clarity were DoCS intake and investigation process and the processes for best endeavours requests with more than half the respondents rating their knowledge of the latter as poor or fair only.

d. There was a common request for more practical and clearer guidance for working with other agencies. Health respondents were particularly interested in knowing more about privacy and information sharing laws while respondents from DoCS requested contact information for other departments, better clarity in relation to the definition of 'child at risk' and information regarding the responsibilities of other agencies.

e. Most respondents, who dealt with child protection matters as part of their normal role, indicated that the Interagency Guidelines had made it easier to work with other agencies on child protection matters, that they assisted in establishing good working relationships and in understanding how to exchange information with other agencies about families that move locations.

f. About one in five of the respondents, felt that the Interagency Guidelines had adversely affected their ability to do their job or allowed them less flexibility when dealing with child protection matters or delayed important decision-making about children. These respondents were more likely to be from Police, Health, or Juvenile Justice.

g. Some respondents raised issues about conflicts between the requirements of the Interagency Guidelines and the practical ability of core agencies to provide timely handling of cases, to provide feedback, and to fulfil other responsibilities, resulting in the Interagency Guidelines not being followed consistently by frontline child protection staff.

h. The Interagency Guidelines were largely congruent with key agency policy and procedures, however this was not the case for NGOs where there is a large potential for conflict with the way the organisations operate.

i. A minority of staff from key frontline agencies are yet to take up the Interagency Guidelines and DoCS staff are still seen as having the central responsibility for child protection.[258]

24.21 The evaluation suggested that consideration be given to practice improvements in relation to training, additional content in the Interagency Guidelines, preparation of an abridged version for staff who only use them occasionally, and exploration of problematic issues (for example, lack of synchronicity between NGO policies and procedures and the Interagency Guidelines).

24.22 Two further reports have been prepared as part of the evaluation of the Interagency Guidelines: a regional analysis of the findings of the survey of staff

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[258] ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Interim report, survey findings,* 12 June 2008, pp.13-15.

and a review of human service agencies' policies and procedures related to child protection.[259]

24.23 The review of policies and procedures noted, in summary that:

> *There was a marked difference in the coverage of the revised child protection practice commitments in policies and procedures across the agencies. Most agencies covered the commitment, "involvement of partner agencies and NGOs in case planning meetings so that an interagency response can be coordinated," in at least one policy. Two other commitments were covered by at least half the agencies, 'Feedback from DoCS to reporters in response to a risk of harm report' and 'DoCS making greater use of referrals and best endeavours requests, when it is unable to provide a casework response.' Only a minority of agencies covered the remaining commitments.*
>
> *Just two agencies, Department of Community Services and Department of Education and Training made reference to all the revised commitments in the policy and procedures provided. These agencies would be expected to have operational staff most directly involved with children and their families as part of normal business. The NSW Police and Office of the Director of Public Prosecutions only referenced the commitment, 'Involvement of partner agencies and NGOs in case planning meetings so that an interagency response can be coordinated'. One agency, the Department of Corrective Services has not referenced any of the revised practice commitments in the two documents provided for the review.*[260]

24.24 The Inquiry acknowledges that the Interagency Guidelines do operate as a reference point for agencies concerning the roles and responsibilities of each agency, and as a basis for staff training, although it may be noted in the latter respect that there does not seem to have been any systematic cross agency training, for workers on the ground. There has been training at a higher level within organisations, including that organised by the Child Protection Senior Officers' Group.

24.25 Otherwise, they do not seem to have brought about significant positive change in the ways in which, or processes by which, agencies work together. They do not replace agency specific policies and practices, and their provisions are not necessarily or uniformly replicated in those policies and practices. They do not

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[259] ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Regional Analysis of Survey Finding*, 5 August 2008 and *Summary of Findings for desktop review of policies and procedures related to child protection.*

[260] ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Summary of findings for desktop review of police and procedures relating to child protection.*

purport to have a statutory basis, and there appears to be some degree of lack of understanding as to their content and use.

24.26 If they are to provide an effective basis for regulating interagency practice then revision in accordance with the findings in the evaluation report would seem to be warranted. Clearly they are not sufficient alone to ensure interagency collaboration.

24.27 The Interagency Guidelines exist alongside some area specific guidelines or interagency accords which remain current, including:

a. *Domestic Violence Interagency Guidelines (2004),* currently under review

b. Interagency Guidelines for early intervention, response and management of Drug and Alcohol Abuse (2005)

c. Interagency Action Plan for Better Mental Health (2005)

d. *NSW Housing and Human Services Accord.*

24.28 It is understood that an interagency action plan is also under development for the coordination of services for youth, with a particular focus on prevention and early intervention, and implementation of the NSW Government's Youth Action Plan.

24.29 The specific guidelines provide a greater degree of direction as to processes and interagency practice than the more general Interagency Guidelines, although the resulting proliferation of documents and instructions does not make for easy navigation. This is further exacerbated by the large number of MOUs and protocols that have also been developed.

Memoranda of Understanding

24.30 DoCS has entered into a number of MOUs, as well as generic agreements and local or regional protocols, providing for interagency cooperation and for the regulation of that cooperation, including the following:

a. MOU between DoCS and DADHC on Children and Young Persons with a Disability (2003), which is currently under review

b. MOU between DoCS and Education in relation to educational services for children and young persons in OOHC (2005), which is also currently under review

c. MOU between DoCS and Juvenile Justice and regional protocols in relation to the responsibilities of each agency where a child in the parental responsibility of the Minister is also a client of Juvenile Justice (2004)

d. MOU between DoCS and Health on prioritising access to health services for children and young persons for whom the Minister for Community Services has parental responsibility or for whom the Director-General of

DoCS has parental or care responsibility relating to residence and or medical issues (2006)

e. Protocol between DoCS, Health and Police concerning homeless people affected by or addicted to alcohol or other drugs

f. Protocol involving DoCS and 10 other agencies concerning homeless persons in public places (2003)

g. Information sharing protocol between DoCS and Health concerning persons participating in opioid treatment who have the care and responsibility for children under 16 years of age (2006)

h. MOU between Health, Police, and DoCS concerning Joint Investigation Response Teams (2006)

i. MOU between DoCS, Health, Police, Housing and Attorney General's in relation to the establishment of a management model to implement the strategy to reduce violence against women (2002)

j. Case management protocol between Commonwealth agencies and State Authorities for Unsupported Young People (the Youth Protocol) for the coordination of welfare, income support and related services for homeless and unsupported young people, and involving DoCS and relevant Commonwealth agencies

k. Joint Guarantee of Service (2003) to deliver mental health service and housing support to people with mental health problems and disorders living in or applying for social housing

l. MOUs and Protocols between DoCS and the Family Court of Australia and the Federal Magistrates Court respectively concerning the exchange of information, requests for intervention and responses to allegations of abuse.

24.31 The Inquiry understands that a draft MOU between DoCS and Police for the exchange of information, which was approved by DoCS in 2007, is awaiting approval by Police.

24.32 These MOUs have the capacity to fill out the Interagency Guidelines in that, at least so far as the parties to them are concerned, they:

a. detail specific roles and responsibilities

b. detail expectations about consistency of interagency relationships and practices

c. state what agencies and/or sectors have committed to

d. provide a basis and process for the negotiation of responses to a situation and for the resolution of differences between agencies.

24.33 In general, the MOUs appear to be comprehensive and well structured. However, the preparation of these documents is only the beginning of the exercise, the success of which depends on whether they are known,

understood and then applied by the staff of the participating agencies. As discussed in Chapter 21, the experience with the DADHC/DoCS MOU provides a clear example of a case where implementation has fallen well short of expectations, has sometimes left families in a vacuum between the two agencies, which has required them to resort to drastic action in order to obtain essential services, such as, respite care.

24.34 In its submission, DoCS has acknowledged that at a practice level multiple agreements may not be effective in streamlining access to services, and that it can be difficult to navigate through these agreements in order to access the right mechanism for a particular client. Additionally it has noted the risk:

> *… that these agreements establish an expectation about service levels that simply cannot be met in light of resourcing for services and, particularly in rural and remote areas, workforce and infrastructure availability.*[261]

24.35 DoCS suggested that rather than having multiple MOUs with separate agencies, it would be preferable to have a streamlined MOU to which all major service delivery agencies was a party.

24.36 The Inquiry considers that there is merit in this suggestion. There is clearly a risk that the multiplicity of governance arrangements in the several guideline documents (which do not have either statutory or contractual force), and in the MOUs, protocols and accords, makes for a very complex and inflexible structure.

24.37 The MOUs are largely irrelevant for the NGO sector whose engagement in the child protection system occurs as a result of their participation as contracted service providers, although the importance of their contribution has been recognised by the *Working Together for NSW*[262] compact which was established in 2005. The Inquiry understands that DoCS has commenced the process of updating the MOUs to include NGOs as part of the case management transfer process.

24.38 The compact provides a framework for service delivery and identifies the goals, values and working principles that are intended to guide the working relationship between the government and non government sectors. The Forum of Non-Government Agencies has a potential role in securing the implementation of this compact, but submissions received by the Inquiry question whether it provides much in the way of concrete results.

24.39 The Catholic Social Services and NSW Catholic Social Welfare Committee observed:

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[261] Submission: DoCS, Interagency Cooperation, p.10.

[262] The *Working Together for NSW Agreement* is an agreement between the NSW Government and the community sector.

> *The Working Together for NSW Agreement was intended to improve the quality of 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. There is a view within the NGO sector that projects attached to the Agreement are driven by the agendas of government departments and that the NGO sector has little ability to influence the Agreement's implementation.*[263]

24.40 NCOSS noted in its submission:

> *The Agreement was formulated on the understanding that an independent, diverse non government sector is an essential component of a democratic, socially inclusive society. Its purpose is to strengthen the ability for Government and NGOs to achieve better outcomes for the people of this State.*
>
> *The benefits of 'Working Together' are seen by the parties to be an improved awareness and understanding of the respective contributions made by Government and NGOs, improved constructive dialogue, clearer expectations, promotion of good practice and improved quality of services and programs provided to the community*
>
> *While NCOSS does not believe that we or the non-government human services sector have utilized 'Working Together' as effectively as we should, we do believe that it provides a useful framework for development of a more collaborative and productive relationship at a whole of government level, departmental level and within departments at divisional and/or regional levels. This requires commitment both in principle and practice by all concerned.*[264]

24.41 It is understood that a further NGO development and support initiative is underway led by DoCS, and involving Health, Housing, DADHC and Education, the purpose of which is to identify and progress strategies to improve the sustainability of the NGO sector.

24.42 These initiatives are welcome and supported. The significant contribution of the NGO sector in providing services on behalf of DoCS, as shown by the fact that it receives about 45 per cent of the overall DoCS budget, underlines the need for its active involvement as a partner in interagency operations. As set out earlier in this report, there is a need to build the capacity of the NGO sector to enable it to perform an enhanced role in early intervention and OOHC.

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[263] Submission: Catholic Social Services NSW/ACT and NSW Catholic Social Welfare Committee, p.37.

[264] Submission: Council of Social Service of New South Wales, pp.8-9.

Acceptance of the need for a cross government response

24.43 In submissions to the Inquiry, each of the key human services and justice agencies expressed commitment to their involvement as partners in a cross government response to child protection, and acknowledged deficiencies in the effectiveness of current interagency involvement.

24.44 Key issues identified included difficulties in relation to information sharing and resource limitations. Difficulties in dealing with chaotic families and those with complex and high needs were also raised. Suggestions for change included interagency training, joint casework meetings and planning, and the greater involvement of NGOs.

24.45 In his submission to the Inquiry, the Ombudsman observed:

> *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…

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.[265]

24.46 This submission noted that auditing work in relation to the Police, in the exercise of the reviewable child death function, and in monitoring interagency cooperation, has generally confirmed the need for shared cooperation and improved coordination between government agencies and community service providers, as well as a need for high level support and clear direction when developing fresh approaches to interagency work.

24.47 Similar concerns to those mentioned above were expressed by the NGO sector and by various professional groups involved in the education or health systems, to the effect that, the aim of the child protection system working effectively across organisational barriers was not being achieved to the extent required, and required strengthening.

24.48 The Benevolent Society in its submission, observed:

Our experiences of interagency cooperation are that we are moving backwards not forwards in NSW,[266]

and suggested that there was need for a strong central leadership which could broker CEO level agreement about the roles and responsibilities of agencies and coordinate implementation of the Interagency Guidelines. It noted that DoCS could not be expected to play this role as it does not have any mandate to instruct other line agencies about what to do or when to intervene if they are not fulfilling their role.

24.49 UnitingCare Burnside observed, in its submission:

Service providers are also concerned that many DoCS workers are unaware of the range of services for children, young people and families available within the non-government sector. They believed this was having a direct impact on the level of service that children, young people and families are receiving. One service provider said, "Getting to know what non-government

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[265] Submission: NSW Ombudsman, Interagency Cooperation, p.5.

[266] Submission: The Benevolent Society, p.19.

services are available should be part of DoCS staff induction process.'[267]

24.50 A suggested solution was the introduction of joint training and professional development.

24.51 In its submission NCOSS observed:

> *Collaboration and coordination works best where there is a clear understanding of each others' roles and responsibilities and a level of trust that people will do their job properly and well. It requires a sharing of knowledge and a willingness to work constructively to overcome problems. There is, however, amongst NGOs a perception that DoCS does not take criticism well and is often more defensive rather than open to suggestions constructively made. NGOs often feel their input is not sought by government and when it is ignored or not considered relevant. It is sometimes seen that DoCS role as funder of NGOs as well as a direct service provider is contrary to a more open approach to working collaboratively with other agencies to achieving better outcomes for the people we are all working on behalf of. It is also clear that the experience varies based on particular individuals and relationships rather than a universal culture or coordination, collaboration and partnership. For all agencies, Government and NGOs, to work more collaboratively these perceptions and differences in culture must be addressed.*[268]

24.52 The advantage of, and the need for, better interagency coordination has also been recognised in a number of official reports.[269]

24.53 An opposing view of the utility of interagency coordination other than at case level was offered by Barnardos Australia to the effect that there is extremely limited evidence that most children are better off if coordination is a focus of services. Barnardos indicated that, in its experience, formalised attempts to direct coordination have been a failure and have "significant costs which draw resources away from direct service provision into endless meetings and coordination attempts"[270], and observed:

> *Over the last decade theories and concepts of interorganisational coordination have been developed and refined … and practice models examined. This work has*

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[267] Submission: UnitingCare Burnside, p.34.

[268] Submission: Council of Social Service of New South Wales, pp.7-8.

[269] For example, those of the NSW Ombudsman, *Report of Reviewable Deaths in 2006*, *Volume 2: Child Deaths*, December 2007, DoCS and NSW Health, *Methadone related child deaths, issues paper*, April 2008, the Standing Committee on Social Issues, *Realising Potential*, *Final Report of the Inquiry into Early Intervention for Children with Learning Difficulties, Report 30*, September 2003.

[270] Submission: Barnardos, p.18.

> *shown the considerable level of complexity and challenges in planning coordinating processes. The work in non hierarchical cooperative systems has shown the strength of informal and local situational coordination.*
>
> *Barnardos believes that the coordination of services at a case level is far better than is recognized as caseworkers negotiate the webs of available services developing multiple collaborative relationships as needed to assist service delivery. We strongly concur with Dorothy Scott that there is effective collaboration*[271] *but we are extremely concerned about imposed collaborative attempts which 'rationalise' a complex system to the detriment of children who are already poorly serviced.*[272]

24.54 Despite the reservations expressed by Barnardos in its submission, the Inquiry accepts that the preponderance of opinion is in favour of interagency cooperation and acknowledges that much more needs to be done in NSW to bring about a workable and integrated system which can overcome the current barriers and problems which are identified later in this chapter.

Models for Interagency cooperation in NSW

24.55 There is ample precedent in NSW for agencies working together in the course of the management of specific cases at local level. Additionally there have been the several targeted and coordinated responses discussed in more detail elsewhere in this report.

24.56 The question which arises is whether the more intensive coordinated model seen in these instances should be confined to specific projects, or used as the basis for a more general cross government approach that would accord with the expectations of the agencies that were reviewed in the preceding section of this chapter.

24.57 The targeted models that have been successfully trialled in NSW in recent years, share the following characteristics:

a. an exemption from or modification to privacy laws

b. a commitment from senior management

c. a specified target group

d. a clear governance structure.

24.58 These models include the Redfern-Waterloo Case Coordination Project, the Anti-Social Behaviour Pilot Project, the Child Protection Watch Team Trial, the

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[271] D Scott, "Inter-organisational collaboration in family-centred practice: A framework for analysis and action," *Australian Social Work, Vol 58 No.2*, June 2005.

[272] Submission: Barnardos, p.18.

Nowra and Shellharbour Project, the Macquarie Fields Case Coordination Project, the Youth Partnership with Pacific Communities, the Integrated Case Management Programs for Young People of Pacific Islander background or coming from an Arabic speaking background, and their families, the Integrated Case Management Project (West Dubbo) the Schools as Community Centres Program and the Primary Connect Program.

24.59 The Inquiry agrees with the comments made by the Ombudsman that the key issues to be addressed for multi-agency forums to succeed relate to the need to:

a. identify the target group as those who are most vulnerable and require a coordinated response, and to make the response integral to the child protection work of each agency rather than an adjunct of it

b. ensure the complete, accurate, timely and easy access to the information held by the participants of relevance for the families and children targeted by these forums

c. include NGOs, key community groups and local government in local interagency committees and structure processes around case management, to send the message that the government agencies have not adopted a closed shop approach, and to take advantage of the information and advice that NGOs can give and the support they can deliver

d. establish suitable resourcing through specific funding, and dedicated staff resources; supported by clear agreement on the purpose, objectives, governance, reporting and operational procedures of the forums; and also supported by the appointment of coordinator positions to provide secretariat services, record keeping and program continuity, with suitable reporting and monitoring

e. establish a structured framework that brings local managers together to coordinate decision making and to make strategic decisions about agency processes and local service provision.[273]

24.60 It is recognised, however, that the specific projects are resource hungry and depend for their success on several factors including dedicated resources, co-location, joint ethos, brokerage to access programs available outside those of mainstream agencies, good data and case tracking, and accountability.

24.61 The combination of these requirements and resource implications inevitably means that such programs need to be directed towards those communities where the needs of children and families are more pressing. This does not, however, mean that elements of these projects cannot be usefully incorporated into a wider strategy that with suitable legislative changes would overcome the barriers to interagency cooperation next considered.

[273] Submission: NSW Ombudsman, Interagency Cooperation, pp.15-19.

The discordant boundaries of the human services and justice agencies

24.62 The regional boundaries of the human services and justice agencies are not well aligned, as is indicated by the significant differences in the way that the organisational basis of each agency is structured. In summary:

a. DoCS has seven regions, within which there are 80 CSCs

b. Health has eight Area Health Services, each of which includes a diverse range of sub management divisions or clusters, as well as The Children's Hospital at Westmead and the Justice Health Unit

c. Juvenile Justice has five regions

d. DADHC has six regions

e. NSW Police has six Field Operations Regions within which there are 81 Local Area Commands, together with a number of specialist squads that do not have any regional limitations

f. Education has ten regions

g. Housing has four regions.

24.63 The closest alignment of these respective boundaries is that of DoCS and DADHC, the principal difference being that DoCS has three Sydney metropolitan regions for an area that is covered by two DADHC regions. The regional offices of the several agencies mentioned are not necessarily located in the same city or town and, at a regional local level, individual staff may have to deal with multiple access points in order to respond to an emerging problem or an individual case, each of which has a different line of command.

24.64 The NSW Regional Coordination Management Groups (RCMGs) effectively span 10 regional areas. Although they are substantially defined by Local Government Areas, their boundaries are also not contiguous with those of the key human services and justice agencies.

24.65 Attempts have been made in the past to align the regional planning boundaries of the key agencies based on a similar aggregation of Local Government Areas, which were themselves aligned as closely as possible to Area Health Service boundaries, but that has not led to any reorganisation of their institutional structures.

24.66 The current extent of overlap is shown in the following table:

Table 24.5 **Comparison of the boundaries of key NSW human services and justice agencies with DoCS regions.**

DoCS regions (7)	*List of regions that lie within DoCS regional boundaries*

	List of regions that lie within DoCS regional boundaries				
	DADHC regions (6)	*Department of Education and Training regions (10)*	*NSW Health Area Health Services (8)*	*NSW Police Force regions (6)*	*Housing NSW Division (4)[274]*
Western (Central West Orana Far West, Riverina Murray)	Western	Western Riverina New England	Greater Southern AHS Greater Western AHS	Southern Western	Southern & Western NSW
Northern (Far North Coast, Mid North Coast, New England)	Northern	North Coast New England	Hunter & New England AHS North Coast AHS	Northern	Northern NSW
Southern (Illawarra, Shoalhaven, Eurobodalla, Cooma, Queanbeyean, Young and Yass)	Southern	Illawarra & South East	South East Sydney & Illawarra AHS Greater Southern AHS	Southern	Southern & Western NSW
Hunter/Central Coast	Hunter	Hunter and Central Coast	Hunter & New England AHS Northern Sydney & Central Coast AHS	Northern	Northern NSW
Metro Central (Northern Sydney, Central and Southern Sydney)	Met North Met South	Northern Sydney Sydney	Sydney South West AHS South East Sydney AHS Northern Sydney & Central Coast AHS	North West Metropolitan Central Metropolitan South West Metropolitan	Central Sydney
Metro South West (Macarthur, Liverpool, Bankstown and Fairfield)	Met South	South Western Sydney Illawarra & South Eastern Sydney	Sydney South West AHS	South West Metropolitan	Greater Western Sydney
Metro West (Cumberland Prospect, Nepean, Blacktown and Baulkham Hills)	Met North	Western Sydney	Sydney South West AHS	North West Metropolitan South West Metropolitan	Greater Western Sydney

24.67 In its submission, DoCS recognised that attempts to determine common service delivery boundaries across DoCS, Health, DADHC and Housing, had not been successful, and that DoCS staff within one region may need to deal with staff of other agencies from several different regions.

24.68 It noted:

> *Differing Departmental boundaries increases the problem of getting interagency agreement. As a recent example one DoCS Regional Director needed to negotiate regional protocols with three CEOs of Area Health Services, two DADHC regions*

[274] These Divisional boundaries have been approximated.

> *and three DET [Education] Regions. It is estimated that senior regional staff (Regional Directors and Directors, Child and Family) spend up to 30 per cent of their time each week in interagency work.*[275]

24.69 Any examination of the way in which the overall structure for the care and protection of children and young persons operates, should not overlook the contribution of local government and non-government agencies. DoCS has advised the Inquiry that 13.9 per cent of DoCS funded projects were delivered by local government in 2006/07, a sum amounting to approximately $20 million, while NGOs received from DoCS in that year a total sum in the order of $540 million.

24.70 Local government funding is derived through a variety of programs or services, and is applied to a wide range of activities that differ from one local government area to another.

24.71 A similar position applies to NGOs, whose potential reach for service delivery may not coincide with the regional boundaries of the government agencies.

24.72 These circumstances add to the complexity of engaging the local government and NGO sectors in interagency cooperation. Their potential role is however important, and the need for them to be suitably engaged is considered elsewhere in this report.

24.73 The Inquiry recognises that there would be significant difficulties in achieving the kind of wholesale restructure of all of the relevant agencies in a single exercise that would provide a total realignment of their boundaries. However, it is of the view that further consideration needs to be given to the possibility of a progressive realignment.

Cross border arrangements

24.74 Each of the agencies faces a potential difficulty in dealing with families who move interstate, in relation to the continuation of funding for the services they need and in the provision and sharing of information. This has a particular relevance for DoCS where children or young persons who are subject to the parental responsibility of the Minister in NSW move to another state or territory as well as where children in care in another state or territory move to NSW. It adds a further complexity to the boundary issues.

24.75 Provision now exists in Chapter 14A of the Care Act, and in legislation of the other states and territories, for the transfer of care and protection orders, and of care and protection proceedings between jurisdictions. A protocol also exists for these transfers and for interstate assistance. In the case of the transfer and

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[275] Submission: DoCS, Interagency Cooperation, p.10.

subsequent registration of orders, it is necessary that there be a compatibility between the kind of order made in the home jurisdiction and that which would be available under the legislation of the transfer state. Additionally, there are a number of requirements relating to notification of the affected parties and consent.

24.76 Inevitably there are difficulties in dealing with a transient population that is not inclined to assist welfare authorities, or with those people who live in border towns and who tend to move from one side of the border to the other, or seek access to health, education and other services on the other side of the border to their usual place of residence. Some of the problems with residents of border towns of this kind are solved by sensible informal arrangements between local agencies, but as the Inquiry heard in relation to the Toomelah-Boggabilla communities they are not always easily resolved. Otherwise, however, questions can arise as to which state agency should assume responsibility for a case where a report is received from a reporter in one state in relation to a child resident in another state.

24.77 DoCS, at the invitation of the Inquiry, identified the following border obstacles which can be encountered:

a. information can only be lawfully shared between DoCS and child welfare agencies in other jurisdictions: there is no provision to share information with interstate Police, Health or Education authorities or with NGOs

b. reporter details cannot be released to other welfare agencies and there is no system for the exchange of carer details

c. the meaning of compatible interstate order is unclear

d. the implementation of the warrants protocol and in particular, the lack of operational Police procedures to support it renders enforcement difficult

e. the incarceration of parents interstate when their child is the subject of care proceedings in NSW results in the parents not being entitled to Legal Aid and not amenable to a NSW order that they be present at the proceedings.

24.78 The Women Lawyers' Association of NSW submitted that there is a problem attributable to the differences in the types of final orders that are available in each state or territory, it being suggested that some orders may be registered in one state but not in others. As the submission recognised, this problem if it be one, can only be addressed by a national harmonisation exercise.

24.79 Youth Off The Streets similarly suggested that harmonisation of the legislation and improved communications between state and Commonwealth agencies would assist in achieving stronger, seamless and sustained partnerships across borders.

24.80 The Inquiry understands that COAG has endorsed recommendations aimed at improving information sharing about children and families at risk, including carers and has agreed to develop new protocol for information sharing between

Centrelink and child protection agencies and to include Centrelink in the alerts system. DoCS is considering legislative amendments in relation to the compatibility of court orders.

24.81 Otherwise it is accepted that problems can emerge as a result of delays in the exchange of information between the home and transfer states and in the registration of orders in the new jurisdiction. Where that occurs the home authority may be required to maintain the carer's allowance and other entitlements until the transfer is registered. This, however, is not a system problem; rather it is a matter for resolution by the Interstate Liaison Officers of the two agencies.

24.82 While clearly there are differences between the states and territories in relation to the quantum of allowances and in relation to the services that can be provided, and while national uniformity may be a worthwhile long term objective, that is not a matter within the Inquiry's terms of reference.

Privacy and exchange of information

24.83 Critical for interagency collaboration is the existence of a clear and workable structure for the flow of information between agencies in NSW. The lack of that structure has been identified as a major barrier to current interagency work.

Legislative framework

24.84 The legislative framework governing the collection, storage and exchange of child protection information is as follows:

a. The Care Act

b. The *Privacy and Personal Information Protection Act (NSW) 1998* (the PPIP Act)

c. The *Health Records and Information Privacy Act (NSW) 2002* (the HRIP Act)

d. The *Privacy Code of Practice (General) 2003*

e. The *Health Records and Information Privacy Code of Practice 2005*

f. The *Privacy Directions and Guidelines* issued by the Privacy Commissioner, which relevantly include Directions concerning:

   i. the Anti-Social Behaviour Project

   ii. the Redfern Waterloo Partnership Project

   iii. information Transfers between Public Sector agencies

   iv. the processing of personal information by certain Public Sector agencies in relation to their investigative functions.

24.85 Annexure A contains a detailed analysis of the key provisions of each Act or instrument.

24.86 These documents which regulate how information is collected, stored or passed to another agency, form only part of the overall picture. Apart from the General and Health Privacy Codes, Police, Housing and Education have their own Privacy Codes; most agencies have an internal Privacy Management Plan; and the NSW Human Services and Justice CEOs Cluster has issued a document, *Information Sharing for Effective Human Service Delivery*, which although it does not have statutory force was intended to provide some guidance for agencies in relation to sharing information.

24.87 In addition, the legislative instrument pursuant to which individual agencies are established or regulated, often contains a specific secrecy position, the breach of which may constitute an offence,[276] while the staff of several of the agencies will be subject to ethical rules or conventions which are directed towards maintaining client confidentiality. It may also be noted that s.254 of the Care Act which makes it an offence to disclose information obtained in connection with the Care Act, is not confined to DoCS staff.

24.88 Many restrictions arise in relation to the legislation mentioned above, and their provisions may be modified or made inapplicable, either through specific exemptions from the Information Protection Principles or Health Privacy Principles, or through the Privacy Codes of Practice, or through Privacy Directions or Guidelines.

Criticisms

24.89 The complexity of the resulting structure, and its potential impact on the system for the care and protection of children and young persons and specifically for interagency collaboration has been the subject of critical observations from a number of quarters.

24.90 For example the Australian Law Reform Commission in its Final Report on Australian Privacy Law and Practice observed:

> *Inconsistent, fragmented and multi-layered privacy regulation can contribute to confusion about how to achieve compliance with privacy regulation. This, in turn, can result in reluctance by agencies and organizations to share information.*
>
> *The ALRC heard numerous examples of agencies and organizations using 'because of the Privacy Act' as an excuse for not providing information. In many cases, however, the*

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[276] *Children and Young Persons (Care and Protection) Act 1998* s.254; *Housing Act 2001* s.71; *Health Administration Act 1982* ss.20 and 22; *Police Regulations 2000* cl.46; *Children (Detention Centres) Act 1987* s.37D; and the *Crimes (Administration of Sentences) Act* s.257.

> *Privacy Act 1989 (Cth) would not have prohibited the sharing of the information.*
>
> *The complexity of privacy laws is a particular issue in the context of service provision to vulnerable people. The Community Services Ministers' Advisory Council (CSMAC) noted that the range of differing privacy regimes across Australia creates problems for information exchange between jurisdictions, including in the critical area of child protection, where state and territory specific legislation applies. Issues also arise in relation to information exchange within jurisdictions, where some non-government welfare organizations are subject to the Privacy Act, and state and territory agencies must comply with State and Territory regimes. CSMAC noted that this inconsistency creates difficulties in relation to the development of memorandums of understanding and other protocols governing the exchange of information.*
>
> *Inconsistency and fragmentation in privacy laws should not prevent appropriate information sharing. Information sharing opportunities, which are in the public interest and recognise privacy as a right to be protected, should be encouraged. Rather than preventing appropriate information sharing, privacy laws and regulators should encourage agencies and organizations to design information-sharing schemes that are compliant with privacy requirements or, where necessary, seek suitable exemptions or changes to legislation to facilitate information-sharing projects.*[277]

24.91 The NSW Law Reform Commission in a consultation paper issued in relation to its Privacy Reference, made similar observations. Specifically it stated:

> *It is obviously essential to have a simple and practical system for the exchange of information between agencies that promotes the safety, welfare and well-being of children … as the law currently stands agencies or organizations sharing information with each other may be in breach of s.248 of the Care Act or of PPIPA or HRIPA or the Privacy Act or may even be committing an offence under s.254 of the Care Act.*[278]

24.92 It noted that there was a 'risk averse' interpretation of the privacy laws encouraged by:

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[277] Australian Law Reform Commission, *For Your Information Report, Australian Privacy Law and Practice, Report 108, Vol 1*, May 2008, pp.508-510.

[278] NSW Law Reform Commission, Consultation Paper 3, *Privacy Legislation in New South Wales*, 2008, p.32.

> *the difficulties of complying with inconsistent, fragmented and multi-layered privacy legislation, which results in a reluctance by agencies and organisation to share information,*[279]

and commented, additionally:

> *while this can impact on business as a compliance costs, its most serious impact is in the provision of services to vulnerable people, particularly in the area of child protection.*[280]

24.93 In his *Report of Reviewable Deaths in 2005,* the Ombudsman noted concerns about effective use of s.248 of the Care Act[281] and his submission to the Inquiry generally mirrors the views of the two law reform commissions.

24.94 Similar observations were made by the Children's Guardian and the Commissioner for Children and Young People in correspondence with the Inquiry.

Agency concerns

24.95 The Inquiry sought the views of the key human services and justice agencies as to their impression of the extent to which the legislation or cultural impediments operated as a barrier to the sharing of information, and to effective interagency engagement. Each of the agencies that responded reported multiple concerns, and recommended that there be a significant reduction in the complexity of the privacy regime, either by amendment of the legislation, or by the introduction of a new Code of Practice.

24.96 The Area Health Services were particularly vocal in their criticism of the workability of the current system.

24.97 DoCS had similar concerns and offered the following recommendations:

> *That principles underpinning the use and disclosure of information within child protection should be clearly enunciated and both State and Commonwealth legislation amended to be consistent with those principles.*
>
> *These principles should include the ability for those prescribed bodies working within child protection to use and disclose information where this is required, in good faith, for the safety, welfare and well-being of children or young people.*
>
> *Where staff of these agencies do act in good faith then they should not be liable to suffer from any offence or other civil*

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[279] ibid.

[280] ibid.

[281] NSW Ombudsman: *Report of Reviewable Deaths in 2005, Volume 2: Child Deaths,* November 2006.

action such as for professional misconduct, disciplinary action or defamation.

Ensure all staff who have access to information on child protection matters have access to appropriate training and testing in regard to privacy compliance and information exchange and this should be part of risk management processes for each agency.[282]

24.98 Without ascribing the specific items of concern to the individual agencies that responded to the Inquiry's request for their views as to the operation of the privacy regime, they included, in summary, the following observations:

a. The various pieces of legislation or related documents can apply differently to the representatives of individual agencies, even where they are working side by side on the same case.

b. While DoCS can direct other agencies to provide information to it, and can then pass that to another agency, that agency is unable to pass any such information which it receives to another agency, with the consequence that they need to communicate using DoCS as a hub, exercising its power under s.248 of the Care Act. The process can be cumbersome, cause delay and some agencies saw it as exercisable only when DoCS had an open case concerning the child or young person.

c. The "serious or imminent threat to life or health" criterion in s.18 of the PPIP Act, and in Clause 11 of the Health Privacy Principles, is unduly narrow and does not cater for the kind of case where there is progressive abuse and neglect; and its application is complicated by the differences in terminology used and by the subjective test involved.

d. The principal privacy Acts apply to different areas, although with some overlap: the PPIP Act being applicable to NSW public sector agencies, the HRIP Act being applicable to the public and the private sector organisations in NSW that provide a health service or that collect, hold or use health information; and the Commonwealth Privacy Act being applicable to Commonwealth Government and ACT Government agencies and to the private sector (with the result that in some circumstances each Act will apply). The combined effect is unduly complicated, a circumstance that is aggravated by the fact that under the NSW Acts, separate regimes exist for health information and for all other kinds of information concerning individuals.

e. The perceived inability of school principals and of Education, to pass information concerning a report that has been made to DoCS, between schools, can seriously impact on their ability to manage the subject child or young person where he or she transfers to a new school.

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[282] Submission: DoCS, Interagency Cooperation, p.18.

f. The perceived inability of the Police to pass information concerning their investigations into alleged criminal conduct, involving the abuse and neglect of a child or young person, to any other agency which might be required, as the alleged perpetrator's employer, to conduct an inquiry into that person's conduct, can adversely affect its ability to carry out that exercise.

g. The authorisation power for which provision is made in the General and Health Privacy Codes is rarely, if ever used, or understood.

h. So far as Housing is concerned there was no apparent basis upon which it could receive information from other agencies concerning families who are tenants in public housing, which could be of relevance for it in deciding whether to attempt to sustain or to terminate a tenancy.

i. Not all of the agencies have a Privacy Code of Practice, and such Codes of Practice as do exist are not necessarily the same.

j. So far as the Police is concerned, it may not be able, under the current law, to obtain the name of a person who makes a report to DoCS, even though that person may be a critical witness for the investigation and prosecution of a serious criminal offence committed upon a child or young person.

k. The Directions made by the Privacy Commissioner are of limited duration, require extension, are not easy to apply and are not a satisfactory alternative to legislation or to a Code of Practice.

l. The power under s.248 of the Care Act to direct the provision of information, and to provide or exchange information is limited to dealings with 'prescribed bodies', as defined by the Act and the Regulations made under the Act, and as a result may not be exercisable in relation to some persons or agencies that do not come within that definition.

24.99 While many, if not most, of the concerns identified by the agencies in relation to the application of the privacy legislation are probably misplaced as a matter of minute legal analysis, the nature and the volume of those concerns and the extent of the misunderstanding displayed, indicates the impracticability of maintaining the present regime in tact.

24.100 Further, the nature of the privacy laws has had the effect of limiting if not preventing state agencies identifying common high end users. Premier and Cabinet has recently carried out work to identify common clients of state agencies who are high users of services, with a particular focus on victims of domestic violence. In DoCS terms, these are the 'frequently reported families.'

24.101 A preliminary report from that work concluded that while some agencies have put in place structured approaches to data and information exchange, those efforts have been largely ad-hoc and limited by privacy concerns. This is a potentially important piece of work which is likely to ultimately be cost effective. If the privacy laws are amended as recommended in this report, the Inquiry supports further work being done to identify those families and offer appropriate assistance. A recommendation to this effect was made in Chapter 10.

24.102 As a final observation, the Inquiry notes the existence of an early draft for a DoCS Privacy Code of Practice which is ultimately to comprise two documents, an explanatory memorandum and the Code. The text currently runs to 75 pages without the several appendices, which include nine Privacy Directions and three Codes. Its stated purpose is "to simplify and clarify what the Department is able to do with its clients' personal and health information under its own Act and under other privacy and health laws."[283]

24.103 The draft code observes that:

a. in order to allow this to occur the code is to modify the existing information privacy principles under the PPIP Act and HRIP Act, so far as DoCS is concerned

b. it is recognised that the draft code could not regulate what other government agencies can do with the personal/health information they hold

c. it is "considerably different from Codes of Practice currently used in other government agencies."[284]

24.104 While the hope is expressed that it will be a 'one shop stop' for DoCS employees in dealing with privacy matters, the Inquiry notes that in several places it requires or invites hot links to other documents, including various Acts and Regulations, as well as to caseworker manuals, and advises that, where there is an inconsistency with privacy principles under other laws pursuant to which DoCS may carry out various functions, those other laws will prevail.

24.105 The reasons for drafting the code are understandable. However, the sheer length and complexity of this document, its expansion by reason of the cross references to a number of other documents, the caution that where it is inconsistent with laws other than the Care Act those laws will prevail, and the further caution that its provisions will differ from the provisions of the code of other agencies, leads to only one conclusion. In its current format, rather than simplifying the work of DoCS staff in managing privacy issues, it will only make that task even more difficult. It will, in the Inquiry's view, do little to resolve the problems faced by DoCS in exchanging information with other agencies, and its publication would not assist the other agencies.

24.106 There is a legitimate and useful, albeit limited, role which codes of practice can play, primarily to assist staff of the agency concerned to understand their obligations in relation to privacy. Their value in enhancing cooperation and collaboration between agencies in relation to matters of child protection, will only be evident if the provisions of each agency's code of practice are, to the extent legislation permits, consistent.

24.107 A key message of this report is the need for a strong interagency response to child protection, which includes both the government and non-government

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[283] DoCS, *Privacy Code of Practice (Draft),* 2008.
[284] ibid.

sectors. Therefore, it is essential that the current problems in relation to the sharing of information between agencies be resolved. The Inquiry's views as to how this may be achieved are set out in the final section of this chapter. The Inquiry recommends legislative change and notes that the NSW Privacy Commissioner endorses this approach.

Other barriers

Cultural divide

24.108 The Inquiry heard that there are times when the perceived or actual differences in the focus of Health and DoCS workers leads to conflict between the agencies.

24.109 The existence of this cultural divide was identified by the Northern Sydney Central Coast Area Health Service:

> *Some Health Services – eg, services working predominantly with adults clients – are reluctant to provide full information in response to s.248 as they are protective of their counselling relationship with client.*
>
> *Organisations who take a strong advocacy role with their adult clients often are reluctant to exchange information with DoCS or other services working with families to address child protection issues. This is true of both NGOs and some services within Health.*
>
> *Some client groups are also suspicious and unwilling to agree to information to be exchanged with DoCS – Indigenous families and some cultural groups who come from countries where human rights abuses occur are examples.*
>
> *Example: adult mental health services until recently asked about the welfare of animals but not children when engaging seriously unwell clients. Any information that is known is often not communicated as it is seen as a breach of confidentiality and/or may lead to what is perceived as a punitive response to parents already struggling with mental health and/or drug use.*[285]

24.110 This was also a matter taken up by the Greater Southern Area Health Service in a letter to the Inquiry:

[285] Correspondence: Northern Sydney Central Coast Area Health Service, 8 May 2008, pp.6-8.

> *While the welfare of children is always the paramount consideration, in situations where a child is identified as at risk of harm in a public hospital or through a community health service the interests of their carers or attendants must also be addressed sensitively. In many instances – for example, in the case of domestic violence – a carer may him or herself be a patient of the hospital or client of the health service. The simple question "who is my patient/client?" is in many cases difficult to answer, and may lead to concerns about disclosing information that may be relevant from a child protection perspective.*
>
> *Health care workers and social workers have a longstanding ethical tradition of maintaining confidences. Full and frank exchange of information between agencies in relation to child protection matters does not always sit easily with that tradition. These sensitivities will need to be addressed in any law reform proposals.*
>
> *A shift in thinking from formal 'agency-to-agency' exchange of information to one in which relevant information is sensitively 'shared' between multi-disciplinary and multi-agency care and service providers may go some way in overcoming these sensitivities.*[286]

24.111 The potential impact of any cultural divide of this kind on interagency work is significant and needs to be addressed, by way of training, preferably of an interagency kind, and by emphasising in the Interagency Guidelines or otherwise that interagency work must give full effect to the paramount interests of the child.

24.112 In Chapter 10 the Inquiry has detailed a way forward in relation to assessment and interventions by DoCS and other agencies that may assist in breaching this cultural divide.

Lack of a common assessment framework

24.113 Earlier in this report we have examined the potential, and reasons, for developing a common assessment framework. Such a framework, as recommended, should assist in agencies working more effectively together.

Lack of coordinated structure for interagency meetings at a local level

24.114 While the Regional Directors of the human service agencies seem to meet on a regular basis to consider system issues, the Inquiry was informed of varying but

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[286] Correspondence: Greater Southern Area Health Service, 2 April 2008, pp.4-5.

inconsistent practices and strategies that were adopted for bringing agencies together at a local level outside the pilot and specific projects that were mentioned earlier in this chapter. Some were ad hoc and depended on the initiative of Local Area Commanders or senior DoCS staff at a CSC, such as, the domestic violence initiative at Ballina that was mentioned earlier, and the Aboriginal Alcohol and Drug Harm Reduction Plan under development at Griffith involving Police, DoCS, the Griffith City Council, Health and a number of Aboriginal organisations.

24.115 Others were more formalised and regular, but some involved only two or a limited number of human service agencies at a local or regional level, and concentrated on general issues and strategies.

24.116 Otherwise it would appear that agencies have tended to meet together only in the context of joint case planning, or on a needs basis, involving a family or group of families in crisis.

24.117 There was support at the Inquiry's regional interagency meetings in which problem families, or families moving into a state of dysfunction, could be discussed, on an interagency basis, so as to provide an early response, modelled on the lines of the Anti-Social Behaviour Pilot Project.

24.118 A valid point made by an officer from DADHC, but repeated at more than one interagency meeting, was "the service system shouldn't just be about an agency service system. A service system for a family should be about the resources that a family needs."[287] In other words, it was pointed out, when a family approaches a government agency for assistance it expects, and is entitled to receive not just the services which the agency can provide which might address only one of several problems, but the range of relevant services which are available across the several government agencies.

24.119 There was general agreement that where these meetings were attended at a local level on a continuing basis by sufficiently senior staff, they were productive and brought the agencies into a better working relationship. The problems they identified largely related to potential differences in the interests or objectives of each agency, the identification of which agency should lead the meetings, and the provision of sufficiently senior officers on a continuing basis. In the case of an agency such as Housing, this could be difficult because of its staffing structure which involves a 'hub and spoke' outreach service.

24.120 Another problem regularly identified with these meetings, in whatever form they took, was the current restriction on the free exchange of information in relation to individual families and children. A need for clarity was also mentioned in relation to the keeping of minutes and the extent to which they should be circulated and used.

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[287] Transcript: Interagency Meeting, Bourke, 5 March 2008, p.36.

24.121 Having regard to the encouraging results of the Anti-Social Behaviour Pilot Projects, and the experience of those who have worked together on an ad hoc basis in developing a cross agency response, the Inquiry is of the view that this type of model should be encouraged both at the local and regional levels and given a more formal structure. This will require:

a. a commitment to provide an interagency response
b. building on existing interagency relationships where they are sound
c. providing a governance and leadership structure
d. establishing a proper basis for the sharing of information
e. securing a commitment for each agency to support the interagency group and to provide ongoing representation at a senior level
f. developing guidelines as to the families or activities to be targeted, and the strategies for providing a response.

Requests for assistance

24.122 As has been noted earlier DoCS can request another government department or agency, or an NGO in receipt of government funding, to provide services to a child or young person or to his or her family.[288]

24.123 The other agency is required to use its best endeavours to comply with such a request if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its own functions.

24.124 The Inquiry was informed that there were variable practices in relation to the exercise of this power, and of the responses to such requests; even though it can be an effective way of enlivening an interagency engagement with the client.

24.125 DoCS does not hold data on the number and nature of responses to requests made by it. However, data from Health as set out in Chapter 5, reveal that few requests to it have been documented.

Agency funding arrangements

24.126 Additional complexity has arisen where programs or individual NGOs engaged in interagency activities are funded through difference sources, which can involve money from state government instrumentalities and/or Commonwealth bodies, and can be subject to different funding cycles. Sometimes these programs involve trials having a limited duration, and specific funding.

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[288] *Children and Young Persons (Care and Protection) Act 1998* s.17.

24.127 Continuity of engagement in interagency work can be threatened where there is a need to depend on multiple sources of funding which are subject to the control of more than one body. Suggestions for change are made in Chapter 25.

Models of interagency collaboration from other jurisdictions

24.128 There are a range of other models for interagency collaboration that were identified in the submissions received by the Inquiry. Some of these which may have features applicable to NSW, are set out below.

Queensland

24.129 A key mechanism referred to in a number of the submissions was the Queensland Suspected Child Abuse and Neglect (SCAN) Teams.

24.130 SCAN teams commenced operation in Queensland in 1980 to provide a formal mechanism to coordinate the activities of the various government departments in relation to child abuse and neglect. The SCAN system currently includes 21 assessment and management teams staffed by professionals from Police, Health and the Department of Child Safety. Staff from other agencies (such as juvenile justice and education etc) can be co-opted for SCAN teams if required. The SCAN team provides a forum for formal consultation on child protection matters where there is a need for a multi-disciplinary approach. While the establishment of the SCAN system is mandated in legislation (Queensland *Child Protection Act, 1999, Part 3*) SCAN teams do not have any distinct decision making authority. The individual agencies retain responsibility for actions in accordance with their legislative authority.

24.131 SCAN teams meet regularly, not just in times of crisis or where conflict between agencies arise. There are mechanisms to monitor compliance of each agency with assigned tasks in relation to specific case plans for children and families. The threshold for referral to the SCAN team does not depend on the case being a high need or complex case.

24.132 A review of the SCAN model planned for 2008 aims to examine issues of interagency collaboration including practice consistency, workload and agency commitment to SCAN. Particular areas of focus for review include: agency adherence to agreed referral criteria; commitment from all agencies to ensure representation from appropriately qualified experienced staff; effective gatekeeping mechanisms to ensure SCAN is not used as a forum when interagency partners are dissatisfied with the Queensland Department of Child Safety's tertiary response; and ensuring that SCAN teams focus on children at risk, rather than children in need.

24.133 Queensland has also sought to improve interagency collaboration in child protection matters through the establishment of dedicated Child Safety Director

positions in the major agencies involved in child protection. The role of the Child Safety Directors is to improve the responsiveness of their own department in meeting the needs of children and families that require child protection services, to act as a change agent and expert adviser on child protection matters, to ensure cross department communication and to drive the implementation of whole of government initiatives. The Child Safety Directors meet regularly through the Child Safety Directors Network, chaired by the Deputy Director-General, Department of Child Safety, to help ensure coordinated child safety responses across Government.

South Australia

24.134 In 2005 South Australia introduced the Rapid Response initiative, an interagency response to the needs of children in OOHC and those formerly in that system. The strategic framework encompasses case management assessment, service response, information sharing and privacy, and regional guardianship service networks. It is directed at providing a more effective response and priority access to services for children and young persons who are growing up, or have grown up in care, and who are likely to have several areas of disadvantage compare to their peers.

United Kingdom

24.135 The UK differs from Australia in that, in the former, responsibility for providing social services and education lies at the local or regional authority level rather than at a central government level. The health system is also structured differently.

24.136 There are, however, some useful mechanisms that have been introduced through legislation in the UK to enforce interagency responsibility.

24.137 In 2003, issues similar to those raised with this Inquiry were evident in the UK system, that is, poor interagency coordination and a failure to share information. In 2006, Local Safeguarding Children Boards, which included local authorities, non-government services, health bodies, the police and others were established. Under s.14(1) of the *Children Act 2004 (UK)* the Boards:

> *(a) coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and*
>
> *(b) ensure the effectiveness of what is done by each such person or body for those purposes.*

24.138 While the Boards have a role in coordinating and ensuring the effectiveness of the work of local individuals and organisations to safeguard and promote the welfare of children, they are not accountable for their operational work. All

Board partners retain their own existing lines of accountability for safeguarding and promoting the welfare of children by their home services. The Boards do not have a power to direct other organisations.

24.139 The Department for Education and Skills completed a Priority Review of the operation of Local Safeguarding Children Boards between September and December 2006.[289] This Review noted that while it is too early to see the full impact they will have, there is good reason to be optimistic about their potential to make a difference, especially if good practice is more widely shared. Findings from this review included the following:

a. The evidence emerging from the Priority Review suggests that the launch of Boards has given local cooperation on safeguarding a new energy. In some areas the statutory footing for the Boards appears to be raising the profile and ownership of safeguarding across local agencies. It is also being used locally as a lever to ensure statutory partners provide resources and attend board meetings.

b. Statutory partners were generally represented on, and showing commitment to their Boards although, in some areas, levels of engagement varied.

c. There was little evidence of Strategic Health Authority involvement, but this was likely to reflect the fact that they were in the process of substantial changes in their role and a decrease in their number from 28 to 10 authorities.

d. Most Boards were chaired by the Director of Children's Services or another local authority employee although several were considering appointing an independent chair.

The way ahead

24.140 As identified in the submissions made to the Inquiry, the need for greater collaboration and ownership of the safety, welfare and well-being of the children and young persons, is widely recognised, as are the barriers to achieving that collaboration. The solutions have been well articulated and the Inquiry agrees with the principles enunciated by the Ombudsman and with the areas which he sees are particularly suitable for cross agency work, as set out earlier in this chapter.

24.141 The Inquiry suggests that the following legal and structural changes may enhance outcomes for children through services for them being better coordinated and delivered.

[289] Local Safeguarding Children Boards: A Review of Progress, p.5, www.everychildmatters.gov.uk.

A statutory obligation

24.142 There should be a strengthening of the obligation of individual agencies to work in partnership in relation to the care and protection of children and young persons, by the introduction of specific legislative provisions calling for that commitment. Such provisions would add significantly to those currently contained in the Care Act (ss.16–18) which, at this stage, place the primary obligation upon the Director-General of DoCS, and contemplates the engagement of other agencies to provide services in response to 'best endeavours' requests made by it.

24.143 A general provision including an object or principle clause in the founding statute of each agency would need to respect their independence and their capacity to provide, or to refuse, services according to current Ministerial policy and budgetary resources. However, a statutory recognition of their obligation to assume a shared responsibility in this area would help to underpin the Interagency Guidelines and the MOUs. It would also help to overcome the current risk of agencies either positively endeavouring to shift responsibility to another agency, or of refraining from action upon an assumption, which may be unjustified, that another agency will take up the case.

24.144 It would also discourage the defensive approach which agencies can adopt, as a response to inquiries or adverse media commentary, in seeking to ascribe blame for any adverse outcome to another agency.

24.145 The Queensland *Child Protection Act 1999* contains provisions to a similar effect and provides a useful guide (see ss.159B, F and M). That Act requires chief executives of human service agencies, including principals of schools, to take reasonable steps to coordinate decision making and the delivery of services to children and their families, in order to appropriately and effectively meet the protection and care needs of children. Various principles are set out which assist in the interpretation of these provisions.

Child protection positions/units in each key agency

24.146 As set out in Chapter 10 positions should be established in each of the key agencies providing assistance to children and young persons, to be staffed by people with child protection expertise and to have responsibilities for:

a. triaging risk of harm reports

b. case managing or coordinating services for those children, young persons and their families who need assistance but where risks do not require statutory intervention as defined under the Care Act

c. more broadly, ensuring communication with other agencies, primarily the human services agencies and relevant NGOs, and providing advice to the Human Services and Justice CEOs Cluster of any problems or emerging trends concerning interagency collaboration.

Leadership and performance agreements

24.147 All Directors-General of the human services and justice agencies are, and should be, responsible for ensuring that their agencies commit to and deliver a collaborative approach to child protection matters. Their leadership is essential. There should be a performance requirement in each employment agreement of senior staff of each agency to ensure that interagency collaboration is achieved. In relation to DoCS, the Director-General, Deputy Director-General and Regional Directors, should be subject to such a requirement to achieve effective interagency cooperation.

Align boundaries

24.148 The boundaries of key human services and justice agencies should be aligned.

Senior executive responsibility

24.149 A member of DoCS senior executive should be responsible for interagency engagement. The present structure in this respect is somewhat ambiguous, and any ultimate decision as to where that position should be located will turn upon the extent to which the current management structure is re-jigged to accord with a new reform process. The tentative view of the Inquiry is that interagency coordination responsibility should sit within the Operations Division, perhaps at Executive Director level.

Regional and local coordination

24.150 Structures need to be strengthened which require regular interagency meetings at the regional and local levels. In addition, CSCs should be provided with detailed and up to date information about the range of services available within their catchment area, not only as a way of encouraging networking but also as a strategy to deal with the problem of staff turnover and transfers.

24.151 In most regions there are Human Service Senior Officers' Groups chaired generally by the DoCS Regional Director with support from Regional Coordinators from Premier and Cabinet. These seem to be an appropriate model for regional meetings, although they may need to operate differently in rural and remote regions. Local interactions will depend to some extent on the size, location and range of issues. Senior managers should ensure sufficient, relevant structures are in place and that local child protection forums are established that involve all key government and non-government agencies providing services to at risk children and families.

24.152 These regional groups need to have formal accountability reporting and linkages with the Human Services and Justice CEOs Cluster and the Child Protection Senior Officers' Group.

Co-location

24.153 Co-location and 'hubs' should be used to greater effect to develop relationships, to enable more efficient communication and information sharing, to increase the understanding of each agency's mandate, procedures, knowledge and skills and to integrate and streamline service provision. The Inquiry supports the model being developed by UnitingCare Burnside in relation to early intervention services:

> *Co-location is helpful and convenient to families, and is also helpful to workers who can more easily communicate and form professional, trusting relationships. We would go further and look to an integrated, place-based service system with family support and early childhood development, including health services and early childhood education and care fully integrated under a common governance model and with a single management. We are actively developing this model. We are opening an integrated child and family centre soon in St Mary's (a disadvantaged suburb in Western Sydney). We are placing a NEWPIN service alongside a quality children's long day care centre and we are offering a community connector to work with families to access the supports they need in the local area. NSW Health (amongst others) will be invited to deliver their services from this convenient base. Other service providers will 'in-reach' at the centre.*[290]

24.154 The Inquiry also sees benefit in promoting the greater use of the Schools as Community Centres model, which is funded through Families NSW. The purpose of the Centres is to operate as hubs for family support and development. Having a point of contact at these locations can allow a softer and coordinated entry into services for those families who need assistance, but who have not reached the stage of statutory intervention.

24.155 The potential value of hubs with co-located workers in remote areas was raised as a way or responding to workforce issues in those regions, possibly with a single reporting line. In particular this could prove of value in recruiting and in providing career development for Aboriginal staff who could be responsible for ensuring and facilitating the delivery of services by more than one agency.

24.156 The creation or greater use of government precincts is also worthy of exploration.

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[290] Submission: UnitingCare Burnside, 19 May 2008, p.7.

Cross agency training

24.157 The Inquiry supports cross agency training. It notes that while the Child Protection Learning and Development Coordination Forum still exists and is led by Education, the unit which delivered cross agency training was disbanded in 2005.

24.158 The work of such a unit would capable of addressing the cultural divide exemplified by the notion that Health is there to support the parent while DoCS is there to support the child.

24.159 It would also assist in building a better understanding by the staff of the several agencies as to the services which each can offer, and how they can work together, and in ensuring that the staff of all agencies are kept up to date with any changes to MOUs or to agency practices.

24.160 The Inquiry is of the view that consideration should be given to its revival, or to the establishment of a similar program. Such a program could possibly take its place within the Education Centre Against Violence Project. Alternatively and perhaps preferably, it could be delivered through the TAFE career development strategy, Pathways, and by permitting staff to acquire additional qualifications or enhanced accreditation. Moreover, it could incorporate or build upon the work that has been undertaken by DoCS and Health towards establishing cross agency drug and alcohol training.

Involving the NGO sector

24.161 The Inquiry has noted the limited extent to which the NGO sector has been involved in the development of the MOUs or Protocols that are intended to assist the government agencies working together.

24.162 The need for their greater involvement is acknowledged by the *Working Together for NSW* compact, and is obvious once consideration is given to the extent that NGOs are funded to provide services. This service provision will only increase if the recommendations of this Inquiry are accepted.

24.163 The Inquiry accordingly supports the Government encouraging a greater involvement of this sector as a partner in interagency arrangements, and in future planning. It also supports the work earlier identified that is addressed at improving the sustainability of this sector.

24.164 In this respect the positive experience of the multi-disciplinary models such as those employed by Barnardos Child and Family Centres, UnitingCare Burnside Family Centres and the Benevolent Society Partnerships in Early Childhood Centres, as well as the Barnardos Substance Use in Pregnancy and Parenting Services which it operates in conjunction with NSW Health and DoCS, and the UnitingCare Burnside NEWPIN Early Intervention Family Support Program

which it operates in conjunction with NSW Health, provide support for their continued engagement within an interagency context.

24.165 Although this is discussed elsewhere, the Inquiry is satisfied that increasing the engagement of the NGO sector in early intervention and OOHC requires performance based contracting, and a simplification or rationalisation of the funding process.

Privacy and information exchange

24.166 An essential key to achieving the kind of effective interagency involvement, considered in this chapter, is the capacity of agencies to exchange information concerning a child or young person, or their family.

24.167 The complexity of the legal and administrative framework governing the exchange of information is such that, once each of the various sources has been examined, it is still not possible to formulate any general rules as to when the exchange of child protection information will be lawfully permitted. Whether a particular exchange is lawful will depend on the circumstances of the exchange, the content of the information that is being exchanged, the agencies between which the information is being exchanged, and sometimes on whether consent has been obtained from a person who is the subject of that information.

24.168 While there was general consensus as to the need for a revision and simplification of the laws relating to the exchange of information, there were differing views as to whether this should be addressed by amendment of the privacy legislation, or by amendment of the Codes of Practice, or by additional Directions.

24.169 While the Australian Law Reform Commission has issued a final report in relation to the Commonwealth, State and Territory privacy legislation, and the NSW Law Reform Commission is working on its final report, the references given to each agency extend well beyond the area of interest for this Inquiry. The likely timeframe for the introduction of uniform privacy legislation of general application, or for the amendment of the NSW laws, arising from the work of the two Law Reform bodies is likely to be lengthy.

24.170 The Inquiry is of the view that the urgency of reform in the application of these laws to the care and protection system is such that it should not await a more general reform.

24.171 While this could occur by way of amendment to the PPIP Act or the HRIP Act, or the Codes of Practice, the resulting structure would still be one of some complexity, while the issue of Privacy Directions is a clumsy, ad hoc solution.

24.172 The Inquiry believes that the answer lies in amending the Care Act in a way that would achieve the desired objective and be relatively simple in its interpretation and application. In coming to this conclusion it acknowledges that it has paid

careful attention to the solution offered by the Ombudsman in his submission to the Inquiry.

24.173 Amendment to the Act should achieve the following objectives:

a. The several agencies including NGOs, that have responsibilities for the safety welfare and well-being of children and young persons, should be able to share information without needing to rely on DoCS as an intermediary, where that information is required to promote the safety, welfare and well-being of any such person.

b. The Care Act should incorporate a statement of principle making it clear that agencies with significant responsibilities of the kind mentioned, are expected to communicate with other agencies having the same responsibilities.

c. In order for a person or agency to exchange information with another agency or with an NGO, that person or agency should believe, reasonably, that such exchange would assist the other agency or NGO to make a decision, assessment, plan, or investigation relating to the safety, welfare or well-being of a child or young person.

d. Agencies should have business plans to support the implementation of such a system.

e. Appropriate thresholds should exist to ensure that the information exchanged is not used or further disseminated or disclosed for any purpose that is not associated with the safety, welfare and well-being of a child or young person, *inter alia* to ensure that information which is untested or unverified is not given any further exposure than is necessary for genuine child protection purposes.

f. Existing protections from civil and criminal liability and ethical requirements should attach where information is exchanged in accordance with these requirements.

g. Agencies should be able to supply to Police information as to the identify of a reporter, that would enable Police to investigate a serious indictable offence committed against a child or young person which directly affected that person's safety, where it was impractical to obtain the consent of the reporter, or where obtaining that consent had the potential to prejudice the investigation, subject to an appropriately senior person certifying that those conditions are present.[291]

h. Principals of schools should be able to exchange details of risk of harm notifications, where there are ongoing concerns about the safety and welfare of students who have moved between schools.

i. The Police should be able to supply information concerning their investigations into criminal offences, involving the abuse of children and

[291] Thereby enlarging the circumstances for disclosure currently permitted under s.29 of the *Children and Young Persons (Care and Protection) Act 1998*.

young persons, to the employers of the alleged perpetrator where the latter would be under a statutory obligation to report to the Ombudsman and to investigate an allegation of such conduct concerning that person.

24.174 In his submission, the Ombudsman proposed a three tier system which would:

a. permit DoCS as a first tier agency to direct another agency to supply information to it and to supply information to another agency, as currently is the case

b. establish a tier two class of agencies having a significant involvement with vulnerable children and their families, with a power to furnish other agencies with information and to request but not direct its supply from other agencies

c. specify a third tier class of agencies or individuals that would be able to furnish information to tier one or two agencies and to receive information from a tier one or two agency

in any such case without any of the participants being in breach of s.254 or of any other privacy law.

24.175 At this stage, the Inquiry has concerns that this three tiered system may become unduly complex in its administration and require an elaborate ongoing process for classification of agencies falling within tiers two or three.

24.176 For the purpose of this report, the Inquiry prefers to make a more general recommendation concerning the need for an amendment of the Care Act that would deliver the essential elements outlined above. Further development would benefit from input by each of the key agencies in conjunction with the Privacy Commissioner and the Ombudsman and by reference to Chapter 5A of the *Child Protection Act 1999 (Qld)*.

24.177 In addition, the Inquiry supports the recommendations endorsed by COAG to improve information sharing on children and families at risk.

Recommendations

Recommendation 24.1

The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons.

Recommendation 24.2

Each human services and justice agency CEO should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.3

The Director-General, each Deputy Director-General and each Regional Director of DoCS should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.4

The boundaries of key human services and justice agencies should be aligned.

Recommendation 24.5

Cross agency training should be delivered in relation to interagency collaboration and cooperation in delivering services to children and young persons.

Recommendation 24.6

The *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person in accordance with the principles set out in Chapter 24. The amendments should provide, that to the extent inconsistent, the provisions of the *Privacy and Personal Information Protection Act 1998* and *Health Records and Information Privacy Act 2002* should not apply. Where agencies have Codes of Practice in accordance with privacy legislation their terms should be consistent with this legislative provision and consistent with each other in relation to the discharge of the functions of those agencies in the area of child protection.

Recommendation 24.7

An improved structure should be established for regular regional meetings between the key human services agencies and NGOs to facilitate collaborative cross agency work, and to be accountable to the Human Services and Justice CEOs Cluster.

25 DoCS funded non-government services

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Introduction

25.1 NGOs are significant players in the delivery of child protection services in NSW, across the continuum of universal, secondary and tertiary services. They range in size from small not for profit groups managed by volunteer committees, to multi-million dollar enterprises. Many receive funds from a variety of sources: local, state and Commonwealth tiers of government and, within each tier, from more than one division or department. They are organised into peak bodies, which, generally are funded by the state to act as a conduit for communication with government on behalf of their members.

25.2 Child protection could not be delivered without them in NSW. The questions for the Inquiry are whether their reach could and should be extended, and whether the system by which they are funded is sufficiently efficient and effective for the purpose.

The system

The funding

25.3 DoCS currently funds approximately 1,850 organisations to deliver over 3,600 projects or services. Over 80 per cent of these services are delivered by not for profit non-government organisations. More than 15 per cent of these services are delivered by other state government agencies (56) and local councils (491). The few remaining services are delivered by a small number of for profit organisations, most of which provide OOHC services under Header Agreements. DoCS advised that an accurate estimate of the services offered by for-profit organisations is not possible without a comprehensive analysis of funding records.

25.4 In terms of size, NGOs can be categorised as follows:

a. micro-organisations receiving funding of up to $100,000 per annum

b. small organisations receiving funding of over $100,000 and up to $1 million per annum

c. medium sized organisations receiving funding of over $1 million and up to $10 million per annum

d. large organisations receiving funding of over $10 million per annum.

25.5 Almost 40 per cent of DoCS' external services budget is paid to 20 large organisations. Around 12 medium sized organisations each receive funding of between $2 million and $10 million per annum, and the remaining budget is allocated to a significant number of small and micro organisations.

25.6 DoCS has informed the Inquiry that there are 55 special rural and remote projects which it funds, representing 1.5 per cent of all funded projects. It has

also advised that it funds 369 projects (9.8 per cent) for Aboriginal clients and 211 projects (5.6 per cent) for CALD clients.

25.7 The following case studies illustrate the complexity of the current funding environment for the non-government sector.

Case Study 27

UnitingCare Children, Young People and Families (UnitingCare) is a large non-government organisation providing a range of services to children, young people and their families across NSW. UnitingCare Burnside forms part of this organisation.

In 2007/08, UnitingCare received over $30 million in Commonwealth and NSW Government funding.

This involved dealing with 11 different government agencies to negotiate 58 service agreements for 104 services.

Of these service agreements, 12 were negotiated with DoCS to fund 59 services across 10 different DoCS funding programs. Six services had separate service agreements, while the remaining 53 services came under six umbrella service agreements for particular areas of the State. For example, UnitingCare has a Metro South Western Sydney Service Agreement with DoCS that covers 15 services.

All the 104 services that received funding had separate reporting requirements. Each required a minimum of annual reporting, with 37 also requiring either quarterly or six monthly reporting.

Case Study 28

Southern Youth and Family Services is a medium sized non-government organisation providing a range of services to young people and their families in southern NSW. The agency covers the four local government areas of Wollongong, Shellharbour, Kiama and Shoalhaven.

In 2007/08, Southern Youth and Family Services received over $7 million in Commonwealth and NSW Government funding.

This involved dealing with eight different government agencies to negotiate 20 separate service agreements, one for each service that received funding. Of these service agreements, six were negotiated with DoCS across four different DoCS funding programs.

All the services that received funding had separate reporting requirements. Each required a minimum of annual reporting, with six also requiring either

quarterly or six monthly reporting. Monthly or quarterly data entry was also required for 12 of the services.

25.8 Clearly, negotiating, administering and reporting on multiple funding contracts with multiple agencies, many with different contractual and reporting requirements or different funding cycles or terms is at best an administrative challenge for NGOs. Managing a system with multiple contracted suppliers and drawing on separate funding streams, similarly can absorb significant resources so far as DoCS is concerned.

25.9 The Inquiry understands that as part of its funding reforms, DoCS has commenced rationalising the number of separate service agreements it has with each of its funded services, starting with larger NGOs. This is evidenced in Case Study 27 where UnitingCare is funded to provide 59 separate services through 12 service agreements. The Inquiry supports moves to rationalise the number of separate service agreements that NGOs are required to negotiate with DoCS. However, the Inquiry believes much more is required to rethink fundamentally the way in which these NGOs are funded. This is addressed later in this chapter.

The programs

25.10 DoCS has funding contracts with external service providers under the key funding programs detailed in Table 25.1.

Table 25.1 **DoCS key funding programs and 2007/08 funding**

DoCS funding program	2007/08 funding
Brighter Futures program	$123.5 million over three years
Out-of-Home Care Program	$164.4 million
Children's Services Program (CSP)	$116 million
Supported Accommodation Assistance Program (SAAP)	$120.8 million
Community Services Grant Program (CSGP)	$79 million
Families NSW	$29.6 million
Better Futures Program	$4.6 million
Aboriginal Child, Youth and Family Strategy (ACYFS)	$4.7 million
Area Assistance Scheme (AAS)	$8.7 million
Alcohol and Other Drugs Program (AODP)	$4.2 million

25.11 There appears to be significant duplication across the funding programs both in terms of the target client groups and the different services and activities funded as the following table illustrates.

Figure 25.1 **Key types of services and activities funded through DoCS funding programs**[292]

Services/ activities	*Brighter Futures*	*Families NSW*	*CSGP activities*	*CSP*	*AODP*	*Better Futures*	*ACYFS*	*AAS*	*SAAP*	*OOHC*
Volunteer home visiting	♦	♦								
Professional home visiting	♦									
Supported playgroups	♦	♦					♦			
Parenting programs	♦	♦	♦				♦	♦		
Family support services[293]	♦	♦	♦		♦		♦			
Family preservation			♦							♦
Family worker		♦	♦				♦			
Family counselling			♦				♦		♦	
Case management	♦		♦		♦		♦		♦	♦
Youth focused support services			♦		♦	♦	♦	♦		♦
Youth worker			♦			♦	♦			
After school/ youth activities			♦			♦	♦			
Alcohol and other drug support services			♦		♦					
Sexual assault services			♦							
Mobile children's services				♦				♦		
Toy library				♦				♦		
Community capacity building		♦	♦				♦	♦		
Community development worker		♦	♦				♦	♦		
Child protection services			♦							
Information and referral		♦	♦		♦					
Crisis accommodation									♦	♦
Supported accommodation									♦	♦
DV support services			♦						♦	

[292] DoCS*, Annual Report 2007/08,* section 8: Funded Services, pp.163-223.

[293] DoCS funds agencies to provide 'family support services.' The actual services provided to clients is based on their needs and can, for instance, include a mix of counselling, home visiting and case management. DoCS also funds agencies to specifically provide such services, as illustrated in the table.

Services/ activities	*Brighter Futures*	*Families NSW*	*CSGP activities*	*CSP*	*AODP*	*Better Futures*	*ACYFS*	*AAS*	*SAAP*	*OOHC*
Women's refuge									♦	
Youth refuge									♦	
Foster care										♦
Residential care										♦
Temporary care										♦
After care										♦
Long day care				♦						
Vacation care				♦			♦	♦		
Preschool				♦						
Occasional care				♦						

25.12 Universal children's services funded by DoCS, with the exception of vacation care, are funded solely through the Children's Services Program. At the other end of the care and support continuum, tertiary OOHC and crisis accommodation services are funded exclusively through the SAAP and the OOHC program. Leaving aside these three funding programs, there is obvious duplication in service funding across the remaining DoCS funding programs that deliver universal, targeted, secondary and some tertiary services, for the most part with an early intervention focus.

25.13 There appears to be a particularly pronounced duplication in relation to the types of services funded under the Brighter Futures, Families NSW, CSGP and ACYFS Programs that target vulnerable families. In the case of the latter funding program, the target client group is Aboriginal specific. There is also duplication evident between the CSGP, Families NSW, AAS and ACYFS funding programs in the area of community capacity building where disadvantaged communities form the target client group.

25.14 The CSGP also funds a range of secondary services targeting youth and a smaller number of tertiary services targeting women, children and young persons who have been abused or have been the victims of domestic violence. Secondary youth services are also funded through the ACYFS, Better Futures and the AAS programs. There is limited duplication in the source of funding for tertiary services, with the exception of drug and alcohol support services which are also funded through the AODP, and domestic violence support services which are also funded through SAAP.

Funding reform

25.15 In advice to Government in March 2008, DoCS noted:

> *In 2002, there was no clear relationship between funding and outcomes for clients or even numbers of client services provided. Allocations of funding across services was inconsistent. Services provided virtually no data by which DoCS could manage their performance or hold them accountable. Alterations to funding by DoCS would often prove highly politically sensitive. Because of these vague boundaries, there was often confusion between the concepts of funding for essential services to clients (such as foster care) and 'grants' to NGOs.*[294]

25.16 The DoCS Funding Policy, published in August 2005, signalled a move away from 'historical' or grants based funding to the funding of services based on achieving:

a. a focus on outcomes for clients and communities

b. greater flexibility for service providers in integrating services and matching them to clients

c. better management of service risks and sharing of management responsibility

d. value for money and use of savings to improve services

e. longer term funding (where appropriate)

f. accountability for funding

g. rewards for enhanced performance

h. consistent yet flexible processes and practices.[295]

25.17 To implement its funding reform principles, DoCS has commenced a process of introducing the following three key elements into its funding programs:

a. Performance based contracting which links funding to results and gives services the opportunity to demonstrate the benefits of the services they provide.

b. Strengthening the service system to increase the capacity of different community services and to help build a robust service delivery system.

c. Diverse funding options, with the aim of ensuring that DoCS selects the service provider that is best placed to deliver the service required.

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[294] Information provided to Government by DoCS, March 2008.

[295] DoCS, *Funding Policy*, August 2005, p.5.

25.18 These funding reforms represent a significant cultural shift for both funded services and for DoCS staff. DoCS has acknowledged to the Inquiry the concerns expressed by the NGO sector about the operational impact of these reforms, and as a result, has planned a staged implementation of the new policy to allow the NGO sector time to adjust to the changes.

25.19 Since 2005, as additional funding has become available, outcome based service specifications and performance based contracting have been part of the funding and contracting process. In the case of existing funding programs that have received no additional funding, the implementation of funding reform is more gradual. DoCS has advised that performance based contracting will be used across all of its funding programs by the end of 2010.

25.20 Fundamental to performance based contracting is the collection of accurate data about client and community needs and the establishment of a monitoring process to ensure that funded services are meeting those needs. DoCS acknowledged that this is a cost to the sector.

Competitive tendering

25.21 To identify service providers for the Brighter Futures program, DoCS undertook a competitive tendering process using a two-staged Expression of Interest (EOI) in 2005. The DoCS information package for the Brighter Futures EOI indicated a preference for agencies working in partnership through a consortium arrangement.

25.22 As a result of this EOI, 14 Lead Agencies were contracted to provide planned early intervention services to families that participate in the Brighter Futures program. There are over 440 partner agencies working with the Lead Agencies to deliver these services. More than 80 per cent of these partner agencies are small to medium sized organisations.

25.23 DoCS has reported that the implementation of Brighter Futures has been protracted due to the scale of the program and because of difficulties NGOs have experienced in recruiting staff and in finding suitable accommodation. The integration of DoCS and NGO service delivery has also taken time.

25.24 Based on this experience, during 2007, DoCS commenced a reform process of the OOHC funded service system made up of three streams: a service plan review to move existing service providers onto performance based contracting; an EOI process for over $600 million in additional OOHC program funding; and a direct negotiation process to fill any service gaps left once the EOI process was finalised.

25.25 The Children's Guardian was supportive of the reforms to the funding of the OOHC service system and stated that they should lead to an improved range of integrated services with the capacity to better match services to children and

young persons in OOHC. The Children's Guardian further noted that the reforms "will allow DoCS to strengthen its focus on managing demand."[296]

25.26 The effect of competitive tendering on the relationship between NGOs was however raised by Professor Alan Hayes, Director of the AIFS. He advised the Inquiry that for many NGOs, competitive tendering was antithetical to cooperation.

25.27 Another criticism of the competitive tendering process used for the Brighter Futures and OOHC programs was that it was "designed to provide the cheapest possible service with minimum standards."[297] It was recommended that DoCS implement "a process that ensures that the final gate in any gated process of assessment of EOI relates to the quality of the outcomes for children rather than unit costing."[298]

25.28 A number of organisations have been critical of the EOI process as failing to take into account local priorities and concerns, and as overlooking smaller more locally focused agencies in favour of larger service providers that in some cases did not have an established presence in the area.

25.29 The consortium model favoured in the Brighter Futures EOI was also the subject of some criticism. Barnardos advised the Inquiry that:

> *formally endorsed attempts to direct coordination such as the attempts by DoCS in Brighter Futures with concepts such as insistence on 'partners' and 'lead agency,' and formalise relationships have in our experience been a failure, and have significant costs which draw resources away from direct service provision into endless meetings and coordination attempts.*[299]

25.30 While broadly supportive of DoCS' reforms to the OOHC program, ACWA raised concerns that the OOHC EOI process was unfair on smaller agencies and on existing OOHC service providers whose tenders were unsuccessful or only partially successful. ACWA stated that:

> *many children in placements that have been funded through temporary funding known as Individual Client Agreements (ICAs), face the possibility of the service which supports them being closed and they may have to experience placement and agency/case worker change.*[300]

25.31 In relation to the OOHC EOI process, it has been claimed that services using the costing benchmarks developed by DoCS were generally unsuccessful in the

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[296] Submission: Children's Guardian, p.36.
[297] Submission: Newcastle Family Support Services, p.1.
[298] ibid., p.2.
[299] Submission: Barnardos, p.17.
[300] Submission: Association of Children's Welfare Agencies, p.24.

tendering process. Concerns have been raised about the sustainability of the services that were successful given that they may have underpriced their service delivery. Concerns were also raised as to the demands in terms of the cost, and the time expended by small agencies in preparing the necessary paperwork and in working with lead agencies in preparing a tender.

25.32 ACWA stated that some agencies facing possible closure have had considerable experience in providing quality OOHC services and have either gained five year accreditation with the Children's Guardian or have made good progress in the Guardian's Accreditation and Quality Improvement Program. ACWA saw this as "an unintended and unfortunate consequence of an EOI process where the final consideration was cost competitiveness."[301]

25.33 DoCS said in reply that the "costs of robust competitive tendering need to be balanced against the benefits of getting the best quality service that provides value for money."[302]

25.34 DoCS has accepted that extra work is involved in implementing the Performance Monitoring Framework, but rejects the criticism that its more rigorous monitoring and accountability requirements are an unnecessary burden on the NGO sector, arguing that it is needed in order to develop a culture of continuous improvement in the quality of service provision.

25.35 While also acknowledging that the implementation of funding reforms has been a difficult process for the NGO sector, the Inquiry supports the general thrust of DoCS funding reform. The introduction of performance based contracting and its associated reporting requirements are necessary components of a robust and accountable government funded service system, particularly in circumstances of the kind presented by the current economic climate in which resources are limited.

Review of the Community Services Grant Program

25.36 The *DoCS Annual Report 2007/08* states that the CSGP "is a funding program to improve the resilience and safety of disadvantaged children, young persons, families and communities."[303] The very broad aims of the program are largely explained by the CSGP's history. It was originally established in 1988/89 when community services, funded under a number of different programs, were amalgamated under the one umbrella program.

25.37 As a result, the CSGP funds approximately 950 diverse projects operated by 600 non-government organisations and local councils. The CSGP 2007/08 funding base was $79 million.

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[301] ibid., pp.24-25.

[302] Submission: DoCS, Funded service system supporting child protection, p.16.

[303] DoCS, *Annual Report 2007/08*, p.20.

Table 25.2 **CSGP funding by sub-program, 2007/08**

Project categories	Project numbers	Funding ($million)	% of Funding
Community Development	438	27.63	34.9%
Family & Individual Support	193	26.03	32.8%
Youth Services	288	22.05	27.8%
Child Protection	30	3.48	4.5%
Total	949	79.19	100.0

Source: DoCS submission: Funded service system supporting child protection, Appendix 1, p.40

25.38 There has been no growth funding in the CSGP since 1990. DoCS has argued that at the same time, "the cost drivers and demand for services have increased considerably, resulting in significantly decreased level of service comparative to 1990."[304] DoCS engaged Ernst & Young to undertake a review of the CSGP in early 2007, with the aim of developing a program structure that aligned with DoCS corporate priorities and provided the basis for a sustainable service system.

25.39 The CSGP review report dated March 2008 identified disadvantaged children, young persons and their families, and disadvantaged communities as the new target group for a reformed CSGP.[305] The review report identified a new 'headline result' and a set of program results for the CSGP, as follows:

a. Headline Result: Disadvantaged children, young persons, families and disadvantaged communities are to be made resilient and safe

b. Program Result 1: Disadvantaged families and young persons are provided support and are linked to services in their communities

c. Program Result 2: Children and young persons at risk are supported in their communities

d. Program Result 3: Children and young persons in crisis are supported

e. Program Result 4: Disadvantaged communities develop the ability to enhance well-being and participation of children, young persons and their families.[306]

25.40 As part of the review, an assessment was undertaken to determine the extent to which current CSGP projects aligned with the new headline result, program results and activities identified during the review process. It was found that 6.40 per cent of projects fully aligned, 88.05 per cent of projects partially aligned and 5.55 per cent of projects did not align.[307]

25.41 DoCS has indicated that it does not propose to exclude services or to defund those which do not align,[308] although new service specifications are to be

[304] Information provided to Government by DoCS, March 2008.

[305] DoCS, Ernst & Young, *Review of the Community Services Grants Program*, March 2008, p.18.

[306] ibid., pp.18-20.

[307] ibid., p.22.

[308] DoCS, *Update from the Community Services Grants Program Roundtable, Communiqué 3*, September 2007, p.2.

developed in 2008/09 with the aim of ensuring that all services receiving CSGP funding align with the results set out above.

25.42 The business case developed in response to the review argues that to meet increased client demand the CSGP would require a budget enhancement of $45 million per annum to be introduced in $15 million increments over three years from 2008/09 to 2010/11.[309]

25.43 That business case was provided to Treasury in February 2008. While there was no additional funding allocated to the CSGP in the 2008/09 budget, the Inquiry understand that DoCS has held discussions with Treasury regarding the availability of resources to implement its recommendations. A final decision regarding the proposed budget enhancement for the CSGP will not be made until after this Inquiry reports.

Need for broader reform of DoCS funding structure

25.44 The Inquiry agrees that it makes sense to move away from a system that focuses largely on inputs and processes to a system that focuses on improving client outcomes and allows service providers to have a greater role in service system design.

25.45 However, the funding reform has largely taken place within each of the funding programs rather than examining the overall basis upon which DoCS funds NGOs and other agencies, and without identifying the outcomes that are needed to address the changing needs of children and families across the continuum of services. As the Inquiry was informed by UnitingCare Burnside:

> *The greatest problem, however, is that we continue to describe the service system in terms of the funding streams rather than in terms of what we want to achieve…families do not fit naturally into separate buckets of funding.*[310]

25.46 There may be historical or political reasons why DoCS administers 10 funding streams and the Inquiry has not devoted much of its limited time to understanding why, or to what end, these programs have proliferated. It offers the observation that the duplication of the programs developed over decades in a largely ad hoc way as is evident from Table 25.2 is wasteful and costly for both DoCS and those it funds. Its apparent breadth may serve to mask areas of deficiency or it may otherwise lead to duplication of services. Significant administrative effort could be saved by reducing the number of streams and by requiring those seeking funding to provide only one submission that covers each area of work funded by DoCS, and that reflects the continuum of services that children and families need, for example, child care, family support services, or counselling.

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[309] DoCS, *Community Services Grants Program Business Case, Draft Version 1*, 17 December 2007, pp.7-8.

[310] Submission: UnitingCare Burnside, 19 May 2008, p.11.

25.47 Administrative effort could also be saved by funding services for at least three years ahead, preferably five years, and by requiring one report rather than multiple reports back to DoCS on outcomes. It is clear that investment in infrastructure and human resources by the NGO sector will not occur without a reasonable period of funding certainty. Employment cannot be offered without that certainty, nor can sensible planning take place.

25.48 The Director-General of Aboriginal Affairs, Ms Jody Broun, made the following comment about Aboriginal agencies which could equally apply to all NGOs:

> *there needs to be longer-term commitment to funding of small agencies as well, so that they are not in a continual cycle of making submissions for funding and can then make long term commitments to their planning and how they are developing in the capacity issues. I think too often Aboriginal organisations across the board are caught in this submission based approach to their funding, with continual cycles of having to acquit those funds and then apply again, and they can't plan into the future and they are always on this tenuous sort of circuit*.[311]

25.49 Barnardos offered the following observation on the barrier to developing integrated service provision created by the structure of the current funded service system:

> *The area of most difficulty is in the provision of integrated services to children and family in their communities. We undertake the support of families whose children are vulnerable to abuse or neglect in five Children's Family Centres in NSW. Each has a range of activities, for example, home visitations, crisis accommodation, group work, domestic violence programs, child care, specialist services. Each activity is separately funded often by the same government department, for example, the Department of Community Services (DoCS), even through the same funding pool, for example, CSGP while on occasion from a separate pool in the same department, for example, SAAP. Each activity needs separate submissions and separate accountability*.[312]

25.50 The issue of overlap is not confined to DoCS. Many services rely on multiple funding sources within the NSW Government. For example, Juvenile Justice has a Community Funding Program which funds some of the same agencies as are funded by DoCS, to provide similar services, such as drug and alcohol support and accommodation support, to a similar client group, namely children and young persons in or at risk of entering the juvenile justice system.

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[311] Transcript: Public Forum, Aboriginal Communities, 24 April 2008, p.28.

[312] Correspondence: Barnardos, 25 August 2008.

25.51 The Inquiry is of the view that a review of all NSW government funding to NGOs delivering universal, targeted and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should occur. The benefits of an integrated funding system are obvious and include reduced administrative costs for government and non-government sectors alike and better targeting of services.

25.52 Many services also rely on funding from the Commonwealth. It is hoped that the current COAG initiatives will enable funding reform in that area.

Role of the NGO sector in the child protection system

25.53 The Inquiry agrees with Premier and Cabinet that the following three challenges apply to developing better working relationships with the NGO sector:

a. providing a clear definition of the precise areas where NGOs are best placed to undertake contracted roles

b. ensuring that NGOs operate according to clear service accountabilities to drive the delivery of outcomes

c. establishing effective coordination mechanisms with the NGO sector, NSW Government agencies and the Commonwealth.

25.54 The role the NGO sector should play in supporting the child protection system and its capacity to take on an expanded role are discussed in earlier chapters, as is the challenge of establishing more effective coordination mechanisms between the NGO and government sector. The impact of DoCS funding reforms in ensuring that services provided by NGOs focus on improving client outcomes has been dealt with earlier in this chapter.

25.55 Given that almost half the DoCS budget is spent purchasing services from NGOs, it is clear that the NGO sector already plays a significant role in delivering most of the support services within the child protection system in NSW.

25.56 DoCS has identified the following advantages to contracting out DoCS services rather than delivering these services directly:

a. they can be delivered at a lower unit cost

b. NGOs are potentially able to engage and maintain some categories of client more readily than a statutory welfare agency

c. most services are well established with strong local knowledge and networks

d. small services have the potential to be more flexible in responding quickly to emerging need with innovative service models

e. DoCS caseworkers can focus on statutory clients.

25.57 In an expanded external service system, DoCS has envisaged that:

> *NGOs will continue to deliver many of the universal and less intensive services within the continuum such as child care, family support and parent education. In addition to this, a proportion of NGOs would deliver services to children and young people with complex needs, and their families. However, statutory child protection will remain the responsibility of DoCS.*[313]

25.58 From the submissions received by the Inquiry and comments made in Public Forums, there is no doubt that NGOs wish to have a greater role in the delivery of services that support children, families and the community across NSW. There has also been a corresponding call for DoCS to devolve responsibility for direct service provision, particularly in the areas of early intervention and OOHC to the NGO sector, each of which is dealt with earlier in this report.

Role of peak organisations

25.59 Within the child protection context, peak organisations play an important role in representing the interests of the non-government service sector and in advocating for children, young persons and families who come in contact with the child protection system. A number of peak organisations also have a strong training focus. ACWA, in particular, runs a broad range of training programs for the community services sector through its Centre for Community Welfare Training.

25.60 In 2007/08, DoCS provided almost $6 million in funding to peak organisations and advocacy groups in NSW for core operations, training and information services. The key peak bodies in the NSW community services system include:

a. Council of Social Services NSW

b. Association of Children's Welfare Agencies

c. NSW Family Services Inc.

d. Aboriginal Child, Family and Community Care State Secretariat

e. Local Community Services Association

f. Youth Action and Policy Association

g. Youth Accommodation Association

h. Homelessness NSW/ACT

i. NSW Women's Refuge Movement Working Party Inc

j. Community Child Care Cooperative NSW

k. CREATE Foundation

l. Foster Care Association

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[313] Correspondence: DoCS, 29 August 2008, p.3.

m. Foster Parent Support Network

n. KU Children's Services

o. Network of Community Activities

p. Country Children's Services Association of NSW Inc

q. Mobile Children's Services Association of NSW Inc.

25.61 While at first glance there would appear to be a proliferation of peak bodies operating in NSW, there is actually minimal duplication regarding target client groups. The exception is the Foster Care Association and the Foster Parent Support Network, which have the same target group, although it is noted that in the current EOI round the former body did not receive DoCS funding.

25.62 The Inquiry received no submissions that were either critical or applauding of the peak organisations, and nor has there been any study indicating the value or lack thereof of these bodies which has come to the Inquiry's attention. The Inquiry has been advised, however, that DoCS plans to commence a review of the peak bodies late in 2008 and therefore should be in a position to critically assess its funding in these areas. The Inquiry is supportive of what it currently knows of their roles in training and communicating with government, and in their advocacy role.

Capacity of NGOs

25.63 Some concern has been expressed by the Human Services and Justice CEOs Cluster that an expansion of the NGO service system would be problematic because NGOs are already suffering from 'reform overload,' and are struggling to maintain long term viability. Further major reform could therefore "create unacceptable instability in the system with possible significant impacts on client outcomes."[314]

25.64 In response to these concerns, DoCS advised the Inquiry that the implementation of its funding reforms actually provided a strong base for any further expansion or changes to the funded service system. Specifically it suggests "the funding reforms are necessary to support the development of an integrated, sustainable and effective service system, regardless of the future 'shape' of the system."[315]

25.65 While there certainly has been significant reform by DoCS, and concern about aspects of that reform has been expressed to the Inquiry, the Inquiry has not found any clear evidence of the struggle referred to by the Human Services and Justice CEOs Cluster. If the concern does have a firm basis, then more needs to be done to build capacity in the vital NGO sector.

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[314] Correspondence: Human Services and Justice CEOs Cluster, 17 June 2008.

[315] Correspondence: DoCS, 29 August 2008, p.7.

25.66 The ability to recruit and retain appropriate staff is another issue that impacts on the NGO sector ability to expand. This is an issue across the human services sector and is currently being addressed at state level by the Human Services and Justice CEOs Cluster and nationally through the Community and Disability Services Ministers' Conference.

25.67 While DoCS has moved to a degree qualification as a prerequisite for its new caseworkers, the qualifications required for employment in the NGO sector are less rigid and vary across agencies. As a result, NGOs are in many cases able to draw from a larger pool than DoCS when employing staff. This can be viewed as an advantage in relation to providing support services at the less intensive end of the care and support continuum. However, the potential shortcoming is that if NGOs are to take on an expanded role providing services for persons with complex and intensive support requirements, they may not have sufficient numbers of appropriate staff available. As the NGOs expand their capacity to deliver more services to children and their families, this may become an increasing issue for the Government.

25.68 The Human Services and Justice CEOs Cluster has also raised doubts about whether the NGO sector has the expertise to provide services to clients with complex needs. DoCS noted that there is sufficient expertise in the NGO sector to support an expansion of the current type and level of services to children and young persons with complex needs. While it is the case that the majority of services provided by NGOs are at the less intensive end of the care and support continuum, many NGOs also offer more intensive support services, including sexual assault counselling, intensive family support services and support for children and young persons in OOHC with high and complex needs.

25.69 Because wage rates in the NGO sector are lower than in the public or private sectors, NGOs can experience difficulties attracting qualified staff, particularly the clinicians needed to successfully engage with clients with complex needs. The Human Services and Justice CEOs Cluster has informed the Inquiry:

> *Most [NGO] workers are paid under the Social and Community Services (SACS) Award - with typical wages at 60 per cent of the average weekly earnings. The low pay scale in NGOs exacerbates the supply and retention problems that are facing the whole of the human service sector.*[316]

25.70 A number of submissions to the Inquiry have called for wage parity between DoCS and NGOs[317] through an increase in the SACS Award to reflect the level of expertise required to undertake community sector work whether by a government worker or an NGO worker.[318]

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[316] Correspondence: Human Services and Justice CEOs Cluster, 17 June 2008.

[317] Submission: The Benevolent Society, p.23; Submission: Centacare Sydney, p.36; Submission: UnitingCare Burnside, p.37.

[318] Submission: Association of Children's Welfare Agencies, p.36.

25.71 The Inquiry notes that DoCS does not set the amount that it will fund for an NGO caseworker as its funding is performance based for results not inputs, and that it is ultimately the NGO's decision. DoCS advised that its funding manual is based on information supplied by NGOs on the amount they pay their workers, and when negotiating for a service, DoCS funds on a unit cost basis, which includes caseworker cost, administration and operating costs.

25.72 Centacare Sydney noted "it is an untenable and unacceptable position for DoCS, as the funder/provider, to only allocate funding to NGO caseworkers, at a rate that is significantly lower than DoCS caseworkers, thus creating an inequitable system."[319]

25.73 Ultimately, the Government will need to fund whatever agency is selected to provide services, be that one within the government or non-government sector. The Inquiry does note that there are attractions in working in the non-government sector over employment in a government welfare agency, and that salary levels are not the only consideration in employment choices. Additionally, it is of the view that consideration should be given to cross secondment of staff to provide a mutual increase in knowledge and experience that could be of particular benefit to NGOs.

25.74 DoCS acknowledges that the successful implementation of its funding reforms will require intensive continued engagement with the NGO sector, and to this end, it is undertaking a series of training and development projects with its funded services.

25.75 DoCS has also developed a series of resources to support DoCS funded service providers in the move to performance based contracting. They include good practice guidelines and a costing manual designed to provide guidance to NGOs in the areas of governance, systems development, human resource development and unit costings when tendering for contracts.

25.76 In conjunction with DADHC and Housing, DoCS has also developed a Common Chart of Accounts, which aims to make financial data consistent across human services community organisations in NSW by providing a common approach to accounting and using the same standard terms and categories to refer to the same activities.[320] This work was undertaken in recognition of the fact that consistent approaches to reporting and accountability can assist those NGOs that have multiple sources of income across a number of government agencies.

25.77 DoCS has sought to engage with peak organisations to strengthen their role in building capacity among member agencies. Actions include a results based accountability peaks project and the provision of funding to NCOSS to develop

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[319] Submission: Centacare Sydney, p.36.

[320] DoCS, *Annual Report 2006/07*, p.74.

and pilot a training and resource kit for use by smaller agencies when forming consortia.[321]

25.78 Time will tell whether this work is sufficient.

25.79 Many small services are governed by volunteer management committees that have variable expertise. The management committees of the 1,600 community based children's services that DoCS funds, for instance, are largely parent based and voluntary, which can result in high turnover and a lack of continuity in governance structure. The Inquiry is aware that the more rigorous performance measurement and financial accountability requirements under the funding reforms can present a particular challenge to such small services.

25.80 Small services have raised concerns that DoCS favours consortium arrangements as part of its competitive tendering processes. Consortia are seen by many agencies to advantage large organisations. Because larger agencies have better economies of scale, the smaller services find it difficult to compete. In reference to the Brighter Futures EOI, some agencies reported missing out on funding, even though they had long standing, well accepted services already operating in the local area.

25.81 As small funded services comprise a major part of the DoCS current service system, and very often are on the ground in locations in rural or remote communities which are not serviced by the larger NGOs or head agencies, it is in DoCS best interests to ensure their continuing viability. The Inquiry notes that the provision of further support to ensure their viability is identified as a priority in DoCS' Funding Policy.[322] DoCS has stated its support for a mixed service system which includes small organisations. Similarly, with specific reference to community preschools, viability funding has been allocated to 539 preschools as part of the NSW Government's Preschool Investment and Reform Plan.[323]

25.82 Further, to assist with skills development, particularly for smaller NGOs, DoCS has established a training program with the aim of improving NGO organisational capacity in the areas of governance, management and child protection. In 2007/08, the program delivered over 4,700 training days to more than 3,500 participants across NSW.[324]

25.83 In 2008, priorities of the training project include support for the ongoing funding reforms, working with clients with complex needs and facilitating service system integration.[325]

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[321] Human Services CEOs and Forum of Non-Government Agencies, *Working Together for NSW: annual implementation meeting, communiqué,* August 2008.

[322] DoCS, *Funding Policy*, August 2005, p.11.

[323] DoCS, *Annual Report 2007/08*, p.34.

[324] ibid., p.67.

[325] Submission: DoCS, Funded service system supporting child protection, p.30.

25.84 The Inquiry appreciates the effect of the funding reform process embarked upon by DoCS on smaller agencies. It acknowledges and supports DoCS' efforts at helping them to keep up the pace as in many parts of the state their viability will be essential. The reform process is vital to the ultimate safety, welfare and well-being of the children for whom the system operates. It will need to take into account the interests of existing providers that have the capacity to delver relevant services, and establish a system for funding, monitoring and delivery of services that is both affordable and comprehensive.

Recommendations

Recommendation 25.1

> All NSW Government funding to NGOs delivering universal, secondary and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should be reviewed, so as to establish a coordinated system for the allocation of their funded resources that will eliminate unnecessary overlap and provide for the delivery of service where most needed.

26 Performance measurements

NSW State Plan **1024**

DoCS Corporate Plan and Results and Services Plan **1025**

Issues arising **1027**

26.1 DoCS' core activities and objectives are set out in a number of planning documents. At the broadest level, the NSW State Plan sets out the goals to be achieved by the Department, with more detail provided in the DoCS Corporate Plan and its Results and Services Plan.

26.2 All of these documents contain a range of performance indicators and measures.

NSW State Plan

26.3 DoCS has lead responsibility for NSW State Plan Priority F7- reduced rates of child abuse and neglect. The State Plan notes that for a child born today in NSW, the probability of being reported as at risk of abuse or neglect before reaching adulthood is now one in five, although that does not equate to a finding of established risk. The target for Priority F7 is to reduce the underlying rate of child abuse and neglect in NSW over the course of the plan.

26.4 In relation to measuring progress, the State Plan notes that there is no indicator currently available that accurately measures the actual prevalence of child abuse in NSW. Most measures, such as the number of child protection reports, are influenced by community attitudes, mandatory reporting rules, changes in DoCS resources, changes in assessment criteria, or changes in population levels. The State Plan notes that the rate of children and young persons who were the subject of a report that was subsequently referred for further investigation per 1,000 population aged 0-17 years is the most consistent measure that can be used at this stage.[326]

26.5 As mentioned earlier, from the data provided by DoCS, that rate has increased from 50.1 per 1,000 population aged 0-17 years in 2004/05 to 54.8 in 2005/06 to 65.1 in 2006/07 and 65.7 in 2007/08.[327] There has also been an increase in the rate of children and young persons aged 0-17 years entering OOHC per 1,000 population since 2004/05. At 30 June 2005, the rate was 6.3 per 1,000, increasing to 9.1 per 1,000 at 30 June 2008.[328]

26.6 Additional State Plan priorities in which Police and Health have lead roles aim to reduce substance abuse, mental health problems and domestic violence. These factors, if prevented or controlled before they have an effect on children should assist in preventing child abuse and neglect.

26.7 DoCS also has lead responsibility for State Plan Priority F6-increased proportion of children with skills for life and learning at school entry. Progress towards that goal depends on developing and trialling an appropriate target and

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[326] NSW Government, *NSW State Plan: A New Direction for NSW*, 2006, p.83.

[327] DoCS, *Annual Report 2007/08.* p.44.

[328] ibid., p.53.

measure of performance.[329] DoCS is currently considering the use of the Australian Early Development Index as the performance measure for this priority.

DoCS Corporate Plan and Results and Services Plan

26.8 Friedman's Results Based Accountability is DoCS' planning model and is also the model used by other NSW Government human service agencies.[330] This model makes a distinction between population level indicators and program or agency level performance measures. Population level indicators measure the community's progress towards a stated result or target, such as the Priority F7 target to reduce the underlying rate of child abuse and neglect. Achieving these population level results often involves a multi-agency response, as is clearly the case with Priority F7. Program or agency performance measures are used to determine how well a service or agency is working and what quality of change has occurred as a result.[331]

26.9 Results Based Accountability has been adopted by NSW Treasury as the model for the Results and Services Plans that NSW Government agencies must submit each year as part of the budget process.

26.10 DoCS' Results and Services Plan, along with its Corporate Plan, set out a range of performance measures from which the Inquiry makes the following observations.

26.11 A key measure identified in the Corporate Plan is the percentage of children and young persons who were the subject of a substantiated report in the previous year, and were the subject of a further substantiation within the following 12 months. The rationale for this measure is that children and young persons who have been the subject of substantiation should have received attention from DoCS to ensure their safety. A further substantiated report suggests they are not safe. There has been an almost doubling of this percentage since 2002/03, increasing from 13.2 per cent in 2002/03 to 24.0 per cent in 2006/07. The Inquiry understands that DoCS no longer considers this measure useful as it depends at least in part on the number of cases allocated to caseworkers and thus, ultimately on resources.

26.12 Another key measure that is identified in both the Corporate Plan and the Results and Services Plan is the percentage of children and young persons in OOHC on final care and protection orders who have had five or more

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[329] NSW Government, *NSW State Plan: A New Direction for NSW,* 2006, p.81.

[330] The Results Based Accountability framework was developed by Mark Friedman, Director of the US based Fiscal Policy Studies Institute. In 2004, NSW Human Services CEOs engaged Mr Friedman to advise on a new way for human service agencies to determine performance and results.

[331] Institute of Public Administration Australia, *Results based accountability. Learning and development program book,* 2007, p.8.

placements. The assumption is that because placement breakdown is linked to poor outcomes for children and young persons, placement stability is an indication of how well children and young persons in OOHC are travelling. There was no change in the percentage of all children and young persons on final care and protection orders who have had five or more placements, as determined at 30 June 2006 and 30 June 2007. It was steady on 21.2 per cent. The percentage of these children under five years increased from 3.2 per cent at 30 June 2006 to 4.3 per cent at 30 June 2007 and then decreased to 3.8 per cent at 30 June 2008.[332]

26.13 Another performance measure identified in the Corporate Plan is the percentage of children and young persons placed in OOHC from IFBS referred families at 12 months after completion of an IFBS program. This would measure the effectiveness of DoCS IFBS program, however DoCS has advised that data for this measure must be collected manually and are not yet available on an ongoing basis.

26.14 Similarly, data are not yet available for the percentage of children and young persons in OOHC with a case plan goal of restoration who are restored to their parents within 12 months of entering OOHC. This is also a performance measure identified in the Corporate Plan.

26.15 DoCS is in the process of developing a full set of baseline data relating to the effectiveness of its Brighter Futures program. Performance measures will include the proportion of children receiving early intervention services who meet age appropriate developmental milestones. When available, the baseline data should provide useful information about DoCS' early intervention strategy.

26.16 DoCS' measure relating to SAAP client outcomes is the percentage of SAAP clients with only one support period per year. Since 2005/06 the percentage has remained steady at 79.1 per cent.[333]

26.17 DoCS also has a series of performance measures that relate to: the cost of service provision across its program areas; the number of services that it provides or activities that it performs; and the efficiency of its service provision. Examples of such performance measures are, in order: the annual expenditure per child or young person in OOHC; the number of child protection reports received and assessed and the number of children involved in these reports; and the average waiting time to talk to a caseworker when calling the Helpline.

26.18 Ultimately, the Inquiry has not relied upon these measures to ground any conclusions about DoCS' performance. The more detailed analysis performed by DoCS at the Inquiry's request or independently undertaken by DoCS has been more useful. That material is, in the main, set out in Chapter 5.

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[332] DoCS, *Results and Services Plan 2008/09,* p.18. Percentage for 30 June 2008 is an estimate.

[333] ibid., p.13.

Issues arising

26.19 Results Based Accountability is an outcomes based framework that encourages agencies to develop performance measures that measure quality and effect rather than quantity and effort. A number of the performance measures identified in the DoCS Corporate Plan and the Results and Services Plan provide an indication of the quality and effect of DoCS services on client outcomes, such as those discussed in the section above. However, many of the measures identified in these planning documents, particularly in the Results and Services Plan are descriptions of quantity and effort; that is, of process.

26.20 Generally, DoCS measures process or outputs rather than outcomes for children. This state of affairs is not limited to DoCS. The non-government sector also appears to be characterised by such reporting, however the Inquiry has had access to limited data relating to non-government sector performance measures.

26.21 Further, a number of key measures are not matched by available data, thus those families who have received an IFBS are not captured nor is data concerning restoration and breakdown. The Inquiry notes that the DoCS' Performance Management Framework for Funded Services 2005 states that performance measures should be clear, sufficiently detailed and include data sources and/or reporting methods that will allow results to be accurately assessed.[334] This policy also acknowledges that current funding arrangements often focus on inputs of service, rather than results for children, families or communities.

26.22 Similar to the current directions for NGOs which aim to link funding to outcomes, the same process should apply to the services DoCS and other government agencies offer. As the child protection system is broader than DoCS there is also a need to develop performance measures for cross agency systems. As identified by Friedman, there is great value in looking at system performance in addition to program and agency performance because of the interconnection and interdependence of different parts of the service system.[335]

26.23 As Health advised the Inquiry, data collection systems held by different government agencies that monitor and respond to child abuse are not aligned. As a result it is difficult to make comparisons across agencies, or to develop an evidence based whole of government approach, an important matter for gauging the success of the kind of interagency collaboration advocated by this report.

26.24 The Inquiry agrees with the comments of Tilbury who suggests that performance measurement has concentrated on the 'child rescue' construction

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[334] DoCS, *Performance Management Framework for Funded Services,* 2005, p.4.

[335] M Friedman, "Trying Hard is not Good Enough, How to Improve Measurable Improvements for Customers and Communities," *Trafford Publishing*, Canada 2005, p.92.

of child protection, that is, it conceptualises child protection as investigation and placement. Despite recent moves to position child protection agencies as part of a broader system of child and family welfare, this has not been reflected in a concomitant shift in performance indicators. The vast majority of performance measures still relate to the effectiveness of investigations and placements:

> *The underlying values of the indicators promote the perspective that 'good practice' in child protection is mainly about achieving safety and placement stability for children.*[336]

26.25 Safety becomes the absence of re-abuse, quality becomes placement stability which relates to the numbers of placement moves or duration in placement. This ignores the broader role of child protection services, in not just keeping children safe from further abuse, but promoting well-being and improving life chances. Tilbury concludes that:

> *there is a disjuncture between the goals expressed in legislation and policy documents and the goals communicated through performance measurement, or between 'professional' and 'management' concerns.*[337]

26.26 From the work it has done, the Inquiry suggests that it would be useful to capture the data on several indicators in order to monitor the performance of the Department, and of the other agencies involved in child protection work. They are aspirational in part, as the Inquiry is conscious that privacy concerns and technology limitations will render some of them unattainable, at least in the short term, or will depend on client cooperation in responding to exit surveys or similar follow up questionnaires. The suggested indicators are:

a. the number of children and families receiving a service

b. continuity of caseworkers

c. outcomes of restoration

d. development of and adherence to case plans/care plans

e. attainment of case goals

f. placements with siblings

g. educational attainment

h. entry into employment and training

i. achievement of developmental milestones

j. health status

k. client satisfaction

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[336] C Tilbury, "Research and Evaluation: Accountability via Performance Measurement: The Case of Child Protection Services," *Australian Journal of Public Administration 65(3),* September 2006, p.58.

[337] ibid.

l. experience after leaving care.

26.27 To measure the overall effectiveness of the child protection system in NSW, such agency performance measures should also be considered alongside population level indicators such as those used to measure the effectiveness of the Families NSW program. The Inquiry notes with interest the work that is being undertaken to identify national headline indicators for children's health, development and well-being on behalf of the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference[338] and indicates its general support for this initiative.

26.28 In summary, performance measurement is important in identifying the most effective allocation of resources and those areas of service that, on the one hand, require modification or remediation, and, that on the other hand, provide good outcomes.

[338] Headline Indicators Steering Group on behalf of the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference, *Headline indicators for Children's health, development and well-being. Final report*, June 2006.

Part 7 Implementation

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Introduction

27.1 The Inquiry acknowledges that much of the 2002 reform process has been implemented, and that within the specific timeframe envisaged by that process, it has achieved significant strategic change, so far as DoCS is concerned.

27.2 This report is focused on the further changes to the child protection system in NSW that are needed to take account of the current and projected demands on that system, and the changed environment in which it is to operate, including the extended participation of other government agencies and the non-government sector in providing for the safety, welfare and well-being of children and young persons.

27.3 For the purpose of implementation, the recommendations made in this report have been ranked in order of priority, that is: “immediate”, where the Inquiry considers that the necessary changes should be substantially commenced within six months; “short term” where implementation should be substantially commenced within 12 to 18 months; and “long term”, where it is anticipated that such work should be substantially commenced within two to three years.

27.4 In a limited number of cases, where it is unlikely that the relevant changes could begin to be achieved within three years, either because of the likely costs involved, or because of the need for other government agencies or non-government agencies to build up capacity, a longer timeframe has been assigned. In other cases where the necessary work is already under way or where an initiative is subject to a trial, or where some general approach is supported as a matter of principle, a timeframe has not been identified.

27.5 The Inquiry has not attempted to place a specific cost on the implementation of the individual recommendations. It has, however, categorised them, in a general way, into high cost, medium cost, or low cost. This categorisation has been based on the information, currently available to it, concerning the nature and quantity of the work likely to be involved in giving effect to each recommendation. In some instances, DoCS has advised the Inquiry of provisional allocations, or estimates of the costs of the changes that were the subject of debate or analysis during the Inquiry’s deliberations, or that were identified in its submissions to the Inquiry. Where that is the case, such estimates have helped to inform the Inquiry as to the appropriate ranking of the recommendations in terms of their likely implementation cost.

27.6 The ranking of the recommendations in terms of their priority and likely cost levels is intended to assist the implementation process outlined in this chapter, and to allow for future planning that could permit early supplementation and/or progressive increases in the budget for the child care and protection system, across all sectors.

27.7 Two remaining observations are necessary. First, a number of the recommendations are inter-dependent, such that unless the primary

recommendation is accepted, either the subsequent recommendation will be superfluous or will require modification. Alternatively their linkage may require a progressive deferral of the implementation of some of them so as to maintain the integrity of the system envisaged in this report.

27.8 Secondly, the Inquiry acknowledges that the potential of the Commonwealth to become more directly involved in the child protection system, on a national basis, has long term significance for State welfare agencies, and for the implementation of this report. It notes that a Discussion Paper was released by the Commonwealth in May 2008, that considerable work has been undertaken since that time in developing a possible national framework, and that this is soon to be considered by COAG.

27.9 In those circumstances, and without any current or clear guidance as to the likely final terms of any national initiative, or of its timing, this Inquiry does not consider that it is in a position to comment on this development. It does however record its general support for the greater contribution of the Commonwealth in funding the child protection system at a state level, and for its encouragement of a model that involves a coherent and consistent government and community wide response, that can draw on the separate strengths and skills of the human services agencies and of the non government welfare sector.

27.10 It assumes from what has been disclosed so far, that any national framework will recognise the imperative of providing, or supporting the provision of, a full range of universal and targeted early intervention services of the kind that are designed to keep families intact and functioning at an acceptable level, while preserving statutory protection as a response of final resort where it is needed to keep children and young persons safe from abuse and neglect.

27.11 It also assumes that any such national framework would be directed at closing the gap in life outcomes for all of those children who come within the potential operation of the child protection system of the states and territories and that it would be inclusive of all sectors of the community, with particular attention being given to those within the most vulnerable sectors, and specifically the Aboriginal community.

27.12 The current report is framed with these objectives in mind. The suggested procedure for its implementation so as achieve these objectives are as follows.

Implementation

27.13 Implementation will necessarily involve two stages:

a. establishing a whole of government response to the Inquiry's report and recommendations and a high level implementation plan

b. carrying into effect those recommendations, or any variation of them, that the Government decides to adopt.

27.14 The whole of government response to the Inquiry's report should be coordinated within the Department of Premier and Cabinet by a Special Commission of Inquiry (SCI) Implementation Unit. This should be undertaken in collaboration with the non-government sector.

27.15 The SCI Implementation Unit should include senior executives seconded from DoCS, Health, Education, Police and Treasury to coordinate work across the respective agencies.

27.16 The SCI Implementation Unit should report on progress against the implementation plan every six months for a period of three years, or for such further period as may be required to complete delivery of the implementation plan. Its progress reports should be made publicly available, including on relevant websites and tabled in Parliament.

27.17 Achievement of the implementation plan should be included in the NSW State Plan and incorporated into relevant Priority Delivery Plans.

27.18 Achievement of the relevant elements of the implementation plan should be incorporated into the performance agreements of relevant Directors-General and key executives across government.

27.19 The recommendations of the Inquiry's report are far reaching and will involve significant change. The successful implementation of change requires committed leadership from the Directors-General of the key agencies and executives, clear and consistent communication about the imperatives for change and what is required of each agency, as well as attention to transparency and accountability. Much will be required of staff to bring about the changes required. There are already significant pressures on staff, some of whom have experienced 'change' or 'reform' fatigue since commencement of the 2002 reform process and timing of changes will need to be carefully managed. The support of the PSA, and its constructive input in relation to the introduction of changes at Helpline and CSC level will be important.

27.20 Given the recommendations of the Inquiry with respect to early intervention and OOHC it will be critical to engage effectively with the non-government sector and to commence any required capacity building as soon as possible. The NSW NGO sector is not a homogenous group and in some instances they have competed for funding. NGOs provide different services to different client groups and have varying levels of expertise and scales of operation. There are also different wage rates and industrial arrangements. A well developed transition strategy will be required to support their progressive increased participation in the system.

27.21 As noted earlier, a number of the recommendations are interdependent, or at least related, and will need to be implemented in tandem, if accepted. Those that fall into this category are identified at the commencement of the Recommendations section of this report.

27.22 The Inquiry emphasises that while the implementation of some recommendations would bring them within the high or medium cost categories, their successful introduction will produce costs offsets, some immediately, and others on a longer term basis. This is a factor that the SCI Implementation Unit will need to take into account. It has a particular significance, for example, in relation to the timeframe which will be required for improved family support and early intervention services to have a significant impact on the number of cases requiring statutory intervention, and removal of children into more expensive OOHC.

27.23 It also recognises that where the implementation of recommendations requires the recruitment and training of additional caseworkers for DoCS or NGOs, there is likely to be a considerable lead time before they can become operational. This will have a particular significance for building the necessary additional capacity for Aboriginal NGOs. It means, that subject to acceptance of the recommendations, it will be important to commence that process early, and to establish a plan for its successive development.

27.24 This aspect of planning will also need to take into account the need for future flexibility, including the capacity to move caseworkers between different functions, once the reforms are progressively implemented, which will also require forward planning that can address acquisition of the range of skills training that will be necessary.

Annexure A Exchange of Information

A.1 A number of different agencies hold information relevant to child protection. These include:

a. DoCS

b. NSW Police Force

c. Department of Health

d. Department of Education and Training

e. Department of Ageing, Disability and Home Care

f. Department of Corrective Services

g. Department of Housing

h. Department of Juvenile Justice.

The Legislative Scheme

The *Privacy and Personal Information Protection Act 1988*

A.2 The *Privacy and Personal Information Protection Act 1988* (PPIP Act) regulates the exchange of 'personal information' between public sector agencies.

A.3 Public sector agency, as defined in s.3, includes a government department, a statutory body representing the Crown, and the NSW Police Force. Each of the agencies listed to above is a 'public sector agency' and must comply with the PPIP Act.

A.4 'Personal information' is broadly defined in s.4 of the PPIP Act to mean information or an opinion about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion. Pursuant to s.4A the definition of personal information in the PPIP Act does not include health information.[1] Personal information that is 'health information' is regulated by the *Health Records and Information Privacy Act* 2002 (HRIP Act), which is discussed below.

A.5 Almost any child protection information, in written or electronic form, is likely to contain information that falls within the definition of 'personal information' The supply of a name, for example, is almost always personal information, even if the document does not contain further information about the person.[2]

[1] Except as provided by the *Privacy and Personal Information Protection Act 1988* or the *Health Records and Information Privacy Act 2002.*

[2] *WL v Randwick City Council* [2007] NSWADTAP 58 at [21]-[22].

Documents which do not contain any obvious features identifying an individual can still be 'personal information' by reason of the context to which they belong.[3] 'Personal information' does not include information that is seen or heard by agency employees, but is not in written form. Information that is only 'held' in the minds of agency staff is not personal information.[4] Consequently, the PPIP Act does not govern oral disclosure of information about a person by one agency to another agency if the information is not sourced from a document. However, if information provided orally to an agency is subsequently recorded in written or electronic from, it may become 'personal information.'[5]

A.6 Frequently, child protection information will contain personal information (or health information or a combination of personal information and health information) relating to one or more persons – for example, such information may contain personal information about a child, a parent or parents and a third party, such as a guardian or carer.

A.7 The PPIP Act establishes a series of 12 Information Protection Principles that regulate the collection, storage, accuracy, use and disclosure of 'personal information' by public sector agencies. Unless an agency has been exempted from complying with a particular information protection principle each of the information protection principles must be obeyed.

A.8 There are three places where a relevant exemption might be found. First, a number of specific exemptions are contained in the PPIP Act itself. Secondly, the Minister may make a Privacy Code of Practice that applies to a particular agency or agencies and modifies or overrides the application of one of more information protection principles to that agency or agencies.[6] Finally, the Privacy Commission may make a written Direction that modifies or overrides the application of the PPIP Act or a Privacy Code of Practice to a particular agency or agencies.

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[3] *WL v Randwick City Council* [2007] NSWADTAP 58 at [15].

[4] *Vice-Chancellor Macquarie University v FM* [2005] NSWCA 192

[5] *Department of Education and Training v MT* [2005] NSWADTAP 77 at [21]. This decision was overturned by the Court of Appeal in *Department of Education and Training v MT* (2006) 67 NSWLR 237, although the Court of Appeal's decision did not make reference to the status of information received orally but later recorded in written or electronic form.

[6] A Privacy Code of Practice may be submitted to the Minister by the Privacy Commissioner, or any public sector agency. Pursuant to s.30 of the *Privacy and Personal Information Protection Act 1988* a code of practice may:

a. specify requirements that are different to those set out in the principles or exempt any conduct or activity of the agency from compliance with the principles;

b. specify the manner in which any of the information protection principles are to be applied or followed by the agency.

c. Exempt the agency or a class of agencies from the requirement to comply with any of the principles.

A code of practice may apply to a specified class of personal information and, a specified public sector agency or class of public sector agency or a specified activity or class of activity: s.29. A public sector agency must comply with any privacy code of practice applying to it: s.32.

A.9 Each public sector agency is required to have a privacy management plan, which outlines the business rules of the agency in relation to privacy matters.[7]

The Information Protection Principles

A.10 The information protection principles are set out in ss.8-19 of the PPIP Act. Sections 8-11 set out principles applicable to the collection of personal information by a public sector agency. Sections 12-14 set out principles applicable to the storage of personal information by a public sector agency. Sections 15-17 set out principles applicable to the accuracy and use of personal information by a public sector agency. Sections 18 and 19 set out principles applicable to the disclosure of personal information by a public sector agency.

A.11 The information protection principles contained in ss.8, 9, 18 and 19 directly impact upon the ability of public sector agencies to exchange child protection information (in written or electronic form).[8]

A.12 In order for an exchange of personal information between agencies to be lawful under the PPIP Act of the HRIP Act, it must be lawful for the receiving agency to collect it from the disclosing agency, and lawful for the disclosing agency to disclose the information to the receiving agency.

A.13 Unless a relevant exemption applies, an agency that *receives* information from another agency must comply with the information protection principles contained in ss.8 and 9 relating to the collection of information.

A.14 Section 8 provides that a public sector agency must not collect personal information unless the information is collected for a lawful purpose that is directly related to a function or activity of the agency, and the collection of the information is reasonably necessary for that purpose. It also provides that a public sector agency must not collect personal information by any unlawful means.

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[7] *Privacy and Personal Information Protection Act 1988* s.33.

[8] The Information Privacy Principles contained in ss.10 and 11 of the *Privacy and Personal Information Protection Act 1988* only apply to personal information that is collected "from the individual": *HW v Director of Public Prosecutions (No 2)* [2004] NSWADT 73 at [25]. Consequently, they have no application where personal information is collected by one agency from another. The Information Privacy Principles contained in ss.12-14 govern the storage of personal information. The Information Privacy Principles contained in s.16 deals with the accuracy of personal information used by an agency. Consequently, they do not impact upon ability of agencies to exchange information. The Information Privacy Principles contained in s.17 deals with the "use" of information by an agency. It has been held that "use" in s.17 refers to the handling of information *within* an agency, whereas "disclosure" refers to the giving of information to a person or body outside the agency: *JD v Department of Health* [2005] NSWADTAP 44 at [93]; *Department of Education and Training v MT* [2005] NSWADTAP 77 at [39]. Consequently, s 17 only applies to the internal use of information by an agency. Forwarding personal information to another body is a disclosure but not a use and is therefore governed by s.18 not s.17: *JD v Medical Board (NSW)* [2005] NSWADT 247 at [79].

A.15 The Information Privacy Principle (IPP) contained in s.8 does not pose any particular obstacle to the exchange of child protection information between key child protection agencies.

A.16 The IPP contained in s.9 is more problematic. It provides that a public sector agency must collect personal information directly from the individual to whom the information relates, unless the individual has authorised collection of the information from someone else or, in the case of information relating to a person who is under the age of 16 years, the information has been provided by a parent or guardian of the person.

A.17 The IPP contained in s.9 has the potential to significantly impede the exchange of child protection information by preventing an agency from collecting child protection information (containing personal information) from another agency without the authorisation of *each* individual (or, in the case of a child under 16 years, the parents or guardians of each child) whose personal information will be collected.

A.18 An agency that *provides* information to another agency must (unless a relevant exception applies) comply with ss.18 and 19.

A.19 IPP 18 prohibits the disclosure of personal information held by an agency to a person or other body, including another public sector agency, unless:

a. the disclosure is directly related to the purpose for which the information was collected, and the agency disclosing the information has no reason to believe that the individual concerned would object to the disclosure, or

b. the individual concerned is aware or is reasonably likely to have been aware that information of that kind is usually disclosed to that other person or body, or

c. the agency believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person.

A.20 The effect of s.18 is that, where an agency acquires information for some other purpose and discovers that the information is also relevant to child protection, it cannot disclose that information to another agency for the purposes of protecting a child other than in the circumstances set out above. The exception in s.18(1)(c) for disclosures necessary to prevent or lessen a serious and imminent threat to an individual's life or health is narrowly construed.[9] It would not apply in many cases where a child is or may be in need of protection. Section 18(1)(c) has been relied upon several times by agencies alleged to be in breach of s.18, but the defence has never been successfully established.[10] In

[9] *MT v NSW Department of Education and Training* [2004] NSWADT 194 at [195].

[10] See *Macquarie University v FM* [2003] NSWADTAP 43 at [91]; *MT v NSW Department of Education and Training* [2004] NSWADT 194 at [197]; *Department of Education and Training v*

addition, as the Northern Sydney Central Coast Area Health Service advised the Inquiry:

> *an 'imminent threat' definition undermines the serious harm inflicted by sustained and ongoing abuse that may not be perceived as immediately life threatening and yet may have a fatal consequent later eg drug overdose, suicide.*[11]

A.21 Section 19(1) regulates the disclosure of certain kinds of sensitive information. Where information falls within one of the categories of sensitive information in s.19(1), s.18 does not apply to that information and s.19(1) applies instead.[12] Section 19(1) provides:

> *A public sector agency must not disclose personal information relating to an individual's ethnic or racial origin, political opinions, religious or philosophical beliefs, trade union membership or sexual activities unless the disclosure is necessary to prevent a serious and imminent threat to the life or health of the individual concerned or another person.*

A.22 The exemption in s.19 is even narrower than the exemption in s18(1)(c). While information can be disclosed under s.18(1)(c) where it would prevent or lessen a serious and imminent threat to the life or health of an individual, information can only be disclosed under s.19 where it would prevent such a threat.

A.23 Significantly, it has been held that in some instances a dissemination of information within an agency may amount to a disclosure such that, in the case of large public sector agencies consisting of specialised units, the exchange of personal information between units may constitute disclosure that must comply with ss.18 and 19.[13]

A.24 The IPPs contained in ss.18 and 19 have the potential to significantly impede the provision of child protection information from one agency to another agency and, in the case of larger agencies, the provision of child protection information within the agency.

Exemptions in the PPIP Act

A.25 There are no exceptions to s.8 under the PIPP Act. There are, however, a number of exceptions to ss.9, 18 and 19.

MT [2005] NSWADTAP 77 at [63]-[79] and *JD v NSW Department of Health (no 2)* [2004] NSWADT 227 at [75].

[11] Correspondence: Northern Sydney Central Coast Area Health Service, 5 May 2008.

[12] *Department of Education and Training v MT* [2005] NSWADTAP 77 at [73].

[13] See *KJ v Wentworth Area Health Service* [2004] NSWADT 84, where a health agency contravened s.19(1) when one part of the agency disclosed psychiatric information about a patient to another part of the agency.

A.26 A public sector agency is not required to comply with s.9 if compliance would prejudice the interests of the individual to whom the information relates.[14] There is no case law on the meaning of this exemption. It is difficult to assess how useful it is in a child protection context. In particular, it is not clear how the exemption operates in circumstances where child protection information contains personal information about multiple parties and the interests of the child will be prejudiced if s.9 is complied with but the interests of other persons, such as the child's parents or foster parents, will not be. For example, where child protection information contains personal information about parental drug and alcohol abuse or domestic and family violence.

A.27 A public sector agency is also not required to comply with s.9 if the information concerned is collected in connection with proceedings (whether or not actually commenced) before any court or tribunal.[15] This exception is of limited assistance in facilitating the exchange of child protection information between agencies.

A.28 A public sector agency is not required to comply with ss.9, 18 or 19 if it is lawfully authorised or required not to comply with the relevant principle, or non-compliance is otherwise permitted, or is necessarily implied or reasonably contemplated under an Act or any other law.[16] This exception is significant, in so far as it allows an agency to provide information about the safety, welfare or well-being of a child under s.248 of the Care Act (or any other relevant law).[17] However, as discussed below, the power to exchange information under s.248 has its own limitations.

A.29 A public sector agency is not required to comply with s.18 or s.19 if the individual to whom the information relates has expressly consented to the agency not complying with the principle.[18] It has been held that:

> *the requirement of express consent must be the subject of administrative action by the agency disclosing the information. It must have gone to the individual concerned and obtained an express consent that is precise as to the kind and, possibly, the exact contents of the information to which the consent relates.*[19]

This exemption clearly does not assist in facilitating a direct exchange of information from agency to agency.

A.30 A public sector agency is also not required to comply with ss.18 or 19 if the disclosure is to another public sector agency under the administration of the

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[14] *Privacy and Personal Information Protection Act 1988* s.26.
[15] *Privacy and Personal Information Protection Act 1988* s.23.
[16] *Privacy and Personal Information Protection Act 1988* s.25.
[17] *MY v Department of Community Services* [2004] NSWADT 203 at [26].
[18] *Privacy and Personal Information Protection Act 1988* s.26(2).
[19] *Macquarie University v FM* [2003] NSWADTAP 43 at [97].

same Minister (if the disclosure is for the purposes of informing that Minister about any matter within that administration) or the Premier (for the purpose of informing the Premier about any matter).[20] This exception is of limited assistance in facilitating the exchange of child protection information.

A.31 In addition to these general exemptions, there are a number of specific exemptions. NSW Police are not required to comply with the information protection principles other than in connection with the exercise of their administrative and educative functions: s.27.[21] Consequently, the principles do not apply to the core functions carried out by police when engaging in the prevention, detection or prosecution of crime.

A.32 There is also a specific exemption in s.24 of the PPIP Act for investigative agencies. 'Investigative agency' is defined in s.3 of the PPIP Act. None of the agencies listed at the beginning of this annexure is an investigative agency (although it is possible for the regulations to prescribe any of those agencies as investigative agencies for the purposes of the PPIP Act.)

A.33 An 'investigative agency':

a. is not required to comply with s.9 if compliance might detrimentally affect or prevent the proper exercise of the agencies complaint handling functions

b. is not required to comply with s.17 if the use of the information concerned for a purpose other than the purpose for which it was collected is reasonably necessary in order to enable the agency to exercise its complaint handling functions or any of its investigative functions, and

c. is not required to comply with s.18 if the information concerned is disclosed to another investigative agency.[22]

A.34 The exemption in s.24 also applies to any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency or that has been referred from or made by an investigative agency.[23]

A.35 There is also a specific exemption in the PPIP Act for 'law enforcement agencies.' Law enforcement agency is defined in s.3. Of the agencies listed at the beginning of this annexure only the NSW Police, Corrective Services and Juvenile Justice are law enforcement agencies (although it is possible for the regulations to prescribe other persons or bodies as law enforcement agencies).

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[20] *Privacy and Personal Information Protection Act 1988* s.28(3).

[21] This exemption also applies to the Independent Commission Against Corruption, the Inspector of the Independent Commission Against Corruption, the staff of the Inspector of the Independent Commission Against Corruption, the Police Integrity Commission, the Inspector of the Police Integrity Commission, the staff of the Inspector of the Police Integrity Commission and the New South Wales Crime Commission

[22] *Privacy and Personal Information Protection Act 1988* s.24.

[23] *Privacy and Personal Information Protection Act 1988* s.24(4).

A law enforcement agency is not required to comply with s.9 if compliance would prejudice the agency's law enforcement functions.[24]

A.36 In addition, a public sector agency (whether or not a law enforcement agency) is not required to comply with s.18 if the disclosure of the information concerned:

a. is made in connection with proceedings for an offence or for law enforcement purposes, or

b. is to a law enforcement agency 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 for the protection of the public revenue, or

e. is reasonably necessary in order to investigate an offence where there are reasonable grounds to believe that an offence may have been committed.[25]

A.37 A public sector agency (whether or not a law enforcement agency) is not required to comply with s.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.[26]

A.38 Again, these exemptions only have a limited application in the context of the exchange of child protection information.

Exemptions contained in Privacy Codes of Practice

A.39 In addition to the exceptions contained in the PPIP Act, there are additional exceptions contained in Privacy Codes of Practice that have been made under the Act.

A.40 The most significant of these is the *Privacy Code of Practice (General) 2003* that was made under the PPIP Act and which modifies the application of the IPPs to 'human services agencies' (the Privacy Code). A similar Code of Practice was made under the HRIP Act in 2005[27] which modifies the application of the HRIPs to 'human services agencies' (the Health Code).

A.41 A 'human services agency' is defined in the codes to mean a public sector agency that provides:

a. welfare services

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[24] *Privacy and Personal Information Protection Act 1988* s.23.
[25] *Privacy and Personal Information Protection Act 1988* s.23(5).
[26] *Privacy and Personal Information Protection Act 1988* s.23(7).
[27] *Health Records and Information Privacy Code of Practice 2005.*

b. health services

c. mental health services

d. disability services

e. drug and alcohol treatment services

f. housing and support services

g. education services.

A.42 Most of the key child protection agencies listed at the beginning of this annexure are human services agencies with the exception of NSW Police, Juvenile Justice and Corrective Services.

A.43 Clause 10 of the Privacy Code provides that, despite the IPPs, a human services agency may collect and use personal information about an individual and may disclose personal information about the individual to another human services agency or an allied agency[28] if the collection, use or disclosure is in accordance with the written authorisation given by a senior officer.

A.44 The authorisation must specify the period, being no more than 12 months, for which it has effect, the classes of information to which the authorisation is to apply, and the human services or allied agencies to whom the specified information may be disclosed.[29]

A.45 The senior officer must not issue an authorisation unless he or she is satisfied that:

a. the individual to whom the information relates is a person to whom services are to be provided

b. the individual (or the individual's authorised representative) has failed to consent to the collection, use or disclosure of the information

c. there are reasonable grounds to believe that there is a risk of substantial adverse impact on the individual or some other person if the collection or use or disclosure does not occur

d. the collection or use or disclosure is likely to assist in developing or giving effect to a case management plan or service delivery plan that relates to the individual; and that

e. reasonable steps have been taken to ensure the individual has been notified of the authorisation.[30]

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[28] An allied agency is an agency (other than a public sector agency) that is wholly or partly funded by a human services agency and that is approved in writing by the head of that human services agency for the purposes of the cl.10 of the *Privacy Code of Practice (General) 2003*.

[29] *Privacy Code of Practice (General) 2003* cl.10(3); *Health Records and Information Privacy Code of Practice 2005* cl.4(3).

[30] *Privacy Code of Practice (General) 2003* cl.10(4); *Health Records and Information Privacy Code of Practice 2005* cl.4(4).

A.46 'Substantial adverse impact' includes, but is not limited to, serious physical or mental harm, significant loss of benefits or other income, imprisonment, loss of a housing or the loss of a carer.[31]

A.47 On its face, cl.10 of the Privacy Code and cl.4 of the Health Code appear to provide a useful mechanism for exchanging child protection information outside of the strictures of the PPIP Act and the HRIP Act.

A.48 However, according to DOCs "the Codes are meant for use in those rare circumstances where clients with complex needs refuse to consent to the sharing of their information between agencies."[32]

A.49 Housing expressed the view that the Code "is not designed to, or capable of, protecting children at risk and was not intended for such a purpose."[33]

A.50 Education appeared to share this view and submitted that the provisions of the Code should be expanded to accommodate circumstances where a service is not being provided but nevertheless access to the information is crucial for the investigation of child protection related issues.[34]

A.51 The Greater Southern Area Health Service informed the Inquiry.

> *Although it is difficult to gauge precisely, I consider it likely that there is not significant awareness of either code within [Greater Southern Area Health Service] or other public health organisations through the state.*[35]

A.52 Presumably, by reason of a combination of the above factors, the ability to issue a written authorisation under the Codes is rarely, if ever, used to facilitate the exchange of information. The Inquiry asked each of the key child protection agencies bound by the Codes to identify the number of occasions on which a written authorisation had been issued by that agency. The Inquiry was informed that, so far as each agency is aware, no written authorisation has ever been issued under the Codes.

A.53 Clause 11 of the Privacy Code provides that a human services agency is not required to comply with s.9 of the Act if it is unreasonable or impracticable in the circumstances to do so. This is a significant modification of the PPIP Act. It means that a human services agency may collect child protection information from another agency without having to first obtain the individual's consent or, where the information relates to a child under the age of 16 years, the authorisation of the child's guardian.

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[31] *Privacy Code of Practice (General) 2003* cl.10(1).

[32] DoCS, *Privacy Management Plan*, p.14.

[33] Correspondence: Department of Housing, 26 March 2008, p.3.

[34] Correspondence: Department of Education and Training, 25 March 2008.

[35] Correspondence: Greater Southern Area Health Service, 2 April 2008.

A.54 Housing, Police and Education also have their own Privacy Code of Practice.

A.55 Police's Privacy Code of Practice has no provisions relevant to the exchange of child protection information.

A.56 Housing's Privacy Code of Practice relevantly modifies the Department's obligation to comply with the information privacy principle contained in s.9 for the purpose of allowing the Department to administer the Priority Housing Assistance program. The Priority Housing Assistance program requires Housing to seek information from other agencies including DOCs and NGOs in order to determine whether an individual has a need for priority housing. In some cases, it is impracticable for Housing to obtain an authority from the individual consenting to the release of that information. The Code permits Housing to collect personal information from other government and non-government agencies for the purpose of assessing an individual's need for priority housing where it is impracticable to obtain the consent of the person to whom the information relates and disclosure of the personal information by the other body is permitted by the PPIP Act or another law. In addition, where a person under the age of 16 applies for housing, the Department may collect information from a third party other than a parent or guardian where that is in the interests of the minor applicant.

A.57 Education's Privacy Code of Practice allows the Department to depart from the information protection principles contained in sections 9, 10, 12(a), 13, 14, 15, 17, 18 and 19 if compliance might detrimentally effect or prevent the proper exercise of its complaint handling functions. The provision makes specific reference to the investigation of allegations in relation to child sexual abuse, inappropriate conduct of a sexual nature involving students, and physical and emotional abuse of students. Various other modifications apply in relation to disclosure of personal information to parents, guardians or care givers. Significantly, the Department may depart from ss.17, 18 and 19 of the PPIP Act where the use and disclosure of information is for the purpose of 'child protection.' Child protection is not defined in the Code.

A.58 While these individual Codes provide useful and significant exemptions, their utility in facilitating information exchange is limited in circumstances where other agencies do not have the benefit of similar exemptions. As Education and Training told the Inquiry:

> *Other agencies may not necessarily incorporate similar exemptions in their codes or have a code at all nor is there an obligation to do so. In the absence of a privacy code to address the issue, the ability of government agencies to freely exchange information about child protection issues is curtailed.*[36]

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[36] Correspondence: Department of Education and Training, 25 March 2008.

Directions

A.59 In addition to the exemptions set out in the PPIP Act and exemptions contained in privacy codes of practice, the Privacy Commissioner may issue a written direction exempting an agency from complying with the privacy principles in the Act or modifying the application of a principle or a code to a public sector agency, on condition that the Commissioner is satisfied that the public interest in making the exemption outweighs the public interesting requiring the agency to adhere to the principles.

A.60 Eight directions have been made under the PPIP Act that are relevant to the exchange of information by agencies involved in child protection. The two most significant are the *Direction on Information Transfers between Public Sector Agencies* (the Direction on Information Transfers) and the *Direction on the Processing of Personal Information by Certain Public Sector Agencies in Relation to their Investigative Functions* (Direction on Processing Personal Information).

A.61 The Direction on Information Transfers was made by the Privacy Commissioner on 28 December 2007. It has effect from 1 January 2008 to 31 December 2008.

A.62 The Direction on Information Transfers expressly applies to each of the key agencies involved in child protection listed at the beginning of this annexure. Under the Direction on Information Transfers, exchanges of information that are reasonably necessary for the purpose of referring inquiries between those agencies, for law enforcement purposes or for the performance of agreements (formal or informal) between those agencies are exempt from the operation of the information protection principles. The Direction on Information Transfers does not apply to health information. This Direction on Information Transfers provides a significant exemption. It means that the exchange of any type of child protection information (that does not include health information) can be exchanged pursuant to an MOU or other agreement.

A.63 The Direction on Processing Personal Information was also made by the Privacy Commissioner on 28 December 2007. It has effect from 1 January 2008 to 31 December 2008. It applies to the same agencies as the Direction on Information, and it does not apply to health information.

A.64 The Direction on Processing Personal Information exempts relevant agencies from ss. 9, 10, 13, 14, 15, 17, 18 and 19(1) of the PPIP Act if non-compliance is reasonably necessary for the proper exercise of any of the agencies' investigative functions or its conduct of any lawful investigations. Agencies also need not comply with ss.18 or 19(1) if non-compliance is reasonably necessary to assist another relevant agency exercising investigative functions or conducting a lawful investigation.

A.65 'Lawful investigation' means an investigation carried out by an agency under specific legislative authority or where the power to conduct the investigation is

necessarily implied or reasonably contemplated under an Act or law. It covers only those investigations which may lead to the agency taking or instituting formal action in relation to the behaviour under investigation. 'Investigative functions' of an agency refer to those functions that are directly related to a lawful investigation and that are necessary for the conduct of that lawful investigation. 'Investigation' includes any examination of or any preliminary or other enquiry into a matter, including matters where it is decided to take no further action and matters which arise by way of complaint.

A.66 It appears reasonably clear that the response of DoCS to a notification pursuant to Chapter 3, Part 3 of its legislation would fall within the definition of lawful investigation.

A.67 In addition, there are a number of other directions that facilitate the collection, use and disclosure of personal information in relation to specific projects that relate to child protection.

A.68 On 7 August 2006 the Privacy Commissioner made a Direction concerning the Child Protection Watch Team,[37] which is a trial involving a number of public sector agencies which have functions affecting the management of high risk offenders. The aim is to monitor and manage registrable persons who are referred to the trial because they pose a high risk of re-offending violently or sexually against children. The public sector agencies are those key agencies involved in child protection and the Direction states that they need not comply with the information protection principles contained in ss.8(1), 9, 10, 13, 14, 15, 17, 18 and 19 of the PPIP Act in collecting, holding, using and disclosing personal information in a manner which is reasonably necessary for the management of a case by the Child Protection Watch Team.

A.69 On 2 September 2008 the Privacy Commissioner made a Direction relating to the Anti-Social Behaviour Pilot Project. That is a project intended to improve case coordination across the Anti-Social Behaviour Project participating agencies regarding the management of complex cases and crisis cases involving children, young people and families who live in, or are habitual visitors to certain specified geographical areas. The public sector agencies covered by this Direction include the key child protection agencies. Those agencies, in collecting, using and disclosing personal information for the purpose of implementing the objectives of the Anti-Social Behaviour Project are not required to comply with the IPPs contained in ss. 8(1), 9,10,17,18 or 19 of the PPIP Act.

A.70 The Ombudsman informed the Inquiry that he had examined the Direction relating to the Anti-Social Behaviour Pilot Project and was of the view that it does not provide a good practical model for a system of information exchange between agencies because:

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[37] Privacy Commissioner, *Privacy Direction on Child Protection Watch Team*, 2006.

> *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 unwieldy and difficult to follow.*[38]

A.71 On 2 February 2006 the Privacy Commissioner made a Direction relating to the Redfern Waterloo Partnership,[39] which is a project intended to improve case co-ordination across participating agencies and NGOs regarding the management of complex cases and crisis cases involving children, young people and families in the Redfern Waterloo area. The Direction is to permit the exchange of personal information between those participating agencies and the NGOs. The participating agencies include all the key agencies involved in child protection. While this Direction has a very specific application, in that the operation of the case coordination framework is described in detail with certain criteria needing to be met before a child or young person or family becomes subject to the project, it may be a model that could be followed in relation to other geographic areas.

The *Health Records and Information Privacy Act 2002*

A.72 The HRIP Act regulates the handling of 'health information' by both the public and private sectors in NSW. It applies to every organisation that is a health service provider or that collects, holds or uses health information.[40]

A.73 Health information is a specific type of personal information. Health information is broadly defined in s.6, and includes personal information that is information or an opinion about the physical, mental health or a disability of an individual as well as any personal information collected to provide a heath service. In many instances, child protection information will contain health information as well as personal information.

A.74 The HRIP Act is structured in the same way as PPIP Act. It establishes a set of 15 health privacy principles to regulate the collection, storage, accuracy, use and disclosure of health information. There are some exemptions to the application of those principles contained in the HRIP Act. In addition, a code of practice may modify or override the principles, and a Direction by the Privacy Commissioner may modify or override the HRIP Act or a code. The Privacy Commissioner may also issue guidelines relating to the protection of health information.

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[38] Submission: NSW Ombudsman, Privacy and Exchange of Information, p.19.

[39] Privacy Commissioner, *Direction relating to the Redfern Waterloo Partnership Project*, 2006.

[40] *Health Records and Information Privacy Act 2002* s.11.

The Health Privacy Principles

A.75 The Health Privacy Principles are set out in Schedule 1 of the HRIP Act. Unlike the PPIP Act, where there is an exception to a health privacy principle, the exception is set out in the same clause as the principle itself.

A.76 Clauses 1-4 of Schedule 1 of HRIP Act (the Schedule) set out principles applicable to the collection of health information by an organisation. Clauses 5-7 set out principles applicable to the storage and holding of health information by an organisation. Clauses 8-10 set out principles applicable to the accuracy and use of health information by an organisation. Clause 11 sets out the principle applicable to the disclosure of health information by a public sector agency. Clauses 12-15 deal with the use of identifiers and the anonymity, transfer and linkage of health information.

A.77 The health privacy principles contained in cls.1, 3, 4 and 11 directly impact upon the ability of public-sector agencies to exchange child protection information that contains health information in written or electronic form.[41]

A.78 An agency that *receives* health information from another agency must (unless a relevant exception applies) comply with cls.1-4 relating to the collection of information.

A.79 Clause 1 of the Schedule mirrors s.8 of the PPIP Act. It provides that an organisation must not collect health information unless the information is collected for a lawful purpose that is directly related to a function or activity of the organisation, and the collection of the information is reasonably necessary for that purpose. It also provides that an organisation must not collect personal information by any unlawful means.

A.80 There are no exceptions within HRIP Act to cl.1 of the Schedule. As a result of cl.1, an agency cannot collect child protection information (that contains health information) from another agency unless the information is directly related to a function or activity of the agency.

A.81 Clause 3 of the Schedule, provides that an organisation must collect health information about an individual only from that individual, unless it is unreasonable or impracticable to do so. There are no exceptions within the HRIP Act to cl.3. However, a statutory guideline has been issued under HRIP Act that identifies particular circumstances in which it will be impracticable or unreasonable to obtain information directly from an individual. None of the circumstances identified in the guideline is relevant in a child protection context. However, the guideline acknowledges that there will be circumstances in which

[41] Principle 2 applies to collection of health information from an individual, not from a third party. Principle 5, 6, 7 deal with the storage of health information. Principles 8 and 9 deals with the accuracy of health information. Principle 10 deals with the use of health information internally within an agency. Principles 12-15 deal with specific uses that are not relevant to the exchange of information between agencies.

it is unreasonable or impracticable to obtain health information about a person directly from the person themselves other than those expressly identified in the guideline.

A.82 Clause 4(2) of the Schedule provides that if an organisation collects health information about an individual from someone else, it must take any steps that are reasonable in the circumstances to ensure that the individual is generally aware of certain matters including:

a. the identity of the organisation and how to contact it

b. the fact that the individual is able to request access to the information

c. the purposes for which the information is collected

d. the persons to whom (or the types of persons to whom) the organisation usually discloses information of that kind.

A.83 However, an organisation is not required to comply with cl.4(2) to the extent that:

a. making the individual aware of the matters would pose a serious threat to the life or health of any individual, or

b. the collection is made in accordance with guidelines issued by the Privacy Commissioner setting out circumstances in which an organisation is not required to comply with cl.4(2).

A.84 The Privacy Commissioner has issued guidelines in relation to the application of cl.4(2). Those guidelines state that an organisation is not required to notify an individual when it collects health information about the individual from someone else in circumstances where:

a. it is unreasonable or impracticable to collect the information from the person concerned, and notifying the person would be unreasonable or impracticable in the circumstances

b. the information is relevant to a third party's family, social or medical history and the collection of the information is reasonably necessary to the organisation to provide a health service directly to the third-party

c. the person is incapable of understanding the general nature of the information in Health Privacy Principle 4(1), the organisation takes reasonable steps to ensure that any authorised representative of the person is aware of that information and, where practicable, explains it appropriately to the person, or

d. the health information was initially collected from the person to whom it relates by another organisation and there are reasonable grounds to believe that that organisation has already notified the person of the information in Health Privacy Principle 4(1).

A.85 An agency that provides health information to another agency (unless a relevant exemption applies) must comply with cl.11 of the Schedule relating to the disclosure of information.

A.86 Clause 11 provides that an organisation that holds health information must not disclose the information for a purpose (a secondary purpose) other than the purpose (the primary purpose) for which it was collected unless one of the exceptions set out in cl.11 applies.

A.87 There are a number of exceptions contained in cl.11. Of those, the following are most likely to be relevant to the key child protection agencies. Clause 11 does not apply if:

a. the individual to whom the information relates has consented, or

b. the secondary purpose is directly related to the primary purpose and the individual would reasonably expect the organisation to disclose the information for the secondary purpose, or

c. the disclosure is reasonably believed by the organisation to be necessary to lessen or prevent a serious and imminent threat to the life, health or safety of the individual or another person, or a serious threat to public health or public safety, or

d. the disclosure 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

e. an agency discloses the health information as a necessary part of its investigation of unlawful conduct or in reporting its concerns to relevant persons or authorities, or

f. the disclosure is reasonably necessary for the exercise of law enforcement functions by law enforcement agencies in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed, or

g. the disclosure is reasonably necessary for the exercise of complaint handling functions or investigative functions by investigative agencies, or any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency, or that has been referred from or made by an investigative agency

h. non compliance is lawfully authorised, required, permitted, necessarily implied or reasonably contemplated under an Act or any other law

i. the organisation is an investigative agency (or any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency, or that has been referred from or made by an investigative agency) disclosing information to another investigative agency

j. the disclosure is by a public sector agency to another public sector agency if the disclosure is for the purposes of informing the Minister about any matter within the Minister's administration, or for the purposes of informing the Premier about any matter.

Codes of Practice

A.88 As noted above, a Code of Practice was made under the HRIP Act in 2005, which modifies the application of the HRIP Act to 'Human services agencies.'

A.89 The Health Privacy Code mirrors cl.10 of the Privacy Code, in permitting the collection, use or disclosure of health information by 'human services agencies' without the consent of the person to whom the health information relates provided the collection, use or disclosure is authorised in writing by a senior officer. The definition of human services agency and the requirements in relation to the issue of an authorisation are the same as in the Privacy Code.

A.90 There is, however, no equivalent in the Health Privacy Code to cl.11 in the Privacy Code.

Directions

A.91 The Privacy Commissioner had made directions under s.62 of the HRIP Act relating to the Anti-Social Behaviour Pilot Project and relating to the Redfern Waterloo Partnership Project, that are in equivalent terms to the Directions of the same name made under the PPIP Act. As far as the Inquiry is aware, no other directions have been made by the Privacy Commissioner under the HRIP Act that are relevant to the exchange of health information by child protection agencies.

Children and Young Persons (Care and Protection) Act 1998

A.92 There are various provisions in the Care Act that impact upon the exchange of child protection information.

A.93 The most significant of these is s.248 which enables the Director-General of DoCS to exchange information with, or provide information to, a 'prescribed body' relating to the safety, welfare and wellbeing of a particular child or young person or class of children and young persons.

A.94 Prescribed body means the Police Service, a government department, a public authority, a government school, a registered non-government school,[42] a TAFE

[42] As defined by the *Education Act 1990*.

establishment,[43] a public health organisation,[44] a private hospital[45] or any other body or class of bodies prescribed by the regulations.

A.95 Prescribed bodies are set out in the 2000 Regulation and include private fostering agencies, residential child care centres or child care services, the Family Court, Centrelink and other organisations with responsibility for health care, welfare, education, children's services, residential services or law enforcement in relation to children.

A.96 Pursuant to s.248 the Director-General may furnish a prescribed body or direct a prescribed body to furnish the Director-General with information relating to the safety welfare and wellbeing of a particular child or young person or class of children or young persons. The provision also provides for unborn children to be the subject of an exchange of information.

A.97 Where information is lawfully exchanged under s.248, the principles contained in the PPIP Act and the HRIP Act do not apply.[46]

A.98 However, the ability to exchange information under s.248 is limited. While it allows DOCs to provide and receive information to and from prescribed bodies, it does not enable any of the prescribed bodies to exchange information directly with each other in relation to the safety, welfare and well being of a particular child or a class of children, even when it has been provided by DoCS.

A.99 As the Ombudsman has observed that:

> *Section 248… seems to proceed on an assumption that DoCS is at the centre of "hub" of all matters in relation to the care and protection of children and young people…. This assumption is misconceived.*[47]
>
> …
>
> *The listing of … agencies as 'prescribed bodies' 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*

[43] As defined by the *Technical and Further Education Commission Act 1990*.

[44] As defined by the *Health Services Act 1997*.

[45] As defined by the *Private Hospitals and Day Procedure Centres Act 1988*.

[46] *Children and Young Persons (Care and Protection) Act 1998* s.248(5).

[47] Submission: NSW Ombudsman, Privacy and Exchange of Information, p.13.

> *need to share information with each other to jointly support the child, without necessarily requiring DoCS to be involved.*[48]
>
> *…*
>
> *Our view is that certain agencies with significant responsibilities relation 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 this.*[49]

A.100 It appears that the current practice is for agencies wishing to exchange information directly with each other, to make the exchange through DoCS, in order to fall within the terms of s.248 and avoid the restrictive provisions of the PPIP Act and HRIP Act. As the Greater Southern Area Health Service told the Inquiry

> *in practice information sharing between agencies often occurs "through" DoCS (essentially as an intermediary) …Whilst…this satisfies privacy obligations, the process is not necessarily facilitative of an exchange of information that is beneficial to the child or young person. Such a process is formal, inefficient, and time consuming for all parties.*[50]

A.101 Section 185 is in similar terms to s.248. It empowers the Children's Guardian to furnish to prescribed persons, or to direct prescribed persons to provide to the Children's Guardian, information relating to the safety, welfare and well-being of a particular child or young person or class of children and young persons. Prescribed persons are defined as the Director-General, a designated agency or authorised carer.

A.102 Where disclosure of information is not expressly authorised by a provision such as ss.248 or 185 of the Care Act, in addition to the provisions of the PPIP Act and the HRIP Act, an agency must have regard to confidentiality provisions that may apply in relation to the information. A number of Acts may contain confidentiality provision that prevent the sharing of information even where this would be permitted under Privacy legislation. For example, s.254 of the Care Act makes it an offence to disclose information obtained in connection with the administration or execution of the Care Act unless the disclosure is made with the consent of the person from whom the information was obtained, in

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[48] Submission: NSW Ombudsman, Privacy and Exchange of Information, p.5.

[49] Submission: NSW Ombudsman, Privacy and Exchange of Information, p.3.

[50] Correspondence: Greater Southern Area Health Service, 2 April 2008, p.4.

connection with the administration or execution of the Care Act or the regulations, for the purposes of any legal proceedings, or with a lawful excuse. Other legislation administered by key child protection agencies has similar confidentiality provisions.

A.103 Section 29 and Division 1A of the Care Act may also need to be considered. Section 29 provides certain protections to persons who make reports or provide certain information to DoCS in relation to a child or young person or a class of children or young persons. Section 29(f) provides that 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 the consent of the person who made the report, or the leave of a court or other body before which proceedings relating to the report are conducted.

A.104 Division 1A Part 2 Chapter 8 the Care Act makes provision for the disclosure to parents and other significant persons of information concerning the placement of a child or young person in out-of-home care. A disclosure of information concerning placement made in good faith under the Division does not constitute a contravention of any provision as to confidentiality in the Care Act, the HRIP Act or the PPIP Act.[51] However, s.149E of the Care Act provides that a designated agency must not disclose high level identification information concerning the placement of a child or young person unless the authorised carer has consented in writing to the disclosure. If the authorised carer has refused to consent to the disclosure, or has not consented within 28 days after being requested to do so, the designated agency may disclose the information if it believes on reasonable grounds that the disclosure will not pose any risk to the safety, welfare or well-being of the child or young person concerned, or to the authorised carer of the child or young person, or to any member of the family or household of the authorised carer of the child or young person, and it complies with ss.149F and 149G.[52]

Commonwealth Privacy Laws

A.105 The legal framework governing the exchange of information in the child protection context is further complicated by the applicability of Commonwealth privacy laws. The *Privacy Act 1988* (Cth) (the Privacy Act) is the key instrument regulating the handling of personal information in the Commonwealth jurisdiction.

A.106 The Privacy Act applies to agencies and organisations in both the public and private sectors, although it does not regulate the handling of personal

[51] *Children and Young Persons (Care and Protection) Act 1998* s.149J.

[52] Section 149F of the *Children and Young Persons (Care and Protection) Act 1998* requires the agency to give the authorised parent (and child if the child is aged 12 years or over) written reasons for deciding to disclose the information without consent and written notice of the right to appeal the decision to disclose the information without consent. Section 149G deals with the process for appealing a decision to disclose the information without consent.

information by the NSW Public Service which, as discussed above, is regulated by PPIP Act. It does, however, apply to private sector health service providers; these are also covered under the HRIP Act, creating some overlap.

A.107 The Privacy Act contains Commonwealth Information Privacy Principles (Commonwealth IPPs) and National Privacy Principles, which regulate the handling of personal information, including the collection, disclosure, storage and accuracy of such information. Commonwealth IPPs apply to Australian Government agencies, and National Privacy Principles apply to private sector organisations with an annual turnover of over $3 million that do not have their own approved privacy code.[53] The two sets of principles are similar, though not the same.

A.108 The provisions of the Privacy Act are subject to a broad and complicated range of exemptions, partial exemptions, and exceptions, which "are scattered throughout the Act in the definitions of terms, in the Commonwealth IPPs and NPPs and in specific exemption/exception provisions."[54]

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[53] A private sector organisation can develop its own privacy codes, which, once approved by the Privacy Commissioner, replace the National Privacy Principles in relation to that organisation. As at June 2008, there were only three approved and operative codes, and thus the National Privacy Principles continue to have wide application in the private sector. NSW Law Reform Commission, *Consultation Paper 3: Privacy Legislation in NSW*, June 2008, pp.14-15.

[54] NSW Law Reform Commission, *Consultation Paper 3: Privacy Legislation in NSW*, June 2008, p 16.

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Appendix 1 Glossary

Administrative Decisions Tribunal (ADT) A body established under the *Administrative Decisions Tribunal Act 1997* to review specific administrative decisions of NSW Government agencies, and to deal with other types of matters such as discrimination, complaints and professional misconduct.

After care Services provided to a child or young person who has left out-of-home care.

Affidavit A statement for the court written in a standard format approved by the court. It is sworn or affirmed to be true by the person making the statement (deponent).

Alternative Dispute Resolution (ADR) A process whereby parties to a conflict may attempt to resolve their differences with the assistance of an independent person, usually referred to as a mediator.

Apprehended Violence Order (AVO) A court order placing prohibitions or restrictions on the behaviour of a person to ensure the safety and protection of another person in need of protection and of children from domestic or personal violence. The making of an order does not give rise to a criminal record. However, the breach of an AVO is a criminal offence, and the police may arrest and charge a person who breaches an order.

Authorised carer A person who is authorised as a foster or relative carer by a designated agency, the principal officer of a designated agency, or any person authorised according to the regulations (Section 137 of the Care Act).

Care Act Refers to the *Children and Young Persons (Care and Protection) Act 1998*.

Care allowance Allowance paid to service providers or authorised carers to contribute to the expected costs of caring for children and young people in their care. This includes, but is not limited to, costs such as rent, energy, food, clothing and footwear.

Care application An application lodged at the Children's Court under the Care Act with the intention of commencing proceedings to obtain a care order or to vary or rescind a pre-existing order.

Care Order An order made under Chapter 5 of the Care Act for the care and protection of a child or young person.

Care plans A tool that may be used within the context of casework to formalise agreements made with the family to meet the care and protection needs of a child or young person, or within a legal context to enable the Children's Court to allocate parental responsibility.

Care proceedings Proceedings before the Children's Court and District Court under Chapter 5 of the Care Act concerning children and young persons considered to be in need of care and protection.

Care responsibility of the Director-General DoCS responsibility for organising a placement for the child or young person and day-to-day care and control. This includes consenting to certain medical or dental treatment, correcting and managing behaviour and giving permission to participate in activities (s.157 of the Care Act). DoCS may delegate care responsibility to an authorised carer or a relative of the child or young person.

Case management Case management is the process of assessment, planning, implementation, monitoring and review that aims to strengthen families and decrease risks to children and young persons in order to optimise their outcomes through integrated and coordinated service delivery. Case management may be the responsibility of DoCS or another agency, depending on the circumstances of the individual case.

Case plan Sets out what action will be taken to enhance the child's or young person's safety, welfare and well-being. The case plan identifies goals, objectives and tasks with clearly identified responsibilities and time frames that are realistic and achievable within available resources.

Casework The practical day to day involvement with children, young persons, their carers and families. It generally includes implementing the case plan, coordinating supports and services and monitoring.

Child Under the Care Act, a child is a person who is under the age of 16 years. Under the *Family Law 1975,* the *Crimes Act 1900,* the *Commission for Children and Young People Act 1998,* the *Child Protection* (*Prohibited Employment) Act 1998* and the *Ombudsman Act 1994,* a child is a person under the age of 18 years. Under the *Young Offenders Act 1997*, a child is a person who is of or over the age of 10 years and under the age of 18 years.

Casework Specialists Regional DoCS officers usually located in CSCs. They provide practice coaching for caseworkers; conduct briefing, training and support on best practice standards; run case review sessions for teams and complex case reviews.

Children's Court Refers to the Children's Court of NSW, which is responsible for care and criminal proceedings relating to children and young persons.

Children's Court Clinic A service established under s.15B *Children's Court Act 1987* and s.58, of the Care Act to provide independent and expert assessment reports to the Children's Court in relation to care matters. The Clinic comes under the administration of the Attorney General's Department.

Children's Guardian Under Chapter 10 of the Care Act, the Children's Guardian is required to promote the best interests and safeguard the rights of

all children and young persons in out-of-home care, and accredit designated agencies and to monitor their responsibilities under the Care Act and the Regulations.

Children's Registrar An officer of the Children's Court who is responsible for the responsibilities described in cl.19 *Children's Court Rule 2000*. This includes arranging and convening preliminary conferences, hearing procedural matters and making decisions on behalf of the court.

Contact can refer to either:

a. For children and young persons not residing with their birth parents or family it refers to all forms of communication between the child or young person and their family members and/or significant others. Contact may occur through planned visits, letters, telephone conversations or other forms of communication.

b. As part of the DoCS 'intake' process, contact refers to a record of communication made to DoCS, usually at the Helpline, by the public or by mandatory reporters regarding a concern for a child or young person, a request for assistance, information about adoption or other information.

Community Services Centre (CSC) A DoCS office that delivers child protection, early intervention and out-of-home care services. There are 80 CSCs located across metropolitan and regional NSW.

Corporate Information Warehouse (CIW) An integrated and aggregated source of information and data about DoCS core operations and performance that went live in December 2005. It provides online access to corporate and business reporting measures.

Culturally and Linguistically Diverse (CALD) Refers to people from culturally diverse backgrounds, particularly people who are immigrants or the descendants of immigrants and who define their own cultural, linguistic and religious identity partly or wholly on this basis.

Designated agency Is an agency accredited in accordance with the Regulations to provide out-of-home care services, and includes DoCS and DADHC.

DoCS Helpline A statewide intake assessment and referral call service operating 24 hours a day, 7 days a week.

Domestic and family violence This is violence when one partner in an intimate relationship attempts by physical or psychological means to dominate and control the other. It occurs within a variety of close interpersonal relationships such as between spouses, partners, parents and children, siblings and among kinship relationships.

Establishment The term commonly used within the care jurisdiction to describe the finding by the Children's Court that a child or young person is in need of care and protection.

Foster care General foster care is defined as 24 hour care for children and young people aged 0-17 years which is provided on a short or long term basis by authorised carers in their own homes, or in a home owned or rented by an agency, who are reimbursed for expenses. The range of placement types available for children and young people include: emergency or crisis placements, short term (temporary) placements, bridging (medium) placements, permanent care placements, respite care placements, and adolescent community placements.

Guardian ad litem A person appointed by the court to instruct a legal representative on behalf of a child/young person or a parent in court where the child/young person or parent is not capable of giving proper legal instructions.

High Needs Kids A term used by DoCS to refer to children and young people in OOHC with high and complex needs.

In need of care and protection A term used by DoCS in two different circumstances, and according to two different standards of proof:

a. when, following a Secondary Assessment, DoCS forms an opinion on reasonable grounds that the level of future risk to a child or young person is sufficient to warrant protective action by DoCS (under s.34 of the Care Act) to safeguard the child's or young person's safety, welfare and well-being. Action by DoCS includes the provision of support services, protective intervention or court action; or

b. when a matter is placed before the Children's Court for a care order, and the court is satisfied on the balance of probabilities that the child is in need of care and protection (s.72 of the Care Act).

Initial Assessment Initial Assessment refers to the first gathering and analysis of information contained in a report about possible risk of harm to a child or young person. It is usually undertaken by the DoCS Helpline. The purpose of the assessment is to assist caseworkers to determine whether or not a child or young person is at risk of harm, and whether that child or young person may be in need of care and protection.

Joint Investigation Response Team (JIRT) Joint investigations of child abuse have been conducted by NSW Police and DoCS since 1997. NSW Health provides support to joint investigations. Joint investigation occurs where there are allegations that a child or young person has been the victim of sexual assault, serious physical abuse or neglect that may involve a criminal offence.

Key Information and Directory System (KiDS) DoCS' electronic system for keeping records and plans of its clients.

Kinship care Care with a person who is not a relative of the child, but who shares cultural, tribal and community connection that is recognised by that child's community.

Mandatory reporter A person who as part of their professional or paid work or as the supervisor/manager of a person who as part of their professional or paid work, delivers health care, welfare, education, children's services, residential services or law enforcement to children or young persons. Mandatory reporters are required under s.27 of the Care Act to make a report to DoCS if they have reasonable grounds to suspect that a child is at risk of harm, and those grounds arise during the course of or from the person's work.

Out-of-home care (OOHC) The care of the child or young person who is in the parental responsibility of the Minister, or a non-related person, residing at a place other than their usual home, and by a person other than their parent, as a result of a Children's Court order that lasts for more than 14 days, or because they are a protected person.

PANOC This is an acronym for Physical Abuse and Neglect Of Children, a counselling and therapy service provided by NSW Health for children or young persons referred to them by DoCS.

Parental responsibility to the Minister An order of the Children's Court that places the child or young person under the parental responsibility of the Minister (s.79(1)(b) of the Care Act).

Permanency planning Permanency planning is a requirement of the Care Act (ss.78A and 83). It involves giving early consideration to the long-term needs of a child in care based on an assessment of family strengths, to work out whether or not there is a realistic possibility of restoration. Permanency planning can include restoration to the birth family, long-term care (including sole parental responsibility orders) and relative/kinship care or adoption.

Protected person Under s.135 of the Care Act a protected person is a child or young person who is a:

a. ward of the Supreme Court or subject to an order by the Court in its *Parens Patriae* jurisdiction who is in the custody or care of the Minister or Director-General, or

b. non-relative child or young person awaiting adoption, or

c. child or young person under the guardianship or custody of the Minister or Director-General by order of the Family Court or the Supreme Court.

Relative Care Care provided to a child or young person by a relative.

Reporter Any person who conveys information to DoCS concerning their suspicion that a child, young person or unborn child (once born) is at risk of harm as defined under s.23 of the Care Act.

Restoration Following the removal of a child or young person from the care of a parent or parents the child or young person is placed back in the care of a parent or parents where that environment is assessed as safe, nurturing and secure.

Secondary assessment Procedurally, Secondary Assessment follows an Initial Assessment where the outcome is that a child or young person is believed to be at risk of harm and may be in need of care and protection. The secondary assessment employs the Secondary Assessment Framework. Secondary assessment is usually conducted by the CSC or JIRT.

Service provider Includes government and non-government agencies, designated agencies and other contracted providers.

Short term re-report A report received, with the same reported issue type, within seven days of another report for the child. For re-reports a report is considered to have the same issue type if any of the three reported issues match those from a previous report. Issues are grouped into physical, sexual, psychological, neglect and carer for matching.

Young person Under the Care Act, a young person is defined as a person aged 16 years or above, but under the age of 18 years. Under the *Crimes Act 1900,* the *Commission for Children and Young People Act 1998,* the *Child Protection (Prohibited Employment) Act 1998,* and the *Ombudsman Act 1974,* any person under the age of 18 years is defined as a child.

Appendix 2 List of legislation (and abbreviations where applicable)

NSW Acts:
Aboriginal Land Rights Act 1983
Aborigines Act 1969 (repealed)
Aborigines Protection Act 1909 (repealed)
Administrative Decisions Tribunal Act 1997
Adoption Act 2000
Child Protection (Offenders Prohibition Orders) Act 2004
Child Protection (Offenders Registration) Act 2000
Children (Care and Protection) Act 1987 (1987 Act)
Children (Criminal Proceedings) Act 1987
Children (Detention Centres) Act 1987
Children (Protection and Parental Responsibility) Act 1997
Children and Young Persons (Care and Protection) Act 1998 (the Care Act)
Children's Court Act 1987
Commission for Children and Young People Act 1998 (CCYP Act)
Community Relations Commission and Principles of Multiculturalism Act 2000
Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)
Community Welfare Act 1987 (Community Welfare Act)
Coroners Act 1980
Crimes (Administration of Sentences) Act 1999
Crimes (Domestic and Personal Violence) Act 2007
Crimes (Serious Sex Offenders) Act 2006
Crimes Act 1900
Criminal Procedure Act 1986
Disability Services Act 1993
Education Act 1990
Evidence Act 1995
Evidence Amendment Act 2007
Health Administration Act 1982
Health Records and Information Privacy Act 2002 (HRIP Act)
Housing Act 2001
Independent Commission Against Corruption Act 1988
Liquor Act 2007
Local Court Act 2007
Local Government Act 1993
Ombudsman Act 1974 (Ombudsman Act)
Pre-Trial Diversion of Offenders Act 1985
Privacy and Personal Information Protection Act 1998 (PPIP Act)
Public Sector Employment and Management Act 2002
Public Sector Management Act 1988 (repealed)
Rural Assistance Act 1989

NSW Acts:
Special Commission of Inquiry Act 1983
State Emergency and Rescue Management Act 1989 (SERM Act)
State Emergency Service Act 1989
Status of Children Act 1996
Supreme Court Act 1970
Young Offenders Act 1997 (Young Offenders Act)

NSW Regulations
Adoption Regulation 2003
Children and Young Persons (Care and Protection) Regulation 2000 (the Regulations)
Children and Young Persons (Savings and Transitional) Regulation 2000
Children's Court Rule 2000 (the Rules)
Children's Services Regulation 2004
Community Services (Complaints, Reviews and Monitoring) Regulation 2004
Police Regulation 2000 (repealed)
Uniform Civil Procedures Rules 2005

Other Acts and Regulations
Adoption Act 1984 (Vic)
Adoption Act 1988 (SA)
Adoption Act 1988 (Tas)
Adoption Act 1993 (ACT)
Adoption Act 1994 (WA)
Adoption of Children Act 1964 (Qld)
Adoption of Children Act 1994 (NT)
Care and Protection of Children Act 2007 (NT)
Child Protection Act 1999 (Qld)
Children Act (1989) (UK)
Children Act (2004) (UK)
Children and Community Services Act 2004 (WA)
Children and Young People Act 1999 (ACT)
Children, Young Persons and their Families Act 1997 (Tas)
Children, Youth and Families Act 2005 (Vic)
Children's Protection Act 1993 (SA)
Family Law Act 1975 (Cth) (Family Law Act)
Family Law Rules 2004 (Cth)
Privacy Act 1988 (Cth)

Appendix 3 Terms of Reference

14 November 2007

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

TO

The Honourable James Roland Tomson Wood AO QC

GREETING:

By these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise and commission you to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

i. The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters;

ii. Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;

iii. Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;

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;

vi. The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies;

vii. The adequacy of arrangements for inter-agency cooperation in child protection cases;

viii. The adequacy of arrangements for children in out of home care;

ix. The adequacy of resources in the child protection system,

and establish a Special Commission of Inquiry for that purpose.

ENTERED on Record by me, in REGISTER OF PATENTS, No, 89 Page 359,
this 14th day of November , 2007

DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS His Excellency
The Honourable James Jacob Spigelman,
Companion of the Order of Australia,
Lieutenant Governor of the State of New South
Wales in the Commonwealth of Australia.

Dated this 14 November 2007.

Lieutenant Governor

By His Excellency's Command,

Premier

7 December 2007

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

TO

The Honourable James Roland Tomson Wood AO QC

GREETING:

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, We appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed,

AND WHEREAS it is desirable that those Letters Patent be revoked and new Letters Patent be issued on the same terms of reference,

NOW THEREFORE, by these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise and commission you to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

i. The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters;

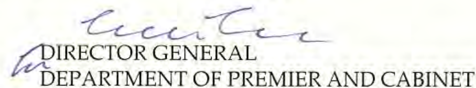
ii. Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;

iii. Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;

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;

ENTERED on Record by me, in REGISTER OF PATENTS, No, 89 Page 361,
this 7th day of December, 2007



DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

vi. The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies;

vii. The adequacy of arrangements for inter-agency cooperation in child protection cases;

viii. The adequacy of arrangements for children in out of home care;

ix. The adequacy of resources in the child protection system,

and establish a Special Commission of Inquiry for that purpose.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS Her Excellency
Professor Marie Bashir,
Companion of the Order of Australia,
Commander of the Royal Victorian Order,
Governor of the State of New South Wales
in the Commonwealth of Australia.

Dated this 7th December 2007.

Marie Bashir
Governor

By Her Excellency's Command,

Premier

4 June 2008

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To the Honourable James Roland Tomson Wood AO QC

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, WE appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.

AND WHEREAS those Letters Patent were revoked and new Letters Patent issued in Our Name by Our Governor of Our said State on 7 December 2007 on the same terms of reference, and it is desirable that those Letters Patent be varied to provide additional time for the preparation and delivery of your report.

NOW THEREFORE WE do, by these Our Letters Patent issued in Our Name by Our Governor of Our said State, with the advice of the Executive Council, and pursuant to section 6 of the *Special Commissions of Inquiry Act 1983*, DECLARE that the Letters Patent constituting your Commission shall have effect as if the paragraph "AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney," were deleted and replaced with the following paragraph:

"AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 September 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney."

ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 403, this 4th day of June, 2008

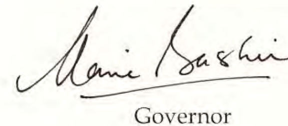
DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

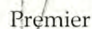
WITNESS Her Excellency Professor Marie Bashir, Companion of the Order of Australia, Commander of the Royal Victorian Order, Governor of the State of New South Wales in the Commonwealth of Australia.

Dated this 4th day of June 2008.



Governor

By Her Excellency's Command,



Premier

10 September 2008

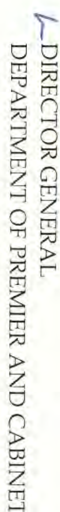
NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To the Honourable James Roland Tomson Wood AO QC

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, WE appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.

AND WHEREAS those Letters Patent were revoked and new Letters Patent issued in Our Name by Our Governor of Our said State on 7 December 2007 on the same terms of reference and varied on 4 June 2008, and it is desirable that those Letters Patent be further varied to provide additional time for the preparation and delivery of your report.



ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 53, this 10th day of September 2008

DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

NOW THEREFORE WE do, by these Our Letters Patent issued in Our Name by Our Governor of Our said State, with the advice of the Executive Council, and pursuant to section 6 of the *Special Commissions of Inquiry Act 1983*, DECLARE that the Letters Patent constituting your Commission shall have effect as if the paragraph "AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 September 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney," were deleted and replaced with the following paragraph:

"AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 31 December 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney."

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS His Excellency
THE HON. J.J. SPIGELMAN
~~Professor Marie Bashir,~~
Companion of the Order of
Australia, ~~Commander of the~~
LIEUTENANT
~~Royal Victorian Order~~, Governor
of the State of New South Wales
in the Commonwealth of
Australia.

Dated this 10th day of September 2008.

LIEUTENANT Governor

By His Excellency's Command,

Premier

Appendix 4 The Inquiry's Approach

Commencement of the Inquiry

As can be seen, the Terms of Reference are wide, and required a systemic inquiry not an inquiry into specific catastrophic incidents, or an inquiry seeking to attribute individual blame for specific cases – those roles belong to other agencies.

The letters patent were amended on three occasions, although the terms of reference did not change. The report to the Governor of NSW was ultimately required by 31 December 2008.

On 17 December 2007 the Inquiry conducted a public sitting to announce the terms of reference and to outline the processes to be followed by the Inquiry, including the means by which it intended to inform itself.

Staff

Gail Furness was appointed as Counsel Assisting the Inquiry on 14 November 2007.

During the information gathering phase of the Inquiry (discussed below), the Inquiry was served by 10 full time staff members with relevant experience, who were seconded from various NSW government agencies.

The staff included two senior officers seconded from DoCS, Anne Campbell (Executive Director, Operations Development) and Helen Rogers (Director, Strategic Policy). Each was quarantined from DoCS for the duration of the Inquiry. Neither accessed any confidential submission from a DoCS employee Without the assistance of these officers, each with significant experience in and knowledge of the child protection system, the Inquiry would not have been able to understand the complexities of that system as quickly or as thoroughly as it did.

The Inquiry was assisted during its term by the following members of its staff who were seconded from other government agencies.

a. Barbara Alvos (Police Integrity Commission)

b. Ben Haylock (Roads and Traffic Authority)

c. Carl Hook (Office of the Protective Commissioner)

d. April Hyde (Department of Health)

e. Marlene Krasovitsky (Department of Premier and Cabinet)

f. Fiona Russell (Police Integrity Commission)

g. Prudence Sawyer (Crown Solicitor's Office)

h. Julie Wynn (Police Integrity Commission)

Clerical staff were engaged on a temporary basis as required.

During the report writing phase, the Inquiry required fewer full time staff, and accordingly, two staff members returned to their substantive positions.

Assistance

Retired Family Court Judge, the Honourable Richard Chisholm, was engaged by the Inquiry as a consultant in relation to the interface between the child protection system in NSW and the family law courts.

Two barristers, Kate Morgan and Caroline Spruce were engaged to provide assistance from time to time.

The Inquiry also received valuable assistance from Judge Ken Taylor AM, (NSW Privacy Commissioner), Professor Patrick Parkinson, (University of Sydney, Sydney Law School) and Associate Professor Dr Judy Cashmore, (University of Sydney, Sydney Law School).

Accommodation

The Inquiry was accommodated at Level 8, John Maddison Tower, 88 Goulburn Street Sydney until 25th July 2008, when the premises were required for other purposes. The Inquiry then moved to accommodation at Darlinghurst Supreme Court, Taylor Square, Darlinghurst.

Public Forums (discussed below) held in Sydney were conducted in Courtroom 8A in John Maddison Tower. Public Forums held in regional areas were conducted in local venues. Meetings (discussed below) were generally conducted either at the Inquiry's premises, or, in the case of meetings with regional government agency staff, at either the local DoCS office, or at another local venue.

Advertising the Inquiry

Between 8 December 2007 and 15 December 2007 advertisements were placed in *The Sydney Morning Herald*, *The Daily Telegraph* and *The Australian*, announcing the Terms of Reference for the Inquiry and inviting interested parties to make submissions by 11 February 2008.

Public Forums held in Sydney were advertised in *The Sydney Morning Herald* and *The Daily Telegraph*. Public Forums held in regional areas were advertised in local newspapers and Indigenous publications. These advertisements also invited interested parties to make submissions to the Inquiry.

The Commissioner also publicised the Inquiry during various radio interviews, including one with Gadigal Koori Radio, and one with ABC Radio Statewide Drive.

The Inquiry's website

On 17 December 2007, the Inquiry established a website at www.lawlink.nsw.gov.au/cpsinquiry which was hosted by the Attorney General's Department. All significant information concerning the progress of the Inquiry, including how to make submissions, was placed on the website.

Various documents were also published on the website. These included agendas and fact sheets in relation to each Public Forum held in Sydney, transcripts of each Public Forum held in Sydney and in regional areas, and public submissions from government and non-government agencies. Before transcripts were placed on the website, information (usually names) which could identify individual children or reporters, or comments which could be defamatory, were 'blacked out.'

As at November 2008, Inquiry staff are continuing to review all submissions made to the Inquiry, with a view to placing any further 'publishable' submissions on the website. A publishable submission is one that has not been marked by the contributor as confidential, does not breach relevant legislative provisions in relation to the publication of information identifying children, and does not contain offensive or defamatory comments, that is material which on investigation was found to be manifestly without foundation such that its further publication would not serve any legitimate purpose.

Processes through which the Inquiry acquired information

Shortly after the commencement of the Inquiry, letters were sent to 147 key government and non-government agencies, inviting the agency to provide information to, and to liaise with, the Inquiry. Some agencies were also specifically asked to provide information in relation to their programs (current or recently completed), as well as in relation to their policies and any agreements to which they were a party, relevant to the provision of services to families and to the protection of children.

Documents produced on summons and documents provided on request

Whilst most of the material obtained by the Inquiry was provided voluntarily, some information was obtained under summons. The Commissioner's power to summons material was derived from the *Special Commission of Inquiry Act 1983*. In providing material pursuant to a summons, individuals were able to provide information and assistance to the Inquiry without breaching confidentiality or secrecy requirements that otherwise would have prevented them from providing material to the Inquiry.

The Inquiry issued 85 summons to produce documents. Thirty two of which were directed to the Director-General of DoCS, 18 to the Director-General of Health, and eight to the Commissioner for Police, and the remainder to various other individuals and agencies.

The Inquiry also made many less formal requests for information from agencies and individuals. Most of these requests were directed to DoCS, which responded to over 250 requests for information.

Submissions

The Inquiry publicly invited submissions from interested parties. The Inquiry made it clear that submissions could be received on either a confidential or non-confidential basis, and were intended to inform it in relation to potential systemic problems.

The Inquiry received 669 submissions from government agencies, non-government agencies, other organisations and members of the public. Some people and organisations made more than one submission. A number of submissions were provided on a confidential basis, some were anonymous, and some were received from people who specified that they did not wish to be identified as having made a submission.

The Inquiry continued to receive submissions until mid-November.

A list of the names of the agencies, other organisations, individuals and academics who provided submissions other than those whose submissions were received on a confidential basis or not to be identified basis is contained in Appendix 5.

Regional visits

Between March and May 2008 the Inquiry travelled to regional centres to conduct Public Forums, interagency meetings, and meetings with DoCS staff. The areas visited by the Inquiry during this time were Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Shellharbour, Toomelah, Wagga Wagga, and Wollongong.

The Inquiry made a second visit to Boggabilla to meet with people from the Boggabilla and Toomelah communities and to further investigate the particular issues faced by these communities, as discussed in Chapter 19 of this Report. On this occasion, the Inquiry invited, by individual letter, 46 members of those communities to a meeting.

In July, the Inquiry travelled to Melbourne to obtain information about its child protection system, including the success of recent reforms, and the models of service available in that State.

Forums and meetings conducted during these regional and interstate trips are discussed below.

Visits to non-government organisations

In February 2008, the Inquiry visited the UnitingCare Burnside Family Services Centre in Minto, near Campbelltown, and met with staff from the Centre, as well as with senior officers from that agency, to discuss the operation of the Centre, and the programs offered in that area.

In May 2008, the Inquiry visited the Barnardos South Coast Children's Family Centre in Warrawong, near Wollongong, and met with staff from the Centre to discuss the programs offered by the Centre, as well as with foster carers to hear about their experiences.

Public Forums

Between February and May 2008 the Inquiry conducted nine Public Forums in Sydney. Each forum concentrated on one of the following specific issues of relevance to the Terms of Reference: mandatory reporting, the role of courts in the child protection system, out-of-home care, the role of oversight agencies in the child protection system, interagency cooperation, health and disability, assessment models and processes, Aboriginal communities, and early intervention.

Representatives of relevant agencies and individuals with relevant experience were invited to participate in panel discussions at these forums. A full list of panel members who participated in each of the Public Forums is contained in Appendix 7 to this report. The Inquiry prepared an agenda and a fact sheet in advance of each of these forums, and published these on its website. Members of the public were invited to attend, and there was some opportunity for members of the public to comment or ask questions at the end of the forums.

Public Forums were also held in Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Wagga Wagga, and Wollongong. These forums did not involve panel discussions, rather, members of the public were invited to attend and share their concerns about the child protection system with the Inquiry. There was some opportunity for those who did not want to share their concerns publicly to talk to Inquiry staff in private.

All Public Forums were transcribed and the transcripts made available on the Inquiry's website.

Meetings with DoCS and the Court

During the initial stages of the Inquiry, the Commissioner and Inquiry staff met on a number of occasions with senior executives from DoCS.

The Inquiry also met with staff and managers from 19 CSCs to hear their views about the child protection system and any problems they may experience in carrying out their work. These CSCs included Ballina, Bourke, Broken Hill, Campbelltown, Central Sydney, Coonamble, Dubbo, Eastern Sydney, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Parramatta, Shellharbour, Wagga Wagga, Wollongong. Staff from near-by CSCs also attended some of these meetings. The Inquiry also spoke with DoCS Project Team about the Toomelah/Boggabilla Child Protection Project.

The Inquiry also visited the Helpline, a Caseworker Assessment Centre, and a JIRT to witness operations and talk to staff. It attended the Children's Court at Parramatta, held meetings with the Senior Children's Magistrate and two former Children's Court Magistrates, and met the Director of the Children's Court Clinic to inform itself as to the way in which the clinic operated. It also had a meeting with members of the Family Court of Australia, and with the Judge of the District Court of NSW managing that Court's appeal jurisdiction in relation to care cases.

Meetings with representatives from key agencies

The Inquiry held individual meetings with senior representatives from each of the government and non-government agencies concerned in the care and protection system, or in the delivery of service to children and young persons.

A list of these agencies with which the Inquiry met in private meetings is contained in Appendix 6 to this report.

Interagency meetings in regional locations

During its visits to Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Griffith, Moree, Newcastle, Nowra, and Wagga Wagga, the Inquiry conducted interagency meetings with senior staff from regional offices of government departments involved in the child protection system (generally, these meetings were attended by representatives from DoCS, Police, Health, Education, DADHC, and Housing. Relevant meetings were also attended by representatives from Aboriginal Affairs and from Premier and Cabinet).

Prior to these meetings, the Inquiry outlined the issues that it wished to discuss, which included the types of services needed in the relevant region, the types of service models that might improve interagency cooperation in the delivery of service, and any barriers to effective interagency relationships.

Meetings with academics

The Inquiry was briefed by a number of academics from NSW, interstate and overseas, with relevant backgrounds in fields related to the care and protection of children. A list of those within this group is included in Appendix 6 to this report.

Other meetings

The Inquiry also met with various other individuals and groups, including young people from the CREATE Foundation, members of the Guardian ad Litem panel, a group of midwives, and lawyers specialising in care and protection law in the Children's Court.

In Melbourne, the Inquiry met with the Victorian Department of Human Services, relevant non-government agencies, the Centre for Excellence in Child and Family Welfare and the Victorian Aboriginal Child Care Agency Cooperative Limited to discuss the Lakidjeka program.

A list of these meetings is included in Appendix 6 to this report.

Case file audit

The Inquiry undertook a review of DoCS case files in relation to 75 children and young persons, in order to examine casework practice compliance against DoCS policies and procedures. All DoCS regions, all program areas (Child Protection, OOHC and Brighter Futures), and all age groups were represented in the audit. The files of the 75 children and young persons included those of 37 females, 38 males, 30 Aboriginal children and young persons and nine children and young persons from CALD backgrounds.

Expression of appreciation

The Inquiry wishes to thank all those who provided submissions, who participated in public forums and meetings, and who otherwise provided assistance. In particular, the Inquiry wishes to thank those who gave their time in providing specific assistance, or in providing feedback in relation to preliminary views formed by the Inquiry which were then taken into account in the finalisation of this Report.

The Inquiry also wishes to acknowledge the cooperation it received from DoCS, and from all other key government and non-government agencies, in the provision of information and advice concerning the operation of the child protection system in NSW and in other jurisdictions.

Appendix 5 Submissions

Submissions from anonymous sources, and submissions from people who stated that their submission was confidential or that they did not wish to be identified as having made a submission, are not included in these lists.

Government Agencies

1. Australian Institute of Family Studies (Commonwealth)
2. Children’s Court Clinic
3. Children's Court of NSW
4. Commission for Children and Young People
5. Community Relations Commission for a multicultural NSW
6. Legal Aid NSW
7. Local Court of NSW
8. NSW Commission for Children and Young People
9. NSW Department of Aboriginal Affairs
10. NSW Department of Ageing, Disability and Home Care
11. NSW Department of Education and Training
12. NSW Department of Health
13. NSW Department of Juvenile Justice
14. NSW Department of Premier and Cabinet
15. NSW Office for Children - The Children's Guardian
16. NSW Ombudsman
17. NSW Police Force
18. Office of the Protective Commissioner
19. Redfern Waterloo Authority
20. Sydney Children's Hospital
21. The Children's Hospital at Westmead

Non-government agencies and other organisations

1. Aboriginal Child, Family and Community Care State Secretariat
2. Aboriginal Legal Service (NSW/ACT) Limited
3. Anglican Church of Australia
4. Anglicare Canberra and Goulburn
5. Association of Children's Welfare Agencies
6. Association of Independent Schools of NSW
7. Australian Association of Social Workers
8. Australian Dental Association (NSW Branch) Limited
9. Australian Lawyers Alliance
10. Australian Medical Association (NSW) Limited
11. Baptist Community Services NSW and ACT
12. Barnardos Australia
13. Berkeley Neighbourhood Centre
14. Binaal Billa - Family Violence Legal Service
15. Bravehearts
16. Care Leavers Australia Network
17. CareSouth
18. Caring and Parenting ACT Inc.

19. Carries Place Inc. - Women's and Children's Crisis Service
20. Casino Neighbourhood Centre - Brighter Futures Early Intervention Program
21. Catholic Commission for Employment Relations
22. Catholic Social Services NSW/ACT
23. Centacare Broken Bay
24. Centacare Catholic Community Services Sydney
25. Child Abuse Prevention Service
26. Child and Family Health Nurses Association (NSW) Inc
27. Clarence Valley Foster Carers Support Group
28. Combined Community Legal Centres' Group (NSW) Inc
29. Council of Social Service of NSW
30. Council of Social Service of NSW – joint submission with:
    a. Local Community Services Association
    b. NSW Family Services Inc
    c. Youth Action and Policy Association NSW
    d. Western Sydney Community Forum
    e. Local Government and Shires Association Illawarra Forum
31. Country Women's Association of NSW
32. CREATE Foundation
33. Disability and Aged Information Services Inc
34. Disability Enterprises
35. Families Australia
36. Family Inclusion Network- Australian Catholic University
37. Family Inclusion Network NSW Inc
38. Family Services Illawarra Inc
39. Federation of Parents and Citizens' Associations of NSW
40. Foster Care Association NSW Inc
41. Foster Parent Support Network
42. Foster Parent Support Network Hunter Region
43. Good Beginnings / National Association for Prevention of Child Abuse and Neglect
44. Gosford Family Support Services
45. Goulburn Family Support Service Inc
46. Homeless Persons Information Centre Sydney
47. Homelessness NSW/ACT
48. Hunter Community Legal Centre and Children’s Court Assistance Scheme
49. Illawarra Multicultural Services Inc
50. Illawarra Neighbourhood Centre Forum
51. Intellectual Disability Rights Service
52. Jannawi Family Centre
53. Katungal Aboriginal Corporation Community and Medical Services
54. Kids Off the Streets
55. Kinship Care Regional Project
56. Law Society of NSW
57. Learning Links
58. Life Without Barriers
59. Lower Hunter Temporary Care Inc
60. MacKillop Rural Community Services
61. Mallee Family Care
62. Marist Youth Care
63. Mission Australia
64. Moree Plains Shire Council

65. Multicultural Disability Advocacy Association of NSW
66. National Abuse Free Contact Campaign
67. National Association for Prevention of Child Abuse and Neglect
68. National Children's and Youth Law Centre
69. National Drug and Alcohol Research Centre
70. National Research Centre for the Prevention of Child Abuse
71. Newcastle Family Support Services Inc
72. Non-Custodial Parents Party (Equal Parenting)
73. Northern Region Young Women's Accommodation Project auspiced by Casino Neighbourhood Centre Inc.
74. NSW Family Services Inc
75. NSW Liberal/National Parliamentary Parties Coalition
76. NSW Primary Principals' Association
77. NSW Schools for Specific Purposes Principals Network
78. NSW Women's Refuge Movement Working Party Inc
79. Official Community Visitors
80. People with Disability Australia
81. Phoenix Rising for Children
82. Public Interest Advocacy Centre
83. Public Schools Principals Forum
84. Public Service Association of NSW
85. Pymble Ladies College
86. Redfern Legal Centre
87. Regional Youth Development Officers Network Inc
88. Regulatory Institutions Network
89. Rekindling the Spirit
90. Royal Australasian College of Physicians
91. Royal Australian and New Zealand College of Psychiatrists
92. Samaritans Foundation - Diocese of Newcastle
93. SDN Children's Services Inc
94. Secretariat of National Aboriginal and Islander Child Care
95. Shoalcoast Community Legal Centre Inc.
96. South West Child Adolescent and Family Services
97. Southern Youth and Family Services
98. Stepping Stone House
99. Stolen Generations Link Up (NSW)
100. The Australian Family Association (NSW)
101. The Benevolent Society
102. The Cottage Family Care Centre
103. The Gunedoo Centre
104. The Joseph Varga School
105. The NSW Secondary Principals' Council
106. Tongan Community Support Services
107. UnitingCare Burnside
108. Victims of Crime Assistance League Inc. NSW
109. Wesley Dalmar Child and Family Services, Wesley Mission
110. West Street Centre
111. William Campbell College
112. Women's Electoral Lobby NSW
113. Women's Lawyers' Association of NSW

114. Women's Legal Services NSW
115. Yawarra Meamei Women's Group Inc
116. Youth Accommodation Association
117. Youth Justice Coalition
118. Youth Off the Streets

Individuals and academics

1. Adams, James and Thompson, Jason
2. Agate, Adelaide and Brian
3. Ainslie-Wallace, the Hon Judge Ann
4. Ainsworth, Dr Frank and Hansen, Dr Patricia
5. Ainsworth, Dr Frank and Pollock, Dr Reg
6. Alderton, Helen
7. Alexander, Susan
8. Allinson, Ross
9. Altman, Darius
10. Anderson, Jordan Thomas
11. Anscombe, Aw (Bill)
12. Austin, Richard And Geraldine
13. Azzopardi, Victor
14. Bailey, Bronwynne and Samuel, Janene
15. Bao-Er, Dr
16. Bartlett, Jane (provided by Harris MP, David)
17. Bartlett, Martin
18. Baxter, Christina
19. Baxter, Terri (provided by Humphries MP, Kevin)
20. Bayona, Aldo
21. Blackburn, Ben
22. Bond, Tamara
23. Bootes, Byron and Phyllis
24. Bor, William
25. Borg, Robyn
26. Bowes, Jennifer Professor
27. Brennan, Regan, Tom and Brett
28. Brown, Micheal John
29. Brown, Michelle Lee
30. Brown, Neil
31. Brown, Yvonne
32. Bull, Karen
33. Burden, Mike
34. Byrnes, Sue
35. Cairns, Andrea
36. Caldersmith, Susie and Warwick
37. Calvert, Gillian; Cashmore, Dr Judy; Scott, Professor Dorothy
38. Campbell, Cheryl
39. Campbell, Linda
40. Campbell, Michael
41. Capsis, Reverend George
42. Carpenter, John

43. Carpenter, Maria (provided by Fardell MP, Dawn)
44. Carter, Mary Lou
45. Catt, Robyn
46. Clancy, Therese
47. Clark, Kathleen
48. Clarke, Christopher
49. Clarke, Jeremy
50. Cleere, Marjory
51. Collinson, Mary and Edward (provided by McFarland, Paulette)
52. Colwell, Deirdre (provided by Fardell MP, Dawn)
53. Conway, Josephine
54. Costello, John
55. Cotter, Carol
56. Cowgill, David
57. Cowie, David
58. Cox, Judith (provided by Allen, Judith)
59. Crawford, the Hon John
60. Crewdson, Gerard
61. Crisp, Denise
62. Crofts, Stuart and Natasha
63. Crowley, Luke
64. Cubbon, Kim and Geoffrey
65. Cunningham, Christine
66. Cuzen, Naomi
67. Davies, Mark
68. De Bussey, Rozlyn
69. De Guio, Anne-Lyse and Fowler, Professor Cathy
70. Dee, Elizabeth
71. Doggett, Charles
72. Donaldson, Tony
73. Doolan, Lynda
74. Eastwood, Joyce
75. Edgar, Jeanette
76. Edmonds, William
77. Edwards, Amanda
78. Eid, Amera
79. Fardell MP, Dawn
80. Farrell, May
81. Fenwick, Kerri
82. Fernandez, Elizabeth
83. Field, Norman
84. Fieldsend, Neil and Yvonne
85. Fisher, Suzanne
86. Foley, Sue
87. Ford, David
88. Ford, Judith and John
89. Fowler, Samantha
90. Francis, Leanne
91. Franklin, Chris and Lyn

92. Fry, Leanne
93. Fuller, Colleen
94. Gam, Maureen (provided by Hodgkinson MP, Katrina)
95. Glen, Sharon
96. Glynn, Christine
97. Goddard, John
98. Grayson, David (provided by Rickuss MP, Ian)
99. Guggisberg, Nick
100. Hamilton, Margaret
101. Hansen, John, Tawa Sandy, Cowan, Angela, Slade, Pettina, Sinclair Jeanette
102. Hapgood, Brett
103. Harwood, Alwin
104. Hayward-Brown, Dr Helen and Nott, Michael
105. Hazell, Kerrie
106. Healy, Associate Professor Karen and Meagher, Professor Gabrielle
107. Helderman, Irene
108. Hellyer, John
109. Heuston, Stan
110. Hiller, Nicholas
111. Hodge, Brian
112. Holborow, Barbara
113. Honey, Kim
114. Hope, Andrew
115. Hughes, Jane
116. Humphries MP, Kevin
117. Humphries, Theresa
118. Hundy, Peter
119. Hutton, Garry
120. Iggleden, Tarlai
121. Ilievski, Lidia
122. Irwin, Michelle
123. James, Dr John and Garvan, Marg
124. Johan, Harley and Smith, Rhonda
125. Johnson, Dee
126. Johnson, Patricia
127. Jones, Jahlia (provided by Fardell MP, Dawn)
128. Joyce, Roger and Karen
129. Jubb, Gavin
130. Kendall, Rod and Robyn
131. Kennedy, Jocelyn
132. Khan, Akmal and O'Donohue, Terry
133. Kiernan, Teresa
134. Kippax, Rod
135. Kirbyshire, Chris
136. Kitching, Lindsay
137. Kozera, Stan
138. La Greca, Gwen
139. Laird, Albert Leo
140. LaMond, Eunice

141. Lee, Kate
142. Lees-Smith, Elizabeth
143. Lewis, John
144. Lloyd, Neridah
145. Lobegeier, Mark and Gillian
146. Lord, Janine
147. Macaulay, Catherine
148. Macpherson, Hilary
149. Madden, Tony
150. Mandeno, Melody
151. Manning, Margaret
152. Marr, Busfield and Lynette
153. Marshall, Gordon
154. Mason, Jan
155. Mathews, Dr Ben
156. Mazlin-Law, Jenni
157. McCarthy, Bernadette and Ray
158. McDonald, Cheryl
159. McDonald, Fiona
160. McFarland Paulette, Beach, Mary Jane and Chilcott, Sandra
161. McFarlane, Abbie
162. McFarlane, Robyn
163. McGuire, Nicole
164. McLennan, Jane
165. McMahon, Jodie
166. McMahon, Julie
167. Millington, John
168. Moore MP, Clover
169. Morgan, Jennifer
170. Morgan, Joy
171. Morgan, Paul
172. Mosley, Raymond and Mechelien
173. Murray, John
174. Muscat, Danielle
175. Musgrave, Carol
176. Nicholson, John
177. Norman, Andrew and Eileen
178. Norman, J
179. Norman, Shauna
180. Nott, Michael
181. O'Donnell, Carol
182. O'Donnell, Tom (provided by O'Farrell MP, Barry)
183. Olive, Leanne
184. Parker, Scott
185. Parker, Wendy
186. Parker-Gallagher, Cynthia
187. Parkinson, Patrick Professor
188. Parry, Sarah
189. Patterson, Andrew

190. Peet, Denise and Cesco, Ray
191. Pemberton, Jan
192. Peters, Vivienne
193. Pettet, Kayleen
194. Phillips, Angelee
195. Philpott, Kenneth Ian
196. Picton, Natasha
197. Pidgeon, Terry
198. Pitney, Ngaia and Paul
199. Podgorczyk, Peter and Lynnette
200. Pollock, Joanna
201. Pottie, James and Jenny
202. Raftery, Garry
203. Rankin, Claire
204. Ratcliffe, Dr Terrence
205. Rayner, Lesley
206. Reicheldt, Lola
207. Reid, Donna
208. Rennie, Maree, Neal, Stuart and Guest Sharon (provided by Rennie, Andrew)
209. Richards, Earl
210. Roberts, Margret
211. Robinson, Alan
212. Robinson, Louise
213. Robinson, Vera
214. Rogan, June
215. Roser, Leonard G
216. Ross, Nicola
217. Rowles, Mark
218. Rowling, David
219. Russell, Suzanne
220. Ryan, Olivia-Mai
221. Sargeson, Bill and Julie
222. Scanlan, Ken
223. Scarborough, Grant and Christina
224. Schultz, Sandy
225. Scott, Greg
226. Scott-Irving, Stewart
227. Seddon, Sarah
228. Seneviratne, Surangani
229. Sentence, Jodi
230. Shaunak, Dr Sunita
231. Sheridan, John and Margaret
232. Sherwood, Yatra
233. Shrayer, Izabella
234. Shumack, Patrick
235. Siddiqui, Jane
236. Singleton, Peter
237. Slatyer, Cheryl
238. Smith, Fred (provided by Stoner MP, Andrew)

239. Smith, Jane
240. Smith, Peter
241. Snell, Leonie
242. Soulter, Kim
243. Spielman, Dr Ron
244. Springthorpe, Dr Barry
245. Steen, Jeanette
246. Stevens, Alan
247. Stewart, Keryn and Bourke, Ben
248. Stien, Rhonda
249. Stokoe, Wendy
250. Stone, Marcia
251. Stubbs, Professor Julie and Graycar, Professor Reg
252. Stubbs, Taryn
253. Sullivan, Gloria
254. Sweeney, Paul
255. Sweeting, Emma
256. Szpak, Michele
257. Szymanski, Steffan
258. Szyndler, Dr Janina
259. Tasker, Chris
260. Taylor, Wanda (provided by Hodgkinson MP, Katrina)
261. Tedd, Catherine
262. Tester, Sherree
263. The Bloggerator
264. Tilly, Julie
265. Todd, Ray
266. Travers, Wendy
267. Trevaskis, Mark
268. Tucker, Heather
269. Turner, Judy
270. van der Veer, Elisabeth
271. Van Gorp, Sean
272. Vimpani, Professor Graham
273. Waddington, John and Dianne
274. Wagstaff, Patricia
275. Walker OAM, Patricia
276. Watts, Jon Richard
277. Wilder, Christine
278. Willetts, Jeffrey
279. Williams, John Stewart
280. Wilton, Jim
281. Witten, Bryan
282. Wooden, Alison
283. Worley, Tracy
284. Youngs, Robin

Appendix 6 Meetings

The Inquiry met with senior representatives from the following Government agencies:

Australian Crime Commission, National Indigenous Violence and Child Abuse Intelligence Task Force (Commonwealth)

Australian Institute of Family Studies (Commonwealth)

Children's Court Clinic

Children's Court NSW

Children's Guardian

Department of Families, Housing, Community Services and Indigenous Affairs (Commonwealth)

Family Court of Australia (including the Honourable Justice Robert Benjamin)

Legal Aid NSW

Ministerial Advisory Committee, Aboriginal child sexual assault task force

NSW Commission for Children and Young People

NSW Department of Aboriginal Affairs

NSW Department of Ageing, Disability and Home Care

NSW Department of Education and Training

NSW Department of Health

NSW Department of Housing

NSW Department of Juvenile Justice

NSW Ministry for Police

NSW Ombudsman

NSW Police Force

NSW Privacy Commissioner

South Eastern Sydney and Illawarra Area Health Service

Sydney Children's Hospital

The Children's Hospital at Westmead

The Inquiry met with senior representatives from the following non-government agencies and other organisations:

Aboriginal Child, Family and Community Care Secretariat

Aboriginal Legal Service (NSW/ACT)

Anglicare Diocese of Sydney

Association of Children's Welfare Agencies

Australian Medical Association (NSW)

Barnardos

Catholic Social Services (NSW/ACT)

Centre for Excellence in Child and Family Welfare (Vic)

Council of Social Services of NSW

Foster Care Association (NSW)

Foster Parents Support Network

Law Society of NSW

Life Without Barriers

NSW Family Services Inc

NSW Primary Schools Principals' Association

Public Schools Principals' Forum

Public Service Association of NSW

Royal Australian and New Zealand College of Psychiatrists (NSW Branch)

Tharawal Aboriginal Corporation

The Benevolent Society

The NSW Secondary Principals' Council

UnitingCare Burnside

Youth Off The Streets

The Inquiry met with the following academics, individuals and groups

Ainslie-Wallace, Her Honour Judge Ann (District Court)

Ainsworth, Dr Frank; Ramjan, Barbara; Foley, Sue (Guardians ad litem)

Brodie, Professor Pat; Homer, Professor Caroline; Everitt, Louise; Smith, Rachel; Minnis, Jeannie (Midwives)

Cashmore, Associate Professor Dr Judy

Crawford, John (former Children's Court Magistrate)

Daniel, Professor Brigid

Dewdney, Micheline

Faulks, John (Deputy Chief Justice, Family Court of Australia)

Freitag, Dr Raelene

Graycar, Professor Reg and Stubbs, Professor Julie

Holborow, Barbara (former Children's Court Magistrate)

Katz, Professor Ilan and Sullivan, Carol

Limbury, Alan (lawyer specialising in Alternative Dispute Resolution)

McLachlan, Robert; Nasti, Sam; Robertson, Laurie; Braine, Peter; Clarke, Ross; Renshall Kathryn (Lawyers specialising in Children's Law)

Morgan, Paul

Munro, Dr Eileen

Parkinson, Professor Patrick

Scott, Professor Dorothy

Spielman, Dr Ron

Symonds, The Honourable Ann

Young consultants from the CREATE Foundation

Appendix 7 Public Forums in Sydney - panel representatives

Mandatory reporting - 15 February 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Helen Freeland	Executive Director, Helpline
NSW Police Force	Det Sup Helen Begg	Detective Superintendent, Child Protection and Sex Crime Squad
Department of Health	Professor Debora Picone AM	Director-General
Department of Education and Training	Mr Michael Coutts-Trotter	Director-General
Department of Housing	Ms Melissa Gibson	Director, Housing Policy and Partnerships
Department of Ageing, Disability and Home Care	Ms Carol Mills	Deputy Director-General, Development, Grants and Ageing
Association of Independent Schools of NSW	Mr Graham Wilson	Director, Compliance
Public Schools Principals' Forum	Mr Brian Chudleigh	Deputy Chairperson
Sydney Children's Hospital	Dr Dimitra Tzioumi	Director, Child Protection
Children's Hospital at Westmead	Mr Mark Palmer	Senior Clinician, Team Leader, Child Protection Unit
Australian Medical Association (NSW) Ltd	Dr Michael Gliksman	Chairman, NSW Council
University of Sydney	Dr Judy Cashmore	Research Academic

Role of courts – 22 February 2008

Agency	*Representative*	*Title*
Department of Community Services	Mr Roderick Best	Director, Legal Services
NSW Police Force	Sup Anthony Tritcher	Superintendent, Court and Legal Services
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
Legal Aid NSW	Ms Deborah de Fina	Solicitor in Charge, Care and Protection Legal Service
Aboriginal Legal Service (NSW/ACT)	Ms Angela Jones	Consultant, Children's Care and Protection Law
Attorney General's Department	Mr Michael Talbot	Assistant Director-General, Court and Tribunal Services
NSW Ombudsman	Mr Steve Kinmond	Deputy Ombudsman, Community Services Division
Children's Court NSW	Her Honour Helen Syme	Deputy Chief Magistrate
Administrative Decisions Tribunal	Ms Anne Britton	Deputy President, Head of Community Services Division

Out-of-home care – 29 February 2008

Agency	Representative	Title
Department of Community Services	Ms Annette Gallard Dr Gül Izmir	Deputy Director-General, Operations Deputy Director-General, Service System Development
Department of Ageing, Disability and Home Care	Mr Brendan O'Reilly Ms Carol Mills	Director-General Deputy Director-General, Development, Grants and Ageing
Department of Health	Ms Cathrine Lynch	Acting Director, Primary Health and Community Partnerships
Children's Guardian	Ms Kerryn Boland	Children's Guardian
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
UnitingCare Burnside	Mr Paul Drielsma	Director, Development
Aboriginal Child, Family and Community Care State Secretariat	Mr Bill Pritchard	Executive Officer
Wesley Community Services	Ms Theresa Burgheim	Manager, Out-of-Home-Care Systems
Centacare Catholic Community Services	Ms Maureen Eagles	Director, Children and Youth Services
Life Without Barriers	Mr Ray Dunn	Chief Executive Officer
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer
CREATE Foundation	Ms Daryn Elston-Smith	Regional Coordinator
Foster Care Association NSW Inc	Ms Mary Jane Beach	President
Foster Parents Support Network	Ms Sue O'Connor	President
University of Sydney	Dr Judy Cashmore	Research Academic

Oversight agencies – 28 March 2008

Agency	Representative	Title
Department of Community Services	Ms Jennifer Mason Ms Donna Rygate	Director-General Deputy Director-General, Strategy, Communication and Governance
Children's Guardian	Ms Kerryn Boland	Children's Guardian
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
NSW Ombudsman	Mr Steve Kinmond Ms Anne Barwick	Deputy Ombudsman, Community Services Division Assistant Ombudsman, Children and Young People
State Coroner's Court	Mr John Merrick	Manager, Coronial Information and Support Program
Department of Premier and Cabinet	Mr Philip Berry Mr Anthony Lean	Policy Manager, Human Services and Justice Branch Policy Manager, Legal Branch
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer

Interagency cooperation - 4 April 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Jennifer Mason Ms Annette Gallard	Director-General Deputy Director-General, Operations
NSW Police Force	Det Sup Helen Begg	Detective Superintendent, Child Protection and Sex Crime Squad
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Education and Training	Ms Robyn McKerihan	General Manager, Access and Equity
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
Department of Juvenile Justice	Mr Peter Muir	Deputy Director-General, Operations
Department of Ageing, Disability and Home Care	Mr Brendan O'Reilly	Director-General
Attorney General's Department	Ms Natasha Mann	Policy Manager, Legislation Policy and Criminal Law Review Division
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer
Department of Premier and Cabinet	Ms Vicki D'Adam	Assistant Director-General, Policy

Health and disability – 11 April 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Annette Gallard	Deputy Director-General, Operations
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Ageing, Disability and Home Care	Ms Carolyn Burlew Ms Lauren Murray	Deputy Director-General, Service Development Executive Director, Community Access
Westmead Children's Hospital	Ms Martine Simmons	Senior Social Worker, Brain Injury Service, Department of Rehabilitation
Sydney Children's Hospital	Dr Vivian Bayl	Developmental Paediatrician, Tumbatin Clinic
Department of Education and Training	Mr Brian Smyth King	Director, Disability Programs
Royal Australian and New Zealand College of Psychiatrists	Dr Michael Bowden Dr Josey Anderson	Chair, Faculty of Child and Adolescent Psychiatry Executive, Faculty of Child and Adolescent Psychiatry
Life Without Barriers	Mr Ray Dunn	Chief Executive Officer
Hunter Children's Health Network	Professor Graham Vimpani AM	Clinical Chair
Royal Australasian College of Physicians	Dr Jacqueline Small	Fellow, Paediatrics and Child's Health Division
People with Disability Australia Inc	Ms Therese Sands	Co-Chief Executive Officer
Royal Far West Children's Health Scheme	Dr Shola Faniran	Clinical Director, Children's Services

Assessment model and process – 18 April 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Annette Gallard Ms Helen Freeland	Deputy Director-General, Operations Executive Director, Helpline
Department of Health	Ms Cathrine Lynch	Director, Primary Health and Community Partnerships Branch
NSW Police Force	Assistant Commissioner Dave Hudson	State Crime Commander
Barnardos Australia	Ms Rosemary Hamill	Senior Manager, Barnardos Auburn Centre
The Benevolent Society	Ms Jenni Hutchins	Senior Manager
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
University of Sydney	Professor Julie Stubbs	Deputy Director, Institute of Criminology
Department of Premier and Cabinet	Ms Vicki D’Adam	Assistant Director-General, Policy
Australian Institute of Family Studies	Dr Leah Bromfield	Manager, National Child Protection Clearinghouse

Aboriginal communities – 24 April 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Linda Mallett Ms Anne-Maree Sabellico	Acting Deputy Director-General, Service System Development Acting Executive Director, Operations Development
Department of Aboriginal Affairs	Ms Jody Broun	Director-General
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
NSW Police Force	Assistant Commissioner Dave Hudson	State Crime Commander
Aboriginal Child, Family and Community Care State Secretariat	Ms Amanda Bridge	Chairperson
Aboriginal Legal Services	Mr John McKenzie Ms Angela Jones	Chief Legal Officer Consultant, Children’s Care and Protection Law
Secretariat of National Aboriginal and Islander Child Care	Mr Julian Pocock	Executive Officer
NSW Aboriginal Justice Advisory Council	Mr Terry Chenery	Executive Officer
Attorney General’s Department	Mr Brendan Thomas	Assistant Director-General, Crime Prevention and Community Programs
UnitingCare Burnside	Ms Servena McIntyre Mr Reg Humphreys	Coordinator, Children’s Services, Orana Far West Manager, Orana Far West

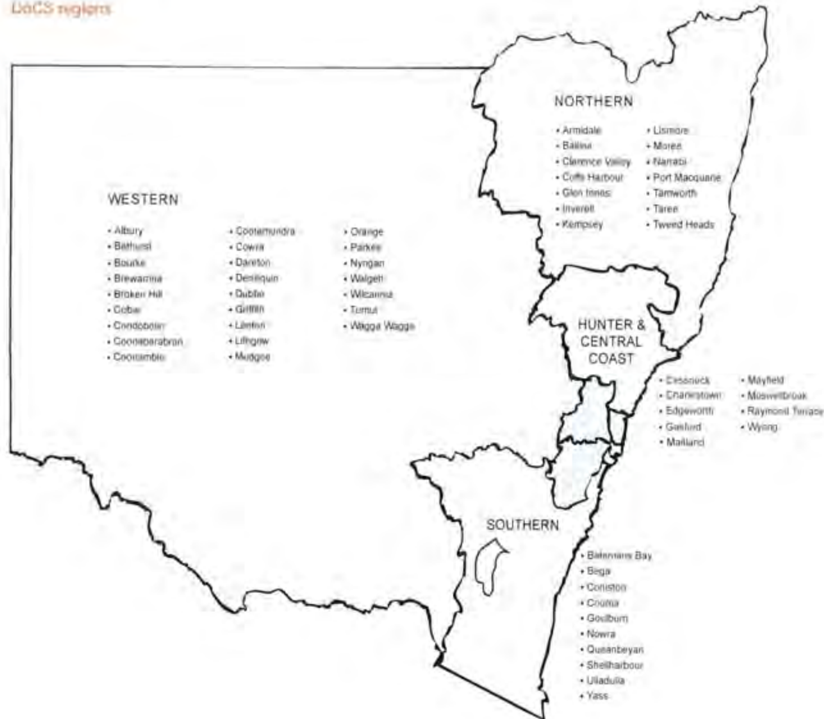
Early intervention – 16 May 2008

Agency	*Representative*	*Title*
Department of Community Services	Ms Linda Mallet	Acting Deputy Director-General, Service System Development
Department of Ageing, Disability and Home Care	Ms Carolyn Burlew	Deputy Director-General, Service Development
	Ms Lauren Murray	Executive Director, Community Access
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Education	Mr David McKie	Director Student Welfare
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
UnitingCare Burnside	Ms Jane Woodruff	Chief Executive Officer
	Ms Linda Mondy	Director Operations, Western Sydney
NSW Family Services Inc	Ms Sue Richards	Chief Executive Officer
Wesley Dalmar	Mr Peter O'Brien	Operations Manager, Family Services
Mission Australia	Ms Helen Lunn	Operations Manager, Child, Family and Migrant Services
The Benevolent Society	Ms Maree Walk	General Manager, Operations
Uniting Church in Australia	Ms Meg Herbert	Associate Secretary
Hunter Children's Health Network	Professor Graham Vimpani AM	Clinical Chair
University of NSW	Professor Ilan Katz	Director, Social Policy Research Centre
Macquarie University	Professor Jennifer Bowes	Director, Children and Families Research Centre, Institute of Early Childhood
SDN Children's Services Inc	Ms Julie Druce	Director, Early Intervention, Family Support

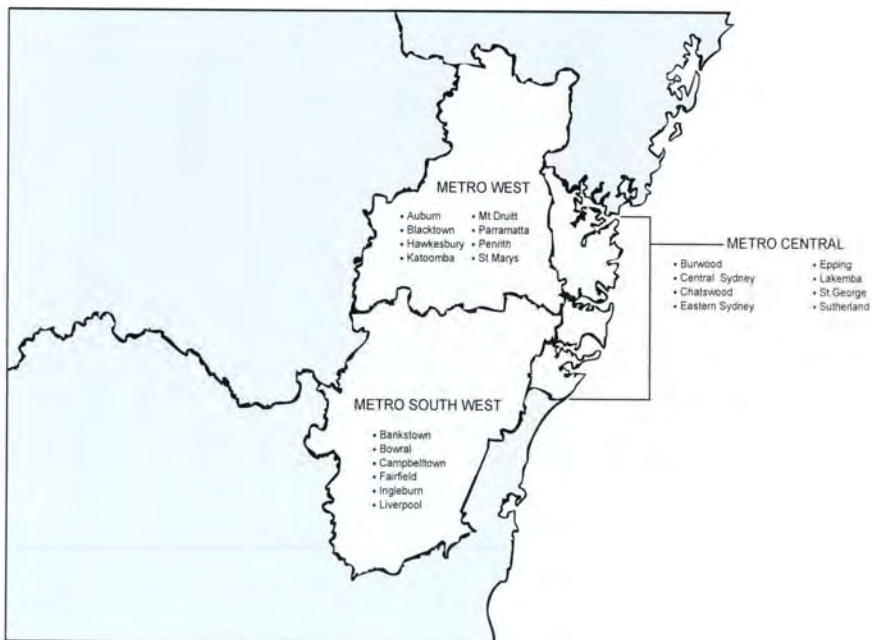
Appendix 8 DoCS CSCs

Directory of DoCS Offices

DoCS regions



DoCS metropolitan regions



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Australian Institute of Family Studies: www.aifs.gov.au

Australian Institute of Health and Welfare: www.aihw.gov.au

Australian Research Alliance for Children and Youth: www.aracy.org.au

Children's Guardian: www.kidsguardian.nsw.gov.au

Commission for Children and Young people: www.kids.nsw.gov.au

CREATE Foundation: www.create.org.au

Department of Families, Housing, Community Services and Indigenous Affairs: www.facs.gov.au

DoCS: www.community.nsw.gov.au

National Child Protection Clearinghouse: www.aifs.gov.au

National Drug and Alcohol Research Centre: ndarc.med.unsw.edu.au

NSW Ombudsman: www.ombo.nsw.gov.au

Secretariat of National Aboriginal and Islander Child Care: www.snaicc.asn.au