



Child Protection Systems Royal Commission Report

Volume 1: Summary and Report

August 2016

The life they
deserve

The life they deserve

CHILD PROTECTION SYSTEMS ROYAL COMMISSION REPORT VOLUME 1: SUMMARY AND REPORT

**The Hon Margaret Nyland AM
Commissioner**

August 2016

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Child Protection Systems Royal Commission

5 August 2016

His Excellency the Honourable Hieu Van Le AO
Governor of South Australia
Government House
ADELAIDE SA 5000

Your Excellency

On 15 August 2014 I was invested with the powers of a Royal Commissioner in respect of an inquiry into the adequacy of existing laws and policies relevant to South Australia's child protection system for children at risk of harm, and improvements that could be made to existing laws, policies and allocation of resources, as well as the practices and procedures of Families SA and other agencies. I now have the honour to present the report of my inquiry into these matters, which consists of two volumes:

- Volume 1: This volume contains details of the work undertaken by the Commission in the course of this inquiry, an analysis of system deficits and recommendations for improvements to the child protection system in this state.
- Volume 2: This volume comprises a summary of five case studies undertaken by the Commission to examine system operation and practice quality in specific areas. Evidence given in these studies informed the recommendations in Volume 1.

I feel privileged to have been entrusted with this task and I hope that the report will lead to a better future for the vulnerable children and young people of South Australia.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'M. Nyland'.

The Hon Margaret Nyland AM
Commissioner

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PREFACE

The activities of Shannon McCoole were the catalyst for establishing this Commission. However, this inquiry was not just about McCoole. Substantial community disquiet and adverse publicity had surrounded Families SA, and the child protection system generally, for some time before McCoole's arrest. The Terms of Reference for this Commission thus required me to conduct a thorough examination of the child protection system in this state, with provision for a supplementary report on McCoole, should his legal proceedings be protracted.

The problems besetting Families SA and the child protection system proved to be far greater than anyone had initially envisaged. McCoole's ongoing criminal investigation and prosecution indicated that his activities were likely to be relevant to other issues being examined by the Commission. I therefore considered it undesirable and unrealistic to treat his case as a discrete matter, and the subject of a separate report. The Government of South Australia granted an extension for the Commission to prepare a comprehensive and integrated report on all matters, including McCoole, and present it by 5 August 2016.

The investigation of McCoole occupied several months, including taking evidence from 76 witnesses and examining more than 4000 pages of written documentation. As anticipated, the evidence proved highly relevant to many issues raised by the Terms of Reference and supported my decision to defer the report until that matter was concluded.

We were faced with many challenges in producing this report. Of concern was the continuation of a number of issues that had been the subject of recommendations from the Layton Review of Child Protection in South Australia and the Mullighan Children in State Care Commission of Inquiry. However, the greatest challenge was trying to find a way to fix a system in disarray. From the outset of this Commission it was obvious that workers undertaking the difficult business of child protection felt undervalued, under-resourced and overwhelmed by a system which lacked the capacity to respond appropriately to children in need of care and protection. At the same time, I was impressed by the enormous goodwill and enthusiasm for change demonstrated by the many workers and other people who came forward and shared with me their concerns, thoughts and suggestions about creating a better system for the vulnerable children and young people of our community.

Regrettably, there is no quick fix to the many problems of the child protection system in this state. Some matters require urgent attention, such as the issues surrounding children in residential care, some matters need to be the subject of ongoing discussion and debate, and some matters require long-term planning.

In conducting this Commission, I have done the best I can to ensure that the report's recommendations are fully informed by relevant sources of information, knowledge and expertise, and that they have a sound evidentiary base.

The substantial reform needed for the child protection system was considered unattainable if Families SA continued to be part of the larger Department for Education and Child Development. The Agency needed to make a fresh start, which would best be accomplished by establishing Families SA as a department in its own right. I made that recommendation in advance of this report, which the government accepted, to enable planning to begin for the organisational changes necessary for this major reform.

I hope that this new child protection department with a refreshed leadership will establish a much improved system to keep children safe from harm, and restore public confidence. I trust it will include early support and assistance for families struggling to care for their children, to keep those children out of the child protection system.

When things go wrong, it is tempting to lay all the blame on the statutory agency. However, child protection is everyone's business. The new agency cannot operate in isolation. It should coordinate and collaborate with all other relevant departments and organisations, both government and non-government, to give children better outcomes. It must also be proactive and engage the community to play its part in developing programs and systems that ensure all children have the best chance possible to be safe and develop to their full potential.

The Hon Margaret Nyland AM
Commissioner

ACKNOWLEDGEMENTS

The extensive work undertaken by this inquiry was only made possible by the efforts of all those who worked for the Commission throughout the inquiry. Emily Telfer, as Counsel Assisting, together with her dedicated and hard-working legal team, worked long hours often into the night and on many weekends to bring this report to fruition. Angel Williams, the Director of the Commission office, capably managed and attended to all administrative matters and I thank her for that. I am particularly grateful to my Personal Assistant, Jackie O'Brien, who coped with my constant tweaking of the many drafts that preceded the production of this report and provided me with ongoing personal support throughout this Commission. I thank all employees of the Commission for their hard work and the support they provided to me in undertaking this task.

Although most of the metropolitan hearings were conducted in the hearing room at the Commission's premises, that room was inadequate for some of the more formal hearings. I acknowledge and thank Chief Justice Kourakis and Chief Judge Muecke and Judges of the Supreme and District Courts for permitting the Commission to use the courtrooms and facilities in the Supreme Court and Sir Samuel Way buildings for those hearings. The Commission also recognises the assistance provided by Judge Roder and Phil Hocking, Executive Director and Principal Registrar, Higher Courts, Courts Administration Authority of South Australia, for making the necessary arrangements with respect to those courtrooms.

I also acknowledge and thank the registrars of the Mount Gambier and Port Augusta courts for facilitating the Commission's use of rooms in their respective court complexes for hearings. I also express my gratitude to the sheriff's officers and reporters of the Courts Administration Authority for their assistance in court during the McCoole hearing.

I would also like to acknowledge the support provided by the Chief Executive and staff of the Attorney-General's Department.

As will be evident from the description of the evidence-gathering processes described in this report, the Commission issued a large number of summons requiring the production of documents and data from various government and non-government organisations. I acknowledge the cooperation of the various organisations who provided information sought in that way.

Staff at the Crown Solicitor's Office, acting on behalf of various government agencies, worked tirelessly to ensure documents were provided to the Commission promptly.

I would also like to acknowledge and thank all those people, including past and present employees of Families SA, who came forward to share their thoughts and suggestions with us as to improvements that could be made to the child protection system in this state.

The Hon Margaret Nyland AM

Commissioner

TERMS OF REFERENCE

By Letters Patent dated 15 August 2014, His Excellency Rear Admiral The Honourable Kevin John Scarce AC, DSC and Governor in and over the State of South Australia, invested Margaret Jean Nyland with the powers of a Royal Commissioner.

The Terms of Reference require the Commissioner to inquire and provide a report on the following matters:

- 1 The adequacy of existing laws and policies relevant to the State's child protection system for children at risk of harm.
- 2 Improvements that may be made to existing laws, policies, structures and allocation of resources relevant to the State's child protection system for children at risk of harm.
- 3 The adequacy of existing practices and procedures adopted by Families SA and other relevant agencies, including entities licenced by the Minister, in implementing the State's child protection system for children at risk of harm.
- 4 Improvements that may be made to the practices and procedures of Families SA and other relevant agencies, including entities licenced by the Minister, to provide for the best practical and financially achievable implementation of the State's child protection system for children at risk of harm.
- 5 The inquiry into the above matters should include consideration of, but is not limited to, the following matters:
 - a The means by which a child who may be at risk of harm is brought to the attention of relevant authorities.
 - b The assessment, by relevant authorities, as to whether a child is at risk of harm.
 - c The assessment, by relevant authorities, about whether to remove, or not to remove, a child from the custody and care of their guardians and to place the child in the custody and/or under the guardianship of the Minister.
 - d Whether the environment into which a child is placed, either on a short-term or long-term basis, is safe.
 - e The assessment, by relevant authorities, of persons who work and volunteer with children in the custody and/or under the guardianship of the Minister.
 - f Management, training, supervision and ongoing oversight of persons who work and volunteer with children in the custody and/or under the guardianship of the Minister.
 - g The reporting of, investigation of and handling of complaints about care concerns, abuse or neglect of children cared for in the custody and/or under the guardianship of the Minister.
 - h The staffing of the State's child protection system to ensure the safety of children at risk of harm.

On 16 July 2015 and 11 February 2016 respectively, additional instruments were issued amending the requirement for the Commission to report on a specific date. The final instrument required the Commission to present its report to the Governor on 5 August 2016.

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SUMMARY

OVERVIEW

Many children in the care of the state have been abused and neglected, not only by their families but by the system that was supposed to protect them. It is time for that to change. It is time for all of us to work together to give all our children the life they deserve.

The child protection system in South Australia involves numerous government and non-government agencies who should work together to improve the state's capacity to protect children. At the heart of the system is the statutory agency, Families SA, which has recently been the subject of a great deal of complaint and dissatisfaction. The heavy focus of this report on reforms to the statutory agency should not be taken as implying that the Agency alone is responsible for the safety of children. For sustainable improvements to the quality of life for children at risk of harm, changes are required well beyond statutory functions at both a government and community level.

The Commission adopted a liberal approach to interpreting its Terms of Reference and conducted a wide-ranging inquiry into the child protection system. Determination of what amounted to a risk of harm was not limited to questions of physical or sexual safety, but was taken to include such matters as emotional, social and educational development. In addition, the Commission examined ways to keep children safe in their environments, such as rotational care and home-based care, and considered the circumstances of children with diverse needs, such as children with disabilities and those in regional or remote locations. The Commission also had regard to preventative and early intervention strategies to keep children and their families out of the child protection system.

This Inquiry reveals a system overwhelmed by the volume and complexity of work, with notifications received every day relating to children living in dire circumstances who desperately need someone to take action on their behalf. In many cases the response comes so late that there is little choice to do anything other than to remove the child from their family.

When this happens it is not always possible to find an alternative care placement that meets their needs. Too many children languish in unsatisfactory rotational care situations (including emergency care) for long periods. As reliance on rotational forms of care has grown in this state, the costs of alternative care have grown to soak up more than 70 per cent of the overall child protection budget. This leaves little to invest in prevention and early intervention strategies to stop children entering the child protection system in the first place.

The reforms recommended in this report will not completely fix the system. Child protection is not a problem with an easily identifiable 'fix' or an end point at which the problem can be assessed as solved. The best that can be hoped for is that the proposed reforms *improve* the system and mark the start of a process of continuous evaluation and improvement.

The Commission's investigations reveal deficiencies across many parts of the child protection system. Under-investment over many years has hindered much service provision. Efforts to grapple with increasingly complex problems with increasingly limited resources have not worked.

The system itself is based on an outdated model constructed many years ago to respond to specific incidents of child maltreatment that were thought to be isolated and rare. The understanding of child abuse and neglect is now more sophisticated, and simply investigating and responding to specific incidents is no longer adequate.

The child protection system in this state (and in other jurisdictions) has developed with little reliance on understanding and developing the evidence base for interventions and strategies. Other professional disciplines, such as medicine, intervene only after an evidence base is established and the interventions are consistently evaluated. In child protection practice, this approach is less common. It is difficult to know whether the interventions offered are good value for the investment, in the sense that they are making a real difference to outcomes for children and their families.

Similarly lacking is investment in growing the knowledge base of the workforce tasked with managing this complex work. The gap between the complexity of the task, and the resources and skills of the Agency required to manage it, has been filled with innumerable policies and processes in an attempt to bring structure and certainty to the work. However, this array of 'guidance' has made little impact on the quality of the work. One of the most striking observations made by the Commission is the yawning gap between policy requirements and day-to-day practice in many areas.

Recurring themes

The recurring themes identified in the course of the Inquiry have informed the Commission's consideration of recommendations for reform across each aspect of the system:

- investing in growing skills and expertise across the child protection workforce, in the Agency, other government departments and the not-for-profit sector;
- relying on professional skills and judgement in decision making more than compliance with processes;
- reforming the Agency's leadership and structures to build an environment where professional knowledge and skill are valued, nurtured and retained;
- investing more in prevention and early intervention for vulnerable families outside the statutory agency, including greater reliance on the not-for-profit sector to deliver and coordinate services;
- growing the evidence base about the services families need, where they need them, and which services are most likely to work, and using this data systematically to plan services statewide;
- emphasising stability and certainty for children who come into the statutory system;
- investing in the out-of-home care sector to ensure that children who can no longer live at home are given stable, nurturing placements appropriately matched to their needs, including therapeutic care to heal past trauma;
- respecting and valuing foster parents and kinship carers;
- improving scrutiny of adults who care for children in out-of-home care placements, whether as foster parents, kinship carers or employees caring for children in rotational care;
- using data to track the quality of care that the state is delivering to children in out-of-home care;
- improving communication between the Agency and other organisations that provide services to children, and within the Agency;
- increasing the influence of independent voices in critical decision making in the Agency, to improve transparency of decision making;
- understanding and prioritising the experiences of children who are at risk of abuse and neglect, who come into the statutory system; and
- increasing the profile of children's opinions, experiences, wellbeing and development across the child protection system and the state more broadly.

The temptation to impose additional layers of policy and process to achieve sustainable change should be resisted. System change does not come from imposing more regulation on *how* the work is to be done; it comes from a greater investment in growing the knowledge base of workers, both at a planning and service delivery level.

If improvements are to be effected to the child protection system, relevant government and non-government departments and agencies also need to play their part in supporting families outside the statutory system. This report emphasises the importance of cooperation and collaboration between all parties and suggests some strategies to achieve that result.

A fundamental shift is required for the system to hear and understand the experiences of children. Too often the Commission heard stories of children whose needs were left unmet because attention focused on what the adults needed and wanted, at the expense of the experiences of the child. Keeping children safe relies on adults listening to them, understanding what they have to say and prioritising their experiences.

The large number of reports, inquests and inquiries on the topic of child protection over the years is testament to the persistence of the problem, in this

state and elsewhere. The Report of the Review of Child Protection in South Australia (Layton Review) in 2003 made a comprehensive series of recommendations for a complete overhaul of the system to keep children safe. Five years later the Children in State Care Commission of Inquiry (CISC Inquiry) focused attention on the experiences of children who had been sexually abused or who died as a result of criminal conduct in state care. The Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry which followed focused on issues relating to Aboriginal children on the Lands.

Each of these reports made important recommendations designed to improve the safety of children in this state. Notwithstanding those recommendations, the child protection system remains ill-equipped to respond to the needs of many children who are at risk in the community, and in out-of-home care.

SUMMARY

CHALLENGES FOR THE AGENCY AND THE WORKFORCE

The Commission received the strong message that morale within the Agency was at the lowest it had been for many years. There was a sense that professionalism and knowledge were not valued in the organisation. Efficient and effective case management was being thwarted by the tight holding of operational decision making within a small group of managers and executives who were distanced from the workers in the field and from the children about whom the decisions were being made. The capacity of front-line workers did not appear to be trusted and a culture of micromanagement was undermining the development of professional skill. The operational orientation of senior staff, including executives, was inhibiting the Agency's capacity to engage in strategic thinking and planning in the medium and long term.

Workers were burdened with a multitude of policies, processes and administrative requirements which had accumulated over time without being rationalised. These policies had come to replace professional practice with process compliance and had diverted the focus from making good decisions for the benefit of children to making decisions that minimised the risk for the Agency.

A NEW DEPARTMENT

It is clear that the Agency needs to make a fresh start. The Commission considered whether the reforms recommended in this report could be achieved if the Agency continued to be part of the Department for Education and Child Development. It concluded that a new independent department should be established with child protection as its primary focus. As this was a major reform, an interim recommendation was made, and accepted by the government, to establish the new department to enable the government to start planning the necessary organisational change in advance of the other reforms set out in this report.

The new Agency requires a refreshed leadership, including a chief executive with established professional credibility in the area, capable of leading by example. The Agency should invest in a high profile professional development and learning unit that can build the capacity of the workforce. It should also have a dedicated data collection and research division to collect, extract and analyse data to monitor the quality of its own services, and the services it commissions. The Agency's case management system (commonly called C3MS) was the subject of critical comment throughout the Inquiry. That system is in need of improvement and should be reviewed to ensure that it can support data collection in the new department, and if, indeed, it is viable in the long term.

INVESTING IN THE WORKFORCE

The workforce that carries the child protection system has been neglected for far too long. The Agency's human resource capacity is crying out for significant investment, as is the capacity to track and plan for its workforce. No overarching workforce plan addresses the challenges of recruitment and retention in either the medium or long term. Recruitment strategies are crisis driven.

Specific attention is needed on developing robust processes to track vacancies, planning the workforce (including recruitment and retention strategies), and creating and retaining complete sets of employee records. Specific measures are needed to counteract the high turnover of staff, and the consequent loss of knowledge, skill and relationships.

Workforce planning should be guided by the overarching principle that child protection is complex work requiring appropriately qualified staff. The professional base of the child protection workforce could be expanded by employing professionally qualified staff from disciplines other than social work, but case management in child protection should be reserved for staff who have relevant tertiary qualifications and appropriate experience.

The Agency has a role to play in leading cross-sector education and training. There are many advantages to closer relationships between the Agency and the not-for-profit sector, as well as tertiary training institutions. Joint training promotes economies of scale as well as important collaborative relationships. The Agency should lead workforce planning and development across the sector. The Commission recommends improvements to support the professional development of staff, which include a professional development reimbursement program modelled on that operating in SA Health.

CHILDREN AT RISK IN THE COMMUNITY

The current system for notification of children at risk relies on the Agency's call centre as the single entry point to receive, assess and funnel notifications for a response. The Agency is currently overwhelmed by the number and complexity of notifications, and only the most serious and critical cases receive a response. In 2014/15 a staggering 61 per cent of notifications assessed as requiring a response were closed with no action, because of more urgent priorities. Notifiers who have contact with children become frustrated because they see no evidence of action and notify again.

Evidence to the Commission indicated the existence of a large cohort of children who are the subject of notifications and need assistance, but do not receive a response until their situation is critical.

A strong and consistent theme in submissions and in evidence was the need to place more emphasis on services that *prevent* children from being harmed, or that respond early, when there is a greater possibility for issues to be successfully resolved.

EARLY INTERVENTION RESEARCH DIRECTORATE

Preventative and early intervention services need to substantially grow to respond to families before their circumstances become untenable. Services that help families to safely care for children should be delivered by a variety of government departments and non-government organisations funded by the government. Services in this category would not be delivered by the Agency, which must focus its work on meeting its statutory mandate. Cases in which the Agency currently delivers some prevention and early intervention services should be devolved to the not-for-profit sector.

Any service that the government provides or invests in should be good value for money. The Commission therefore proposes the establishment of a cross-departmental Early Intervention Research Directorate (EIRD). That directorate would be responsible for creating and coordinating a five-yearly whole of government prevention and early intervention strategy. This strategy would guide funding priorities and enable greater coordination of services in each local area. Only services identified in the strategy should be pursued. The first step for EIRD would be a comprehensive mapping of all services currently available across the state.

Immediate funding priorities should include services to families in the prenatal period, services for young and first-time parents, and targeted services for care leavers who become parents.

EIRD should also be tasked with evaluating innovative service models in operation in other jurisdictions to ascertain their suitability for South Australia. EIRD should require evidence-based evaluations, or clear program principles with a framework for future evaluation, as a condition of program funding.

A DUAL PATHWAY SYSTEM

Additional services will make no difference to children's lives unless they appropriately match family needs and are delivered in accessible ways.

A number of models in Australia provide 'dual pathway' mechanisms which allow families to be referred to services as opposed to being the subject of a report to the relevant statutory agency. Such a dual pathway program should be developed in South Australia to divert appropriate families from the statutory system.

CHILD AND FAMILY ASSESSMENT NETWORKS

Child and family assessment and referral networks should be established in each metropolitan region, and in the largest country centres (Mount Gambier and Port Augusta or Whyalla). These networks would rely on a lead not-for-profit organisation in partnership with the Agency receiving reports from notifiers and coordinating service responses. Legislative amendments would be required to enable notifiers to satisfy their mandatory reporting obligations by referring families, where appropriate, to such networks rather than making a report to the call centre. These networks should also be tasked with preparing an annual local area needs assessment which would report to EIRD to inform funding decisions for services in that area.

CHILD WELLBEING PRACTITIONERS AND CHILD WELLBEING ASSISTANTS

Two other strategies would encourage government staff to consider making a referral to a network rather than a report to the Families SA Call Centre. Child wellbeing practitioners are now employed in Education sites to help educators understand and clarify child protection issues and in particular whether an identified problem should be the subject of a mandatory report. This important initiative is strongly supported. It should also be permissible for educators to satisfy their mandatory reporting obligations by making a report to a child wellbeing practitioner at the school.

In addition, government agencies should train some of their existing staff to act as child wellbeing assistants, equipped to guide their colleagues on options that might be available to support vulnerable families. A report to a child wellbeing assistant would not be a substitute for making a mandatory report but should help prospective notifiers better understand how to deal with the problem and determine the appropriate pathway.

CHILD ABUSE REPORT LINE

The Child Abuse Report Line (CARL) is the subject of constant complaint, primarily due to the unreasonably long waiting times imposed on people who are trying to make a report about a child protection matter.

Implementation of a referral pathway should reduce the demand on the statutory agency and early intervention services should, over time, limit the cycle of notification and re-notification.

There is a perception that some of the overload of work at CARL is due to unnecessary reports. This in part is attributed to notifiers reporting any sort of concern to avoid the possibility of a breach of their mandatory obligations without proper regard to the nature of the problem and whether the matter should be the subject of a mandatory report.

SUMMARY

That does happen on occasion, but the examination of files by the Commission did not disclose this to be a significant issue. To the contrary, many notifications screened out as not warranting a response revealed children left in unacceptable circumstances in which they needed help.

The Commission is also not persuaded that legislative change would necessarily modify notifier behaviour. Therefore, no change is proposed in mandatory notification duty. However, some categories of mandatory notifiers should be obliged by law to attend regular training to ensure that key messages about notifiers' responsibilities are heard and understood. A mandatory notifiers' guide should be prepared to complement this additional training.

Notifiers should also be advised of the Agency's intended response. Knowing whether the Agency will or will not respond to a notification helps a notifier to decide what, if any, action they may need to take.

The long waiting times suffered by notifiers calling CARL are unacceptable. The Commission understands there is a call-back feature currently available at CARL, which should be activated. Callers then have a choice to wait on hold, or to receive a call back when their position in the queue is reached. Workloads and staffing levels should be reviewed to achieve the following service benchmarks:

1. maximum wait time of 30 minutes for a call to be answered;
2. maximum 24 hours for an eCARL notification to be assessed; and
3. maximum delay of two hours wait for a call back.

The ballooning rate of notifications that do not receive a response should be acted on. It will take time to resolve. The alternative referral model should eventually reduce the number of notifications, but the rate needs to be closely monitored and publicly reported. The government should provide sufficient staff in the Agency so that it takes no more than five years to phase out the closure of files without any action.

BETTER INFORMATION AND ASSESSMENT EXPERTISE

Where children are identified as living in circumstances that cannot be ameliorated by preventative or early intervention strategies, an effective and decisive response is required from the Agency.

The Commission's investigations revealed consistently poor quality assessments undermined by excessive optimism, lack of focus on the child's experience, too little reliance on the expertise of other practitioners and unrealistic reliance on informal agreements in which

parents promise to reduce their dangerous behaviour. Greater training and skill development is required to improve the quality of this work.

Legislative reform is required to give the Agency greater powers to obtain information to inform quality assessments at an early stage. The Agency should be empowered to obtain a range of information about children at risk, and about their parents, from both government and non-government sources without a court order.

The *Children's Protection Act 1993* (SA) has a provision for the Chief Executive to apply to the Youth Court for an order requiring parents to undergo a drug or alcohol assessment in certain circumstances. These powers should be amended to permit the Agency in appropriate cases to issue a written direction to the parents to undergo such an assessment without having to make an application to court.

There is a need for greater reliance on independent expert assessment with respect to matters that proceed to court. A model of independent expert assessment should be developed which gives the court power to order expert assessments independent of either party to the court action. The current Child Protection Services at the Women's and Children's Hospital and Flinders Medical Centre should be developed to provide this service.

The north has a high level of need for hospital-based child protection services, and a child protection service modelled on that in operation at Flinders Medical Centre should be established at Lyell McEwin Hospital.

CERTAINTY FOR CHILDREN ON SHORT-TERM ORDERS

By the time children's circumstances are dire enough to attract a response, issues in the family often require the child's removal to attend to entrenched safety concerns. Once removed, the child's need for stability and certainty is given insufficient weight. Attempts to reunify children with their parents drag on for far too long, causing instability as well as denying young children the certainty of the attachment relationships crucial for their development. It is also of concern that many children taken into care are subsequently reunified with their parents when the issues that undermined their safety in the first place have not been sustainably addressed. Of the children who entered care in 2014/15, 36 per cent had spent previous time in care. In the same period, 20 per cent of children reunified with their parents returned to care within six months. These are children whose development is undermined by lengthy uncertainty about their relationships and care arrangements.

When children are removed into the care of the state, it is essential that decisions are made in accordance with a developmentally appropriate time line. When an application is made to the court for a short-term order for care and protection, a permanency plan should be prepared and filed in court by the Agency. That plan should detail the contemplated timeframe for reunification of the child with their family, the changes expected of the family to enable that to occur, and the services given to the family to help them make those changes. The timeframe in the vast majority of cases should not exceed six months for a child under two years, or 12 months for older children. If at any time it appears that reunification is not realistic, the Agency should immediately apply for a long-term order and file a permanency plan which sets out the proposals for the long-term care of the child.

The Commission recommends improvements to some procedures in the Youth Court. All matters should be heard expeditiously. Greater use should be made of Family Care Meetings, which could be held at any time and not simply as a precursor to court proceedings. Contact arrangements should not be included as part of a court order but should be the subject of negotiations with the Agency or determined by a case review panel with independent membership in the event of a dispute.

CHILDREN IN OUT-OF-HOME CARE

When a child is removed, the state assumes a heavy burden to provide safe and nurturing care. Evidence to the Commission highlighted that this burden is not always met and service barriers continue to exist.

The specific recommendation from the CISC Inquiry in 2008 that all children in care be allocated a case manager and have face-to-face contact at least monthly remains unmet. Many children do not have an allocated case manager, or are subject to what is called a 'differential response'. That means they are visited rarely, if at all. This is particularly concerning—the CISC Inquiry recommendation noted that many children who had experienced abuse in care lacked a caseworker to whom they could complain.

It also appears that the South Australian Standards of Alternative Care, in place since 2008, are routinely breached. Of particular concern are:

- standards that require allocation of a caseworker, frequency of caseworker contact, and regular case planning;
- health standards that require comprehensive health assessments for children entering care; and
- the legislative requirement to conduct an annual review of the circumstances of all children in care.

Only 83 per cent of children entitled by legislation to an annual review in 2014/15 had received a review, although this was an improvement on 53 per cent in the preceding year.

TRACKING THE QUALITY OF CARE BEING DELIVERED

In order to track the quality of care the Agency gives children in care, the Agency should be required to report quarterly both to the Minister and the Guardian for Children and Young People (GCYP) against the following measures:

- all children in care have an allocated caseworker;
- the allocated caseworker has face-to-face contact with the child at least monthly;
- every child in care has a case plan that is actively monitored and reviewed every six months;
- every child who enters care has preliminary and comprehensive health checks, in accordance with the Health Standards for Children and Young People under the Guardianship of the Minister; and
- every child has their circumstances reviewed at an annual review in compliance with section 52 of the Children's Protection Act.

IMPROVING SERVICE DELIVERY

South Australia has an extraordinarily high rate of placement instability compared to other Australian jurisdictions. Of the children who left care in 2014/15, 13 per cent had had more than 11 different placements during their period in care. Placements that appear to be in danger of breaking down should be promptly identified. Early therapeutic support would help carers who may be having difficulty in coping with the challenges of caring for children with high or complex needs.

It also appears that gains made in service accessibility for children in care through the government's Rapid Response plan have not been sustained. The plan should be renewed and reinvigorated. An interdepartmental committee to review and refocus Rapid Response should also be reinstated, and the document should be updated every two years.

A panel led by the Child and Adolescent Mental Health Service could bring greater focus on linking children to relevant therapy by considering the therapy needs of children in care and advocating for access to appropriate services where necessary.

SUMMARY

IMPROVING CHILDREN'S PARTICIPATION IN DECISION MAKING

The files examined by the Commission and the detailed case studies showed little evidence of children being given appropriate opportunities to participate in decisions about their care. Legislative amendments are recommended to require children to be included in decision making about their care to the extent that they are capable and willing to do so, and that their views be given weight in accordance with their age and maturity.

HOME-BASED CARE

Foster parents play an important role in the care and protection of children who can no longer safely live with their families. Developing the number of home-based care placements is a key aim for a reformed child protection system. When children are removed from abusive or neglectful families they need quality, nurturing, consistent environments to help them heal. Unfortunately, the gap is ever widening between the demand for home-based carers and the number of people available to perform that role. Not only does this mean that children are sometimes removed to unsuitable environments, it can also affect a decision about removal. When a child protection worker fears that the removal of a child from an unsatisfactory family environment will place that child in an unsuitable care environment, they are faced with an invidious choice as to which is the lesser of two evils.

While greater effort needs to be made to recruit new carers, existing carers must also be valued, and ensuring that the experience of caring is a positive one is essential.

More than 80 per cent of children in care live in home-based placements. These placements are described broadly as foster care (carers previously unknown to the child) and kinship care (relatives of the child who deliver care on behalf of the Minister as the guardian). Kinship care has contributed most of the substantial growth in home-based care in South Australia, but regulation and assessment processes have not kept pace with that growth.

REFORMING KINSHIP CARE

When children are placed with kinship carers in urgent circumstances, provisional registration is facilitated with a short-form assessment. It does not include child-related employment screening, which is a mandatory part of a full assessment. This provisional assessment is considered to be acceptable for no longer than three months. However, the Commission discovered that as at 9 October 2015, 34 per cent of children in kinship care placements (a total of 334 children) had been there longer than three months without the necessary comprehensive assessment of the suitability of their carers. Almost 150 of those children had been in the placement for more than 12 months.

The processes by which full assessments are completed for kinship carers are not subject to the same rigour applied to assessing foster parents. An appropriate tool for the assessment of kinship carers should be identified, and endorsed for use.

The current regulatory regime that applies to kinship carers should be comprehensively reformed. This includes amending the *Family and Community Services Act 1972* (SA) to ensure that the registration and monitoring requirements apply to both foster parents and kinship carers for a child who is under the guardianship, or in the custody of, the Minister.

The assessment and support of kinship carers should be outsourced to the not-for-profit sector, on the same terms as currently apply to the sector's work as registered foster care agencies.

RELATIONSHIP OF CARERS WITH THE AGENCY

A number of foster parents told the Commission that they loved their foster children, but they would not recommend the experience to others. There were some examples of good cooperative relationships but, in many other examples, carers were treated poorly and the value of their contribution was minimised. They were often met with the comment, 'You're just the carer'.

The Layton Review emphasised that the state cannot parent, but it must facilitate and support the parenting done by others. Thirteen years later, a lack of clarity remains about the reach of the Agency into day-to-day decision making for children in home-based placements.

Foster parents consistently complained about receiving insufficient information to help them manage the needs of the children. Support was inadequate to meet many of those needs and when they sought help, the Agency attributed the children's problems to them. Legislative amendment is required, giving:

- carers the right to access information they may need to make an informed decision about whether or not to accept a placement;
- carers the right to information they will need to properly care for a child;
- children a right to information about a carer before the placement; and
- carers the right to participate in decision making about matters which go beyond the day-to-day care and control of the child.

Carers do not have an independent advocacy service to help them deal with the Agency, or to exercise rights they may have to make submissions in proceedings in the Youth Court according to section 47A of the Children's Protection Act. An advocacy service should be funded that includes specific funding to raise awareness among carers of their legislative rights to contribute to decision making about children in their care.

TRANSPARENCY OF DECISION MAKING

Carers provide day-to-day care for children while living in fear that the Agency will remove the child from them at any time. Recent high profile cases reported in the media have further fuelled this fear. Sometimes removal is unavoidable, but greater transparency should accompany such a decision.

Decisions to remove a child from long-term foster parents should not be arbitrary. They should be made by a panel located in the Agency, but chaired by an expert independent of the Agency. The focus should always be on the best interests of the child.

The panel should consider the need for such removal, whether the proposed alternative placement meets the child's needs, and the adequacy of any transition plan. The carer should also be able to make representations to that panel.

SUPPORT PROVIDED TO CARERS

The current level of reimbursement to foster parents should be reviewed to ensure equity across general and specialist models of care. Carers should have access to a package of training to equip them to care for children with complex needs. Suitable carers should be identified to undertake this training. Carers who do so should be entitled to a care payment that acknowledges that quality care to a child helps *prevent* the development of complex behaviours. Helping carers to deliver this quality of care is economically responsible in the long term.

CHILDREN IN OTHER ENVIRONMENTS

Rotational care describes any care arrangement in which children are cared for by adults who are employees and who work on a shift basis. Rotational care of two types is delivered in South Australia: emergency care (also referred to as commercial care) and residential care.

South Australia relies on rotational care more than any other jurisdiction in Australia. It has the dubious distinction of caring for a higher proportion of infants and young children in this form of care than anywhere else. Rotational care is developmentally inappropriate for most children and is a poor substitute for the care provided in a loving family home. Despite universal acceptance that rotational care is developmentally

unsafe for children in their active attachment phase, 48 children under the age of three years were cared for in this way in South Australia in 2014/15.

The proposed reforms of early intervention in families should reduce the number of children coming into care, and reforms to home-based care should build the numbers of kinship carers and foster parents. Nevertheless, rotational care will still be needed in specific circumstances. Recommendations for reforming emergency and residential care are made against that background.

If the state can reduce its reliance on rotational care, it will significantly improve the quality of care for children. It will also free up funds for investment in more productive child protection services.

EMERGENCY CARE

Children placed in emergency care are looked after by staff who have minimal training and are employed through commercial agencies. These staff are deployed in shifts to care for children in locations such as motels, caravan parks, bed and breakfast cottages, and short term rentals. These 'emergency' arrangements are intended to be short-term and stop gap until a more suitable placement can be identified. However, children remain in these circumstances for much longer than the term 'emergency' implies.

Reliance on emergency care by commercial carers should cease in all but genuine emergency circumstances. This will take some time, and require considerable investment in building other care options, including the capacity of the residential care workforce in the Agency.

In the interim, greater scrutiny and supervision must be applied to emergency care environments, including the workers who staff them. Service agreements with agencies that provide staff should be reviewed to ensure consistent standards for the selection and appointment of workers. The establishment and supervision of placements should be consolidated in the residential care directorate of the Agency. Workers engaged by commercial agencies should be restricted from working for the Agency through more than one employer at a time. They should also be required to register with the Agency and be pre-approved before being rostered to work.

The risks of sexual abuse in rotational care have been well known by the Agency for many years. However, Shannon McCoole's offending occurred in that environment and his actions demonstrate that the risk has not diminished, and action is long overdue.

SUMMARY

The risk of children being cared for by commercial care workers on single shifts (that is, working alone) is substantial. Single shifts should cease immediately. Carers employed through a commercial agency should be restricted to shifts with two workers at any one time.

RESIDENTIAL CARE

The experiences of children in residential care were examined in detail in the case studies. Residential care provided by the Agency has grown without adequate planning to ensure that enough well trained staff are available to work in those facilities. It has also grown with inadequate attention to the changing population of children who live there. Residential care traditionally housed adolescents for whom home-based care was no longer appropriate or available. Now more children and infants, who are especially vulnerable in rotational care environments, are housed there.

This does not mean that there is no continuing role for residential care. Some children are not suited to being cared for in a home-based setting, and good residential care can meet their needs. The home-based care sector is also unlikely to experience sufficient growth in the immediate future to enable residential care to shrink quickly.

However, wholesale reform of residential care is needed. A streamed model of residential care should replace all other forms of residential care being delivered. The streamed model should:

- apply a therapeutic framework applicable across all care environments, which gives a theoretical background for care decisions;
- endorse consistent standards and approaches to care as a solid basis for supervision and performance management of staff who work outside this endorsed approach;
- have facilities for short-term assessment of children over a period of no more than eight weeks to assess the needs of the child;
- include facilities for children on long-term orders who do not have high or complex needs;
- include facilities for children with high or complex needs, whether psychological, physical or behavioural;
- house no child under 10 in residential care, except where necessary to keep a sibling group together; and
- house no child in a facility with more than four children, except where necessary to keep a sibling group together.

Adoption of an appropriate therapeutic model should be accompanied by an obligation to make a substantial investment in the training of workers in residential care.

Too many children continue to reside in large residential care units (sometimes called congregate or community care units) which cater for up to 12 children. Large units do not provide the homely environment that children need, and the warehousing of a large number of children with complex behaviours under one roof inevitably leads to residents learning new behaviours from each other. It creates an unsafe living environment.

A focus on keeping residents safe in such a volatile environment has increased their institutional atmosphere. Children as young as nine live in facilities where they have to ask staff to unlock their bedroom door if they need time to themselves, or ask for the kitchen to be unlocked if they want something to eat. The risks of peer-to-peer sexual abuse, assaults and other critical incidents are aggravated by poor matching of residents within the units. The evidence against this form of care continuing is overwhelming and recommendations for their closure have been made repeatedly. The Commission recommends that these units be closed.

PROTECTING CHILDREN FROM SEXUAL ABUSE

Children in institutional care are especially vulnerable to sexual abuse, and if they are to stay safe, this risk must be addressed. Children and infants who are too young to understand what is happening to them, or for whatever reason are unable to complain, rely on the presence of consistent and attentive caregivers who understand when they feel secure and well, and when they do not. There are difficulties in providing this security in a rotational care environment.

Single-handed shifts by residential care workers should be abandoned. This too will take time and depends on building the number and capacity of the workforce significantly.

The McCoolle case study showed up gaps in the knowledge of workers about the behaviour of child sex offenders and responses of children to sexual abuse. It highlighted a dangerous naivety about the risks to children in rotational care. Expectations of workers were confused and senior staff did not follow up disciplinary matters. Information from various sources was never compiled to give a complete picture of McCoolle's behaviour.

Carers employed in rotational care (both emergency and residential care) should be subject to much greater scrutiny in the workplace. Measures that should be implemented to improve the Agency's ability to identify risk are:

- a unit specifically dedicated to tracking information on the conduct of carers, including from care concerns, critical incident reports, supervision records and information from other staff;
- compulsory training for all residential care workers in the dynamics of sexual abuse in institutional environments, grooming behaviour, children's responses to sexual abuse, and how to respond to children whose behaviour or statements raise the possibility of sexual abuse; and
- specific obligations imposed on all workers to report issues which concern them, even those which fall short of activating mandatory reporting obligations.

The process by which McCoole was able to gain employment with the Agency was investigated in detail. A reformed recruitment process has since been established and that model should continue to be used.

However, a fundamental change in the organisational culture in the residential care directorate is required. That change will only be effective if it is sustained and helps develop a culture of openness, where concerns are routinely discussed and addressed, and the issue of the ongoing risk to children is kept high on the agenda.

Prioritising the experiences of children, and creating an environment in which children can speak and be heard, can prevent sexual abuse. When the experiences of children are ignored or dismissed, those who are minded to commit abuse will flourish. To date, the voices and perspectives of children living in residential care have not been heard and there are no clear pathways to enable those children to complain.

Regulations that require staff using physical force against a child to ensure the child records their own version of events have been systematically ignored. When some children complained about their treatment, their version of events was disregarded.

Reforms are required to improve the profile of the perspectives of children:

- Amendments to section 56 of the Family and Community Services Act should be made to require the Chief Executive to hear complaints from all children who live in residential care or emergency care, not just those who live in licensed facilities.
- An accessible process should be developed for children to exercise their rights according to section 56.

- Amendments to the Family and Community Services Regulations are required to improve the accuracy of records of physical force being used against children in care.

GCYP should develop an education program for children in residential and emergency care to advise them about their rights. A community visitors scheme should also be developed to focus on children and young people in residential and emergency care.

SECURE THERAPEUTIC CARE

Establishment of a secure therapeutic care facility for children has been debated for many years. It was the subject of recommendations in both the Layton Review and CISC Inquiry.

The obvious concern about such a facility is that it could be regarded as a form of incarceration, or simply used as a dumping ground for difficult children. However, some children have high needs that can be dealt with only if they are kept securely in place for therapy. This Commission considers that there is a need for such a facility but that any such model should have the safeguard of oversight by the Supreme Court. It should also have appropriate step-up and step-down services for children so detained and a scheduled evaluation of outcomes for the children subject to this intervention.

ADOPTION AND OTHER PERSON GUARDIANSHIP

Stability of care relationships for children is an important precondition to their development. Adoption is one way of securing that stability. Some members of the community hold the view that adoption of children from care solves the problem of the shortage of suitable home-based placements. However, the Commission is not persuaded that an increased emphasis on making children in care available for adoption is necessarily appropriate, when fundamental considerations of the child's best interests are brought into account. That is not to exclude the possibility of adoption of children in care when it is genuinely in their best interests.

However, children can gain additional feelings of security within a loving family through Other Person Guardianship where guardianship responsibilities and powers are shifted in certain circumstances from the Minister to the carer of the child under the Children's Protection Act. It can bring a greater sense of stability, certainty and normalcy to a child's life, including placing important decision making in the hands of the adults who know the child best.

Other Person Guardianship has been under-used in South Australia. The Agency has retained decision-making powers over many children in situations in which, for all intents and purposes, they are a settled part of a new

SUMMARY

family. In 2014/15 South Australia had the lowest rate of Other Person Guardianship carers of any state in Australia.

The focus on Other Person Guardianship should be renewed. The Commission recommends a new procedure to facilitate such applications being made by foster parents—an independent expert panel established to enable foster parents and relative carers to apply for an official assessment of their suitability and timely consideration of such applications.

The Children's Protection Act should be amended to limit the ability of a child's birth parents to oppose the making of an Other Person Guardianship order if the court is satisfied that such an order is in the best interests of the child.

LEAVING CARE

Children in care leave the system on the automatic expiry of their care order, when they reach the age of 18. However, this is a time when many adolescents experience challenges in education, health, life skills, housing and relationships. Care leavers embark on these challenges of adulthood without the safety net offered by a traditional family structure. The way in which the state supports children and young people to transition out of care is a measure of the success of those charged with raising them. Young people approaching care-leaving age are entitled to be part of specific planning addressing their goals and plans on leaving care. However, since 2011/12 no more than one-third of these young people had transition plans. Very few young people received any support from the Agency after they turned 18.

Amendments to the Children's Protection Act are required to enable the state, in appropriate cases, to help care leavers up to the age of 25. This should include expanding the eligibility of some Rapid Response initiatives to them.

Some children are fortunate enough to be able to remain with their long-term foster parents or kinship carers after they reach the age of 18 and have the benefit of their support while they pursue training and educational opportunities. In such situations, changes to carer support payments should be made to help young people to study or undertake a course of training while they remain at home. For young people living independently, the Commission endorses Housing SA initiatives to develop flexible models of housing which support care leavers.

INVESTIGATING ABUSE AND NEGLECT

When children in care do not receive quality care, or when abuse or neglect in out-of-home care is suspected, the Agency must be able to provide a timely and focused investigation which is procedurally fair, but keeps the safety and interests of the child firmly at its centre.

Since its establishment, the Department's Care Concern Investigations Unit (CCIU) has struggled to define its role or establish clear processes and standards for its work. Evidence to the Commission disclosed a high level of frustration and concern about delays in the care concern investigation process, and the way in which investigations were conducted.

The Commission's investigation of CCIU during the McCoolle case study highlighted a number of deficiencies and underlined the need for substantial reform to investigative processes in order to keep children safe.

The Commission recommends that care concerns be managed between two units:

1. an investigative unit staffed by a multidisciplinary team of child protection specialists and people with law enforcement expertise; and
2. a response unit in the Agency's quality and practice section that liaises with staff in the field, monitors care concern data and identifies system-wide issues.

A maximum timeframe of six weeks should apply for most investigations. Some delay is inevitable when the conduct is the subject of a criminal investigation but in such cases liaison between the response unit and South Australia Police would identify aspects of the care concern that may be investigated by the Agency while criminal proceedings are pending.

In appropriate cases, some less serious care concerns could be managed by staff in the field. A structured screening tool is recommended for implementation at CARL which would enable staff to direct a concern to the field or for an investigative response, as appropriate. For matters that require an investigative response, a panel of three senior staff would determine whether it should be undertaken by the investigations unit or by staff in the field. Any allegation of sexual misconduct would always be addressed by the investigation unit.

Consistent with other recommendations, quarterly reports should be made to the Minister and GCYP on key performance indicators for CCIU:

1. the number of care concerns received and response provided;
2. the number of care concerns completed;

3. the proportion of investigations completed within set timeframes, and for those not completed, the reason for delay; and
4. details of system issues identified and how they are being addressed.

CHILDREN WITH DIVERSE NEEDS

Some children in South Australia's population have needs that will not be met by a one-size-fits-all approach, and for whom particular approaches should be designed. The Commission considered the needs of four particular groups:

1. Aboriginal and Torres Strait Islander children;
2. children who live in regional areas;
3. children with disabilities; and
4. children from culturally and linguistically diverse backgrounds.

ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Aboriginal and Torres Strait Islander children are still vastly over-represented in the children reported to the child protection system and brought into care. Greater effort is needed on specific issues for Aboriginal families, both in helping them to care safely for children, and helping Aboriginal children in care retain connections to their community and culture.

All the reforms in this report are recommended against the fundamental principle that all children, regardless of their race or culture, are entitled to a full life, including care and protection, and an adequate standard of living. In assessing whether Aboriginal children who come to the attention of the child protection system are having these needs met, it is necessary for workers to understand their observations in a cultural context, specifically the strengths of some Aboriginal parenting practices.

The recommendations made by the Commission for a strategic approach to early intervention programs (EIRD) should take account of the specific needs of Aboriginal communities (including remote communities). It is also important that new services take advantage of referral pathways from existing credible services, especially those that are led by the health sector and those that have contact with Aboriginal parents in the prenatal period.

THE ABORIGINAL AND TORRES STRAIT ISLANDER CHILD PLACEMENT PRINCIPLE

The Agency continues to be challenged by its ability to comply with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP). In some cases suitable Aboriginal carers are not located for children

until well after their entry into care. The creation in the Agency of a family scoping unit for Aboriginal children is recommended. This unit should have access to other organisations with relevant records and build a database of information about families to help locate safe and appropriate carers in a timely way.

Compliance with ATSICPP requires more than simply following a hierarchy of care options. It requires genuine partnership with Aboriginal-led organisations when making decisions about the welfare of Aboriginal children. The Agency has not always embraced this obligation. It needs renewed focus on consulting with prescribed agencies as required by the Children's Protection Act.

The gap between available Aboriginal carers and the number of children needing care will not close quickly. Better support for non-Aboriginal carers should include help in attending to the cultural needs of Aboriginal children in their care.

APPROPRIATE CARER ASSESSMENT TOOLS

With more than 50 per cent of Aboriginal children in care being looked after by relatives, the problems that beset the assessment and monitoring of kinship carers require specific attention. Current assessment tools do not adequately capture the strengths and needs of many Aboriginal families, and the Agency should invest in a culturally appropriate tool that engages potential carers to deliver better quality care.

ALTERNATIVE CARE OPTIONS IN REMOTE AREAS

Some Aboriginal children in remote communities such as the APY Lands continue to live in unsafe conditions, despite improvements since the APY Lands Inquiry.

Because there are no foster parents or residential care facilities on the APY Lands, children taken into care are either looked after by relatives or are removed from their community to a regional town or even to the metropolitan area. Greater effort needs to be made to identify alternative care providers in Alice Springs and Coober Pedy, where children who are removed from their communities are more likely to have family or cultural connections.

A working group should be established to promote collaborative practice between the South Australian, Western Australian and Northern Territory child protection agencies in the tri-border region, including working towards an across-border legislative scheme for child protection in the three jurisdictions.

SUMMARY

Many children in remote areas are placed in relative care (the care of relatives) through Family Care Meetings without formal court orders. Where these arrangements are made, monitoring by the Agency should continue to ensure that they are safe and sustainable.

COORDINATION OF SERVICES IN REMOTE COMMUNITIES

The Commission has emphasised the advantages generally of colocated services through Children's Centres in metropolitan and regional areas. In remote communities, service delivery could be similarly coordinated. The facilities available in each community should be audited and, through EIRD, services coordinated and colocated where possible.

CHILDREN IN REGIONAL AREAS

Suitable placements can be hard to find for children in the metropolitan area, but the situation in a regional area can be much worse. Children removed from the care of their families are sometimes placed many kilometres away, interrupting their education, their stability and their ability to maintain contact with their family and friends.

Children in regional areas who need specific therapeutic or health services find it difficult to access them locally. The Agency's in-house psychological services should place greater focus on service provision in regional areas to ensure equity of access.

Judicial officers rarely travel to regional areas for hearings on children in need of care, and some of the arrangements for hearings in regional areas are unsatisfactory. The government should collaborate with the Courts Administration Authority to improve access to justice for children in regional areas, for example by using appropriate technology.

CHILDREN WITH DISABILITIES

The services available for children with disabilities, both those at risk of coming into the child protection system and those living in out-of-home care, can be improved.

The rollout of the National Disability Insurance Scheme (NDIS) could give families struggling to safely care for children with disabilities additional support to meet the necessary standard. Because NDIS does not assertively engage with families who might benefit from involvement, staff in the child protection system should be mindful of potential eligibility and help eligible families to obtain access.

Children in out-of-home care rely on attentive case managers to recognise their potential eligibility and negotiate on their behalf. Many children who enter care with developmental delays, or psychological conditions originating in abuse and neglect, might benefit from

NDIS services. To ensure this group of children is proactively supported to access NDIS, and to help with forward planning, the Agency should track children who are potentially eligible to participate in the scheme. Employment of disability specialists and additional training are also recommended to develop expertise in the Agency.

CHILDREN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Children from culturally and linguistically diverse backgrounds received little attention in submissions and evidence before the Commission. It may be that the challenges of responding to child abuse and neglect in those communities are not yet well known. However, these communities experience many of the disadvantages which are risk factors for child abuse and neglect, including social isolation and socioeconomic disadvantage. Some families' pre-migration experiences may have left a lasting traumatic legacy.

The challenges of responding in a culturally appropriate way in Aboriginal communities are similar in culturally and linguistically diverse communities. The Agency should improve its cultural understanding of those families who come to the attention of the child protection system as well as for those children who are already in care.

It appears that the Agency currently knows very little about the population of culturally and linguistically diverse families who might need a child protection response. Data about the origin of children reported to the system has been inconsistently recorded and retained, and is not likely to be reliable.

Without a reliable picture of the cultural origins of the children and families coming into contact with the system, planning is difficult. Data recording and collection about the diverse backgrounds of children at risk should be improved, and that data should be used to plan services which respond to the strengths and challenges of this particular population.

SYSTEM-WIDE CHANGES TO IMPROVE SAFETY

The Commission's enquiries focused substantially on the reforms needed within the statutory agency, but other government structures and services could work more effectively and efficiently. In particular, the Commission considered:

- Department for Community and Social Inclusion's (DCSI's) Screening Unit;
- Ombudsman SA, and Health and Community Services Complaints Commissioner;
- Guardian for Children and Young People;

- Child Death and Serious Injury Review Committee;
- Council for the Care of Children; and
- proposed Children's Commissioner.

SCREENING FOR RISK

Screening adults who come into contact with children through paid or voluntary employment is a strategy by which children's environments can be kept safe. However, it is not the only strategy required. Caution must always be exercised to ensure that people are not lulled into a false sense of security by the fact that a person holds a screening clearance.

The current system for screening in South Australia is in need of reform. Delays in responding to applications for screening clearances are an ongoing vexed issue and the subject of considerable media attention. Unreasonable delays undermine the capacity of people to engage or volunteer in their community. It can interfere with their employment and might cause prospective foster parents to lose interest. Nevertheless, the current rigour of the process must not be diluted simply for the sake of greater efficiency.

An Australia-wide screening system has been under consideration since 2005. A 2015 report by the federal Royal Commission into Institutional Responses to Child Sexual Abuse focused attention on a proposed national model. Any reforms to the South Australian system must take the proposed national scheme, and the changes that might be required to join such a scheme, into account.

At present, South Australia has two pathways for obtaining a screening clearance: a check completed by a proposed employer or the more rigorous check completed by the DCSI Screening Unit. The DCSI check has regard to a much greater breadth of information than is available to an employer. An applicant could obtain a clearance from an employer when they would not get a clearance from the Screening Unit. This is clearly inconsistent and unsatisfactory—and confusing for people working or volunteering in more than one role who may have to apply for multiple clearances.

A single screening pathway should be implemented for all applicants through the DCSI Screening Unit. Organisations should no longer be permitted to complete their own assessments. Individuals who want to undertake a child-related employment role should be required to obtain a clearance directly through the Screening Unit, rather than an organisation making the application on their behalf. This would overcome confusion surrounding intrastate portability. In addition, exemptions for teachers should no longer apply.

The current fragmentation of information across the Children's Protection Act, the Regulations and the standards issued by the Chief Executive is difficult to

negotiate. A single piece of legislation should consolidate the relevant screening requirements and standards with greater clarity.

This legislation should provide for:

- one authorised screening unit for the state;
- one clearly defined pathway to obtaining a clearance through the screening unit;
- an employee or volunteer driven system, where clearance cards or unique electronic identification numbers are issued;
- clarity on who must hold a clearance for employees, volunteers and organisations;
- portable clearances across roles within the state;
- a register of all clearances issued;
- a requirement for employers to register the use of a clearance with the Screening Unit, to ensure they can be notified if a clearance is cancelled; and
- offences for both individuals and organisations for failing to comply with the legislation, in particular undertaking child-related employment in the absence of a clearance.

Legislation should also provide for a right of appeal against a refusal to grant a clearance, which could be heard by the South Australian Civil and Administrative Tribunal.

The Commission has considered the recommendations in the report of the federal Royal Commission and supports continued negotiation towards a national standard to achieve national consistency. However, there is a need for caution to avoid the adoption of any recommendations which diminish the rigour of the current DCSI screening process.

The timeliness of assessments by the Screening Unit has improved since January 2015, when its staffing complement grew significantly. The changes proposed by the Commission inevitably mean a greater workload for the unit. Staff levels should therefore be re-assessed to ensure that excessive delays do not result. Assessments should be performed against a service benchmark of seven days for those applications which can be considered administratively (that is, no adverse information located), and 28 days for those which require assessment (some adverse information; needs closer assessment).

In light of these service benchmarks the Commission does not recommend that applicants be permitted to begin work while their application is pending.

SUMMARY

STRUCTURES TO PROMOTE COLLABORATION

A consistent theme in this Commission (and other inquiries across Australia) is the need to improve collaboration and cooperation between agencies involved in service delivery to children.

Caution about information sharing between government departments and other non-government services has created administrative barriers to meeting the needs of children. The current balance assumes that information is confidential except in certain circumstances.

This balance should shift to give greater emphasis to information sharing as a responsibility of those working in the child protection system. This would require legislative change to establish a scheme for information sharing between prescribed agencies. The arrangement should be modelled on the New South Wales scheme, which provides for prescribed bodies to share information on the safety, welfare or wellbeing of a child, to help with providing services to, or managing risk to, a child. Strict controls will be needed to ensure shared information is used only for its permitted purpose.

Improved information-sharing powers will enable more efficient action, and smooth the way for better collaboration and coordination in service provision. To emphasise the importance of such cooperation, an amendment to the Children's Protection Act could impose a duty on the prescribed bodies to coordinate decision making and delivery of services for children.

At a strategic level, the executive leadership of government and non-government agencies involved in the child protection system should meet at least quarterly to address issues of common concern and promote inter-agency work.

To help busy executives prioritise this work, the Commission recommends that chief executives from government agencies with responsibility for the health, safety and welfare of children should have included in their performance agreements provisions that oblige them to promote inter-agency collaboration in child protection matters, and key performance indicators against which performance can be measured.

Barriers to information sharing between states also inhibit service delivery. The Family Law Council's recent interim report on the intersection of child protection and family court systems recommended a database to facilitate the sharing of information on court orders made by each state jurisdiction and the Family Court. The Commission recommends that the South Australian Government support and promote this recommendation for action.

PROMOTING SYSTEM TRANSPARENCY

It is clear that the child protection system, in particular Families SA as the statutory agency, has been the source of a great deal of dissatisfaction and complaint in the community. However, child protection is difficult and demanding work and the Agency has been operating for a considerable period of time without adequate resources to meet demand. Greater transparency is needed to promote the rights of service users and others who are affected by the operation of the system.

To facilitate this transparency, the Commission recommends establishment of a number of panels with independent membership within the Agency to consider major decisions such as removal of children from long-term carers and applications for Other Person Guardianship assessment.

Greater oversight is also needed at a system level.

A CHILDREN'S COMMISSIONER

The Layton Review's recommendation for appointment of a Children's Commissioner was not implemented. It has continued to be the subject of discussion and there is now strong bipartisan support for such an appointment. However, the precise model and powers of that office have not yet been agreed. Many people expressed a hope that a Children's Commissioner would be capable of 'fixing' the system by providing a comprehensive independent complaints function. The functions of a Commissioner should be clearly identified at the outset. The Commissioner would be required to have oversight of all children, not just those who are in care or in need of protection. If the Commissioner is tasked with investigating individual complaints, the danger is that important systemic oversight and promotion of the rights and wellbeing of *all* children, not just those in care, will be sidelined.

The Commission is not persuaded that investigation of individual complaints that do not have the capacity to identify system issues is a function that should be performed by the Children's Commissioner.

The Commission recommends the appointment of a Children's Commissioner with the following functions:

1. Promote and advocate for the rights and interests of children and young people in South Australia.
2. Promote participation by children and young people in making decisions that affect their lives.
3. Advise, and make recommendations to, Ministers, state authorities and other bodies (including non-government bodies) on matters related to the rights, development and wellbeing of children and young people at a systemic level.
4. Help ensure that the state, as part of the Commonwealth, satisfies its international obligations to children and young people.

5. Inquire into and investigate topics concerning the rights, development or wellbeing of children at a systemic level, including investigating individual cases which, in the opinion of the Children's Commissioner, could identify systemic issues of sufficient importance to warrant inquiry.
6. Prepare and publish reports on matters related to the rights, development and wellbeing of children and young people at a systemic level.
7. Engage with children in the performance of other functions and develop a strategy for doing so.
8. Undertake or commission research into topics that relate to children and young people.

The Children's Commissioner should hold powers equivalent to those currently held by the Ombudsman. The Commissioner should also have an unfettered power to publish information and reports relevant to their legislative mandate.

A key part of the Children's Commissioner's work would be promoting the experiences and views of children and young people. Consultation with this group should be the primary focus, although the Commissioner should consult with other groups as appropriate.

The Children's Commissioner should be empowered to make recommendations for system reform, including the power to report to the Minister responsible for the aspect of government services under consideration.

The Children's Commissioner should also be empowered to require a report from state authorities on whom recommendations have been made. If the Commissioner remains dissatisfied with the response, he or she should be able to escalate the matter by reporting the case to the relevant Minister, who should report to Parliament on the matter. The Children's Commissioner should also retain an absolute right to publicly report on any matter escalated in this way.

OTHER OVERSIGHT BODIES

It is not proposed that the Children's Commissioner replace or incorporate either the Child Death and Serious Injury Review Committee (CDSIRC) or the Guardian for Children and Young People (GCYP). Each of these bodies has specialist functions and they should retain their current legislative independence. However, there are opportunities for the functions of those important oversight bodies to be colocated and coordinated.

Recommendations made by bodies such as CDSIRC and GCYP have not always been actioned, or achieved the required improvements for children. There should be greater capacity to require agencies to report their response to recommendations. Rather than develop separate reporting lines, CDSIRC and GCYP should be empowered to refer matters to the Children's

Commissioner where actions they regard as necessary are delayed, or barriers to action appear to exist. The Children's Commissioner may then action those matters in any way deemed appropriate, including in accordance with the powers held to monitor and escalate his or her own recommendations.

The functions of the current Council for the Care of Children should be absorbed into the functions of the Children's Commissioner, and a newly appointed Child Development Council.

REVIEW ARRANGEMENTS

A separate child protection complaints agency is not necessary. The powers of the Health and Community Services Complaints Commissioner (HCSCC) and the Ombudsman are adequate for the review of decisions and services in the child protection system.

However, HCSCC, which is currently empowered to investigate most matters relating to child protection, is not necessarily best placed to perform that function.

The matters which appear to form the bulk of complaints about the child protection system frequently concern administrative decisions, rather than the quality of service. Accordingly, complaints about the child protection system should, in the main, be considered by the Ombudsman. Legislative change to this effect would be needed.

To allow flexibility in the response to complaints there should be a legislative amendment to permit the Ombudsman to exercise the jurisdiction of the HCSCC where the nature of the complaint makes that appropriate. An administrative agreement between the Ombudsman and the HCSCC would identify the appropriate categories of matters.

A number of contributors to the Commission (in particular from foster parents and kinship carers) advocated for a right to appeal on some major decisions made by the statutory agency about the care of children (for example, decisions to remove a child from long-term foster parents). The South Australian Civil and Administrative Tribunal could be the avenue for such appeals.

However, the consequences of such a right would not necessarily promote the best interests of the children at the centre of the decision. In particular, the right of appeal would exclude the jurisdiction of the Ombudsman in most cases, which is better placed to use its substantial powers to investigate. Appeals in an adversarial forum could exclude a child from participating, as a child would not necessarily be a party to the appeal and would need to obtain representation to have their perspective heard. In these circumstances, the Commission does not recommend such change.

SUMMARY

IMPLEMENTATION AND MONITORING

The government will need committed, strategic and transparent implementation processes in place to make the reforms recommended in this report. The Commission hopes that this report is the start of a new approach to child protection in this state, where blame is replaced with constructive participation in a well overdue reform process.

The Commission recommends a reporting regime on recommendations from this report to maintain the necessary momentum:

- a report on or before 30 December 2016;
- a further report on or before 30 June 2017; and
- an annual report for a period of not less than five years after the 30 June 2017 report.

Regular, accessible reports should be published online to keep the community informed of progress.

The reform to the system to protect children in this state is not the responsibility of government alone. The entire community can play a greater role to ensure that South Australia's children are safe and well.

RECOMMENDATIONS

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 1 Establish a protocol to govern eligibility for a grant of legal aid to carers, where the child's best interests would be better or more appropriately secured by obtaining Family Court orders, rather than by proceedings in the Youth Court. Further, that funding be provided to the Legal Services Commission and quarantined for this specific purpose.
- 2 Fund, subject to a protocol, any required filing costs where there is a need for Youth Court orders to be registered in the Family Court to improve the safety of the children to whom they relate.
- 3 Support and promote for action, recommendation 5(a) of the Family Law Council interim report (June 2015), which advocates for the development of a national database of child protection and Family Court orders.
- 4 Reinstitute the court liaison role as a strategic link between the Agency, the Family Court and the Youth Court, to improve system interface and to develop service responses in accordance with the requirements of each jurisdiction.
- 5 Move the office of child protection and the functions of Families SA out of the Department for Education and Child Development to establish a separate department that has the business of child protection as its primary focus, and which has elements and functions as set out in this report.
- 6 Appoint a Chief Executive of the new department who has strong leadership skills and recognised credibility in child protection work, and who has a direct line of ministerial responsibility.
- 7 Implement a structure in the new department that reduces the hierarchies between leadership and front-line workers.
- 8 Establish a refreshed leadership in the new department with emphasis on the attraction and retention of leaders who have recognised credibility in child protection work, and who have the capacity to lead a major reform of organisational culture.

- 9 Review the delegation of powers to enable decision making to occur at the closest possible level to the child, subject to questions of fiscal responsibility and sensitivity or complexity of the issues.
- 10 Adopt a policy that gives a child's caseworker the primary responsibility for case management and, except in special circumstances, ensures that the caseworker is made aware of all discussions and decisions that affect the child.
- 11 Conduct a formal review of Solution Based Casework™ (SBC) to critically examine whether the model is being used with fidelity to the original model in practice.
- 12 Provide an ongoing SBC consultation and training service to be delivered by principal social work staff and appropriately accredited trainers in SBC who remain within the Agency.
- 13 Audit the range of process and policy documents to identify and discard those that are out of date. Develop a single database that is accessible to all staff via the Agency's intranet, to electronically file all current documents.
- 14 Employ administrative assistants at adequate levels of expertise to support casework teams to manage the administrative requirements of C3MS.
- 15 Develop clear guidelines for recording information on C3MS, which identify those responsible for data entry and the categories under which data is entered. Rationalise available categories to limit inappropriate categorisation of important information.
- 16 Develop training in the use of C3MS to ensure that practitioners understand their obligations in uploading data, and the limitations of the incident-based nature of recording.
- 17 Provide practitioners with mobile devices to allow access to C3MS from remote locations.
- 18 Permit stakeholders such as other government agencies and not-for-profit organisations limited access to C3MS to facilitate cooperation, collaboration and transparency.

19 Set constructive and practical benchmarks for the development of critical enhancements to C3MS. 20 Conduct a review of the long-term viability of C3MS, and monitor research and developments in the area of electronic information management systems with a view to determining whether C3MS should be replaced with a more suitable and effective electronic information system. 21 Establish a human resources unit in the Agency that has sufficient specialist expertise and resources to develop and implement strategic workforce plans and to manage operational demands to ensure high quality child protection practice. 22 Establish a learning and professional development unit in the Agency to lead training and professional development, for both professional and operational staff. 23 Require professional staff in the Agency to complete a minimum number of hours of professional development each year as a condition of their employment. 24 Charge the executive of the Agency, through the human resources unit, with a review of current practices and the development of evidence-based strategies relevant to: - a workforce records and data management; - b workforce qualification profiles, including requiring any staff holding a case load to be degree qualified in a discipline relevant to child protection; - c the recruitment, selection, induction and retention of staff, including managing all recruitment and selection centrally; - d career, including management, pathways; - e workload management; - f performance planning, support and monitoring for enhanced staff performance; and - g professional development requirements, opportunities and resourcing, including adopting a professional development reimbursement program modelled on that operating in SA Health.	25 Provide a psychological service to work with the executive to address the high levels of workplace stress in the Agency. 26 Appoint clinical managers to each metropolitan hub and regional office of the Agency and review professional line-management structures accordingly. 27 Invest in clinical management, supervision and practice improvement, including the development of a supervision framework. 28 Establish formal and regularly evaluated relationships between the Agency and the tertiary education sector that are designed to: - a enhance student and academic knowledge and experience of child protection practice; - b attract desirable graduates; - c expand and focus child protection practice research; and - d ensure that the Agency and its staff are kept abreast of contemporary professional research and literature. 29 Establish a postdoctoral fellowship program in conjunction with the tertiary education sector to advance areas of research relevant to the Agency. 30 Require the Agency to take a lead role with other stakeholders to develop and implement a workforce strategy designed to improve staffing practices and performance across the broader child protection system. 31 Maintain the current mandatory reporting threshold set out on section 11 of the <i>Children's Protection Act 1993</i>. 32 Review the screening and response priority tools to ensure they give due weight to cumulative harm, chronic neglect, social isolation, underlying causes of dysfunction, the need to conduct timely forensic medical assessments, and the expertise and experience of professional notifiers. 33 Review screened-out notifications periodically to ensure the threshold is being correctly applied.

RECOMMENDATIONS

34 Invest in the professional development of the Agency's Call Centre practitioners, including, but not limited, to: - a the implementation of case reading; - b regular clinical supervision; - c the introduction of a tailored induction program; and - d ongoing training in the specific skills required of Call Centre practitioners. 35 Implement the automated call-back feature at the Call Centre for a trial period, followed by an assessment to determine whether its ongoing use is justified. 36 Staff the Call Centre at a level that would permit the achievement of the following service benchmarks: - a a maximum waiting time of 30 minutes for a telephone call to be answered; - b a maximum of 24 hours to assess an eCARL notification; and - c a maximum delay of two hours for a call back. 37 Ensure that the Call Centre is never left unattended. Crisis Care staffing levels should be immediately increased to no fewer than three staff at each shift. 38 Abandon the proposal to engage unqualified call agents to receive telephone notifications. Telephone calls from notifiers must only be taken by degree-level, tertiary qualified and experienced practitioners. 39 Update, as a matter of urgency, public information concerning the services offered by the Crisis Care service. 40 Provide automated electronic feedback to all notifiers, confirming receipt of their notification (in the case of eCARL) and, post-assessment, what screening and response priority assessments were made in relation to their notifications.	41 Record notifications directly into an electronic log sheet that pre-populates the C3MS intake record. 42 Review and improve the efficiency of recording practices of Notifier Only Concerns (NOCs). 43 Ensure the Agency regains control of, and strictly oversees, mandatory notification training, including creating and updating an appropriate training package and a mandatory notifiers' guide, and regularly auditing training to ensure fidelity. 44 Make mandatory notification training compulsory for: - a registered teachers; - b general medical practitioners; - c police officers; and - d other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, childcare or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children. 45 Restrict access to eCARL to notifiers who have completed mandated notifier training. 46 Include an interactive mandatory notifier guide at the start of eCARL. 47 Amend Part 4, Division 1, of the <i>Children's Protection Act 1993</i> to include a new provision permitting, but not requiring, a notifier to report concerns about an unborn child, regardless of the stage of pregnancy. 48 Abandon the policy restricting the recording of Report on Unborn (ROU) children to 34 weeks' gestation or later. 49 Institute longer term funding arrangements for prevention and early intervention services, subject to evaluation and performance criteria.

50	Establish an Early Intervention Research Directorate (EIRD) to:	52	Employ qualified child wellbeing practitioners (CWPs) accessible to all staff in the Department, but focusing on locations of greatest need, to consult with staff and to work directly with vulnerable families. CWPs should have on-site access to the Agency's electronic database.
	a prepare a Prevention and Early Intervention Strategy that is updated at least every five years:		
	i to identify service models that have proved effective or show promise in promoting the health, safety and wellbeing of children in South Australia;	53	Equip relevant government agencies to support vulnerable families by appointing existing employees as child wellbeing assistants (CWA), in addition to their usual role, to provide staff guidance about options to support vulnerable families.
	ii to serve as the basis of decisions by South Australian Government agencies to fund prevention and early intervention services;	54	Implement a simple, common assessment framework, such as Common Approach, for use by government and not-for-profit services who work with vulnerable children and families.
	iii to form the basis of negotiations with the federal and local governments, with a view to coordinating funding priorities;	55	Convene regular cross-agency training and networking sessions for all CWPs and CWAs in each local metropolitan and country region to increase their knowledge and support local inter-agency collaboration.
	b establish research partnerships and fund evaluations of innovative service models to determine their effectiveness and value for money; and	56	Amend the <i>Children's Protection Act 1993</i> to permit mandated notifiers to discharge their obligations by: reporting to the Agency's Call Centre (Child Abuse Report Line); or to designated child wellbeing practitioners, or by referral to a child and family assessment and referral network where the notifier believes a child's circumstances would be adequately attended to by a prevention or early intervention program.
	c focus on the prevention and early intervention investment priorities identified in this report.		
51	Establish child and family assessment and referral networks in each region of Greater Adelaide and regional South Australia that include:		
	a a lead not-for-profit agency to manage, in partnership with the Agency, a local entry point to services provided by partner agencies in the region, focusing on collaborative practice and coordinated, multi-service responses, when required;	57	Review procedures for strategy discussions to ensure they are convened promptly upon the receipt of notifications requiring investigation (and without delay when children present with physical injury). Discussions should include all relevant government and non-government participants and be re-convened as necessary.
	b an annual Local Assessment of Needs (LAN) prepared by the lead not-for-profit agency after mapping the needs of vulnerable families and children in each region. The LAN would inform funding decisions for services; and	58	Provide the Agency's practitioners with training, support and supervision to equip them to make realistic assessments of risks, particularly in areas of chronic maltreatment, cumulative harm, social isolation, drug and alcohol abuse, mental health, family violence, and attachment and care needs of young children, to consider the views of children and to develop appropriate safety plans.
	c child protection practitioners in each child and family assessment and referral network to support decision making in relation to child safety including when to refer higher risk families for a statutory response by the Agency.	59	Reconcile and integrate the Agency's assessment tools and documentation (including Solution Based Casework™, the assessment framework and decision-making tools).

RECOMMENDATIONS

- 60 Amend section 20 of the *Children's Protection Act 1993* to delete section 20(2) and (3), and include a provision which empowers the Agency to issue a written direction to parents, guardians or other persons requiring them to submit to a drug and alcohol assessment, with the results to be provided to Families SA.
- 61 Ensure the Agency responds to all screened-in notifications, either directly, or by appropriate referral, including responding promptly (including after hours) to notifications in which physical injuries are notified and the Agency's assistance is required to facilitate a forensic medical assessment.
- 62 Phase out the closure of intakes and files due to a lack of resources. This should occur over a period of no more than five years from the date of this report. In the interim, practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate. There should be quarterly reports to the public on the rate of closures that are due to a lack of resources.
- 63 Amend section 19(1) of the *Children's Protection Act 1993* by deleting section 19(1)(b) thereof to provide that:
- a if the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.
- 64 Ensure that the Agency focuses on case management of protective intervention cases and that not-for-profit agencies provide direct service delivery to families. All protective intervention programs should be evaluated on a regular basis to ensure that all such programs have an established evidence base.
- 65 Establish a Child Protection Service (CPS) unit at the Lyell McEwin Hospital.
- 66 Amend the *Children's Protection Act 1993* to provide an independent model of expert assessment in similar terms to the Children's Court Clinic in New South Wales.
- 67 Amend the *Children's Protection Act 1993* with respect to the procedures relating to Family Care Meetings (FCMs) as follows:
- a amend section 27(1) to provide that the Agency should consider causing an FCM to be convened whenever it is of the opinion that a child is at risk but the risk appears capable of being addressed at an FCM;
 - b repeal section 27(2);
 - c amends 36(6) to provide that an FCM decision would not be valid without the agreement of the relevant members of the family and the Agency;
 - d require the Agency to give effect to FCM decisions, unless they are impracticable or inconsistent with the principles of the legislation, in which case the FCM should be reconvened or proceedings commenced in Court; and
 - e require FCM decisions to be reviewed after three months, but provide that any party to the decision may request an earlier and/or subsequent review, if required.
- 68 Review procedures and funding arrangements for the Youth Court Conferencing Unit:
- a to enable the Unit to recruit and train a panel of child advocates for Family Care Meetings (FCMs)—advocates should hold a valid child-related employment screening clearance; and
 - b to consider whether in an appropriate case a child's foster parent should be invited to an FCM.

69 Amend the *Children's Protection Act 1993*:

- a to require the child's lawyer to:**
 - i act in accordance with the child's instructions to the extent the child is able and willing to give such instructions**
 - ii supplement those instructions with his or her own view of the child's best interests to the extent the child is not able and willing to give instructions (provided the lawyer's views do not contradict any instructions the child is able and willing to give)**
 - iii indicate the nature of the role to the child, in accordance with the child's developmental capacity**
 - iv indicate to the court on which basis submissions are made; and**
- b permit the court to appoint a child's representative or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the proceedings to enable a duly instructed lawyer to represent the child.**

70 Amend the *Children's Protection Act 1993* as follows:

- a repeal section 38(1)(a) which concerns the making of orders for supervision and undertakings and section 38(2)(a);**
- b include as an object in the Act the importance of timely decision making to promote stability and maintenance for a child;**
- c at the time of the commencement of care and protection proceedings the Agency should assess whether there is a realistic possibility of reunification:**
 - i within six months for a child under two years, or**
 - ii within 12 months for a child over two years; and**

- d if there is a realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should seek an order placing the child under the guardianship of the Minister for a period of either six or 12 months (depending on the age of the child), and file a permanency plan setting out the proposals for reunification;**
- e if at the commencement of care and protection proceedings, or at any time thereafter, there does not appear to be any realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should immediately apply for an order placing the child under the guardianship of the Minister until the age of 18 years and file a permanency plan setting out the proposals for the long-term placement of the child;**
- f if at any time special circumstances arise (particularly with respect to an older child) which make it necessary to extend the timeframes set out in Recommendation 70(c) hereof the Court shall have the discretion to extend the timeframe for a period no longer than six months. In any such case the onus will be on the parties to demonstrate the need for such extension having regard to the child's best interests and the potential risk to the child's need for stability and permanence;**
- g amend section 39(a) to delete the requirement to commence a hearing within 10 weeks, but provide that all proceedings be heard and determined expeditiously and that once the hearing commences, without special reasons, it should continue until the conclusion of evidence with the judgement delivered as soon as practicable thereafter.**

71 Encourage lawyers employed by the Legal Services Commission and the Crown Solicitor's Office to undertake child protection training and require lawyers engaged through the Legal Services Commission to represent children in state child protection proceedings to hold a valid child-related employment screening clearance.

72 Ensure that contact arrangements meet the changing needs of children with respect to such matters as venue, transport arrangements and supervision and that contact never occurs when the parent is or is suspected of being affected by drugs and/or alcohol.

RECOMMENDATIONS

73 Amend the <i>Children's Protection Act 1993</i> to exclude contact arrangements from orders of the court and require all contact arrangements be referred to the Agency for determination in accordance with the best interests of the child. The permanency plan filed at court should include a provision as to the resolution of contact disputes, including mediation procedures wherever possible. 74 Establish an independent standing expert Case Review Panel to review the issue of contact when mediation is unsuccessful and it is necessary to resolve any dispute as to contact arrangements. 75 Review and republish Rapid Response with updated guidance as to the extent of priority access for children in care. 76 Reinstate the inter-departmental committee overseeing Rapid Response to review its operation, at least biannually. 77 Ensure that every child or young person in care has an allocated caseworker who has face-to-face contact with them once a month at a minimum. 78 Assess all children who are currently receiving a differential response for eligibility for Other Person Guardianship. 79 Assess whether allocation of a primary and secondary worker to deliver guardianship case management would improve the continuity of relationships with children. 80 Review the policy guidance and all other documents used for annual reviews to ensure compliance with section 52 of the <i>Children's Protection Act 1993</i>, including requiring greater sharing of the information discussed at annual reviews. 81 Require that all annual reviews be chaired by a suitably qualified person who is independent of the case. 82 Give concurrent planning greater emphasis in case planning, especially for children during their active attachment period. 83 Review all placement breakdowns to determine and correct identified system deficits. 84 Provide therapeutic support to placements that are identified as being at risk or under stress.	85 Fund initial health assessment clinics at the Women's and Children's Hospital, Flinders Medical Centre (FMC) and Lyell McEwin Hospital to operate in accordance with the service model employed at FMC. This includes funding clinics at a level that enables a psychosocial component to be offered at every initial health assessment. 86 Invest in the ongoing development of a therapeutic needs assessment panel led by Child and Adolescent Mental Health Services for children in care whose therapeutic needs are identified in their initial health assessment. 87 Develop an inter-agency panel modelled on the Exceptional Needs Unit's management assessment panel to support case management of those children in care with complex needs who are not appropriately managed by existing services. 88 Develop a mobile outreach service modelled on Yarrow Place's mobile youth team for children and young people who frequently abscond from placement, and who are at risk because of factors other than sexual exploitation. 89 Improve the profile of Strategies for Managing Abuse Related Trauma (SMART) training for educational staff, requiring that to be part of professional development where appropriate. 90 Review and promote Education's policies regarding school suspension, exclusion and expulsion to ensure that they are used as strategies of last resort for children in care. 91 Regularly conduct an audit of children in care who are on reduced hours of attendance at school and ensure they have plans to re-engage them in mainstream education. 92 Require Education to fund any in-school support needed by children in care. 93 Recruit and train a panel of school services officers to support children with trauma-related behavioural challenges. 94 Amend the practice guidelines regarding written directives to comply with the provisions of the <i>Children's Protection Act 1993</i> and provide training to child protection workers to ensure that they understand them.

- 95 Amend section 51 of the *Children's Protection Act 1993* to include a requirement that in all decisions affecting the child that are made in accordance with an order for guardianship, the child must be included in the decision making to the extent that they are capable and willing, and that the views of the child are given due weight in accordance with the age and maturity of the child.
- 96 Require the Agency to report quarterly to the Minister and to the Guardian for Children and Young People, and make public a report as to the following matters:
- a compliance with the Standards of Alternative Care in South Australia 2.1, 2.2 and 2.6;
 - b the proportion of children entering care whose health needs are assessed in accordance with the requirements of the relevant health standards; and
 - c the number and proportion of children and young people who have been reviewed in accordance with section 52 of the *Children's Protection Act 1993* at the time the review falls due.
- 97 Amend the *Family and Community Services Act 1972* to include relative carers within the regulatory provisions of Part 4, Subdivision 3 and section 80. The definition of relative carers should include the categories of relatives who are currently excluded from the definition of foster parent in section 4 (step-parent, brother, sister, uncle, aunt, grandfather or grandmother), who care for children in the custody of, or under the guardianship of, the Minister.
- 98 Amend the *Family and Community Services Act 1972* to provide approved carers with a right to information for the purposes of caring for children in the same terms as in sections 143–145 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- 99 Amend the *Family and Community Services Act 1972* to provide for approved carers to be involved in decision making concerning a child in their care, in the same terms as in section 146 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- 100 Amend the *Family and Community Services Act 1972* to provide a specific right to approved carers to contribute to a child's annual review pursuant to section 52 of the *Children's Protection Act 1993*.
- 101 Amend section 80 of the *Family and Community Services Act 1972* to repeal the current requirement that foster parents care for a child for three years or more before delegations of powers can be made, and instead prescribe a minimum period of 12 months.
- 102 Outsource assessment and support of kinship carers to appropriately qualified non-government organisations in accordance with the service models which currently apply to foster care.
- 103 Develop or purchase a comprehensive kinship assessment tool for assessing the safety and appropriateness of kinship placements.
- 104 Invest resources in the Department's Carer Assessment and Registration Unit to expand services to include consideration of applications for registration by kinship carers. These registrations would be in accordance with an appropriate assessment tool, and would authorise the carer to provide care to a specific child or children only.
- 105 Establish a Families SA Carer Assessment and Registration Unit service benchmark for assessment and registration decisions of 14 days where the assessment is complete and further information is not required from the assessing agency.
- 106 Develop a process for carers seeking approval (foster parents and kinship carers) to provide preliminary information about themselves and other adults who frequent their home to enable comprehensive C3MS checks to be done before a full Step by Step or other appropriate assessment is completed.
- 107 Include in the service agreement with all registered agencies the requirement that Families SA Carer Assessment and Registration Unit be notified of any person who begins an assessment process for carer registration (by Step by Step or another appropriate process) who is screened out, or, for whatever reason, subsequently withdraws from the assessment.

RECOMMENDATIONS

108 Develop an approved panel of practitioners authorised to provide priority assessments of specific child only carers on behalf of registered agencies.	118 Create an expert panel within the Agency to consider the removal of children from long-term home-based placements.
109 Create a project team to address the backlog in assessments of kinship carers and comprehensively review carers whose assessment is limited to an IREG assessment where the child has been living in the placement for more than three months.	119 Review reimbursement rates to bring general foster rates with loadings for children with complex needs closer to rates payable to therapeutic carers.
110 Cease reliance on medical self-assessment forms and response priority assessments for kinship carers.	120 Develop a specific package of training for general foster parents which can lead to payment of additional skills based loadings.
111 Enter an administrative arrangement with the Department for Communities and Social Inclusion to provide priority screening clearances for carers where a child has been placed pursuant to an IREG process.	121 Support carers who are registered to general agencies to transfer to therapeutic agencies where the needs of children in their care require it.
112 Review initial orientation training for carers seeking approval to include training on recognising and managing trauma related behaviours, together with information as to availability of, and access to, therapeutic assistance if required.	122 Conduct a review of contractual conditions and payments to registered agencies to promote greater consistency of payments to agencies which support foster parents.
113 Include Agency staff, children in care and existing foster parents and kinship carers in the delivery of preliminary information and training for new and prospective approved carers.	123 Update the Alternative Care Support Payments: Manual of Practice and make it available to all approved foster parents and kinship or relative carers.
114 Develop a practice guide identifying the circumstances in which delegations pursuant to the amended section 80 of the <i>Family and Community Services Act 1972</i> should be made.	124 Monitor developments in professional models of foster care in other states with a view to adopting or adapting a proven model.
115 Develop a written document which sets out the role and duties of the supporter of carers (SOC), including their role if care concerns arise, and to whom various duties are owed. This document should be freely available to home-based carers.	125 Engage and support the Child and Family Welfare Association to develop more coordinated provision of training to carers.
116 Fund Connecting Foster Carers, or an appropriate alternative agency, to deliver an advocacy service with paid staff to support carers to access and exercise their rights.	126 Engage and support CAFWA to improve the coordination of respite provision to carers.
117 Fund the advocacy service to develop education material which clearly describes foster parents rights to contribute to decision making, and their rights of review regarding decisions which affect them.	127 Develop a centralised system for receiving and resolving complaints from carers, including informal mediation or escalation to executive staff where appropriate. Timely written responses should be made to complaints.
	128 Phase out the use of commercial carers in any rotational care arrangements except in genuine short-term emergencies.

- 129 Review service agreements with commercial agencies who supply emergency care staff to:
- a require the commercial agency to develop job and person specification and selection criteria which must be approved by Families SA;
 - b prohibit workers from undertaking shifts through more than one commercial care agency at a time when engaged by Families SA to look after children in care. This includes a prohibition on undertaking shifts for a commercial care agency at the same time as undertaking shifts for Families SA;
 - c require commercial care workers to be registered and approved by Families SA before their employment begins; and
 - d require commercial agencies to report any information that reflects on the suitability of a care worker, to initiate tracking via the system outlined at Recommendation 142.
- 130 Provide Families SA staff who work with commercial carers with access to relevant portions of service agreements to clarify work expectations and specific conditions of engagement.
- 131 Provide the residential care directorate with sole responsibility for engaging, supervising and supporting emergency care placements.
- 132 Forthwith abandon single-handed shifts by commercial carers engaged through commercial agencies.
- 133 Reform the manner in which the use of force against children in residential care facilities is recorded and tracked by:
- a amending regulation 14 of the Family and Community Services Regulations to require any worker who participates in or witnesses an incident involving or leading to the use of force against a child to verify the accuracy of the written report of the incident or, in the alternative, where the accuracy of the written report is not verified, provide an independent written account with respect to the incident;
 - b amending the pro forma of the report to clarify the requirements of regulation 14(3);
 - c requiring supervisors to reject any report that does not comply with regulation 14(3) in the absence of any adequate explanation for non-compliance. If a non-compliant report is accepted, the supervisor should specify the reason for acceptance in the absence of compliance; and
 - d regularly audit reports to ensure compliance with the regulations.
- 134 Amend section 56 of the *Family and Community Services Act 1972* to extend the operation of the section to children in all facilities (including emergency care) established by the Minister, and develop a specific and identifiable pathway to enable a child to make a complaint to the Chief Executive pursuant to that section.
- 135 Require the Chief Executive to provide a quarterly report to the Guardian for Children and Young People (GCYP) and the Minister with respect to the number of complaints received, and any recurring themes which emerge from those reports.
- 136 Request GCYP to develop an education program for children in facilities run by the Agency or non-government organisations (emergency and residential) to explain and promote their rights pursuant to regulation 14(3) of the Family and Community Services Regulations 2009 and section 56 of the *Family and Community Services Act 1972*.
- 137 Legislate for the development of a community visitors' scheme for children in all residential and emergency care facilities.
- 138 Recruit child and youth support workers in accordance with the 2016 recruitment model, including a requirement that all applicants for those positions undergo individual psychological assessment.
- 139 Require all new child and youth support workers to complete a minimum six-month probationary period, to be followed by a rigorous performance review before approval for further employment.

RECOMMENDATIONS

140 Require all child and youth support workers to complete ongoing professional development and training, particularly in the following areas: - a the dynamics of abuse in institutional environments; - b understanding children who are at risk from institutional environments; - c the way in which children react and respond to abuse; - d how to respond to children whose behaviour or statements may indicate the possibility of abuse; and - e the early years child development, and caring for infants and young children (for selected workers).	143 Create a specific unit and database to receive and track information about the conduct of staff from: - a care concerns; - b critical incident reports; - c information from other staff; and - d complaints made by children. This process should apply to staff employed by the directorate and those engaged through commercial agencies. Staff should be permitted to provide information directly to that unit.
141 Review and clarify policies that guide the behaviour of workers, particularly in relation to: - a physical contact with children (to provide clear and unambiguous guidance); - b recording observations in observation logs; and - c reporting lines for information about the wellbeing of children.	144 Review the conduct of the specific staff identified in Volume 2, Case Study 5: Shannon McCooie and consider their ongoing suitability for employment in their role.
142 Develop a clear process for workers in the residential care directorate which: - a obliges workers to report any concerning behaviours from other workers, including those behaviours that do not necessarily meet the requirements for a mandatory report; - b obliges workers to report concerning behaviours from children in the absence of action by case management staff; and - c clarifies the availability of reporting pathways external to workers' immediate line of supervision.	145 Develop a streamed model of residential care with the following elements: - a short-term assessment; - b long-term care for children who are not suitable for home-based care; - c care for children with high therapeutic needs; and - d built-in measures of outcomes that can be used to evaluate performance of the model on a regular basis.
	146 Identify and adopt a model of therapeutic care which is sufficiently flexible to be applied across all categories of residential care, and which promotes a consistency of approach and standard of care for all children.
	147 Replace operational services (OPS) 5 supervisors in residential care with allied health professional (AHP) or professional officer (PO) degree qualified staff, and recast the job and person specification to focus on the provision of staff with high level expert knowledge.
	148 Ensure that all youth workers in residential care have regular supervision as a means to promote their professional development and, where necessary, manage deficits in their performance.

- 149 Apply the following standards across residential care:
- a no child under 10 years to be housed in a residential care facility except where necessary to keep a sibling group together; and
 - b no child to be housed in a facility with more than four children, except where necessary to keep a sibling group together.
- 150 Recruit a sufficient complement of staff to:
- a cease using commercial carers in residential care facilities;
 - b develop a casual list to provide staff who are available on a flexible basis; and
 - c abandon single-handed shifts.
- 151 Abandon any plan to outsource any residential or emergency care service that is currently delivered by the Agency.
- 152 Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.
- 153 Amend the *Children's Protection Act 1993* to enable carers to apply to be appointed an Other Person guardian where children who are subject to long term orders have been in their care for a minimum period of two years, or such lesser period as the court in its absolute discretion determines is appropriate in the circumstances.
- 154 Amend the *Children's Protection Act 1993* to provide that biological parents who oppose an application for the appointment of an Other Person Guardian bear the onus of proving to the court on the balance of probabilities why the order should not be made.
- 155 Establish an independent assessment panel to consider applications for Other Person Guardianship, in accordance with the following procedures:
- a the application to be made by a foster parent in person or by a caseworker or foster care support worker on behalf of the carer;
 - b an initial review be carried out by the Assessment Panel to determine the utility of referring the application for a full assessment;
 - c the application to be referred to the caseworker or such other appropriate person as is available to carry out the assessment and prepare the case plan in a timely manner;
 - d when the assessment has been completed and case plan prepared, the application to be referred back to the Assessment Panel for final determination;
 - e all decisions of the Assessment Panel are to be final.
- 156 Promote the use of section 80 of the *Family and Community Services Act 1972* for the delegation of decision making to support potential applications for Other Person Guardianship.
- 157 Consider the question of adoption where that is in the best interests of the child and an Other Person Guardianship order would not be appropriate.
- 158 Amend the *Children's Protection Act 1993* to require the Minister to provide or arrange assistance to care leavers aged between 18 and 25 years. Assistance should specifically include the provision of information about services and resources; financial and other support to obtain housing, education, training and employment; and access to legal advice and health care.
- 159 Expand financial counselling services to manage access to post-care financial support from the Agency provided in accordance with Recommendation 158.
- 160 Amend the *Children's Protection Act 1993* to permit care leavers to access, free of charge, original and copy documents that relate to them from the Agency, approved carers, and any non-government agencies contracted to provide care to them.

RECOMMENDATIONS

161 Continue to make modified payments to foster and kinship carers where the care leaver is engaged in tertiary education, apprenticeship, or any post-high school training, and where their best interests would be served by remaining in foster or kinship care until the qualification is completed. 162 Review the Rapid Response policy to identify opportunities to expand priority services to care leavers up to the age of 25. 163 Prepare a new service model and work instruction for leaving care that incorporates the relevant elements of the National Approach, including specific reference to supporting care leavers who want to access further education and training. 164 Redeploy transition-from-care caseworkers to provide an add-on service for young people planning their move to independence. 165 Reach an administrative arrangement with the CREATE Foundation to provide it with the names and contact details of children entering care and/or their carers (as appropriate). 166 Fund the development of a smartphone application that provides young people with up-to-date information about services and entitlements when leaving care. 167 Review contractual conditions governing service specifications for non-government independent living programs to develop greater flexibility in the age of admission and the age of discharge from programs. 168 Fund Housing SA to develop innovative housing models, particularly those that use supported share housing where appropriate for care leavers. 169 Fund a pilot program of intensive case management assistance for vulnerable care leavers, to be delivered by an agency with established relationships with vulnerable children in care. 170 Conduct a review of the needs of the population currently accessing Relationships Australia's services to identify the specific needs of service users. 171 Make a significant injection of funds into post-care services currently provided by Relationships Australia, to enable these to be delivered more flexibly and more assertively.	172 Provide specialist training and documented guidance to staff within the Agency, as well as home-based carers and carers engaged through commercial agencies, as to their roles and responsibilities with respect to identifying and reporting conduct that may amount to a care concern, and the processes that follow such a report. 173 Consider developing technology to provide children in care with a user-friendly mechanism to engage with caseworkers in the care team and other responsible adults about their experiences and concerns. 174 Review and implement the Structured Decision Making⁷ care concern screening criteria tool for use by Call Centre practitioners. 175 Establish a panel in the Agency to determine the appropriate response pathway with respect to a care concern that is not diverted by the Call Centre to the field, but noting that all allegations that raise a suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) must be investigated by the investigations unit. 176 Establish in the Agency an investigations unit independent of the operations of the Agency to investigate matters referred to it by the panel, and staff that unit with a multidisciplinary team of investigators with expertise in child protection and law enforcement, and provide training and guidelines as to the scope of their roles. 177 Ensure that all care concern notifications are investigated in a timely manner: - a investigations should commence within 48 hours of the receipt of a notification; and - b in the absence of ongoing criminal proceedings or special reasons, investigations should be completed within six weeks from receipt of the notification. 178 Require a strategy meeting to be held at the start of all investigations undertaken by the investigations unit. 179 Define the standards against which deficiencies in the care provided to a child in care should be assessed.

- 180 Clarify the powers available to investigators, including putting in place appropriate delegations and authorities pursuant to sections 45 and 47 of the *Family and Community Services Act 1972* and section 19 of the *Children's Protection Act 1993*.
- 181 Ensure that staff are available in the investigations unit who are trained in forensic interviewing of children when this service is required.
- 182 Amend section 104 of the *Summary Procedure Act 1921* to permit the filing in committal proceedings of a transcript of a recorded interview with a child under the age of 14 years that has been verified by a person in attendance at the interview, other than an investigating officer as defined in the Act.
- 183 Require investigators to record an outcome as 'undetermined' in any case in which there is insufficient evidence to make a definitive finding.
- 184 Establish a response unit within the directorate responsible for quality and practice to:
- a provide advice to front-line staff about care concerns;
 - b provide a report to the Chief Executive of the Agency outlining responses and intended actions to issues identified in an investigation report. This should be provided within four weeks of the response unit receiving the investigation report;
 - c undertake a monitoring role in respect of all care concern notifications;
 - d analyse trends in care concern data to proactively address systems issues and inform the management of staff and carers; and
 - e make recommendations to the Chief Executive of the Agency as to proposed improvements in response to identified systems issues.
- 185 Establish a liaison function between the response unit and SAPOL, particularly with respect to identification of aspects of a care concern investigation that may be commenced by the Agency while criminal proceedings are pending.
- 186 Require the Agency to provide quarterly data to the Minister and the Guardian for Children and Young People about care concerns, including:
- a the number of care concern notifications received and their response pathway;
 - b how many care concern investigations have been completed;
 - c whether investigation timeframes have been met and the reasons for timeframes not being met;
 - d the outcomes of investigations; and
 - e how identified systems issues are being addressed.
- 187 Develop an Aboriginal recruitment and retention strategy in the Agency as part of a broader workforce strategy.
- 188 Review procedures to streamline the sources of internal cultural advice to the Agency.
- 189 Review practice guidance, funding arrangements and the range of declared agencies to ensure that a recognised Aboriginal agency is consulted on all placement decisions involving Aboriginal and Torres Strait Islander children, in accordance with the provisions of section 5 of the *Children's Protection Act 1993*.
- 190 Establish a dedicated family scoping unit.
- 191 Provide all practitioners in the child protection system with training, support and clinical supervision to give them the knowledge, skills and techniques to work effectively with Aboriginal children and families, including, where appropriate, the specific skills required to work effectively in remote Aboriginal communities.
- 192 Use the proposed Early Intervention Research Directorate to identify evidence-based service models for early intervention that meet the needs of Aboriginal children and families.
- 193 Outsource the services currently provided by Kanggarendi to an appropriately qualified and experienced non-government organisation.
- 194 Commission not-for-profit agencies to develop service models that can respond to higher risk Aboriginal families with multiple, complex needs.

RECOMMENDATIONS

195 Ensure that Local Assessments of Needs (LANs) specifically consider the needs of Aboriginal children and families and consult with local Aboriginal people and service providers. 196 Place local Aboriginal support services within child and family assessment and referral networks to promote service coordination and act as a visible point of entry. 197 Adopt a culturally appropriate assessment tool, such as Winangay, for the assessment of foster parents and kinship carers in the Aboriginal community, initially in remote communities, and more widely if the tool proves promising. 198 Require the Agency to report to the Minister and the Guardian for Children and Young People quarterly on service criteria 3.1.4.1, 3.1.4.4 and 3.1.4.6, which form part of standard 3.1.4 of the Standards of Alternative Care in South Australia. 199 Consult with each remote Aboriginal community about the implementation of the recommendations following this report, as part of ongoing engagement with communities about the strategic direction of services to improve the health, safety and wellbeing of their children. 200 Offer stable employment arrangements with competitive, ongoing retention allowances to attract and recruit six permanent Lands-based workers to support the Agency's fly-in fly-out teams. 201 Actively pursue joint training opportunities for agencies in remote communities and require operational managers from agencies to meet regularly to identify areas for collaboration and to resolve issues of concern. 202 Ensure that at least one principal Aboriginal consultant has experience and expertise in remote Aboriginal communities, including in the APY Lands. 203 Identify opportunities to develop strength in the interpreter service available in remote communities, and ensure that the Agency's practitioners use interpreters where possible. Consider the viability of interpreters accompanying the Agency's fly-in fly-out teams.	204 Ensure that the Agency's practitioners monitor children cared for in accordance with Family Care Meeting agreements to ensure the safety of the child. 205 Commission not-for-profit agencies to provide alternative care in areas close to the APY Lands, such as Alice Springs and Coober Pedy. Alternative care could include a mixture of foster care and residential care. 206 Require that full carer assessments be completed in a timely manner in remote communities. 207 Ensure that approved carers in remote communities receive the same level of support as carers elsewhere in the state, recognising the particular challenges faced by carers in these remote areas. 208 Ensure that the unit tasked with investigating care concerns offers a service in remote communities equivalent to that provided elsewhere in the state. 209 Provide secure, long-term funding for playgroups in remote Aboriginal communities, administered by a single agency. 210 Establish an integrated administration information communication technology (ICT) system to allow access to a complete range of student data to children who move schools in remote Aboriginal communities. 211 Provide additional funding to meet demand for the Walytjapiti program, and ensure that the Agency keeps case files open for participants until satisfied about the child's ongoing wellbeing over a sustained period. 212 Commission an early intervention service for families in remote communities for whom the Agency has lower level concerns and who could benefit from support to prevent escalation of issues. 213 Conduct an audit of services in remote Aboriginal communities to ensure access to adequate facilities to serve as a service hub for playgroups, preschools and other services that visit the community.

214 Reform funding and structural arrangements to enable a single agency to oversee the service hub facilities across all communities. This agency should regularly map, in collaboration with the local community, the needs of children and families through an annual Local Assessment of Needs. 215 Establish a working group to promote collaborative practice between South Australian, Western Australian and Northern Territory agencies involved in the child protection system in the tri-border region, including working towards a cross-border legislative scheme for child protection across the three jurisdictions. 216 Review child protection service provision in Ceduna, Yalata and Oak Valley, including the viability of introducing a fly-in fly-out service. 217 Develop strategies to improve out-of-home care options in regional areas including: - a focusing attention on the recruitment of foster parents, particularly in areas of need; and - b identifying areas where there is a demand for residential care placements and develop facilities in those areas. 218 Require the Agency to develop a dedicated psychological service to deliver therapeutic services to children in care in regional areas. 219 Collaborate with the Courts Administration Authority to improve access to justice for children in need of care in regional areas, including providing appropriate technology with respect to hearings in remote locations. 220 Prepare an annual Local Assessment of Needs for each regional area. 221 Ensure that the Agency's practitioners in regional areas have access to ongoing professional development, through locally delivered training and videoconferencing. 222 Require the Agency to develop attraction and retention strategies specific to building workforce sustainability in regional areas, including the use of financial incentives for staff.	223 Ensure that every child in care, or who enters care, and who is potentially eligible, applies to participate in the National Disability Insurance Scheme (NDIS). For children already in care, this must occur by 31 March 2017. 224 Develop the function in C3MS to require caseworkers to input information when a child enters care, and for those children already in care, as to their potential eligibility for NDIS. This data should be extractable for analysis. 225 Determine and fund demand for specialist disability foster care placements in accordance with the available data about children in care who are eligible for NDIS. 226 Employ specialist disability workers to consult across the Agency in matters involving children with disabilities. 227 Train Agency caseworkers to recognise and respond to the needs of children with disabilities, particularly in accessing and maximising support services offered by NDIS. 228 Ensure Agency caseworkers, when participating in NDIS planning, prioritise the use of the Alternative Care Therapeutic Team program when appropriate to meet the therapeutic needs of a child in care. 229 Develop clear guidelines on the role of home-based carers in planning and decision making in NDIS for children in their care. 230 Require child and family assessment and referral network members to provide support for families who are caring for children with disabilities, to enable them to engage with NDIS. 231 Require that the cultural background of children coming into contact with the child protection system be recorded on C3MS, including in the Life Domains area, for all children in care who have a culturally and linguistically diverse background. 232 Analyse data collected regarding the cultural background of children coming into contact with the child protection system to determine how to best respond to children at risk in culturally and linguistically diverse communities. 233 Undertake a qualitative review of the capacity of the Agency's Multicultural Community Engagement Team (MCET).

RECOMMENDATIONS

- 234 Evaluate the effectiveness of specialist MCET staff working together with front-line practitioners on child protection cases and assess the value of collocating MCET staff in the Agency's offices.
- 235 Assist staff and carers who work with children in care who have a culturally and linguistically diverse background to achieve culturally informed best practice through the development of practice guides.
- 236 Ensure that every child in care with a culturally and linguistically diverse background has a comprehensive cultural maintenance plan that is regularly reviewed, having regard to the child's age and placement circumstances.
- 237 Identify key performance indicators on the cultural competency of the Agency's workforce, and regularly review the effect of these recommendations on that competency.
- 238 Enact a stand-alone legislative instrument to regulate the screening of individuals engaged in child-related work which:
- a declares that the paramount consideration in screening assessment must be the best interests of children, having regard to their safety and protection;
 - b invests powers in only one authorised government screening unit which is charged with maintaining a public register of all clearances and their expiration dates;
 - c empowers the screening authority to take into account in its assessments criminal offence and child protection history, professional misconduct or disciplinary proceedings, and deregistration as a foster parent or other type of carer under the *Family and Community Services Act 1972*;
 - d provides a clear definition of child-related work, including the meaning of incidental or usual contact;
 - e declares that the outcome of a screening assessment will be limited to either a clearance or a refusal and that all applications, even if withdrawn, will be assessed;
 - f requires individuals to seek and maintain a personal clearance, valid for a period of up to five years, through a card or unique electronic identifier system, which has portability across roles and organisations in the state; and to notify the screening authority of relevant changes in their offence, conduct or child protection circumstances;
 - g requires employers to ensure that all relevant personnel in their organisations, at all times, hold current clearances;
 - h precludes exemptions from screening requirements for—
 - i registered teachers
 - ii applicants waiting on screening outcome decisions
 - iii those working or volunteering with children who are in care
 - iv those who have been refused a WWCC;
 - i details offences for individuals and organisations who fail to comply with the provisions of the legislation, including engagement in or for child-related work without a clearance, and dishonesty in the application process; and
 - j permits appeals from decisions of the screening authority to the South Australian Civil and Administrative Tribunal or other independent body.
- 239 Establish a real-time monitoring system which ensures that changes in screened individuals' circumstances are communicated to the screening authority, that clearances are reviewed, and that changes are reflected in the register, and communicated to employers.

- 240 Charge the screening authority with:
- a ensuring that it has access to forensic expertise in child protection and behavioural indicators of risk;
 - b developing a consolidated set of standards, matrices, and weighting guidelines for use in screening assessments, that include substantiated and unsubstantiated criminal, child protection and disciplinary matters, and ensuring that assessors are appropriately trained in their application;
 - c developing guidelines for ensuring that applicants are afforded appropriate procedural fairness, including circumstances in which information may be withheld from applicants;
 - d developing and promulgating timeline benchmarks for screening outcomes, and procedures for informing applicants whose clearances may fall outside benchmarked times;
 - e developing information sharing protocols with interstate screening units.
- 241 Develop an independent mechanism and evaluation process for reviewing the performance of the screening authority.
- 242 Amend the *Children's Protection Act 1993*:
- a to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies that have responsibilities for the health, safety or wellbeing of children where it would promote those issues; and
 - b to require prescribed government and non-government agencies to take reasonable steps to coordinate decision making and the delivery of services for children.
- 243 Require senior leaders from government and non-government agencies that have responsibilities for the health, safety and wellbeing of children to meet at least quarterly to identify strategic measures to promote inter-agency collaboration and information sharing.
- 244 Review procedures and employment arrangements so that chief executives of government agencies with responsibilities for the health, safety and wellbeing of children have a provision included in their performance agreements that obliges them to ensure inter-agency collaboration in child protection matters, and measure that performance.
- 245 Establish the statutory office of the Commissioner for Children and Young People and provide the Commissioner with the functions and powers referred to in this report.
- 246 Consolidate the legislation for the Children's Commissioner, the Guardian for Children and Young People (GCYP), the Child Death and Serious Injury Review Committee (CDSIRC) and the Child Development Council in a single Act of Parliament.
- 247 Empower GCYP and CDSIRC to refer matters to the Children's Commissioner, where they are of the view that escalation through processes available to the Children's Commissioner is appropriate.
- 248 Empower the Children's Commissioner to exercise its statutory powers and functions in relation to such matters, including employing the regime to monitor government responses to recommendations, and escalate the matter to the Minister and Parliament where necessary, at his or her sole discretion.
- 249 Collocate the Children's Commissioner, GCYP, CDSIRC and the Child Development Committee, and make arrangements for the sharing of some administrative functions.
- 250 Amend legislation to permit, but not require, GCYP, CDSIRC and the Children's Commissioner to share de-identified data.
- 251 Amend legislation to empower the Children's Commissioner or GCYP to make complaints to the Ombudsman and HCSCC on behalf of a child.
- 252 Amend the *Ombudsman Act 1972* (SA) to ensure that complaints about the actions of government agencies, and other agencies acting under contract to the government, concerning child protection services, find principal jurisdiction with the Ombudsman, and not the Health and Community Services Complaints Commissioner, where the complaint is about an administrative act.

RECOMMENDATIONS

- 253 Amend the *Ombudsman Act 1972* to permit the Ombudsman to exercise the jurisdiction of Health Care and Community Services Complaints Commissioner (HCSCC) in appropriate cases.
- 254 Develop an administrative arrangement between the Ombudsman and HCSCC to determine matters in which the Ombudsman would exercise dual jurisdictions, including, but not limited to, child protection complaints.
- 255 Develop the capacity of the Ombudsman's Office to respond specifically to child protection complaints.
- 256 Develop a package of information regarding making complaints about child protection matters, including information and complaint forms which are suitable for children and young people.
- 257 Establish an across-government steering committee to monitor and oversee the implementation of recommendations. Membership of the committee should include representation by senior executives from relevant government agencies and include at least one independent member external to the South Australian Government. The Committee should report directly to the Minister for Child Protection Reform as Chair of the Child Protection Reform Cabinet Committee.
- 258 Establish a response and implementation team consisting of staff with expertise in child protection, policy, data analysis, stakeholder engagement and legislative development.
- 259 Ensure the implementation of recommendations within the newly formed child protection department is adequately managed with high-level change agents and appropriately qualified and skilled child protection staff.
- 260 Respond to the recommendations in this report as follows:
- a on or before 31 December 2016, provide a report setting out—
 - i the recommendations of the Commission that have been implemented either partly or in full
 - ii the recommendations of the Commission that have been accepted, but have not yet been fully implemented, the manner in which they will be fully implemented and the intended timeframe for that implementation
 - iii the recommendations of the Commission that will not be implemented and the reason for not implementing them;
 - b on or before 30 June 2017, provide a further report as to—
 - i the recommendations that have been wholly or partly implemented and the manner in which they have been implemented
 - ii if a decision has been made not to implement a recommendation that was to be implemented, the reason for not implementing that recommendation
 - iii if a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for that decision and the manner in which the recommendation will be implemented;
 - c for a period of not less than five years after the provision of the report referred to in paragraph 4(b) hereof, provide an annual report setting out—
 - i the recommendations that have been wholly or partly implemented in the relevant year and the manner in which they have been implemented
 - ii if, during the relevant year, a decision has been made not to implement a recommendation that previously was to be implemented, the reason for not implementing that recommendation
 - iii if, during the relevant year, a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for the decision and the manner in which the recommendation will be implemented;
 - d make reports publicly accessible, including being published online.

PART I

INTRODUCTION

1

ESTABLISHMENT AND APPROACH

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1 ESTABLISHMENT AND APPROACH

BACKGROUND

Many children in state care have been abused and neglected, not only by their families but by the system that was supposed to protect them. It is time for that to change. It is time for all of us to work together to give all our children the life they deserve.

This Child Protection Systems Royal Commission was established at a time of escalating public concern about the child protection system in South Australia. The arrest of Shannon McCooles for despicable crimes against children in the care of the state understandably shocked the public and highlighted the need for a detailed examination of the child protection system, including a consideration of the reforms needed.

Although those events brought about the Commission's establishment, the Terms of Reference required a more comprehensive examination of the child protection system. The Commission adopted a liberal approach to the Terms of Reference. The determination of what amounted to a risk of harm was not limited to questions of physical or sexual safety, but was taken to include such matters as emotional, social and educational development.

Many inquiries, reviews, reports and political statements have focused on issues of child protection in South Australia. Against the background of such scrutiny over a long period, with little evidence of change, the Commission was challenged to ensure that this inquiry would make a difference, not just to statistics or performance measures but to the lives of children.

Many sections of the community were also concerned about whether another report would make any difference. The Commission often heard, particularly in its early days, comments to the effect that it would be pointless to assist because all that would be achieved would be yet another report, and then everything would remain the same.

Problems with the child protection system are not unique to South Australia. In the course of this inquiry the Commission did extensive research in the hope of finding the perfect system to emulate. That search was unsuccessful, as it became evident that governments everywhere continue to struggle to find the best possible system to protect some of the most vulnerable members of our society.

THE APPROACH

In gathering evidence to understand the nature of the problems, and their potential solutions, the Commission considered it important to provide a process that was accessible to people working in the child protection system, carers, service users and children. In particular, the Commission made an early decision to receive some submissions on a confidential basis, and generally hold private hearings.

The Commission received written submissions, and then embarked on a hearing schedule shaped by the issues raised in the submissions. A number of witnesses who had contributed written submissions, and others who the Commission identified as having relevant information, gave oral evidence. The Commission travelled to Port Augusta and Mount Gambier to hear evidence, and heard from a number of witnesses from the APY Lands and interstate via video-link. In the course of the hearing schedule, a number of senior executives and managers from government and non-government organisations were called to give evidence.

Many witnesses told the Commission that they felt more able to speak freely about matters in private hearings. Evidence sometimes included the sharing of personal information about witnesses' own families, which assisted the Commission by highlighting system challenges and gaps as they relate to children's actual experiences. Private hearings also made it possible for witnesses to speak openly about children without compromising the children's privacy. Witnesses also felt able to give candid and forthright evidence about contentious issues, unlikely to be aired in a public hearing. The quality of the evidence received confirmed that the Commission's evidence-gathering processes were well served by the decision to take evidence in private.

Although the Terms of Reference required a consideration of system issues, the Commission also heard five case studies (see Volume 2) which investigated particular matters of importance:

- 1 Vulnerable children, birth to school age (James);
- 2 Intervening in high risk families (Abby);
- 3 Leaving care (Hannah);
- 4 Children with complex needs in out-of-home care (Nathan); and
- 5 Keeping children safe in their environment (Shannon McCooles).

Each of the children in the first four case studies came to the attention of the Commission through oral evidence or consultations. They were selected on the basis of the capacity of the circumstances to elucidate system issues, and the valuable insight obtained in the course of these case studies highlighted the value of this process. In case study 4, Nathan, the Commission also heard specific evidence on the topic of Families SA's compliance with a number of summonses issued by the Commission. This evidence informed the Commission's consideration of the adequacy of Families SA's record keeping and information technology systems. McCoole gave evidence in the course of case study 5.

The Commission was also assisted by an Expert Advisory Panel, established pursuant to section 7 of the *Royal Commissions Act 1917* (SA). Members of the panel were Dr Diana Hetzel, a medical practitioner, Di Gursansky, a social worker, and Rosemary Kennedy, a registered psychologist. They conducted research and prepared a number of reports which the Commission relied on in forming conclusions and recommendations.

Further detail about establishing and staffing the Commission, other experts who assisted the Commission, and the qualifications and experience of the expert panel can be found in Appendix B.

Evidence from Families SA workers, both past and present, provided considerable assistance. Some current employees made submissions or gave evidence, notwithstanding concern that in so doing their employment might be jeopardised. The thoughtful information from these witnesses on deficits in the system was invaluable, but the vast majority of them appeared overwhelmed by the nature and volume of their work, and the weight of community expectation that the child protection system should be capable of fixing all of society's ills. It was apparent that many of these workers felt unsupported by senior management as they struggled to perform their daily tasks in the face of ongoing adverse publicity directed at Families SA.

In the course of examining deficits in the child protection system, it has been necessary to make certain observations about the current standard of work of Families SA. In so doing, the Commission is mindful of the impact such observations may have on an already compromised workforce. However, comments about practice quality and past inadequacies must be included to explain past system failures and the changes needed.

A consistent challenge for this Commission was to examine a system which appeared to be in a constant state of flux. The Commission appreciated that some administrative and legislative change was likely before delivery of this report but expected to be kept informed of such changes. On a number of occasions, the Commission discovered, usually in response to a

summons for information, that substantive changes in the Department for Education and Child Development had been made without notice or advice. In some cases, the Department had commissioned additional reports from outside sources on topics that were the subject of the Commission's investigation. The Commission's processes were sometimes frustrated and distracted, and time was wasted because documentation, policies and procedures changed. This created an extra burden for the Commission in carrying out its investigation.

STRUCTURE OF THE REPORT

In presenting the various observations and recommendations, the Commission has attempted to group topics in the most logical and accessible way. Part I, Introduction, reviews some fundamental considerations important to understanding the approach taken in the rest of the report. These include: why the child protection problem is persistent, and apparently resistant to reform; how abuse and neglect affect children and why safe care of children is essential for their long-term development and wellbeing; and the major external influences on the system in South Australia.

Part II considers some fundamental challenges to reform of the child protection system. It considers in detail challenges for the Agency and its workforce.

Terminology

A major recommendation of the Commission is for a structural change that will locate statutory child protection services in a new department devoted to that function.

The Commission thus faced a challenge in the language that it would use to describe the statutory agency's operations in the past, and what is intended for the future.

The Commission uses the terms Families SA and the Agency interchangeably. The Office for Child Protection (called the Office for Child Safety until 25 October 2015) is the administrative division of the Department for Education and Child Development responsible for child protection. Families SA refers to the office's service delivery or operational arm, although the name is often used to refer to the office as a whole.

References to the Department are references to the Department for Education and Child Development, which, for the moment at least, is the department within which the statutory agency sits.

1 ESTABLISHMENT AND APPROACH

Parts III and IV consider issues arising at each stage of a child's journey through the system: identification and notification of children at risk of harm; prevention and early intervention; the response delivered to children who are at immediate risk; and keeping children safe in out-of-home care. The Commission has also considered issues relevant to children's transition out of care as they approach the age of 18, and the use of legal options that give carers greater permanency, such as adoption and Other Person Guardianship. In Part V the Commission considers overarching topics relevant across each stage: specific issues relating to Aboriginal and Torres Strait Islander children, children living in regional areas, children with disabilities and children from culturally and linguistically diverse backgrounds. Part VI outlines the reforms necessary at a system level: screening adults who work and volunteer with children, better coordination of responses from various government and non-government agencies, and changes to information-sharing powers and obligations to keep children safe.

CONFIDENTIALITY

Most of the cases examined by this Commission relate to children whose circumstances are still current. The Commission examined hundreds of files relating to children and young people, and considered many confidential submissions in which children and young people were mentioned by name.

Information that the Commission received about these children and young people informed the findings in this report. In some cases, such as the factual background of the case studies, it was difficult to recite the facts and present intelligible findings anonymously. Accordingly, for ease of reading and understanding the Commission has replaced the name of any living child mentioned in this report with a pseudonym. Sometimes, because of the specificity of the circumstances described, other details have been changed to preserve privacy, such as the names of persons associated with the child or children, or the geographical location of their residence. Such details have been changed only where the Commission considered it would not affect the description of the child's overall circumstances.

THE VOICE OF THE CHILD

The guiding aim of any reform of the child protection system must be keeping children safe and improving the quality of their lives. Thus children's experiences must be understood, and children must be heard. The evidence in the McCoole case study highlights the dangers of a system that fails to listen to what children say, either directly or through their behaviour.

In the course of hearing evidence the Commission was privileged to hear from children whose lives had been affected by the child protection system. Contributions were also sought in a group consultation from children currently in care, or who had recently left care. Staff from the Guardian for Children and Young People (GCYP) and CREATE Foundation, the peak national body that represents the voices of children and young people with an out-of-home care experience, arranged and undertook this consultation. The full report is available at www.agd.sa.gov.au/child-protection-systems-royal-commission

Verbatim contributions from some of the participants are, where appropriate, reproduced throughout this report. They include the following messages, for the Commission and the community as a whole, about some basic notions for taking better care of children:

- *Show us respect by informing us what is going on and seek our input to decision making that affects our lives*
- *Talk to us in a way that we understand*
- *Acknowledge our cultures*
- *Treat us fairly*
- *Don't overburden us, but when we can lead, let us*
- *Don't just look after us, take care of our families (we know our situations are just part of bigger problems)*
- *If adults see something bad happening, they should do something*
- *Provide us with someone we can trust*
- *Make the system work for us ...*

The Commission thanks all the children and young people who generously contributed their wise words and shared their knowledge with us.

The recent past has exposed occasions where children at risk have not been well served by the very system established to keep them safe. For the reforms outlined in this report to have any effect on the lived experience of children, the system needs to place greater weight on understanding and valuing the experience of children. For children who are at risk, or who are taken into the care of the state, the system needs to do better to deliver them the life they deserve.

2

THE PERSISTENCE OF THE CHILD PROTECTION PROBLEM

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2 THE PERSISTENCE OF THE CHILD PROTECTION PROBLEM

OVERVIEW

Child protection has been, and continues to be, a persistent challenge throughout the developed world. Numerous national and international inquiries into child protection systems—many resulting from deaths of children—attest to the systems' inability to adequately meet the complex needs of the families and children involved in notifications to authorities. The systems are complicated and highly intertwined with other, equally complex service systems.

It has been evident since at least the mid-1980s¹ that child protection systems need major reform, yet attempts to achieve this have generally made few inroads.² Further, policy makers have found it difficult to fix problems with the system because legislation and interventions are underpinned by unsupported assumptions.

A SYSTEM OUTGROWN BY SOCIAL CHANGE

The rate of child maltreatment in a community is a barometer of its psychological and physical health, and social and economic wellbeing.³ In Australia during the past three decades there has been a rise in the recorded rates of child maltreatment, which reflects both a more advanced understanding of the detrimental outcomes of child abuse and neglect and an increased focus on intervening to prevent harm to children. This more developed understanding has produced an increasingly sophisticated range of preventative and tertiary interventions that focus on vulnerable children and families.⁴ Rising child maltreatment rates also attest to the extreme disadvantage facing some children and families in Australia today.

Contemporary child protection systems are ill-equipped to deal with the social and economic complexities of the 21st century and were never designed to do so. Child protection issues intersect with the health, education, police, probation and justice systems, but the challenge of protecting vulnerable children primarily remains the remit of relatively small statutory child protection systems.⁵

Australian child protection systems, as well as those of other countries including the United Kingdom and the United States of America, have developed a strong focus on receiving reports and conducting investigations that consider whether alleged child maltreatment has been substantiated. A response from the statutory agency is often only activated after a child has been harmed. Statutory agencies rely on reports of suspected abuse and neglect from the community and professionals, some of whom are mandated to make such reports. This approach assumes that children's needs are met within their families and that child protection services have a role only when this fails. Conversely, countries such as Norway and Sweden have adopted a family services

approach, where the care of children is viewed as both a state and family responsibility, and the focus is on providing services to vulnerable families and children.⁶

Today's child protection response originates from the discovery in the 1960s by Kempe and colleagues of the 'battered-child syndrome'.⁷ Out of this research developed an individualised forensic-legal approach to what was conceived as a detectable problem affecting a small number of children. The primary aim of this approach was to produce evidence of whether harm to children had occurred and, if so, to determine who was responsible.

Since the 1960s the circumstances that child protection services were originally designed to address have changed. With increasing knowledge of what harms children, statutory services now respond to physical abuse, sexual abuse, emotional abuse, neglect and, more recently, exposure to domestic violence.⁸ The threshold at which statutory child protection services intervene to protect a child has been lowered from severe physical harm such as bone fractures in the 1960s to now include outcomes such as bruising, developmental delay and psychological harm.⁹

Historically, children who could no longer live with their families were placed into foster care arrangements. The voluntary nature of these arrangements was more easily accommodated in single-income families where there was a larger home and someone at home full-time to care for the children.¹⁰ These conditions are less likely to exist today.

While the scope of child protection services has grown significantly since the 1960s, until recently the design of the system had not. Consequently, it has struggled to respond appropriately to vulnerable children whose families require support to meet their children's needs, rather than coercive court-ordered interventions to protect children.¹¹

WHY THE CHILD PROTECTION PROBLEM PERSISTS

Some commentators have argued that attempts to reform the child protection system have failed because they are predicated on a flawed view that child abuse, as currently conceived, is a solvable problem. They argue that the problem of child protection requires re-conceptualisation to acknowledge that it is a 'wicked problem': that is, a problem resistant to resolution.¹² Wicked problems are highly complex and often arise where the components of the system in which the problems reside are interactive and intertwined. The solution to one problem often reveals another problem of greater complexity.¹³ Policy solutions are traditionally linear and presuppose that each part of the system or problem is distinct and logically follows from the part before it. When applied to wicked problems, such solutions are bound to fail.¹⁴

The child protection system is fundamentally complex and highly intertwined with other difficult and complex socioeconomic drivers and associated service systems. It is not surprising that resolving its shortcomings poses significant challenges.

Families entering the child protection system are typically contending with a complex combination of chronic issues, including substance abuse, mental illness, young parenthood, violence, multi-generational abuse, homelessness, poverty and the impact of child removal.¹⁵

Aboriginal families are grossly over-represented in the system, which still seeks to address the complexity of unique challenges in these families and communities with mainstream child protection approaches.¹⁶

The signs and symptoms of child abuse and neglect are often ambiguous and difficult to identify. Predictions as to the risk of future abuse are inevitably imperfect and often based on the performance of an imperfect system.¹⁷

Historically, there has been a chronic lack of evidence-based child protection interventions, a lack of access to existing interventions, and poor translation of available evidence into practice.¹⁸ Further, there is no certainty that any particular intervention will result in a permanent change in family behaviour.¹⁹

The organisations within which child protection workers are expected to manage the ambiguity and uncertainty of practice are often defensive and sometimes toxic. They are also likely to experience chronically high workloads and ongoing staff shortages.²⁰

The child protection policy domain is highly complex. Traditionally contested values about the role of the state in the family, strong community emotions, intense media attention and political sensitivity become the major drivers of policy development.²¹

Re-orientating to an evidence-based policy-making environment is hampered by the differing drivers of policy, practice and research.²² For example, the work of policy makers is to implement political decisions that take account of divergent views and controversies, and often require answers to questions of feasibility, implementation benefit and relevance in a short timeframe.²³ Similarly, practitioners strive to respond to pressing human needs and want instant answers as to what works and whether it is effective and efficient.

On the other hand, researchers require longer timeframes to produce quality research, are interested in questions that can be answered scientifically, and seek to be objective and value free. Their research is influenced by academic achievement, international research reputation

and sources of funding. These key differences create barriers to producing and using research evidence to inform policy making and practice.²⁴

In this politically fraught environment, ideas that might appear radical or new may not find traction. Public tolerance for new approaches to the problem can be heavily influenced by fluctuating levels of media interest, which is often linked to child deaths and major inquiries into child protection systems.²⁵

Policy making in child protection has also struggled to rectify problems with the system because both legislation and available interventions are underpinned by assumptions that are not supported, have not been challenged, and have often resulted in unintended consequences for children and families.²⁶

The key assumptions are that²⁷:

- 1 the child protection problem is measurable and solvable;
- 2 risk can be eradicated;
- 3 child abuse and neglect are relatively rare in Australia;
- 4 doing nothing costs nothing and harms no one;
- 5 simply referring families involved in child protection to services will reduce child abuse and neglect and thereby demand on the system; and
- 6 getting the mainstream system 'right' will have flow-on effects for Aboriginal families.

These assumptions and some of their unintended consequences are discussed below.

ASSUMPTION 1: THE CHILD PROTECTION PROBLEM IS MEASURABLE AND SOLVABLE

Policy makers and child protection organisation managers often assume that 'there is a "right way" to both manage the social ill of child abuse and to measure this performance' and 'the outcomes of an intervention or policy are predictable and that the organisation which they are managing is controllable'.²⁸ As a result, the current child protection system directs its efforts and resources towards the short-term outcome of identifying and securing the safety of children who are at immediate risk of harm. This approach is detrimental to achieving longer-term outcomes, such as addressing early the risk of abuse and neglect, and detrimental to children who have already been abused or neglected.²⁹

2 THE PERSISTENCE OF THE CHILD PROTECTION PROBLEM

ASSUMPTION 2: RISK CAN BE ERADICATED

It is assumed that uncertainty in child protection work can be managed by assessing and managing risk. However, as Professor Eileen Munro argues in her review of the United Kingdom child protection system, 'Risk management cannot eradicate risk; it can only try to reduce the probability of harm'. Further, low probability events still occur in circumstances where the risk has been assessed as low, even where the quality of professional practice is high.³⁰

'Risk management cannot eradicate risk; it can only try to reduce the probability of harm'

Traditional risk management strategies focus on improving practice by standardising service systems including case management, developing prescriptive practice and standardised assessment frameworks, and imposing practice targets and performance indicators. These strategies have, over time, diminished the function of professional judgement in decision making and de-skilled workers who are tasked with wrangling these complex issues.

Limiting the professional ability of workers to adequately respond to children's needs has created a perpetual cycle of unintended consequences.³¹ Prescriptive practice at the expense of professional judgement creates job dissatisfaction, leading to high staff turnover and larger workloads for the staff who remain. This has produced adverse work cultures that affect workers psychologically, emotionally and professionally. These work environments compound the difficulty in attracting and retaining experienced staff, producing even higher numbers of vacant positions and placing inexperienced workers in key front-line child protection roles.³² The ability of workers to adequately address the needs of children is further eroded, creating greater job dissatisfaction; thus the cycle begins again.³³

The overall impact of this cycle is that families are less likely to receive a comprehensive and continuous service, leading to a deterioration in trust and rapport, and greater dissatisfaction with child protection services.³⁴ Children are more likely to experience placement instability, a reduced chance of permanent care, loss of trusting relationships, longer stays in foster care, and a decreased chance of family reunification.³⁵

ASSUMPTION 3: CHILD ABUSE AND NEGLECT ARE RELATIVELY RARE IN AUSTRALIA

There is a tendency to assume that child abuse and neglect are relatively rare in Australia. This is primarily because a child protection system with a primary focus on incident-based detection and investigation severely misrepresents the prevalence of child abuse and neglect in the community.

Current methods for detecting child abuse apply thresholds to determine whether individual incidents reflect child maltreatment at a level that would be likely to cause long-term harm. Research shows that children reported to child protection systems for whom concerns are not substantiated demonstrate poor outcomes commensurate with children for whom reports are substantiated.³⁶ A study by Bromfield and Higgins indicated that in 65 per cent of families where a notification to child protection had been made, maltreatment was chronic.³⁷ Because child protection legislation has a single incident focus, these families may never receive the help they need and family dysfunction may escalate; eventually meeting the threshold for statutory intervention but at a high cost to the child. This is especially alarming in cases of children under one year of age. One study reported that between 26 and 31 per cent of babies who returned home after abuse were abused again.³⁸

The consequence of an incident-based system approach is that the shortcomings of the system become the focus of reform, perpetuating the myth of rarity instead of exposing the larger problem of child maltreatment, which is a genuine public health problem.³⁹

ASSUMPTION 4: DOING NOTHING COSTS NOTHING AND HARMS NO-ONE

The assumption that child maltreatment is relatively rare necessarily leads to the assumption that doing nothing costs nothing and harms no one. However, burden of disease studies, which estimate total years of life lost due to premature death or disability (DALYs), show that child maltreatment potentially accounts for 20 per cent of the burden of self-harm and between 15 and 20 per cent of the burden of anxiety and depression.

Table 2.1 shows that doing nothing has profound public health implications. It ranks the leading causes of burden of disease measured in DALYs. Child maltreatment is ranked tenth after prostate cancer for men and seventh after breast cancer for women. It is clear that tackling child abuse and neglect by intervening early could significantly reduce the burden of disease for adult populations and the long-term cost to the community. The burden of disease lifetime cost for the population of children reportedly abused for the first time in 2007 is estimated to be \$7.7 billion.⁴⁰

Table 2.1: Leading causes of burden of disease (DALYs) by sex, Australia 2003

RANK	MALES	DALYs	% OF TOTAL	FEMALES	DALYs	% OF TOTAL
1	Ischaemic heart disease	151,107	11.1	Anxiety & depression	126,464	10.0
2	Type 2 diabetes	71,176	5.2	Ischaemic heart disease	112,390	8.9
3	Anxiety & depression	65,321	4.8	Stroke	65,166	5.1
4	Lung cancer	55,028	4.0	Type 2 diabetes	61,763	4.9
5	Stroke	53,296	3.9	Dementia	60,747	4.8
6	Chronic obstructive pulmonary disease	49,201	3.6	Breast cancer	60,520	4.8
				Childhood maltreatment	55,881	
7	Adult-onset hearing loss	42,653	3.1	COPD	37,550	3.0
8	Suicide & self-inflicted injuries	38,717	2.8	Lung cancer	33,876	2.7
9	Prostate cancer	36,547	2.7	Asthma	33,828	2.7
	Childhood maltreatment	35,876				
10	Colorectal cancer	34,643	2.5	Colorectal cancer	28,962	2.3
11	Dementia	33,653	2.5	Adult-onset hearing loss	22,200	1.8
12	Road traffic accidents	31,028	2.3	Osteoarthritis	20,083	1.6
13	Asthma	29,271	2.1	Personality disorders	16,339	1.3
14	Alcohol abuse	27,225	2.0	Migraine	15,875	1.3
15	Personality disorders	16,248	1.2	Back pain	15,188	1.2
16	Schizophrenia	14,785	1.1	Lower respiratory tract infections	14,233	1.1
17	Osteoarthritis	14,495	1.1	Falls	13,269	1.0
18	Back pain	14,470	1.1	Parkinson's disease	13,189	1.0
19	Melanoma	13,734	1.0	Schizophrenia	12,717	1.0
20	Parkinson's disease	13,664	1.0	Rheumatoid arthritis	12,062	1.0

Sources: Australian Institute of Health and Welfare, *The burden of disease and injury in Australia 2003, 2007*, www.aihw.gov.au/publication-detail?id=6442467990; SE Moore et al., 'Burden attributable to child maltreatment in Australia', *Child Abuse & Neglect* 48, 2015, pp. 208–220, <http://dx.doi.org/10.1016/j.chiabu.2015.05.006>

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Current faith in the form, as opposed to the function, of existing child protection systems has meant that the child protection workforce in this state is primarily mono-disciplinary and not adequately trained to address the complex needs of vulnerable children. This is in contrast to fields such as health, which could also be conceived as a wicked problem but has sophisticated systems and highly specialised workforces to address the complex issues.

Despite accumulating evidence that child maltreatment is an urgent public health problem, the child protection system has failed to recognise that:

- children who have been extremely maltreated require evidenced-based therapeutic responses; and
- prevention of abuse is essential to the success of public health interventions, but has, to date, been neglected.⁴¹

ASSUMPTION 5: SIMPLY REFERRING FAMILIES INVOLVED IN CHILD PROTECTION TO SERVICES WILL REDUCE CHILD ABUSE AND NEGLECT AND THEREBY DEMAND ON THE SYSTEM

A consequence of continuing to invest in a dysfunctional system is that alleviating *demand* becomes the focus of policy at the expense of *reducing harm* to children. This in turn skews the aim of prevention and early intervention towards alleviating system demands rather than addressing the needs of children.

A synthesis of the common themes of recommendations made in recent major reports and inquiries into Australian jurisdictional child protection systems illustrates this point (see Table 2.2).

One consequence of this focus on alleviating demand is a scarcity of evidence-based approaches to working with children and families.⁴² It is estimated 80–90 per cent of practitioners in the United States children's services system do not use evidence-based interventions.⁴³ In an effort to meet the urgency of system demands, major funding initiatives are implemented before well-designed research has occurred.⁴⁴ Service providers are given short-term funding to address the needs of families that require an intense, long-term commitment, at the same time as being pressured to show evaluation outcomes, no matter how small, to support continued funding.⁴⁵

Any attempts to implement evidence-based practices are often quickly adapted or changed, losing the key ingredients that were critical for effectiveness.⁴⁶ To be effective, programs require five elements:

- an explicit objective;
- a clear target population;
- a clear theory of change;

- program components implemented as intended; and
- clear alignment between the first four elements.

A review of 52 home-visiting interventions for vulnerable families with infants found that programs incorporating these five elements were successful in preventing abuse and neglect. Where only some of the elements were present, 60 per cent of programs were successful, and where none of the elements was present, no program was successful.⁴⁷ Evaluation efforts in the sector have highlighted that the links between service activities, their intended target group, the issue they are intended to address and their anticipated outcomes are not always clear.⁴⁸

Vulnerable families have highly complex needs and often live in chaotic circumstances characterised by parental alcohol and drug misuse, parental mental health problems, and high levels of family conflict and violence.⁴⁹ Approaches to working with vulnerable families that are not evidence-based may not only be ineffective, but also harmful.⁵⁰

ASSUMPTION 6: GETTING THE MAINSTREAM SYSTEM 'RIGHT' WILL HAVE FLOW-ON EFFECTS FOR ABORIGINAL FAMILIES

Nationally, Aboriginal and Torres Strait Islander children (birth to 17 years) are seven times more likely to be the subject of a substantiated report of child maltreatment than other children. In South Australia, the figure is 10½ times.⁵¹ A statistical analysis of longitudinal child protection data relating to South Australian children born in 1991 showed that when compared to non-Aboriginal children, Aboriginal children were more likely to:

- be the subject of a child protection notification, investigation and substantiation (40 per cent of Aboriginal children receiving a notification had abuse substantiated compared to 24 per cent of non-Aboriginal children);
- be the subject of higher ranked (more serious) notifications of abuse;
- be notified for emotional abuse and neglect;
- have a first notification at a younger age;
- be notified on multiple occasions; and
- go on to experience an alternative care placement, adolescent at-risk intake, emergency financial assistance, or young offender order.⁵²

A comparative analysis of children born in 1991, 1998 and 2002 showed Aboriginal and non-Aboriginal children born in the later years were increasingly more likely to be notified.⁵³ The rate of notification for Aboriginal children appears to have increased at a faster rate than for non-Aboriginal children. The belief that if effort is applied in the mainstream system, the benefits will flow on for Aboriginal families, is not borne out by these observations. The consequences of inter-generational trauma remain unaddressed.

Table 2.2: Ten common themes of recommendations from major Australian child protection reports, 1999–2012

1	Accountability and transparency	• External review and monitoring of, as well as regular reporting by, government departments and non-government organisations
2	Community, child, youth and family involvement	• Involvement in policy and decision-making processes of services and programs (both as clients and as employees or consultants), as well as in service provision • Providing information to children about what is happening to them and giving them opportunities to contribute
3	Complaints handling	• Development, amendment and clarification of procedures for receiving, assessing and responding to complaints, including of child abuse in out-of-home care settings and juvenile detention
4	Funding and resources	• Additional funding or resources for specific services and programs, as well as the termination or merging of funds and other resources
5	Information systems	• Information, data and records collection and management
6	Inter-agency collaboration	• Inter-agency consultation, partnerships and information-sharing processes
7	Legislation change and policy making	• Amendments to expand the power or responsibility of departments or services, reflect suggested organisational changes, and improve services to children and young people and their families
8	Organisational reform	• Merger, separation and termination of various departments, services and specific programs. Includes appointing new positions at varying levels of management
9	Services and programs	• Provision, expansion and development of specific services and programs
10	Staffing and management	• Recruitment, professional development and training, clarity of responsibility and supervision/management chains • Workload assessments to determine staffing need

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2 THE PERSISTENCE OF THE CHILD PROTECTION PROBLEM

THE MEDIA'S ROLE IN PUBLIC PERCEPTIONS

The mainstream media plays a crucial role in shaping the public perception of child protection issues and in promoting changes to policies, practice and systems.⁵⁴ Media campaigns can shift both public and political attitudes by drawing attention to scandals, tragedies and system failures, and can be more influential in initiating policy reform than calls for change from child protection workers.⁵⁵

The fast-paced media environment, the need for newsworthy stories, a focus on politically oriented reporting, restricted publication space, and the non-cooperation of official child protection sources can result in child protection issues being sensationalised, distorted and incompletely reported by the media.⁵⁶ Hostile reporting and intense media scrutiny can generate a climate of fear, mistrust and blame in public attitudes towards child abuse, the effectiveness of child protection services, and the actions of individual child protection workers.⁵⁷

In reporting one particular child protection tragedy in England, individual social workers connected to the case were 'named and shamed' with calls from the media to have them 'sacked'.⁵⁸ This experience has parallels with recent experiences in South Australia concerning the reporting of high-profile inquests into child deaths. This approach has significant ramifications, not only for those individuals named, but also for overall staff morale, wellbeing, recruitment and retention. Media reporting can also skew public understanding of the nature and incidence of child maltreatment, including emotional abuse and neglect, due to its focus on criminal cases that involve physical abuse, sexual abuse or severe neglect.⁵⁹

The media has an important role to play in directing public attention towards system failures and reform. However, this attention often has the inadvertent consequence of adding to already overburdened services by arguing for narrowly conceived responses which result in increases in notification of children and applications for children to be placed in out-of-home care.⁶⁰ Experts in child protection need to have a more prominent voice in the current public discourse about child protection. While maintaining confidentiality in relation to particular cases will need to be the dominant consideration, there is no reason why staff from the statutory agency should not be authorised to attempt to improve the information base on which the current debate proceeds.

THE IMPACT OF EARLIER SOUTH AUSTRALIAN INQUIRIES

Four independent child protection inquiries have been undertaken in South Australia. They are:

- RA Layton, *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, 2003 (the Layton Review);
- EP Mullighan, *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct*, Children in State Care Commission of Inquiry, Adelaide, 2008 (the CISC Inquiry);
- EP Mullighan, *Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A report into sexual abuse*, Children on APY Lands Commission of Inquiry, Adelaide, 2008 (the APY Lands Inquiry); and
- BM Debelle, *Royal Commission 2012–2013: Report of Independent Education Inquiry, Independent Education Inquiry*, Adelaide, 2013 (the Debelle Inquiry).

This Commission asked the Australian Centre for Child Protection (ACCP) to review the implementation of recommendations from the four inquiries.⁶¹ The review identified that the intent of only the CISC and Debelle inquiries had been generally met. It was difficult to ascertain the status of many recommendations of the Layton Review. Many recommendations of the APY Lands Inquiry remained outstanding.

The overall intent of the CISC Inquiry was to ensure the safety and wellbeing of children in the care of the state, including those children who run away from their out-of-home care placement. Forty-two of the 54 recommendations were fully or partially implemented. Recommendations were broad ranging, from establishing advocacy positions for children in care to fast-tracking sexual abuse cases involving minors through the court systems. The ACCP found that the state government's response generally met the intent of many of the recommendations, but concerns were identified about how well it satisfied the intent in relation to others.

The overall intent of the DeBelle Inquiry was to ensure that allegations of sexual misconduct involving schoolchildren are identified, responded to and documented appropriately by school staff; that the Minister for Education and Child Development is kept informed; that support is provided to victims, their parents and other school members; and that schools are equipped to manage the complexities of informing the school community about such incidents. Thirty-seven of the 43 recommendations were wholly or partially implemented. The process of making recommendations was consultative, whereby round-table discussions with the relevant department and SA Police were held to ensure that recommendations were useful and practical. In response to the recommendations, the government implemented the *Managing allegations of sexual misconduct in SA education and care settings* policy in all schools, including non-government schools. Overall, the government's responses appeared to satisfy the intent of the recommendations.

The Layton Review made 206 recommendations. Their scope was broad and far-reaching, reflecting the review's vast terms of reference. The recommendations had a strong preventative focus and recognised the need for major reform. Accordingly, many had heavy resource implications, and were not actioned. The Government response to the Layton Review did, however, result in the introduction of key reform initiatives, including the establishment of the Guardian for Children and Young People, the expansion of the categories of individuals required to hold a working-with-children check, and the publication of *Information sharing: Guidelines for promoting the safety and wellbeing of children, young people and their families* in 2008 as part of the government's Keeping Them Safe child protection reform program. However, in its assessment of the Layton Review, the ACCP had difficulty locating reliable evidence of the implementation of other recommended reforms. Given this, and the fact that it has been 13 years since the Layton Review was published, it was not possible to determine whether the intent of the review's recommendations was met.

The primary intent of the APY Lands Inquiry was to address the issue of child sexual abuse on the APY Lands. The 46 recommendations ranged from mandatory reporting and policing reform to service provision and community education. The ACCP review found that government responses either missed the intent of the recommendation or did not achieve the desired outcome. Further, a number of responses that are listed as complete involve ongoing or outstanding items, particularly where services or policies were due for review. The Anangu Lands Paper Tracker, a Uniting Communities' project launched in 2007 to monitor government commitments to Anangu people, highlights concerns regarding the monitoring of both child protection issues on the APY Lands and the inquiry's

outstanding recommendations. The lack of funding for continued reform stymied implementation of a number of recommendations.

MAKING GOOD RECOMMENDATIONS

In addressing its terms of reference, the Commission has sought to better understand why some past recommendations for reform of the child protection system in South Australia have not been implemented.

While there has been wide-scale *acceptance* in principle of a large number of past recommendations, in many cases it is difficult to identify whether the recommendation has been implemented in a way that is true to its intent.

Recent research into the impact of inquiries into child protection issues provides an insight into the factors that influence the extent to which their recommendations find traction.

A review of recommendations of five reports concerning child protection failings in Ireland identified several key factors that influence reform and the implementation of recommendations.⁶² These include:

- policy fit;
- political and professional 'buy in';
- resources and funding;
- attitude towards, or resistance to, change;
- congruence with current social and cultural norms;
- degree of consultation between the inquiry team and policy makers;
- 'ownership' over the recommendations;
- clarity—vague or aspirational recommendations are difficult to address; and
- repetition of inquiry recommendations.

Recommendations involving management, inter-agency information sharing using central registers, and disciplines that lie beyond the child protection system's realm of influence were repeatedly made, but implementation fell short.

Buckley and O'Nolan propose a collaborative approach to developing recommendations, as an alternative to today's reactive approach.⁶³ They say recommendations should be non-prescriptive, supported by a base of evidence, promote learning, and clearly state desired outcomes. Further, recommendations should include an explanation of how the outcomes can be attained and who is responsible for implementation.

2 THE PERSISTENCE OF THE CHILD PROTECTION PROBLEM

Munro emphasises, in reference to the recommendations in her final report, that: 'The recommendations are to be considered together' and cautions strongly 'against cherry picking some of the reforms to implement'.⁶⁴

A recent report produced by the Parenting Research Centre (PRC) for the Royal Commission into Institutional Responses to Child Sexual Abuse, which researched previous Australian child protection inquiries and interviewed 44 current public servants and 43 key stakeholders, identified a number of factors that help to facilitate the implementation of recommendations.⁶⁵ These include:

- processes and structures to facilitate implementation;
- strong leadership and stakeholder engagement;
- an accountability framework and monitoring process;
- consultation with stakeholders before recommendations are handed down, and articulation of the 'vision' of the reforms to gain support;
- development of recommendations that focus on outcomes and are evidence based, realistic, feasible and tailored to different jurisdictions and agencies; and
- the consideration of resourcing implications.

In her review of the United Kingdom child protection system, Professor Munro emphasised the pitfalls of relying on procedural and administrative reforms to address the shortcomings of the system. As highlighted earlier, this not only increases the administrative and supervisory burden on workers in child protection services, but also diverts the focus from vulnerable children and families involved with these services.

Munro reported that in this situation workers become more focused on adhering to procedure and protocol—even if they do not understand the underlying reasons why—than on improving outcomes for vulnerable children and families. For example, workers often have to complete forms before a child or family becomes eligible for services, which diverts workers from immediately addressing their urgent or obvious needs.

Focusing on prescriptive processes also promotes passive compliance and stifles the development of expertise and professional growth.⁶⁶ Guidelines cannot fully encompass the variety of possible scenarios that can occur in the child protection arena, and attempts to make guidelines do so have led to large, cumbersome manuals that are harder for workers to apply in their daily practice.

Munro argued that the overall effect of emphasising prescriptive practice is greater system malfunction through the perpetual cycle of job dissatisfaction, high turnover and heavy workloads referred to earlier in this chapter. However, it is important to emphasise that Munro warned against reducing prescriptive practice without also creating a learning system and supporting professional development:

*Reducing prescription without creating a learning system will not secure the desired improvements in the system. On the other hand, delaying the reduction of prescription until services show they can take responsibility prevents them from demonstrating it.*⁶⁷

The ACCP analysis of the South Australian inquiries also provided an important insight into the factors that make recommendations 'stick'. It found that the way recommendations are conceived and framed will assist those charged with implementation to capture the intent without having to slavishly adhere to recommendations that do not prove to be meritorious in practice. The following factors emerged as important considerations:

- The more targeted the inquiry (for example, the DeBelle Inquiry), the more likely that recommendations would be implemented.
- The broader the terms of reference, the less likely that all recommendations would be implemented.
- Reform efforts directed at the government department that is responsible for implementing them often focus on managing, rather than on meeting, demand (that is, meeting the needs of children and families).
- Recommendations are more likely to be implemented where some form of accountability framework and monitoring process is in place.

THE DANGERS OF PIECEMEAL, REACTIVE REFORM

The interconnectedness and complexities of child protection policy and service systems create complex or wicked problems that are difficult to solve, particularly when their resolution is left to one component of the system.⁶⁸

As highlighted earlier, rational policy-making approaches cannot solve intractable problems. Piecemeal attempts at reform, particularly when driven by public discourse and media criticism or following an emotional response to inquiries into system failures, are bound to fail. At worst, such reforms have unintended consequences for the system itself, for those working in it, and for the families with whom they work.⁶⁹

Attempts to address intractable problems should instead aim to achieve sustained behavioural change through collaboration as a response to social complexity.⁷⁰ An Australian Government discussion paper on wicked problems from a public policy perspective suggested that tackling such problems requires⁷¹:

- holistic, not partial or linear, thinking;
- innovative and flexible approaches;
- an ability to work across agency boundaries;
- an increase in understanding and applying the accountability framework;
- effective engagement of stakeholders, including the public, to help them understand the problem and identify possible solutions;
- skills including communication and big-picture thinking, and the ability to work cooperatively with, and influence, others;
- a better understanding of behavioural change by policy makers;
- a comprehensive focus and strategy;
- tolerance of uncertainty; and
- acceptance of the need for a long-term focus.

With these challenges in mind, the Commission has attempted to make recommendations that will address system changes in a cohesive way. Where possible, the Commission has avoided making recommendations that would increase the administrative burden and create an over-prescriptive practice. Doing these things will not improve the quality of professional practice in child protection. Rather, sustainable improvement will be achieved by supporting the development of the professional staff who are charged with performing this important work.

Similarly, in expressing recommendations the Commission has attempted to precisely identify the issue and what is currently the best way to address it. There will be occasions in the implementation of these reforms when an alternative approach to the problem is identified. Some reforms may not have the desired impact. As noted in this chapter, reform of complex problems requires a degree of tolerance of uncertainty. It is critical that those charged with the implementation of these important reforms are empowered to deliver the reform program flexibly, with an understanding that if a proper evidence-based review suggests that the reforms are not achieving the desired result, they are adjusted.

The recommendations in this report should be seen as the starting point of this important reform process. The implementation of the recommendations and the evaluation of strategies as implementation proceeds are critical parts of transforming the system to one based on best evidence and ongoing evaluation.

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3

HOW ABUSE AND NEGLECT AFFECT CHILDREN

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3 HOW ABUSE AND NEGLECT AFFECT CHILDREN

OVERVIEW

The Terms of Reference require the Commission to review the adequacy of the state's child protection system in protecting children at risk of harm. Historically, harm has been narrowly interpreted as physical harm resulting from abuse. As our understanding of what children need to grow and flourish develops, so too does our understanding of what harms children. Therefore the Commission has taken a broad view of what risk of harm means, which includes threats to children's physical, developmental, emotional and psychological safety.¹

A good childhood is one in which children have their physical, developmental, emotional and psychological needs met, and their care environment and experiences do not significantly compromise their ability to achieve their life potential. A good childhood provides a child with the developmental foundation for physical, mental and economic wellbeing as adults. Securing good childhoods therefore improves the collective prospects of the next generation.

The strongest level of influence on a child's development is the family environment, which includes extended family and other carers. Where families are able to do so, the state should allow them to determine how optimal growth and development of a child is best achieved.

However, when this proves difficult, supporting a family to parent well rather than removing the child from that family is morally and economically responsible social policy. Identifying families who cannot provide good enough parenting, even with support, is also a critical part of the state's responsibilities. Where families show themselves incapable of providing the environment necessary to secure their children's safe development, it is the task of the child protection system to intervene in an efficient, proportionate and well-aimed way.

This chapter considers the range of environments, both inside and outside the family, which can influence a child's development.

Consideration of reforms to improve outcomes for children at risk must include the social conditions that exist beyond a child's immediate family. Protecting children at risk of harm cannot be achieved by focusing entirely on a child's immediate family environment as the source of beneficial and/or detrimental experiences. Just as improvements in family conditions can affect a child's care, improvement in other spheres of influence—such as local neighbourhoods, early childhood programs, childcare, schools and other key health, welfare and housing services—can assist to keep children safe.² Research has shown that conditions outside a child's family can contribute to resilience, which might strengthen a child's capacity to flourish in less than ideal family conditions.

If society intervenes early enough, outcomes for disadvantaged children can be improved. Such interventions are estimated to have high benefit-cost ratios and rates of return. The longer society waits to intervene in the life of a disadvantaged child, the more costly it is to remediate the effects of that disadvantage.

Critically, any intervention must be accomplished with the child's right to a good childhood—the satisfaction of their social, emotional, psychological and developmental needs—kept firmly at the centre of decision-making. The starting point for any reform effort in the child protection system must be what *children* need, not what the system needs.

The matters discussed in this chapter as to what supports children to become healthy adults and the circumstances that threaten their growth and development have informed the Commission's consideration of what reforms are necessary to improve the South Australian child protection system.

Much of this chapter draws on a report prepared for the Commission by Dr Diana Hetzel, a member of the Commission's Expert Advisory Panel.³

INFLUENCES ON CHILD DEVELOPMENT

At the most fundamental level, child development is the result of the interplay between a child's environment, and characteristics such as their genes, gender and temperament, both before and after birth.

Before birth, biological and physical factors influence the developing foetus. Maternal nutrition, smoking, illicit drugs, infections such as bacteria and viruses, and exposure to toxic stress and violence all affect the development of different areas of the brain at different stages of pregnancy.⁴ Alcohol consumption during pregnancy can have an insidious impact on the developing foetus, and pre-natal alcohol exposure can affect children even when the specific features of foetal alcohol syndrome are not present.⁵

Infancy and childhood are particularly important and sensitive periods in brain development. Permanent, large-scale changes in brain circuitry are produced through particular sensory experiences during this time.⁶ These 'sensitive periods' follow the same chronology for all human beings. The first two years of life, in particular, are likely to be critical to the development of capacity for attention, perception, memory, motor control and the modulation of emotion.⁷ At this stage, the qualities of a child's immediate environment (most often their parents and wider family) have the most significant impact on their development.⁸

New but increasingly coherent evidence⁹ traces chronic disease, behavioural problems and lasting afflictions of adulthood to experiences of adversity, maltreatment and stress in the early years of life, and highlights the resilience of individuals despite such experiences.¹⁰

PARENT-CHILD ATTACHMENT

Researchers since the 1950s have been aware of the developmental significance of the parent-child attachment relationship. Attachment refers to the selective relationship that infants develop towards their primary caregiver between about six months and four years of age.¹¹ It is thought the drive to develop an attachment relationship is an inbuilt and genetically determined motivation which carries a survival advantage for the infant insofar as it ensures the infant remains close to adults.

Attachment is thought to influence four principal areas of child development: physical, social and emotional development; pro-social attitudes and positive relationships; concept of self; and ability to take risks, accept challenges and cope with failure.

Several aspects of caregiver behaviour affect the quality of the developing attachment relationship. Accessibility and responsiveness describe the extent to which a caregiver is available, physically and emotionally, and the extent to which the caregiver is able to understand and respond to the child's needs. Children who consistently have their physical and emotional needs met will feel secure as to future needs and safer about exploring and experiencing their world. A child whose needs have been inconsistently met and whose caregiver has been inconsistently responsive may 'remain pre-occupied with needs provision and this leaves an indelible mark on their behavior and adjustment'.¹² For example, children who have experienced inconsistency in having their needs met may go on to have long-term issues with hoarding and stealing food, long after they are removed to an environment where food is plentiful and their needs are consistently met.

The role of attachment can be described in the following terms:

Although infants become attached to their caregivers whether or not those caregivers are sensitive and responsive, attachment thrives especially on predictable, sensitive, attuned communication in which a parent shows interest in, and aligns states of mind with those of a child ... Early attachment experiences directly affect the development of the brain ... Human connections create neuronal connections ... Caregivers are the architects of the way in which experience influences the unfolding of genetically pre-programmed but experience-dependent brain development ... These salient emotional relationships

*have a direct effect on the development of the domains of mental functioning that serve as our conceptual anchor points: memory, narrative, emotion, representations and states of mind. In this way, attachment relationships may serve to create the central foundation from which the mind develops.*¹³

ATTACHMENT, STRESS AND ADVERSITY

Learning how to cope with adversity is an important part of healthy child development. When a child's stress response systems are activated in an environment of supportive relationships with adults, these physiological effects are buffered and brought back to baseline. The result is the development of a healthy stress response.

How this occurs in the context of healthy attachment relationships can be explained as follows:

Normal development, expressed in play and exploratory activity in children, requires the presence of a familiar attachment figure or figures, who modulate their physiological arousal by providing a balance between soothing and stimulation. The heart rate curves of mothers and infants parallel each other during interactions. This capacity of the caregiver to modulate physiological arousal reinforces the child's attachment to her, and allows a smooth alternation between activities, that increase and reduce arousal as they go back and forth between exploring the environment and returning to their caregiver.

The response of the caregiver not only protects the child from the effects of stressful situations by providing soothing where appropriate, it also enables the child to develop the biological framework for dealing with future stress. In this process, the caregiver plays the critical role. The caregiver is the leader of the child, helping the child to know their own feeling states by giving words to their experience (oh, you look tired, what a beautiful smile, you look so happy, you're really upset now), helping the child to regulate their physical bodies and to know physical boundaries by holding, touching, playing with and comforting them. Without these early experiences, children grow up not recognising or understanding their emotional and physical states and consequently not able to make good decisions and judgements, not able to manage strong emotions and lacking trust in the world.

*Another important thing a secure infancy gives a child is the capacity to cope with stressful or traumatic events. If we have been well cared for, we will have responses to stress and trauma but we will recover more quickly than those who had neglectful or harsh early parenting. Those children who had a caring, attentive caregiver were more likely to be comforted when something painful or scary happened, than those who did not.*¹⁴

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If the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened stress systems and brain architecture, with lifelong repercussions.¹⁵

Three different responses to stress are recognised: positive, tolerable and toxic. These terms refer to the effect that the stress response system has on the body in each type of response:

- Positive stress response is a normal and essential part of healthy development, characterised by brief increases in heart rate and mild elevations in hormone levels.
- Tolerable stress response activates the body's alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.
- Toxic stress response can occur with strong, frequent and/or prolonged adversity without adequate adult support. Adversity may include ongoing physical or emotional abuse, chronic neglect, caregiver substance use or mental illness, exposure to trauma and violence, and/or the accumulated burdens of family economic hardship. This prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk of stress-related disease and cognitive impairment, well into the adult years.

When toxic stress response occurs continually or is triggered by multiple sources it can take a cumulative and lifelong toll on an individual's physical and mental health.

FAMILY

To become productive and competent adults, children need to live in environments that provide order and meet their developmental requirements, as well as their physical, learning, emotional and material needs.¹⁶

A family's social resources will dictate the extent to which it is able to provide this environment. Family resources include parenting skills and education, cultural practices and approaches to child-rearing, physical and mental health, and the nature of intra-familial relationships. It is possible in many cases to improve a family's resources by providing appropriate support and services.

Families are also responsible for controlling a child's exposure to the wider community and protecting a child from negative influences. Children who thrive in spite of adversity often do so because of the influence of a consistent, caring adult who engages the child in an ongoing relationship.¹⁷ Children also require adults

in their immediate environment who instil a positive sense of responsibility and pass on social and moral expectations.¹⁸

There is an association between socioeconomic status and outcomes across an individual's lifespan. Family socioeconomic status is also associated with other developmental outcomes for children, such as low birth weight, risk of child abuse and neglect and family violence, poorer cognitive test scores, risk of disengagement from school, difficulties with behaviour and socialisation, and adult education attainment, health and employment.¹⁹ Inadequate economic resources in a family can also increase family stress, affecting its capacity to maintain the supportive environment that is necessary for child development.²⁰ Improvements in basic aspects of a family's economic status can therefore improve the quality of care available in that family.

RELATIONAL COMMUNITIES

Children's development is shaped by the nature of the relational communities which surround their families.²¹ Relational communities are a primary support for many families and are often the source of information about child-rearing practices and child development.²² These communities influence how children identify themselves and others, help build self-worth and a sense of belonging, and can be a source of social inclusion.

Relational communities that occur naturally for families who are socially well-connected can be devised for socially isolated families through the delivery of appropriate services.

Programs that improve social connectedness, provide parent education and enrichment, and child care can replicate for socially isolated families the support available in naturally occurring networks.²³

Early child development programs are an effective way to address inequalities in learning and development.²⁴ There is good evidence that investment in effective programs that enhance all aspects of children's development can reap benefits many times over for children, families and communities, if the children start the programs early and continue throughout childhood.²⁵ The quality of these programs and services is critical to achieving good developmental outcomes, especially for children from disadvantaged families.²⁶

Early childhood education and quality childcare can also enhance children's development. It is important that children in vulnerable families with few economic resources are not denied access to these important opportunities.²⁷

CHILDREN’S DEVELOPMENT: RISKS, PROTECTIVE FACTORS, AND RESILIENCE

RISKS AND PROTECTIVE FACTORS

A child’s developmental outcomes will be the result of multiple influences, and the interplay of risk factors, protective factors and individual responses to those factors will be determined differently for each child. This is evident in the number of children who manage to flourish despite adversity.

Protective factors are those influences, characteristics, and conditions that buffer or mitigate a person’s exposure to risk. They are individual characteristics and environmental conditions which interact with specific risk factors present in either the child or the child’s environment.²⁸

Until recently, the main approach to understanding childhood vulnerability was to study how specific risk and protective factors in individuals and populations were associated with undesirable life outcomes. This approach failed to recognise the complexity of child development and the joint interaction of genes, biology and environment.²⁹ It also implied that outcomes generally were explicable as the balance between risk and protective factors. That suggests that protective factors can be identified on the basis of their nature, rather than their effects. In many circumstances that may be true, but protection also comes from risk experiences that lead to successful coping. The approach also assumes that most individuals will respond to stress and adversity in much the same way and to the same degree. However, that is not the case.³⁰

Research indicates that the presence of co-occurring risk factors (sometimes referred to as ‘cumulative’ risk) rather than a single risk factor affects negative outcomes. The greater the number of risk factors the greater the prevalence of clinical problems.³¹ Timing also seems important, with the number of risks in early childhood predicting an increase in behaviour problems.³² Other research suggests that the impact of abuse and neglect on children’s wellbeing may be greater during critical periods of early brain development.³³

The cumulative impact of protective factors is as important as the cumulative impact of risk factors. With an increasing number of protective factors, there is likely to be an increase in positive outcomes.³⁴

QUALITY PARENTING

One of the most important influences on whether a child flourishes is the quality of parenting they receive. Our current state of knowledge has brought us nearer to agreeing where parenting is clearly competent and children are thriving; and where it is undoubtedly dysfunctional and there is evidence of abuse or neglect. Parenting behaviours and practices identified

from research are listed in Table 3.1, and different combinations of these make up an adult’s parenting style.³⁵

Table 3.1: Characteristics of ‘good’ and ‘poor’ parenting

GOOD PARENTING	POOR PARENTING
Realistic expectations of the child	Unrealistic expectations of the child
Providing a secure environment, attentive to the child	Inability to provide security or continuity of care
Good supervision	Poor supervision/intrusion
Attachment and bonding	Lack of bonding and attachment
Maturity	Inexperience/ ignorance
Affection	Conditional affection
Flexible control	Cruel control
Acceptance	Rejection
Positive affectivity	Negative affectivity
Warmth and positive regard	Low warmth, provocation and high criticism
Consistent, predictable, appropriate and non-harsh discipline and limit-setting	Unpredictability, harmful or cruel discipline, laxity and inconsistency
Absence of violence in the family	Violence in the family
Meets the child’s physical, emotional and developmental needs	Unable/unwilling to meet the child’s physical, emotional and developmental needs
Child centred	Lack of empathy for child
Absence of hostility and aggression	Hostility and aggression
Behaviours/activities that promote health, learning or development	Behaviours/activities that impair health, learning or development
Teaching by example	Exposure to inappropriate role models
Engaged with child’s education	Not engaged with child’s education

Source: J Taylor, N Spencer & N Baldwin, ‘Social, economic and political context of parenting’, *Archives of Disease in Childhood* 82, no. 2, 2000, pp. 113–120; M Hoghughi & A Speight, ‘Good enough parenting for all children: A strategy for a healthier society’, *Archives of Disease in Childhood* 78, no. 4, 1998, pp. 293–296; VC McLoyd, ‘Socioeconomic disadvantage and child development’, *American Psychologist* 53, no. 2, 1998, pp. 185–204.

3 HOW ABUSE AND NEGLECT AFFECT CHILDREN

However, there are many circumstances where parenting cannot be easily defined as 'good' or 'bad', or where there are complicating factors, for example, a parent with intellectual and learning difficulties, or a child with complex needs. Although individual parenting attributes are important contributors to child wellbeing, the broader social, economic and political contexts of children's and their families' lives are also powerful influences on parenting quality.³⁶ Parents who experience significant social and economic hardship, such as poverty, family violence, homelessness, war and dislocation, face challenges that make parenting a far more difficult task.

RESILIENCE: WHEN A CHILD PREVAILS OVER ADVERSITY

Resilience refers to an individual's capacity to adapt successfully to change and to manage stressful events in healthy and constructive ways.³⁷ It is a dynamic process involving an interaction between both risk and protective processes that act to modify the effects of adverse life events.³⁸

Complex interactions of child resources and family and community supports are likely to be the best predictors of resilience.

Resilience can be strengthened by encouraging positive environments in families, schools and communities to counteract risks in children's lives

Resilience can be strengthened by encouraging positive environments in families, schools and communities to counteract risks in children's lives. Of these three environments, the family as the immediate care-giving environment has the greatest impact on the development of resilience in children.³⁹ However, there is evidence from Australian and international studies that the level of neighbourhood advantage and disadvantage is also strongly associated with children's behaviour and development.⁴⁰ Strengthening protection in communities and neighbourhoods may therefore provide a buffer for the risks experienced by some children.⁴¹ This observation highlights the opportunities to improve outcomes by improving social conditions more broadly.

CHILDREN'S VIEWS OF WHAT MAKES A GOOD CHILDHOOD

Internationally, researchers have recognised the importance of listening to what children tell us is important to their wellbeing. From 2006 to 2008, the UK Children's Society conducted *The Good Childhood Inquiry*, which included a survey of more than 18,000 children and young people for their views as experts in childhood in the 21st century.⁴²

Seven significant elements emerged from this survey of what children need to flourish. They need⁴³:

- loving families, where they observe and experience love, and thus learn how to love others. They also need boundaries to be set by parents and carers who are firm but not dictatorial;
- friends, as they begin to explore relationships outside the family. From developing their friendships, they learn many of the basic lessons of living;
- a positive lifestyle, in which they develop interests which satisfy them and avoid the enticements of excessive commercialism and unhealthy living;
- solid values, which give meaning to life and are acquired from parents, schools, media, political and faith organisations;
- good schools, where they can acquire both values and competence;
- good mental health, and help with any difficulties; and
- enough money to live among their peers without shame.

In an Australian project, researchers worked with 126 children (aged 8–15 years) in rural and urban locations to develop indicators of wellbeing from the children's perspectives.⁴⁴ The study concluded that the three overriding concepts of wellbeing were: a positive sense of self, security, and agency. Emotional and relational wellbeing were integral to these concepts.⁴⁵

WHAT THREATENS A GOOD CHILDHOOD

ABUSE AND NEGLECT

The overwhelming majority of abuse and neglect of children is committed by parents and caregivers. Of all the categories of abuse and neglect, child sexual abuse is the only category more likely to have been committed by a perpetrator who is other than a caregiver.⁴⁶ By definition, neglect can be committed only by a person obliged to provide a child with appropriate care. In those circumstances, it is not surprising that biological parents are responsible for the majority of neglect and, of those parents, mothers are responsible for neglect more often than fathers.⁴⁷

This observation does not reflect a higher risk of neglect by a mother over a father, but rather reflects the social reality that mothers are more likely to be engaged as a child's primary caregiver and placed in a position where they are obliged to provide appropriate care.⁴⁸ The limited research available suggests that emotional abuse originates mainly from caregivers, approximately evenly spread between male and female carers.⁴⁹

What must be borne in mind is that most families want to do a good job of parenting their children. However, poverty, social isolation and deprivation, drug and alcohol abuse, family violence, mental illness, and psychological or intellectual deficits can all challenge parents' determination to do the best for their children.

THE PREVALENCE OF CHILD MALTREATMENT

At what point child maltreatment becomes severe enough to pose a threat to the safety and healthy development of children is difficult to identify with precision. What is damaging to wellbeing is different for every child and depends on the interplay of individual risk and protective factors, together with a child's unique capacity to respond to those factors.

Commonly identified categories are used to describe behaviours which have the potential to harm children. They are broadly divided into conduct of omission (neglect and emotional neglect) and commission (physical abuse, sexual abuse, some forms of emotional abuse). Increasingly, researchers and commentators include witnessing family violence as a child maltreatment category warranting separate attention.

The rate of abuse in the population is measured and tracked in different ways. There is no nationwide rigorous study which measures the prevalence of child abuse and neglect. Measurement of prevalence relies on several smaller-scale studies which have reached varying conclusions or assessments from proxy measures such as child protection notifications. Some differences in prevalence rates reported in these studies can be traced to variation in study design, definitional differences associated with each type of abuse, and the manner and frequency with which questions seeking a response about certain kinds of abuse are asked.⁵⁰

Professor Fiona Arney, Director of the Australian Centre for Child Protection, told the Commission that:

*If anyone ever asked me ... [the] question, 'Is abuse and neglect getting worse?', I have no answer for that. Are we detecting more? I have no answer for that, simply because we have no prevalence rates. We do not know the level of child abuse and neglect that's happening in our community.*⁵¹

Professor Arney said proxy measures of prevalence such as child protection system notification or substantiation rates should be viewed cautiously because of what is known about the underreporting of child abuse and neglect.⁵²

The fact that abuse types are separately defined and counted for statistical purposes should not be misunderstood as indicating that each type occurs in isolation. Many maltreated children experience multiple types of abuse or neglect across their lifespan. In addition, many acts of maltreatment can be counted in more than one category, depending on the way in which they are described.

For example, a caregiver who engages in excessive physical discipline might at the same time use insulting and belittling words to the child. In the long term the emotional damage of the insults may be more pervasive than the physical harm. Is such an event properly characterised as physical abuse or emotional abuse? If a caregiver sexually assaults a child, but at the same time uses physical force, is that physical or sexual abuse? What of the gross breach of trust that is inherent in that act, and associated emotional damage? Is the act also emotional abuse? The approach taken to the behaviour by the person coding the notification often therefore will influence the approach to assessment and, subsequently, how the notification is counted.

Noting these limitations, the smaller-scale prevalence studies have been relied on to estimate nationwide prevalence rates and these figures are quoted in this chapter. The rates in general relate to at least one occurrence of the abuse or neglect type during an individual's childhood.

Physical abuse is commonly defined as the infliction of a physical injury (whether an injury was intended or not) by punching, kicking, beating, burning or otherwise harming the child. The injury may result from excessive discipline, or discipline that is inappropriate to a child's age and development (for example, shaking an infant). Examination of data across a number of studies has estimated the prevalence of physical abuse of children in the general population at approximately five per cent.⁵³

Sexual abuse encompasses a wide range of conduct. Some behaviour is easily defined as sexual abuse, for example, sexual activity of any kind with a young child. However, there may be disagreement about other behaviour. For example, consensual sexual activity between a 19 year old and a 15 year old might attract the attention of the criminal law in this state, but people might not agree that it constitutes child abuse. Circumstances such as the parties' respective ages, the existence of a familial relationship and an unequal power relationship would be relevant to whether consensual sexual activity amounted to child abuse.

3 HOW ABUSE AND NEGLECT AFFECT CHILDREN

Determining prevalence rates for sexual abuse is complicated by very low disclosure rates and factors (which are becoming increasingly well recognised) that prevent victims from disclosing their abuse, sometimes until many years after they have grown to adulthood. Australian studies suggest a prevalence rate for penetrative abuse of 4–8 per cent for male children and 7–12 per cent for female; and for non-penetrative abuse of 12–16 per cent for male children and 23–36 per cent for female.⁵⁴

Emotional (or psychological) abuse includes emotional neglect. Issues arise in assessing whether some neglectful behaviours fall within emotional abuse or neglect categories for statistical purposes. Some research includes exposure to family violence in this category. The following behaviours are typically defined as emotional abuse:

- rejection, refusal to show affection, and behaviour which suggests child abandonment;
- isolation and preventing the child from participating in normal opportunities for social interaction;
- threatening severe or sinister punishment, or deliberately creating a climate of fear or threat;
- ignoring a child, being psychologically unavailable to the child and not responding to their behaviour; and
- corrupting behaviour that encourages a child to adopt false social values and reinforces deviant or antisocial behaviour such as aggression, criminality or substance abuse.

The prevalence of emotional abuse is estimated at about 11 per cent of the population.⁵⁵ National data collected by the Australian Institute of Health and Welfare shows that emotional abuse is the most commonly substantiated form of child maltreatment in Australia (43 percent of substantiations in 2014/2015).⁵⁶ The inclusion of reports that relate to children witnessing family violence and a growing awareness of the impact of this type of environment on children are likely to be contributing to this high level of substantiations.

Children who experience chronic stress associated with ongoing domestic violence can suffer the effects of toxic stress discussed earlier. Some research estimates the co-occurrence rate of domestic violence and other forms of child abuse and neglect as between 40 and 80 per cent⁵⁷, highlighting the need for child protection authorities to look beyond the immediate physical safety concerns associated with children being present during violent episodes, and to closely examine the child's lived experience.

Neglect refers to a failure by a parent or caregiver to provide the conditions which are culturally accepted as being essential for a child's physical and emotional

development and wellbeing. The following subcategories describe the range of behaviours which may be considered in this category:

- failure to provide basic physical necessities such as housing, food, healthcare, clean and adequate clothing;
- lack of caregiver warmth, nurturing, encouragement and support;
- failure to provide appropriate educational opportunities; and
- failure to provide a safe environment (including supervisory neglect).

One of the challenges of identifying the prevalence of child neglect is that neglect inevitably exists on a continuum (from meeting all a child's needs to meeting none), and it is difficult to determine the point at which the standard of care crosses over to being unacceptable.⁵⁸ A related difficulty is that social and cultural groups have differing ideas as to what constitutes acceptable parenting behaviour. For example, in some cultures it is considered acceptable to leave younger siblings in the care of children as young as eight without an adult caregiver, while in others that would be considered supervisory neglect.⁵⁹ The best available evidence estimates neglect prevalence at approximately 12 per cent of the population. However, more research is needed.⁶⁰

These prevalence figures create a somewhat alarming view of high levels of substandard care experienced by children in Australia. However, not every incident of neglect or emotional, physical or sexual abuse will necessarily require a response from a child protection service. Many people can identify incidents in their childhood that constituted abuse or neglect, yet they regard their childhood as having been good overall. The response to abuse or neglect would depend on its severity, persistence and impact on the child. The occurrence of an incident or circumstances that might be defined as abuse or neglect does not mean that the child's safety is necessarily compromised on an ongoing basis. Prevalence rates highlight the pervasiveness of the problem of child maltreatment, but they do not equate to an estimate of the numbers of children who require a child protection response.

The maltreatment might be isolated, unlikely to recur and have no lasting impact on the child's wellbeing. In many cases, a protective and competent caregiver will recognise the abusive nature of the behaviour and take steps to protect the child. In these cases no state response would be required. However, a child protection system response is required when the child's caregivers are incapable of providing the protection that the child needs, and there is evidence that the maltreatment is affecting the child's wellbeing.

THE IMPACT OF CHILD ABUSE AND NEGLECT

Maltreatment can affect all areas of a child's development. Infants and babies who are maltreated or who are deprived of the opportunity to develop healthy attachment relationships with a consistent caregiver are at risk of developing insecure or disorganised attachment patterns. Where the caregiver, who should be a consistent source of safety, comfort and protection, instead becomes the source of danger and harm, the capacity of a child to develop the ability to communicate, interact and maintain healthy relationships with others is compromised. These issues can persist and develop into adult psychological difficulties.⁶¹

Children can also suffer lifelong effects from chronic low-level maltreatment. Research has shown that this can lead to poorer outcomes for children than abuse that is restricted to transitory or isolated incidents of maltreatment.⁶² Children who are victims of more than one type of maltreatment also suffer poorer outcomes.

'Complex trauma' describes the range of cognitive, affective and behavioural outcomes that arise from experiencing trauma.⁶³ A characteristic of complex trauma is a disturbed ability to relate to others and form healthy relationships.⁶⁴ Sufferers often have difficulties with emotional regulation and an impaired sense of self and of wellbeing.⁶⁵

Cumulative harm is used to describe outcomes from child maltreatment that occurs over a period of time, often across different developmental periods. Chronic trauma and maltreatment that persist over time increase the risk of a range of adverse outcomes, such as⁶⁶:

- disturbed patterns of attachment;
- difficulty in controlling the emotional state;
- rapid behavioural regression and shifts in emotional states;
- loss of autonomous striving (independent actions);
- aggression towards self and others;
- anticipation and expectation of trauma;
- lack of awareness of danger and self-endangering behaviour; and
- self-hatred, self-blame, and chronic feelings of ineffectiveness.

Developmental impacts of childhood trauma have been found to include⁶⁷:

- memory and attention disturbance; dissociation, sleep disturbance and trauma re-experiencing;
- difficulties with interpersonal relationships;
- changes in systems of meaning, leading to feelings of despair and hopelessness, loss of beliefs that were previously sustaining, suicidal thinking, and risk taking, including risky sexual behaviour;
- alterations of perception and distorted thinking about their abuser and themselves;
- disturbances of information processing;
- physical symptoms related to the digestive system, chronic pain and cardiopulmonary symptoms; and
- anxiety and personality disorders.

Long-term harm to a child is more likely to result from a chronically abusive environment and the emotional impact of abuse, than from physical injury. The personal experience of the child, how they perceive the abuse, and the meaning they attribute to it is more determinative of the degree of psychological harm than the force used or the degree of injury caused.⁶⁸

These findings underscore the importance of understanding the child's cumulative experience of their caregiving environment, as well as the objective seriousness of the caregiver's acts or omissions when determining what, if any, child protection response is required.

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NOTES

- 1 The *Children's Protection Act 1993* (SA), s. 6, defines abuse and neglect to include physical, sexual or emotional abuse of a child. The definition also refers to the infliction of a physical or psychological injury detrimental to a child's wellbeing, or where a child's physical or psychological development is in jeopardy. The test for statutory intervention is necessarily higher than the test for harm which might justify some other kind of voluntary assistance or family support.
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OVERVIEW

Child protection policy and practice are influenced by a number of forces at a national and international level. The child protection system must not only operate in accordance with local conditions, but also have regard to national and international obligations and research, child protection systems in other states and the political priorities of the governments of the day.

There is a strong movement towards closer relationships between Australian child protection jurisdictions, and the current pressure at a national level towards standardisation of systems across state boundaries is likely to continue. South Australia's child protection system must be structured and positioned to enable it to flexibly respond to these various—and sometimes competing—influences on its operations.

This chapter sets out some of the major influences that should guide any reform of the system. It principally relates to the Commission's Terms of Reference 5(a) to 5(h), in the context of Terms of Reference 2 and 3.

INTERNATIONAL INFLUENCES

Australia is a signatory to several international conventions that influence the protection of children. While international conventions are not binding in domestic law, by ratification Australia is obliged to recognise the human rights conveyed. Recognition of these international obligations must find expression in both strategic direction and law and policy reform.

The United Nations Convention on the Rights of the Child¹ applies to all children and catalogues their human rights, including the right to education, an adequate standard of living and health care.² Of specific application in the child protection system are the rights guaranteed in the following articles of the convention:

- Article 3—that the best interests of the child are the primary consideration in actions concerning children;
- Article 9—that a child should not be separated from its parents against their will, except in prescribed circumstances with judicial oversight;
- Article 18—that the state render appropriate assistance to parents and legal guardians in their performance of their child-rearing responsibilities;
- Article 19—that the state ensure that children are protected from maltreatment and abuse;
- Article 20—that a child deprived of his or her home environment in their best interests will be entitled to special protection and assistance provided by the state; and
- Article 34—that children should be protected from sexual abuse.

Specific reference to children with disabilities and Aboriginal and Torres Strait Islander children is found in the UN Convention on the Rights of Persons with Disabilities³ and the UN Declaration on the Rights of Indigenous Persons⁴ respectively. It is important that specific regard is had to these conventions in light of the over-representation of children with disabilities and Aboriginal and Torres Strait Islander children in the child protection system.

Both the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities require Australia to report regularly to the UN on their commitment to the preservation and recognition of children's rights.⁵ Accordingly, the conventions identified should be reflected in the strategic direction and policies of all agencies operating in the child protection system by identifying how these human rights will be recognised in practice.

A substantial and growing body of evidence exists about child protection. This includes peer-reviewed literature, professional knowledge and experience, all of which are available to people working in the South Australian child protection system. This evidence must inform education and training, and lead policy and practice development. Subscription journals that focus specifically on child abuse and child protection, such as *Child Abuse & Neglect*, *Child Abuse Review* and *Child and Youth Services Review*; and resources including the United Kingdom's National Society for the Prevention of Cruelty to Children and Barnardos Ireland are available via the internet. Each year, there are opportunities for practitioners and leaders to attend international conferences on topics of child abuse and protection.

Remaining up to date with the most recent research and thinking in the field is a critical part of ensuring that South Australia's child protection system is efficient and effective. The need for a greater connection to universities and other centres of research for the statutory agency is discussed later in this report.

NATIONAL INFLUENCES

The division of government power mandated in Australia's Constitution leaves the protection of children at risk of abuse and neglect, by and large, the responsibility of the states and territories. Although physical borders between states and territories have become less important than they once were, and the population is far more mobile, system boundaries remain. Information held by child protection agencies in each jurisdiction is not freely shared, and there are barriers to the transfer of orders made to secure the safe care of children.

There is increasing pressure at a federal level for greater standardisation and integration of the child protection systems operating in each state and territory. There is merit in this objective, as the breaking down of jurisdictional boundaries and a simplification of information-sharing processes are critical to meeting the challenges of a mobile population of children who require a child protection response.

NATIONAL FRAMEWORK FOR PROTECTING AUSTRALIA'S CHILDREN

The National Framework for Protecting Australia's Children 2009–2020 is an initiative of the Council of Australian Governments (COAG). It provides an overarching plan for the development of child protection services across each Australian jurisdiction. The priorities and actions identified through the National Framework action plans must be closely considered in any cohesive reform at a state level. In the course of its investigations, the Commission became aware of some areas where South Australia has a poor level of compliance with national standards and insufficient regard to national approaches.

The National Framework is a strategic plan that mandates collaboration among jurisdictions to 'provide the foundation for national reform'.⁶ It aims to raise the national profile of child protection and improve standards for children in care, as well as develop coordinating mechanisms between the jurisdictions. It has one high-level outcome—that Australia's children are safe and well—underpinned by six outcomes:

- Children live in safe and supportive families and communities;
- Children and families access adequate support to promote safety and intervene early;
- Risk factors for child abuse and neglect are addressed;
- Children who have been abused or neglected receive the support and care they need for their safety and wellbeing;
- Indigenous children are supported and safe in their families and communities; and
- Child sexual abuse and exploitation is prevented and survivors receive adequate support.

The National Framework also promotes a change of focus from solely responding to abuse and neglect to promoting the safety and wellbeing of children through prevention. It recommends the public health model (see box) as the appropriate model to achieve this shift.⁷

Figure 4.1 represents the recommended distribution of resources under the public health model.

The public health model

The public health model proposes multiple levels of intervention:

- Primary or universal interventions target whole communities to build public resources and prevent child maltreatment before it arises through support and education that focus on the social factors that contribute to maltreatment.
- Secondary or targeted interventions target vulnerable families who exhibit risk indicators for child maltreatment, including poverty, parental mental health problems, marital discord, family violence and parental drug and alcohol abuse, and who are in particular need of support. They 'address risk factors, alleviate problems and prevent escalation with a focus on early intervention'.¹
- Tertiary interventions target families in which child maltreatment has occurred. They focus on reducing the long-term consequences of maltreatment and preventing maltreatment from recurring or escalating. They include statutory child protection services.²

¹ Australian Research Alliance for Children and Youth, *Inverting the pyramid: Enhancing systems for protecting children*, The Allen Consulting Group, 2008, p. 4.

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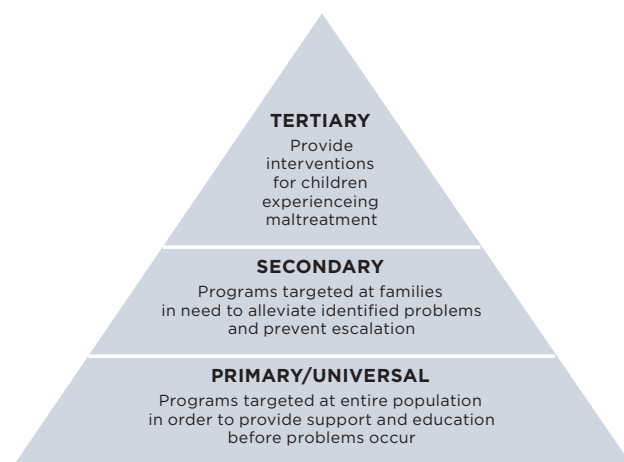


Figure 4.1: The public health model

Source: Australian Institute of Family Studies, *Defining the public health model for the child welfare services context*, CFCA Resource Sheet, AIFS, 2014, <https://aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-servi>

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The model invests most resources in primary services, which are aimed at the population as a whole. The rationale is that this will prevent child maltreatment and reduce the amount of resources at the secondary and tertiary levels. By contrast, child protection systems in Australia tend to resemble an inverted pyramid, with too much emphasis on tertiary interventions and too little on secondary and primary interventions.⁸

Primary or universal services tend to carry less stigma for the families that use them. Seeking help from these services is seen as a normal, positive step that all families take from time to time. Examples of universal services for children and families in South Australia include the education system, including schools, kindergartens and children's centres, and the health system, including general practitioners, health clinics and the universal contact visits made after the birth of a new baby. These services spend time with vulnerable families and are well placed to identify when extra support is needed and either provide that directly or refer families to services which can provide it. At times, they serve as 'lifelines for very isolated, scared parents'.⁹

There are limits to the support these services can offer to families with complex problems. Families who come into contact with child protection systems often face multiple inter-related problems, including domestic violence, substance abuse and poor mental health. Addressing complex or entrenched problems is specialised work. It requires intensive, longer-term service models staffed by experienced workers with specialised training.¹⁰

Primary services may not be able to address these needs directly, but can serve as non-threatening entry points to engage families and form trusting, therapeutic relationships with them. In so doing, primary services need to be equipped to identify more complex needs and coherent pathways to refer families to secondary services that can address these needs.

There is a growing interest in developing and delivering primary services on the basis of 'proportionate universalism'. Proportionate universalism describes an approach where 'actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage'.¹¹ This addresses the argument that universal services deliver benefits to families that are least in need because the most vulnerable families are more likely to face barriers to services, including cost, transport, language or stigma. On the other hand, targeted programs do not necessarily eliminate barriers such as stigma and they have the potential to miss many people who, while not the most vulnerable, are vulnerable nonetheless.¹² Proportionate universal services offer some support to all of the population through primary interventions, with increasing levels of service for those who need it.

Under the National Framework, three action plans have been developed (2009–12, 2012–15 and 2015–18), which set out strategies to achieve the outcomes. For the first plan, nationally consistent approaches to out-of-home care standards and the provision of support to young people leaving care were among the 12 priorities. Actions have resulted in the development of national standards for out-of-home care, and a nationally consistent approach for transition planning.¹³

The second action plan identified the need to integrate the National Framework with other national social reform priorities, in particular:

- early childhood;
- education;
- domestic and family violence;
- health and mental health; and
- disability.

The need to invest in the development of the non-government sector and engage the whole community in taking responsibility for child protection was also identified.¹⁴

The current action plan identifies early intervention (particularly action in a child's first 1000 days) as a key focus.¹⁵ Actions under this strategy include increasing community awareness of child development and normalising the seeking of help to raise safe and healthy children. The plan also identifies the need for an increased focus on joined-up services for families, in particular greater integration of child care, maternal and child health, and family support services.¹⁶ The Commission has also identified these principles as priorities at a state level, and they inform the recommendations in this report.

An ongoing priority for the National Framework is reducing the over-representation of Aboriginal and Torres Strait Islander children in the child protection system. Pursuant to the National Framework's outcome that 'Indigenous children are supported and safe in their families and communities'¹⁷, the Secretariat of National Aboriginal and Islander Child Care has produced a policy and practice framework, *Pathways to Safety and Wellbeing for Aboriginal and Torres Strait Islander Children*.¹⁸ It identifies four 'pathways' to providing better support to families and communities:

- Supporting families and communities to stay together;
- Aboriginal and Torres Strait Islander participation;
- Trauma and healing informed approaches; and
- Systems accountability to Aboriginal and Torres Strait Islander priorities.

A number of witnesses commended this framework to the Commission as a starting point for policy development for the protection of Aboriginal and Torres Strait Islander children.¹⁹

ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE

The Royal Commission into Institutional Responses to Child Sexual Abuse is due to deliver its final report on 15 December 2017. It released an interim report on 30 June 2014 and has published other reports on particular topics, including working with children checks and redress and civil litigation.²⁰ The Commission also has a substantial research program, the results of which are generally available to the public. It appears to be committed to research-based recommendations for reform.

The recommendations of the federal Commission are likely to result in an even greater focus on standardisation across jurisdictions of some aspects of child protection. For example, its interim recommendations on working with children checks favour a uniform system across Australia's states and territories, and greater portability of the checks.²¹

Given the breadth of the inquiry, it is likely that its recommendations will have a major impact at the state level. South Australia's reform program must progress mindful of the federal agenda that is likely to arise following the publication of the Commission's final report. Recommendations that provide a national framework for greater portability of child protection orders, and more streamlined and open information sharing, should be welcomed as a starting point for standardised reforms.

THE FAMILY COURT

The Family Court hears private applications for parenting orders that deal with where a child will live, and specific issues relating to parental responsibility or child maintenance. The way in which legislative power is allocated in Australia's Constitution has created a system whereby issues of child abuse and neglect are dealt with in different ways, depending on their context and circumstances. As Daryl Higgins, a prominent researcher in this area, describes:

Although each of these systems deal with child abuse issues, it is important to appreciate that they play very different roles and consequently function according to distinct legislative, philosophical and operational imperatives ... the key difference between the two systems is the fact that child protection law is concerned directly with state intervention into private family life. The FLA [Family Law Act] in contrast, is concerned with resolving private law disputes over parenting arrangements between two parties, most often the parents of the child who is the subject of the dispute.²²

The two jurisdictions intersect when Family Court proceedings relate to children who are under child protection orders. Section 69ZK of the *Family Law Act 1975* (Cth) prevents the Family Court making orders in relation to these children unless the 'welfare authority' consents.²³ In South Australia, the relevant welfare authority is Families SA. The operation of section 69ZK ensures that children are not returned to the care of their parents where the Youth Court has determined that a relevant risk of abuse or neglect exists.²⁴

Child protection concerns may also be raised for the first time by parties to Family Court proceedings. The Family Court has no power to investigate concerns raised on its own behalf and must refer the matter to Families SA, as the responsible welfare authority.²⁵ Parties to a Family Court action often lack the resources and access to systems to comprehensively investigate child protection concerns. The parties therefore often rely on investigations conducted by Families SA.

The intersection of the two jurisdictions has recently been the subject of terms of reference from the federal Attorney-General, Senator George Brandis QC, to the Family Law Council to consider the following matters:

- 1 The possibilities for transferring proceedings between the family law and state and territory courts exercising care and protection jurisdiction within current jurisdictional frameworks (including any legal or practical obstacles to greater inter-jurisdictional cooperation).
- 2 The possible benefits of enabling the family courts to exercise the powers of the relevant state and territory courts including children's courts, and vice versa, and any changes that would be required to implement this approach, including jurisdictional and legislative changes.
- 3 The opportunities for enhancing collaboration and information sharing within the family law system, such as between the family courts and family relationship services.
- 4 The opportunities for enhancing collaboration and information sharing between the family law system and other relevant support services, such as child protection, mental health, family violence, drug and alcohol, Aboriginal and Torres Strait Islander and migrant settlement services.
- 5 Any limitations in the data currently available to inform these terms of reference.

The interim report of the council, published on 30 June 2015, focused on the first and second terms of reference.²⁶ The final report on all matters is due by mid-2016. The interim report sets out in some detail the advantages and disadvantages of a closer relationship between the two systems. It is unnecessary to repeat those matters in this report.

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THE STATE INTERVENING IN FAMILY COURT CASES

When the Family Court believes it is necessary in the interests of the child, it may request that the relevant statutory authority intervene in proceedings.²⁷ Research shows that state agencies may decline to intervene for a variety of reasons, including that the allegations relate to an historical concern or do not meet the statutory threshold, the agency has limited resources or the referral does not attract the necessary priority rating for action. In *Secretary for the Department of Health & Human Services and Ray & Ors*, the Full Court set aside an order requiring the secretary of the Tasmanian Department of Health & Human Services to intervene in proceedings relating to two children at risk of emotional, physical and sexual abuse. The Judge at first instance was concerned that neither party, nor any available family member, was suitable to take parental responsibility.²⁸ The secretary declined the invitation to be joined, but the Judge nonetheless made an order in his favour. The Full Court set aside that order and held that the Family Law Act did not confer power to make parental responsibility orders in favour of state child protection authorities without the consent of the relevant authority.

Whether or not a child protection agency agrees to intervene in proceedings, the Family Court can make orders requiring that documents related to notifications, assessments or commissioned reports be produced.²⁹ However, production of a child's file can give an incomplete picture of a party's parenting capacity. A party may have other children for whom there have been child protection concerns, but who are not the subject of the Family Court proceedings, and material contained in those files may well be relevant to the Family Court proceedings, although they are often not subpoenaed.³⁰

The Family Law Council interim report refers to the discrepancy between the family law and child protection systems 'concerning the point in which poor parenting behaviour can be regarded as neglect or abuse'.³¹ The council argues that this gap has created difficulties in Family Court cases where the threshold for child protection intervention is not met, but, for the purposes of making parenting orders, neither party to the family law proceedings has the capacity to support the child's safety and wellbeing. This leaves the Family Court in the situation of being left to pick the least worst of the adults with whom the children shall live.³²

The Family Court's Magellan Project is a collaborative case management approach for matters where allegations of serious physical or sexual abuse are raised in the context of litigation. The project aims to resolve cases within six months. Cases brought within the project benefit from a closer connection to the relevant statutory agency, as the project has the power to request intervention from the agency and/or a report on the allegations and any investigation conducted. The project

is an important example of the way in which bridges can be built between systems to enhance the operation of each.

THE APPROACH OF THE STATUTORY AGENCY TO THE FAMILY COURT

The Commission heard evidence that a perception exists in Families SA that if the Family Court is involved, the case can be closed.³³ The Commission also received a large number of submissions from litigants to Family Court matters where allegations have arisen in the course of litigation, but Families SA has not acted on notifications made. Family Court litigants have been frustrated that Families SA seemed reluctant to act on allegations made in this context.

Allegations made in the context of Family Court proceedings may not attract a response because of the statutory system's obligation to prioritise its responses according to urgency of need. For example, if a relevant notification is made by one parent who appears to be acting in an appropriately protective way (pursuing Family Court action to prevent contact from the parent alleged to be the source of the risk) and the child's arrangements do not reveal a current risk of abuse or neglect, it is unlikely to attract a priority ranking for a child protection response. The tension arises when litigants want to activate the forensic investigation powers of the statutory agency to influence future Family Court orders, which they fear may expose a child to a risk of abuse or neglect.³⁴

The Commission is not in a position to ascertain whether and to what extent the existence of a Family Court action influences the response to a child protection notification in South Australia.³⁵ If the clear perception on the part of various Family Court litigants is right, and those notifications are less likely to attract a response, there is a risk that serious child protection concerns could fall through the gap because the Family Court does not have the powers of investigation available to Families SA, and could make orders that place a child at risk because of an absence of information quantifying that risk. There is a corresponding danger that litigants to Family Court disputes that involve no child protection issues might be tempted to activate the investigative powers of the child protection system to lever an advantage in court.

Practitioners assessing child protection notifications must have a well-developed understanding of the role and limitations of the Family Court to intervene and investigate when child protection matters arise in those proceedings. While a background of Family Court proceedings might introduce additional complexity to the assessment of a child protection notification, it must never be a factor which is decisive of whether Families SA becomes involved.

In particular, assessment practitioners must be aware of the investigational limitations of the Family Court and the danger that a child might be placed at risk by Family Court orders absent information addressing or quantifying a risk of abuse or neglect.

Until the end of 2013, Families SA employed several court liaison officers, led by a principal liaison officer. The court liaison role crossed between the Youth Court and the Family Court. It provided a contact point for strategic issues between each court and Families SA and worked to streamline processes through developing a better understanding of the work of each organisation. Liaison officers were also able to support children in care who appeared in the criminal jurisdiction of the Youth Court with no youth or social worker present.³⁶ In light of the gap to be bridged between the Youth Court, the Family Court and the statutory agency, a resource dedicated to that liaison role should improve both the relevant system interface and the mutual understanding of each organisation.

GRANDPARENTS AND KINSHIP CARERS BEFORE THE FAMILY COURT

There is potential for family members who are looking after children who cannot be safely cared for by their parents (kinship carers) to apply to the Family Court for a parenting order pursuant to section 64B of the Family Law Act. Such orders have the advantage of providing the kinship carer with the legal authority to make decisions about the child's education, health and travel needs, and to access support services and government benefits associated with the child. However, as the Family Law Council commented, 'Some stakeholders observed that some family members, such as grandparents who are living off retirement savings or a parent who has been the victim of family violence, may be ill-equipped to manage the demands of private legal proceedings without support'.³⁷ These concerns were also reflected in submissions made and evidence given to the Commission on this topic. Concerns also existed about the relatively slow pace of Family Court proceedings, and the associated cost implications for the person who had assumed the care of the child.³⁸

In its report, the Family Law Council referred to the Senate Community Affairs References Committee's report, *Grandparents who take primary responsibility for raising their grandchildren* (October 2014), which suggested that grandparents' ability to acquire cost orders was significantly restricted by the cost of legal representation. This was particularly so for grandparents who were not in paid employment.³⁹

The council's report also said that legal aid was not always available to help family members, noting that:

As a result of these financial constraints, protective carers might have to represent themselves in family law proceedings with responsibility for preparing their own documentation and running their own case.⁴⁰

There is merit in appropriate carers being able to make applications to the Family Court as an alternative to seeking a guardianship order. Some kinship carers request the support of Families SA to obtain Family Court orders in order to secure continuity of care for children, without the ongoing involvement and case management of Families SA.⁴¹ However, without a state funding model, this support is provided on an ad hoc basis through local Families SA budgets.⁴² It is more common in these circumstances for guardianship orders to be sought from the Youth Court over parenting orders from the Family Court.⁴³

It would seem that at present pursuing parenting orders in the Family Court is sometimes not viable for kinship carers, for the reasons set out in the Family Law Council's Interim Report. The answer to these challenges lies in either a closer connection between the family law and child protection systems insofar as they concern kinship carers, or more formalised funding support for kinship carers to be represented to make Family Court applications. For appropriate cases, it may be more cost effective to support kinship carers to secure parenting orders through a grant of legal aid than to bring the child unnecessarily into the child protection system. Opportunities to improve access of kinship carers to the Family Court are being pursued through actions resulting from the Family Law Council report.

The Family Law Act contemplates the registration of state child orders in the Family Court.⁴⁴ Such action gives Youth Court orders the status of orders made 'by that court under this Part'.⁴⁵ Importantly, registration would thereby give the orders a force beyond state boundaries. This is another potential mechanism to improve the flexibility of orders to protect children who are mobile across state boundaries. In appropriate cases, funding should be available to kinship and foster carers to register orders with the Family Court.

4 EXTERNAL INFLUENCES ON SOUTH AUSTRALIA

THE CALL FOR A NATIONAL DATABASE

Recommendation 5 of the Family Law Council's interim report suggested that the federal Attorney-General raise the following matters at the COAG level:

- (a) *The development of a national database of court orders to include orders from the Family Court of Australia, the Family Court of Western Australia, the Federal Circuit Court of Australia, state and territory children's courts, state and territory magistrates courts, and state and territory mental health tribunals, so that each jurisdiction has access to the other's orders.*
- (b) *The convening of regular meetings of relevant stakeholder organisations, including representatives from the children's courts, child protection departments, magistrates courts, family courts, legal aid commissions and attorney-general's departments, to explore ways of developing an integrated approach to the management of cases involving families with multiple and complex needs.*
- (c) *Amending the prohibition of publication provisions in state and territory child protection legislation to make it clear that these provisions do not prevent the production of reports prepared for children's court proceedings in family law proceedings.*
- (d) *The entry into memoranda of understanding by state and territory child protection agencies and the federal family courts to address the recommendations of Professor Chisholm's reports.⁴⁶*
- (e) *The co-location of state and territory child protection department practitioners in federal Family Court registries.*
- (f) *The development of dual competencies for Independent Children's Lawyers to achieve continuity of representation for children, where appropriate.*

Given the national focus of these recommendations, it is likely that reform will be driven by forces outside South Australia. However, it will be necessary for the state's child protection system to be mindful of the deficits that exist at this interface, and be open to changes that will increase connections.

While all the matters raised in recommendation 5 have merit, number 5(a) is especially significant. In Vol. 2, Case Study 1: James, serious issues are identified regarding the availability of interstate child protection information to inform assessment decisions made at Families SA. The case study's evidence supported the conclusion that obtaining information from interstate child protection agencies can be difficult, and is not always quickly provided. Information about previous child protection concerns, particularly the removal of other children, can be critical to properly assess new notifications.

A database of court orders from the child protection jurisdictions of each state and territory and the Family Court has the potential to be a powerful tool for child protection agencies. In many cases, a database search would quickly identify parents against whom formal care and protection orders and family court orders have been made. At the most fundamental level, such a search might identify the existence of other children in a family, which could open other avenues of enquiry to assess current levels of risk. Therefore, the Commission supports the development of a national database of the kind contemplated in the Family Law Council report.

The South Australian Coroner, in an inquest into the death of Ebony Simone Napier, an infant who died at the hands of her parents against the background of an inadequate child protection response, made recommendations about the relationship of Families SA to other interstate child protection agencies.⁴⁷ The Coroner advocated for the development of a national child protection database of all information collected by child protection agencies across the country. While such a database would significantly improve the sharing of intelligence across jurisdictional boundaries, in the short term there are likely to be considerable implementation barriers. A more realistic strategy in the short term would be to support recommendation 5(a) of the Family Law Council report as a starting point for the development of closer information links between jurisdictions.

LESSONS LEARNED FROM OTHER STATES AND TERRITORIES

In their approaches to child protection, each Australian state and territory has a slightly different model and legislative scheme.⁴⁸ South Australia's child protection system has lagged behind a number of other states in its attention to early intervention and other preventative programs and policies. Many of the changes that South Australia must consider as part of a comprehensive reform process will have been implemented in, or at least assessed by, other jurisdictions. The state's inactivity presents opportunities for it to draw on the best of what has been tried and tested by other jurisdictions. In particular, there are lessons to be learned from other jurisdictions' collaborations with the non-government sector and innovative funding mechanisms.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 1 Establish a protocol to govern eligibility for a grant of legal aid to carers, where the child's best interests would be better or more appropriately secured by obtaining Family Court orders, rather than by proceedings in the Youth Court. Further, that funding be provided to the Legal Services Commission and quarantined for this specific purpose.
- 2 Fund, subject to a protocol, any required filing costs where there is a need for Youth Court orders to be registered in the Family Court to improve the safety of the children to whom they relate.
- 3 Support and promote for action, recommendation 5(a) of the Family Law Council interim report (June 2015), which advocates for the development of a national database of child protection and Family Court orders.
- 4 Reinstitute the court liaison role as a strategic link between the Agency, the Family Court and the Youth Court, to improve system interface and to develop service responses in accordance with the requirements of each jurisdiction.

4 EXTERNAL INFLUENCES ON SOUTH AUSTRALIA

NOTES

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- 3 United Nations (UN), Convention on the Rights of Persons with Disabilities, entered into force 3 May 2008.
- 4 UN, Declaration on the Rights of Indigenous Peoples, adopted 13 September 2007.
- 5 UN, Convention on the Rights of Persons with Disabilities, Article 35; UN, Convention on the Rights of the Child, Article 44.
- 6 Council of Australian Governments (COAG), *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Canberra, 2009, pp. 5, 9.
- 7 *ibid.*, p. 7.
- 8 Australian Research Alliance for Children and Youth, *Inverting the pyramid: Enhancing systems for protecting children*, 2008, p. 5; Australian Institute of Family Studies, *Defining the public health model for the child welfare services context*, CFCA Resource Sheet, 2014; COAG, *National framework for protecting Australia's children*.
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- 15 COAG, *National framework for protecting Australia's children 2009–2020, Third three-year action plan 2015–2018*, Canberra, 2012, pp. 4, 8.
- 16 *ibid.*, p. 8.
- 17 COAG, *National framework for protecting Australia's children 2009–2020*, p. 28.
- 18 Secretariat of National Aboriginal and Islander Child Care (SNAICC), *Pathways to safety and wellbeing for Aboriginal and Torres Strait Islander children*, 2015, www.snaicc.org.au/pathways-safety-wellbeing-aboriginal-torres-strait-islander-children/
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- 23 Submission: S Holmes.
- 24 *ibid.*
- 25 *Family Law Act 1975* (Cth), ss. 67Z–67ZA.
- 26 Family Law Council (FLC), *Interim report to the Attorney-General into the first two terms of reference on families with complex needs and the intersection of the family law and child protection systems*, Attorney-General's Department, Australian Government, June 2015.
- 27 *Family Law Act 1975* (Cth), s. 91B.
- 28 *Secretary of the Department of Health & Human Services and Ray & Ors* [2010] FamCAFC 258, Family Court of Australia.
- 29 *Family Law Act 1975* (Cth), s. 69ZW(2).
- 30 Oral evidence: R Palachicky.
- 31 FLC, *Interim report to the Attorney-General*, p. 32.
- 32 *ibid.*
- 33 Oral evidence: R Palachicky. Submission: R Palachicky.
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- 38 Submission: Name withheld (S95).
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- 40 *ibid.*
- 41 Oral evidence: Name withheld (W35).
- 42 *ibid.*
- 43 Submission: Name withheld (S95).
- 44 *Family Law Act 1975* (Cth), s. 4.
- 45 *ibid.*, s. 70E.
- 46 The FLC's interim report refers extensively to two reports written by Professor Richard Chisholm AM for the Attorney-General's Department, Canberra: *Information-sharing in family law and child protection: Enhancing collaboration* (March 2013) and *The sharing of experts' reports between the child protection system and the family law system* (March 2014). His recommendations concerned information sharing between the child protection and family law systems.
- 47 Coroners Court of South Australia, Finding of the inquest into the death of Napier, Ebony Simone, Inquest number 16 of 2015, p. 131.
- 48 L Bromfield & D Higgins, National comparison of child protection systems, National Child Protection Clearinghouse, no. 22, 2005, p. 1.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

PART II

CHALLENGES

5

CHALLENGES FOR THE STATUTORY AGENCY

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OVERVIEW

The strong national message in relation to child protection is that 'child protection is everyone's business'. It is vital that this message continue to be promoted. The statutory agency is a crucial part of the system and should be the agency that leads child safety in the state. A functional child protection system should be led by a highly functioning expert statutory agency.

Child protection is complex and difficult work. Every day workers make decisions that have the capacity to fundamentally change children's lives. Getting it right can deliver extraordinary benefits to a child, and getting it wrong can unnecessarily tear families apart.

The expert panel who reviewed practice within Families SA (the Agency) for the Royal Commission was struck by the complexity and difficulty of the work it performed. They noted evidence of entrenched inter-generational patterns of family dysfunction, including welfare dependence, domestic violence, housing instability, substance abuse and mental health issues. In the majority of cases examined, most or all of these factors were present. The panel observed that the files reflected a sobering and tragic picture of family life for many children in the 21st century. It is in this complex social environment that Families SA practitioners work to secure the safety of children.

Children who participated in the Commission's consultation¹ demonstrated a good understanding of why the state had become involved in their family. They understood the benefits that state intervention had brought to their lives:

The reality is that some parents aren't capable of being with their kids.

If I had stayed with my parents I would not have ended up the person I am now....It might not have ended up so good.

In facing these substantial challenges, workers do not appear to be well supported by their organisation. The Commission heard overwhelmingly of an organisational culture that was top heavy, procedure driven and risk averse. The mood of the workforce was described as at an all-time low, driven by a combination of internal pressures and external publicity following the Chloe Valentine Coroner's inquest and the events surrounding the exposure of Shannon McCooale.

Many committed front-line child protection workers told the Commission that they felt disillusioned about their circumstances. They felt a high level of anxiety about the level of risk being carried by the Agency because of vulnerable children to whom they simply could not provide a service.

One highly experienced child protection worker encapsulated the challenges facing the workers in the statutory agency:

The role of a care and protection worker is complex and difficult ... Research on the experiences for children, parents, foster carers and other agencies of the child protection system is replete with criticism: service recipients and agency partners feel excluded and not listened to, with a significant lack of respect and significant power imbalances prevailing in favour of the statutory agency. It is definitely not a partnership process, despite the espoused rhetoric.

The causes of tensions and difficulties are very complex, and simplistic explanations that blame individual workers are faulty. Some of the explanation lies in the nature of the work itself: child protection is fraught with conflict, emotion and often disputed accounts. Conflicting ideologies about the rights of children and parents and the expected role of the state is often the unarticulated subtext. Decision making seeks to be evidence-based, but in practice often requires a high degree of subjectivity ... As commentators have often remarked, social workers may do everything right and still end up with bad outcomes, given the highly unpredictable nature of human behaviour. The individual blame game has too often prevailed in analysis of child protection processes, and it is never helpful, as the causes are always multiple and systemic.²

Social workers may do everything right
and still end up with bad outcomes

In order for the system to work more effectively and efficiently, the statutory agency at its apex should be significantly reformed and reoriented to better meet the substantial challenges of protecting the most vulnerable children.

This chapter principally relates to the Commission's Terms of Reference 5(a) to 5(h), in the context of Terms of Reference 2 to 4.

A WICKED PROBLEM

As outlined in Chapter 2, child protection is a 'wicked problem': that is, a problem which is complex and highly resistant to resolution. The term has been applied to describe problems that cannot be resolved within a single organisation, and which attract disagreement about the best approach.³

In its 2009 'Inverting the Pyramid' report, the Australian Research Alliance for Children and Youth (ARACY) outlined the characteristics of 'wicked' problems and applied them to the issues arising in child protection.⁴

The characteristics of wicked problems

From the literature, several key characteristics of 'wicked' problems emerge. Generally, 'wicked' problems:

- are difficult to clearly define. The nature and extent of the problem depends on who has been asked; that is, stakeholders have different versions of the problem. For example, in child protection, practitioners from primary systems conceptualise the problem very differently from those providing tertiary services.
- have many interdependencies and are often multi-causal. Stakeholders may disagree based on the different emphasis they place on causal factors and how to focus efforts. Child protection is interrelated with other similarly complex policy problems including poverty, mental health, and drug and alcohol use.
- are often not stable. The context and/or evidence base is often changing as policy makers are attempting to address the problem. In child protection, changes in legislation and political responses to crises have the ability to significantly change the operating environment.
- usually have no clear solution. Solutions to wicked problems are often not right or wrong, but rather better or worse or good enough. Wicked problems also have no 'stopping rule'; that is, the problem can never be completely solved.
- are socially complex and hardly ever sit conveniently within the responsibility of one organisation. The social, rather than technical, complexity of wicked problems generally overwhelms traditional problem-solving and project management approaches. Solutions to wicked problems generally involve coordinated effort by a range of stakeholders including government organisations (at several levels), non-government organisations and individuals.
- involve changing behaviour. Solutions to wicked problems often involve changing the behaviour of individual citizens and organisations. This is certainly true for preventing child abuse and neglect, where the solutions involve building capability in vulnerable families.

In addition, some wicked problems are characterised by chronic policy failure.

TACKLING WICKED PROBLEMS AT AN ORGANISATIONAL LEVEL

Some authors have argued that the key to tackling wicked problems is to identify the most appropriate management approach. Problems that have a limited scope and a natural stopping point where they can confidently be declared 'solved' may be dealt with through administrative and management measures.⁵ Wicked problems, however, demand a special type of leadership, one that involves 'coaxing people, both professionals and the lay public, to an acceptable solution', because we do not know what the right answer is.⁶ Leadership in this context involves acknowledging that child protection is a risky business. While revised process and procedural controls might provide organisational comfort, it is a false comfort if they serve to undermine the professional skills and competence.

The Commission heard evidence from Families SA employees at all levels of seniority and experience, in both country and metropolitan locations. A consistent theme was that while there was tight control of decision making at a high level, there was a deficit of true leadership. Workers spoke of feeling that their professional expertise was not valued and that there was little investment in growing practitioners' knowledge base. They felt that their professional practice was restricted by administrative processes and rules that focused on agency risk management rather than the best outcomes for children.

There is, however, a tension between observing that the quality of practice is poor and needs to be improved, and advocating a more hands-off management approach to allow people to apply and develop their professional judgement. Professor Eileen Munro in her review of child protection practices in the United Kingdom observed that there is a need to strike a balance between reducing the level of prescriptiveness in an organisation to give workers a chance to demonstrate professional judgement but at the same time ensuring they have the capacity to do so where prescriptiveness is absent. She emphasises that prescriptiveness must be reduced in tandem with the development of a learning system, and that the process must be conceptualised as a longer term proposition.⁷

The same observations apply to reform of the statutory agency in this state. Although the necessary shift will not occur quickly, it is critical to long-term success that a greater emphasis be placed on professional skill, knowledge and influence.

THE GROWTH OF PRESCRIPTIVE MEASURES OVER PRACTICE

In the context of what research tells us about the best ways to grapple with wicked problems, of particular concern is the move by Families SA towards providing detailed instructions on how each job is to be performed, in the expectation that this will improve the quality of decision making. This 'command and control' approach assumes that failures can be reduced by tightly controlling the processes by which a job is performed.⁸ If there is a failure and harm is caused, there is a presumption that instructions or guidance were insufficiently clear, and processes and protocols are rewritten.⁹ This systematically reduces the need for employees to think for themselves about important professional and moral issues that are part of risk assessment and decision making.¹⁰

Command and control has produced perverse and particularly widespread side-effects in sensitive human service environments such as child protection systems. The approach perpetuates risk-averse and defensive practices, thereby de-skilling workers and worsening rather than improving outcomes for children. Munro's review observed that the cumulative effect of a heavily bureaucratised system is a shift towards defensive practice where concern with protecting oneself or one's agency has competed with, and sometimes overridden, a concern with protecting children.¹¹ A command and control strategy is unable to grapple with complex wicked problems.

Sue Macdonald, the Director of Quality and Practice for Families SA, acknowledged the dangers of growing prescriptiveness in the Agency. She said:

I think the danger in having guidelines that are too prescriptive is that actually, what it does is make people anxious because what it makes you do is worry about following the procedure rather than engaging with the family. And so ... it is that fine balance between ensuring that people have sufficient access to information to assist them to do their job, while also encouraging them to bring their skills and knowledge to the work. We are increasingly ... a workforce that has overall a fairly limited experience base at the moment ... so the lack of experience married with some of the other ... things that have happened, public scrutiny, increasing workload, all those things ... I think has created anxiety, so in those times, people do want to grab onto something that they feel sure about. The challenge is to move people to a point where they feel sure about the work they are doing, rather than ... how it is prescribed.¹²

The challenge is to move people to a point where they feel sure about the work they are doing, rather than how it is prescribed

The danger lies not in the existence of the guidance alone, but in the manner in which it is used. The growth of prescriptive processes without a corresponding investment in the workforce may lead to technical competence, not quality practice.¹³ The Commission heard that a significant number of practitioners lack a solid understanding of the rationale for the mandated processes.¹⁴ This situation has grown out of the focus on processes and protocols replacing investment in professional judgement. The Agency, a former executive observed, had become 'bureaucratised and over-mechanised to the point of stupidity'.¹⁵ The Commission's examination of the available policies, process guides and work instructions in a number of areas confirmed the validity of this criticism.

A LACK OF CLARITY ABOUT APPLICABLE POLICIES

The Commission was regularly confounded by the array of documents that child protection workers were expected to consult. Commonly, different versions of documents existed, and there was doubt about which were the current operational versions.

The Child Protection Manuals Volumes 1 and 2 contain the most comprehensive guidance on the issues confronting workers but they are so out of date that they still refer, in some instances, to the Client Information System (CIS) database, which was superseded by a new case management database in 2009.

The Care Planning Policy, a seminal document which sets out the principles under which decisions about the care of children should be made, has an uncertain status. Rosemary Whitten, the Executive Director in charge of Metropolitan Services and Residential Care at Families SA, was not certain whether the document was current, and could not say with clarity whether it might have been superseded by a new document. Ms Macdonald noted that the most recent version of the document retained Department of Families and Communities branding, so had not been updated since the merger of Families SA with the Department for Education and Child Development (DECD) in 2011.

5 CHALLENGES FOR THE STATUTORY AGENCY

Ms Whitten agreed that the Agency faced significant challenges identifying what was and was not current policy. 'Redesign', a recent reform program, has exacerbated rather than resolved these issues. Under Redesign a large number of new documents guiding practice have been produced but many have been released to the workforce as trial processes, not yet final or approved. As a result, staff remain uncertain about their status.¹⁶ Despite the release of these new documents, there has not been a corresponding rationalisation of other documents, a situation that has further troubled an anxious workforce.

An audit of policies and process documents is necessary to identify which documents are current, which are outdated but still apply, and which have been superseded. They should be organised into a single database that is easily accessible to staff through the Agency's intranet. Documents that are outdated in some respects but remain relevant to practice should be clearly identified as such.

A LACK OF TRUST IN FRONT-LINE WORKERS

Evidence also suggested a level of confusion about decision-making delegation within the organisation. A number of more senior staff members held the view that decision-making delegation had moved upwards in recent times. Supervisors within local offices are not authorised to approve interstate travel for children in care. They may not authorise payments over \$500 and they may not authorise annual leave requests by staff under their management for periods exceeding one day.¹⁷ In remote areas where workers frequently need to cross state borders to deliver services (the APY Lands being the most obvious example, where the closest hospital for residents is in Alice Springs), permission must be obtained on each occasion from an assistant director.¹⁸ Managers at the local office cannot authorise foster parents to take a child on a short interstate trip, and requests to travel overseas are escalated to the Deputy Chief Executive for approval.¹⁹

Consultations with children and young people in care revealed that the challenges that high level delegation bring also have an impact on the ability of children and young people in care to live the most normal way possible. They told the Commission:

You have to ask a million people to do anything—the social worker asks the senior who asks the big boss. Last-minute things cannot be organised, like normal sleep-overs.²⁰

Etienne Scheepers, the Deputy Chief Executive of the Office for Child Protection (as such, head of Families SA), told the Commission that in general terms he

regarded the current operational delegations as appropriate. He believed that there might well be good reason that interstate travel, for example, should be escalated beyond the local office for approval, because some decisions required distance between the decision maker and the case manager. Mr Scheepers considered that the additional risk posed to a child travelling away from their home environment might justify the escalation of such a decision. However, it is difficult to understand why the level of risk inherent in travel necessarily escalates with the movement of a child across a state border.

Mr Scheepers also made the point that the organisation had difficulty with accountability for decisions. Some decisions that should be made at a lower level are escalated because there is an unwillingness at that level to assume accountability.

In late 2015, a group of senior executives seconded from other government departments was tasked with investigating opportunities for improvement within Families SA. The resulting report identified a number of reform priorities. The group's observations about delegation were consistent with those made by the Commission. The group observed that the consistent focus on responding to crises had led to an erosion of autonomy from non-executive leaders and the upwards movement of decision-making power. The impact of this had been to focus 'executive leaders on operational decision making at the expense of setting strategic directions and resolving complex problems; and it disempowers and demotivates non-executive leadership (particularly at the manager level) within the agency'.²¹ The current hierarchical arrangements are set out in Figure 5.1.

The group further observed that the separation of routine decision making from the everyday management of the child is not always in the child's best interests. That is, risk aversion at higher levels can lead to greater weight being placed on organisational risk, rather than the interests of the child. Restricting the need for executive level staff to become involved in everyday decision making would also send the important message to the community that children and young people are in 'experienced, safe hands'.²²

The group's enquiries suggested that the current delegations resulted at least in part from a concern about the quality of non-executive leaders in the Agency. They concluded that stronger human resources processes should be made available to manage performance deficits, rather than implement a structure that 'assumes poor performance from its non-executive leadership'.²³ The group recommended that existing delegations be reviewed and rationalised.

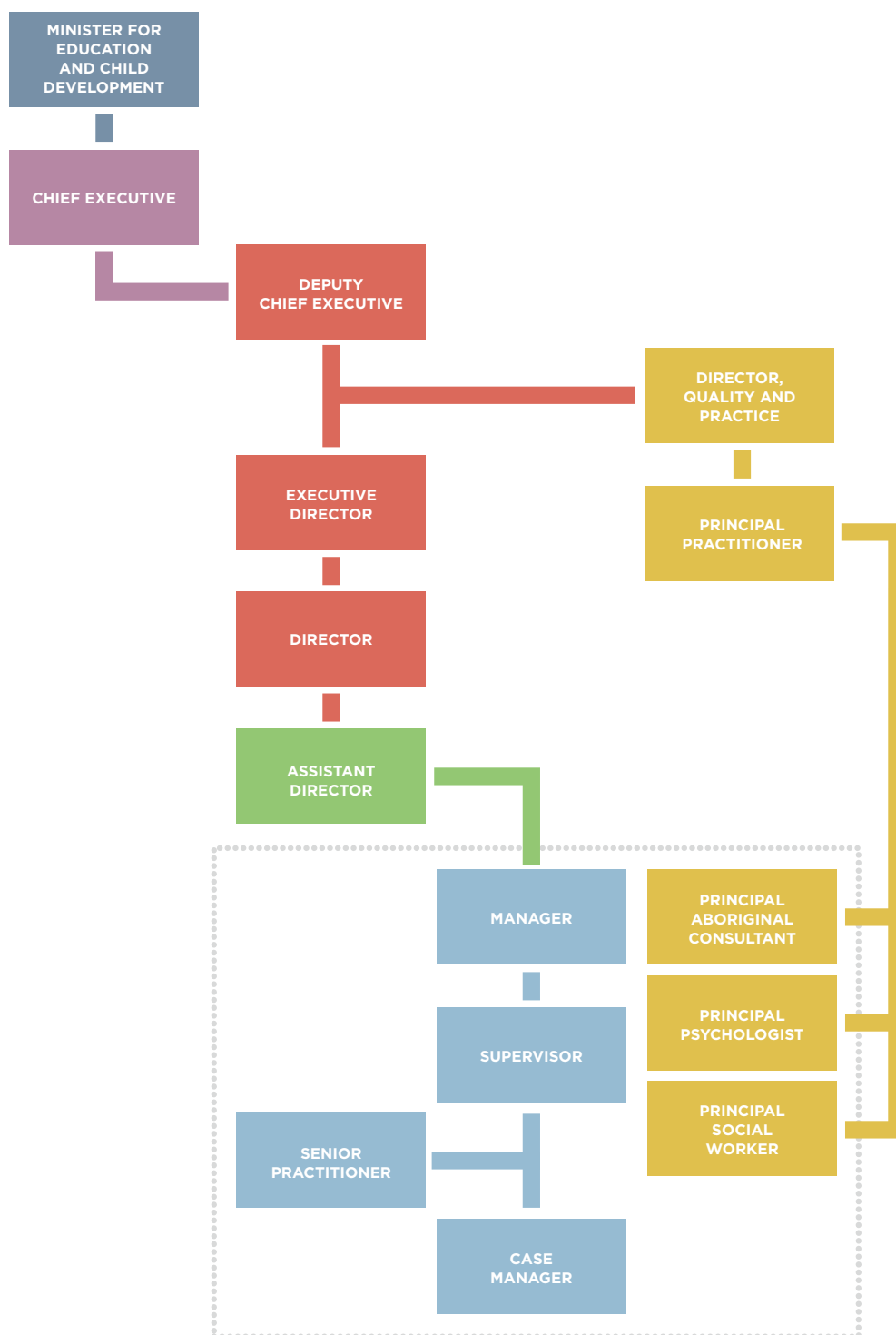


Figure 5.1: Multiple layers between the Minister and case managers

Notes: At June 2016, the position of Principal Practitioner was vacant and the future of the reporting line for the principal's group (gold) was unclear. The dotted line indicates the consultation relationship between the principal's group and front-line practitioners (blue).

This recommendation is supported by the Commission. All decisions that affect the experiences of children in care should be delegated at a level that gives precedence to knowledge about the individual child. This of course should be balanced against the need for fiscally responsible decision making and ensuring safety for children in care. The Commission considers that the current balance needs adjustment, and greater weight should be given to the experience and knowledge of front-line workers.

Nathan—A child with complex needs in out-of-home care

(The full case study of Nathan is in Volume 2, Case Study 4: Nathan—Children with complex needs in out-of-home care.)

The story of 'Nathan' highlights the difficulties that arise when case management decisions are escalated beyond the local office and executive staff become involved in operational matters. Nathan's background of severe abuse and neglect meant that his needs were complex. It was clear to his case management team that significant financial investment was needed to support an appropriate care model. A plan was developed for him to be accommodated in premises separate from other young people, with selected carers with whom Nathan had positive connections. It was appropriate that expenditure of the order contemplated in this plan was escalated to a high level for approval. However, the Commission heard evidence of numerous meetings and conversations from which Nathan's case manager was excluded. Such processes led to a level of confusion on the part of those responsible for Nathan's care about what was and was not possible for him long term.

Rosemary Whitten, the Executive Director for Metropolitan Services and Residential Care, became involved. Between Ms Whitten and the caseworker responsible for Nathan's day-to-day care were a director of metropolitan services, an assistant director, a local office manager and a social work supervisor. Because Nathan was housed in residential care, a manager of residential care and a director of residential care also became involved. It is hardly surprising given the enormous layering of bureaucracy associated with this decision making that the proposal ultimately 'drifted into obscurity'.¹ No one who gave evidence about the plan for Nathan was able to identify the person responsible for not approving the plan. Ultimately, the state of inertia continued to the point that the care workers originally identified to care for Nathan had moved on, and Nathan's level of functioning had deteriorated to such a level that the original proposal was no longer appropriate.

¹ Oral evidence: R Whitten.

A ROTTEN CULTURE

In 2007 a Select Committee was appointed by the Legislative Council to examine and report on Families SA. The Committee heard overwhelming evidence from foster parents, family members, advocacy agencies, staff and experts in child protection that a 'culture of arrogance, mistrust, bullying and dishonesty is endemic within the department'. The Committee heard of a 'pervasive and rotten culture'.²⁴ There were complaints that policy decisions were made without consulting those working at the coal face.²⁵ The Committee handed down 16 recommendations, one of which was that the Minister take steps to address the rotten culture.²⁶

Despite these observations and recommendations being made in such strong terms, evidence to the Commission suggested that nothing has changed. The overwhelming message from witnesses was that the culture described in the Select Committee report in 2007 remains pervasive. One former worker described the culture in the organisation as 'conformist, expedient and anti-intellectual'.²⁷

VALUING PROFESSIONAL SKILL

A common reason cited for a level of professional dissatisfaction in the organisation was a feeling that tertiary qualifications and social work knowledge were not valued. There has been a movement towards employing operational level staff in positions traditionally held by tertiary qualified workers, due to budgetary pressures and a growing workload. Operational stream workers are employed in country offices as caseworkers doing all but the most complex work expected of qualified AHP (allied health professional) staff. In metropolitan areas, operational workers have recently been employed as caseworkers for older teenagers who have started the process of transitioning from care.

Workers feel that they are heavily managed from a high level, particularly by executives who micromanage casework decisions and do not give sufficient weight to the professional expertise held by staff. The following words from various workers in the agency represent the overwhelming sentiment:

- *They felt hugely disrespected [and] demoralised that their expertise wasn't valued.*²⁸
- *I would say the last two years have been the worst two years I've ever experienced in any employment in my whole life ... the goodwill of social workers in our department is unbelievable—not just social workers, I mean anyone who works there ... and I think the organisation has taken advantage of that goodwill ... I personally don't believe that we are being listened to. You know, people in the field have not been consulted enough.*²⁹

- *The culture of our department in the last five or six years has been very one way, one-directional, top-down and any worker, whether it be a supervisor or manager, who ... speaks out tends to leave the agency very quickly.*³⁰
- *I've definitely seen changes in the last probably six or so years. I think there is far less consultation with the field; I think there is much denigrating and dismissal of social work as a profession and social workers, I don't think they're valued at all by executive or their opinions or their assessments. I think that there is a culture of bullying; I think there's a culture of blame; I think people have been very badly treated; and I think people are quite fearful and find it a very difficult culture in which to work.*³¹
- *They're pretty disenchanted with the whole de-professionalisation of social work ... and the micromanaging, it's just horrendous.*³²

The Australian Association of Social Workers (AASW) told the Commission:

*The AASW believes that Families SA has recently become de-professionalised with professional opinion about child protection decisions being ignored or minimised. One of the problems affecting the practice of the department is a too great concern about the political ramifications of any decision. This means decisions are top down and not taking into account the actual face-to-face experiences of those doing the work. The professional knowledge of assessment, systemic influences, social disadvantage, child development, neurobiological reactions to trauma are overridden by political and risk-averse decisions made too far from the 'coal face' to be fully relevant, timely and useful to individual cases.*³³

Many significant decisions about children's lives have come to rest with local office managers, or higher. Many of these positions are held by staff who do not have a professional child protection background or formal qualifications in child protection. As one former employee observed, 'It would be unheard of for the CEO of Health to give advice or make decisions on clinical matters, yet the equivalent of this routinely happens in Families SA'.³⁴ The job and person specification for managers at each local office require that the incumbent 'provide leadership and direction of critical, complex and highly political case management issues involving children with high and complex needs that are at risk of death or serious injury'.³⁵ They are required to perform this role, notwithstanding that there is no requirement that they hold a tertiary level qualification in any human services field. At the highest level of leadership, the current Deputy Chief Executive holds formal

qualifications in law and management, but was appointed to the position with no previous experience in child protection.³⁶

THE CHALLENGE OF REDESIGN

The state of the Agency, and the deficits in its ability to manage the increasingly complex demands of child protection, were formally acknowledged in 2012, when the Families SA Executive resolved to embark on a complete reform program. The Executive was interested in the advantages of driving its own agenda, rather than being driven (as is often the case in child protection reform) by an external review such as an inquest or Royal Commission.³⁷ The reform needed to be ambitious and comprehensive. In one former executive's words:

*This ship was going down and, you know, nothing short of a nuclear option was going to save it.*³⁸

By February 2013, a business case had been prepared, and Families SA Redesign was launched. The program was required to be completed without additional staff and within existing budgetary restrictions.³⁹ The board of management for the reform was the Families SA Executive, which was tasked with managing the process in addition to its substantial normal workload.⁴⁰ An external change management consultant, Genene Kleppe, was engaged to assist. Ms Kleppe had extensive experience in change management but very little exposure to human services environments, and no professional experience in child protection. This appointment became a source of dissatisfaction within the Agency.

There is no doubt that the reform agenda identified was well aimed and necessary. The way in which the reforms were developed and implemented, however, caused dissent and disquiet throughout all levels of the Agency, including the Families SA Executive. Three of the original eight Executive Board members left the Agency at least in part due to issues arising from Redesign.

The Commission heard considerable evidence about the Redesign process. Overwhelmingly the message was that workers felt shut out, silenced and disrespected. The process was the source of a great deal of ill feeling across the Agency.

It is not within the terms of reference for the Commission to apportion blame or responsibility for the various failures of that reform. It is sufficient to observe that there exists a widespread perception that the Redesign process further disengaged front-line child protection staff and devalued the contribution of professional staff in the Agency.

5 CHALLENGES FOR THE STATUTORY AGENCY

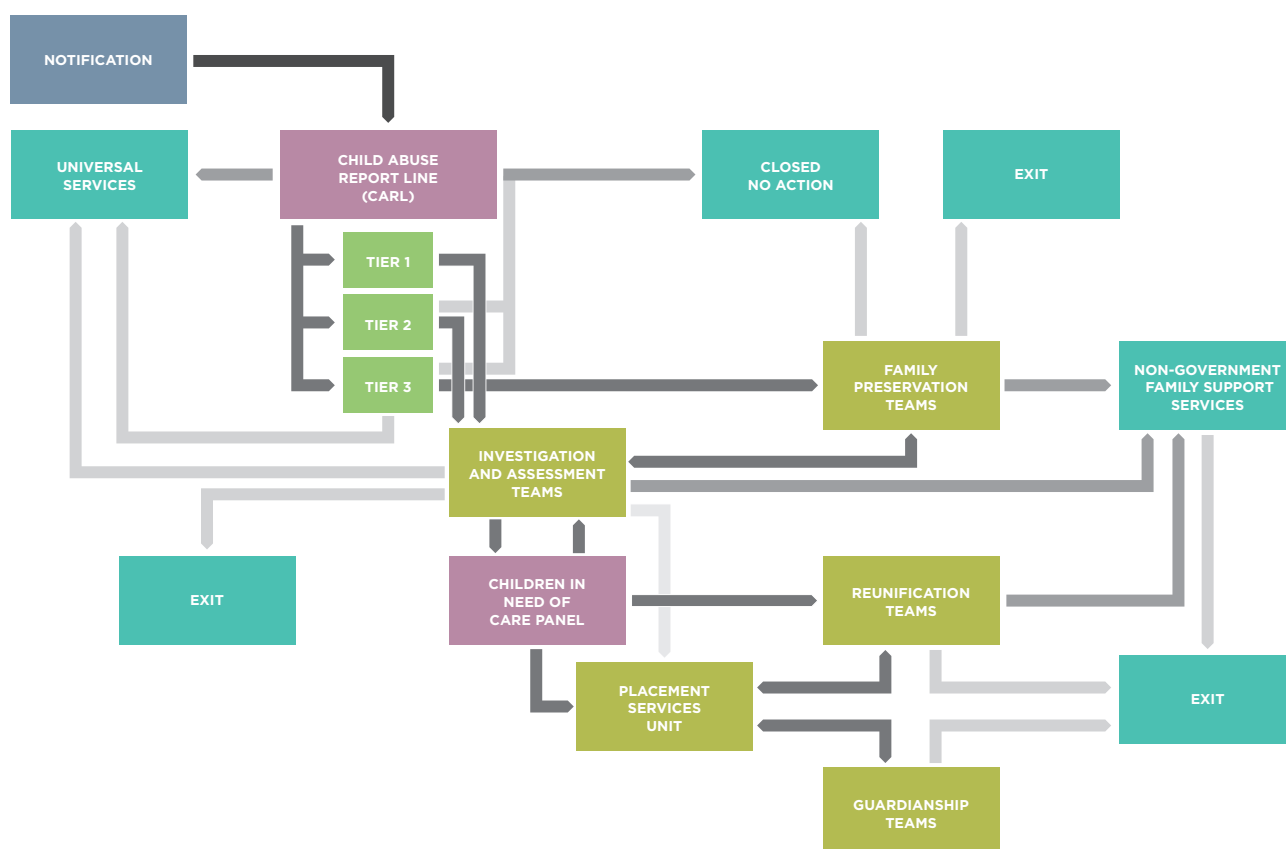


Figure 5.2: Families SA Redesign process flow chart (the 'factory model')

The high levels of resentment felt in the organisation towards the process impeded the workforce's acceptance of the significant reforms that needed to be made.⁴¹ Workers in the field came to associate Redesign with two reform processes: the move to a specialist hub structure and the implementation of a universal practice approach (Solution Based Casework™). As will be further discussed in this chapter, both were poorly managed.

The promoted change agenda was based on what came to be known as a 'factory model'. One version of that model is reproduced at Figure 5.2. The idea that the complexities of child protection could be reduced to a factory process offended many professionals, and led them to conclude that those leading the reform had an insufficient understanding of the complex system they had been tasked to reform.⁴²

In 2014 Ms Kleppe's engagement ended and a new manager for the Redesign process, Shirley Smith, was appointed from within Families SA. Ms Smith had experienced some of the reform process from her previous position as Manager of Service Accountability

and Development. She observed that one of the things that most concerned her about the process was the lack of engagement with experts and practice leaders within the Agency, in particular principal social workers and principal psychologists. She described it as 'one of the most disrespectful things I have come across in my career'.⁴³

The Families SA submission in 2014 to the Select Committee on Statutory Child Protection and Care in South Australia referred to the Redesign process. It boasted an 'ongoing consultation with staff complemented by a strong and effective communication strategy'.⁴⁴ The evidence heard by the Commission does not bear out this claim. Rather, it is apparent that the processes adopted further alienated the workforce and exacerbated an already toxic state of affairs. Staff continued to feel almost completely disengaged from important decision making.

SPECIALIST HUBS

One of the major reforms advanced through the Redesign process was the rearrangement of work management across local offices. Prior to Redesign, the Families SA offices delivered services covering each stage of a child's journey in the child protection system: assessment and support, protective intervention, and long-term guardianship.

The metropolitan offices were located in Adelaide, Woodville, Blair Athol/Modbury (office split across two sites), Salisbury, Elizabeth, Noarlunga, Aberfoyle Park, Marion; country offices were located in Gawler, Port Pirie (satellite office at Kadina), Port Augusta, Whyalla, Port Lincoln, Ceduna, Mount Barker (satellite office at Victor Harbor), Murray Bridge, Limestone Coast (located at Mount Gambier) and Coober Pedy.

The geographical reach for service delivery was restricted to the immediate local area, bringing advantages of a greater local focus.⁴⁵ This included accessibility and reduced travel time for clients. For staff, there was the capacity to hold a high level of knowledge about local conditions, local services and particularly vulnerable families in the local catchment area. The reduced travel burden permitted a greater percentage of working time to be spent in family engagement.

Redesign aimed to specialise functions, increase worker skill, and quarantine some resources for the important role of protective intervention, a function that had become neglected in busy offices attempting to manage a heavy workload of new intakes as well as the long-term guardianship of children.⁴⁶

Redesign's solution was a restructure of functions in the metropolitan area to create specialist hubs. The metropolitan offices were divided into north, south and central groups, and each office within that area was assigned a specialised function:

Assessment and Support (intake and initial assessment)

- Elizabeth (North)
- Noarlunga (South)
- Woodville (originally based at Adelaide) (Central)

Long-term Guardianship

- Salisbury (North)
- Marion (South)
- Hindmarsh (originally Woodville) (Central)

Protective Intervention

- Blair Athol (North)
- Aberfoyle Park (South).

The specialist hub structure builds into the system response (assuming that the child is taken into care on a long-term order) at least three different workers, and attendance at three different locations. The move reduced the range of functions being performed at each office, and expanded the geographic reach over which it was to be performed. Challenges for already vulnerable clients attempting to engage with the system were multiplied. One witness described the change for clients negotiating the child protection system as turning a 'sheer rock face into a bit of an overhang'.⁴⁷

The scope of the restructure was restricted by the availability of only eight metropolitan offices, and no capacity to develop a ninth. The specialist hub structure ideally required nine sites, to deliver three functions in the north, south and central regions. Ultimately, a decision was made to implement the hub structure with two rather than three protective intervention centres. Ms Whitten described this decision as a 'flaw' that she has been working on ever since.

Ms Whitten told the Commission that the issues outlined above were well known prior to the decision to restructure to specialist hubs. She thought that many of them were issues that existed even with the functions combined in local offices. In the end, it was the desire to build specialist centres of expertise that won the day.⁴⁸

It seems that some of the benefits of specialisation have been realised in the guardianship hubs where opportunities have been capitalised to bring together communities of foster parents around common challenges and experiences.⁴⁹ The experience in assessment and support and protective intervention has been less positive.

The challenge with separating assessment and support from protective intervention is that the two are enmeshed to a great degree, and court processes dominate the timeframes that potentially drive both. Intervention in families is a continuum and in some respects it is artificial to divide it across two phases.

As originally conceived, the specialist hub structure contemplated the exit of a number of cases at the protective intervention phase. It was assumed that intervention would resolve the areas of risk and provide services that would enable the family to leave the system at that point (see Figure 5.2).

The reality did not match this expectation. The fact that families entering the system were generally highly dysfunctional, with complex and entrenched problems, meant that there was reduced scope for interventions that would, in the short term, address the issues and enable those families to safely leave the system.⁵⁰

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In many cases protective intervention simply exposed a level of family dysfunction that made removal of the children for the sake of their safety inevitable.

As a result of the blockage of workflow to the protective intervention hubs, assessment and support workers often held on to files well after short-term guardianship orders were made. This in turn meant that capacity to act on new notifications became blocked, contributing to a rising rate of notifications coded Closed No Action, which indicates that Families SA has closed the notification without taking any action.⁵¹ Previously these issues could be dealt with in the local office by temporarily redeploying resources; now, a higher level negotiation between offices is required.⁵²

The most urgent need in this regard was reported to be in the northern hubs. The significant socioeconomic disadvantage in these areas has led to a high service demand, and the Blair Athol protective intervention hub has struggled to keep pace. Families SA argued for a third protective intervention hub and the area of greatest current need was the Elizabeth/Salisbury area.⁵³

It is argued in this chapter that the statutory agency urgently needs to invest in upskilling the knowledge base of its staff, and treat child protection work as a profession that demands the attention of the best and brightest professional workforce. The move to the hub structure was motivated by a desire to move in that direction, to provide an environment where specialisation of skill and quality practice was supported. The move has, however, come at a price. The Commission regards it as counterproductive to wind back the clock to reclaim the benefits of the local office structure. However, Families SA should continue to work towards a better integration of the assessment and support and protective intervention work, so that a more flexible approach to changing workloads is possible. This is especially important when the improvements anticipated through the growth in early intervention and preventative services are realised.

SOLUTION BASED CASEWORK™

As part of the ambitious process of reform proposed by Redesign, executive staff were asked to consider the value of adopting an overarching practice approach across the various functions of Families SA, to overcome a perceived lack of consistency and quality.

Mr Tony Kemp, then Director of Practice and Policy, conducted a comprehensive survey of practice approaches which showed promise for the South Australian environment. He ultimately favoured an approach developed in the United States of America called 'Solution Based Casework™' (SBC), developed by Dr Dana Christensen.

The approach had been implemented in a number of jurisdictions in the USA, but was at that stage entirely untested in the Australian social environment.⁵⁴

SBC draws on three theoretical foundations: family life cycle, relapse prevention and cognitive behavioural therapy, and solution-focused family therapy.⁵⁵ Those foundations support three fundamental assumptions for casework:

- Full partnership with a family is a critical and vital goal for every case.
- The partnership for protection should focus on the patterns of everyday life of the family.
- The solution should target preventative skills that are needed to reduce risk in everyday situations.⁵⁶

SBC focuses on the family unit and the everyday lifestyle of its members, endeavouring to help them find their own solution to problems. Once identified, problems become the target of specific plans of action that the whole family agrees to work on under the supervision of the caseworker. The model places a heavy emphasis on encouragement, and celebrating success when families achieve even small changes.⁵⁷ Witnesses described SBC as 'common-sense social work'⁵⁸, a description endorsed by its creator.⁵⁹

SBC places a heavy emphasis on partnerships with families, and reaching consensus with a family about their challenges.

In selecting SBC as the preferred practice model, Families SA was heavily influenced by the existence of research which showed that, if properly implemented and used with a high level of fidelity to the model, the approach was effective in supporting families. The same results were not observed in the absence of good implementation and high fidelity.⁶⁰

The research also showed that the approach, if used correctly, reduced the rate of child removal. This aspect of the evaluation particularly appealed to Families SA. It is critical to understand, however, that a reduction in child removal is not an aim of the approach, but simply a by-product of the good practice that the approach supports. Where there is poor implementation, and workers are not sufficiently trained in the model, there is a danger that the *effect* of improved practice becomes conflated with the intent of the model. That is, workers mistakenly believe that the model endorses a different approach to decisions about safety for children, and a tolerance of a higher degree of risk.⁶¹

The other major danger of SBC when poorly implemented is that the emphasis on consensus goals and family engagement is mistaken for a requirement that therapeutic work should proceed on terms dictated by the family, and workers lose sight of child safety.⁶²

The initial training in SBC was delivered to all staff during a two-and-a-half-day training session, beginning in June 2013. It was expected that this session would equip staff to begin a 'case consultation' process, which was the second stage of learning, and involved a group discussion led by a supervisor about the application of SBC to a particular case. The case consultation stage was designed to enable staff to consolidate and build on the theoretical learning delivered during the initial training. It was critical therefore that the case consultation phase follow closely the initial training.⁶³ However, after the delivery of the initial training, there was no centralised structure to support and promote engagement with the model. Although local office managers were trained as SBC 'coaches', many of them experienced their own uncertainties and anxieties about their role, and ongoing support for that function was not available.⁶⁴

As part of the contractual conditions of using the SBC model, practitioners work towards proficiency certification. However, at the time that the initial training was rolled out, there was no clear plan available for workers to understand what processes and steps sat between the training and their ultimate certification. There was no guidance about how long the case consultation phase would last, and what process would follow to enable staff to become certified.⁶⁵

In March 2014 a survey of managers from local offices revealed a high level of anxiety and confusion about SBC. A number of office managers not trained in social work were concerned that they lacked the knowledge to lead implementation. Many managers complained that there was no ongoing support available in the field to answer questions about the SBC model and the certification process.⁶⁶

It was not until May 2014, 11 months after initial training, that a detailed commissioning plan for the approach was developed.⁶⁷

In October 2014, a further review was conducted. The resulting report concluded:

The uptake and application of [SBC] across Families SA has not progressed as well as expected. Dr Christensen's recent September visit to South Australia identified that the current approach to certification with Families SA, while starting to show some signs of improvement in practice, is not achieving traction and application at the desired level.⁶⁸

The evidence supported the conclusion that good implementation was not achieved in the initial phases. Practice leaders in the organisation were excluded from implementation plans⁶⁹, the success of which depended on the model being accepted as credible and useful in the field. The absence of a comprehensive implementation plan guiding work from the outset resulted in uncertainty and frustration in the field, undermining the implementation of the model.

In May 2015, it became clear that a reorientation of implementation was needed, and the involvement of the principal practitioners was vital. A 'recommissioning' was launched, driven by principal practitioners as practice leaders.⁷⁰ This was augmented by the development of a certification manual completed in May 2015.⁷¹ SBC training is now also being delivered to not-for-profit agencies who work with Families SA.

Many workers who gave evidence were concerned about the suitability of the SBC model for the complex issues they were being asked to manage. In particular, many witnesses were concerned by the family rather than child focus of the SBC model. While the two are not always incompatible, there was a concern that the focus on family engagement and consensus might overshadow a close forensic examination of the safety of the child in their environment.

Dr Christensen, the architect of the model, acknowledged that there were concerns of this kind held by workers within Families SA but he regarded this as a function of an incomplete immersion in training, and the lack of opportunity to correct misconceptions that might arise with the workers' cursory exposure.⁷² Rebecca Starrs, an experienced SBC trainer, agreed that the model was appropriate for complex work, and felt that the widespread belief to the contrary was a function of the model introducing demands that had not been present before, and requiring a much deeper understanding of, and engagement with, family dynamics.⁷³

The productive deployment of SBC in child protection work assumes that workers also have a good working knowledge of child safety. Dr Christensen emphasised that workers:

need to know, for instance, knowledge about bruising, maltreatment ... They need to know some medical knowledge about what kinds of things can lead to bruising other than physical assault. They need knowledge about domestic violence and the various forms that it can take. They need to acknowledge the dynamics of sexual abuse victims so that they are sensitive when they interview. All these are layered-on skills ... Solution Based Casework doesn't try to do all of that. It tries to give them a structure within which they can make sense of all the knowledge that they have to have.⁷⁴

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It is critical that an ongoing effort to properly embed SBC is accompanied by a high level of investment in the workforce's knowledge base more generally. A failure to do so compromises the Agency's ability to deliver a better quality service, but also risks practitioners applying a simplistic and erroneous version of SBC that potentially endangers the safety of children. To properly evaluate the extent of the problem, a critical review should be undertaken to assess the degree to which current practice is applying SBC in compliance with the model. To support implementation and skill development, there should be ongoing consultation on SBC with principal social workers and the provisions of accredited trainers.

SBC was rolled out as a practice approach which was to have application across the three phases of work: assessment and support, protective intervention and long-term guardianship. Its focus on family strength lends itself most naturally to work being done in the protective intervention phase. Evidence before the Commission, however, raised valid concerns about its suitability and application in assessment and support and long-term guardianship work.

Because the model had not been well embedded in the current work of Families SA, the Commission heard very little evidence about how it was being applied in situations beyond family strength focused work. In these circumstances the Commission is not in a position to draw a conclusion about its effectiveness across all three work phases. It will be necessary to address the issues in training, accreditation and documentation before its effectiveness can be properly assessed. It is appropriate to record, however, a note of caution about the applicability of the approach to all aspects of Families SA's work.

RECORD-KEEPING CHALLENGES

Families SA's ability to perform its statutory functions efficiently and effectively is also undermined by deficiencies in record-keeping systems and processes. These challenges, particularly those originating in electronic information management, are not unique to South Australia, but are experienced by other child protection agencies and practitioners more broadly.

Research supports the conclusion that electronic information systems often undermine the practice of front-line social workers, and are not fit for purpose.⁷⁵ Child protection reviews and inquiries have reported on observations that these systems substantially increase workloads and lack reporting functionality⁷⁶, are a burden rather than a tool which supports casework practice⁷⁷ and create 'substantial obstacles to good practice'.⁷⁸

There is no doubt that 'recording is a key social work task and its centrality to the protection of children cannot be overestimated'⁷⁹, and that effective recording systems that support rather than drive practice are critical.⁸⁰ Quality record-keeping is especially significant for children who in later years want to understand their life in care.⁸¹

FROM CIS TO C3MS

Prior to 2009, the work of Families SA was recorded on the Client Information System (CIS) database. CIS stored information as a history that could be reviewed by scrolling through a continuous narrative of the child's contact with the statutory agency.⁸² It provided a longitudinal picture: a record of each occasion a child came into contact with the child protection system.⁸³ CIS was used in conjunction with hard-copy files, with some records being handwritten or typed for filing, rather than being recorded on CIS.⁸⁴

In 2009 Families SA introduced the Connected Client and Case Management System (C3MS). This development brought significant changes in recording practices. Whereas CIS was a mere information database, C3MS was a case management system.⁸⁵

C3MS was introduced to become a 'repository of knowledge about a particular case'⁸⁶. It was anticipated that C3MS would be the primary source of client information and only very limited information would be maintained in hard copy.⁸⁷ Practitioners, it was thought, would no longer be hindered by having access to a partial picture of a child's experiences through the electronic system.⁸⁸

The experience of the Commission suggests that this aim has not been fully realised.

C3MS is a modified version of the Client Relationship Information System (CRIS), developed for use in child protection by the Victorian Department of Human Services.⁸⁹ Families SA determined that the broad architecture of CRIS would be suitable for use in South Australia. Families SA procured CRIS for a nominal fee and focused expenditure on customising and enhancing the system for its use.⁹⁰

THE DEFICITS OF C3MS WERE WELL KNOWN

Families SA acquired C3MS at a time when CRIS was being heavily criticised in Victoria. It was reported that, among other failings, CRIS was not more effective than its predecessor, that it impaired efficiency without providing adequate functionality, and was a significant contributor to the system's lack of responsiveness.⁹¹

Families SA was aware of these criticisms. The Commission was told Families SA therefore had ‘a lot of opportunity to step back and learn from what Victoria had done’.⁹² Nevertheless, the evidence leads to the conclusion that similar limitations to those identified in Victoria have been experienced in this state.

THE SHORTCOMINGS OF AN INCIDENT-BASED SYSTEM

C3MS is incident-based. It encourages practitioners to only address immediate child protection concerns. It places practitioners at risk of missing critical information about a child’s story as it does not promote exploration of the cumulative picture.⁹³ Instead, C3MS was described by one user as being ‘like a jigsaw puzzle and it’s still in the box ... in discrete pieces and, yes, you can eventually put a picture together but not easily and not in a reasonable time’.⁹⁴

The Commission reviewed a number of files directly through C3MS and also considered large amounts of information extracted from it. Continuous and sequential narratives were not readily attainable. The files do not give a sense of people or the nature of their relationships. Files contain disparate pieces of information that are not well integrated or ranked by importance.

It is a laborious and frustrating task to read a C3MS case file, particularly for the purpose of developing a picture of a child and their situation. There are strong disincentives to consider current events in the light of any previous notification history.

DRIVING PRACTICE AND IMPAIRING PROFESSIONAL JUDGEMENT

C3MS was described as a tool that drives rather than assists practitioners: ‘It is so prescriptive ... and humans are not like that; lives are not prescriptive’.⁹⁵ An overly prescriptive system, particularly one incorporating risk assessment tools like C3MS, ‘may inhibit the professional development of new staff and restrict the creativity of experienced staff’.⁹⁶

The need to standardise information for recording purposes can lead to superficial descriptions of actions rather than meaningful explanations of assessments or planned interventions.⁹⁷ Focusing the attention of practitioners on standardised data input may minimise the importance of using professional judgment and developing professional expertise.⁹⁸

This challenge is not one that will be overcome simply by opting for a different electronic information system or by modifying C3MS. Practitioners should be given the confidence to approach practice not in accordance with C3MS recording requirements but with sound professional judgment. This confidence will not be

developed through interaction with C3MS: it will develop over time through meaningful training, support and supervision.

THE ADMINISTRATIVE BURDEN OF AN ELECTRONIC INFORMATION SYSTEM

Electronic information systems that are not fit for purpose can dominate workloads and distract front-line staff from their primary task. Practitioners are spending a disproportionate amount of time recording data on, or retrieving information from, an unwieldy system⁹⁹; some spend more time completing administrative tasks on C3MS than engaging in social work. For those who strive for meaningful and comprehensive client engagement, this can come at the cost of office-based work. However, if records are lacking on C3MS, practitioners are unable to account for their actions if an adverse incident occurs.¹⁰⁰

THE CONTRIBUTION OF RISK AVERSION

The preoccupation with recording may not simply be the product of a burdensome information management system, but rather a broader systemic aversion to risk, which can cause responsibilities to the Agency to be prioritised over accountability to clients.¹⁰¹ When quality practice is equated with documentation, effort is devoted to paperwork.¹⁰² As risk aversion increases and practitioners focus their attention on recording rather than doing, the engagement and time spent face to face with clients decrease.¹⁰³

C3MS also provides a monitoring and surveillance tool for management, which can review and examine the records kept on any child, and allows access to client information at all levels of the Agency. This can be used or misused in a micromanagement setting, with some workers complaining they felt spied upon when managers chose to examine practice concerns by reviewing C3MS documentation rather than addressing the worker directly.¹⁰⁴ In this sense, it is not C3MS that is to blame: it is how Families SA chooses to use the technology, which is no doubt a symptom of the hierarchical issues and the distrust that is evident between front-line workers and management.¹⁰⁵

REDUCING THE BURDEN

To reduce the administrative burden and encourage staff to treat C3MS as the single repository of information, Families SA should consider who should be responsible for administrative data entry. Supporting practitioner teams with a dedicated administration officer who can assist with administrative and organisational tasks should redirect the attention of practitioners from the office to the clients. This has proven effective in other child protection areas.¹⁰⁶

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A further option is to make better use of C3MS in an online environment, as there is scope for practitioners to have remote portable access to C3MS. Armed with the right equipment, a practitioner would be able to access C3MS away from the office, allowing them to enter information at a point closer to their activity. This has the potential to reduce double-handling and promote greater client interaction. It should encourage efficiencies and support practitioners to better balance their time between field work and office-based tasks.¹⁰⁷

The Commission proposes that initially there be a pilot program for remote access to C3MS in country regions where the burden of travel away from the office can magnify the administrative burden. Evaluation of this pilot should examine whether there have been resource savings (in terms of time and money), and also assess whether the information captured is more valuable. It should also critically examine whether the availability of technology disrupts engagement with clients or diminishes communication and relationships between the practitioner and supervisors.¹⁰⁸

REAL AND APPARENT GAPS IN ELECTRONIC CASE FILES

The effectiveness of C3MS as a case management system is also undermined by the manner in which information is input by users. It is often not entered correctly and the system is swamped with duplicate entries and documents. Evidence consistently given to the Commission was that finding and extracting data from C3MS is a cumbersome process.

Families SA staff receive limited training on the use of C3MS and there is little clarity as to what, and how, information should be recorded.¹⁰⁹ Although there is probably no practical limit to how much information can be stored on C3MS¹¹⁰, the system is already slow at retrieving data because of the quantity of information stored. This situation will deteriorate as it is inundated with more.¹¹¹

FINDING RELEVANT INFORMATION

Several witnesses told the Commission that finding information in C3MS is increasingly akin to finding the proverbial needle in a haystack. Important information is essentially irretrievable when stored in a generic section of C3MS among a raft of other information, such as emails and miscellaneous notes.¹¹² C3MS does not provide easy retrieval of information about a child's journey in care, including how many, and the type of, placements a child has had, or basic information about their medical history.¹¹³

Navigating C3MS to obtain a narrative of a child's history would be less onerous if all staff entered data onto the system consistently and in the correct location.¹¹⁴ However, inconsistent storage of information is encouraged by the diversity of descriptors available to users of C3MS.¹¹⁵ This contributes to difficulties in retrieving information. The sea of descriptors should be rationalised. It is essential that Families SA establish very clear naming conventions and guidelines regarding the storage of information on C3MS. This should improve the ease with which information can be located and retrieved.¹¹⁶

There is also a need to provide staff with comprehensive training about the recording of information. It should resolve who is responsible for entering data, with the aim of reducing duplication of records. It should emphasise the practice implications of the system's incident focus, which does not easily produce a picture of a child's cumulative experience. A balance should also be struck between accountability and the recording of information that is relevant to the needs of the client and the provision of care.¹¹⁷

The gaps in electronic case files cannot be entirely attributed to information becoming lost within C3MS. The Commission's examination of C3MS revealed examples of what appeared to be poor case management resulting either from deficiencies or inactivity in casework. However, some of these gaps may have been the result of information simply not being uploaded. While recording on hard-copy files is reducing, the Commission discovered that some staff, rather than upload information to C3MS, keep large private holdings of documents (discussed later in this chapter). Satisfactory explanations were not supplied to justify this practice. C3MS therefore does not provide a single source of truth about a child's journey.

DATA INTEGRITY

Accurate statistical data is critical to the effective functioning of Families SA. The reliability of C3MS as a tool for statistical analysis is heavily dependent on the consistency and accuracy of the data recorded.¹¹⁸

Data needs to be captured and stored in a way that supports the sometimes competing requirements of practice, retrieval and statistical analysis. Without a capacity to extract accurate and reliable data it is difficult to understand how the Agency can monitor the needs of children, and scrutinise its performance in responding to those needs. Accurate data is also critical to future planning.

In the course of this Inquiry the Commission summonsed a large quantity of statistical data from Families SA. The examination of the summonsed data was important for a number of reasons.

To understand the magnitude of the challenges facing the statutory agency and the broader child protection system, it was necessary to analyse trends and patterns in how the statutory agency responded to children and families. It was also necessary to consider to what extent the data supported some of the contentions made in evidence before the Commission.

In responding to summonses, Families SA repeatedly demonstrated a compromised ability to produce sound statistical data from C3MS. The Commission's work was regularly thwarted by incomplete, inconsistent or inaccurate data. These deficiencies were more often than not only uncovered following queries or concerns raised by the Commission.

For example, the Commission issued a summons for annual data about the number of children who had entered the care of the Minister pursuant to the *Children's Protection Act 1993*. A query about the figures produced revealed they were incorrect: they excluded children who had entered the care of the Minister pursuant to a voluntary custody agreement (section 9 of the Act) or an investigation and assessment order (section 21 of the Act). Families SA had, however, included children who entered care under other legislative instruments, such as the *Adoption Act 1988* (SA) and immigration laws.

The Commission has gone to significant lengths to verify that statistical data produced by Families SA is accurate, or at the least that the limitations of the data are known. Nevertheless, the data extracted from C3MS appears at times to be unreliable and easily manipulated. Fundamentally, C3MS was not designed as a tool for statistical analysis. But currently, and for the foreseeable future, it is the tool on which Families SA must rely. In doing so it should be mindful of the deficiencies in the reporting functionality of C3MS.¹¹⁹ Regrettably, this caution was frequently lacking in Families SA's approach to producing statistical data to the Commission.

ENHANCING C3MS

Families SA has an ongoing process to identify and address deficiencies in C3MS functionality and develop enhancements. The timeframe to implement enhancements depends on their complexity and staffing availability. To date, the challenge for Families SA has not been the resolution of technological issues but rather the time lag for development. The estimated completion time for some enhancements is well over 200 days, and in some cases almost 500 days.¹²⁰

In 2009 the Victorian Ombudsman recognised a need to consider whether the Department of Human Services' incremental improvements strategy could ultimately deliver a satisfactory case management system.¹²¹ In 2014, the Victorian Auditor-General, reviewing the Department of Human Services' residential care services, criticised

CRIS for being 'cumbersome and disorganised'¹²², observing that the system was operating 'as a depository rather than a Client Relationship Information System' and that important documents were 'often buried amongst hundreds of other documents'. The Ombudsman also observed that compliance reporting based on data in the system was unreliable.

Evidence before the Commission suggested there was scope to continually enhance C3MS. However, this may be a treacherous path, given that over the course of about five years the Victorian statutory agency has struggled with this approach.

Like CRIS, C3MS has become a vast repository of information about vulnerable children in this state. In the short term, the statutory agency should create smarter ways for practitioners to access its contents.¹²³ In the immediate future the enhancement program should continue. Currently, some important enhancements are delayed by more than 12 months. These delays should be addressed, and constructive and practical benchmarks should be established for their development. In the longer term, the viability of C3MS as a supportive case management system should be critically reviewed.

C3MS BEYOND THE STATUTORY AGENCY

There is scope for agencies beyond Families SA to be given access to portions of C3MS to promote information sharing and encourage efficiencies in the child protection system. For example, C3MS is used in youth justice, and health and education professionals are able to input information directly into a child's life domains. There is the opportunity for key stakeholders to become part of the C3MS workflow, such as not-for-profit organisations who assess foster parents or Child Protection Services in SA Health who receive and respond to referrals from Families SA.¹²⁴

C3MS could also be better utilised to share information with a child's care team across services and agencies. CRIS, for example, includes a common client layer to allow various practitioners to see interactions between the client and other parts of the system. CRIS has also been released to non-government service providers.¹²⁵ The manner in which this is approached should be guided by the extent to which it will improve service coordination, collaboration and transparency.

There is scope for limited aspects of C3MS to be accessed and contributed to by service users, such as foster parents and children in care.¹²⁶ The Australian Centre for Social Innovation (TACSI) has developed the concept of Single View, a computer application that would overlay C3MS and extract information to provide a snapshot of a child's or family's details. Single View screens could be created for children and carers, giving them easy access to relevant information.¹²⁷

5 CHALLENGES FOR THE STATUTORY AGENCY

THE FUTURE OF ELECTRONIC INFORMATION SYSTEMS IN THE STATUTORY AGENCY

There is no doubt C3MS is shaping and constraining professional activity in Families SA, disproportionately consuming the time of practitioners and fragmenting the recording of client experiences.

The Commission is not aware of any comprehensive evaluation of the performance of C3MS, nor is there any evidence that a better electronic information system currently exists. However, the Commission is not confident C3MS can meet the needs of the statutory agency into the future.

Families SA is not alone in grappling with this challenge. Electronic databases are a fact of contemporary child protection practice. Effective electronic information management is an issue facing many child protection agencies and one that receives international attention. Concurrent with enhancing and refining C3MS, Families SA should dedicate resources to monitoring research and developments in this area, and contributing when opportunities present. A system is needed that can effectively manage the dual functions of organisational administrative oversight, as well as the recording of developmental, relational work with clients.

A decision to replace C3MS with a more suitable and effective electronic information system should be evidence based, and accompanied by a comprehensively planned implementation program, including the review of a pilot system and the thorough training of staff.

An effective electronic information system will not solve organisational culture issues.¹²⁸ Technological improvements are unlikely to realise their full potential if the culture of avoiding blame rather than maintaining quality practice is not shifted.¹²⁹ It is critical that new technology does not become infected with Families SA's old way of doing things.¹³⁰

SUMMONS NON-COMPLIANCE

Beyond data integrity issues, the Commission's inquiries were repeatedly frustrated by Families SA's incomplete compliance with summonses. This came to a head during the hearing of Case Study 4: Nathan, when it was discovered that before producing a summonsed document, senior staff within Families SA had made substantial alterations to it.

This discovery necessitated the calling of evidence to understand the circumstances in which that occurred, and whether those circumstances resulted in the alteration of other documents. The evidence relating to this issue revealed a fundamental misunderstanding

by senior staff within the Agency of their specific legal obligations, but not a dishonest intent to circumvent the Commission's processes.

THE SUMMONSED DOCUMENT

The document in question, referred to as a background situation report, was prepared by Nathan's social worker. The report contained a summary of Nathan's entry into care, his placement history and his current circumstances. The social worker made a series of candid observations on system issues that, in her view, had prevented the achievement of better outcomes for Nathan.

Mr Scheepers on behalf of Families SA was legally obliged to produce to the Commission any document that answered the terms of the summons on the date it was served. The terms of the summons required the production of the report authored by the social worker. At the time that the summons was served, a document answering the description existed, at least in draft form.

After the summons was served, instructions were given from within Families SA that any document would have to be reviewed prior to being produced.¹³¹ Caroline Keogh was an assistant director for the southern region and the review was to be undertaken by her.¹³² However, any review of the document by Ms Keogh or any other person, according to law, would be restricted to whether the document answered the terms of the summons and whether any grounds existed to legally resist production or redact portions.

The Crown Solicitor's Office (the Crown) acted as the legal representative for Families SA in making arrangements for the production of documents on summons. Summonsed material was forwarded by Families SA to the Crown, and from the Crown to the Commission, subject to any legal advice given by the Crown to the Agency.

Before the original report was produced to the Commission, Mr Scheepers became aware that the Crown had raised an issue of concern about the report.¹³³ Rather than focusing on his legal obligations pursuant to the summons, Mr Scheepers asked himself whether the document was in a proper form and had been approved through the required channels.¹³⁴ However, those matters were irrelevant to the question of the Agency's legal obligations.

A series of emails then ensued between Mr Scheepers and senior staff. Susan O'Leary, the Director of Metropolitan Care and Protection Services, undertook to ensure the report was 'done properly', noting it had not 'gone through the correct channels'.¹³⁵ In response, Mr Scheepers queried if the report could still be amended.¹³⁶

Ms Whitten was concerned that the social worker's report lacked endorsement from any senior officer. She took the view that in these circumstances it could be considered a draft and did not have to be produced to the Commission.¹³⁷ Ms Whitten's actions were dictated by a preoccupation with the usual authorisation processes and the document's adherence to a particular form, rather than a consideration of the agency's legal obligations.

EDITING THE DOCUMENT

Ms Keogh, at the direction of her manager, Ms O'Leary, then edited the social worker's original report.¹³⁸

A number of the social worker's observations that reflected poorly on Families SA were removed. Some of the observations made by the social worker were altered to convey an entirely different meaning. Ms Keogh denied in evidence that her intent had been to provide a sanitised account. Her intent, she said, had been to remove personal opinion and present a more professional document to the Commission.

Ms Keogh's alterations, in total, had the following effect:

- All references to the deleterious impact that Nathan's period in emergency care had on his development and psychosocial functioning were excised.
- Criticisms of the failure of the Education arm of the Department to provide a suitable educational environment for Nathan were deleted.
- Observations of some challenging aspects of Nathan's living environment were deleted, as were references to the inappropriateness of a residential care unit for Nathan.
- The social worker's opinion that Nathan's needs were not being adequately met by Families SA and the Education arm of the Department more broadly were removed.

The document produced to the Commission in response to the summons could not be said to have been authored by the social worker (as required by the summons). Rather, unbeknown to the author, Ms Keogh's amendments changed the overall thrust of the report. It was this amended document that was then produced in answer to the summons.

The extensive editing that had occurred after the report left the social worker's hands was not declared on the face of the document. It was presented to the Commission in a way that suggested it was the work of the social worker alone. This had the potential to mislead the Commission and misrepresent the social worker's well-informed professional opinions.

Producing the altered document, and failing to produce any report authored by the social worker, was a clear breach of the summons. A number of factors contributed to the breach:

- an absence of training regarding the Agency's legal obligations for all staff involved in producing documents in answer to a summons;
- poor communication from higher management levels through to the social worker, about the state of the report at the time the summons was served;
- a culturally ingrained lack of organisational candour as to the challenges the system has faced caring for Nathan;
- an organisational culture that encouraged uncritical compliance with direction rather than independent thinking about the action being proposed; and
- an unquestioning acceptance of 'chain of command' requirements within the organisation.

A CLAIM FOR LEGAL PROFESSIONAL PRIVILEGE

During the critical period where the obligations to produce were being considered, Families SA obtained legal advice from the Crown. The advice clearly concerned the Agency's obligations pursuant to the summons. In the usual course of events, contents of legal advice would be privileged from disclosure to the Commission. Mr Scheepers had previously declared an intention to be open and transparent with the Commission, saying he regarded that as the way in which appropriate reform would be accomplished. In the course of evidence Mr Scheepers was given the opportunity to waive the privilege that prevented the Commission from understanding the nature of legal advice given with respect to this document. Mr Scheepers declined to do so. The maintenance of the claim obscured the Commission's ability to fully understand the events that resulted in the production of the altered document.

In particular, it is impossible to ascertain whether the failure to comply with the summons was the result of Families SA's decision making or whether its actions relied on legal advice.

Some Families SA staff involved in these events gave evidence that they believed that both the original and the altered report were to be produced to the Commission. The maintenance of the claim of privilege over the contents of the advice means the Commission is unable to explore these claims. The Commission is therefore unable to determine the ultimate responsibility for the failure to produce the original report.

5 CHALLENGES FOR THE STATUTORY AGENCY

A MUCH BROADER PROBLEM

The discovery of the irregularities relating to compliance with this particular summons prompted the Commission to embark on a wider inquiry into Families SA's processes with respect to its response to summonses.

Significant deficits were uncovered in the processes employed to identify relevant records for production. These deficits were compounded by inconsistent record-keeping practices which created formidable barriers to the statutory agency meeting its legal obligations.

The Commission issued three summonses to capture all records, whether held electronically or in paper form, relating to Nathan. Investigations revealed that compliance with these summonses was incomplete. Searches conducted within Families SA to respond to the summonses were insufficient to identify the range of records that were held by different workers and in different offices. Many important records were later located in the private email holdings of senior staff members, including members of the Executive. C3MS was found to have been interrogated inadequately, and critical records from that system had not been produced. There was a clear lack of structure and consistency in the management of the child's records. This must challenge a practitioner's ability to obtain a comprehensive understanding of relevant decision making. Importantly, in the long-term, poor record keeping undermines the statutory agency's ability to provide children with a complete and genuine picture of the care provided to them by the state.

SYSTEMIC FAILURES

Non-compliance with the summonses in relation to Nathan's records was not an isolated oversight. It was just one example of a series of failures by Families SA to comply with summonses.

Failures were identified in three principal areas:

- failure to produce a particular category of hard-copy file across six separate summonses. The evidence before the Commission did not permit a conclusion as to the reasons for this failure;
- incomplete interrogation of C3MS across 56 summonses resulting in potentially widespread non-compliance; and
- records relevant to the care of children being held personally by staff, including very senior staff members, rather than being uploaded to C3MS.

In the lead-up to the case study into Nathan's care, documents produced by the Guardian for Children and Young People alerted the Commission to important events that should have been detailed in Families SA

records. Repeated enquiries were made to Families SA about full compliance with the summons, which had been due about six months earlier.

For two weeks after hearing of evidence commenced, Families SA continued to produce additional records to the Commission in a piecemeal fashion. The Commission was repeatedly assured there were no further records to be produced and that the process was complete, only to be repeatedly faced with the discovery of additional records.

C3MS IS NOT THE SINGLE SOURCE OF TRUTH

The extent of the problem was astounding. Approximately 1000 further pages were produced to the Commission six months after the original date for compliance with the summons. These were, in the main, records about Nathan that were stored in places other than the central repository for his records.

Various reasons were given by Families SA for this failure:

- When the summons was initially received, some staff members involved in decision making relevant to Nathan's care were not asked to produce documents.
- Correspondence, in particular emails, relating to Nathan's case management were held privately by senior staff members including Ms Whitten, Ms O'Leary and Ms Keogh, and not stored on C3MS.

A considerable portion of the records belatedly produced to the Commission were stored by Ms Whitten in her government email inbox. They documented her involvement in the management of Nathan's care over a number of years. These documents, along with those held by other senior staff, revealed important features of the statutory agency's response to Nathan's care needs and the relationships between Families SA and other stakeholders, particularly in the face of differing views and priorities. Ms Whitten's records contained key directions about significant aspects of Nathan's case management. No satisfactory explanation was provided to the Commission as to why these records were not uploaded to C3MS. Layer upon layer of staff not only involved themselves in the decision making for Nathan, but their private holding of relevant documents fragmented the overall record, making it almost impossible to obtain a complete picture of events.

A GROSS BREACH

The breach of the legal obligations imposed by the service of summonses relating to Nathan highlighted major deficiencies in Families SA's systems. Evidence about the extent of the non-compliance uncovered a significant misunderstanding about basic concepts such as what the term 'document' encompasses. There was an alarming disconnection between staff responsible

for coordinating responses and field staff who had the most detailed knowledge of how and where records were retained.

There is no doubt the strong hierarchical culture within the organisation contributed to Families SA's inability to structure itself to properly comply with summonses. It relied on a complex layered structure to communicate requests for documents, with no individual in the hierarchy taking responsibility for quality assurance.

When Mr Scheepers joined Families SA in November 2014, he became responsible for compliance as the person to whom summonses were generally addressed. Mr Scheepers accepted the assurances of existing staff that the processes in place were robust and effective. To the contrary, however, the Commission's inquiries revealed that those processes were inadequate from the outset and over time proved to be deficient.

As a result of these issues the Commission cannot be confident that there has been proper compliance with all the summonses issued to Families SA.

Although it is not intended to impose a penalty on anyone in Families SA for non-compliance with the four summonses issued in Nathan's case, it is necessary to record a formal finding that there was a failure to comply with summonses to produce documents in breach of section 11(1)(f) of the *Royal Commissions Act 1917*.

A STRUCTURAL SOLUTION

It is clear that the problems of child protection cannot be solved by the statutory agency acting alone. These problems require the coordinated and collaborative attention of various services across the government and non-government sectors. In South Australia, there has been a growing awareness of the potential advantages of aligning Families SA with other services whose services are complementary. In recent times Families SA has been the subject of considerable negative media attention and some reports raised the question of whether a structural solution (that is, the realignment of departmental and ministerial responsibility) might contribute to improving the outcomes of children's safety. However, some contributors urged a cautious approach to the issue of change, bearing in mind the number of changes that Families SA has already undergone in recent times and the impact of this on the workforce.¹³⁹ Any consideration of a structural solution needs to carefully balance the benefits of such a change against the appetite and capacity of the Agency for that change.

A BRIEF HISTORY OF THE STATUTORY AGENCY

In the late 19th century, relief and care of destitute persons, including children, was provided by the Destitute Poor Department throughout South Australia. The Children's Department later assumed responsibility for state children until 1927 when the Children's Welfare and Public Relief Department took on that responsibility. In 1965 this department was renamed the Department for Social Welfare, and approximately five years later, joined the Department of Aboriginal Affairs to form the Department of Social Welfare and Aboriginal Affairs. A further change in 1972 saw it become the Department for Community Welfare. Mr Ian Cox, who had a background in social welfare, was the Director-General of that department from 1970 to 1984. Under his leadership, the department underwent reforms which included new ways of working with families and children with disabilities as well as advocating for the rights of parents to own their information and have their voices heard in professional discussions about their children.

In 1990 the Department became the Department for Family and Community Services (FACS). In 1998 FACS amalgamated with Health and Housing to form a 'super department', the Department of Human Services. The child protection agency then became known as Family and Youth Services (FAYS). From that point to the present, child protection functions have been located within larger departments and managed alongside other human service functions.

In 2004, the Department of Human Services was reconfigured and FAYS was replaced by Children, Youth and Family Services (CYFS) as part of the newly created Department for Families and Communities. In 2006 there was yet another name change when CYFS was renamed Families SA.

In 2011/12, as part of state government changes, the Department for Families and Communities was renamed the Department for Communities and Social Inclusion (DCSI) but Families SA was merged with the new Department for Education and Child Development (DECD). In the move, Families SA was separated from youth justice functions, and the College for Learning and Development.

THE MOVE TO THE DEPARTMENT FOR EDUCATION AND CHILD DEVELOPMENT

The news release on 21 October 2011 that accompanied the amalgamation of services for children in the new department said:

The Department for Education and Child Development will work with children and their families to lead and deliver high quality public education and care to give every child in South Australia the best start in life. Key services of the current Families SA will be brought together with the Education and Child Development roles into one department.¹⁴⁰

The merger of Families SA with DECD was intended to provide 'stronger integration of education, early childhood health and protective services, as well as strengthen partnerships across government and community so that every child will get the best possible start in life'.¹⁴¹

Keith Bartley had been appointed the Chief Executive of the Department for Education and Children's Services in January 2011 to lead the reform of school and preschool education. At the time of his appointment, Mr Bartley was the head of England's professional teaching regulatory body of the General Teaching Council. He had previously run the integrated education and children's services department of Oxfordshire in England and had been a high school teacher and school leader for 13 years. Mr Bartley was subsequently appointed as the Chief Executive of the new department.

Although planning for these changes must have been in progress well before the public announcement, the then head of Families SA, David Waterford, was not advised until the date of the public announcement in October 2011. He had not contributed to discussions preceding the announcement, and was interstate at the time. Immediately thereafter, Mr Waterford was asked to move his office location to join other DECD executives.¹⁴² The changes officially took effect on 1 January 2012.

A project team, 'Integrated Services, Improved Outcomes', was established to identify opportunities arising from delivering services in a more integrated way.¹⁴³ The research and engagement project findings were intended to be used to inform future planning.¹⁴⁴

In April 2013 DECD's 'Brighter futures ... From blueprint to action' plan was published.¹⁴⁵ The document described the Agency as having been involved in a 'period of intense discussion, consultation and organisational change, in order to achieve the state government's vision of a fully integrated child development, education and child protection system for South Australia'. The plan argued that the DECD workforce needed to take collective responsibility for all children and young people,

and that the department needed to work differently to fulfil its mandated role. The plan introduced the idea that DECD would be structured into five separate offices, starting March 2013 with the Office for Child Safety, through to July 2013 when other offices would follow:

- the Office for Education;
- the Office for Children and Young People;
- the Office for Child Safety (Families SA);
- the Office for Resources, Operation and Assurance; and
- the Office for Strategy and Performance.

More detailed planning was to occur and be shared with DECD staff by July 2013. It was anticipated that changes would be in place from January 2014, together with plans about how the organisation would move through 2015 to 2016.

On 1 July 2013, Commissioner Debelle published a report on the failure of a metropolitan school to notify parents about an incident of child sexual abuse. The Debelle Inquiry found significant failings in DECD's handling of the matter and made relevant recommendations.¹⁴⁶

About a fortnight after publication of the Debelle Inquiry, Mr Bartley resigned his position, citing health and family reasons. Tony Harrison, a former Assistant Commissioner of Police, was subsequently appointed to replace him. With Mr Bartley's departure went his expertise and experience in the delivery of integrated education and children's services.

INTEGRATION ISSUES

Mr Waterford continued as Executive Director of Families SA (later Deputy Chief Executive, Child Safety) in the move to DECD. Notwithstanding that he was not consulted about the move, he told the Commission that he 'saw the theoretical value in associating child protection with an Education and Child Development Department'. He had a concern, however, that:

the Department for Education and Children's Services, as it then was, was essentially a schools department—it wasn't an education and child development department. If it had been an education and child development department, then placing child protection in there would have, I think, enhanced the state's response to child protection issues. Because it was a school's department, in essence ultimately as I feared, it did become quite burdensome and eroding of capacity experience for child protection.

He was also concerned that the relative sizes of the existing education arm of the department would swamp the much smaller Families SA in terms of strategic agenda. This had been the experience of the statutory

agency when it was placed within the large Department of Human Services in the 1990s. Mr Waterford had not sensed the same dilution of focus when the Agency had been managed within the Department for Families and Communities, although that was also a large department. He observed that senior executives within that department had experience in, and understood the business of, child protection. The client groups serviced by the various agencies within the department had similar challenges, and the operational demands were similar. The agencies within that department, Mr Waterford observed, 'understood one another's positions and the corporate services were structured to support those operational requirements'.

It was obvious that, as part of the move to DECD, corporate services would need to be rationalised. The challenges of this process were underestimated, and as the merger proceeded additional challenges emerged.¹⁴⁷ Assumptions had been made about how resources were being used within each agency, and how much rationalisation would be possible. Staff from Families SA were integrated into areas working alongside workers from education. They soon realised that historical considerations meant that staff from education were classified at a much higher level than staff from Families SA for the same work. These unforeseen issues delayed integration and resulted in continued duplication of functions.

A critical corporate service for Families SA was human resources. In the merger, Families SA lost human resources staff who had an established expertise in the demands of the Families SA workforce. Mr Waterford said he complained of a resultant 'lack of corporate understanding'. There was a significant distance between human resources support and line management, and the level of support Families SA had been used to was no longer provided.

As part of delivering savings across government, executive positions within the new department were reduced. Resignations from Families SA, and a failure by the education side of the department to achieve its targets, resulted in an overall loss of expertise from child protection that was not replaced.¹⁴⁸

Also lost was the College for Learning and Development, a registered training organisation that delivered training in-house to Families SA workers, enabling them to obtain formal certificate qualifications in relevant areas. The college remained part of the newly formed DCSI, and there were issues with continuity of learning for Families SA staff.

One witness described the benefits of the college as follows:

Some 25–30 years ago, Families SA had a learning and development branch that was focused on preparing and supporting staff to be competent and capable child protection operators. There was a clear training program facilitated by personnel who were or had been child protection practitioners in their own right. This unit was significantly impacted when Families SA became part of the Department of Human Services. During this period, significant funding was transferred to Health and the role of the learning unit minimised. It has struggled to recover, despite efforts by previous Chief Executive Officers such as Sue Vardon to reinstate its important role.

For a time there was a defined learning program based on job roles and this worked reasonably well and was TAFE-accredited. However the establishment of DECD again saw the learning and development component of Families SA falter.¹⁴⁹

Another senior and experienced former staff member observed:

Previously we were offering staff who came in as child protection workers, that they could do a course which was accredited as a diploma in child protection, and then that would give them some status and additional knowledge. Now that we've moved into this Education and Child Development, that's gone.¹⁵⁰

A number of present and former employees of Families SA referred in evidence to their concerns about the placement of Families SA within DECD. Some witnesses considered child protection to be a specialist welfare function, which belonged in a department that had links to other family and community services for children and young people.¹⁵¹ However, the majority understood the rationale behind the move and had no reservations about collocation with other services. Some recalled past benefits as a result of physical collocation with offices such as Centrelink, Housing SA, Child and Family Health Services, and Drug and Alcohol Services.

Rodney Squires, a former executive in Families SA, had extensive experience with the department in its various historical iterations including previous mergers. He regarded this merger as the poorest he had experienced.¹⁵²

The respective staff sizes of education and child protection is an important consideration. At June 2015 DECD had a total of 29,793 employees¹⁵³, with Families SA having 1742¹⁵⁴. One worker described Families SA in a larger department as 'the poor relation ... we need someone who understands the work that we do—and it's completely different to education'.¹⁵⁵

5 CHALLENGES FOR THE STATUTORY AGENCY

Another observed that:

I understood the vision ... When Families SA first went to DECD I was like, 'You know, that could really work'. I think there are some real benefits to it because education, child development, and then the trajectory of that child coming into care is so interrelated. So it really works on paper, but I think it's just the amount of staff that are in DECD compared to our little pond, just really bad behaviour ... I have never been spoken to the way that I've been spoken to by DECD employees ... I don't know, we're clearly not wanted.'¹⁵⁶

The Commission was told that Education, in the main, had not embraced its relationship or role with regard to child protection, despite the amalgamation. There was a strong sense that Education staff wanted to focus on the core business of education, and felt that departmental arrangements that widened this focus were not in their interests. At an individual level educators wanted to focus on educating, and were reluctant to embrace a role that required them to monitor and contribute more widely to children's wellbeing more widely.

The Commission heard a number of examples of educational staff insisting that Families SA contribute financially for educational services and support for children in care that other children were entitled to have supplied to them free of charge. This was particularly evident in a number of squabbles about funding for school support officers (SSOs). SSOs are provided within the education system for children with high needs who require extra support in the classroom environment. Parents and caregivers are not asked to contribute financially to this support. For children in care, however, the Commission heard that Families SA was frequently asked to contribute to the cost of these supports, and negotiation about these matters delayed enrolment and service provision for vulnerable children.

The perception that Families SA has not truly been accepted into the larger department was summarised by former Families SA executive Mr Kemp in the following way:

Bureaucracies being what they are ... the small guy gets swallowed up by ... big education departments; the Families SA is sort of sitting over here on the sidelines, waving to this huge great big dinosaur of a department called the Department of Education which just swallowed us up, basically. And, you know, a year into the project...there were still teachers who didn't know that Families SA was part of [DECD] so we hadn't landed what this was about.

... If Families SA left in the morning or Education left in the morning, nobody would notice.'¹⁵⁷

The impression that Families SA had not been accepted or wanted by those in Education is to some extent borne out by a media release issued by the Australian Education Union (SA Branch) on 2 February 2015. The release coincided with the announcement by Ms Jennifer Rankine that she would be resigning as Minister. The State President of the Australian Education Union, Mr David Smith, issued a statement arguing that the resignation provided the state government with an opportunity for Education and Families SA to return to operate as separate departments. Mr Smith stated:

Both Education and Families [SA] are major departments that require their own leadership and focus to function properly. We are particularly concerned that the combination of the two departments has led to a loss of focus on the provision of high quality education for our children.

Teachers and leaders working in public preschools and schools feel that since the departments were combined, Families SA issues have very much replaced teaching and learning as the key focus of the Education Department (DECD). They believed strongly that a return to the previous arrangement where Education was managed by a dedicated department with its own Minister led to better outcomes for preschools, schools and their students.

Today, AEU branch executives passed a resolution calling on the Premier to act in the best interests of South Australian public education and the thousands of children who attend public preschools and schools by returning the department's focus to teaching and learning.

Now is a good time for the Premier to concede the combining of two departments is a failed experiment. We strongly urge his government to reinstate DECD and Families SA as two separate departments who can cooperate in the best interests of our children.

Further, we see it as vitally important that the Department of Education's leadership is strongly grounded in education, theory and practice. We have hundreds of experienced educators in this state and it's time we looked to them to provide leadership for our preschools and schools.'¹⁵⁸

Although there appeared to be a high level of dissatisfaction about the way in which the merger had occurred, there was a general acknowledgement of the value of the original founding principles. It is difficult to identify exactly why advantages that were initially envisaged were not realised, but the difference in size between the two departments of education and child protection, and the challenges in merging two disparate cultures, appear to have played some part.

A STAND-ALONE DEPARTMENT

Careful consideration has been given to whether the necessary reforms to the Families SA organisational culture, workforce capacity and quality of work can be achieved if it continues to be located in the larger department. There is a danger that the department's strategic focus will continue to prioritise the much larger educational arm. If Families SA is to transform itself it needs careful and close attention. It requires leadership from executives who have an understanding of the challenges of child protection work. Some witnesses argued that these things should be developed in the focused environment provided by a stand-alone department with a direct line of ministerial responsibility.

However, there are advantages to collocation, some of which have been realised in more recent times. Mr Scheepers told the Commission that he considered that Families SA had now realised the benefits of shared corporate services. He pointed to the advantages of access to highly experienced finance officers in DECD who were used to engaging in long-term budget discussions at a level that had not previously been possible for Families SA.¹⁵⁹ He also pointed to the recent development of an important joint education/child protection initiative of placing child wellbeing practitioners in schools, a development he did not think would have been possible from a stand-alone department.¹⁶⁰

A move to a stand-alone department would therefore require the development of corporate services that are currently shared with other functions within DECD in order to accomplish the wholesale reform anticipated by this report.

Across Australia, each jurisdiction arranges its child protection functions in slightly different ways. The size of the jurisdiction and the spread of the demographic serviced will dictate many aspects of the arrangements. It is important to note that no jurisdiction collocates child protection with education functions.

A SEPARATE DEPARTMENT: THE WA EXPERIENCE

In 2007 a review was conducted of the WA Department for Community Development (the Ford Review). That department was responsible for child protection but also included a number of other functions. The department had originally been created with the objective of responding effectively to the needs of all Western Australians and to help individuals, families and communities shape their own lives positively.¹⁶¹

The Ford Review found that the department's mandate was all-encompassing, and that child protection had 'lost its focus'. The reviewer observed that there was confusion about the dual role expected of the department: on the one hand, child protection and

accompanying supervision and potential removal; on the other, more positive family support, advice and positive interventions for families in need.¹⁶² The review was satisfied that the system was 'close to collapse' and a different approach was needed.¹⁶³

Some of the review findings were:

- The child protection system was overwhelmed, with the system being unable to meet the demand for the increasing number of notifications.
- The number of children being taken into care had increased by over 75 per cent in eight years.
- The system was operating beyond capacity.
- The foster care and relative care systems were under significant pressure.
- Children in care were not receiving the services they needed.
- There was poor interdepartmental cooperation.

There are obvious parallels with the current predicament of Families SA.

The Ford Review recommended the establishment of a new Department of Child Safety and Wellbeing to draw a sharper focus on vulnerable children and young people in the context of their families and community. The reviewer observed that:

*The decision to make this recommendation was not taken lightly. Structural change alone has all too frequently been the unsuccessful panacea for perceived underlying policy tensions, lack of coordination and cultural issues. Moreover, the creation of two departments comes at a non-monetary as well as financial cost as a result of the inevitable periods of uncertainty experienced by staff and the necessary effort required in establishing new planning and operational systems.*¹⁶⁴

The stand-alone Department for Child Protection and Family Support as at 30 June 2015 had 2765 full-time employees.¹⁶⁵ Departmental responsibilities include:

- child protection;
- protection of children and young people from harm;
- supporting children and young people in CEO's care; and
- supporting families and individuals at risk or in crisis.

THE WAY FORWARD

There is no doubt that public confidence in the ability of Families SA to fulfil its statutory mandate is at an all-time low. The system has not been working for some time and is now in crisis. Greater resourcing is part of but not the whole answer.

5 CHALLENGES FOR THE STATUTORY AGENCY

Families SA needs to be completely overhauled. The critical issue is whether this can be achieved within the current structures of a larger department or whether it should be a new independent structure with a reinvigorated leadership that values and promotes expertise in child protection.

The Commission is mindful of the potential impact of further change on a workforce that is overwhelmed by the challenges it faces on a daily basis; however, public confidence in the capacity of the Agency must be restored. Child protection workers cannot continue to function in an environment where their difficult professional decisions are questioned and criticised at every turn, and where they feel unsupported by senior management.

The Agency tasked with primary responsibility for child protection needs a fresh start. It needs to be closely monitored and supervised by a refreshed leadership that has recognised credibility in child protection work and is capable of modelling the standards of professional excellence that should be expected of staff. The Agency's agenda cannot continue to be subservient to the overpowering agenda of the larger department.

Child protection is a difficult business which requires many departments and agencies to work together. This includes Education, Police, Housing and Health as well as services for disability, mental health, financial counselling, drug and alcohol treatment, domestic violence (such as the Multi Agency Protection Service, or MAPS) and early intervention programs. Each of them has a part to play in the protection of vulnerable children. However, in the four years since Families SA has been part of DECD there appears to have been limited progress towards the holistic approach initially contemplated by the merger of the two departments. The integration of corporate services mentioned by Mr Scheepers in evidence has only occurred relatively recently, and the joint Education and child protection initiative to which he referred was an initiative of Families SA but was not progressed until after an informal recommendation in support was made by this Commission. That initiative is as much an example of what can be achieved by two departments working together cooperatively as it is the product of Families SA being within DECD.

If public confidence in the Agency is to be restored, Families SA needs to be established as a department in its own right with a strong commitment to the care and protection of children. That does not mean that it should operate in isolation. On the contrary, it should be a forward-thinking and proactive department that acts as the lead agency to coordinate and bring together other departments and agencies, both government and non-government, and to engage the community to develop programs and systems that focus on the safety and welfare of children everywhere.

In order to gain the necessary leadership credibility, the Agency's executive staff should have recognised expertise in child protection. Front-line caseworkers should be confident that the staff tasked with making critical decisions understand the core business of the organisation from the inside out. The promotion of bureaucratic over professional skills in the organisation sends the wrong message about the focus and priorities of the organisation. Professional skills and knowledge should become the central commodity of the organisation.

These changes will also require a rebranding of Families SA to demonstrate that the new department's focus is on the care and protection of vulnerable children and young people in our community.

The distance between front-line workers and executive managers should be reduced. It is not acceptable for multiple layers of consultation to slow the making of important decisions. The organisational structure needs to be significantly flattened to improve executive engagement and communication with the workforce.

The Commission is not in a position to be prescriptive about how this department would be structured and managed, and does not exclude the possibility of it sharing some corporate services with a larger department. However, any such arrangement should not compromise the foundational elements of the department, set out below.

The new independent department for child protection should have the following elements:

- a Chief Executive who is capable of leading by example in professional practice, and who has recognised professional credibility in child protection and a direct line of ministerial responsibility;
- corporate services staff who are experts in their field, particularly in finance and human resources. The department should have the ability to negotiate for funding in the long term and at a high level in order to process the reforms proposed in this report. Human resource support is also critical and should be resourced to acknowledge the challenges for this agency in performance management, recruitment and retention. A proactive and high-profile human resources function is critical to cultural change;
- a dedicated learning and professional development section that is equipped to source and deliver training that is appropriate for both tertiary qualified professionals who make up the bulk of the case management workforce and operational staff, especially those working in residential care;

- a dedicated data collection and research division that has the capacity to evaluate programs and interventions that are relevant to the new department;
- a procurement and service accountability function that is resourced to carefully supervise the quality as well as the quantity of work delivered by not-for-profit agencies contracted to deliver services;
- a flattened structure with a closer connection between executive management and the front-line workforce;
- decision-making delegations that permit most decisions about children to be made at a local level, except in cases of special risk or extraordinary expenditure;
- consideration of the appropriate location of the various hub offices. In the longer term, as opportunities arise, efforts should be made to relocate them in accordance with community need; and
- a willingness to contribute to public debate on child protection issues, as part of a wider, positive public engagement to promote the message that child protection is everyone's responsibility.

The Commission is mindful of the scepticism with which some may view another structural change. It is also aware that structural change and a change of name alone are not enough to fix the problems that currently beset Families SA. To succeed, the change of departmental location should be accompanied by a committed, serious and profound shift in leadership and culture. It is also critical to the success of this change that staff in the organisation are closely consulted. There is an enormous appetite within the Agency to grow and share the knowledge base of the organisation to produce better outcomes.

A refreshed organisation should be outward looking and promote an open culture. It should also invest resources to engage with the media about the substantial challenges facing child protection, how the Agency grapples with those challenges and how the community can help.

This important reform will need to be guided by the practice leadership of the new executive team. It is an organisational change that should be carefully managed. The lessons of Redesign should be heeded. Business-as-usual functions should not be compromised in order to achieve the structural changes.

The changes should be properly resourced to ensure that the creation of the new department does not overshadow the implementation of other urgent reforms that will make an immediate difference to the lives of children and young people.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		14	Employ administrative assistants at adequate levels of expertise to support casework teams to manage the administrative requirements of C3MS.
5	Move the office of child protection and the functions of Families SA out of the Department for Education and Child Development to establish a separate department that has the business of child protection as its primary focus, and which has elements and functions as set out in this report.	15	Develop clear guidelines for recording information on C3MS, which identify those responsible for data entry and the categories under which data is entered. Rationalise available categories to limit inappropriate categorisation of important information.
6	Appoint a Chief Executive of the new department who has strong leadership skills and recognised credibility in child protection work, and who has a direct line of ministerial responsibility.	16	Develop training in the use of C3MS to ensure that practitioners understand their obligations in uploading data, and the limitations of the incident-based nature of recording.
7	Implement a structure in the new department that reduces the hierarchies between leadership and front-line workers.	17	Provide practitioners with mobile devices to allow access to C3MS from remote locations.
8	Establish a refreshed leadership in the new department with emphasis on the attraction and retention of leaders who have recognised credibility in child protection work, and who have the capacity to lead a major reform of organisational culture.	18	Permit stakeholders such as other government agencies and not-for-profit organisations limited access to C3MS to facilitate cooperation, collaboration and transparency.
9	Review the delegation of powers to enable decision making to occur at the closest possible level to the child, subject to questions of fiscal responsibility and sensitivity or complexity of the issues.	19	Set constructive and practical benchmarks for the development of critical enhancements to C3MS.
10	Adopt a policy that gives a child's caseworker the primary responsibility for case management and, except in special circumstances, ensures that the caseworker is made aware of all discussions and decisions that affect the child.	20	Conduct a review of the long-term viability of C3MS, and monitor research and developments in the area of electronic information management systems with a view to determining whether C3MS should be replaced with a more suitable and effective electronic information system.
11	Conduct a formal review of Solution Based Casework™ (SBC) to critically examine whether the model is being used with fidelity to the original model in practice.		
12	Provide an ongoing SBC consultation and training service to be delivered by principal social work staff and appropriately accredited trainers in SBC who remain within the Agency.		
13	Audit the range of process and policy documents to identify and discard those that are out of date. Develop a single database that is accessible to all staff via the Agency's intranet, to electronically file all current documents.		

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OVERVIEW

'Above everything, child protection is a human undertaking, and good outcomes depend on the calibre and capacity of the human beings who are doing the work.'¹

The workforce is a fundamental component of an effective and safe child protection system. A supportive and strategic human resource setting is integral to developing and maintaining a skilled, stable workforce that is committed to quality practice.

Training and education, recruitment and selection, professional development, industrial conditions and performance management define and shape a workforce and service delivery. These organisational responsibilities can be managed, reformed and improved through strong human resource capabilities.

The workforce in Families SA (the Agency) has been under significant pressure for a long time. The human resource challenges are now considerable and entrenched. The reasons for this are numerous and include: the inadequacy of proactive and deliberate human resource systems, a lack of accessible human resource expertise, poor leadership and the failure of management to strategically address human resource demands and workforce deficits.

The failure to establish a robust human resource function has affected the Agency's capacity to attract and retain a workforce that is complete in number, knowledge and skills.

Despite these challenging working circumstances, the Commission was impressed by the commitment and passion of Agency staff. It is clear many are drawn to this complex work because of their desire to improve the lives of vulnerable children. The Agency's human resource system should support its practitioners to deliver skilled and effective child-focused services.

This chapter sets out the current workforce profile of Families SA, highlights gaps in the human resource systems and examines approaches to resolving those deficits. It discusses the steps required to establish and maintain a healthy, functioning workforce for the benefit of the children in this state.

While the focus is on the Families SA workforce, particularly the front-line staff, some of the observations apply more broadly to other workers in the child protection system.

This chapter principally relates to the Commission's Terms of Reference 5(f) and 5 (h), in the context of Terms of Reference 1 to 4.

Related topics, such as staffing the residential care workforce and child-related employment screening, are examined in Chapters 12 and 20 respectively.

ENTRENCHED HUMAN RESOURCE CHALLENGES

During the past 13 years, the South Australian child protection system has been the subject of a series of independent reviews, all of which have made commentary and findings on human resource issues in the Agency.

In 2003, the Layton Review highlighted²:

- the incident- and crisis-driven approach of workers in the Agency, resulting in only cases of serious risk being followed up;
- the use of contract, inexperienced and untrained workers, leading to children and families receiving less than optimal services;
- workers having a poor understanding of child development, mental health issues, the impact of drug and alcohol abuse and early intervention models, as a result of inadequate university and/or in-house training; and
- the lack of appropriate management and measurement of workloads.

These factors, characteristic of a system in crisis, coincided with difficulties in recruitment and poor staff retention. In part, this was attributed to the use of contract positions, disparity of wages and classification levels between the Agency's social workers and others across the public sector, and a lack of career progression.³

In 2008 the Children in State Care (CISC) Inquiry heard evidence that the Agency continued to face difficulty in recruiting and retaining social workers. The reasons given then for the high turnover of staff included large case loads, poor supervision and support, stress and workers being young and inexperienced.⁴ To achieve better service delivery for children in care, the inquiry recommended that⁵:

- sufficient resources be allocated to recruit and retain qualified social workers, with emphasis placed on their professional development and support;
- all social workers employed in supervisory roles undertake mandatory training in supervision; and
- a system of registration or accreditation for social workers be developed, which required ongoing professional development and training.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

In 2009 a parliamentary Select Committee reporting on the Agency concluded the statutory child protection system was in crisis, finding that⁶:

- many of the recommendations made by the Layton Review still required action;
- staff were under-resourced, overworked and under-trained;
- building the capacity of the workforce had not been a priority; rather, it tended to employ poorly trained and inexperienced workers to save expenditure on wages; and
- there was ample evidence of dysfunctional behaviour that could be described as professional misconduct and that the 'pervasive culture' was entrenched and widespread.

In September 2015 another parliamentary Select Committee found that Families SA's resource needs required urgent reassessment; front-line staff were under significant workload pressure, which was affecting their capacity to deliver services; and social workers needed support in their professional development and training in child development.⁷

The evidence before this Commission is to similar effect. In 2016 the attraction and retention of social workers persist as significant issues, the training of social workers in areas relevant to child protection is wanting, there is limited attention given to professional development and supervision of staff at all levels, senior staff are generally not trained in supervision or management, and no system of registration or accreditation for social workers has been implemented.

The challenge for this Commission is to make recommendations to improve the human resource function of the Agency to better support the workforce entrusted with the difficult work of child protection.

HUMAN RESOURCE MANAGEMENT IN FAMILIES SA, 2011-14

When Families SA merged with the Education department in 2011, the Agency brought with it a heavy human resource workload in areas such as workers compensation claims, performance management, investigations and conduct management.⁸

In December 2012, the Office for Corporate Services in the new Department for Education and Child Development (DECD)⁹ completed a review of the Families SA workforce.¹⁰ The review identified the perpetual human resource issues of staff attraction and retention and, more specifically, noted that:

- there was a decreasing supply of social workers;
- very experienced staff were leaving Families SA;

- graduate social workers were not equipped for child protection work;
- attracting staff to regional locations and attracting Aboriginal staff were particularly challenging;
- no person in Families SA was responsible for improving retention;
- career progression in Families SA was limited;
- some social workers were being asked to undertake an unreasonable workload;
- there were difficulties with team structures and disparities in the number of staff being managed within teams; and
- further analysis of the workforce was required to determine where and what positions had a high turnover rate.

The findings led the former Executive Director of the Office for Corporate Services, Phil O'Loughlin, to form the view that Families SA had a 'burn and churn' workforce. They demonstrated that the Agency had failed to improve its human resource processes despite the recommendations of the earlier reviews. There did not even appear to be a strategic plan in place to deal with well-documented issues.

Families SA had a 'burn and churn' workforce

Families SA Executive and management were to respond to the issues identified in the 2012 review.¹¹ It is not clear what human resource expertise was available to help with this task. However, recent history suggested leaving Families SA to sort out its human resource deficits was unlikely to achieve the desired results.

In 2012 a human resource function sat in the Office for Corporate Services, outside the Office for Child Protection (which encompasses Families SA).¹² This was staffed predominantly by pre-existing Education department human resources consultants. Families SA was to seek guidance and assistance on an 'as needs' basis. However, many of the entrenched issues required specialist human resources assistance and there was no-one in Families SA clearly responsible for that task. Executive and managers were focused on operations rather than strategic workforce planning. Mr O'Loughlin commented that while the intention was there, staff were probably subsumed in the day-to-day realities of the workplace.

REDESIGN

In early 2013 Families SA embarked on the Redesign reform process (discussed in Chapter 5). Although the internal review the previous year had identified that the workforce was not in a healthy state and had not been stabilised, the Redesign business case did not expressly deal with how the human resource issues would be resolved.

In the first half of 2014, amid a struggling Redesign, Mr O'Loughlin concluded that the way Families SA tackled human resources had to be reformed. It was proposed that engaging a human resources expert in Families SA would be a powerful way to shape human resources policy, build systems and structures, and attempt to overcome Families SA's strong cultural resistance to the merged department. A human resources expert started in about June 2014, just before Families SA was rocked by the arrest of residential care worker Shannon McCoolle for serious sexual offences against children (see Vol. 2, Case Study 5: Shannon McCoolle).

THE HYDE REVIEW

Following the arrest of McCoolle, concerns were raised about the standard of care being provided to children under the guardianship of the Minister who were placed in residential care.

As a result, the Minister for Education and Child Development commissioned a review into the residential care workforce to be undertaken by the former South Australian Commissioner of Police Mal Hyde (the Hyde Review). The review took place in August and September 2014 and focused solely on Families SA's residential care workforce, in part considering the human resources practices of the residential care directorate. The review is discussed in more detail in Chapter 12.

The Hyde Review made a number of findings, including highlighting potential operational risks. The residential care directorate did not have a workforce management plan that outlined a strategic approach to recruitment, selection, training and retention. There was no data that clearly identified where the vacancies were in the directorate. The management style of the directorate was reactive, not proactive, and decision making was concentrated in key executives and managers.¹³ There was a 'lack of an effective performance management and a managerial accountability culture and system'.¹⁴ Such findings epitomise the significantly compromised human resource function of Families SA.

THE IMPLEMENTATION OF THE HYDE REVIEW'S RECOMMENDATIONS

The significant deficits in human resource management in the residential care directorate identified by the Hyde Review required urgent attention. Unlike the earlier 2012

review, the implementation of the recommendations was not left to Families SA. Instead, a project team was established that, while still within the Department, was external to the Office for Child Protection. It was crucial that the recommendations were addressed outside the Office for Child Protection, as implementation required independence from the operational demands and inadequacies of Families SA.¹⁵ Mr O'Loughlin was not confident that Families SA staff had the skills and abilities required to implement the recommendations, because of an absence of significant human resource expertise.¹⁶ It was intended that the project team would eventually embed the recommendations in Families SA. The work of the project team is discussed further in Chapter 12.

The findings of the Hyde Review were not circulated in Families SA. At October 2015, the Director of the residential care directorate, who held significant responsibility for the functioning of the workforce, had not been provided with, or read, a copy.¹⁷ In October 2015, the Deputy Chief Executive of the Office for Child Protection, Etienne Scheepers, told the Commission he had received a copy of the Hyde Review 'the other day'.¹⁸ It is surprising that the head of the Office for Child Protection and the head of the residential care directorate were not provided with a copy of the review soon after it was finalised. It directly related to their business. It was important that they understood the effect of the identified deficits, and ensured any decisions that were made with a view to improving or developing the workforce were consistent with the recommendations.

FACTORS THAT HAVE CONTRIBUTED TO THE FAILINGS

Despite the past reviews and recommendations, little appears to have been done to address the challenges facing the Agency's workforce.

It was evident to the Commission that both executive and managerial staff in Families SA were highly operational and constantly responding to the crisis of the day. There was no discipline in the Agency to look beyond the crises and think strategically about the future of the workforce.¹⁹ As discussed in Chapter 5, micromanagement became a feature of the Agency's business. Micromanagement of casework has overshadowed strategic management.

There does not appear to be any one factor to blame for the Agency's failings in its human resource processes. However, the lack of clear responsibility for the work at a strategic level, the lack of accountability on the part of management and the Executive, the absence of in-house human resource expertise and running the Agency in crisis mode without the resources to strategically address short- and long-term functioning all appear to have played a part.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

ESTABLISHMENT OF THE HUMAN RESOURCES UNIT

In September 2014, a specialist Human Resources Unit (the HR Unit) was established in Families SA. The HR Unit became responsible for²⁰:

- recruiting across the agency (with the exception of Executive appointments and administrative officer employment);
- implementing whole-of-workforce recruitment strategies;
- managing workforce data;
- providing specialist human resources support and expertise to all Families SA staff; and
- managing the peer assessment process for staff in the allied health practitioner (AHP) stream. This process, also referred to as peer progression, allows staff at the first classification level (AHP1), when they have fulfilled certain criteria, to apply to a peer assessment panel to be reclassified to AHP2.²¹

However, the task facing the HR Unit was immense and improvements were not immediate. Mr Scheepers, who had started as Deputy Chief Executive in November 2014, said there was no 'meaningful HR system, HR process, HR policies, workforce planning ... all the HR components were either not done or done ad hoc'.²²

By late 2014 there were a range of longstanding issues that needed attention, all of which were urgent, but a number of barriers stood in the way. These issues are discussed below.

COMPILING THE VACANCY DATA SET

Reliable workforce data is essential for making key decisions about employment contracts, deployment of staff resources and, more generally, the budget.²³ However, for a number of years Families SA has been operating in the absence of reliable and accurate data on vacancies, turnover and retention, making it difficult for management at all levels to run the business.²⁴

A number of witnesses reported a high level of vacancies in Families SA to the Commission. Accurately identifying how many positions were vacant in the Agency, and where they were located, was fundamental to the HR Unit fulfilling its mandate and tackling many of the workforce challenges.

Due to an absence of appropriate reporting systems, the HR Unit struggled to compile an accurate vacancy data set.²⁵ While efforts were made to collate the data systematically, the HR Unit initially had to rely on managers of local offices to identify vacancies.

The Commission was informed that accurate vacancy data would be finalised by the end of October 2015. However, Families SA did not provide this to the Commission until February 2016.

The inability of Families SA to produce basic workforce data demonstrates the lack of attention it paid to human resource functions. It could not have escaped the attention of the Executive over a number of years that the level of vacancies, and challenges in recruitment and retention, were significant issues affecting the workforce, requiring a whole-of-agency response.

THE ABSENCE OF A WORKFORCE PLAN

Workforce planning provides a framework for 'getting the right number of people, with the right competencies, in the right jobs at the right time'.²⁶ It is a 'process in which an organisation attempts to estimate the demand for labour and evaluate the size, nature and sources of supply which will be required to meet that demand'.²⁷ In other statutory child protection agencies around Australia, targeted workforce planning strategies have been developed.²⁸ Such strategies provide a useful tool to address the types of human resource issues that have impeded Families SA for a long time.²⁹

The Commission had no evidence that a workforce plan, including robust attraction and retention strategies, has been developed, endorsed or put into action, despite being told this was to be completed by the end of January 2016.³⁰ This should be a fundamental priority for the Agency.

Strategic workforce planning should now be undertaken to map how the capacity of the workforce, in terms of number, skill and experience, will be developed and stabilised over the short, medium and long term.

EMPLOYMENT RECORDS

The method of creating and storing employment records should also be addressed urgently. It is concerning that the creation and storage of personnel records, such as employment applications and contracts, have been decentralised, fragmented and held inconsistently across individual sites.³¹ The Commission discovered that supervision records were also held in ad hoc ways, with local offices lacking any system for their filing and storage.³²

A consistent storage method is necessary to support the management and development of staff, both individually and across the Agency. The supervision of an employee should not become disjointed because of a change in line manager or office. The Commission understands that through centralisation, the HR Unit is endeavouring to gain visibility and control of all employment records.³³ Electronic systems should also be put in place to allow line managers, and other relevant senior staff, ready access to records that may be germane to the day-to-day management, supervision and professional development of their staff.

THE FUTURE OF THE HR UNIT

Families SA has operated for a long time without sufficient human resources expertise that is tailored to the organisation. Human resource issues have been left to managers and senior staff to manage in a decentralised manner.

The HR Unit has appeared to operate in crisis mode, with the resources primarily directed towards filling vacancies. However, the human resource function is more than this. A high functioning HR Unit is essential to the future of the Agency. The unit should be able to provide expertise in workforce planning, particularly in attracting, recruiting and retaining staff. It should sit outside the operational arm of the Agency, so as not to be distracted by day-to-day practice matters. It should be sufficiently resourced to undertake strategic planning, which is desperately required, and not be left to tackle staffing issues in crisis mode.

It has been said that a good child protection system depends on:

*building and sustaining intelligent, compassionate and imaginative staff who have the courage to engage with the complex circumstances our societies' most vulnerable children live in.*³⁴

The leadership of the Agency, guided by the expertise of the HR Unit, should strive to build and sustain such a workforce.

THE EDUCATION OF CHILD PROTECTION WORKERS

As part of its inquiry into the staffing of the state's child protection system, the Commission sought to gain an understanding of issues relevant to the education of social workers, the registration of their profession and human services workers more broadly. To assist with these matters, Di Gursansky, a member of the Commission's Expert Advisory Panel, prepared a discussion paper to seek comments on social work education, professional development and registration.³⁵ The paper was circulated to 13 stakeholders from academia, the social work professional body, Families SA, the two schools of social work in South Australia and other social work educators. There were seven responses to the paper, including from both the national and South Australian branches of the Australian Association of Social Workers (AASW), Mr Scheepers, and the two South Australian schools of social work, at the University of South Australia and Flinders University.

The Commission also received written submissions from a number of contributors, including Emeritus Professor Dorothy Scott, Adjunct Professor, Australian Centre for Child Protection, and Professor Lesley Cooper,

Professor of Social Work, University of Wollongong. The submissions, together with evidence given to the Commission, covered a range of issues including how social workers are educated, the nature of the degree, the role of field placement, the role of the AASW as the professional body, how social work education intersected with professional development and the appropriate educational pathway. All of these matters were incorporated into a paper prepared by Ms Gursansky on behalf of the Commission³⁶ and this paper has informed the Commission's consideration of those issues.

THE CURRENT WORKFORCE PROFILE

At 30 June 2015, the Department had 29,793 employees, of which about 23,550 were full-time equivalents (FTEs).³⁷ Families SA had 1742 employees (about 1634 FTEs), which is only 6 per cent of the Department's workforce. Table 6.1 outlines the demographics of Families SA's workforce from 2012 to 2015.

In terms of FTE positions, the workforce has only increased by 4 per cent from 2012 to 2015. Against the background of significant increases in workload across the Agency during the same period (at the most basic level demonstrated by the number of notifications received and the number of children coming into care), this increase is negligible.

At June 2015, 5 per cent of the workforce identified as Aboriginal—a slight decrease from the previous year.³⁸

The workforce is predominantly female (on average making up 74 per cent of employees). This is consistent across Australia, with women making up more than 75 per cent of the statutory child protection workforce.³⁹ Since 2012, there has been a 22 per cent decrease in the number of part-time employees. At June 2015, 17.3 per cent of the workforce was working part time. These figures are somewhat surprising in light of the expected need to support the female workforce through flexible working arrangements. In comparison, part-time (including casual) employees made up 45 per cent of the General Government Sector workforce in June 2015.⁴⁰

Since 2012 there has been a significant increase (34.7 per cent) in the number of persons employed temporarily, from 294 to 396, and a marginal increase (0.5 per cent) in permanent employees, from 1394 to 1401.

Families SA has a gradually ageing workforce with 41 per cent of staff aged 45 and over in 2015.

All these characteristics need to be factored into workforce planning.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

Table 6.1: Workforce demographics of Families SA, 2012 to 2015

	2012	2013	2014	2015
Total employees	1725	1704	1690	1742
Full-time equivalent (FTE)	1570.9	1563.6	1585.1	1634.0
Aboriginal	N/a	N/a	92	87
Females	1274	1257	1237	1303
Males	451	447	453	439
Full-time employees	1339	1363	1406	1441
Part-time employees (percentage of total)	386 (22.4%)	341 (20%)	284 (16.8%)	301 (17.3%)
Permanent employees	1394	1373	1375	1401
Temporary employees	294	296	353	396
Average age	41	42	42	42
Percentage of workforce aged 45 and over	39%	40.9%	40.5%	41.1%

Note: Permanent and temporary employees are subject to different counting rules to other categories in this table. This accounts for the variation between these and other categories, for example between total employees and the sum of permanent and temporary employees.

Source: Data from DECD, 'Office for Child Safety summary' and 'Office for Child Safety—Aboriginal and Torres Strait Islander workforce profile', internal unpublished documents, Government of South Australia, June 2015.

CLASSIFICATION STREAMS AND SALARIES

The Families SA workforce consists of six classification streams: allied health professionals (AHP), operational services officers (OPS), administrative services officers (ASO), managers—administrative services (MAS), South Australian public sector executives and health ancillary employees. The breakdown of the workforce by classification is shown in Table 6.2.

Table 6.2 shows that the workforce is predominantly made up of staff classified as either OPS (40 per cent) or AHP (35 per cent). These proportions have been constant since 2012.⁴¹ Staff in these two classification streams deliver services directly to the clients of Families SA. The OPS workforce is mainly located in the residential care directorate, as discussed in Chapter 12, although some front-line roles are also filled by OPS staff.

In the Agency, front-line child protection work is predominantly undertaken by staff in the Assessment and Support, Protective Intervention and Long-term Guardianship teams (in both metropolitan and regional offices) and the Call Centre. Staff employed as principal social workers, principal psychologists or principal

Aboriginal consultants (the principal's group), in part provide a consultative role to front-line staff. They are not collocated with front-line staff.

As shown in Table 6.3, qualified social workers are employed across levels 1 to 5 of the AHP stream, with case loads carried by practitioners at the lower classifications. Families SA also employs psychologists in the AHP stream, who are not collocated with the front-line staff. Aspects of the role of the Agency's psychologists are discussed in Chapters 9 and 10.

Not all front-line staff are required to hold a qualification in social work. As shown in Table 6.4, some workers employed at the OPS3 classification carry case loads despite not being required to hold a qualification. While some office managers do hold a social work qualification, it is not universal and not a requirement of their role. Nevertheless they are expected to contribute to decision making on important, complex and highly political case management issues.

Table 6.2: Families SA workforce by classification stream, June 2015

CLASSIFICATION	EMPLOYEES	FTE
Administrative services officers (trainees and levels 1 to 8)	391	365.4
Allied health professionals (levels 1 to 5)	605	574.6
Operational services officers (levels 1 to 5)	698	646.4
Manager—administrative services (levels 2 and 3)	38	37.9
South Australian Executive services (levels 1 and 2)	6	6.0
Health ancillary employees ^a (levels 2 to 4)	4	3.7

^a These employees work as cooks in the Agency's large residential care units.

Source: DECD, 'Office for Child Safety summary', internal unpublished document, June 2015.

Figure 6.1 shows that 61.4 per cent of Families SA employees earn less than \$71,500 a year. The General Government Sector average salary at June 2015 was \$76,440.⁴² For an agency that undertakes such difficult, complex and important work it is surprising that more than half its workforce receives less than the average government salary. This may be a factor affecting staff attraction and retention.

VACANCY LEVELS

As noted, the Commission had difficulty obtaining accurate data on vacancy levels across the Agency. In lieu, the HR Unit had to estimate AHP vacancies using information from local offices.⁴³ In March 2015, the HR Unit manager estimated there were 70 AHP vacancies in the Agency, with a high proportion of these being in regional areas.⁴⁴ At about the same time, an experienced human resources staff member told the Commission they had not previously seen vacancy levels of this severity in a government agency.⁴⁵ In October 2015 the Commission was given a figure of 100 AHP vacancies (50 in regional areas and 50 in the metropolitan area), despite recruitment occurring between March and October 2015. This figure was still not precise.⁴⁶

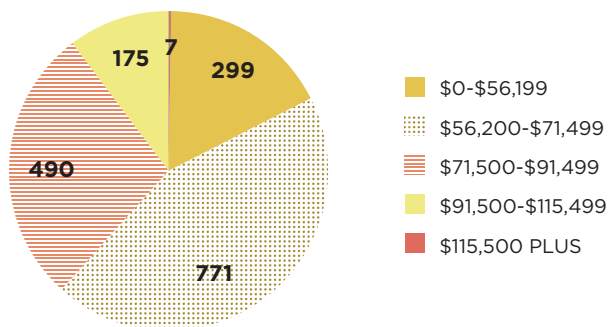


Figure 6.1: Families SA workforce by salary bracket, June 2015

Source: Data from DECD, 'Office for Child Safety summary', internal unpublished document, June 2015

Four months later, the Commission received a complete set of Agency workforce data figures. At 19 February 2016 there were 293 vacant positions (272.42 FTEs), or approximately 17 per cent of the workforce, including 104 positions in the AHP stream.⁴⁷

Staff on temporary contracts were filling 160 vacant positions (152.62 FTEs), leaving 133 positions without a staff member appointed. The classifications of these 133 vacant positions were: 40 AHP, 41 ASO, 47 OPS and one managerial (MAS3). The four health ancillary positions (residential care cooks) were also vacant. Of the AHP vacancies, 19 of the 40 positions were in regional locations.⁴⁸

The persistent vacancy levels across Families SA, and the use of temporary staff to fill positions, places pressure on staff to work beyond their capacity and serves to destabilise the workforce. In turn, service delivery is compromised, potentially risking the safety of vulnerable children.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

Table 6.3: Front-line and consultative social work roles in Families SA

POSITION TITLE	CLASSIFICATION	WAGE (\$)	REQUIRED QUALIFICATION	CASE LOAD	ROLE
Social worker	AHP1	58,555–71,864	A degree or qualification which gives eligibility for full membership of the Australian Association of Social Workers In South Australia these degrees are Bachelor of Social Work, Bachelor of Social Work/Social Planning or Master of Social Work	Yes, with the exception of social workers in the Call Centre	Provide a statutory child protection service to respond to the needs of children and their families, including: • undertaking child protection investigations and assessments • planning and delivering focused intervention to safeguard children • assisting families to reunify children into their care • working with children in the care of the state
Senior social worker	AHP2	75,856–87,833	As above	Yes, with the exception of social workers in the Call Centre	As per social worker, undertaking more complex cases
Senior practitioner	AHP2	75,856–87,833	As above	No	Quality assurance, enhance social worker capacity and the principles of social work practice
Supervisor	AHP3	90,495–96,484	As above	No	Lead, develop and manage the performance of a social work team
Principal social worker	AHP4	99,810–109,126	As above	No	Provide high quality information and practice advice to staff to improve outcomes for vulnerable children, their families, and their carers, including: • identifying practice quality issues and proposing ways to resolve them • contributing to the training, learning and development of staff • contributing to departmental practice policy and development of programs/initiatives
Principal Practitioner ^a	AHP5	111,788–122,433	As above	No	To lead practice in Families SA, including departmental practice, policy and development programs/initiatives

^a In May 2016 the Principal Practitioner was appointed to the newly created position of Director of Quality and Practice. Since that time, no person has been appointed to this position.

Note: Persons of Aboriginal or Torres Strait Islander descent who have the appropriate background and skills but do not have the essential qualification, can apply for any Allied Health Professional roles requiring a qualification in Social Work in Families SA.

Sources: Office for the Public Sector, *South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2014*, Department of the Premier and Cabinet, Government of South Australia, 1 October 2015; Families SA, Role descriptions for front-line and consultative social work roles, September 2013, February 2014 and May 2014.

Table 6.4: Front-line roles, other than social work roles, in Families SA

POSITION TITLE	CLASSIFICATION	WAGE (\$)	REQUIRED QUALIFICATIONS	CASE LOAD	ROLE
Support/access support worker	OPS2	49,565–53,661	None	No	Assist social workers to provide an efficient client service and maintain and enhance positive relationships between children and their birth families
Family development worker	OPS3	57,738–61,822	None	No	Support parents to strengthen their capacity to provide a safe and nurturing family environment
Case/care and protection worker	OPS3	57,738–61,822	None	Yes	Undertake case management, under professional direction, of care and protection or guardianship cases
Office manager	MAS3	112,260	None	No	Lead staff and manage resources of a Hub or local office, including: • building and fostering positive community relationships and strategic inter-agency partnerships • providing leadership and direction of critical, complex and highly political case management issues involving children with high and complex needs that are at risk of death or serious injury • assisting in the development of, and effectively implementing, policy

Sources: Office for the Public Sector, *South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2014*, Department of the Premier and Cabinet, Government of South Australia, 1 October 2015; Families SA, Role descriptions for front-line roles, other than social work roles, September 2013 and October 2013.

WORKERS COMPENSATION CLAIMS

The level of workers compensation claims in an organisation is a good indicator of the wellbeing of the workforce.⁴⁹ In 2012 Families SA staff, particularly residential care workers, were over-represented in workers compensation claims made across the Department. Although there have been incremental improvements since that time, the underlying problems have not been addressed.⁵⁰

Between July 2011 and December 2014, Families SA staff reported 1719 workplace incidents, with the number of incidents steadily increasing each year. Generally, a workplace incident is one that results in an injury or has the potential to cause an injury. Hazards in the workplace may also be reported as incidents. About half the reported incidents involved deliberate injury, verbal harassment and/or workplace bullying or a traumatic experience.⁵¹

About 20 per cent of the 1719 reported incidents resulted in a workers compensation claim. 'Mental stress' and 'Being hit by moving object' have been the most common type of injury mechanism. About 55 per cent of claims were made by OPS classified staff working in the residential care directorate.⁵²

Table 6.5 shows work pressure was the major cause of mental stress. Its incidence increased significantly in the first six months of 2014/15. This coincided with the aftermath of McCoole's arrest, when the residential care workforce was the subject of a review and affected by significant staff shortages.⁵³

Poor staff selection, inadequate training and professional support, unrelenting workloads, the stressful and traumatic nature of child protection work and the lack of access to specialised psychological support all contribute to mental stress claims.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

Table 6.5: Families SA workers compensation claims as a result of 'Mental stress' or 'Being hit by moving object', 1 July 2011 to 31 December 2014

MECHANISM	CAUSE	2011/12	2012/13	2013/14	1 JULY 2014— 31 DECEMBER 2014
Mental stress	Work pressure	11	14	15	20
	Exposure to workplace or occupational violence	3	11	10	5
	Work-related harassment and/or workplace bullying	5	7	8	6
	Exposure to traumatic event	3	1	1	Nil
Being hit by moving object	Being assaulted by a person or persons	10	13	22	4
	Being hit by moving object	2	10	7	Nil

Source: Data from Families SA.

Exposure to traumatic events and occupational violence are to some extent unpredictable. However, good leadership, management and supervision can ease other causes of mental stress such as work pressures, harassment and bullying.

The Agency should establish appropriate structures to support staff who are experiencing mental stress or suffering other injuries in the workplace. All staff have access to counselling services through an employee assistance program but this must be sought out by the individual on an as needs basis. A more proactive, targeted approach to supporting staff is required, particularly when an adverse or traumatic event occurs.⁵⁴

The increasing level of mental stress claims requires attention and action. Improving the support to staff through meaningful supervision, effective management and a commitment to ongoing professional development should have a positive effect on employee wellbeing. In addition, as part of its HR Unit, the Agency should establish a psychological service to share responsibility for employee wellbeing with the leadership of the agency. The service should complement good management practices, and not be seen as a substitute for them. The service should also take steps to identify underlying causes of mental stress in the workforce and develop strategies to address them.

RECRUITMENT

THE CENTRALISATION OF RECRUITMENT

Until recently the recruitment of staff to Families SA offices, both metropolitan and regional, was undertaken in a decentralised manner. If an individual office identified a vacancy, they would advertise the position, undertake a selection process and appoint an applicant.

In early 2015, as a result of concerns highlighted by the Hyde Review and the establishment of the Families SA HR Unit, the recruitment of AHP and OPS staff was centralised.⁵⁵ The HR Unit was initially consumed by coordinating the recruitment of residential care workers. This responsibility was then shifted to the Hyde Review project team.

Significant vacancies across the Agency required a major recruitment of social work staff and this occurred under considerable pressure.⁵⁶ The task was made more difficult because of the longstanding absence of workforce planning and lack of any clear strategy to attract workers to the much-maligned Agency.

The Commission was told that centralisation provided a more consistent approach to recruitment by ensuring that processes aligned with merit selection principles.⁵⁷ Concerns had been identified in the Agency that some local selection processes were influenced by favouritism, cronyism or nepotism. Centralisation reduces the risk of a selection process being infected in this way.⁵⁸ It also ensures selection panels include human resource expertise.

However, local offices expressed concern that centralised selection processes took longer than those run locally and could lead to the appointment of staff who were not the right fit for an office.⁵⁹ The HR Unit has been taking steps to address these concerns by including local staff members on selection panels, appointing additional staff to assist with the timeliness of selection processes, and prioritising recruitment to positions that the local offices identify as essential.⁶⁰

Given the Agency's need to fill widespread persistent vacancies and to develop meaningful strategies to attract the right staff, the Commission supports the continuation of a specialist human resources unit that is responsible for centralised recruitment.

The timeliness of recruitment processes is essential. This needs to be constantly monitored and, if necessary, further resources assigned. The key to the success of a centralised recruitment system is open and transparent communication between the HR Unit and the local offices, and an understanding of each other's needs. While the needs of the Agency as a whole will guide the HR Unit's overall approach to recruitment, the needs of local offices should also be given weight.⁶¹

Centralised recruitment would also allow for staffing levels to be managed in line with the Commission's recommendations, such as achieving suggested benchmarks in some of the Agency's core business areas and the transfer of some functions to the non-government sector.

THE NUMBER OF AHP STAFF RECRUITED IN 2015

As shown in Table 6.6, 145 applicants were recommended for AHP positions in Families SA in the 10 months to December 2015. They included 129 applicants in metropolitan locations and 16 in regional locations. Despite this, as highlighted above, 40 AHP positions remain without a staff member. It is not clear whether this is a result of pre-existing vacancies that are yet to be filled or ongoing staff turnover, with staff not being replaced as quickly as they are leaving. Some recruitment processes for regional locations offered positions in both the AHP and professional officer streams, and this is discussed below.

The 145 applicants were selected from a total of more than 550 applications. That is, only about one-quarter of applicants were considered suitable for an AHP role. While 360 applications (65 per cent) came from persons external to the Agency, only 24 of these (less than 7 per cent) were recommended for positions. Given the persistent vacancy levels in the Agency, the low yield of staff from recruitment processes is concerning. It calls into question whether the Agency is attracting applicants with the right skills and experiences. It also

requires consideration of whether there are aspects of the selection process that are unnecessarily screening out suitable employees.

The Commission was told the HR Unit had identified a need to work towards improving the yield of external applicants, without compromising the quality of staff recruited to the Agency.⁶² The HR Unit considered improvements could be achieved by better targeted recruitment drives to attract more suitable applicants and selection panels giving weight to transferrable skills that could be developed by the Agency, rather than simply focusing on an applicant's experience in child protection. As Table 6.6 shows, the appointment of staff is skewed significantly in favour of internal applicants (more than 80 per cent of recommended applicants were internal). This could be indicative of the Agency appointing temporary staff to ongoing positions, or internal applicants applying for advertised positions at higher classifications in circumstances where they have not been re-classified through peer progression. Placing too much weight on an applicant's experience in child protection may also skew recruitment in favour of the internal workforce, particularly given the limited opportunity outside Families SA to obtain experience in child protection.⁶³

THE SELECTION PROCESS

The Agency has now developed a more coordinated and targeted approach to advertising vacant positions. Positions have been advertised across multiple sources and represented differently in the marketplace: as 'careers' in child protection.

The HR Unit also made a major change to the process of selecting AHP staff, by requiring applicants to undertake a psychometric test. The testing tool used was the same as the Agency had used for a number of years in the recruitment of residential care workers. This test was designed to be used when selecting staff for public safety roles, not for the selection of social workers.⁶⁴

It is not clear why the Agency decided to use the psychometric tool in the selection of social workers. Unlike the residential care workforce, the Agency's social worker selection processes had not been the subject of a comprehensive review. It is also not clear what shortcomings had been identified in the current workforce that it was thought the tool could help prevent in the future.

There is not sufficient evidence before the Commission for a conclusion to be reached as to whether psychometric testing has a role to play in the selection of social workers. The low yield of appointments (see Table 6.6) suggests the Agency should carefully consider the value that psychometric testing adds to the selection process.

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Table 6.6: Applications and recommendations for AHP positions in Families SA, April 2015 to December 2015

	METROPOLITAN	REGIONAL
Total applications	484	70
Internal applications (percentage of total)	171 (35.3%)	23 (32.9%)
External applications (percentage of total)	313 (64.7%)	47 (67.1%)
Total recommendations (percentage of total applications)	129 (26.7%)	16 (22.9%)
Internal recommendations (percentage of total recommended)	108 (83.7%)	13 (81.3%)
External recommendations (percentage of total recommended)	21 (16.3%)	3 (18.7%)

Note: Some recruitment processes for regional locations included offering positions in the AHP stream and the professional officer (PO) stream.

Source: Data from Families SA.

It would be disappointing if suitable applicants were being screened out because the Agency was using a tool that was not fit for purpose.

ADDRESSING VACANCY LEVELS

There is an urgent need to address vacancy levels, but crisis-driven recruitment will not provide the workforce with long-term sustainability. In the face of immense pressure to recruit staff and fill longstanding vacancies, robust recruiting practices should be developed and maintained.

Informed by the Commission's observations in this chapter regarding the attraction and retention of staff, the HR Unit should review the processes used to recruit front-line workers to the Agency. The Agency should develop an evidence-based best practice approach with the aim of selecting staff who not only meet the required competencies, but who are also fit for the role and committed to a career in child protection. Consideration needs to be given to the skill sets of front-line staff to ensure that applicants are not overlooked because of a lack of experience in child protection. Recent selection processes conducted by the HR Unit should be examined to determine at what stage applicants are being screened out and on what basis. The review should be guided by human resources expertise, with input from an organisational psychologist and front-line staff. Selection processes used in child protection workforces

in other jurisdictions may also inform the review, as well as consultation with members of the tertiary education sector involved in the training of social workers.

It is estimated that in the next five years, demand for social workers across Australia will increase by nearly 30 per cent.⁶⁵ Even as an employer of choice, it would be difficult to fill every position with a social worker.⁶⁶ However, there may be advantages in having a stronger, multidisciplinary base of professionally qualified staff. There appears to be uncertainty as to the appropriate qualification for a child protection worker across Australia.⁶⁷

It is estimated that in the next five years, demand for social workers across Australia will increase by nearly 30 per cent

Unlike most other jurisdictions, South Australia restricts its workforce to those holding an undergraduate or postgraduate degree in social work. As shown in Table 6.7, although social work qualifications are generally preferred, other jurisdictions recognise a broader range of qualifications related to human services fields.⁶⁸ The Commission understands that previously in South Australia a wider range of graduates was also considered eligible in the AHP stream for work with Families SA. The Commission is unaware of the reason for subsequently limiting the workforce to social workers.

Instead of recognising a wider range of qualifications to broaden the pool of applicants, Families SA recruited unqualified staff to the OPS classification as 'care and protection workers' and 'caseworkers' who perform essentially the same role as a qualified social worker, with similar case loads and work complexities.⁶⁹

Families SA adopted the use of the unqualified OPS classification without exploring the recognition of broader human services qualifications as has occurred in other jurisdictions. Nor does it appear that any additional training was provided to address the skill and knowledge base of OPS staff.

Given the complexity of the work, child protection practitioners should hold a degree-level qualification relevant to their role.

THE PROFESSIONAL OFFICER STREAM

The South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2014 (the Enterprise Agreement) provides for a professional officer (PO) stream, which encompasses a diverse range of roles across the public sector that require a degree-level qualification. The remuneration levels of PO classified workers are comparable to those in the AHP stream.

Recruiting to PO classifications in addition to AHP classifications throughout the state would increase the selection pool, and has the potential to diversify the workforce through fostering multidisciplinary teams. For example, the qualifications of teachers, early childhood educators, and occupational therapists could be recognised under this classification.

There is merit in adopting the approaches taken in other jurisdictions, where social work is regarded as a preferred qualification, but other relevant qualifications are also recognised.

FACTORS THAT AFFECT THE ATTRACTION AND RETENTION OF STAFF

WORKPLACE CULTURE

The negative organisational culture in Families SA is discussed in Chapter 5. Staff do not want to be a part of an organisation that:

- does not value, respect or trust the ability of front-line staff;
- encourages blame avoidance and blame shifting;
- emphasises risk aversion over client outcomes;
- does not support staff when under fire from external scrutiny;
- does not welcome differences in professional opinion or fresh ideas;
- allows career progression to be driven by personality not merit; and
- does not stamp out bullying.

The observations in this chapter regarding the attraction and retention of staff are directed towards developing a workforce that is encouraged and valued for its professional practice and is supported by the leaders of the Agency; one that can treat an adverse event as a learning opportunity as opposed to an occasion for blame.

THE FAMILIES SA BRAND

It is evident that in recent times Families SA as a brand has been tarnished, in part due to chronic public scrutiny and adverse commentary through previous reviews, reports, inquiries, coronial investigations and the media more generally. Against that background, it is not surprising that Families SA would not be considered an employer of choice.

UNMANAGEABLE WORKLOADS

The Commission received a considerable body of evidence about high workloads. One senior staff member described it as 'more dire' than she had seen across her almost 20-year career with the Agency. She told the Commission:

the things that [we] have to approve at the end of the day to say, 'We're not going to go and investigate this,' are horrific ... it's difficult to go home sometimes and think, 'I can't believe we can't get to that child' ... It's a real crisis.⁷⁰

The effects of high workloads are far-reaching. Significant strain is placed on staff, but more importantly staff are unable to respond to the needs of the state's vulnerable children. A supervisor who has worked in Families SA for more than 30 years told the Commission, 'the workload has become unmanageable because we're just not getting additional staff to meet the additional children coming into care'.⁷¹

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

Table 6.7: Qualifications required for a child protection practitioner in Australia

JURISDICTION	ROLE	QUALIFICATION REQUIRED	ENTRY-LEVEL WAGE (\$)
Australian Capital Territory	Case manager	Tertiary qualifications in social work, psychology, social welfare, social science or related discipline ^a	55,410–70,598
New South Wales	Caseworker	Australian Association of Social Workers (AASW) accredited degree preferred (Bachelor of Social Work, some combined or double degrees that include a Bachelor of Social Work or Master of Social Work) Bachelor-level degrees with child protection core content or diploma-level qualifications that include child protection core content also accepted ^b	62,587–86,472
Northern Territory	Child protection practitioner	Relevant degree of an Australian tertiary institution that gives eligibility for membership of the Australian Community Workers Association, the AASW, the Australian Psychological Society or equivalent or a Diploma of Child, Youth and Family Intervention <i>and</i> Vocational Graduate Certificate in Community Services Practice (Statutory Child Protection)	63,661–73,619
Queensland	Child safety officer	A degree in social work, human services, social welfare, psychology or behavioural science or Master of Social Work (Qualifying) Other bachelor degrees are considered provided certain criteria are met ^c	55,750–71,354
South Australia	Social worker	An AASW-accredited degree (Bachelor of Social Work, Bachelor of Social Work/Social Planning or Master of Social Work)	58,555–71,864
Tasmania	Child protection worker	Bachelor of Social Work or a diploma of Community Welfare Work Other qualifications will be considered on application ^d	52,833–66,857
Victoria	Child protection practitioner	AASW-accredited degree preferred (Bachelor of Social Work, Bachelor of Social Work/Social Science, Bachelor of Human Services/Master of Social Work or Master of Social Work) Bachelor-level degrees with child protection core content or diploma-level qualifications that include child protection core content also accepted ^e	60,551–73,521
Western Australia	Child protection worker	A Bachelor of Social Work, Bachelor of Psychology or Master of Social Work Other degrees in a relevant human services area will be considered on an individual basis ^f	65,156–89,345

^a Community Services Directorate, Position description: Case manager, website, ACT Government, www.jobs.act.gov.au/__data/assets/pdf_file/0008/782171/P00608-Selection-Documents.pdf, accessed 28 June 2016, p.5.

^b Department of Family and Community Services, 'Qualifications assessment guide: Caseworker, casework manager and helpline team leader', website, NSW Government, 2014, www.facs.nsw.gov.au/__data/assets/file/0012/300018/Qualification_Guide_Caseworker.pdf, accessed 28 June 2016, pp. 2–6.

^c Department of Communities, Child Safety and Disability Services, 'Applicant guide: Information about the child safety officer application process', Queensland Government, website, 2015, www.communities.qld.gov.au/resources/careers/child-safety/cso-info-guide.pdf, accessed 7 June 2016.

^d Department of Health and Human Services, 'Working in child protection in Tasmania', Tasmanian Government, website, www.dhhs.tas.gov.au/career/home/statewide_services/children_and_youth_services/child_protection_work, accessed 7 June 2016.

^e Department for Human Services, 'Qualifications for careers in the Victorian child protection program', Victorian Government, website, January 2014, www.dhs.vic.gov.au/__data/assets/pdf_file/0008/669923/2014-Guidelines-on-child-protection-qualifications.pdf, accessed 7 June 2016.

^f Department for Child Protection and Family Support, 'Child Protection Qualifications Framework', website, Western Australian Government, 2010, www.dcp.wa.gov.au/Organisation/employment/Documents/Child%20Protection%20Qualifications%20Framework.pdf, accessed 7 June 2016.

Note: In some jurisdictions, staff who identify as Aboriginal are not required to hold degree-level qualifications.

The inability to respond to children who are at risk or who have been brought into care leaves many practitioners questioning the worth of their role and the compromise of their ethical obligations as professional practitioners. Although employed by the Agency, social workers have to 'live with [their] own conscience and [their] own professional wellbeing'.⁷²

An experienced supervisor who had formerly worked for Families SA referred to the high workloads and said:

*I've seen workers burning out ... I've seen bad decision making because people don't have the time to think about what they're doing and to reflect about their practice ... it leads to no space to even think about training.*⁷³

Not only are practitioners contending with highly complex and skilled work, they also face 'after-hours work, it's going out on removals on a public holiday. It's not a 9 to 5 job and it never could be'.⁷⁴

High workloads also affect child protection practitioners' access to professional development, supervision and time for reflective practice.⁷⁵

'I've seen workers burning out. I've seen bad decision making because people don't have the time to think about what they're doing and to reflect about their practice'

WORKLOAD MANAGEMENT TOOL

The Layton Review recommended that Families SA develop 'a workload measurement and management system that appropriately calculates workload volume and takes into account regional and sociodemographic factors'.⁷⁶ This has not yet been developed for use across the organisation, although initial planning for it was underway in October 2015. It is concerning that managers and supervisors are still not able to determine easily the extent of work being undertaken by teams and individuals at any point in time.⁷⁷

While individual case loads can be counted, this is not generally an accurate reflection of workloads. Complex cases consume much more time than less complex cases. In practice, cases regarded as low complexity are often few and far between.⁷⁸

One local office developed its own workload management tool to⁷⁹:

- provide a snapshot of the workforce and the work being undertaken;
- account for the varying complexities of cases;
- measure, over a period of time, how the office was performing; and
- highlight the actual risks the office carried.

Unfortunately the growth of this initiative beyond the local office was not supported by upper levels of management. This work needs to be progressed as soon as possible.

OFFERING TEMPORARY POSITIONS

The Layton Review highlighted the use of contract staff as an issue affecting the attraction and retention of Families SA staff.⁸⁰ Temporary staff, also referred to as 'term employees', have a fixed contract for a set period of time, generally up to two years but sometimes as short as four weeks.

In March 2015 it was suggested that the number of employees on temporary contracts was reasonably high due to the need to backfill staff who were on maternity leave or acting in higher roles.⁸¹ In October 2015, Families SA could not identify how many staff were employed on an ongoing (permanent), term (fixed contract) or casual basis.⁸² This was an impediment to forward planning and the guiding of future recruitment processes.⁸³ It is yet another example of the Agency operating in the absence of essential information about its workforce.

The Commission was eventually informed that 461 staff, or 26 per cent of the Families SA workforce, were on temporary contracts as at 19 February 2016. In relation to the AHP stream, of the 673 positions, 201 (33 per cent) were filled by a person on a temporary basis. The length of each temporary contract varied, ranging from a month to two years, with the average AHP1 contract being eight months.⁸⁴ The Commission was not able to ascertain from the data provided by Families SA how long a position had been filled by an employee on a temporary contract, or whether an employee on a temporary contract held a permanent position elsewhere in the Agency.

Substantive positions that have been vacated indefinitely should not be filled through the use of temporary contracts and employees should not continue to sit in vacant substantive positions on successive temporary contracts. However, rolling temporary employees into permanent positions should only occur with a comprehensive review of their employment.

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Whether a position is advertised as temporary or permanent can affect the number and quality of applicants. For example, when residential care positions were advertised as permanent rather than temporary there was a significant increase in the number of applications received, as well as in the number of applicants recommended for the positions.⁸⁵

Recruitment processes should give attention to whether a position is temporary or ongoing as the position may be more attractive to potential applicants if advertised as a permanent position. A robust recruitment process, followed by a properly managed probationary period, should be used to give the Agency confidence in the appointment of ongoing employees to the public sector.

THE TURNOVER AND SEPARATION OF STAFF

The Layton Review highlighted that a high staff turnover rate has a significant negative impact on the Agency's effectiveness and morale, through impeding the development of collaborative relationships with clients and other service providers and destabilising teamwork in local offices.⁸⁶

Research suggests that a range of organisational workforce mechanisms can adversely influence staff retention. These include poor management and leadership, inadequate supervision, a lack of opportunity for ongoing professional development, poor induction, high workloads and poor workforce culture.⁸⁷

Current and former Families SA staff spoke of a high turnover of staff and, consistent with the research, attributed it to a number of factors, including⁸⁸:

- the high workload demands placed on staff;
- the pace and confronting nature of intake work;
- a lack of training and support provided to new staff;
- a lack of appreciation for good, hard-working employees;
- a lack of career progression opportunities;
- the use of short-term contracts for staff, resulting in a lack of job stability; and
- a long-established culture of bullying.

A consequence of staff turnover, particularly the loss of experienced workers, is the loss of key skills that benefit clients. Clients, including children in care, birth families and foster parents, may be faced with engaging with multiple practitioners.⁸⁹ This can be challenging for clients who struggle to establish relationships and find it difficult, and sometimes traumatic, to retell their stories.

Staff turnover also affects the ability of Families SA to engage with other stakeholders in the child protection system. While some stakeholders work hard to connect and establish constructive relationships with local Families SA offices and individual practitioners, staff turnover undermines this. Relationships need to be constantly re-built and this frustrates the progression of cases and, more broadly, strategic planning.⁹⁰

Staff turnover can also increase pressure on recruitment and training resources. Valuable relationships between colleagues may be lost and the stress on remaining staff increases as they carry a greater workload. This persists while new staff are trained. Turnover also reduces the access of newer staff to experienced practitioners who may be able to guide and mentor them.⁹¹

TURNOVER AND SEPARATION RATES

Table 6.8 shows Families SA's turnover rate since the 2010/11 financial year and Table 6.9 shows the separation rate annually from 2013 to 2015. The turnover rate indicates the number of permanent staff who have left Families SA, while the separation rate represents both permanent and temporary staff who have left the agency. The turnover figures do not take into account all movement of staff away from the Agency, for example, they do not include employees who have left on long secondments to other government departments or agencies and still retain a permanent position with Families SA. This movement of staff is accounted for in the separation rates.⁹²

Table 6.8: Families SA turnover rates, 2010/11 to 2014/15

FINANCIAL YEAR	PERMANENT STAFF WHO CEASED EMPLOYMENT WITH FAMILIES SA	TURNOVER RATE
2010/11	96	5.42%
2011/12	74	4.80%
2012/13	81	5.36%
2013/14	98	6.29%
2014/15	N/a	About 7% ^a

^a Figure not available at the time turnover data was sourced from Families SA; subsequently provided in oral evidence by the acting manager of the Families SA HR Unit.

Source: Data from Families SA and oral evidence from M Pamminger.

Table 6.9: Families SA separation rates, 2013 to 2015

	PERMANENT AND TEMPORARY STAFF WHO HAVE SEPARATED FROM FAMILIES SA	SEPARATION RATE
2013	246	12.6%
2014	211	11.1%
2015	175	9.1%

Source: DECD, 'Office for Child Safety summary', internal unpublished document, June 2015, p. 5.

While the loss of permanent staff has increased, the separation rate has decreased, which may indicate that staff employed on a temporary basis are continuing in their positions.

A HIGHER TURNOVER IN PARTICULAR AREAS?

In October 2015, Families SA could not produce accurate data to inform the Commission whether particular offices or areas experienced higher turnover rates.⁹³ Using the workforce data set that has now been compiled, the Agency should be able to identify areas where there is a need to reduce high turnover. Such data should continue to be maintained to give the Agency a clear picture of staff movement at any time.

Evidence before the Commission suggested some areas of the Agency had a much higher turnover of staff than others. A number of witnesses reported that the Northern Protective Intervention hub at Blair Athol had a staff turnover rate of about 75 per cent since Redesign in November 2013.⁹⁴ The Commission was told this had a significant effect on casework and that morale was very low. The turnover and its effect could have been a consequence of the decision under Redesign to create only two Protective Intervention hubs in the metropolitan area. It would be understandable if staff left the office as a result of feeling overwhelmed by the enormity of their workload.

It was also reported that the Northern Assessment and Support office at Elizabeth had a 40 per cent staff turnover rate between May 2014 and January 2015.⁹⁵ An experienced, senior staff member who had recently worked in the office described the workload as 'insane' and 'not sustainable for most people'.⁹⁶ This is not surprising. In 2014/15, this office received by far the largest proportion (28 per cent) of screened-in notifications of any office across the state and 45 per cent of all screened-in notifications in the metropolitan area. Due to a lack of resources, the office closed 84 per cent of the screened-in notifications it received without actioning them (see Chapters 7 and 9 for discussion on notifications received and the practice of coding screened-in notifications as Closed No Action).⁹⁷

This 'deluge' of work⁹⁸ and the level of unmet need no doubt have an effect on the resilience of staff and their willingness to remain working under those pressures.

The turnover and separation figures reported by staff on the front-line are higher than the official figures shown in Table 6.8 and Table 6.9. This may be indicative of staff remaining with Families SA, but moving to a different office or area. The work across the various hubs and locations brings different pressures and complexities. Retention strategies should be targeted to the type of work being undertaken or the particular location.

If offices are resourced inequitably, staff may look to change offices. Table 6.10 shows the staffing levels of the three metropolitan Assessment and Support offices at 19 February 2016. The proportion of screened-in notifications being received by the Northern Assessment and Support office are not reflected in the comparative staffing levels. That is not to say that resources should be taken from other offices and moved to the Northern office. The evidence before the Commission demonstrates that all three offices are struggling to meet demand. However, the Agency needs to pay closer attention to workloads in particular areas, determine where further resources are required and deploy resources to best meet need.

REDUCING STAFF TURNOVER

High staff turnover is an issue in statutory child protection agencies around the world. Approaches to counter this in Families SA have been identified in previous reviews and inquiries and, more generally, in the research.⁹⁹ Despite this, there is little evidence of the Agency taking action to reduce turnover. Although the former acting manager of the HR Unit told the Commission the turnover rate compared favourably with that of the public sector¹⁰⁰, other evidence indicated that it was having an effect on remaining staff, clients and other stakeholders.

The Agency should put a plan in place to encourage staff to remain. There should be an investment in staff: in their supervision, professional development and good management. It requires senior staff to acknowledge the pressures on the workforce and provide tangible, supportive leadership with demonstrated confidence in the capacity of staff.

STRATEGIES TO IMPROVE THE ATTRACTION AND RETENTION OF STAFF

LEADING PRACTICE IMPROVEMENT

During the period of Redesign, investment in the development and improvement of clinical skills was neglected. Sue Macdonald was appointed Principal Practitioner in October 2014. At the time of her appointment, she was to lead clinical practice across the Agency, focusing on quality assurance and practice improvement.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

Table 6.10: Staffing levels in Families SA metropolitan Assessment and Support offices

	TOTAL POSITIONS	AHP POSITIONS	OPS POSITIONS	ASO POSITIONS	PROPORTION OF SCREENED-IN NOTIFICATIONS CLOSED NO ACTION (CNA) 2014/15
Northern	49	37	8	4	83.58%
Central	45	33	8	4	71.18%
Southern	40	28	8	4	54.34%

Source: Data from Families SA

In 2016 Ms Macdonald was appointed to a newly created executive position of Director of Quality and Practice. This position, and the directorate Ms Macdonald oversees, are integral to the ability of the Agency to develop a workforce that is capable of delivering a high standard of care to the state's vulnerable children. Some other statutory child protection agencies have a similar clinical leader role. New South Wales has an Office of the Senior Practitioner, which is 'dedicated to practice leadership' and 'to promote good practice, inspire, support and review the work of the front-line.'¹⁰¹ Victoria has the Office of Professional Practice, which 'provides practice leadership and evidence-informed directions and recommendations about human services, policy and service design to promote continuous improvement in client outcomes'.¹⁰²

The Commission endorses the creation of the position of Director of Quality and Practice. It is a positive step and the clinical leader should continue to be part of the executive to ensure the Agency establishes and maintains a commitment to practice quality. The clinical leader should have recognised expertise in child protection and the capacity to be a leader of practice.

It is not clear whether the Principal Practitioner position still exists following Ms Macdonald's promotion, but an experienced practitioner should continue in that position to support the work of the Director of Quality and Practice.

The quality and practice directorate in Families SA has a diverse range of functions including the Learning and Practice Development Unit (LAPDU) and practice inquiry/adverse events.

PRACTICE INQUIRY/ADVERSE EVENTS

In the past the Agency has had an Adverse Events Review Committee, which, in recent times, has been engulfed by other operational needs and has suffered from a lack of staffing. It appears that recommendations following adverse events reviews have not been implemented systematically. Internal inquiries into

adverse events are an important mechanism to develop a reflective child protection agency, dedicated to continual practice improvement.

THE LEARNING AND PRACTICE DEVELOPMENT UNIT

LAPDU is tasked with providing training opportunities for all staff. In February 2015 it consisted of 12 staff, including nine trainers, a decrease from 2005, when the unit had 22 staff.¹⁰³ In about the same time, the number of staff in Families SA has grown from 1089 FTE (in 2003)¹⁰⁴ to 1643 FTE (in 2015). Not surprisingly, LAPDU has been hampered by resource constraints, which has affected the type and frequency of training that it can offer staff.¹⁰⁵ It has been forced to focus on particular areas of the business, leaving others areas, such as kinship care support, financial counselling and business support, neglected.¹⁰⁶

There were also no courses available for staff who wanted professional development to be able to be considered for leadership roles.¹⁰⁷ Since about 2007 supervisors have had few opportunities for training in supervision, performance development and performance management.¹⁰⁸ This is concerning, particularly given the importance of these areas to developing and maintaining a high-functioning, professional and stable workforce.

The Redesign process and the implementation of Solution Based Casework™ significantly impaired the ability of LAPDU to deliver its usual suite of training.¹⁰⁹ Topics necessary to arm new staff with basic knowledge and skills for their work in statutory child protection could not be accessed. Despite expectations, new training programs did not emerge from Redesign.¹¹⁰ The Agency has failed to support staff with a well-resourced and comprehensive internal learning and development unit. This has compromised the professional development of staff.

The need for a dedicated learning and development section in the new Agency has been recognised in Chapter 5. This section would have a fundamental role to play in the ongoing professional development of staff.

ONGOING PROFESSIONAL DEVELOPMENT

The ongoing professional development of staff is essential to increase their capacity and capability. It contributes to morale and keeps staff up to date with current and emerging practices, and encourages new ways of thinking. Professional development opportunities influence how well organisations perform their functions and play a crucial role in staff retention.¹¹¹

Families SA supervisors expressed frustration to the Commission about the lack of funding available for training to develop their staff. They explained that when areas of improvement were identified as part of an employee's professional development plan (discussed below), there was often no way to finance the recommended training.¹¹²

Mr Scheepers told the Commission that Families SA's investment in professional development and support for staff had either disappeared or dropped off significantly since 2010. He acknowledged staff had 'been let down, to a large extent, by the organisation in supporting them in the direction of their development', but he was planning to invest significantly in building the capacity of staff.

Staff had 'been let down, to a large extent, by the organisation in supporting them in the direction of their development'

While lack of financial investment is a key factor in the reduction in professional development, other factors contribute. They include high workloads, the failure of the Agency to value learning and create a positive learning culture, and the lack of staff incentive to undertake professional development.

The professional development of staff is not necessarily costly. An essential factor is the provision of time to allow staff to attend courses or conferences, review relevant research or literature, undertake secondments in other locations or agencies, shadow a more experienced worker or talk to a peer mentor.

Professional development is an ongoing requirement throughout a practitioner's career, no matter the level of their experience. Supporting the workforce to undertake a minimum amount of professional development per year would be beneficial to staff and lead to an increase in professionalism.¹¹³

THE REGISTRATION OF SOCIAL WORKERS

Unless a social worker is a member of the Australian Association of Social Workers (AASW), they are not obliged to complete a certain number of hours of professional development each year. There is also no obligation on Families SA social workers to undertake professional development as part of their employment. As a result, individual practitioners are left to be responsible for their own professional development.

In 2008, the CISC Inquiry recommended that a system of registration or accreditation for social workers be introduced, which included ongoing professional development and training requirements.¹¹⁴ This recommendation was not implemented. The question of registration is a longstanding issue. Early advocacy for registration divided the profession and state governments were not satisfied there was sufficient risk to dedicate resources to a more robust model of accountability.

According to AASW and other supporters of registration for social workers:

*A statutory model of regulation will provide a legally enforceable set of probity, qualification and practice standards for entry into the profession and maintenance of continuing professional development as a requirement for maintaining registration and accreditation. It will therefore provide members of the public with greater confidence that a person stating they are a social worker is qualified and conforms to ethical practice.*¹¹⁵

It is expected that through statutory registration and accreditation a registration board would be given powers to investigate practitioners following complaints and provide legally enforceable penalties where a breach of a standard occurs including, in serious cases, removal from the register of practitioners. Formal adverse findings would make it difficult for a social worker to move without detection to another organisation.¹¹⁶

Recently the South Australian Coroner recommended registration of social workers following his inquest into the death of Chloe Valentine.¹¹⁷

While the Commission understands the benefits of registration, and does not discount the evidence of witnesses who regard it as essential, it is also important to recognise that achieving registration would not resolve all concerns in child protection practice. Systemic, organisational and industrial issues that have been at the crux of many complaints about the practice of social workers will not be overcome through statutory registration and accreditation. There is also a risk that through complaint mechanisms and investigative and deregistration processes, registered professionals will become scapegoats for what are in fact failings of the system, not failings of an individual. This risk will be particularly high where practitioners find themselves contending with a culture that is risk averse and quick to apportion blame.

Much of the demand for registration focuses on social work. Whatever direction emerges from the current dynamic environment of regulation it is essential to recognise the range of occupational groups that can be engaged in child protection work. Some of those professions are already regulated but the focus is on their primary professional tasks and within their institutional base. Consideration needs to be given to the specifics of practice in child protection across professional and occupational groupings if there are to be standards of practice that can be endorsed and enforced. It could be argued that practitioners need to be identified as child protection workers and that it is this activity that is being registered, rather than the social workers who might be in the role.

The registration of social workers is considered to be a national issue. State-based registration would not protect the public from practitioners who have been the subject of professional misconduct from moving between jurisdictions. AASW considers the National Registration and Accreditation Scheme (NRAS) to be the only pathway to achieve statutory professional standards for social workers. National support would be required for social workers to be included in the scheme.¹¹⁸

The AASW President, Karen Healey, states that AASW will continue to lobby for registration as it will improve public safety in relation to all social workers. The professional association acknowledges the limitation of self-regulation, because it applies only to members and has limited impact on employment options for anyone breaching standards. In addition, AASW has indicated it will continue to work with other allied health professions to establish a National Alliance of Self-Regulating Health Professions.¹¹⁹

Because statutory regulation is more expensive than self-regulation, it requires policy makers and legislatures to be satisfied that social work poses sufficient risk to the public to warrant the additional expenditure. Despite the registration of social workers being a persistent issue, with strong advocacy from AASW, to date it has not gained national traction.¹²⁰ The need for cross-jurisdictional involvement takes the issue of registration beyond the scope of this Commission's Terms of Reference.

The Commission believes that at this stage the emphasis should be on effecting improvements with respect to the education, training and professional development of child protection practitioners. However the efforts of AASW to achieve national registration are encouraged and, the Commission would support South Australia's participation in a scheme which may eventually be established.

INDUCTION

The deficiency of Families SA's induction process was a consistent theme across the evidence. Senior staff questioned the quality of the process and whether it met the needs of new staff.¹²¹ There was said to be variability

between local offices, a likely consequence of the lack of formal guidelines setting out how new staff were to be inducted.¹²² High workloads made it difficult for local offices to put the time and energy into the training of new staff.¹²³

Effective induction processes are important in supporting new staff to manage both the professional and personal demands of the work and develop essential skills. Ultimately, they have a role in staff retention.

In the second half of 2015, the Agency introduced a 10-week induction program for AHP and OPS front-line staff, which covered topics including attachment and childhood trauma, child development, models of practice and Solution Based CaseworkTM, information gathering and assessment skills, and report writing. It is delivered both centrally in a classroom scenario and in the offices where new staff are located.

During the first six weeks of this program, it is intended that new staff should not be allocated a case load. In the final four weeks, it is expected that new staff will shadow more experienced workers in their local office.¹²⁴ This is an important change. Previously, new staff were often assigned casework on their first day and, on occasion, had removed children from their parents and were writing the ensuing report for court in their first few weeks.¹²⁵

Ms Macdonald said that the primary aim of the new induction program is to ensure that the Agency is:

inducting people in a way where they feel they are safe to do this sort of work. The work is hard, and there is no getting around that ... and there is no getting around the confrontational nature of taking a child away from [his or her] parent ... that's not a job that is pleasant for anybody. Even where children are ... in terrible situations it's still a parent and it's still a person you are interacting with.

She went on to say that they were trying to support the staff in the first 12 months to see if they could resolve some of the retention issues.¹²⁶

There is insufficient evidence for the Commission to draw a conclusion as to the efficacy of the new program but it appears to be a significant improvement on previous practices. The effectiveness of this program should be monitored and evaluated regularly. Evaluation should include feedback from facilitators of the program as well as participants and, importantly, staff who are responsible at a local level for the supervision of new staff. Understanding how the new program is contributing to practice quality and service delivery would underpin its continuing development.

Inviting experts external to Families SA to deliver some aspects of the induction program would also strengthen the learning opportunities and foster relationships between the Agency and other stakeholders in the child protection system.

SUPERVISION

Supervision is regarded as central to the development and maintenance of best practice social work and all staff involved in child protection.¹²⁷ It aims to ¹²⁸:

- enhance the professional skills and competencies of social workers;
- engage social workers in ongoing professional learning that enhances their capacity; and
- retain social workers in organisations by supporting and resourcing them to provide a quality service.

The importance of supervision to child protection practice has been long recognised and was highlighted in the Layton Review.¹²⁹ Supervision encompasses three elements that are interrelated and will often overlap: accountability, education and support. The accountability aspect of supervision relates to the oversight of day-to-day work and ensures adherence to organisational practices. The educational aspect focuses 'on developing practice-based knowledge, understanding and skills that will improve the competence and the professional satisfaction of social workers'.¹³⁰ It also involves encouraging social workers to engage in critical reflection on practice. The support element of supervision involves recognising the personal impact of the work on practitioners and allowing them a space where they can 'become more aware of how their work is affecting them and, in turn, how their personal reactions and emotional state are impacting on practice'.¹³¹

Child protection practitioners often confront disturbing, painful and distressing situations. The supportive function of supervision can assist practitioners to manage the effects of these stresses through creating a safe environment in which they can acknowledge the demands of their practice and reflect on their experiences. Through this process, supervision can also support practitioners to build and maintain resilience, which is essential throughout a career in child protection.¹³²

Despite the clear benefits, supervision in the Agency has been described as 'ad hoc'.¹³³ In February 2014, Families SA undertook an internal Performance Culture Pilot Project, with the aim of ascertaining what supervision was taking place, the barriers to good supervision and how it could be improved. The project highlighted a number of issues including¹³⁴:

- there was no supervision policy or preferred theoretical model for supervision;

- a lack of consistency in the structure and provision of supervision, including how and when supervisors address an employee's professional development;
- there was no quality control of supervision;
- Solution Based Casework™ was unable to fulfil the function of a supervision framework; and
- there was no document management system for the filing and storage of supervision records, resulting in them being stored informally by supervisors.

The current status of the project is unknown. While a supervision policy and implementation plan was put to the field for comment, leading to some changes being made to the plan, by October 2015 it appeared to have reached a standstill.¹³⁵

Supervision enables staff to build on their skills in a structured, professional manner and demonstrates that the Agency values staff as a fundamental resource. It is required across all levels, from the most recent graduate to the most senior child protection practitioner. The Agency should develop and implement a supervision framework for all front-line staff. Any staff member responsible for delivering supervision should be given clear guidelines and training. Staff require adequate time to provide and engage in supervision. External practitioners may be an additional resource for professional supervision.

OTHER INTERNAL PROFESSIONAL DEVELOPMENT STRATEGIES

PERFORMANCE DEVELOPMENT

Department policy requires each staff member to have an annual performance development plan. The aim of the plan is to improve the staff member's professional capacity.¹³⁶

The Performance Culture Pilot Project identified confusion among Agency managers and supervisors about their responsibilities in relation to the performance development of staff, including the documentation and storage of plans. The staff also appear to be unclear about instituting formal performance management processes.¹³⁷ Inadequate guidance from the Department's human resources function¹³⁸, together with the failure of the Agency to invest in the training of supervisors and managers, has contributed to this confusion.

Every staff member should have a current, individualised performance development plan. This should be developed annually by a line manager, in collaboration with the staff member, and be informed by performance strengths and weaknesses. Staff should be given the opportunity to meet the aims of their plan. This would include accessing professional development.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

STUDY SUPPORT POLICY

A Study Support Policy gives Families SA employees who want to undertake study the possibility of fee reimbursement, support for field placements and study leave.¹³⁹ Applicants approved by the Study Support Panel and in turn an executive director are eligible to be reimbursed 75 per cent of their course fees upon successful completion. Aboriginal employees are reimbursed all their course fees upon successful completion.¹⁴⁰

The Commission was told some staff would use study support and then leave the Agency after they had completed their course.¹⁴¹ This denies the Agency the benefit of the skills development it has financed. Supporting staff to undertake study is an important component of encouraging ongoing professional development, and may be attractive for those considering a career with the Agency. While the policy expects the employee to be committed to long-term employment with the Agency, consideration needs to be given to mechanisms and improvements to assist in the retention of staff when they complete their study, such as career pathways or improved wages and conditions.

CENTRAL CONFERENCE FUND

The Agency has a Central Conference Fund with an annual budget of \$20,000.¹⁴² The purpose of the fund is to encourage staff to attend conferences and bring back to the Agency their learning and improved knowledge. Across a workforce of about 600 practitioners in the AHP stream, the fund provides a meagre \$33 per person. This is significantly less when the large OPS workforce in residential care is taken into account.

Due to its limited size, staff must compete to receive financial support from the fund and generally only five or six are successful each year. Many staff simply opt not to apply and are left to fund these learning opportunities themselves.¹⁴³

In contrast to the Central Conference Fund, SA Health administers the Allied Health Professionals plus Professional Development Reimbursement Program (AHP+PDRP).

There is an expectation under the Enterprise Agreement that employers will reimburse the reasonable cost of appropriate professional development expenses of staff in the AHP stream. The Enterprise Agreement provides for staff in the AHP stream to undertake 2.5 days professional development each year, with agencies funded to backfill staff. Rather than using this funding to backfill positions, SA Health has created a professional development reimbursement fund for staff. It uses this fund to reimburse the reasonable costs of its AHP staff undertaking professional development.¹⁴⁴

Through the AHP+PDRP, qualifying staff can access up to \$2000 worth of professional development funds each year and individuals can pool their allocation and undertake professional development as a group where appropriate. This is a prominent policy in SA Health and well regarded by staff.¹⁴⁵

The Central Conference Fund administered by the Agency pales by comparison. This may also be a factor relevant to staff attraction and retention. It appears there is scope in the Enterprise Agreement for the Agency to explore establishing a similar scheme to SA Health. This should be pursued.

DEVELOPING A CAREER PATHWAY

Developing a career pathway is an important aspect of the attraction and retention of all staff employed by the Agency.

At present, AHP2 level is the ceiling for social workers who carry case loads in the Agency. For a social worker to progress beyond this classification, they must be appointed to a supervisory role. Although the Commission was told that supervisors in some areas were managing cases due to a high volume of work¹⁴⁶, this is outside the position's role description. Generally, supervisors should not be expected to have a case load. Similarly, for a supervisor to progress they must be appointed to a principal social worker position or move out of the AHP stream into a managerial position, where they will often focus more on resources than clinical practice.

KEEPING EXPERTISE ON THE FRONT LINE

It is necessary for the Agency to recognise that not all front-line staff will want to pursue a managerial, supervisory or consultative position. Importantly, service delivery will benefit from having clinical specialists carrying case loads on the front line. This is warranted by the complexity of the work. How staff progress beyond the AHP2 classification should be reviewed.

There is a need to provide a career pathway that encourages experienced staff to remain in front-line roles. To retain staff in these positions, they must be presented with advancement opportunities and pay and conditions that are attractive when compared to those offered in management and administrative stream positions.

Chapter 5 observed the need to flatten the hierarchical structure of Families SA. An opportunity exists to remove a layer between the Director level and the local offices. This should coincide with a greater investment in decision making and clinical expertise in the local offices. This could be achieved by offering positions that carry complex case loads at an AHP3 level. For example, consideration could be given to recasting the

senior practitioner role at a higher classification with an expectation that complex cases will be carried, in addition to the quality assurance and mentoring role.

Chapter 5 highlighted that involving unqualified and clinically inexperienced office managers in practice decisions is not indicative of sound practice. Reforming this aspect of the office structure presents an opportunity to offer supervisors a progression pathway with a focus on clinical practice. The appointment of a clinical manager in each office would ensure an experienced practitioner was responsible for leading clinical practice, supporting complex interventions, overseeing learning and development of clinical staff, and providing a clear link with the quality and practice directorate. The office manager would in turn have oversight of the office's resourcing, both financial and staffing; be responsible, in collaboration with the clinical manager, for the strategic direction of the office in line with the broader agency; and provide leadership in engaging the office with other local stakeholders.

With this reformed office structure, it would be necessary to revise delegations. This would address many of the concerns about micromanagement that have been identified as a weakness in the current system.

Training to enhance the competence and confidence of front-line staff is an important tool in addressing issues of micromanagement. Staff need to be supported to engage in training. Senior staff need to be aware of the training that is delivered and acknowledge child protection practitioners' increased competence.¹⁴⁷

How classifications in local offices sit against those in the Agency's principals' group (principal social workers, principal psychologists and principal Aboriginal consultants) also needs to be considered. The principals are called on to consult on cases, but most decision-making authority sits with supervisors who are appointed at a lower classification. An office manager told the Commission that this can lead to tensions:

What then happens is a supervisor will come and say, 'I think we need to remove these children on the grounds of'—they are expected to consult with the principal social worker of which some have not been in the field for decades ... They consult with the principal social worker ... in my opinion, their job is to add value to the bigger discussion, not to make a decision on whether we should or shouldn't [remove the child] ... The culture of the organisation is that whatever the principal social worker says, goes. The risk sits with my office; it is our decision, and at the end of the day I tell my staff, 'You get what you need to from a lot of sources, then you make the decision'.¹⁴⁸

Every person in a front-line clinical position should have the opportunity for career development, in terms of professional development, classification levels and recognition of expertise. Roles and classification levels

need to be explicitly defined in terms of expected skill and demonstrated capacity. This will provide staff with an identifiable career pathway and allow tailored professional development so that interest and skill sets are aligned either to clinical practice or to resource and strategic management.

THE NEED TO DEVELOP MANAGEMENT CAPABILITIES

Many aspects of the Agency's attraction and recruitment strategies rely heavily on the capability of managers who have day-to-day supervision of front-line staff. Evidence before the Commission indicated that the breadth and depth of management skills and experience were very low. Mr O'Loughlin described the line management as:

very underdeveloped ... quite dissipated, and it didn't have a managerial culture ... of people understanding and seeing as integral to their role that they fulfilled line management responsibility as regards managing people. It was a bit like it was an annexure.¹⁴⁹

Unwillingness and a lack of capacity of some of the Agency's managers to deal with staff performance and misconduct issues were identified as a problem. Some seemed unaware of their responsibilities and performed their roles with a lack of structure, discipline or follow-through.¹⁵⁰

The former head of the Agency, David Waterford, told the Commission that management capacity was in short supply across Families SA. While some senior staff were very competent at managing the supervision and development needs of their staff, others were verging on incompetent. This had the potential to affect the Agency's capacity to fulfil its legislative mandate.¹⁵¹

Nevertheless, it does not appear that there has been any attempt by the Executive leadership of Families SA to ensure managers and other senior staff are trained and developed in their key roles. The lack of management density has been amplified by the absence of an effective human resources unit within the Agency. It has essentially been left to staff in management positions to fulfil human resource functions with very little support, while managing crisis driven day-to-day work.

The management capabilities of staff across all levels of the Agency need to be developed. The Agency should be committed to identifying and developing potential managers, and increasing the skills of existing managers. The Agency should require staff who take on management positions to undertake appropriate courses, aimed at building management skills.

THE COMPETITION WITH OTHER AGENCIES FOR SOCIAL WORKERS

In the face of a poor brand and culture, the Agency has had to compete with other, often more attractive agencies that require staff with similar skill sets. The

Agency struggles to compete for social workers with several other government departments, including agencies in SA Health that play a significant role in the child protection system (in particular Child and Adolescent Mental Health Services and Child Protection Services), and with agencies in the non-government sector. One reason advanced for this was wage parity, particularly with SA Health.

THE ISSUE OF WAGE PARITY

Some witnesses told the Commission about SA Health 'poaching' social work staff, who were lured by better pay and better working conditions.¹⁵² Some staff in the Agency held the view that SA Health employed graduate social workers at the AHP2 level, rather than the entry-level AHP1 classification offered by the Agency, making it difficult for the Agency to compete for the state's best graduates. It was suggested that the Agency's major leverage against SA Health was a basic ability to attract those graduates who specifically wanted to work in statutory child protection.¹⁵³

The Layton Review highlighted the importance of wage parity between Families SA and other government agencies in South Australia, particularly SA Health. All public sector social workers in South Australia, regardless of the department in which they work, are subject to the Enterprise Agreement. This agreement states that the AHP2 classification is not entry level and requires post-qualification experience. SA Health informed the Commission that all AHP2 social work roles in its department require post-qualification experience.¹⁵⁴ That is, SA Health does not employ graduate social workers at an AHP2 level.

SA Health determined that some positions were not suitable for graduate social workers due to the complexity of the work or additional requirements of the role. The client groups, the complexity of the client groups' illnesses and situations, and the specialisation of the position are all relevant factors to this determination. Some of these positions are in child protection teams.

It is possible that graduate social workers who obtain post-qualification experience at the AHP1 level with the Agency, successfully apply for AHP2 positions in SA Health rather than remaining with the Agency waiting for their classification to be peer progressed to an AHP2 level. This may create the perception of poaching. The challenge for the Agency is not only to attract graduates, but to retain them.

THE IMPORTANCE OF EFFECTIVE RELATIONSHIPS WITH THE UNIVERSITIES

There should be close links developed between the Agency, the local universities and social work students. The Agency must demonstrate to students the merits of practising in child protection and the career opportunities in child protection that are available in

the organisation. Ms Macdonald has recently engaged with the local universities and started to strengthen the Agency's relationship with the tertiary education sector. The HR Unit has also facilitated the Agency attending careers fairs and has timed recruitment rounds to coincide with the graduation of social work students.¹⁵⁵

The Commission was told that in 2008 the Families SA office at Elizabeth created a regional field education coordinator position, to attract more social work students to undertake placements at the Agency's northern metropolitan offices. In about 2014, the coordinator became responsible for the oversight of social work student placements in the Agency as a whole. The Commission was told in August 2015 that Families SA had become a sought-after placement for students, with more applications than placements available.¹⁵⁶

The schools of social work at the University of South Australia and Flinders University have provided detailed submissions to the Commission as to core course requirements and field education¹⁵⁷, and it is important that the Agency collaborates closely with both schools.

OBTAINING A QUALIFICATION SPECIFIC TO CHILD PROTECTION

Previously, the College for Learning and Development (see Chapter 5) provided child protection workers with the opportunity to obtain a diploma in Child, Youth and Family Intervention. The diploma covered essential topics such as working with children with complex trauma and attachment issues; working with adolescents, including those experiencing drug-related issues; and mental health.¹⁵⁸ Staff employed as youth workers in the OPS stream could also obtain a qualification relevant to their role.¹⁵⁹

The obtaining of a qualification will not necessarily improve practice.¹⁶⁰ A distinction can be drawn between training—a simple transfer of knowledge—and learning and development, where what is learnt is embedded in a person's day-to-day practice.¹⁶¹ The latter must be the aim of the Agency's learning and development section.

It is essential that the Agency focus on the content of the training it delivers internally, ensuring that what is taught is relevant and improves practice. There may be other ways to offer child protection qualifications to staff, including collaborating with the tertiary education sector to offer postgraduate qualifications to degree-qualified staff. The Agency should provide leadership across the child protection system in this regard.

For example, in Victoria the Department of Human Services has two accredited pathways for experienced statutory child protection staff, which are used to improve staff retention, make the sector an employer of choice and improve outcomes for children. Two courses are offered: a graduate certificate in Child and Family Practice and a graduate diploma in Child and Family

Practice Leadership. The graduate certificate is for staff with at least two years' experience in front-line work, while the graduate diploma is aimed at more senior staff as it covers leadership capabilities. Both courses are funded by the Department of Human Services, with positions available to child protection practitioners in both the statutory child protection agency and the non-government sector.¹⁶²

POSTDOCTORAL RESEARCH MODEL

Another way to build a mutually beneficial relationship with the tertiary education sector is to commission research in an area of interest to the Agency. There is a clear need for the Agency to evaluate programs independently and be able to conduct research into best practice. The Australian Centre for Child Protection (ACCP), a research body at the University of South Australia, was established in about 2004 to bridge the gap between what is known in child protection and what is done in child protection. It aims to produce new evidence and research to support policy and practice development, and where research and evidence do exist, translate that into policy and practice.¹⁶³

ACCP has established a research model that allows a postdoctoral research fellow to undertake an independent program of research for three years. The Western Australian Department for Child Protection and Family Support has recently funded such a research program with ACCP. The research relates to the Signs of Safety approach, which has been introduced in WA's statutory child protection practice.¹⁶⁴

If the Agency invested in a postdoctoral research fellowship program, it would be able to identify and dictate research areas of interest and relevance to its work. Such an investment would also assist the Agency to develop a closer relationship with the university sector in South Australia.

PARTICULAR CHALLENGES

ABORIGINAL STAFF

The Agency's ability to attract Aboriginal staff is a challenge that requires particular consideration. In 2012, an internal review found that Aboriginal staff have not been well supported in the Agency, affecting staff performance, recruitment and retention.¹⁶⁵ The roles undertaken by Aboriginal staff in the Agency, and how the Agency may better support them, are discussed in Chapter 16. In October 2015, the Agency appointed a Strategic Aboriginal Advisor, and it is expected the role will include the development of a strategy to attract Aboriginal staff.¹⁶⁶

REGIONAL STAFF

The Agency's challenge to attract and retain staff in regional locations was a consistent theme in the evidence before the Commission. Some regional offices reported high and longstanding vacancy levels.¹⁶⁷ While the Commission's observations in this chapter are generally applicable to staffing in regional areas, the regional workforce faces particular challenges (see Chapter 17).

THE CHILD PROTECTION WORKFORCE BEYOND THE AGENCY

Although this chapter has focused on the child protection workforce in the Agency, it is important to acknowledge that the child protection workforce in this state is broader than the statutory agency. The workers in the Agency are an integral element of the child protection system, but the Agency does not have the expertise or resources to meet the needs of the entire system, and some services are more appropriately delivered by other stakeholders. In addition to contracting with non-government organisations, the Agency relies on other government agencies, such as Child Protection Services, the Child and Adolescent Mental Health Service and Drug and Alcohol Services South Australia, to deliver assessment and therapeutic services that are outside its area of expertise.

The National Framework for Protecting Australia's Children 2009–2020 has recognised that 'the attraction and retention of an appropriately skilled and qualified workforce—including statutory and non-government service workers, as well as voluntary carers—is a high priority'.¹⁶⁸ All organisations in the system, government and non-government, should have highly skilled, well-functioning workforces with relevant expertise in child protection. While each organisation is primarily responsible for the development of its workforce, consideration should be given to how stakeholders can work together to develop a strong, sustainable workforce across the whole system.

The need for system-wide child protection workforce strategies has been recognised in other jurisdictions.¹⁶⁹ For example, in January 2016, the Queensland Family and Child Commission released a draft workforce strategy aimed at encouraging stakeholders to work together to strengthen the child protection and family support workforces. The strategy recognises that apart from children and their families, the workforce is the most vital element of the service delivery system. It highlights the need for a whole-of-sector focus on professional development, career progression, building leadership and the sharing of learning. Importantly, the strategy recognises the importance of attraction and retention to the system as a whole, not simply an individual organisation.¹⁷⁰

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

There is value in stakeholders in the South Australian child protection system collaborating to develop a workforce strategy that brings together employees, organisations and professional culture.¹⁷¹ There would be cost efficiencies for all stakeholders where opportunities are taken for shared learning.

THE FUTURE WORKFORCE

The Agency should value professional development and encourage staff to draw on their learnings and try different approaches. Staff should be encouraged to voice professional opinions without fear of repercussions and apply their professional expertise to decision making, rather than being weighed down by bureaucracy. They should be able to practise in an environment of trust, not risk aversion, fear and disrespect. Flexible working arrangements should be a strategy to attract and retain staff. Senior staff must have the ability and capacity to manage in both an operational and strategic sense.

Staff should be encouraged to voice professional opinions without fear of repercussions and apply their professional expertise to decision making, rather than being weighed down by bureaucracy

- appointing leaders who are capable of fulfilling all aspects of their management duties, including supporting the professional development and supervision of their staff; and
- transforming organisational culture, to cultivate a positive and supportive workplace that values and respects staff, is committed to learning and is able to deliver a high quality child protection service to the state's vulnerable children.

The workforce plan should allow the Agency to address human resource issues proactively, rather than reactively. It should be a plan that allows the Agency to stabilise and manage its workforce, anticipate change and meet its statutory obligations.

The human resources unit should be appropriately resourced to provide operational services, such as recruitment, oversight of performance management and advice to staff and managers, as well as strategic services, in particular development and oversight of the workforce plan.

The Commission recognises the human resources unit's operational services will be under significant pressure until vacancy levels are reduced and the workforce is stabilised. However, the unit should not be required to operate in a crisis mode. This has been the failing of the Agency for far too long.

PRIORITIES

Transformation of the system cannot happen overnight. Planning needs to be initiated and systematically pursued. The priorities are:

- appointing departmental executives with the knowledge and understanding of the demands and complexities of child protection work, who are able to support the child protection workforce to deliver quality service;
- establishing a high-functioning human resources unit, which combines human resource expertise with an in-depth understanding of the Agency's core business of statutory child protection;
- developing a comprehensive workforce plan, including how the Agency will attract, recruit and retain staff to lead to a sustainable, well-functioning workforce;
- assigning responsibility for oversight of the workforce strategy to ensure it is implemented and progress is monitored and reviewed over time;

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

21 Establish a human resources unit in the Agency that has sufficient specialist expertise and resources to develop and implement strategic workforce plans and to manage operational demands to ensure high quality child protection practice. 22 Establish a learning and professional development unit in the Agency to lead training and professional development, for both professional and operational staff. 23 Require professional staff in the Agency to complete a minimum number of hours of professional development each year as a condition of their employment. 24 Charge the executive of the Agency, through the human resources unit, with a review of current practices and the development of evidence-based strategies relevant to: - a workforce records and data management; - b workforce qualification profiles, including requiring any staff holding a case load to be degree qualified in a discipline relevant to child protection; - c the recruitment, selection, induction and retention of staff, including managing all recruitment and selection centrally; - d career, including management, pathways; - e workload management; - f performance planning, support and monitoring for enhanced staff performance; and - g professional development requirements, opportunities and resourcing, including adopting a professional development reimbursement program modelled on that operating in SA Health. 25 Provide a psychological service to work with the executive to address the high levels of workplace stress in the Agency. 26 Appoint clinical managers to each metropolitan hub and regional office of the Agency and review professional line-management structures accordingly.	27 Invest in clinical management, supervision and practice improvement, including the development of a supervision framework. 28 Establish formal and regularly evaluated relationships between the Agency and the tertiary education sector that are designed to: - a enhance student and academic knowledge and experience of child protection practice; - b attract desirable graduates; - c expand and focus child protection practice research; and - d ensure that the Agency and its staff are kept abreast of contemporary professional research and literature. 29 Establish a postdoctoral fellowship program in conjunction with the tertiary education sector to advance areas of research relevant to the Agency. 30 Require the Agency to take a lead role with other stakeholders to develop and implement a workforce strategy designed to improve staffing practices and performance across the broader child protection system.

6 CHALLENGES FOR THE CHILD PROTECTION WORKFORCE

NOTES

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PART III

CHILDREN AT RISK IN THE COMMUNITY

7

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7 IDENTIFICATION AND NOTIFICATION

OVERVIEW

Abuse and neglect of children typically occur in private. Because most children are unable to protect themselves, they rely on interested and responsible adults who are close to them, such as friends, relatives, teachers or health practitioners, to identify signs of abuse and neglect. It is expected those adults will take steps to protect a child they suspect is, or is at risk of, being abused or neglected, and assist them to find safety. Reporting concerns to child protection authorities is an essential step in assisting to protect a child who is at risk.

In South Australia, some adults, by virtue of their profession or involvement with children, are legally obliged to report signs of abuse or neglect. These mandated notifiers form a critical part of the child protection system. Through notifiers an otherwise invisible child will come to the attention of child protection authorities.

The predominant role of the Families SA Call Centre is to receive notifications from mandated notifiers and other members of the community about the suspected abuse or neglect of children, and to conduct an initial assessment as to whether there should be a response to those concerns. As such, the Call Centre, commonly referred to as the Child Abuse Report Line or CARL, is the primary entry point to the child protection system. However, as outlined in this chapter, to consider this entry point as a typical customer call centre would misrepresent the critical and complex work undertaken by its practitioners.

This chapter examines how children at risk come to the attention of Families SA (the Agency), and consequently other government and non-government agencies through the process of notification. The rising demand for the Call Centre's services must be addressed. The tools used, and thresholds applied, by practitioners when undertaking assessments must be reviewed. Against this background, the interface between notifiers and child protection authorities is significant. The need for Call Centre staff to be skilled and experienced practitioners is as important as the need for mandated notifiers to be able to identify the signs of abuse and neglect and to have a clear understanding of their role in the child protection system.

This chapter principally relates to the Commission's Terms of Reference 5(a) and (b), in the context of Terms of Reference 1 to 4.

MANDATORY NOTIFICATION

GLOBAL TRENDS

Mandatory notification legislation began in the 1960s when jurisdictions in the United States enacted legislation that required medical practitioners to report suspected serious physical abuse inflicted by a child's parent or caregiver.¹

Since that time, mandatory notification legislation has spread through many countries, including Brazil, Canada, Denmark, France, Hungary, Israel, Norway, Saudi Arabia and Sweden. A 2013 survey of 73 countries (made up of 33 high-income, 33 medium-income and seven low-income countries) found that 61 per cent of high-income, 85 per cent of middle-income and 29 per cent of low-income countries had some form of mandatory notification legislation.²

There are notable exceptions: Germany, the Netherlands, New Zealand and the United Kingdom retain voluntary notification systems. However, these countries generally have industry policies that act as an alternative means of requiring members of relevant professions, such as doctors and teachers, to report suspected child abuse.³

The trend around the world appears to be towards some form of mandatory notification. Saudi Arabia recently introduced mandatory notification legislation and Ireland is in the process of so doing. There is a strong push in the United Kingdom to do the same.⁴

REPORTING DUTIES BY AUSTRALIAN JURISDICTION

In 1969, South Australia became the first Australian state to introduce mandatory notification legislation. That legislation now requires a wide range of employees and volunteers who work with children to notify Families SA if they suspect that a child is, or is at risk of, being abused or neglected.⁵

All other states and territories have now done the same, most recently Western Australia in 2009. However, as Table 7.1 and Table 7.2 show, significant differences remain between Australian jurisdictions in relation to:

- the range of people who must notify;
- the types of abuse and neglect they must notify; and
- the state of mind of the notifier.

Table 7.1: Overview of legislative reporting duties by Australian jurisdiction

JURISDICTION	LEGISLATIVE PROVISION	STATE OF MIND	EXTENT OF HARM
Australian Capital Territory	<i>Children and Young People Act 2008</i> , s. 356	Believes on reasonable grounds	Any sexual abuse or non-accidental physical injury
New South Wales	<i>Children and Young Persons (Care and Protection) Act 1998</i> , ss. 23, 27	Suspects on reasonable grounds	Risk of significant harm, being current concerns for the safety, welfare or wellbeing of the child because of the presence, to a significant extent, of: basic physical or psychological needs not being met; not receiving necessary medical care or education; physical or sexual abuse or ill-treatment; exposure to domestic violence causing a risk of serious physical or psychological harm; serious psychological harm; or the child being subject to a prenatal report and the mother did not engage successfully with support services
Northern Territory	<i>Care and Protection of Children Act 2007</i> , ss. 15, 26	Believes on reasonable grounds	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child
Queensland	<i>Child Protection Act 1999</i> , ss. 9, 13E.	Becomes aware of, or reasonably suspects	Significant detrimental effect on the child's physical, psychological or emotional wellbeing
South Australia	<i>Children's Protection Act 1993</i> , ss. 6, 11	Suspects on reasonable grounds	Any sexual abuse; physical or psychological abuse or neglect to the extent that the child has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy
Tasmania	<i>Children, Young Persons and their Families Act 1997</i> , ss. 13-14	Believes or suspects on reasonable grounds, or knows	Any sexual abuse; physical or emotional injury or other abuse, or neglect, to the extent that the child has suffered, or is likely to suffer, physical or psychological harm detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy
Victoria	<i>Children, Youth and Families Act 2005</i> , ss. 162, 184	Believes on reasonable grounds	The child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type
Western Australia	<i>Children and Community Services Act 2004</i> , s. 124B	Believes on reasonable grounds	Any sexual abuse
Commonwealth	<i>Family Law Act 1975</i> , ss. 4, 67ZA	Suspects on reasonable grounds	Any assault or sexual assault; serious psychological harm; serious neglect

Source: Adapted from B Mathews & D Scott, *Mandatory reporting of child abuse and neglect*, CFCA Resource Sheet, Australian Institute of Family Studies, 2014, updated J Commerford, May 2016.

7 IDENTIFICATION AND NOTIFICATION

Table 7.2: Mandated notifier groups by Australian jurisdiction

JURISDICTION	LEGISLATIVE PROVISION	TEACHERS	POLICE	DOCTORS	NURSES	OTHERS
Australian Capital Territory	<i>Children and Young People Act 2008</i> , s. 356	Yes	Yes	Yes	Yes	Dentists, midwives, home education inspectors, school counsellors, childcare centre carers, home-based care officers, public servants working in services related to families and children, the public advocate, the official visitor, paid teachers' assistants/aides, paid childcare assistants
New South Wales	<i>Children and Young Persons (Care and Protection) Act 1998</i> , s. 27	Yes	Yes	Yes	Yes	A person who, in the course of his or her professional work or other paid employment, delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children (and managers in organisations providing such services)
Northern Territory	<i>Care and Protection of Children Act 2007</i> , s. 26	Yes	Yes	Yes	Yes	All persons
Queensland	<i>Child Protection Act 1999</i> , s. 13E	Yes	No	Yes	Yes	Persons engaged as child advocates
South Australia	<i>Children's Protection Act 1993</i> , s. 11	Yes	Yes	Yes	Yes	Pharmacists; dentists; psychologists; community corrections officers; social workers; religious ministers (but not information communicated in a confessional); employees and volunteers in religious or spiritual organisations; teachers in educational institutions (including kindergartens); family day care providers; and employees and volunteers in organisations providing health, welfare, education, sporting or recreational services to children or who deliver or supervise the delivery of those services to children or hold a management position in the organisation
Tasmania	<i>Children, Young Persons and their Families Act 1997</i> , s. 14	Yes	Yes	Yes	Yes	Midwives, dentists, psychologists, probation officers, principals and teachers, childcare providers, and employees and volunteers in government-funded agencies providing health, welfare or educational services to children
Victoria	<i>Children, Youth and Families Act 2005</i> , s. 182	Yes	Yes	Yes	Yes	Midwives; school principals; certain officers of children's services; people with prescribed post-secondary qualifications working in health, education, community or welfare services; youth and child welfare officers; psychologists; youth parole officers; youth justice officers
Western Australia	<i>Children and Community Services Act 2004</i> , s. 124B	Yes	Yes	Yes	Yes	Midwives
Commonwealth	<i>Family Law Act 1975</i> , s. 67ZA	No	No	No	No	Some Family Court or Federal Court staff, family consultants, family counsellors, family dispute resolution practitioners, arbitrators, children's lawyers

Source: Adapted from B Mathews & K Walsh, '14. Mandatory reporting laws', *Families, policy and the law: Selected essays on contemporary issues for Australia*, Australian Institute of Family Studies, May 2014.

The first mandatory notification legislation in South Australia applied only to medical practitioners, dentists and others groups proclaimed by the Governor. It required them to report suspected criminal ill-treatment of children under the age of 12 years that was committed by parents or caregivers.⁶

The duty has since widened considerably. Section 11 of South Australia's *Children's Protection Act 1993* (the Act) requires mandated notifiers to notify the Department if they 'suspect on reasonable grounds' that a child has been or is being abused or neglected, and the suspicion is formed in the course of the person's work (whether paid or voluntary). They must notify the Department as soon as practicable after forming the suspicion.

The Act defines 'abuse or neglect' to include⁷:

- sexual abuse of the child;
- physical or emotional abuse of the child, or neglect of the child, to the extent that the child has suffered or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy; and
- a reasonable likelihood of the child being killed, injured, abused or neglected by a person with whom the child resides.

This is similar to the position in New South Wales, the Northern Territory and Tasmania, although those jurisdictions also refer to the exposure of children to family violence, which is covered in South Australia by the concept of 'emotional abuse'. By contrast, the duty in the Australian Capital Territory, Queensland, Victoria and Western Australia is generally limited to reporting physical and sexual abuse.

The groups required to notify in South Australia have also expanded. The most recent expansion followed the 2003 Layton Review which, in effect, recommended that all people who work with children, in either paid or voluntary capacities, be required to notify.⁸ Accordingly, the duty now applies in South Australia to the wide group of community members listed in Table 7.2. Apart from the Northern Territory, where all adults must notify suspected abuse or neglect, South Australia has the nation's widest range of mandated notifier groups.

THE FUTURE OF THE DUTY TO NOTIFY

There is debate about the growth of mandatory notification legislation into areas such as emotional abuse and neglect. Some argue that this has encouraged large numbers of unnecessary notifications that overwhelm child protection agencies, divert resources from more serious child protection concerns, intrude unnecessarily in the lives of ordinary families and focus resources on forensic investigations, rather than helping families and preventing concerns from escalating.⁹

Recent child protection inquiries in Australia have supported the maintenance or expansion of mandatory notification, including in South Australia in 2003, the Australian Capital Territory in 2004, the Northern Territory in 2007, New South Wales in 2008, Victoria in 2012 and Queensland in 2013.¹⁰ A 2007 inquiry in Western Australia recommended that mandatory notification should not be enacted. Nevertheless, mandatory notification of sexual abuse was introduced the following year.¹¹

There is no doubt that children exposed to emotional abuse and neglect sustain profound, long-term physical and psychological damage. The groups mandated to notify under South Australian legislation are well placed to identify and report early signs of these types of abuse.

Experience indicates that voluntary notification is not enough. A range of factors make notifiers reluctant to report, including:

- the fear that their suspicion is misplaced;
- the fear that a notification will make matters worse, anger the family or harm a therapeutic relationship;
- an unwillingness to become involved; and
- a lack of confidence in the child protection system.

Mandatory notification makes the duty plain and is an important statement about the community's commitment to protect children from all forms of harm.¹²

Evidence suggests that mandatory notification is effective, in that it tends to identify cases of abuse and neglect that would otherwise not come to light. Most cases of child maltreatment—whether physical, sexual or emotional abuse or neglect—are identified as a result of a report by a mandated notifier. Non-mandated notifiers make a 'significant but far smaller contribution to case identification'.¹³ Countries with mandatory reporting tend to have higher rates of substantiated abuse or neglect than countries without mandatory reporting.¹⁴

Most abuse and neglect occurs in private. Victimised children rarely report their own situation. They need caring adults committed to notify on their behalf.¹⁵

As discussed in this chapter, the rising numbers of notifications present a significant resourcing challenge for the child protection system. Better training and alternative sources of advice for mandated notifiers may moderate demand and improve the general quality of notifications. However, as discussed below, claims that a large number of notifications are unnecessary appear to be exaggerated. Many notifications that are presently assessed as not requiring a response are in fact important matters that need to be brought to the attention of child protection authorities.

7 IDENTIFICATION AND NOTIFICATION

Proposals to narrow the legislative duty on mandated notifiers tend to assume this would necessarily change notifier behaviour. However, the factors that lead a notifier to report are complex and interrelated, including not only the legislative duty, but also notifier training, system characteristics and reporting culture. There is little research about the empirical effects of mandatory notification legislation on over-reporting. The available evidence does not suggest that amending any particular element of the legislative duty would improve the quality of notifications or reduce the burden on the system. It is tempting to conclude that behavioural change would not follow statutory change. It is worth noting when New South Wales increased its notification threshold in 2010 to a 'risk of *significant* harm' [emphasis added], notifications to the statutory helpline reduced. However, most were diverted to the state's Child Wellbeing Units for a 'differential response'. This shifted the destination of notifications, but did not reduce overall demand on the system. Notifiers continued to notify by default, rather than considering options to support families and there was 'considerable "gaming" of the system' by notifiers to ensure that children met the revised threshold at the helpline and therefore received a statutory response.¹⁶

There is a need to emphasise to notifiers that mandatory notification is not the end of their duty. It is important to encourage the whole community, including government and non-government agencies already engaged in the lives of families, to consider how they might better support families and children at risk and to view themselves as joint partners in the broader child protection system. The Commission is however satisfied that the existing duty on mandated notifiers in South Australia to bring at risk children to the attention of the system should be maintained. Chapter 8 recommends significant changes to the way this duty is discharged.

SATISFYING THE DUTY

The Act provides that mandated notifiers must notify 'the Department', defined as 'the administrative unit of the Public Service prescribed by regulation for the purposes of this definition'.¹⁷ The Act does not specify how mandated notifiers should notify. Nor does it specify who in the Department should be notified. On one view, a notifier 'notifies the Department' by telling any officer in the Department. For example, a teacher in a departmental school arguably complies by informing the school principal. That position was never intended.

Families SA operates a 24-hour Call Centre to receive notifications of abuse or neglect by telephone or the internet. Practitioners in the Call Centre are ostensibly trained and equipped to receive and assess notifications. In practice, and as a matter of Families SA policy, this is how mandated notifiers satisfy the duty to notify.

In addition to recommending changes to how the mandatory duty to notify is discharged, Chapter 8 also recommends legislative change to make clear to whom a notifier must report their concerns.

FUNCTIONS OF THE FAMILIES SA CALL CENTRE

The Families SA Call Centre is the primary means by which professional notifiers and members of the public bring child protection concerns to the attention of Families SA. Call Centre practitioners assess the concerns to determine whether they should receive a response and, if so, the nature and timeframe of that response.

The Call Centre operates a number of telephone numbers. They include:

- a general line used by mandated notifiers and members of the public. The Call Centre generally answers these calls in order of how long the call has waited, but with some priority to calls from police officers;
- a dedicated line for police officers, the two hospital-based Child Protection Services and hospital emergency departments to use in genuine emergencies. This line is answered almost immediately; and
- a dedicated line for Families SA staff who need to discuss assessments made by the Call Centre. This line is answered by supervisors or senior practitioners.

Together, these lines are commonly known as the Child Abuse Report Line (CARL). The Call Centre also operates the electronic Child Abuse Report Line (eCARL) service, which allows notifiers to report suspected abuse or neglect over the internet.

Between 4pm and 9am Monday to Friday, and 24 hours a day on weekends and public holidays, the Call Centre operates an after-hours Crisis Care service for families and individuals in crisis. When the Crisis Care service is operating, Call Centre practitioners divide their time between assessing telephone and eCARL notifications and responding to crisis care requests.

HOW NOTIFICATIONS ARE ASSESSED

SCREENING IN AND SCREENING OUT

Whether a notification is made by telephone or eCARL, Call Centre practitioners assess the notification and determine the appropriate response by first determining which matters are 'screened in' to enter the child protection system and which are 'screened out', which means they do not receive a response from Families SA. The practitioners then apply a tier rating to all screened-in notifications to determine how quickly Families SA should respond.¹⁸

A notification is screened in for response if it constitutes physical, sexual or emotional abuse or neglect by the child's parent or caregiver. Practitioners are guided in this decision by the Structured Decision Making® (SDM) screening criteria and definitions¹⁹ (the screening tool). The screening tool contains more than 50 specific grounds of physical, sexual and emotional abuse and neglect, and provides a detailed definition for each ground. If the information in the notification falls within one or more of these grounds, it is screened in for a response.

The screening tool effectively distinguishes between the types of adversity that children commonly experience from time to time and that many families are able to deal with, and unacceptable abuse and neglect from which all children are entitled to be protected. It uses words including 'serious', 'significant', 'extreme', 'immediate' and 'repeatedly' to quantify the level of risk or harm a child must experience for it to constitute abuse or neglect.

GROUNDINGS FOR SCREENING OUT NOTIFICATIONS

There are also a number of grounds that, if applicable, result in a notification being screened out, including the following²⁰:

- Notifier Only Concern (NOC)—the notification is insufficient or vague, the notifier lacks credibility or the notification does not meet the definition of abuse or neglect.
- No Grounds for Intervention (NGI)—the concern meets the threshold, but there is no need for Families SA to respond because the event is historical, another agency is addressing the matter or the perpetrator no longer has contact with the child and the caregiver is protective. The child must be safe from further harm.
- Divert Notifier Action (DNA)—the concerns meet the definitional threshold, but the notifier has agreed to intervene with the family to address the protective issues/concerns.
- Adolescent at Risk (AAR)—the notification identifies an adolescent at risk of harm from their own behaviour or a set of circumstances, such as homelessness, drugs or alcohol, family conflict, self-harm or suicidal ideation.
- Extra-familial Cases (EXF)—the alleged perpetrator is not the child's parent or carer. Practitioners must consider whether there are intra-familial concerns related to a failure of the caregiver to protect the child.
- Report on Unborn (ROU)—there is high risk to an unborn child and the mother is within six weeks of giving birth (34 weeks' gestation).

Screened-out notifications do not generally receive a response from Families SA. AAR and ROU matters are referred to Families SA Assessment and Support teams where they sometimes receive a response. Some AARs are referred on to other agencies, such as Streetlink or the Metropolitan Aboriginal Youth and Family Services.²¹ EXF matters are referred to South Australia Police.²²

TIER RATINGS FOR PRIORITISING SCREENED-IN MATTERS

Next, the Call Centre assigns a response priority to all screened-in notifications in the form of a tier rating. (Screened-out notifications do not receive a tier rating.) The rating determines what type of response the notification should receive and how quickly the investigation, assessment or other response should start.²³

Practitioners are assisted in this task by the SDM Response Priority Assessment: Assessment, Policy and Procedures (the response priority tool). The tool contains decision trees based on actuarial measures to help assess how urgently risks facing children need to be addressed. The decision trees ask a series of questions that ultimately lead to the following tier rating²⁴:

- Tier 1 intakes require an emergency response within 24 hours because the child is in immediate danger or at imminent risk of serious harm.
- Tier 2 intakes involve a moderate to high risk of significant harm and require a response within five or 10 days, depending on the circumstances. If the child is 12 months or younger, the response should be within three days.
- Tier 3 intakes involve 'low risk of further harm or low-level care concerns, but there may be high needs which, if not addressed, might have long-term detrimental effects on the child'.²⁵ There is no set timeframe for responding to Tier 3 intakes.

As discussed in Chapter 9, the response timeframes are misleading, because most screened-in notifications are currently Closed No Action, a closure code that indicates that Families SA has closed the notification without taking any action.

The tier rating also determines the type of response that Families SA should provide. Families SA policy provides that Tier 1 and 2 intakes are generally investigated. Tier 3 intakes should receive a 'community response' which, until recently, generally meant an invitation by letter to attend a meeting at a Families SA office.²⁶ As discussed in Chapter 8, the Linking Families team, which started in mid-2015, now generally responds to Tier 3 cases by letter or telephone.

7 IDENTIFICATION AND NOTIFICATION

THE RISING NUMBERS OF NOTIFICATIONS

In 2003, the Layton Review observed that South Australia, like every other jurisdiction in Australia, was experiencing rising numbers of child protection notifications. It noted that notifications in Australia increased from 91,734 in 1995/96 to 137,938 in 2001/02, a rise of about 50 per cent.²⁷

Since then, notifications have continued to rise across Australia. In 2010/11, notifications in Australia totalled 237,273. In 2014/15, they increased to 320,169, a rise of 35 per cent. Between 1995/96 and 2014/15, notifications increased by 349 per cent.²⁸

In South Australia, as Table 7.3 shows, total notifications have also risen in each of the past four years. In 2011/12, 40,507 notifications were received, increasing in 2014/15 to 57,810, a rise of about 40 per cent. In the same period, screened-in notifications also rose, albeit more slowly. There were 17,290 screened-in notifications in 2011/12, growing to 19,160 in 2014/15, a rise of nearly 11 per cent.

Table 7.3: Screened-in notifications and Notifier Only Concerns as a percentage of total notifications, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Total notifications	40,507	43,539	48,837	57,810
Screened-in notifications ^a (percentage of total)	17,290 (43%)	16,947 (39%)	16,932 (35%)	19,160 (33%)
Notifier Only Concerns (percentage of total)	16,239 (40%)	18,072 (42%)	22,048 (45%)	27,965 (48%)

^a For the purposes of this report, 'screened-in notifications' are limited to Tier 1, Tier 2 or Tier 3 intakes, excluding Extra-familial Cases (EXF). EXF, although technically 'screened in' for some statistical purposes, are referred to South Australia Police.

Note: The Commission also had regard to longitudinal statistics of child protection reporting in South Australia in B Mathews et al., *Child abuse and neglect: A socio-legal study of mandatory reporting in Australia-Report for the South Australian Government*, Queensland University of Technology, Brisbane, 2015. The Commission has confirmed with Families SA that the longitudinal statistics exclude screened-out notifications at least from 2010 onwards and are therefore not directly comparable with the statistics provided by Families SA and published in this report.

Source: Data provided by Families SA.

A RISING THRESHOLD FOR INTERVENTION?

Table 7.3 shows that the proportion of screened-in notifications declined from 43 per cent of all notifications in 2011/12 to 33 per cent in 2014/15. Notifier Only Concerns (NOCs) rose in corresponding terms from 40 per cent of all notifications in 2011/12 to 48 per cent in 2014/15.

As shown in Table 7.4, in the same period that NOCs grew as a proportion of all notifications, the proportion of screened-in notifications classified as Tier 3 declined from 13 per cent in 2011/12 to 7 per cent in 2014/15. In the same period, Tier 2 notifications increased in absolute number and as a proportion of screened-in notifications.

Table 7.4: Response priority (tier) ratings as a percentage of screened-in notifications, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Screened-in notifications	17,290	16,947	16,932	19,160
Tier 1 (percentage of total)	1387 (8%)	1506 (9%)	1156 (7%)	1061 (6%)
Tier 2 (3 days infant)	3172	2908	3100	3611
Tier 2 (5 days) ^a	1296	5949	6498	7611
Tier 2 (10 days)	9119	4682	4712	5565
All Tier 2 (percentage of total)	13,587 (79%)	13,539 (80%)	14,310 (85%)	16,787 (88%)
Tier 3 (percentage of total)	2316 (13%)	1902 (11%)	1466 (9%)	1312 (7%)

^a The Tier 2 (5 days) rating was established in late 2011 (Families SA, 'Divisional circular no. 161', internal unpublished document, Government of South Australia, 2011).

Source: Data provided by Families SA.

Table 7.5 provides an historical comparison of notifications from 1998/99 to 2001/02, the period examined by the Layton Review.

Table 7.5: Response priority (tier) ratings as a percentage of total notifications, 1998/99 to 2001/02

	1998/99	1999/2000	2000/01	2001/02
Total notifications	13,132	15,181	16,314	18,681
Screened-in notifications (percentage of total)	8218 (63%)	8627 (57%)	8854 (54%)	9872 (53%)
Tier 1 (percentage of screened in)	419 (5%)	358 (4%)	500 (6%)	778 (8%)
Tier 2 (percentage of screened in)	5884 (72%)	5961 (69%)	5821 (66%)	6382 (65%)
Tier 3 (percentage of screened in)	1915 (23%)	2308 (27%)	2533 (29%)	2712 (27%)

Note: The term 'CP reports' in the Layton Review appears to correspond to 'total notifications' as used elsewhere in this report. For comparison purposes, 'screened-in notifications' continue to include only Tier 1, 2 and 3 matters.

Source: RA Layton (Chair), *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, 2003, pp. 9.27–9.41.

Total notifications in 2001/02 were one-third of the level in 2014/15 (as shown in Table 7.3), while screened-in notifications were one-half. Despite this, there were more than twice as many Tier 3 notifications in 2001/02 as in 2014/15. The result is that more than 25 per cent of screened-in notifications were classified as Tier 3 in 2001/02, compared with 7 per cent in 2014/15.

Chapter 9 describes how Families SA has increasingly struggled in recent years to respond to screened-in notifications. Families SA uses the closure code Closed No Action (CNA) to close cases owing to a lack of resources. In 2014/15, 61 per cent of screened-in notifications were Closed No Action, including 63 per cent of Tier 2 intakes and 83 per cent of Tier 3 intakes.

Call Centre practitioners are keenly aware of the pressure on Assessment and Support teams and this potentially affects screening decisions. A practitioner described a tendency in the Call Centre 'to try and reduce the amount of child protection work that was screened in because the field could not cope with it'.²⁹

The decline in Tier 3 ratings and the rise in NOCs may suggest the Call Centre's practice has shifted to classify lower level concerns as NOCs, rather than Tier 3 intakes. For example, it is possible that:

*working definitions of what constitutes 'risk' and 'safety' are influenced by the pressure of demand, rather than having any fixed meaning that arises from an evidence-based approach to practice.*³⁰

Whatever the cause, the result is a hollowing out of lower level concerns from the child protection system, with fewer families and children receiving a response unless the concerns escalate.

AN ASSESSMENT OF SCREENED-OUT NOTIFICATIONS

DIVERSION OF RESOURCES OR OPPORTUNITY FOR EARLY SUPPORT?

Screened-out notifications are sometimes regarded as matters that do not need to be reported and that divert limited resources away from more deserving child protection matters.³¹ A recent newspaper article described about half of all telephone calls to the Families SA Call Centre as 'unnecessary'.³² Some witnesses told the Commission that some notifiers are 'risk averse' and report too readily in order to transfer responsibility to Families SA³³:

*We've become an agency for the protection of the mandated notifier rather than the child ... over half our daily work is not a genuine or reasonable belief that a child is at risk or has been harmed.*³⁴

While this criticism may have merit in some specific cases, the Commission considers it is too simplistic. There are at least three reasons why the Agency needs to receive many—quite likely, most—of the notifications that its Call Centre is screening out. First, they are an opportunity to provide early intervention and support to families in need. They are 'ideal candidates for service provision to prevent a continuance or escalation of maltreatment'.³⁵

Second, the notifications allow the Agency to build a more complete picture of the family and may later provide vital background information, intelligence and context if further concerns arise.

Third, they allow the Agency to offer support and guidance to members of the community and government and not-for-profit agencies who are providing primary assistance to the family.

7 IDENTIFICATION AND NOTIFICATION

NOTIFIER ONLY CONCERN (NOC)

As shown in Table 7.3, notifications screened out as NOCs have risen from 40 per cent of all notifications in 2011/12 to 48 per cent in 2014/15.

During the course of its Intake review (see methodology in Appendix C), the Commission examined 20 notifications screened out as NOCs, including the following:

- A seven-year-old child, with ongoing poor hygiene, dirty clothes, wrong-sized shoes and chronic head lice, was 'very emotional', 'easily angered' and said 'no one loves her'. She was isolated and her grandfather told her that she could only have one friend: him. She was tired because she shared a mattress on the floor with siblings and dogs ran around the house. There were 14 prior notifications for the family, including an allegation that her elder sibling was raped and her grandfather permitted ongoing contact with the perpetrator. The child had also previously disclosed that her brother tried to kill her.
- A mother had full-time care of two primary school-aged children, but used the drug 'ice' and sometimes passed out. She did not always cook dinner.
- A 13-year-old boy smashed glass doors at his house and tried to strangle his sisters. The mother did not let the repairer inside to repair the doors. The children had poor school attendance and limited food for breakfast and lunch. There were longstanding concerns, including neglect, exposure to domestic violence, drug and alcohol use, and the mother's poor mental health.
- A father when drunk had made threats towards the children and the mother, who locked themselves in a room. They left in the morning, but were shaken and the nine-year-old child felt sick. The mother contacted emergency accommodation. The parents had a history of violence, including the mother in her previous relationships. The 10-year-old child had a history of self-harm and aggressive behaviour.
- Police attended an argument between two parents who each wanted to sleep in rather than prepare breakfast for the children. The mother screamed throughout the police attendance. One child was upset and cried the whole time. The parents smoked marijuana every day, but decided to stop, which is why the mother lost her temper. The mother was isolated and had no money. She planned to drive until she ran out of petrol, then sleep by the road with her children. An extensive child protection history existed for the children, relating to exposure to domestic violence, parents' drug use and poor mental health, homelessness, poor attendance at school and medical appointments, poor supervision and neglect.

- A five-year-old child attended school late and required a change of clothes because they were soaked with petrol. The father was unaware of the situation when he collected the child from school. The family had no child protection history.

The Commission considered that 15 of the 20 screened-out notifications needed assessment within about a week and should have been screened in as Tier 2 intakes. Another three required assessment, but less urgently and should have been screened in as Tier 3 intakes. The Commission found that only two of the 20 matters would not have required a response by Families SA.

The phrase 'notifier only concern' suggests that any concerns are misplaced or somehow idiosyncratic to the notifier. Yet, when it is used to describe almost half of all notifications (27,965 in 2014/15), it raises the question of whether Families SA's screening-in threshold is too high. Matters such as those extracted above should not be referred to as Notifier Only Concerns. To the contrary, they are cases suggestive of children at significant risk of serious harm. They require an assessment by Families SA to determine the level of risk, the needs of the family, and what intervention or support is required to keep the children safe from harm.

NO GROUNDS FOR INTERVENTION (NGI) OR DIVERT NOTIFIER ACTION (DNA)

About five per cent of all notifications are classified as NGI or DNA. They are usually matters that would meet the threshold for intervention, but are screened out because Families SA or another agency is already assisting the family. In some cases, the notifier is assisting the family, but is seeking further guidance and ensuring Families SA is aware of the situation.

During the course of its Intake review, the Commission examined 20 notifications screened out as NGI, including the following:

- The mother had a history of mental health problems, drug and alcohol abuse, and domestic violence relationships. She had stopped taking her mental health medication, was experiencing anxiety and suicidal thoughts, and had recently smashed a glass and punched a hole in the wall in the presence of her five-year-old child. The mother was receiving support from a not-for-profit agency and a mental health provider.
- Six children aged two to 13 years were living in squalid conditions, with old food, mould, rats and cockroaches. They had many health issues, including lice, sores and scabies, and were often under-dressed for the weather. The mother was unwell and felt depressed. One child was often late for school and suffered from poor hygiene and incontinence. The father had a history of violent and aggressive

behaviour, and criminal offending. The parents had a history of abusing drugs and alcohol, domestic violence, poor supervision and chronic neglect. The children had unexplained injuries. The family were supported by a not-for-profit agency that reported some inroads regarding cleanliness of the house.

- The mother had not booked appointments at the dentist and optometrist for her primary school-aged children, despite frequent reminders and home visits. The children were at risk of harm due to neglect, but the family was being supported by a number of not-for-profit agencies.

In each of these cases, the notification was screened out on the basis that an agency was already supporting the family. However, the interventions were not mitigating the risk to the children. The child protection concerns remained or were escalating. In some cases, the support agency itself was notifying Families SA of the increasing risk. Such cases should not be permitted to drift. A more proactive assessment is called for to determine what further intervention is required and to coordinate the agencies already involved.

The Commission considered that four of the 20 NGI notifications it reviewed required assessment within about a week and should have been screened in as Tier 2 intakes. Another five required assessment, but less urgently and should have been screened in as Tier 3 intakes. Nine notifications related to open Families SA files: this information could have informed the ongoing casework. The Commission found that only two matters did not require a response.

ADOLESCENT AT RISK (AAR)

Between six per cent and eight per cent of notifications are classified as AAR.

During the course of its Intake review, the Commission examined 20 notifications screened out as AAR, including the following:

- A 17-year-old child's father was getting drunk and calling her a 'bitch' and a 'slut'. She was cutting herself and had suicidal thoughts.
- A 14-year-old child was found walking alone at 3am, carrying cannabis, which he smoked 'to relax'. The child did not seem upset, but was cold and asked for a lift. His mother was not concerned regarding the cannabis or him walking the streets at that time. The parents had a history of severe domestic violence, to which the child was exposed and during which he was physically injured. The mother had a history of drug use, and verbal and physical abuse of the child. The child had poor school attendance and exhibited disruptive, sexualised behaviour.
- A 16-year-old girl residing in a small residential care home was supplied with 'acid' by another resident. They went 'tripping' together at 4am and engaged in consensual sexual activity in bushes.
- A 13-year-old had been using marijuana since she was nine and had a history of self-harm. Her father did not supervise her as he spent most of his time in his bedroom, where he smoked marijuana and 'crack'. He had a glass pipe on his bedside table. Although the mother no longer lived with the family, the parents had a history of domestic violence and the mother had a long history of intravenous drug use, to which the child was exposed.
- A 14-year-old child said her father continued to use heroin; she was petrified of him and did not want to live with him because he verbally and physically abused her. The notifier described the father as 'pure evil'. The child had a history of suicidal ideation and was taking medication for depression. The father had a history of drug and alcohol abuse, poor mental health, domestic violence and physical child abuse.

These cases are suggestive of children at significant risk of serious harm. The Commission considered that seven of the 20 AAR notifications it reviewed required assessment within about one week and should have been screened in as Tier 2 intakes. Another nine required assessment, but less urgently and should have been screened in as Tier 3 intakes. Another two related to open Families SA child protection files, where assessment was ongoing.

Three of the 20 AAR notifications related to children already in care. These were clearly matters that needed to be reported. As outlined in Chapter 10, Families SA carries a special burden to ensure these children experience the best possible care and therapeutic interventions to give them every opportunity to reach their full potential.

Children who are the subject of AAR notifications are often among the most distressed, disadvantaged and vulnerable in the state. Many face complex challenges and exhibit complex behaviours that are not easy to resolve. Of course, many have experienced significant abuse and neglect as younger children and their complex behaviours are a predictable consequence of past trauma.³⁶

The circumstances surrounding some screened-out AAR notifications examined by the Commission were difficult to distinguish from screened-in notifications relating to younger children. In those cases, Families SA appeared to apply a higher threshold to screening-in notifications concerning adolescents than younger children.

7 IDENTIFICATION AND NOTIFICATION

One witness stated that the Call Centre gives ‘a relatively lower priority’ to child protection concerns involving adolescents.³⁷ A submission to the Commission emphasised that older youth, particularly those over the age of 12 years ‘are unlikely to receive an intervention unless they are already in the care system’.³⁸

Children of all ages are entitled to safety from harm and the opportunity to reach their full potential. The Commission considers that the AAR classification should be restricted to cases where the risk to a child is genuinely related to their own risk-taking behaviour. Children of any age who experience neglectful or abusive care should be screened in for a response.

EXTRA-FAMILIAL (EXF)

About five per cent of notifications are classified as EXF because the risk to the child lies outside the family. Families SA refers these matters to South Australia Police. It is important to note that many EXF notifications also give rise to screened-in notifications where there are also intra-familial risks, such as the caregivers not being protective of the child. In any event, the Commission considers that EXF notifications are generally matters that need to be reported.

REPORT ON UNBORN (ROU)

ROU matters represent about one per cent of all notifications. Families SA describes them as ‘essentially “advance notice” of a High Risk Infant’ and policy requires that ROUs only be recorded from 34 weeks’ gestation.³⁹ One experienced Families SA Call Centre practitioner expressed concern that ROUs were sometimes recorded earlier than 34 weeks, as ROUs create thousands of case files for individuals who may never be born and most of whom will not be Families SA clients.⁴⁰

The pre-birth period is, however, a time in which many families are receptive to therapeutic input. Parents tend to identify with their baby in utero and are more likely to be motivated to make changes.⁴¹ Requiring a minimum period of gestation for a ROU notification jeopardises a critical engagement period and only delays this important work. ROU matters are an opportunity to support many expectant parents, and this outweighs the fact that some pregnancies may not result in a live birth.

In Victoria and New South Wales, specific reference is made in legislation to notifiers reporting concerns of a risk of harm with respect to unborn children. In each case the concern held must relate not to current safety of the unborn child, but to concerns about their safety after birth.⁴² Although there is no legislative impediment to such reports in this state, the manner in which reports have been dealt with at a policy level highlights the need for clarity. The reporting and recording of concerns should be encouraged as early as possible. Legislation

should specifically permit, rather than oblige, notifiers to report concerns about unborn children, regardless of the stage of pregnancy, in circumstances when it is presently necessary to offer services and supports to the mother to improve outcomes, or to have a properly planned child protection response, when the child is born. Correspondingly, the policy restricting the recording of ROU matters until 34 weeks’ gestation must be abandoned.

IGNORING SCREENED-OUT NOTIFICATIONS CAN BE DANGEROUS

It is potentially dangerous and not appropriate to regard screened-out notifications simply as unnecessary distractions from Families SA’s core business. They involve many matters that need to be reported for a variety of reasons, including:

- there is an open Families SA file and the notification would form part of the ongoing assessment;
- the notification, although not requiring a response, might offer a more complete picture of the family, which might assist in future assessments;
- the notifier is working with the family and might require support and guidance. This could be an opportunity for Families SA or another agency to help coordinate the intervention; and
- despite the screening assessment, the child appears to be at risk and further assessment is required to determine their safety. In some cases, the assessment might be brief and somewhat informal, with a focus on identifying the needs of the family and referring them to a support agency that could meet those needs. However, without some form of assessment, there can be no confidence that the child is safe.

The Intake review revealed that the vast majority of the 60 notifications screened out as NOC, NGI or AAR were serious matters that needed to be reported. Forty-three of the 60 matters appeared to involve children at significant risk of serious harm, who required assessment. A further 11 notifications related to open Families SA files and would have informed ongoing assessments. The Commission considered that only six matters did not require a response.

It is not possible to express any final conclusions based on such a small sample. However, it is clear that more work is needed to ensure the Agency is applying the correct practical threshold for intervention. This is particularly the case given the concerns discussed below that the screening and response priority tools give insufficient weight to important issues such as neglect and cumulative harm. Currently, more than half of all notifications are assessed as ‘notifier only concerns’. It is naïve to assume that so many notifiers are applying the wrong threshold, without reflecting on whether Families SA itself has the balance right.

FAMILIES SA RECORDING PRACTICES

INACCESSIBILITY OF LOG SHEETS

Families SA Call Centre practitioners complete a handwritten log sheet when they receive telephone notifications. After the telephone call, the practitioner enters the data from the log sheet into the case management system, C3MS. The log sheets are then physically archived. They are not scanned into C3MS and are not readily accessible to Families SA workers. They are usually only retrieved when requested by the Coroner or other inquiries.⁴³

During its Intake review, the Commission sought to retrieve the relevant log sheets. Families SA advised that it would take one staff member about one month to retrieve them. In view of this time cost to Families SA, the Commission ultimately decided to request log sheets only for the 20 notifications assessed as NOCs. The request identified the log sheets by case number. Families SA still took a number of weeks to produce them.

Two of the log sheets contained significant detail that was not entered on C3MS. A log sheet concerning a domestic violence incident included the words ‘drunken rampage’, ‘yelling, banging door’ and ‘scared’. Another log sheet concerning chronic neglect recorded that the mother tells the child to ‘fuck off’ and the grandparents smoke when with the child in a poorly ventilated house. As these details were omitted from C3MS, they were essentially lost to the system.

Notifications should not be recorded on a paper log sheet. The Call Centre should implement an electronic log sheet to permit the ready transfer of data into C3MS. The content of an electronic log sheet should be searchable. Potentially, an electronic log sheet could automatically pre-populate the C3MS intake record.

The Commission heard evidence that C3MS has a propensity to crash, frustrating efforts to input data (discussed further below). Therefore, an electronic log sheet must be implemented in a way that isolates the entry of data while the notification is being received, before it is uploaded to C3MS.

AVAILABILITY OF NOC INFORMATION

Families SA is considering reducing the recording requirements for notifications assessed as NOCs because they take considerable time to enter on C3MS. The options being considered include creating a brief intake page for NOCs or allowing them to be entered as a ‘note’ on C3MS.⁴⁴

It is understandable that the Agency would like to reduce the time taken to record matters that are viewed as only the concern of the notifier. However, given that some NOC matters should be screened in for a response and others would be important to build a more complete picture of the family, it is vital that any changes to recording requirements for NOC matters ensure the information received remains readily accessible and searchable. In particular, there must be a continuing record of family relationships to allow a complete record of a family’s child protection history to be retrieved.

ENCOURAGING HIGH-QUALITY ASSESSMENTS

PROPER USE OF THE DECISION-MAKING TOOLS

Families SA’s Care and Protection Assessment Framework helps the Agency’s practitioners to assess ‘the needs of children, their families and carers throughout different stages of contact with Families SA’, including at the point of notification.⁴⁵ The framework encourages practitioners to consider principles of assessment, theoretical perspectives on child wellbeing, and child, parent and family domains. These are offered not as a checklist, but as themes to consider and as a ‘consistent method of gathering, organising and interpreting information to better understand a child and their world’.⁴⁶

Families SA policy describes the relationship between structured tools, such as screening and response priority tools (the decision-making tools), and professional assessment:

*The Assessment Framework provides the professional assessment that is complemented by the use of structured tools. The Assessment Framework is grounded in social work theory and practice and guides workers to prepare the narrative required for thorough assessment. Professional social work assessment encompasses the ability to engage in reflective analysis, interpret and integrate complexities and present sound rationale. The Structured Decision Making tools assist workers to make critical decisions with increased validity, reliability and consistency and importantly to target scarce resources to those children and families at highest risk.*⁴⁷

While the tools support consistent decision making, they are not intended to replace professional judgement.⁴⁸ Interpreting whether a notification amounts, for example, to a significant risk of serious harm clearly involves an element of subjectivity and requires professional judgement.⁴⁹

7 IDENTIFICATION AND NOTIFICATION

There are potential drawbacks to using structured tools in decision making. Practitioners may apply the tools mechanistically, confining their assessment to the factors listed in the tools and disregarding the child's circumstances beyond those factors. Focusing too much on the tool may also result in insufficient attention being paid to the 'thoughts, feelings and words of children'.⁵⁰

There can be a significant gap between organisational policy and practice. Policy may emphasise the need for professional judgement in conjunction with decision-making tools, yet practitioners, particularly those with less experience, may be reluctant to look beyond the tool. Consequently, if not properly implemented, tools may impair professional judgement.⁵¹

These criticisms apply to the use of the decision-making tools in the Families SA Call Centre. Some staff are 'overly reliant' on the tools, rather than using 'their own skills, experience and knowledge base to make assessments'.⁵² This leads to decisions which are potentially dangerous to children.

In addition to its Intake review, the Commission also reviewed a random sample of 60 C3MS child protection files to gain an insight into Families SA's usual case practice (see methodology in Appendix C). Across the two reviews, the Commission observed that the decision-making tools did not seem to promote good or consistent decision making in the Call Centre. The tools appeared to be used in a mechanical way, without sufficient recognition of the psychological, developmental and behavioural effects of traumatic, unsafe and chaotic environments on children. There was little evidence of the integration of all information concerning a child. Instead, the tools isolated circumstances into discrete parcels.

There is little room for Call Centre practitioners to exercise professional judgement that is in variance with the decision-making tools. Practitioners apply a 'mandatory override' to increase the response priority rating to Tier 1 where (a) the carer has avoided a previous Tier 1 or 2 investigation and is likely to avoid further investigation; or (b) the carer has previously caused death or serious injury to any child due to abuse or neglect.⁵³ Practitioners are permitted to apply a 'discretionary override' to increase or decrease the tier rating, but only where 'unique circumstances' in the allegations 'are not captured within ... the decision trees'. The practitioner must document the rationale and seek approval from a supervisor or senior practitioner. Importantly, discretionary overrides 'must not be used simply because the [practitioner] does not agree with the Families SA policy thresholds for tier ratings articulated in the decision trees'.⁵⁴

While this policy reflects a desire to promote consistent, high-quality decision making, it gives the tools a primacy they do not deserve. It constrains professional judgement in a way that makes it harder for practitioners to keep a clear focus on the needs of children. The limited scope for discretionary override appears inconsistent with the policy sitting around the tools.

Rather than focusing on process and prescription, it is better to invest in highly trained, skilled practitioners, who are supported and supervised to make high quality professional judgements.⁵⁵ This focus on clinical practice, rather than process, will give practitioners greater confidence to use the decision-making tools as a support, not a replacement, for professional judgement. In turn, practitioners and their supervisors will develop a clearer understanding of the circumstances in which the tools should be overridden to ensure the safety of a child.

INDUCTION AND ONGOING TRAINING

It is crucial that Call Centre staff are properly trained and supported to broaden their professional knowledge and assessment skills. Currently, new practitioners receive training in a range of areas, such as answering telephone calls, uploading information on to C3MS, and using the screening and response priority tools. Practitioners start by processing eCARL notifications, before progressing to answering telephone calls. A senior practitioner sits alongside practitioners during their first few calls. This training process takes about two weeks.⁵⁶

Families SA recently revised its induction program for all new staff.⁵⁷ However, it still lacks a specific induction package for Call Centre staff.⁵⁸ This is compounded by the fact that the Call Centre's policies and procedures need to be revised urgently. An internal review in 2012 observed:

*[The Call Centre's] extensive soft copy documentation, including the CARL and Crisis Care Manuals of Practice, is significantly out of date and in need of urgent review. Most of the content in these documents is outdated and in some cases key information is missing.*⁵⁹

Four years on, these documents have still not been revised. Staff are still expected to have regard to a large number of overlapping, inconsistent and out-of-date documents. For example, the Call Centre's Manual of Practice makes no reference to the response priority tool, a critical document when assessing notifications. Similarly, none of the documents references Solution Based Casework™, the practice framework which Families SA implemented in 2014.

The result is that the reader would have little confidence that the principles contained in any one document actually govern practice in the Call Centre. This is likely

to promote confusion and disparate practice between individual practitioners and teams. The Commission shares the lack of confidence.

Call Centre staff have access to fortnightly workplace learning on topics such as infant mental health, infant bruising, sexualised behaviours and homelessness.⁶⁰ However, as outlined in Chapter 6, workplace learning in Families SA remains an area of ongoing concern. There is a need to review the induction and ongoing training offered to Call Centre practitioners to ensure it meets their specific needs. A particular focus should be on supporting high-quality assessments and the proper use of the decision-making tools.

THE NEED FOR EXPERIENCED STAFF

According to the Manual of Practice:

*The information [Call Centre practitioners] need to get from the caller is not just confined to any particular incident that is being reported, but must include any other information known about the family. CARL workers need to give sufficient time to a caller to ensure that a full and proper assessment can be made. The quality of a child protection assessment is the basis upon which every other intake decision rests and therefore must be given priority in terms of time and skill.*⁶¹

Good assessments in the Call Centre depend on skilled practitioners eliciting the right information from notifiers. This involves asking useful contextual questions to explore and tease out the scenario. In gathering information, practitioners need to respond sensitively to notifiers who may be distressed about the situations they are describing. They also need theoretical learning and practical experience to recognise information that suggests a family is in need of support or a child is at risk of harm. Options the notifier may have to support the family need to be explored and consideration given not only to the particular incident being reported, but also a child's broader experiences of care.

This all needs to be achieved over the telephone, a medium that makes establishing rapport more challenging.

It takes time to develop the expertise required to make well-rounded assessments. A Families SA executive director told the Commission that in her view new practitioners take three to five years to develop this experience.⁶² In the 1980s, practitioners required seven years' experience in child protection field work before working in the Call Centre.⁶³

The Layton Review emphasised that the Call Centre was employing practitioners 'with less experience than is desirable to service a specialised and critical intake entry point to the child protection pathway'.⁶⁴ It recommended

that all practitioners receiving calls have 'at least two years' field experience in child protection with an optimal level of experience being five years or more'.⁶⁵

In theory, Families SA recognises this principle:

*Research has indicated that it is of benefit for staff at the Call Centre to be the most experienced workers, those workers who have an established knowledge base, well developed social work skills and practice experience.*⁶⁶

As discussed later in this chapter, a recent proposal to trial call agents in the Call Centre would entrench the use of inexperienced and untrained workers.

The primary entry point to the child protection system is so much more than simply a call centre. It is clear that to collectively describe the Child Abuse Report Line and Crisis Care service as a call centre is misleading and has the potential to devalue and de-skill the work undertaken by the practitioners. It is in fact an intake, assessment and triage centre. It would be appropriate to rename the Call Centre to reflect this and ensure its significant role in the child protection system is not misunderstood or underestimated.

Practitioners receiving calls and making assessments in the Call Centre must hold degree-level tertiary qualifications relevant to working in child protection. Generally, this will be a qualification in social work. They should have at least three years' field experience in child protection work, with an optimal level of experience being five years or more.

While there is value in having a stable workforce that is experienced in this specialist area, a mixture of experienced staff is required across the Agency. Regularly rotating staff through the Call Centre would ensure that practitioners remain familiar with fieldwork.⁶⁷ Three to five year rotations would serve both objectives.

THE NEED FOR ADEQUATE TIME

Quality assessments also require time. Call Centre practitioners need enough time to:

- elicit all relevant information from the caller;
- review the child's and the family's child protection history, as recorded on C3MS;
- consider the information and complete the decision-making tools as part of their assessment; and
- consult with colleagues (if required) and, in the case of Aboriginal or Torres Strait Islander children, consult with Aboriginal family practitioners or principal Aboriginal consultants.

7 IDENTIFICATION AND NOTIFICATION

If any stage is rushed, the ultimate assessment and response may be flawed, jeopardising the outcomes for the child, who is the centre of the concern.

A Families SA assistant director told the Commission:

*I would rather [Call Centre practitioners] took their time to get the information properly the first time round, and if that takes a little bit longer, so be it. I would rather that than having the wrong information recorded, and then a wrong assessment, wrong decision, wrong intervention, we're stuffed.*⁶⁸

The Commission agrees with this sentiment.

Poor systems can also affect efficiency when practitioners are assessing information. In 2009, the Call Centre started using C3MS, which replaced the former Client Information System (CIS).⁶⁹ In 2010, Families SA undertook a time and motion study that compared the productivity of Call Centre staff using CIS with C3MS. It found that it took staff between 7 per cent and 26 per cent longer to perform a variety of tasks using C3MS.⁷⁰

In 2012, Families SA undertook a further time and motion study, which compared staff productivity as captured in 2007 using CIS with productivity in 2012 using C3MS.⁷¹ The study found even greater declines in productivity than the 2010 study. Despite staffing having increased 125 per cent from 2007 to 2012, call abandonment rates⁷² were 15 per cent higher and staff were answering about half as many calls and recording about 28 per cent fewer intakes. A number of the study's other findings suggest C3MS contributed to this decline in productivity:

- It took 105 per cent longer to record a new intake in C3MS, with increases of 267 per cent in the time it took to review history relevant to the notification and 126 per cent in database recording time.
- It took 120 per cent longer to record NOCs in C3MS. NOCs were the largest percentage of work recorded in both 2007 (using CIS) and 2012 (using C3MS), but it took staff more than twice as long to record them in C3MS.
- C3MS, unlike CIS, would not generally permit the adding of new information to existing intakes. Rather, C3MS generally required the creation of a new intake, even if the notification related to an open case. This process took 166 per cent longer in C3MS than in CIS.
- CIS permitted the recording of concerns across siblings in a single intake, whereas C3MS required the creation of separate intakes, which took longer.

Tracking the same experienced practitioners in 2007 and 2012, it took on average:

- 27 minutes to record a new child protection intake in CIS, but 48 minutes in C3MS;

- 14 minutes to add to an existing intake in CIS, but 31 minutes in C3MS; and
- 24 minutes to record a new NOC in CIS, but 40 minutes in C3MS.

In July 2012, an internal review of the Call Centre's operations concluded that the findings of the 2012 time and motion study:

*provide strong evidence in support of staff feedback that C3MS limitations are a significant cause of inefficiency at [the Call Centre] and that a disproportionate percentage of social workers' time is spent on system processes that do not add value to the delivery of child protection services.*⁷³

Since then, Families SA has taken steps to improve the functionality of C3MS. For example, it has developed a summary history view, which makes it easier to access an overview of a child's history of notifications.⁷⁴ Information recorded in relation to one child can now be more readily copied across siblings in the same family.⁷⁵

However, the Commission heard staff describe C3MS as time-consuming to enter data, prone to 'crashing', difficult to retrieve a coherent narrative of a child's history, and slow to search for and retrieve information. Further, unless bandwidth is increased, it will only become slower as records are added.⁷⁶ The shortcomings of C3MS and the challenges it presents for practitioners are outlined in Chapter 5.

A business case was developed for the Call Centre as part of the Redesign of Families SA operations that occurred in 2013. It provided a rationale for the proposed remodelling of the Call Centre. The business case calculated that although Call Centre practitioners should be able process an average of 9.5 notifications per day, they were only processing four to five. This is based on an average talk time⁷⁷ from 2012/13 plus an average time to record a notification on C3MS involving two children who already existed on the system (based on figures from the 2010 time and motion study). Overall, this gave an average of 38 minutes, 7 seconds, to receive and record a notification. The 9.5 notifications figure was achieved by applying an efficiency rate of 80 per cent to this time.⁷⁸ The business case argued that enhancements to C3MS since 2010 mean this benchmark is likely to be a significant overestimate of the time it takes to process notifications.⁷⁹

There are problems with this benchmark. First, it does not allow practitioners any time to consult with senior colleagues, Aboriginal family practitioners or principal Aboriginal consultants.⁸⁰ Second, it draws exclusively on the 2010 time and motion study, with no reference to the more recent 2012 study. While both studies found that tasks took longer on C3MS than CIS, the 2012 study showed C3MS to have a greater effect on processing time. This study found it took an average of 60.8 minutes

to process a notification, including 14 minutes talk time.⁸¹ This would have produced a much lower benchmark of 5.9 notifications per practitioner per day (also assuming practitioner efficiency of 80 per cent). The evidence before the Commission is that Families SA simply preferred the 2010 study and based its benchmark on that.⁸²

The business case does not contain any analysis of the optimal time a practitioner should spend, for example, on the telephone with a notifier. It identifies that the average talk time increased by 6.9 per cent from 2010 to 2013, but does not discuss whether this is an effective use of time. It mentions that the Diversion Assessment Response Team⁸³ and Yaitya Tirramangkotti⁸⁴ talked longer than other teams, without acknowledging the specific duties of these teams might require more talk time. It notes that a call centre in Victoria that also received child protection notifications had an average talk time of about 30 to 45 minutes, without reflecting on whether this produced better assessments or saved time in other areas, such as assessment of the notification.⁸⁵

The work of Call Centre staff is not suited to an inflexible benchmark. The time to process a notification varies markedly depending upon the complexity of concerns, the ability of the notifier to marshal his or her thoughts, the number of children involved and the extent of relevant child protection history held by the agency. Notifiers already engaged in supporting the family may require particular support and guidance. Some cases require extensive consultation with senior colleagues and Aboriginal family practitioners and/or principal Aboriginal consultants.

Practitioners must spend as much time as is necessary to gather enough useful information to undertake a high-quality assessment about the needs of a child. Of course, in the face of rising demand on the Call Centre's services, practitioners must spend no more time than is necessary. However, an inflexible benchmark, particularly one based on flawed calculations, will focus practitioners on the quantity of work at the expense of quality.

Poor productivity of particular practitioners should be addressed through supervision and performance management. The case reading process discussed later in this chapter, for example, can assist in addressing both the quality and quantity of assessments, where this is required.

Families SA has identified and scheduled improvements to C3MS that aim to improve its usability.⁸⁶ These enhancements should be implemented as a priority. System slowness must be addressed through the progressive upgrading of infrastructure to accommodate the growing numbers of records.

QUALITY ASSURANCE AND SUPERVISION

Because every child in South Australia is equally entitled to be safe from harm and cared for in a way that allows them to reach their full potential, it is important that the Agency is consistent in its assessment of notifications. The Call Centre needs quality assurance processes that promote such consistent decision making among individual practitioners and across teams.

Until early 2015, the senior practitioner in each team reviewed every notification and assessment before it was finalised.⁸⁷ While this provided a level of quality assurance, it did little to promote consistency among senior practitioners and between teams.

Consistent with the findings of its own reviews, the Commission heard from an experienced Call Centre practitioner that the screening and response priority tools are applied differently across the Call Centre, which creates inconsistency of screening decisions between teams.⁸⁸

It has been recognised that it is time consuming and inefficient to review every notification.⁸⁹ The need to review every notification decision, particularly for experienced staff who generally produce high quality intakes, has been questioned. The Call Centre has now shifted to the practice of senior practitioners reviewing intakes more randomly, but paying particular attention to intakes by less experienced staff.⁹⁰

Case reading involves the monthly review of a small, random sample of the work of each practitioner, senior practitioner and supervisor against a specific set of criteria. The process monitors and evaluates assessment practice within and across teams, and helps supervisors and senior practitioners to understand the strengths and needs of practitioners in their teams and to promote a 'culture of reflection, learning and continuous improvement'.⁹¹ The aim is to ensure that practitioners use the assessment tools to structure and guide their professional judgement, rather than as tick-the-box exercises.⁹²

In addition to quality assurance, case reading is designed to inform clinical supervision, which is a critical component of effective social work practice.⁹³

The creators of the screening and response priority tools regard case reading as integral to their use.⁹⁴ In May 2013, the Families SA Executive approved the implementation of a case reading tool and practice guide in the Call Centre.⁹⁵ Despite this, they have not yet been implemented. As at November 2015, the intention of Families SA was to review and consider case reading as part of developing a new quality assurance framework for the Call Centre.⁹⁶

While case reading is not the only method of quality assurance, it is supported by the developers of the screening and response priority tools and its implementation was endorsed by the Families SA Executive. Case reading would help ensure that each child who comes into contact with the child protection system through the Call Centre receives a consistent response. It would also support staff learning through more effective clinical supervision. The Commission considers that it should be implemented.

PROBLEMS WITH THE DECISION-MAKING TOOLS

NEGLECT, CUMULATIVE HARM AND SOCIAL ISOLATION

The Call Centre decision-making tools give insufficient weight to issues of neglect, emotional abuse, cumulative harm and social isolation. This potentially contributes to an inflated or overly rigid threshold for intervention.

Abuse and neglect cannot be viewed as isolated events in a child's life. A single incident, viewed in isolation, may not be extreme or significant. There is growing awareness of the effect of cumulative harm, being chronic incidents of maltreatment over a prolonged period that affect a child's sense of safety, stability and wellbeing:

The unremitting daily impact of multiple adverse circumstances and events on the child can be profound and exponential. The exponential nature of chronic maltreatment means that children who have experienced maltreatment in the past may be more vulnerable to subsequent incidents of maltreatment than children who have not been maltreated.⁹⁷

Although it may be less visible, neglect has profoundly damaging consequences for child development, including impoverished social relationships, attachment and emotional difficulties, language, communication and cognitive developmental delays, impaired neurological development, poor physical health and delayed physical development, and even death or serious injury through poor supervision, malnutrition, dehydration, exposure to infection and medical neglect.⁹⁸ Indeed, it is potentially even more damaging than other forms of maltreatment, such as physical or sexual abuse.

Neglect also indicates that other forms of maltreatment may be present. There is growing evidence that 'experiences of abuse or neglect seldom occur in isolation, and that the majority of individuals with a history of maltreatment report exposure to two or more subtypes'.⁹⁹ A child who experiences neglect is also likely to have experienced at least one other form of maltreatment, such as sexual, physical or emotional abuse.

The Commission observed in its review of a random sample of 60 C3MS child protection files that Call Centre staff applied an extremely high threshold for responding to neglect cases (see methodology of the Usual Practice review in Appendix C). There was apparent acceptance of chronic neglect, in particular, as a regrettable fact of life for many children.

The language of the screening and response priority tools requires practitioners to look for 'extreme', 'serious', 'significant', 'immediate' or 'urgent' circumstances and for entrenched patterns of behaviour. For example, the screening tool defines neglect as:

*The child's basic necessities of life are **repeatedly** unmet by his/her caregiver to the extent that the child is not receiving the care and supervision necessary to protect him/her from harm, the child suffered physical injury or illness or there is **significant risk of serious harm** to the child's well-being and development due to neglect [emphasis added].¹⁰⁰*

To satisfy one of the screening-in grounds for neglect, the practitioner must also identify factors such as 'extreme isolation', 'significant health or behavioural issues' and 'significant lack of parenting skills'.¹⁰¹ Families SA has accepted that the assessment tools need to be revised to better deal with cumulative harm and neglect.¹⁰²

The tools also give insufficient weight to social isolation, including a lack of engagement with the community or services. For example, the key question in the response priority tool for children under the age of five years experiencing neglect is: 'Is there a severe condition or pattern of caregiver behaviour that presents significant risk of serious neglect?'¹⁰³ Only if answered 'yes' will the notification be prioritised as a Tier 2 intake.

The requirement for a pattern of behaviour is problematic in cases of very young or socially isolated children. These children are potentially vulnerable because they are invisible to the outside world. Yet they present on C3MS as having few child protection notifications and, as a result, are less likely to receive a response from Families SA.¹⁰⁴ Without critical analysis, children most at risk because they are invisible will continue to be passed over because of the absence of a pattern of caregiver behaviour.

In some cases, social isolation is a significant risk factor. A review of United Kingdom child protection cases in which children were killed or seriously injured identified 'closure' in more than half the cases examined. This expression refers to episodes when the family deliberately shut itself away from contact with the outside world, including refusing to open the front door, not attending appointments, and keeping children away from school or other services.¹⁰⁵

The screening and response priority tools do not encourage practitioners to look beyond the immediate safety concern. For example, if a notifier reports that a child is living in squalor, the tools focus on the symptom (the state of the house), rather than the cause (why the parents are unable to keep the house in a habitable condition) and what effect that underlying cause might be having on the child.

Volume 2, Case study 1: James, describes the circumstances of a child who was removed from his parents when he was four years old. He was found by police, locked in a filthy bedroom, severely malnourished and dehydrated. He had been there for 12 days and fed very little food, on plates slid under the door. He was within days of death.

Eighteen months before his removal, Families SA was notified that police and a support agency had attended his home and found it filthy and uninhabitable. The mother was reported to have poor mental health. The notification was screened in, but only as a Tier 3 intake. The Call Centre practitioner did not regard the available evidence as a 'severe' condition or a 'pattern of caregiver behaviour'. Families SA responded to the notification by writing a letter to the parents inviting them to attend a meeting.¹⁰⁶ Unsurprisingly, there was never any response to the letter.

The assessment tools did not encourage the practitioner to ask important questions, such as, 'If this family cannot keep the house in a hygienic condition, do they have the capacity to safely parent a small child?' or 'What is the cause of the family living like this and what impact might that have on the child?'.

The assessment tools should reinforce and support good professional judgement. Currently, they send the wrong message concerning neglect, cumulative harm and isolation. The tools need to be reworked to instil good practice. Call Centre practitioners will need intentional training and supervision to reinforce the need to respond proactively in these areas.

A REVIEW OF TIER 3 ASSESSMENTS

Families SA describes Tier 3 intakes as involving 'a low risk of further harm or low level care concerns',¹⁰⁷ yet some Tier 3 matters involve serious concerns that require prompt assessment. The Commission's Intake review included 20 Tier 3 notifications. Examples of those notifications follow:

- A mother chased her 12-year-old son outside the house, struck him and called him a 'lazy cunt'. When her seven-year-old son tried to intervene, she pushed him into the fence and threatened to choke him. The parents argued and the children felt distressed and

unsafe. The parents had a long history of previous notifications, including exposing the children to domestic violence.

- Three children, aged seven, 12 and 14 years, lived with their mother, who suffered from mental illness and heard voices. When police attended, the mother exhibited paranoia, reported not having slept for three nights, and started screaming at imaginary people. The mother kept the children home from school. The children had previously been removed from the mother's care due to domestic violence, neglect and her drug use.
- The parents were heavy drug users who neglected their 15-year-old child in various ways, including not providing enough food, allowing poor school attendance and not providing lunch when she did attend school. The parents were aggressive towards her and she was visibly fearful of them. She spent a lot of time in her room worried about her future. The parents had a long child protection history, including physical abuse, exposing children to domestic violence, drug use and attempted suicide.
- Three children, aged six, nine and 16 years, witnessed a community fight, possibly concerning drugs. The mother removed the children from the house due to domestic violence. The nine-year-old child attended school in dirty, blood-stained clothes, stating that she was there to be safe and to escape fighting. There were seven previous notifications, which included the children being exposed to sexual activity in overcrowded housing and the father threatening suicide in their presence.

The Commission was guided in its review by both professional judgement and the screening and response priority tools. The review concluded that 13 of the 20 Tier 3 intakes, including the four examples above, required assessment within about one week and should have been assessed as Tier 2 intakes. The Commission considered that a further two of the 20 cases required immediate assessment and should have been screened in as Tier 1 intakes. The remaining five required assessment, but less urgently than within one week.

Because of the very small sample size, the Commission is cautious about extrapolating these findings. However, the results highlight that, even when children at significant risk of harm are screened in for a response, the priority given to them may not reflect their needs or level of vulnerability.

7 IDENTIFICATION AND NOTIFICATION

IMPROVING TOOLS AND TRAINING TO BETTER RESPOND TO CHILDREN

The results of the Intake review's assessment of Tier 3 ratings reinforce the need for Families SA to review the response priority tool to encourage better responses for children at risk. Families SA also needs to invest in improved training, supervision and quality assurance to support Call Centre practitioners to make appropriate, consistent decisions.

There is a fundamental connection between the decision-making tools and how Families SA responds to a child. Chapter 9 describes the poor responses by Families SA to the vast majority of Tier 2 and Tier 3 intakes. Any review of the response priority tool must

be accompanied by appropriate policy and resourcing to ensure that all screened-in notifications receive an effective response.

GIVING WEIGHT TO A NOTIFIER'S EXPERIENCE OR EXPERTISE

In 2014/15, the Call Centre received 57,812 notifications. Table 7.6 and Figure 7.1 show the percentage of notifications made by different groups of notifiers from 2011/12 to 2014/15. Three groups—police, education (school or pre-school) and health—provided 62 per cent of notifications. A further 12 per cent were drawn from non-government agencies and 6 per cent from other government agencies. Together, these sources accounted for about 80 per cent of notifications.

Table 7.6: Notifications by notifier group, 2011/12 to 2014/15

	2011/12	PERCENTAGE OF TOTAL NOTIFICATIONS	2012/13	PERCENTAGE OF TOTAL NOTIFICATIONS	2013/14	PERCENTAGE OF TOTAL NOTIFICATIONS	2014/15	PERCENTAGE OF TOTAL NOTIFICATIONS
Police	8713	22%	9387	22%	10,468	21%	15,568	27%
School or preschool	8357	21%	9695	22%	11,967	25%	12,359	21%
Health	6211	15%	6727	15%	7614	16%	8059	14%
Non-government agency	4676	12%	5643	13%	6506	13%	6753	12%
Family/friend/neighbour	6185	15%	6109	14%	4984	10%	5794	10%
All other government	1631	4%	1524	4%	1899	4%	3654	6%
Unknown/other	3227	8%	2891	7%	3364	7%	3213	6%
Child care	547	1%	609	1%	913	2%	1209	2%
Families SA personnel	896	2%	894	2%	1074	2%	1173	2%
Self-report (child)	64	<1%	60	<1%	48	<1%	28	<1%
Total	40,507	100%	43,539	100%	48,837	100%	57,810	100%

Source: Data provided by Families SA.

Note: 'Unknown/other' includes legal professionals, ministers of religion, other religious/spiritual personnel, sport or recreational personnel, family law system notifiers, and notifiers marked as 'anonymous' or 'unknown' or the notifier category left blank. 'All other government' includes allied health, Centrelink, Corrections, Disability SA, drug/alcohol workers, Housing SA, interstate counterparts, psychologists, social welfare professionals and social workers. 'Non-government agency' includes accommodation/shelter workers, drug/alcohol workers, family support workers, psychologists, rape and sexual assault workers, social welfare professionals, social workers and volunteers.

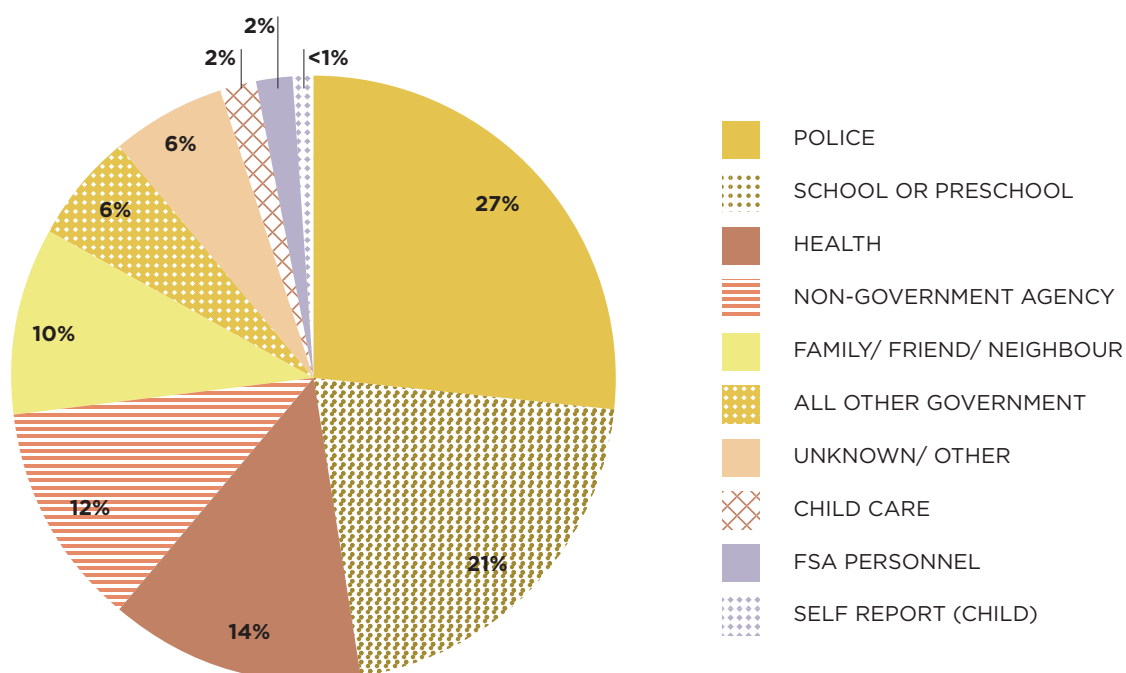


Figure 7.1: Notifications by notifier group in 2014/15

Source: Data provided by Families SA.

Note: See note for Table 7.6.

Table 7.7: Proportion of notifications screened in by notifier group 2011/12 to 2014/15

	2011/12		2012/13		2013/14		2014/15	
	NUMBER OF NOTIFICATIONS SCREENED IN	PERCENTAGE SCREENED IN OF GROUP'S TOTAL NOTIFICATIONS	NUMBER OF NOTIFICATIONS SCREENED IN	PERCENTAGE SCREENED IN OF GROUP'S TOTAL NOTIFICATIONS	NUMBER OF NOTIFICATIONS SCREENED IN	PERCENTAGE SCREENED IN OF GROUP'S TOTAL NOTIFICATIONS	NUMBER OF NOTIFICATIONS SCREENED IN	PERCENTAGE SCREENED IN OF GROUP'S TOTAL NOTIFICATIONS
Police	4167	48%	4436	47%	4214	40%	5332	34%
School or preschool	2892	35%	2928	30%	3305	28%	3428	28%
Health	3025	49%	2877	43%	2980	39%	3190	40%
Non-government agency	1912	41%	1946	34%	2074	32%	2178	32%
Family/ friend/ neighbour	2573	42%	2338	38%	1875	38%	1906	33%
All other government	742	45%	679	45%	760	40%	1336	37%
Unknown/ other	1182	37%	979	34%	783	23%	674	21%
Child care	218	40%	250	41%	307	34%	446	37%
Families SA personnel	563	63%	499	56%	628	58%	663	57%
Self-report (child)	30	47%	26	43%	18	38%	15	54%
Total	17,304	43%	16,958	39%	16,944	35%	19,168	33%

Source: Data provided by Families SA.

Note: See note for Table 7.6.

7 IDENTIFICATION AND NOTIFICATION

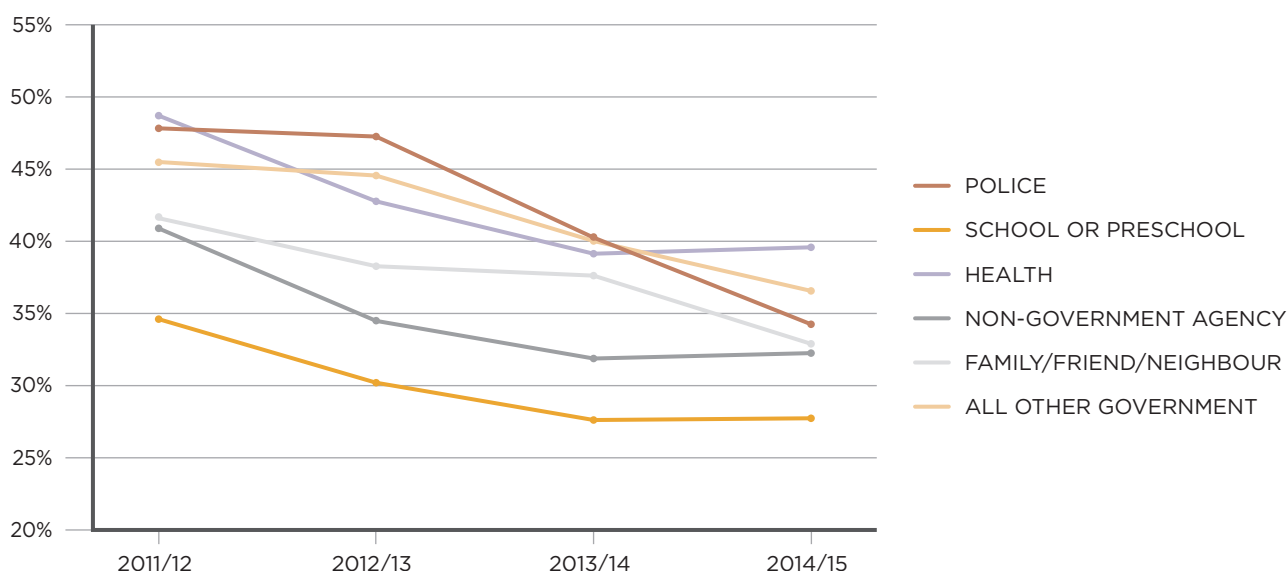


Figure 7.2: Proportion of screened-in notifications for the six largest notifier groups, 2011/12 to 2014/15

Source: Data provided by Families SA.

Table 7.7 and Figure 7.2 show the percentage of notifications from each notifier group that were screened-in.

The proportion of screened-in notifications in recent years has fallen markedly across all major notifier groups. There are a number of possible explanations for this shift, including:

- notifiers generally have become more risk-averse;
- the use of eCARL has increased, causing notification quality to decline (as discussed below); and
- the screening threshold has increased over time.

Whatever the explanation, the fact remains that many of these notifiers have regular contact with the child, giving them the opportunity to observe the effect their concerns are having. They will often know considerably more about the child than the practitioner assessing the notification. Many also have experience and qualifications in areas such as education, health or disability services, making them well placed to assess the risks facing the child. For instance, a teacher who has had the child in class all year, or a doctor who has seen worrying or unexplained injuries, should be listened to very carefully.

Yet Families SA policy and its decision-making tools do not encourage practitioners to place any weight on the notifier's experience, expertise or contact with the child. The Commission heard evidence that this is also the case

in practice. For example, notifications from experienced forensic paediatricians are treated like those from any other notifier.¹⁰⁸

While the status of a notifier is not determinative, it is a factor that should be considered. The Agency's policy should expressly require that assessments give weight to the relevant experience and expertise of notifiers. Particular attention should be given to the extent and nature of contact that the notifier has had with the child concerned.

THE NEED FOR TIMELY FORENSIC MEDICAL ASSESSMENTS

Children who present with physical injuries frequently need a forensic medical assessment to determine the cause of their injuries. If the assessment does not occur promptly, optimally within 24 hours, then crucial evidence may be lost, which could jeopardise future prosecutions or assessments of child safety. Importantly, if parents refuse to consent to a forensic medical assessment, it cannot proceed without the intervention of Families SA.¹⁰⁹

Families SA only employs a Tier 1 rating if a child is in immediate danger. If a child has sustained physical trauma and is admitted to hospital, the Call Centre will generally consider that the child is conditionally safe as he or she is in hospital and therefore not in immediate danger. The case will receive a Tier 2 rating and a

response would be expected within three to 10 days, depending on the circumstances.¹¹⁰ In that time, the opportunity to gather evidence may be lost.

Moreover, unlike Tier 1 intakes, Families SA policy permits Tier 2 intakes to be Closed No Action by Assessment and Support teams. This means the injured child may receive no response at all.

The Commission was given a number of examples where evidence of children's physical trauma was lost because Families SA did not respond soon enough for a forensic medical assessment to occur. The Commission heard that the Women's and Children's Hospital Child Protection Services has advocated for a long time, without success, for Families SA to revise the tier ratings with respect to the bruising or injury of children, particularly babies.¹¹¹

If parents will not consent to a child's forensic medical assessment after hours, the responsibility falls to Families SA's Crisis Care service to intervene. However this service principally responds only to Tier 1 cases. Tier 2 intakes may receive a response where there is an 'absolute need' for a child to be removed from their parent.¹¹² A Families SA assistant director was asked if this meant that a child presenting with injuries on the weekend might only receive a response the following Monday morning. She responded, 'I would hope not', adding that the Call Centre would hold a strategy discussion¹¹³ with the relevant Child Protection Services over the weekend, 'if it had capacity'.¹¹⁴ This less than definitive response gives the Commission little confidence.

The Call Centre, in particular its Crisis Care service, must be adequately resourced so that forensic medical assessments are not dependent on Call Centre capacity. The response priority tool must be reviewed to ensure due weight is given to the need to conduct timely forensic medical assessments, and Call Centre practitioners must be trained in the importance of these assessments occurring without delay.

CALL CENTRE WAITING TIMES

Dismay regarding the length of time spent waiting to have telephone calls answered by the Call Centre was a prevailing theme across the submissions and evidence of notifiers. As discussed later in this chapter, the eCARL service provides an alternative notification option in some cases, but it cannot be used to report serious, urgent matters or those involving infants under the age of 12 months. In those cases, the telephone service is the only option.

It is difficult to get a true measure of the Call Centre's waiting times. Families SA provided average waiting time statistics to the Commission. They indicate that across the Call Centre the average waiting time was only

11 minutes, 57 seconds (11:57) in 2014/15. This does not accord with evidence gathered by the Commission from users of the Call Centre. The average, in fact, understates the waiting times experienced by most users of the Call Centre, because it gives equal weighting to waiting times on the general, health and non-emergency police lines—which each receive many thousands of calls a year and which experience relatively long waiting times—as to the emergency line, which receives relatively few calls and is answered almost immediately.

Table 7.8 shows the increasing average waiting times on the Call Centre general, health and police lines during the past four years.

Table 7.8: Average waiting times (minutes, seconds) of the general, health and police telephone lines, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
General ^a	10:57	15:42	17:40	23:49
General after-hours ^b	10:35	11:37	19:18	N/a
Health ^c	N/a	N/a	N/a	24:26
Police ^c	N/a	N/a	N/a	16:02

^a Prior to 2014/15, this category included telephone calls received during business hours from the general public, police, education and health sectors and emergency calls. From 2014/15, this category included calls received at all hours from the general public and education sector, but excluded calls from the police and health sectors and emergency calls.

^b An after-hours line that received telephone calls from the general public and police, education and health sectors, including emergency calls.

^c From 2014/15, Families SA separated waiting times for health and police notifiers from all other notifiers. These categories exclude emergency calls.

Source: Data provided by Families SA.

The wait times prior to 2014/15 are understated somewhat because they include calls to the emergency line which are separately reported for the first time in 2014/15. Even so, the steady rise in average waiting times can be observed.

Even the 2014/15 figures represent averages across the year. At particular times of day, the Call Centre experiences much higher demand, resulting in correspondingly longer waiting times. For example, while the overall Call Centre average waiting time in 2014/15 was 11:57 between 5.01pm and 9pm, this increased to 26:14, a figure that gives equal weighting to the emergency line.

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Table 7.9: Average monthly waiting times (minutes, seconds) for selected Call Centre lines, 2014/15

	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE
General	18:30	26:49	25:28	28:37	29:54	15:35	8:12	20:57	24:26	21:00	27:46	38:32
Health	18:20	28:07	26:13	27:46	27:23	16:00	8:29	23:15	25:58	22:07	25:24	44:09
Police	16:06	23:09	18:55	17:44	18:15	12:37	8:13	16:19	15:16	14:55	15:21	15:20
DART ^a	12:14	19:05	16:50	19:08	21:44	10:47	0:55	11:38	14:37	15:59	16:03	42:25
Crisis Care ^b	14:44	18:11	15:32	17:55	19:38	14:51	9:38	14:06	18:08	12:19	17:56	21:30
Emergency ^c	N/a	1:24	0:15	0:16	0:17	0:20	0:00	0:16	0:20	0:17	0:17	0:15

^a The Diversion Assessment Response Team (DART) was dedicated to receiving telephone calls from the education section. The team has now changed focus and is known as Linking Families.

^b The after-hours service provided by the Call Centre.

^c The emergency line offered to police and health notifiers in limited circumstances.

Source: Data provided by Families SA.

Table 7.9 shows waiting times are also sensitive to the time of year. January, which covers the school holidays, was the quietest period, with average waiting times of 8:12 for the general line and 8:29 for the health sector. By contrast, in June average waiting times rose to 38:32 for the general line and 44:09 for the health sector.

Maximum waiting times are startling. The longest waiting time in 2014/15 was a call received between 5.01pm and 9pm in November, during which a caller waited three hours, 43 minutes and 40 seconds for the call to be answered. Table 7.10 shows that maximum waiting times have grown considerably longer during the past four financial years.

Table 7.10: Maximum waiting times (hours, minutes, seconds) for the Call Centre, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Maximum waiting time	2:42:35	2:48:40	3:15:21	3:43:40

Source: Data provided by Families SA.

Further, every month between 1 July 2014 and 30 June 2015 had a call that took more than two hours to answer, and there were four months in which a call took more than three hours to answer. While there will always be periods of unexpected demand, this is clearly unacceptable.

Many callers give up waiting. Table 7.11 shows the number of telephone calls to the Call Centre that were attempted, answered and abandoned during the past four financial years.

Table 7.11: Attempted, answered and abandoned telephone calls to the Call Centre, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Total calls attempted	54,528	54,941	52,829	66,983
Calls abandoned	21,470	22,030	26,727	25,227
Calls answered (percentage of total)	33,058 (61%)	32,911 (60%)	26,102 (49%)	41,756 (62%)

Source: Data provided by Families SA.

The situation grew dramatically worse in 2013/14, when less than half of attempted calls were answered, before returning to trend in 2014/15, when about 60 per cent of attempted telephone calls to the Call Centre were answered.

Some notifiers try to call several times before their call is answered. This has the potential to inflate the number of abandoned calls recorded in Table 7.11. The Call Centre has no means of determining what proportion of these are repeat calls.

Notifiers are ordinary members of the community, who have their lives to lead. Many are busy professionals, including police, teachers, doctors and nurses, who are satisfying their public, ethical and legal duties by contacting the Call Centre. It is unreasonable and grossly inefficient to expect notifiers to wait such long periods of time.

THE CALL-BACK OPTION

The telephone system used by the Call Centre has a call-back feature. However, Families SA has decided not to activate it. This feature would allow notifiers to telephone the Call Centre and, rather than waiting in a queue, leave their telephone number and receive a call back. The provided call-back number could remain in the queue along with live calls and be dialled automatically when a practitioner is available.¹¹⁵ It would avoid notifiers having to wait unproductively on the telephone, sometimes for more than two hours, for their call to be answered.

In 2012, Families SA surveyed 1195 notifiers as part of an internal review of the Call Centre's operations. Of those, 84 per cent said they would like the option of a call back. The most commonly perceived benefit was that it would save notifiers' time.¹¹⁶

The Commission was told that Families SA held concerns that the system could bank more calls than the Call Centre had the capacity to return in a timely fashion. Further, other jurisdictions have found the feature so popular that demand outstrips the ability to return calls, leading to poor customer service and, more critically, the potential for a high-risk situation involving children waiting for a call back.¹¹⁷

The Commission was told that an option to overcome these concerns would be to cap the number of call-back requests, so the system only banks as many calls as the Call Centre can respond to in a day.¹¹⁸

When the Commission raised the option of the automated call-back feature with a Families SA senior staff member, she was sceptical of its utility. She agreed it could 'potentially' be beneficial for notifiers to continue their normal work while waiting for a call back. However,

she suggested offering a call back to one notifier would make another person wait longer in the queue: 'It's hard to understand what the net gain would be'.¹¹⁹

This assertion does not carry weight. A notifier occupies a place in the queue whether he or she physically waits on the telephone line or for a call back. Either way, the Call Centre must attend to that notifier before responding to a subsequent notifier. The subsequent notifier waits no longer because a call back is offered. The 2012 internal review of the Call Centre concluded that automated call backs would reduce 'call volumes as repeat calls, made by notifiers unable to get through, are minimised'.¹²⁰

The net gain of a call-back service is to notifiers, by saving their time. It may also reduce call abandonment rates. It should be implemented promptly. It may be necessary to cap the number of call backs to ensure demand does not outstrip the Call Centre's capacity. However, in cases of extraordinary demand, consideration should be given to the use of overtime, which could include seconding former experienced Call Centre practitioners who are working elsewhere in the Agency, to assist in clearing backlogs.

Following a trial period, the effectiveness of the call-back feature should be reviewed, in particular its effect on waiting times and call abandonment rates, to determine whether its ongoing use is justified.

THE RELEVANCE OF STAFF ROSTERING

Staff rostering has a significant effect on waiting times. At 8 January 2016, the Call Centre had 73.6 full-time equivalent (FTE) positions, with 4.5 FTE vacancies. Practitioners are divided into teams. A day team and a Linking Families team work normal business hours from Monday to Friday. In addition, three shift teams are rostered flexibly across day, afternoon and night shifts in an effort to meet periods of peak demand.¹²¹

The current roster has operated with minimal change for 15 years.¹²² A review in mid-2014 found that there was a mismatch between the rostering of staff and times of peak demand. Staff were also consistently being paid for more hours than they worked.¹²³ An assistant director who oversaw the Call Centre for about two years told the Commission:

*I looked at their roster and I couldn't understand it, no matter which way I turned it. It ... often meant that staff were paid for work that they hadn't done.*¹²⁴

The Commission was told rostering was the 'the biggest issue with the Call Centre'.¹²⁵ Although that may not be the case, rostering clearly requires significant attention and revision. The Commission understands Families SA has started negotiations with staff and their union in this regard.¹²⁶

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The Call Centre has a workforce management tool to better respond to call demand. It captures call trends by day, week and year, to enable the centre to predict periods of peak demand based on factors such as school terms, public events and public holidays. In theory, this will more closely match rostering levels to demand.¹²⁷

In April 2015, Families SA was using the workforce management tool to gather data and hoped to interpret that data to make better use of staff to meet periods of peak demand.¹²⁸ A year later, the system continued to capture call data, but no changes to the roster had been implemented, although Families SA was consulting staff about possible changes.¹²⁹

In the medium term, measures outlined in this report may reduce demand on the system, and therefore the Call Centre.

In general, callers should not wait more than 30 minutes to have their call answered and no eCARL notification (discussed later in the chapter) should take longer than 24 hours to be assessed. If the call-back function is activated, then no caller should wait longer than two hours for a return call. The Agency should undertake a thorough review of its staffing levels, rostering and deployment of resources, informed by data from the workforce management tool, to meet this service standard.

THE CRISIS CARE SERVICE

SCOPE OF SERVICES

The Call Centre operates an after-hours Crisis Care service each weekday from 4pm to 9am. It operates 24 hours a day on weekends and public holidays.¹³⁰

The service has contracted significantly in recent years. As recently as June 2016, information displayed prominently on the South Australian government website stated that the service assisted people in crises as a result of¹³¹:

- child abuse or neglect;
- children needing foster care or alternative care;
- domestic violence;
- high-risk adolescence behaviour or need;
- parent-child disputes;
- homelessness;
- urgent financial need;
- suicidal behaviour;
- personal trauma; and
- natural disasters, such as floods.

It stated that Crisis Care could offer services including:

- child abuse investigations;
- placement and support to children in Families SA care;
- emergency food and material assistance assessment;
- counselling, information and support; and
- referrals to other agencies.

In fact, Crisis Care no longer provides most of these services. Assistance is predominantly limited to abuse and neglect matters where children require out-of-home care and services for children in out-of-home care. The other services listed are either not provided or are referred to another agency.¹³²

An internal review of the Call Centre in 2012 identified that information on the South Australian Government website was out of date.¹³³ This remains the case. Incorrect information potentially increases the Call Centre's workload, through people telephoning for services that are no longer provided. The Commission was told that information on Crisis Care available via the internet was being rewritten.¹³⁴

The Agency needs to review Crisis Care to ensure that it is offering appropriate services. Ongoing, up-to-date information needs to be provided to the public concerning the services that are offered.

STAFFING LEVELS

Due to low average demand overnight, staffing in the Call Centre is reduced to two employees from about midnight until 7am.¹³⁵

At times, the Crisis Care service requires staff to leave the Call Centre, for example, to remove a child who is in imminent danger, to visit a family home to check on a child's welfare or to transport a child in care. According to an assistant director, if staff leave the Call Centre at night, they travel in pairs for safety reasons.¹³⁶ However, the Commission heard evidence that from time to time a practitioner may leave the Call Centre alone, which could be 'quite risky, depending on what you're dealing with'.¹³⁷

Families SA policy states that the Call Centre must never be left unattended. This is because it is the primary means of reporting child abuse or neglect for the entire state. If practitioners need to leave, they are supposed to contact their on-call supervisor, who should either attend the Call Centre personally or arrange for someone else to do so. Staff should wait for the replacement staff member to arrive before leaving.¹³⁸

Contrary to policy, the Call Centre has been closed twice in the past few years. In late 2013, it was closed for about 90 minutes so that staff could attend a meeting with the then Families SA Deputy Chief Executive,

David Waterford, about proposed reforms to the structure and model of service delivery of Families SA. Calls during this period were placed on hold and, when staff returned, the longest waiting time exceeded three hours.¹³⁹

It beggars belief that the state's only child protection Call Centre was closed for an extended period for a staff meeting. Of further concern is the fact that callers were not told the Call Centre was closed, but were left languishing on hold.

In December 2014, the Call Centre closed between about 1am and 2am when the two rostered staff went to a nearby hospital to remove a newborn infant from the care of the child's parents. Telephone calls continued to queue in their absence.¹⁴⁰ It is unclear who authorised the closure. However, the assistant director of the Call Centre agreed in hindsight that it should not have been closed.¹⁴¹

The critical point is that the Call Centre is staffed for about seven hours overnight at a level that prevents practitioners from readily performing Crisis Care duties that require travel off-site. While staff can organise replacement practitioners, this involves delay and, in practice, there appears to be some reluctance to do this.¹⁴²

There is no place for such reluctance. It would be surprising, given the population of greater metropolitan Adelaide, if Call Centre staff were not often required to attend off-site between midnight and 7am to undertake duties such as responding to children at risk of immediate harm, facilitating forensic medical assessments of children, transporting children in care and conducting welfare checks. The Call Centre needs to be resourced to perform these tasks at any hour, while also maintaining a telephone notification service to the state.

This means the Call Centre should have a minimum of three staff rostered on at all times. This would allow two practitioners to attend off-site when required, with the third person remaining to answer telephone calls. Although demand for the telephone service is generally lower at night, there are always eCARL notifications to be assessed. Therefore, a third staff member would always have useful work to do.¹⁴³

Another option, if Crisis Care staff have to attend off-site, would be for calls to the Call Centre to be diverted to an on-call staff member who has remote access to C3MS. Chapter 5 discusses the need for remote access to C3MS using mobile devices.

NOTIFYING ELECTRONICALLY THROUGH eCARL

Since July 2013, the eCARL service has allowed all members of the public to report their concerns over the internet. Table 7.12 shows that demand for eCARL has grown quickly and now accounts for about 37 per cent of all notifications.

Table 7.12: eCARL notifications as a percentage of total notifications, 2013/14 and 2014/15

	2013/14	2014/15
Total notifications	48,837	57,810
eCARL notifications (percentage of total)	13,355 (27%)	21,536 (37%)

Source: Data provided by Families SA.

In April 2015, the system was receiving between 1900 and 2000 notifications a month.¹⁴⁴

In June 2013, the Debelle Inquiry welcomed eCARL being offered to all members of the community as 'a very effective reform [that] might assist in reducing delays on what is already a very busy, if not overloaded, service'.¹⁴⁵

As Table 7.11 and Table 7.12 show, although eCARL has proven popular, it has not reduced demand on the telephone service. Since 2011/12, attempted and answered telephone calls have risen by 23 per cent and 26 per cent respectively, alongside growing demand for eCARL.

Some notifiers also telephone the Call Centre to confirm that their eCARL notification has been received. This may be because the system does not send an automated response to the notifier confirming the notification has been received and its status.¹⁴⁶

The Commission was told that eCARL is 'an excellent example' of pressure to address the ongoing issue of waiting times exacerbating the problem.¹⁴⁷ A senior officer in Families SA gave evidence that the launch of eCARL to the public was rushed for reasons unrelated to service need.¹⁴⁸ As a result, a 'botched' version was launched.¹⁴⁹ Key features were not ready, nor was adequate staffing in place to respond to eCARL notifications. Further, C3MS crashed when practitioners tried to enter data from eCARL.¹⁵⁰

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DEALING WITH BACKLOGS

Of particular concern were key periods when backlogs developed, causing delays of up to a week to assess eCARL notifications.¹⁵¹ In response, in April 2015, a dedicated team of eight employees was established to process eCARL notifications. This team processes about half of the 500 eCARL notifications received each week, with the remainder processed by other Call Centre staff during quiet periods.¹⁵²

However, backlogs remain a problem. Table 7.13 shows the peak number of eCARL notifications waiting to be assessed each month from July to December 2015.

Table 7.13: Peak number of eCARL notifications awaiting assessment, July to December 2015

	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
eCARL notifications	565	1157	1219	1186	1770	1861

Source: Data provided by Families SA.

As shown in Table 7.14, the maximum amount of time taken to assess eCARL notifications has also steadily risen.

Table 7.14: Maximum time to assess an eCARL notification from time of receipt, July to December 2015

	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Days	8	12	17	22	23	36

Source: Data provided by Families SA.

These figures show a system spiralling out of control. The steps taken to respond to the problem have proved to be inadequate, and the backlog has built over time to crisis proportions.

Backlogs cannot be permitted to persist. While the system attempts to prevent the notification of very urgent matters via eCARL, in practice notifiers routinely report matters assessed as Tier 2 intakes, which require a response within five days. If the Call Centre delays processing notifications, then vulnerable children could be left without assistance or intervention for extended periods.

Backlogs must be cleared promptly through staff overtime, including by seconding former experienced Call Centre staff working elsewhere in the Agency. If backlogs persist, additional staff should be employed on an ongoing basis.

THE INAPPROPRIATE USE OF eCARL

Because eCARL notifications are not responded to immediately, Families SA seeks to prevent notifiers using the system for both urgent notifications, which are normally assessed as Tier 1, and those involving infants under 12 months of age, which are normally assessed as Tier 1 or Tier 2 (3 days infant). eCARL directs notifiers to report these matters by telephone. This is a sensible precaution.

However, the system is not foolproof. Sometimes notifiers inappropriately submit notifications via eCARL that are later assessed as Tier 1, by, for example, incorrectly answering directed questions and entering serious allegations in the 'free text' boxes.

Table 7.15 compares the annual number of eCARL notifications with the number of eCARL notifications that were ultimately assessed as either Tier 1 or Tier 2 (3 days infant).

Table 7.15: Total eCARL notifications and those assessed as Tier 1 or Tier 2 (3 days infant), 2013/14 and 2014/15

	2013/14	2014/15
eCARL notifications	13,355	21,536
eCARL notifications assessed as Tier 1 (Percentage of eCARL notifications)	150 (1%)	200 (1%)
eCARL notifications assessed as Tier 2 (3 days infant) (Percentage of eCARL notifications)	778 (6%)	1522 (7%)

Source: Data provided by Families SA.

In 2014/15, 1722 eCARL notifications, or about 8 per cent of eCARL notifications, were ultimately assessed as either Tier 1 or Tier 2 (3 days infant). This may not entirely be the result of the inappropriate use of eCARL to submit serious and urgent allegations. This is because a notification may comprise information from more than one notifier, including information received separately by telephone and eCARL. A notifier might use eCARL to report a relatively low-level concern at about the same time another notifier uses the telephone service to report more serious, urgent concerns about the same family. Similarly, a teacher might report concerns using eCARL about a school-aged child, independent of concerns reported to the telephone line about an infant sibling. In each case, the combined information may result in an elevated tier rating, even though the notifier may have followed eCARL's guidelines.

On the evidence available to the Commission, it cannot be determined how many of the eCARL notifications assessed as Tier 1 or Tier 2 (3 days infants) are a result of contemporaneous notifications and how many a result of notifiers inappropriately using eCARL. However, it is unlikely that contemporaneous notifications would account for all 1722 Tier 1 and Tier 2 (3 days infant) notifications in 2014/15.

Despite this uncertainty, the significant and rising number of eCARL notifications that ultimately receive an elevated tier rating is cause for concern. It emphasises the need to process all notifications promptly. It also underscores the need to ensure that only notifiers who are properly trained use the service, as discussed below.

QUALITY OF eCARL NOTIFICATIONS

The Commission has received evidence that eCARL notifications often contain significantly less detail and are of poorer quality than telephone notifications.¹⁵³ To offset this, the Call Centre could telephone notifiers for more information, but it generally does not because of time constraints.¹⁵⁴

Table 7.16 shows that a significantly higher proportion of eCARL notifications are assessed as Notifier Only Concerns (NOCs) than for notifications generally. (NOCs are screened out as not requiring a response.) While the Commission has concerns about the use of the NOC classification generally, there appear to be particular challenges related to the quality of eCARL notifications.

Table 7.16: eCARL Notifier Only Concerns (NOCs) as a percentage of total NOCs, 2013/14 and 2014/15

	2013/14	2014/15
Total eCARL notifications ^a	13,355	21,536
eCARL NOCs (percentage of total e CARL notifications)	7678 (57%)	12,856 (60%)
Total notifications	48,837	57,810
Total NOCs (percentage of total notifications)	22,048 (44%)	27,965 (48%)

^a Includes notifications where there was at least one eCARL notifier. In some cases, a notification may be contributed to by more than one notifier. For this reason, 'total eCARL notifications' may include notifications where there was both an eCARL notification and a telephone notification.

Source: Data provided by Families SA.

eCARL has a limited role to play in the reporting of child protection concerns and its current high level of use is unhelpful. However, in the face of extended waiting times in the Call Centre, it is understandable why busy professionals might opt to use the internet.

The convenience of eCARL comes at significant cost. The lack of interaction between the notifier and the Call Centre practitioner is a significant drawback. eCARL separates the recording of the notification from its assessment, not unlike the use of call agents (discussed below). Because the practitioner has no opportunity to clarify the notifier's concerns or elicit further details, there is real potential for miscommunication or inadequate information undermining the assessment. If the true nature of the concerns is not understood, the notification is much more likely to be assessed as a NOC on the basis that it is vague or contains insufficient information. The risk is that serious concerns may go unheeded.

The lack of interaction also limits the opportunity to use the notification process to strengthen relationships between the Agency and notifiers, whether they are members of the public or employees of government or non-government agencies. Interaction during a telephone notification presents an opportunity to educate and provide feedback to the notifier about the relative severity of the concerns and to explore what assistance the notifier is able to provide to the child or family.

The following measures would help refocus the use of eCARL. First, as discussed below, the Agency is revising mandatory notifier training. The revised training must include specific guidance on the use of eCARL, including the types of matters that it is appropriate to report using eCARL, the level of detail required and the potential drawbacks of eCARL compared to the telephone service.

Second, eCARL's use should be limited to notifiers who have completed mandatory notification training. The system should prevent other notifiers from using eCARL and direct them instead to the telephone service. It is unrealistic to expect untrained notifiers to know which matters are appropriate to report by eCARL and to provide sufficiently detailed yet targeted accounts without interacting with an experienced Call Centre practitioner.

Third, the Agency has proposed introducing a mandated notifier guide at the start of the eCARL application, similar to an interactive guide used in New South Wales.¹⁵⁵ The guide would be based on the screening and response priority tools used by the Call Centre. Giving notifiers access to the same tools that inform assessments would help them decide whether a matter need be reported.¹⁵⁶ This makes it even more important to revise these tools to address the shortcomings identified in this chapter, for example, in relation to neglect and cumulative harm. With these revisions in place, the guide would be likely to foster greater understanding between the Agency and notifiers about assessments made by the Call Centre and, in turn, assist in reducing the number of eCARL notifications screened out because of deficient information.

Fourth, the eCARL system should be upgraded to provide automated electronic feedback to notifiers. Notifiers should be advised when their notification has been received and when their notification will be assessed. This is important so that the notifier is aware when the assessment will be made, and can re-notify immediately if concerns surrounding the child worsen.

Once the notification has been assessed, the notifier should be advised what screening and response priority decisions were made. If the notification is referred to a particular Assessment and Support team, they should be advised of this as well. Where an eCARL notification is screened out, for example, because the concerns are too vague, the notifier must be given brief but specific feedback to this effect, together with an invitation for the notifier to supply further detail by telephone.

Finally, from the perspective of notifiers, eCARL's primary benefit is that it eliminates waiting on the telephone. By addressing excessive telephone waiting times, including through a call-back service, demand for eCARL should return to more manageable levels.

THE PROPOSAL TO USE CALL AGENTS

As at January 2016, all staff who receive telephone calls or process eCARL notifications were employed in the allied health practitioner (AHP) stream, an employment category that effectively requires staff to hold a social work degree.¹⁵⁷

In February 2015, a cross-government Executive Change team reviewed the Call Centre and recommended that Families SA trial a dedicated team of call agents to address waiting times.¹⁵⁸ The proposal argued that while the average telephone call occupied only 10 to 12 minutes, 'inefficiencies' meant that a Call Centre practitioner could only process one call every 45 minutes.¹⁵⁹ The proposal would separate the function of receiving and recording telephone notifications from their assessment.

Ten call agents would be rostered on between 7am and 7pm each weekday to receive and record telephone notifications. They would be supervised by a supervisor with significant child protection experience and provided with a detailed script to guide their conversations with notifiers. A screening tool and training would help them to identify potential Tier 1 notifications, which they would transfer immediately to a social worker.¹⁶⁰

The proposal suggested agents could each receive about five telephone calls an hour during peak periods and therefore process up to 300 calls a day and 60,000 notifications a year. The expectation was that these agents would receive and record all telephone notifications, other than Tier 1 notifications. Based only on the information recorded by the agents, qualified practitioners in the Call Centre would then screen the notifications and apply response priority ratings.¹⁶¹

There is uncertainty as to the proposed classification of the call agents.¹⁶² One proposal was to employ unqualified, operational services (OPS) stream workers, rather than qualified social workers.¹⁶³ Yet a draft budget assumed the employment of AHP1 base grade social workers.¹⁶⁴

The Commission does not endorse the use of call agents for a number of reasons. First, the proposal assumes the tasks of receiving calls and assessing notifications can be separated, when they are fundamentally intertwined. It stands to reason that experienced, qualified practitioners commence their assessment during the telephone call. They begin to identify areas of concern and ask questions to explore those areas to produce a more comprehensive assessment.

A pre-prepared script, no matter how detailed, is no substitute for practical experience and theoretical learning. Call agents would inevitably miss important cues and therefore fail to obtain crucial details. They would not have the same depth of knowledge as an experienced social worker to be able to divert from a script when necessary, to be flexible in how information is elicited and to ask the right questions. Social workers would then be left to make screening and response priority assessments based on information that is sub-optimal. In these circumstances there is a real danger that a child's safety would be placed at risk through an inaccurate assessment being made on the basis of incomplete information.

The critical work of social workers at the point where children come to the attention of the state's child protection system cannot, and must not, be reduced to a script followed by call agents.

At a practical level, the Executive Change review's proposal insisted that call agents would overcome 'inefficiencies'. However, it is hard to avoid the conclusion that it would result in inefficient double handling. There

is also significant risk of miscommunication of a child's circumstances from notifier to call agent to social worker. Notifiers would surely prefer to speak to the person undertaking the assessment.

The use of call agents should not be presented as answering the underlying problem of resourcing the Call Centre. Even if call agents could answer the projected 60,000 calls a year, those notifications would still need to be assessed by social workers. The proposal identified a high risk that social workers might not be able to keep pace with the incoming notifications received by the call agents. The only countermeasures proposed were to increase reporting, accountability and benchmarks for workers, to be developed after the model is implemented.¹⁶⁵

As discussed above, there are significant system, rather than workforce, impediments to processing notifications and there are real flaws associated with applying benchmarks to Call Centre work. In any event, it is unacceptable to identify a high risk that social workers could be overwhelmed and recommend that mitigating measures are developed only after the pilot commences.

The main justification for call agents is their ability to receive more calls and to record them more quickly, therefore reducing waiting times. This is a worthwhile objective. However, activating the call-back feature is a better alternative. It would avoid callers having to wait on the line without the drawback of separating the receiving and recording of the notification, from its assessment.

MANDATED NOTIFIER TRAINING

The Act does not expressly require notifiers to undergo mandatory notification training. Instead, section 8C requires government and non-government organisations that provide health, welfare, education, sporting or recreational, religious or spiritual, child care or residential services wholly or partly for children to develop child-safe policies and procedures. These may vary depending on the size, nature and resources of the organisation, but must comply with principles published by the chief executive of the Department. The principles include ensuring that volunteers and employees are able to identify and respond to children at risk of harm and are aware of their responsibilities to report under the Act.¹⁶⁶

As a matter of policy, Families SA recommends that new mandated notifiers complete a seven-hour training program, with a three-hour refresher course every three years, but there is no obligation on section 8C organisations to follow this recommendation, nor is there any individual obligation on mandated notifiers to complete training.¹⁶⁷

The statutory scheme for mandatory notification training should be streamlined. The current list of persons obligated to notify is wide and captures, for example, a variety of professionals who may work exclusively in aged care or very rarely come into contact with children.¹⁶⁸ As discussed above, if those professionals come across information in their employment that indicates suspected child abuse, they should be required to report it. However, it is unduly onerous to require all mandated notifiers to complete training.

Some groups of mandated notifiers by virtue of their occupation or the nature of their work are more likely to come into contact with children. The Commission recommends the following categories of notifiers be obliged to complete training:

- registered teachers;
- general medical practitioners;
- police officers; and
- other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.

Table 7.17 shows that the vast majority of notifications are made by mandated notifiers, a proportion that has risen in recent years.

Table 7.17: Total notifications by mandated notifier status, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Total notifications	40,507	43,539	48,837	57,810
Notifications by mandated notifiers (percentage of total notifications)	31,254 (77%)	35,290 (81%)	41,825 (86%)	50,243 (87%)
Notifications by non-mandated notifiers	9253	8249	7012	7567

Source: Data provided by Families SA.

7 IDENTIFICATION AND NOTIFICATION

By targeting training to mandated notifiers involved in providing services to children there is significant potential to improve the quality of reports that are received generally by the Call Centre.

Families SA runs a three day train-the-trainer program and accredits training providers to provide mandated notification training. There are currently about 900 approved trainers. The Families SA Learning and Practice Development unit, responsible for overseeing the training, does not know what training the trainers are actually delivering. The unit is rewriting the train-the-trainer program.¹⁶⁹

The Commission heard evidence that Families SA 'lost control' of the training when it handed it to private providers.¹⁷⁰ The quality of training currently varies markedly. There has been a proliferation of approved training organisations and key messages are being missed, including the types of matters that need to be reported. The Agency should take greater control of training so that messages in training more closely reflect a notifier's obligations.¹⁷¹ It would be beneficial to have front-line child protection practitioners deliver portions of the training.¹⁷²

The Agency, as the peak body responsible for child protection, should take charge of the content and provision of this training. For example, the training should not be limited only to the process of making a notification, but extend to identifying the signs of possible abuse or neglect in children and how to respond to those signs. The Act should permit Families SA to prescribe the form of that training and to approve certain training providers to provide that training. Providers who cannot demonstrate they are communicating key messages should have their accreditation revoked.

As discussed above, Families SA has proposed developing a mandatory notification guide, similar to that used in New South Wales. Teaching notifiers to use this guide should be incorporated in the mandatory notification training.

FEEDBACK TO NOTIFIERS

The Commission received numerous submissions indicating that notifiers do not receive sufficient feedback from Families SA concerning their notifications, for example, whether the notification was screened in, what response priority rating it received and what practical response Families SA intends to take to address the concerns.¹⁷³

Providing appropriate feedback to notifiers is critical. If notifiers do not receive feedback, it undermines their ability to provide the family with ongoing support. They might, for example, assume that a family is receiving support when they are not. Indeed, lack of

feedback to notifiers tends to fuel the perception that their responsibility ends with the notification. Out of frustration at a perceived lack of response, notifiers who do not receive feedback might be provoked to make multiple notifications with no new information.

All notifiers are entitled to be advised by the Call Centre whether their notification was screened out and on what basis and, if it was screened in, the response priority rating that was applied. It is particularly important that notifiers are advised if their notification was classified as a NOC, and why. This would help to educate notifiers about the extent of information that is required and the thresholds that the Agency applies to determine whether to respond to child protection concerns.

Given the workload of the Call Centre and the relative ubiquity of electronic communication, feedback of this sort should generally be provided electronically. Currently, the system does not provide automated electronic feedback of this kind. To ensure the already scarce capacity of practitioners would not be affected, a function to facilitate feedback to notifiers should be developed as a priority.

The Call Centre is reluctant to provide feedback as it does not know whether the Assessment and Support teams have the capacity to respond to screened-in notifications or will decide to close them without assessment.¹⁷⁴ This reluctance is misplaced. As discussed in Chapter 9, the current Closed No Action (CNA) rate is unacceptable and must be addressed. In the meantime, if an Assessment and Support team decided to close a screened-in notification without assessment, providing feedback to notifiers would afford some accountability for that decision. The notifier is entitled to know both the response priority rating, if and when it is applied, and if the file were to be closed with no assessment. If the Agency cannot respond to the child, then it must at least advise the notifier and give them the opportunity to support the child and family in some other way, if possible.

Current advice to Call Centre practitioners emphasises that information is confidential and should only be shared with notifiers under the South Australian Government's Information Sharing Guidelines for Promoting Wellbeing and Safety (ISGs) where 'a child or young person is in immediate danger'.¹⁷⁵ That advice is too narrow. The ISGs were amended in 2013 and now extend to non-immediate threats to child wellbeing, including situations of cumulative harm and chronic neglect.¹⁷⁶ There would be very few circumstances brought to the attention of the Call Centre that would not satisfy this definition. Chapter 21 discusses the need for an expanded duty for agencies to share information more proactively where this promotes child safety and wellbeing. The Call Centre's procedures need to be revised in light of those recommendations.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		38	Abandon the proposal to engage unqualified call agents to receive telephone notifications. Telephone calls from notifiers must only be taken by degree-level, tertiary qualified and experienced practitioners.
31	Maintain the current mandatory reporting threshold set out on section 11 of the <i>Children's Protection Act 1993</i> .	39	Update, as a matter of urgency, public information concerning the services offered by the Crisis Care service.
32	Review the screening and response priority tools to ensure they give due weight to cumulative harm, chronic neglect, social isolation, underlying causes of dysfunction, the need to conduct timely forensic medical assessments, and the expertise and experience of professional notifiers.	40	Provide automated electronic feedback to all notifiers, confirming receipt of their notification (in the case of eCARL) and, post-assessment, what screening and response priority assessments were made in relation to their notifications.
33	Review screened-out notifications periodically to ensure the threshold is being correctly applied.	41	Record notifications directly into an electronic log sheet that pre-populates the C3MS intake record.
34	Invest in the professional development of the Agency's Call Centre practitioners, including, but not limited, to: - a the implementation of case reading; - b regular clinical supervision; - c the introduction of a tailored induction program; and - d ongoing training in the specific skills required of Call Centre practitioners.	42	Review and improve the efficiency of recording practices of Notifier Only Concerns (NOCs).
35	Implement the automated call-back feature at the Call Centre for a trial period, followed by an assessment to determine whether its ongoing use is justified.	43	Ensure the Agency regains control of, and strictly oversees, mandatory notification training, including creating and updating an appropriate training package and a mandatory notifiers' guide, and regularly auditing training to ensure fidelity.
36	Staff the Call Centre at a level that would permit the achievement of the following service benchmarks: - a a maximum waiting time of 30 minutes for a telephone call to be answered; - b a maximum of 24 hours to assess an eCARL notification; and - c a maximum delay of two hours for a call back.	44	Make mandatory notification training compulsory for: - a registered teachers; - b general medical practitioners; - c police officers; and - d other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, childcare or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.
37	Ensure that the Call Centre is never left unattended. Crisis Care staffing levels should be immediately increased to no fewer than three staff at each shift.		

RECOMMENDATIONS

- 45 Restrict access to eCARL to notifiers who have completed mandated notifier training.
- 46 Include an interactive mandatory notifier guide at the start of eCARL.
- 47 Amend Part 4, Division 1, of the *Children's Protection Act 1993* to include a new provision permitting, but not requiring, a notifier to report concerns about an unborn child, regardless of the stage of pregnancy.
- 48 Abandon the policy restricting the recording of Report on Unborn (ROU) children to 34 weeks' gestation or later.

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OVERVIEW

Where a child's family has the capacity and skill to provide safe and nurturing care, then that is overwhelmingly the best place for that care to be provided. The existence of the child protection system is, however, a testament to the fact that some parents struggle to provide appropriate care. For some families, the provision of timely, adequate support will allow them to make the changes needed to provide safe care before problems become entrenched and escalate, ultimately requiring statutory intervention by Families SA (the Agency)—by which time the children have already suffered harm.

To prevent child abuse and neglect, the public health model of child protection promoted in the National Framework for Protecting Australia's Children 2009–2020 (the national framework) emphasises investment in programs (both universal and targeted) delivered at the primary and secondary services levels. Consistent with this national focus, which is supported by a growing evidence base, an improved child protection system in South Australia should aim not merely to respond better to child maltreatment, but to prevent it in the first place.

In recent years, South Australia has under-invested in services for at-risk families. The state should make a greater investment in early intervention services that target families with known risk factors for child abuse and neglect, and that deliver evidence-based interventions. There are also opportunities to build on existing, adult-focused government services to include a focus on children. If an investment in new services is to be effective, formal pathways should be established to link families into services, and to link the data gathered by these services to the statutory system. For a number of reasons, the statutory system is an inappropriate route for early intervention referrals to be received and actioned.

South Australia has an existing network of mandatory notifiers who work in health, education, law enforcement and community organisations and who have regular contact with children. There is an opportunity to ask these people to consider whether it might be more appropriate, and more productive, to refer families to relevant services, effectively bypassing a report to the Agency.

Such an alternative for mandatory notifiers would require an accessible local referral point, which would also perform as a coordinated local intake point for service users. By positioning this intake point at the local level there would be opportunities for data to be gathered and analysed about service needs at this level.

This chapter principally relates to the Commission's Terms of Reference 5(a) and 5 (b), in the context of Terms of Reference 1 to 4.

THE ARGUMENTS FOR EARLY INTERVENTION

Early intervention is defined as:

Interventions directed to individuals, families or communities displaying the early signs, symptoms or predispositions that may lead to child abuse or neglect.¹

It is not limited to interventions in the early years of a child's life, but includes work delivered early in the development of a problem.² The inter-generational nature of child abuse and neglect means that any intervention along the causal pathway could be considered early intervention because it relates to the next generation. For example, risk factors can usually be identified well before a woman becomes pregnant. Children who have suffered abuse or neglect are at heightened risk of facing challenges in their own parenting. To avoid this, therapeutic work with late adolescents and young adults who have been abused or neglected can help them recover from trauma and can also better equip them for parenthood.³

There are at least three arguments in favour of early intervention. First, early intervention offers an opportunity to interrupt painful, adverse experiences for children; experiences that could profoundly damage their later development and opportunities.⁴ Article 19 of the United Nations Convention on the Rights of the Child requires parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of maltreatment. This includes measures that not only identify and respond to maltreatment in a reactive sense, but also prevent it from occurring in the first place.⁵

The second argument is to act 'now or never'.⁶ Damage caused by abuse and neglect is difficult, sometimes impossible, to reverse. For example, the child's brain develops rapidly in the first 18 months of life. Maltreatment interrupts this development, undermining the child's ability to develop empathy, regulate emotions and develop social skills. It places the child at risk of a range of future difficulties, including poor mental health and antisocial behaviour. It follows that intervening early may be the only opportunity to address these problems successfully.⁷

Third, because it is costly and difficult to try to solve these problems in adulthood, early interventions are often a cost-effective and prudent use of public resources.⁸

The Commission's consultation with children and young people (see Appendix B) revealed that children at the centre of the child protection system want parents who experience challenges to be supported to change. Where possible, they want to be able to remain with their parents, as long as they can be safely cared for. A number of children understood that some adults were not capable of making the changes that were necessary, but they wanted their parents to have that chance. They wanted people who knew parents were experiencing challenges to get involved, and early.⁹

INCREASING SERVICES

COST EFFECTIVENESS OF EARLY INTERVENTION

Child abuse has significant economic costs, including in health care, child protection services, policing, correctional services, reduced productivity of victims and premature death. In 2007, the cost of abuse and neglect in Australia was estimated to be about \$4 billion a year, with burden of disease¹⁰ adding \$6.7 billion a year.¹¹ The combined cost of \$10.7 billion was almost three times the cost of obesity in 2005 (\$3.8 billion).¹²

The economic costs of child abuse and neglect show that prevention and early intervention are fiscally prudent investments

The lifetime cost of children experiencing abuse or neglect for the first time in 2007 was estimated at \$6 billion, with burden of disease adding \$7.7 billion.¹³ Child abuse is associated with a number of negative outcomes, which can be estimated in economic terms. Where interventions are effective, 'downstream budget costs' are avoided.¹⁴

Using the figures cited above, against the number of new substantiations according to productivity commission data for 2007, a potential saving of \$245,000 per child has been estimated for each case of maltreatment prevented. This is an average saving. Costs and potential savings are significantly higher for some children, such as those who go on to develop severely disturbed behaviours.¹⁵

In addition to the powerful moral arguments for early intervention, these figures show there is a strong economic incentive to prevent and reduce child maltreatment. They position prevention and early intervention as fiscally prudent investments.

A review of early intervention options in the United Kingdom found that many were 'astoundingly good value for money'¹⁶, offering a range of pay-offs for the public sector and for society more broadly. Benefits were sometimes spread over many years, but generally costs were fully recovered in a relatively short time. It noted evidence of potential savings in the six years following the intervention. For every £1.00 of expenditure, the savings were¹⁷:

- £7.89 for parenting interventions to prevent persistent conduct disorders in their children;
- £83.73 for school-based social and emotional learning programs; and
- £11.75 for GP screening for alcohol misuse.

ADEQUATE FUNDING OF PREVENTION AND EARLY INTERVENTION

The *Children's Protection Act 1993* (SA) imposes a number of functions on the relevant Minister that are related to furthering the objects of the Act. These functions are not limited to actions at the tertiary end of child protection. They include:

- 'to promote and assist in the development of coordinated strategies for dealing with the problem of child abuse and neglect'¹⁸;
- 'to provide or assist in the provision of preventative and support services directed towards strengthening and supporting families, reducing the incidence of child abuse and neglect, and maximising the wellbeing of children generally'¹⁹; and
- 'to assist the Aboriginal community to establish its own programs for preventing or reducing the incidence of abuse or neglect of children within the Aboriginal community'.²⁰

The Layton Review, published in 2003, recommended a greater focus on evidence-based early intervention and prevention services.²¹ It included recommendations for changes to the early intervention and prevention system to improve accessibility, planning and service coordination. It also recommended a greater focus on strategic planning.

Despite the fact that 13 years have passed since the Layton Review, a consistent theme of witnesses and submissions to the Commission was that South Australia does not sufficiently fund early intervention services.²² National comparisons bear out this criticism. The Productivity Commission keeps statistics on spending by Australian governments on a range of areas in child protection services. These statistics need to be read with some caution because individual governments record spending in different ways. However, the broad picture is clear. Figure 8.1 and Figure 8.2 compare South Australia's expenditure per child on family support services and intensive family support services.

8 EARLY INTERVENTION

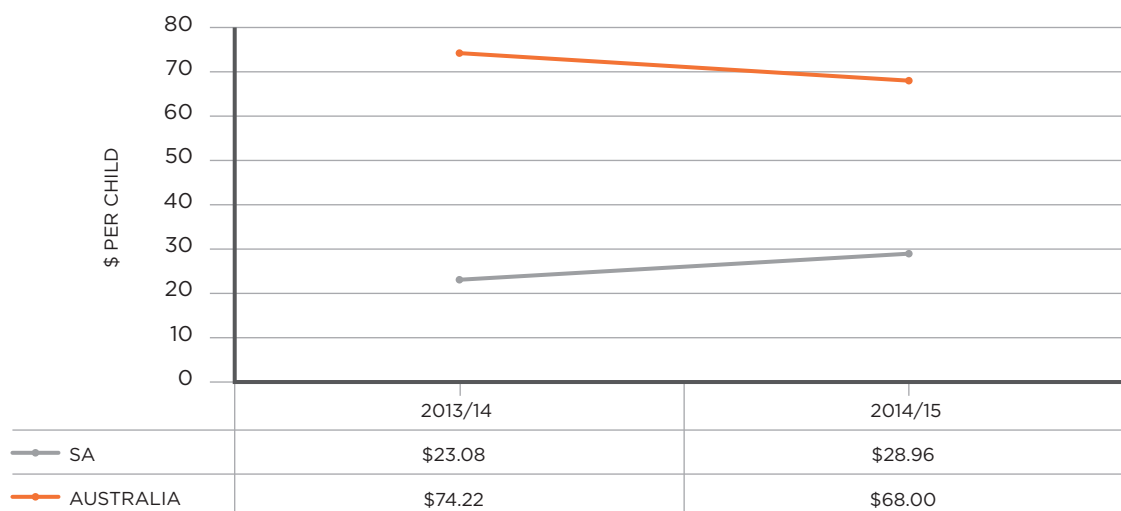


Figure 8.1: South Australian family support services' expenditure per child compared with the Australian average, 2013/14 to 2014/15

Note: Family support services include activities typically associated with the provision of lower level, non-intensive services to families in need. They include identification and assessment of family needs, provision of support and diversionary services, some counselling, and active linking and referrals to support networks.

Source: Productivity Commission, 'Child protection services', *Report on government services 2016*, Government of Australia, 2016, table 15A.3 and p. 15.47.

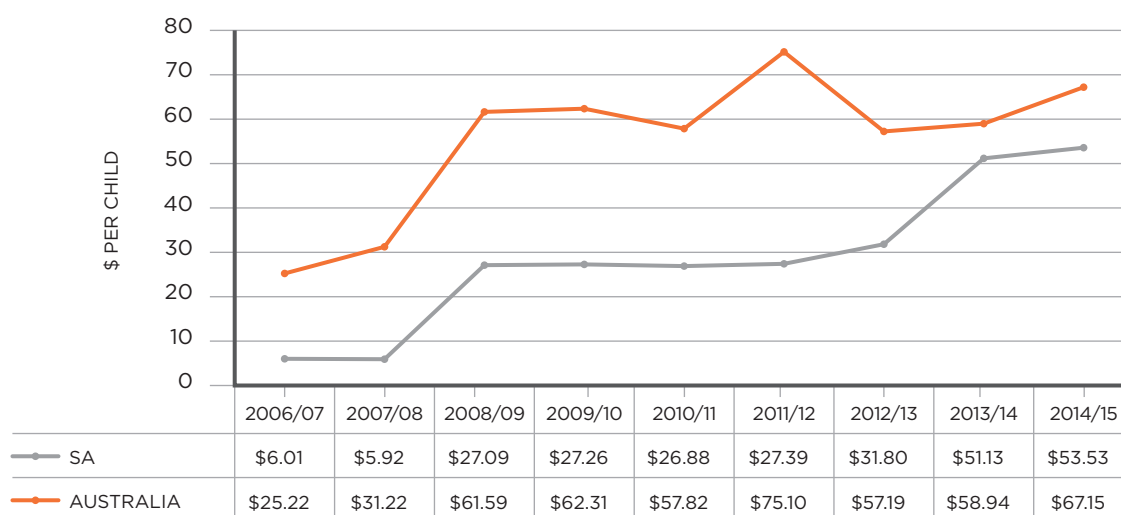


Figure 8.2: South Australian intensive family support services' expenditure per child compared with the Australian average, 2006/07 to 2014/15

Note: Intensive family support services are specialist services that aim to prevent the imminent separation of children from their primary caregivers as a result of child protection concerns, and reunify families where separation has already occurred. They are intensive in nature, averaging at least four hours of service per week for a specified short period that is usually less than six months and generally respond to referrals from a child protection service.

Source: Productivity Commission, 'Child protection services', *Report on government services 2016*, Government of Australia, 2016, table 15A.3 and p. 15.47.

Other Australian jurisdictions have reported spending on family support services since 2011/12, but South Australia has produced data only for 2013/14 and 2014/15. However, the available statistics show that the state's spending per child in 2014/15 was the second lowest in Australia (ahead of Queensland), at 43 per cent of the national average, a rise from 31 per cent in 2013/14.

South Australia's spending per child on intensive family support services has lagged behind the national average for many years, although this gap has narrowed during the past three financial years. The state's spending per child in 2014/15 remained the third lowest in Australia (ahead of Western Australia and the Australian Capital Territory) and only 80 per cent of the national average.

Figure 8.3 shows South Australia's real recurrent expenditure in four key areas of child protection.

The rapid rise in out-of-home care has dominated spending, with spending on child protection services, family support and intensive family support services remaining steady. The rise in spending on out-of-home care reflects growth in emergency and residential care at the expense of relative care and foster care. Figure 8.4 compares spending in 2014/15 in the four key areas of child protection.

In 2014/15, South Australia spent 71 per cent of its child protection budget on out-of-home care alone and 20 per cent on child protection services, leaving only 6 per cent and 3 per cent respectively for intensive family support services and family support services. Statistics such as these cause child protection experts to refer to the Australian system as an 'inverted pyramid', which invests disproportionately at late stages in the system at the expense of prevention and early intervention.²³ It could be compared to a health system without a general practitioner service, requiring hospital emergency departments to respond to every cold or minor infection.²⁴

Some submissions to the Commission argued that the system should redirect resources from the tertiary end into early intervention.²⁵ In a similar vein, a recent United Kingdom study observed:

*A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.*²⁶

This is an attractive proposition and should represent a medium-term ambition. Over time, investment in early intervention should prevent child maltreatment and save significant public revenue in other areas, including tertiary child protection.

However, it is plainly false that the child protection system currently conducts too much tertiary intervention or that the threshold for Families SA to investigate and exercise its statutory powers to keep children safe is too low. To the contrary, the Commission found many examples of children left in situations of significant danger to their health, safety and wellbeing for prolonged periods of time. As discussed in Chapter 9, far too many screened-in notifications are coded as Closed No Action or given a cursory assessment that cannot hope to explore the needs of children and their families, far less ensure that those needs are met.

In the short term, the contest between primary, secondary and tertiary interventions is a false one. As discussed above, there is a strong economic as well as moral case for investing in early intervention; however, under-investing in tertiary interventions to protect children who are in demonstrable danger is an affront to those children's human rights. While there should be an expansion of early intervention and preventative services, this cannot be at the expense of tertiary intervention, which should, for a time at least, expand to protect the many vulnerable children whose urgent needs are unmet.

SELECTING THE RIGHT INTERVENTIONS

It is critical that additional investment in early intervention should represent value for money and be aligned to the necessary outcomes. Poor quality or inappropriate intervention programs waste public money and can further damage families.

The offering of services that are funded at a local level should be matched to the social issues that confront families in that area. Efforts should be directed towards using data to build a picture of local needs, so that services can be tailored to the needs of the community. For example, in communities where high numbers of children are identified as at-risk because of domestic violence, a substantial investment in a generic family support or parenting skills program is unlikely to yield great benefits. However, communities with high numbers of very young or new parents might benefit from programs on parenting or addressing social isolation. Research should also be aimed at establishing the effectiveness of such programs in meeting the community's needs.

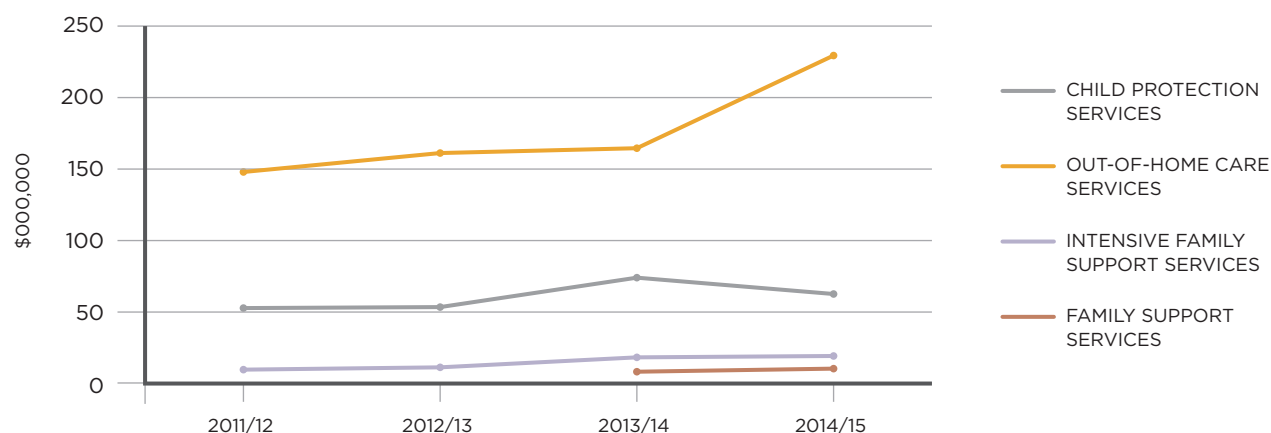


Figure 8.3: South Australia's real recurrent expenditure on child protection services, out-of-home care services, intensive family support services and family support services, 2011/12 to 2014/15

Note: Child protection services refer to the functions of government that receive and assess allegations of child abuse or neglect and/or harm to children; provide and refer clients to family support and other relevant services and intervene to protect children. Out-of-home care refers to overnight care, including placement with relatives (other than parents) where the government makes a financial payment, including subject to an order or under a voluntary arrangement, but excluding placements solely funded by disability services, psychiatric services, youth justice facilities and overnight child care services.

Source: Productivity Commission, 'Child protection services', *Report on government services 2016*, Government of Australia, 2016, table 15A.1 and p. 15.47.

The Family by Family program

Family by Family is an early intervention program offered in four areas of Adelaide, as well as Mt Druitt in Western Sydney. It is run by the Australian Centre for Social Innovation. The program recruits two cohorts: 'seeking' families, who are experiencing problems they want to change, and 'sharing' families, who have dealt with similar problems and are willing to share what they have learned. The program tackles a range of problems, including poor financial management, isolation, inappropriate age expectations, poor discipline, neglect, poor mental health and parental substance abuse.

Professional coaches match each seeking family with a sharing family in a 10-week 'link-up'. Sharing families spend up to three hours a week with the seeking family, helping them to set goals to overcome their difficulties and connect with new people, places, groups and services in their community. The coaches help sharing families with training, support and ideas for activities and community resources. Seeking families who need more time to work on their goals can do multiple link-ups. Sharing families receive a small grant to cover out-of-pocket expenses.¹

The matching process appears successful, with few families wanting to be removed from the program once they have been linked up. The program is relatively low cost and non-stigmatising:

There's something nice about being with somebody who can give you a little bit of a hard word sometimes, but is coming from a place of truly understanding what you feel and what you experience. So that seems to be why people come.²

The program has kept data to track changes for seeking and sharing families over time. An early evaluation in 2012 found 80 per cent of seeking families said things were 'better' or 'heaps better' at the second coaching session and about 90 per cent at the subsequent sessions. Interviews with families, Families SA workers and Family by Family staff identified positive outcomes in relation to confidence and self-esteem and a variety of positive outcomes for children, including areas relevant to child development.³ A more extensive evaluation is expected later in 2016.

¹ The Australian Centre for Social Innovation (TACSI), *Family by Family explained for professionals*, TACSI, Adelaide, 2012.

² Oral evidence: Dana Shen.

³ Community Matters Pty Ltd, *Family by family: Evaluation report 2011-12*, 2012, pp. 3-4.

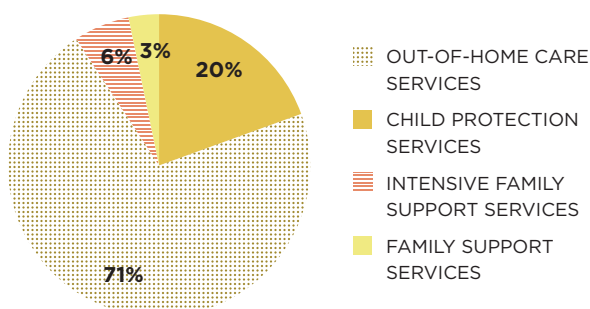


Figure 8.4: South Australia's real recurrent expenditure on child protection services, out-of-home care services, intensive family support services and family support services, 2014/15

Source: Productivity Commission, 'Child protection services' Report on government services 2016, Government of Australia, 2016, table 15A.1.

Not all intervention programs are created equal. A 2012 review of 33 infant home visiting programs across a number of western countries found their cost effectiveness varied significantly. The estimated cost per case of maltreatment prevented varied from \$22,000 to several million dollars. Seven programs were found to be cost saving, with regard to lifetime costs. In light of this variation, programs should be carefully selected and targeted to ensure they produce the intended social benefits.²⁷

Yet in practice many services are funded:

*without a clear practice or program model and without being underpinned by an evidence base. These services run the risk of being ineffective and thus failing to aid in the prevention of child abuse and neglect. At worst, they may do further harm to highly vulnerable children and families.*²⁸

In the place of a sound evidence base to establish their effectiveness, many programs rely on the confidence of front-line workers. This confidence may be misplaced. The shift to evidence-based practice in fields such as medicine recognises that 'experts' may be poor judges of the efficacy of their interventions: the wisdom of front-line workers should be supplemented by testable, independent research data.²⁹

One complication of this approach is that much of the outcomes-based data for existing interventions comes from other countries, particularly the United States of America. While this is a useful starting point, there are significant differences between Australia and other countries. Findings from one community cannot necessarily be applied without further analysis in another:

*The costs and benefits for any given program are specific to the environment in which they are implemented. The demographics of the target population, labour market conditions and local infrastructure are just three examples of important contextual factors that can significantly change the costs and benefits of programs.*³⁰

Successful pilots in the United States have not always been replicated successfully elsewhere.³¹ Even when programs have a strong evidence base, attention should be paid to program design and implementation to ensure that the positive outcomes are replicated in the local environment.³²

These challenges do not mean that interventions should not be pursued: many service models are effective in supporting vulnerable families and improving outcomes for their children. Instead, it underscores the need to ensure that funding of services is determined by the best available evidence and is accompanied by ongoing, robust independent research to build knowledge about the interventions most effective in South Australia.³³

GOVERNMENT MEASURES TO RESPOND TO VULNERABLE FAMILIES

In recent years, a number of South Australian Government agencies that have frequent contact with vulnerable families have adopted measures to better equip their staff to support the families. Government services whose primary mandate is service delivery to adult clients can deliver preventative services by shifting their focus to also consider the needs of children in the family setting.

Such services might also be effective in providing less stigmatising pathways for families into appropriate support. That is, where intensive assistance is offered as a follow-on (without the need for a new referral) from a universal service such as new-born home visiting, clients are much less likely to see that service as identifying them as a 'poor parent' or their children as 'at risk'.

For these reasons, it is critical that agencies in frequent contact with at-risk families are part of coordinated service provision to be developed at the local level. The initiatives described below form a solid basis for growth in the government services contribution to early intervention.

HOUSING SA

Housing SA administers South Australia's stock of public housing and supports people to access the private housing market and housing offered by the not-for-profit sector. Its new service model has shifted the agency's focus from managing assets to engaging the people who receive its services. In particular, it equips staff to consider the needs of children. By responding earlier to problems, it is designed to reduce the risk of harm to children and to prevent families from entering the child protection system.³⁴

The model aims to recruit front-line workers with skills in engaging clients in order to identify potential issues. Each such worker is responsible for a geographical area. This encourages them to become familiar with their area: the households, as well as local services such as schools and community centres. They use a risk identification tool (RIT) to identify risk and vulnerability and respond accordingly. While many Housing SA staff are mandated notifiers, they are encouraged to view their role as not only notification, but also engaging and supporting clients in relation to the issues identified.³⁵

The service model introduces two specialist support-focused roles:

- Tenancy practitioners offer tailored support to households identified by the RIT to be at moderate risk. They make referrals to, and collaborate with, other government and not-for-profit services. They also provide direct assistance; for example, by helping a family to start the day, prepare breakfast and lunch, and get the children to school. If a mother is isolated and her children are at school, the practitioner might discuss opportunities to enrol in training or volunteer in the community.³⁶
- Regional Response Teams deliver multidisciplinary, specialist case management for households identified by the RIT to be at high risk. The teams include social workers, senior Aboriginal consultants, community development workers and community response coordinators. They respond to all concerns relating to child protection, domestic violence and imminent homelessness.³⁷

Housing SA aims to visit all tenancies at least once a year. Staff are encouraged to focus on the people in the house, rather than simply the asset. In particular, staff should sight children under five years of age who are known to reside at the property, and to ask questions if a child is not present and to explore potential issues. For example, if there are no toys or bed in the bedroom, workers should ask where the child is sleeping. All service delivery staff and their managers are trained in issues such as child protection, domestic violence and child development to instil an understanding of children as clients in their own right, whose needs should be prioritised.³⁸

DRUG AND ALCOHOL SERVICES SOUTH AUSTRALIA

Drug and Alcohol Services South Australia (DASSA) workers have frequent contact with adult clients who care for dependent children.³⁹ In recognition of this, DASSA has moved to adopt child and family sensitive practice (CFSP), which is defined as:

*raising awareness of the impact of substance abuse upon families, addressing the needs of families and seeing the family—rather than an individual adult or child—as the unit of intervention. It necessitates identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of treatment and intervention processes, in order to ensure that as parents they are supported and child wellbeing and safety [are] maintained.*⁴⁰

The approach has broad support across Australia.⁴¹

In 2012, DASSA reviewed its implementation of CFSP. The evaluation found that staff supported it and were committed to using it with clients, but faced key barriers, such as a lack of organisational support (including appropriate policy and guidelines), insufficient training, heavy workloads, and competing priorities concerning the needs of the client and his or her family.⁴²

The review recommended improved policy and procedure, increased educational and training opportunities, and the introduction of professional and clinical supervision and clinical guidelines. These measures required modest additional resources and were implemented either as recommended or by an equivalent measure. For example, the Australian Centre for Child Protection helped develop staff training on issues such as the effect of parental substance use on children.⁴³

The review recommended that a resource person be identified for each DASSA site as a CFSP 'champion'. The person would be the repository of relevant information, help upskill new staff and supervise where appropriate. DASSA invited expressions of interest from staff at each site to serve in this role.⁴⁴

A final recommendation stated that DASSA should consider establishing a specialist position to oversee its approach to child and family sensitive policy and practice. The position was to be at least the level of senior clinician in nursing, social work or psychology, with substantial prior experience in child and family sensitive practice. It was estimated to cost about \$100,000 a year. This has not been implemented because of limited resources.⁴⁵

A practice leader of this kind would likely bring coordination and focus to DASSA's work in this area. However, the Commission does not have sufficient evidence to recommend that the role be established ahead of the agency's other priorities. Instead,

DASSA should consider an updated evaluation of the measures implemented so far, to assess whether this recommendation has continuing potential.

WOMEN'S AND CHILDREN'S HEALTH NETWORK

The Women's and Children's Health Network (WCHN) has used research commissioned from the University of Adelaide to form the basis of its service reform plan. The research sets out five basic development domains (physical, language, attachment, social/emotional and cognitive) that children should achieve in five stages (pregnancy, postnatal, infancy, toddlerhood and early childhood) before starting school.⁴⁶

The WCHN offers a nurse home visit soon after birth for every child born in South Australia. The service aims to identify family, child development and health issues early, and to promote optimal development through early access to child health services, parenting information and support pathways for families. In accordance with the principle of proportionate universalism, families identified with particular needs are offered extended home visits over two years. Home visiting offers practical support to develop parenting skills, but is not necessarily equipped to support families with more complex needs who might find the service more of 'an irritation'⁴⁷, than a help.⁴⁸

For those families, the WCHN's Wellbeing teams and Strong Start teams offer intensive, ongoing interventions, staffed by multidisciplinary workers. The Wellbeing teams work with families at moderate risk and Strong Start teams with those at higher risk. In Adelaide, Wellbeing teams operate in the northern and western suburbs and Strong Start teams in the northern and southern suburbs.⁴⁹ These services promise a flexible response that is proportionate to the needs of vulnerable families. However, as discussed below, the teams' operations are limited by restrictive referral criteria.

There is significant potential for these health-oriented services to be a launching point for providing targeted services to address identified risk factors, especially in families with very young children.

AN INTEGRATED SYSTEM

Effective prevention and early intervention require an integrated system of primary, secondary and tertiary interventions (whether delivered by government, not-for-profit or community organisations) to identify and respond to the needs of vulnerable and at-risk families and their children. A public health approach, as advocated in the National Framework, involves more than providing generic services that fit the intensity level of universal, secondary and tertiary responses. It requires identifying and addressing the risk factors that compromise the safety of children in families, and delivering services that respond to those needs. Funding the right services, however, is not the end of

the story. The right services should be delivered as part of a cohesive system that families can easily access and negotiate.

The coordination of services for vulnerable families has a range of potential benefits, including⁵⁰:

- the ability to address complex, interrelated issues simultaneously;
- reduced financial costs, through identifying needs and targeting support earlier and reducing multiple visits to separate support services and duplication of services;
- improved access to services;
- improved information sharing and cooperation between service providers; and
- improved service quality, outcomes and satisfaction with service delivery among service users and providers.

Yet collaboration is a challenge:

There are good reasons why people don't want to work together. So goodwill isn't enough; you need a process requiring people to work together.⁵¹

In evidence and submissions, the Commission heard often that prevention and early intervention services in South Australia are fragmented and poorly coordinated. They are not commissioned in accordance with an overriding plan that emphasises the needs of children. Interventions by one agency do not complement those of others, and inconsistent, inflexible eligibility criteria leave large service gaps. Further, there is no easy way for practitioners and the public to become aware of the services available in their local area.⁵²

As part of its evidence-gathering process, the Commission attempted to identify and map the major services being delivered by not-for-profit agencies that had the potential to deliver preventative or early intervention services. The task proved difficult and time consuming, and highlighted the challenges for vulnerable families in trying to negotiate the service system.

SERVICE GAPS

Referral criteria can usefully direct clients towards services that address their needs. However, inflexible criteria that do not consider system implications can leave vulnerable people without a service. For example, the Strong Start team offers intensive support to families with high level needs. They only work with first-time mothers referred before their child's birth, who reside in certain northern or southern suburbs of Adelaide. An early evaluation of the program noted that there is little evidence to support limiting the service to families referred before birth. While recruiting prenatally may improve engagement with services, it excludes mothers whose issues present after birth, or who have not previously engaged with health care during pregnancy, or who birth early. Further, the service offers no support to families who reside outside its catchment: 'If you live in Modbury, you don't get this service'.⁵³

'If you live in Modbury, you don't get this service'

The Wellbeing teams respond to families experiencing medium-level needs. Their criteria are more flexible than Strong Start's and include accepting referrals before and after birth and for subsequent children; however, they are restricted to some northern and western suburbs.⁵⁴ There is no equivalent service for clients in other suburbs or in regional and remote areas. Strong Start and Wellbeing teams are important service innovations, but their referral criteria exclude many families who need the service.

SERVICE SILOS

Families involved in the child protection system often experience multiple problems, for example, substance abuse, mental illness and/or domestic violence. This is known as comorbidity. Comorbidity of substance abuse and mental illness is particularly prevalent, with estimates that between 25 per cent and 80 per cent of mental health service users have substance abuse issues. Unless recognised and dealt with, this particular comorbidity 'substantially impacts people's mental and physical health and social wellbeing and significantly shortens their lives'.⁵⁵

Yet support services tend to operate as silos, focusing on problems in isolation. For example, a mental health service may treat patients for depression and refer them on to another agency for their drug problem, often without sharing background information, including that the patient is a parent.

A recent review of mental health and alcohol and other drugs services in northern Adelaide found that services were delivered in isolation. Mental health service providers were neither trained nor equipped to

respond to drug and alcohol problems, and vice versa. The treatment that people receive and the nature of the service provided depend on which service people first attend.⁵⁶

The review made recommendations in support of an integrated system, including that⁵⁷:

- mental health and alcohol and other drug comorbidity should be prioritised in state and federal policies, funding decisions and directions;
- all mental health and alcohol and other drug leaders, clinicians and workers should be knowledgeable and competent in delivering evidence-based comorbidity services as their 'core practice';
- mental health and alcohol and other drug services should avoid 'siloed' service delivery and instead deliver evidence-based comorbidity services in which consumers are assessed and treated appropriately, no matter which service they seek help from
- government should establish a non-competitive funding and procurement model to enable the not-for-profit sector to deliver a sustainable, skilled workforce that can deliver evidence-based comorbidity services that can engage, maintain and assure consumer confidence and service improvements. Funding cycles should be run for a minimum of four to five years.

These are excellent recommendations and their intent is reflected in the Commission's own recommendations. Parents with multiple, complex problems should not be given the service run-around:

*When working with a parent who is dealing with multiple and complex problems, practitioners are likely to have to try to support them on different fronts. Referring the family to a different service or professional for each problem or trying to tackle all problems simultaneously will be overwhelming for the family. An effective intervention is planned and purposeful, based on a comprehensive assessment and staged to meet the family's needs and capacities over time.*⁵⁸

Flexible service models should be funded to respond to common co-morbid problems, such as substance abuse and poor mental health. In other cases, one agency should be identified as case manager to ensure a coordinated, staged response.

FUNDING ARRANGEMENTS

Family support services in South Australia are provided by a mixture of public sector, not-for-profit agencies and community organisations. Individual agencies have their own organisational culture, skills and working conditions—differences that present additional challenges to collaboration.

Children's Centres

Collocating services in a 'one-stop shop' is a common form of service integration.¹ An example of such integration in South Australia is Children's Centres. In late 2015, there were 42 Children's Centres, or Children and Family Centres, across the state.² They are usually located at a school or preschool site, and they bring together a range of support services for families.

Although these services vary among centres, they commonly include preschool, occasional care, parenting and personal development programs, targeted playgroups and access to health services such as Children and Family Health Service (CaFHS) nurses, occupational therapists and speech pathologists. They offer space for local agencies to deliver services. Some centres offer prenatal classes and health checks, which provide an opportunity to engage parents before a child is born.³

A Community Development Coordinator in each centre analyses the needs and aspirations of the local community and ensures that services respond to these. The coordinator identifies and coordinates local services and those offered in the centre. Most centres also have a Family Services Coordinator, who is generally a social worker experienced in working with vulnerable families to address parenting difficulties and child development issues. They offer one-on-one support to families and refer them to services available outside the centre. They also support other centre staff to respond to the needs of vulnerable families.⁴

As a primary service, Children's Centres offer non-threatening universal support and at the same time can identify families with more pronounced needs, for which they can tailor programs or refer to appropriate local services. Perhaps more fundamentally, the centres offer isolated parents a supportive community, linking them to other parents in similar situations.⁵

¹ Organisation for Economic Co-operation and Development (OECD), *Integrating social services for vulnerable groups: Bridging sectors for better service delivery*, OECD Publishing, Paris, 2015, p. 209.

² Oral evidence: H Ward. Children's Centres are funded by the South Australian Department for Education and Child Development; Children and Family Centres are similar in purpose, but were initially established with funding from the Australian Government and have a stronger focus on services for Aboriginal families.

³ Oral evidence: H Ward; P Strachan. Department for Education and Child Development (DECD), *Community Development Program*, brochure, Children's Centres for Early Childhood Development and Parenting, 2015, www.childrenscentres.sa.gov.au/files/links/2013_April_cc_Community_De.pdf

⁴ Oral evidence: H Ward. DECD, *Family Services Program*, brochure, Children's Centres for Early Childhood Development and Parenting, 2015, www.childrenscentres.sa.gov.au/files/links/familyservices_apr15.pdf

⁵ Oral evidence: H Ward. Submission: M Kyrkou.

These challenges are exacerbated by short-term funding arrangements that undermine employment security and make it harder for agencies to retain staff and build a strong culture that supports collaborative practice. Competitive tender processes pit not-for-profit agencies against each other in a way that can undermine future collaboration. Frequent, short-term tender cycles of three years or less leave little time between tenders to restore cooperative relationships:

*Everyone just gets to a point where, yes, we are all going to work together on this particular area and then suddenly a competitive tender comes in and you are pitted against each other.*⁵⁹

Accordingly, state government agencies should generally avoid short-term funding arrangements, preferring where possible to fund services for at least five years to improve employment security and allow more meaningful service evaluations. Agencies should explore alternatives to competitive tendering for family support services, such

as preferred provider panels or a lead agency model, such as the Australian Government's Communities for Children program.

DIVERTING FAMILIES

THE CURRENT ENTRY POINT

As discussed in Chapter 7, the Families SA Call Centre (commonly referred to as the Child Abuse Report line) is the central entry point to the statutory child protection system. People who suspect a child is at risk of being, or has been, abused or neglected must report this to the Call Centre; indeed, many professionals are legally obliged to do so.

Many vulnerable families are reported but do not get any response or service from the Agency, although they would benefit from a service referral. Concerned adults who report these matters generally become increasingly frustrated by the lack of action on their notifications, yet they have few other options if they want to access services to support families.

In recent years, total notifications have risen rapidly, yet screened-in notifications⁶⁰ have remained relatively steady. In 2014/15, the Call Centre screened in only 33 per cent of all notifications received. However, many notifications coded for screening out as Notifier Only Concern (NOC), Adolescent at Risk (AAR) and Report on Unborn (ROU) could be dealt with through an early intervention response. Currently NOCs do not receive a response and AARs and ROUs receive a response only if resources are available.⁶¹

Nor is the response to screened-in notifications much better. As discussed in Chapters 7 and 9, until recently Families SA's response to Tier 3 intakes was to write a letter to the parents, inviting them to attend a meeting to discuss concerns, usually at the Families SA office. The meeting was voluntary and the letter stated that the concerns would not be investigated. Families SA did not generally visit the home or sight the child.⁶² The process has been criticised by successive reviews.⁶³ Further, most Tier 2 and Tier 3 intakes are Closed No Action (CNA) due to a lack of resources.

The poor response to Tier 2 and Tier 3 intakes, and NOC, AAR and ROU notifications represents a lost opportunity to respond early to (relatively) less serious, less urgent concerns. Only when concerns escalate to a Tier 1 classification is a response guaranteed. In the meantime, parental problems become entrenched and children sustain significant, lasting trauma.

FamilyZone, Communities for Children

FamilyZone is a children and family service hub located at the Ingle Farm Primary School and funded as part of the Communities for Children program (CfC). Under the CfC model, a not-for-profit agency is funded as the facilitating partner to consult with local stakeholders and prepare a whole-of-community plan for early childhood development for the area. The facilitating partner funds not-for-profit community partner agencies to provide services in accordance with the plan, including parenting support, case management, home visiting services and other supports to prevent child abuse and neglect. Some programs have a focus on supporting men to parent well. The model aims to improve service collaboration to benefit local children and families, whether or not they use CfC services.¹

A nationwide evaluation found that CfC had a 'significant impact on the number, types and capacity of services available in the communities in which it has been based'.² Collaboration between agencies in CfC communities improved in key respects. Between 2006 and 2008, trust and respect between agencies improved and the proportion that worked closely together most of the time rose from 34 per cent to 66 per cent. In the same period, the proportion of agencies that referred clients rose from 86 per cent

to 92 per cent and the proportion conducting inter-agency staff training rose from 57 per cent to 73 per cent.³

FamilyZone opened in July 2006 after the facilitating partner, the Salvation Army, identified gaps in services for families with preschool-aged children in suburbs surrounding Ingle Farm. FamilyZone offers activities including supported playgroups, parent groups, early learning activities, home visiting, crèche activities, support groups for culturally and linguistically diverse (CALD) families, postnatal support groups, young parent education and support, community events and community engagement initiatives that raise awareness of early childhood issues. A home visiting service engages families identified to be at risk.

An evaluation in 2011 found this provided a vital intake point for parents who may never have engaged support services without it and for whom it built confidence and awareness of options to improve their circumstances. The evaluation also found that FamilyZone improved child health and development; increased parents' knowledge, competence and family resources; and improved service coordination and access to health, education and other services.⁴

¹ K Muir et al., 'The national evaluation of the Communities for Children Initiative', *Family Matters*, no. 84, 2010, pp. 35–36; Department of Social Services, 'Families and Children's Services', Families and Children, Australian Government, last updated 26 April 2016, www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/family-and-children-s-services

² K Muir et al., 'The national evaluation of the Communities for Children Initiative', pp. 35, 37.

³ *ibid.*, pp. 35, 39.

⁴ E McInnes & A Diamond, *Evaluation of child and family centre: FamilyZone Ingle Farm hub*, University of South Australia and The Salvation Army, 2011, pp. 6–12, 15.

THE TARGETED INTERVENTION SERVICE

Families SA funds a family support program, the Targeted Intervention Service (TIS), which is delivered by a number of contracted not-for-profit organisations, including Centacare, Uniting Care Wesley and Aboriginal Family Support Services. It is a non-intensive family support program that can be accessed by families only through a referral from a Families SA case worker. A referral depends on the family being notified, and the notification being screened in and then allocated for a response. Each organisation funded to deliver the program is obliged to report regularly to Families SA against key performance indicators, including numbers of families engaged in the program.

TIS offers support to families at moderate risk for about three hours a week for up to 12 months. An evaluation in 2012 supported TIS, finding that children in the program were less likely to be placed in care than the control group and estimating that it saved about \$16.8 million.⁶⁴ Yet families must be referred to TIS by Families SA, which in practice requires notifying the Call Centre.⁶⁵

The agencies contracted to Families SA all told the Commission that their service capacity was under-utilised because of poor referral numbers.⁶⁶ With the statutory system stretched to the extent that only very high-risk cases are being allocated to caseworkers, few cases appropriate for this less intensive service were available. Centacare and other organisations observed that some referrals to TIS were inappropriate and involved families with far more complex and entrenched problems than the service was designed to address. Referral to a service also depended on Families SA having the capacity to engage with the family to make the referral. In recent times this has been so stretched that Families SA's ability to perform this referral role has been undermined.

Families SA is aware of these challenges:

*Targeted Intervention really relies on the moderate cases to be referred out. There can be high risk cases referred to these programs, but they have to have other services in place, and they have to be willing and voluntary clients. So there are a number of referrals that could be referred out to Targeted Intervention, but they are just not making it there. So that has been an issue for these programs for three years that we have been attempting to resolve.*⁶⁷

The experience with TIS highlights the need to facilitate access to preventative and early intervention programs from pathways outside the statutory system. Families who can be adequately supported outside the statutory system should be.

GREATER RELIANCE ON SERVICES OUTSIDE THE AGENCY

For many families, Families SA is associated with blame and the removal of children, rather than seen as a place for genuine assistance:

*The attitude towards 'the welfare' is deep and ingrained and, unfortunately, you can rebadge, you can relocate, you can do all sorts of things, but you will still be 'the welfare', the ones who take our kids away, and the degree of trust, zero.*⁶⁸

Using not-for-profit agencies and non-statutory government agencies, rather than Families SA, to work with vulnerable families avoids some of that stigma. Families are more willing to accept support and to develop trusting, therapeutic relationships.⁶⁹

Serious child protection notifications continue to require a statutory response by Families SA. These include all Tier 1 and 2 cases and more serious Tier 3 cases, such as the examples of Tier 3 cases given in Chapter 7.

Other government or not-for-profit agencies are better placed to respond to cases that are screened out as NOC, AAR or ROU, as well as some lower risk Tier 3 intakes. In its Intake Review of 20 Tier 3 notifications that were made between 1 July 2014 and 1 December 2014, the Commission identified three less serious notifications to which a support agency could have responded (see Appendix C):

- A mother with two teenage children used to be assaulted by her former boyfriend, including in the presence of her children. On one occasion she was hospitalised as a result. An intervention order was in place, but one of her children was concerned that the mother wanted to reconcile with her boyfriend and the mother confirmed that this was the case.
- The parents had three children, aged from two to 11. The father was an alcoholic and used to physically assault the mother. An intervention order was in place, but both parents had been charged for breaching it. The father had attempted suicide a number of years ago. At the time of the notification, the police had been called to the mother's home, where the father was present. The mother denied that he had assaulted or threatened her, but they had been arguing and she was concerned because he had been harming himself.
- The mother had two children, aged eight and nine. At the time of the notification, the mother had recently been evicted from accommodation provided by a not-for-profit agency and was staying in emergency accommodation provided by another not-for-profit agency. There was a long child protection history, mainly concerning homelessness as well as the mother suffering serious domestic violence from various partners.

Non-statutory agencies have an opportunity to engage hard-to-reach families simply because they are voluntary services. They have no authority to operate in a mandatory, heavy-handed manner. However, they should be assertive and perseverant. As one witness told the Commission: 'It's not a statutory relationship, but it's a persistent, helping relationship'.⁷⁰ They should not simply allow families to drift away.

For harder to engage families, agencies need to invest in service models that are flexible, such as by allowing repeated attendance at a family home and at various times, if necessary. These models aim to remove barriers to engagement and make more difficult any decision by the parents not to engage.

Agencies should have workers who are trained, supervised and supported to not only attend to the needs of parents, but also to keep steadfastly in mind the health, safety and wellbeing of any children in the household. Workers need to be prepared to have difficult conversations with parents about patterns of behaviour that could place children at risk, and about areas of need and how to address these. For example, they should be able to detect signs of potential child trauma and be willing to report back to the Agency if their concerns persist. If concerned about the veracity of a parent's account of child trauma, they should be assertive enough and adequately resourced to insist on gaining an independent perspective from the child's doctor, school or childcare centre, or from a relative, friend or neighbours.⁷¹ In short, they should engage the whole family to address the risk to the child.

Importantly, if the family refuses to engage with the support agency or fails to progress therapeutic goals and child safety concerns persist, then the case should be referred back to the Agency for statutory intervention.

THE DIFFERENTIAL RESPONSE MODEL

Differential response (DR) is a reform model adopted in different forms in many jurisdictions around the world.⁷² It developed from dissatisfaction with traditional responses to suspected child abuse or neglect, which have been incident-based investigations into alleged maltreatment to determine whether intervention is required. Agencies become overwhelmed trying to fully investigate all notifications, leading to long waiting lists and many cases receiving no response. Families end up receiving too little support, too late, and the confrontational nature of an investigation means that families are less willing to take steps to address the child protection concerns. These criticisms apply to South Australia's child protection system.⁷³

DR proposes an alternative response to a statutory response. It allows notifications to be filtered, and the appropriate response determined—whether non-statutory or statutory—according to the level of risk. The rationale for DR is that families are more likely to respond favourably if 'approached in a non-adversarial, non-accusatory way'.⁷⁴ Critically, the access to services delivered through a DR does not depend on an incident-focused investigation, but on a comprehensive assessment of family needs.⁷⁵

There are a number of examples of DR in Australia, and a variety of ways in which notifiers are supported to link families to these diversionary pathways. Each example of DR responds slightly differently to the challenges of increasing referral pathways and the level of services for families in need; however, they have some common features, including⁷⁶:

- customised assessment processes and service procedures;
- the diversion of appropriate families away from a statutory response;
- the encouragement of family cooperation with community-based services;
- family assessment, rather than incident-based investigation; and
- the reduction of the over-representation of some cultural groups in incident-based investigations by improving access to a broad range of services.

The success of a DR system relies on a greater number of intake points and referral pathways, as well as the development of available services. Families who should benefit from this alternative response are those who are unlikely to otherwise attract a service on the basis of risk and/or workload management.

The response to a child's circumstances that is delivered by the child protection system is generally dictated by the information that is available to the notifier, which is assessed at the system's entry point. There is no guarantee that what the notifier has seen reflects the child's experience and what is assessed is the accurate level of risk to the child within the family. The comprehensive assessment of families as part of the referral process is therefore a crucial feature of any differential response.

That is, the accurate level of risk to the child should be identified and the right response chosen:

Child welfare organisations must be able to negotiate the slippery slope that balances family engagement with child protection. Slipping too far to one side relegates us to being a government intervention that can tear families apart in the name of child safety. Too far to the other side, we become a supportive community cushion for needy families that fails to identify children at heightened risk and denigrates our fundamental responsibility to act quickly and definitively to protect them. In this context [differential response] means knowing with reasonable certainty which level of intervention is best for which families, by taking sufficient time at the front end to make the most accurate assessment of both imminent and future risk and by planning interventions best suited for the family's situation, and by continuing fact finding related to risk factors and protective capacities as long as the family is being served.⁷⁷

A family that enters the system through an early intervention pathway may later need a statutory response to deal with a newly identified level of risk. Conversely, a family that enters through the statutory pathway may, after investigation, be found to require a less heavy-handed approach. For these reasons, it is critical that any preventative and early intervention pathway has firm connections to the statutory system and enough flexibility to enable the response to change if needed.

In considering referring families to other than a statutory response, it is important to bear in mind that they may move between being in need and at risk, depending on the particular circumstances at the time of assessment. To deal with this, the service response should be flexible and permit referrals between tertiary, secondary and primary systems. It is also highly valuable to capture information from mandatory notifiers (whether by way of report or referral) in a single database. This would mean notifications by referral would be recorded in the C3MS system.

DR is no panacea. While it promises better links to early intervention and remedial services for families who need them, the success of this approach depends on support services being properly resourced to meet the needs of children and families:

If a differentiated response is developed but under-resourced, the families with generic welfare problems will be no better served than they are under current 'forensic investigation' models.⁷⁸

Services need to be coordinated to avoid duplication and gaps in service provision:

The success of a differential model relies, in part, on the creation and development of strong community support agencies that are willing and able to become partners with the state to protect the interests of children. However, collaborations are not always easy to establish and maintain.⁷⁹

SOUTH AUSTRALIAN DIFFERENTIAL RESPONSE INITIATIVES

LINKING FAMILIES

In June 2015, Families SA introduced Linking Families (LF) to respond to Tier 3 intakes, some lower-risk Tier 2 intakes, and some Adolescent at Risk and Report on Unborn notifications. LF is a phone-based service located at the Families SA Call Centre.⁸⁰

If LF knows that an existing government or not-for-profit support agency is involved with a family, an LF worker telephones the agency to discuss the new concerns raised in the notification. If the agency is able and willing to address the concerns, it negotiates an action plan with LF, detailing what it will do to address the concerns.⁸¹ LF then closes the file.

If LF is not aware that any agency is involved with a family, or where an agency is unable or unwilling to address concerns involving the family, it attempts to contact the parents by letter or, failing that, by telephone. If parents are contacted, an LF worker discusses the concerns with them, with the ultimate aim of referring them to a service provider for support.⁸²

LF is a voluntary process. If parents cannot be contacted by letter or telephone, the case is closed. If they are contacted but refuse to engage, the case is closed. If a support agency accepts the referral, the case is closed on LF's books, even if the parents refuse to engage with the agency or address the concerns. There is no guarantee that the child will be sighted or spoken to. The matter would return to Families SA only if there was a further notification.⁸³

LF commenced operations on 29 June 2015. In its first six months, LF accepted referrals for 593 children.⁸⁴ It referred families of 453 of those children (76 per cent) to a service. Families of the remaining 140 children (24 per cent) were not referred to a service. In one of these cases, the support agency did not accept the referral. In every other case, the child's family declined to be referred, failed to respond or could not be located. Those children received no response.⁸⁵

The Gateway model, Tasmania

Not-for-profit agencies operate Gateway intake points in four regions of Tasmania. As highly visible entry points to local support services, Gateway accept referrals from vulnerable families, professionals and members of the public. They offer information and advice, assess families' needs, and refer families to support services as an alternative to the statutory helpline. Each Gateway also has an Integrated Family Support Service (IFSS) that coordinates service provision. Cases requiring only brief intervention are handled by the Gateway, while the IFSS is responsible for cases requiring intensive, longer-term interventions. Each Gateway has a child protection team leader, who serves as a conduit between the diversionary and statutory service systems.¹

A review after two years of Gateway's operation broadly supported the model, finding that it slowed the rate of entry of children into out-of-home care and resulted in many children being referred to family

support instead of to the statutory system. Gateway resolved 75 per cent of cases without the need to progress them to family support services, and was described by the review as 'a clear demonstration of ... value for money'.² The IFSS provided intensive support to 500 more families than forecast over the two years. Interviews with 20 current and past clients showed that they were highly satisfied with the services received and that the services had given them increased confidence in parenting skills and greater family cohesion.³

However, 56.3 per cent of children referred to either Gateway or IFSS experienced subsequent re-notifications. A number of high-risk families who had been historically hard to engage agreed to a collaborative intervention by IFSS and the statutory agency, but, in each case, the families disengaged when the agency closed the case.⁴

¹ Disability and Community Services, *Gateway and family support services: Midterm review report*, Department of Health and Human Services, Government of Tasmania, February 2012, pp. 17-18, 33, 44.

² *ibid.*, p. 33.

³ *ibid.*, pp. 26, 33-34.

⁴ *ibid.*, pp. 22, 26, 33-34.

The Child FIRST model, Victoria

Child FIRST (Family Information Referral and Support Teams) is an intake point operating in 24 subregions in Victoria. It accepts referrals from professionals and members of the public, and focuses on children who are not at risk of significant harm, but whose situations raise 'significant concerns for their wellbeing'. Child FIRST assesses child wellbeing and family needs, before referring children or families to the appropriate support services or the statutory agency for investigation.

Each subregion is supported by a Child and Family Services Alliance, which consists of a lead community agency and partner service agencies. Each alliance

promotes collaborative inter-agency relationships and prepares a three-year plan for improving local service delivery.

An evaluation in 2011 found that Child FIRST and related early intervention initiatives had increased service capacity, visibility and accessibility. Compared with 2005/06 levels, services supported more families and delivered twice as many service hours. They also supported more families with complex problems. The report concluded that the initiatives had moderated growth in child protection notifications and investigations.¹

¹ B Lonne et al., 'Victoria's Child FIRST and IFS differential response system: Progress and issues', *Child Abuse & Neglect* 39, 2015, pp. 42-43; KPMG, *Child FIRST and integrated family services: Final report*, prepared for the Department of Human Services, Victorian Government, February 2011, pp. 1-3, 139-149; KPMG, *Evaluation of the Child and family services reforms: Stage 1 final report*, prepared for the Department of Human Services, Victorian Government, February 2011, pp. 25-41.

The Family Support Networks model, Western Australia

Family Support Networks (FSNs) are local partnerships between not-for-profit agencies and the Western Australian statutory child protection agency. Each FSN covers a geographical area. In each area, a lead not-for-profit agency manages a common entry point to local secondary services. The lead agency brings together local secondary service 'partner agencies', including those who provide intensive family support, counselling, targeted parenting services, homelessness services, domestic violence services, services for young people and targeted community support. The lead agency also establishes strong links to and referral pathways with:

- local universal services, particularly education, health and early childhood services;
- secondary services outside the network, including drug and alcohol, mental health, child and adolescent health, housing support and disability services;
- specialist crisis response and medical services that lie outside the network, but provide key referral options.

Agencies or members of the public generally contact the common entry point by telephone and an initial screening determines if the FSN is the best response for the family's needs. If so, an assessment officer completes a comprehensive assessment to understand the child's experiences and developmental progress, any negative patterns or family risk factors, and past involvement with services. Some clients require only a brief intervention, such as the provision of information or limited advice. In other cases, a case plan is developed with the client, which includes goals for an intervention by a partner agency or agencies with the capacity to address the family's needs. The assessment determines the service intensity. For families with complex or entrenched needs who require a multi-service response, a range of practitioners participates in a multi-agency assessment to plan a coordinated response, with one agency acting as lead case manager.²

Agencies in the FSN use the same assessment framework to ensure common language and a consistent approach to risk, needs and strengths. Agencies in the FSN commit to a 'no wrong door' philosophy, which means that clients who contact a partner agency but do not require that agency's service are referred to an appropriate service in the network or to the common entry point for assessment and referral. The emphasis is on supporting clients to access the appropriate service as soon as possible. Clients' consent is sought for their information to be shared on the FSN database, accessible by all partner agencies.³

Each FSN has a child protection leader (CPL), who is engaged by the statutory agency. The CPL helps with decision making about child safety and wellbeing, and also helps the FSN manage risk for children and families. The FSN continues to refer cases that meet the statutory threshold to the statutory agency, but in consultation with the CPL. The CPL develops collaborative relationships between partner agencies and the statutory agency, educates partner agencies and the statutory agency about their respective roles, and improves the two-way referral process between secondary services and the statutory agency.⁴

The FSN model is designed to improve service integration and outcomes for children and families. By providing earlier responses to vulnerable children and families, it aims to reduce referrals to the statutory agency. Other benefits include reducing the need for referrers to maintain relationships with the vast array of secondary services in their area and reducing the need for referrers and clients to make multiple telephone calls seeking a service response.⁵

A 2014 evaluation of one FSN found that notifications to the statutory agency had declined. The FSN provided consistent, strong delivery and allocation of family support services, with promising evidence of improved circumstances for vulnerable children and their families. A cost-benefit analysis indicated that every \$1 invested in the FSN produced savings to the government and community of \$3.65.⁶

¹ Department for Child Protection and Family Support, *Western Australian family support networks: Operating framework*, Government of Western Australia, 2014, pp. 17, 21–23.

² *ibid.*, pp. 33–36, 42–43.

³ *ibid.*, pp. 32–34.

⁴ *ibid.*, pp. 46–47.

⁵ *ibid.*, pp. 9, 32.

⁶ KPMG, *Update to the evaluation of the family support networks: Final report*, prepared for the Western Australian Department for Child Protection and Family Support, Government of Western Australia, 2014, pp. 3–4.

LF records the referral of families to a service, not whether the family actually engages with the service or makes changes that address the concerns. As families involved in the child protection system tend to be difficult to engage, it is likely that these statistics significantly overstate those who meaningfully engaged with services. In cases where LF approached the family of the referred child directly because no service provider was yet involved (273 children), more than half of the families (139 children) did not connect to a service: they declined, failed to respond or could not be located. In other words, when the family, rather than an agency, decided whether the family would be referred to a service, most families declined.

LF will no doubt drastically reduce Closed No Action rates for Tier 2 and 3 intakes in 2015/16. It also provides some response to Adolescent at Risk and Report on Unborn notifications, which historically have received little response. However, this apparent improvement masks the fact that for many children, the response is an offer of services that their parents decline.

LF's service model is not flexible or assertive enough to respond to families who are resistant to services. There are benefits to using agencies other than Families SA to respond to lower level concerns. However, there should be clear processes to facilitate the flow of information and cases back to the Agency if parents refuse to engage in a way that will secure the health, safety and wellbeing of their children. LF also lacks a structure to coordinate local service provision. If a support service has a concern, its only option is to communicate this back through the Call Centre for fresh triaging. This is not conducive to effective collaboration.

It is also a mistake to engage families directly by telephone. It is notoriously difficult to establish rapport over the telephone, particularly when discussing sensitive matters. Families SA acknowledges these limits by warning workers not to conduct family meetings by telephone:

The views of all family members cannot be gained, Families SA concerns cannot adequately be explored over the telephone, there is no opportunity to sight the child [and] there is limited opportunity to explore supports/services with the family.⁸⁶

LF also omits the critical steps of assessing the family's needs, as well as the health, safety and wellbeing of the children. If these are not properly assessed, services may be mismatched. Some services that LF refers to may be able to do this assessment, but they should be funded and supported to do so, with procedures that make clear this is their role.⁸⁷

CHILD WELLBEING CONSULTANTS AND PRACTITIONERS

From June 2012 to August 2013, Families SA ran a pilot program with one of its experienced social workers working across three primary schools in Adelaide's northern suburbs as a part-time child wellbeing consultant (CWC).⁸⁸ School staff, including teachers and counsellors, who were concerned about vulnerable children, could consult the CWC to help assess a family's level of risk and needs, and consider how the school could better support it. In some cases, the CWC worked with staff to directly support families. The CWC developed partnerships with local services and could recommend services to which staff could refer families. Because staff had an ongoing relationship with families, they could follow up whether parents had engaged with the service and whether the concerns remained.⁸⁹

The CWC had access to Families SA's electronic database and shared relevant information about family backgrounds with staff to gain a more complete assessment. If a notification was required, the CWC advised staff about the information needed to make a high quality notification, such as patterns of risk and past attempts to address problems. After a notification had been made, the CWC gave staff feedback about the response Families SA intended to make.⁹⁰

Over 14 months, 91 families were referred to the CWC. Of these, 62 families were diverted from a notification to the Call Centre, including 47 families who were referred to support services. An evaluation found the program was well received by Families SA and education staff.⁹¹

In late 2015, the South Australian Government announced it would employ up to 60 child wellbeing practitioners (CWP's) in a role modelled on that of the CWC, to help staff identify vulnerable children and families and connect them to relevant services. The program will be rolled out in stages, focusing on school sites of vulnerability and need.⁹²

A REFORM MODEL FOR EARLY INTERVENTION AND SERVICE COORDINATION IN SOUTH AUSTRALIA

SELECTION AND FUNDING OF EVIDENCE-BASED SERVICE MODELS

Effective prevention and early intervention depends on a number of key factors, including:

- adequate funding of prevention and early intervention services;
- selecting and funding of appropriate, evidence-based service models;

- robustly identifying vulnerable families, assessing their needs and referring them to evidence-based services; and
- coordinating support services with coherent referral pathways, and committing to share information and promote collaborative practice.

Because resources are finite, they should be devoted to effective programs with a sound evidence base. A bewildering range of programs claim to reduce child maltreatment, including physical and mental health initiatives, home visiting programs, early childhood and preschool education, intensive family support programs, and parenting programs. The outcomes of these programs are difficult to track as they should be measured over a number of years. Programs cross multiple portfolios, including health, education, child protection, disability and community services. They are provided by a variety of government departments and not-for-profit agencies, and funded by a combination of federal, state and local governments, as well as philanthropic sources.⁹³

The potential for silos exists, with individual agencies unaware of evidence concerning alternative service models. Agencies may persist with a familiar service model, even though it is less effective than a potential alternative.

Addressing these challenges requires a process to evaluate available evidence and make funding decisions based on the effectiveness of the various options. Effective service models should be expanded, while less effective ones should be adapted to reflect the best available evidence or lose their funding. It is critical that evaluations collect data on outcomes, not simply activities. In particular, re-notification rates for children in families who have been involved in programs should be carefully monitored.

To meet this need, a cross-departmental Early Intervention Research Directorate (EIRD) should be established in South Australia and located in the Department of the Premier and Cabinet (DPC) or in the office of the proposed Children's Commissioner, with links to the Child Wellbeing Committee, the function of which is further discussed in Chapter 22. Consideration could also be given to locating it in the research division of the new agency. Every five years, the EIRD should prepare a systematic, whole-of-government Prevention and Early Intervention Strategy to promote the health, safety and wellbeing of children in South Australia. In preparing this strategy, the EIRD would⁹⁴:

- identify all service model options to address child maltreatment, stretching across government portfolios, government and not-for-profit sectors, programs areas, target populations and settings;

- gather available evidence for those options, including their relative economic performance. Wherever possible, effectiveness should be measured by objective outcomes in reducing child maltreatment, for example, by numbers of child protection reports, substantiations, and entry to or time in out-of-home care; and
- prepare a whole-of-government early intervention strategy, identifying the service models that have sound evidence of their effectiveness in improving children's health, safety and wellbeing.

The strategy should include service models that respond to the complex, varied needs of families who come to the attention of the child protection system. Particular consideration should be given to service models that are flexible enough to respond to common comorbidities and that are effective at supporting particular subsets of vulnerable parents, such as young people, care leavers, or women who are pregnant for the first time. The strategy should encompass service models that represent early intervention for the benefit of the next generation. In particular, it should consider services that could be delivered from colocated centres, such as Children's Centres.

The strategy would inform state government funding decisions, and would also form the basis of negotiations with the federal and local governments regarding their funding priorities.

The EIRD should invest resources in robust, independent, outcomes-based evaluations of innovative service models to determine their effectiveness, including their cost, in the South Australian context. Specifically, the Cabinet should direct that South Australian Government agencies that deliver or fund family support services only pursue service models identified in the strategy as effective. Where a sound evidence base is not yet available, a program would need to demonstrate a theory of change, identifying the principles on which the program logic is based. The EIRD should put in place an evaluation framework as a condition of funding such programs. Generally, the results of EIRD evaluations should be made public.

Further, the EIRD should establish research partnerships with universities and research bodies such as the Australian Centre for Child Protection. There is value in establishing a mechanism such as an expert panel, which could be called on to give advice and input at all stages of decision making.

The first step for the EIRD should be to conduct a comprehensive mapping of the available services, their therapeutic objectives and geographical reach.

The Commission is aware of a large-scale project, the SA Early Childhood Data Project, which has been conducted by BetterStart, the University of Adelaide's Child Health and Development Research Group. The project links administrative data, from areas including child protection, CaFHS, public housing, school enrolments, perinatal records, births and deaths registrations, children's hospitalisations, National Assessment Program—Literacy and Numeracy (NAPLAN) testing and the Australian Early Development Census, in a way that enables risk factors to be identified and children (tracked through de-identified codes) to be followed over time. It currently provides data from 1999 to 2015, which includes about 300,000 children born from 1999 to 2013.

The Commission understands that the DPC is aware of the project. If the project were supported to provide continuous tracking and linking of the data, it would have the potential to be a powerful tool to inform the work of the EIRD. The Commission supports the investigation of potential links in this regard.

INVESTMENT PRIORITIES

The risk factors for child abuse and neglect are well known. They include domestic violence, parental substance abuse and parental mental health problems, together with housing instability, poverty, low education, social isolation, neighbourhood disadvantage and past trauma. Clearly, not all parents who experience these issues proceed to harm their children; however, they are likely to benefit from additional support to nurture their children.⁹⁵

It is critical that investment is made in addressing need in families who have identified risk factors, but where no abuse or neglect has yet been identified. Referrals to services should not depend on the existence of a notification to the Agency.

The Commission heard evidence that the prenatal period can be a critical intervention point for parents-to-be—a time when they are more likely to be receptive to services that could help them develop good parenting skills and address factors that might compromise their parenting.

There is also evidence that children who are reported to child protection services for the first time before the age of one year are at greater risk of being reported again. One US study tracked a cohort of children aged under one year who were first reported to child protection services in 2006. Data showed that after five years, 60 per cent of the children who remained living at home after that initial report had been reported again (20 per cent of these had had five or more child protection reports).⁹⁶

One study used South Australian child protection data for children born in 2001 to examine patterns of repeat involvement in the child protection system. Of one cohort

of children who were reported to Families SA in their first year of life, 55 per cent of them went on to be reported five or more times before the age of twelve. Similarly, an examination of children who at the time that they turned 11.5 years who had 10 or more reports made about them, just over half had been first reported to Families SA before the age of two.⁹⁷

Studies of this kind support the idea that intervention prenatally and in families with infants has the potential to be worthwhile:

There is perhaps no greater opportunity for [Child Protection Services] and other systems to positively intervene than during the first year of life, both because maltreatment that begins during infancy has the potential to become quite chronic in duration and because its timing is developmentally consequential.⁹⁸

South Australia is well positioned to capitalise on the existing well-developed universal services available at the major birthing hospitals and through the Women's and Children's Health Network universal home visiting services. Work is underway to extend the capacity and flexibility of these services to meet the needs of especially vulnerable families, and the Commission also supports continued investment in this regard.

A growth in services for women in the prenatal and immediate postnatal phases should complement the changes to the receipt of, and response to, Report on Unborn notifications recommended in Chapter 7.

Care leavers are identified as more likely to experience the disadvantages that place their children at greater risk of abuse or neglect. For example, they are more likely to experience unstable living arrangements and mental health issues, and to become parents at a young age.⁹⁹ The state owes a special duty to parents who have a care history, and appropriate services should give priority access to this group. Because of their experiences, care leavers may be at particular risk of disengaging from services. A service designed for this group would need to consider how to overcome that.

CHILD AND FAMILY ASSESSMENT AND REFERRAL NETWORKS FOR SOUTH AUSTRALIA

The South Australian Government should establish child and family assessment and referral networks, which would have the function of coordinating services and be attached to an assessment and referral service, in each region of Greater Adelaide and in the state's two largest regional areas: Mount Gambier and either Port Augusta or Whyalla. There is value in the alignment of the Families SA hubs geographical boundaries with the boundaries to be serviced, although some flexibility in this regard would be needed to ensure that the services are accessible.

James: A vulnerable child from birth

(The full case study of James is in Volume 2, Case Study 1: James—Vulnerable children, birth to school age.)

James's mother was 18 years old when he was born. She had a history of abuse and neglect at the hands of her own mother, and had spent time under the guardianship of the Minister. She had unstable living arrangements and little, if any, family support. She was poorly equipped for the challenges of parenting. Her social isolation put James at particular risk.

The Department received the first notification about James before his birth, when a health professional involved in his mother's care raised concerns. After his birth, further notifications were received from the birthing hospital. Families SA did not conduct an investigation into the notifications on the basis that service referrals had been made for James's mother.

However, one of the referrals was for a service that turned out not to be available in her residential area. Her engagement with the universal home visiting service was poor and she declined the additional support that would have been available under the extended two-year home visiting scheme. The universal home visiting service was not designed or equipped to deliver the intensive engagement that James's mother needed.

When James was a little older, Housing SA social workers were aware of Families SA's early intervention program, the Targeted Intervention Service (TIS), and wanted to refer his mother. They thought she needed the kind of support that TIS would offer. However, when child protection concerns were reported to the Families SA Call Centre, they were not sufficiently serious to justify the allocation of a caseworker, and a referral to the TIS program was therefore not available.

The Commission is not in a position to assess the relative merits of the service designs in operation in other jurisdictions. Therefore, a detailed service model is not prescribed. Further work would be required in the implementation phase to consider what has been learned from the implementation of similar services interstate, and to build on that knowledge and evidence.

Practitioners who are engaged in receiving and assessing notifications in these networks should hold the level of experience and qualifications described in Chapter 7 for Call Centre practitioners. They must also have full access to the Agency's electronic database.

The assessment and referral service should accept referrals from all sources (including the public). However, if these services were to contribute to the diversion of families from the statutory system, mandatory notifiers would need to be able to discharge their legal obligation by reporting concerns through this alternative route. Legislative amendments would be necessary.

ASSESSMENT, SCREENING AND SERVICE COORDINATION FUNCTION

In each area, a lead not-for-profit agency would be identified to partner with the Agency to:

- manage a local entry point to access services provided by partner agencies in the region;
- coordinate partner agencies that provide services in the region to ensure that referral criteria and procedures complement other services and avoid duplication and service gaps;

- promote, among partner agencies, collaborative practice, information sharing and the use of a common assessment framework; and
- form strong links and referral pathways to local primary services, any secondary services not part of the network (such as statewide health services) and tertiary services (such as the Agency and the hospitals' Child Protection Services).

The local entry point would screen referrals and provide assessments to determine whether the services available through that point would be the best option to support a family. If so, the entry point would refer the family to a partner agency to provide that support. Where necessary, the entry point would convene a multi-agency assessment meeting with relevant practitioners. A lead case manager would coordinate a multi-service response.

Although there would need to be a flexible approach to what kinds of concerns this early intervention/prevention pathway would deal with, unborn child concerns would be especially suitable. Similarly, notifications about neglect or low-level maltreatment that have the potential to become chronic might be best actioned through this pathway.

Partner agencies should adopt a 'no wrong door' approach. If clients contact an agency network member but do not require the services offered by that agency, the agency should refer them to a partner agency who can help them, or to the local entry point for assessment. The emphasis is to provide clients with the support they need, as soon as possible.

8 EARLY INTERVENTION

Each coordination service network would have collocated child protection practitioners who have on-site access to the Agency's electronic database, to enable the sharing of information with network staff. The practitioners would have clear lines of communication to each local Agency office, so they could provide feedback about particular issues or cases of concern. It would be critical for information about families of concern to flow both from and to the Agency to ensure that children who are at heightened risk are properly responded to.

TRAINING AND CONSULTANCY FUNCTION

As noted in Chapter 7, Figure 7.1, 62 per cent of all notifications to the Families SA Call Centre in 2014/15 came from three mandatory notifier groups: police, education and health. Given this percentage, it would make sense to focus on supporting these groups to refer, rather than notify, appropriate concerns.

Local coordinating service networks should be resourced to provide a consultation service for notifiers who are considering making a referral rather than a notification. Where the level of risk does not justify a notification, notifiers can be supported to make relevant referrals without the involvement of the statutory system.

The assessment and referral service should also develop training and promotional material to highlight the benefits for children of referring for services rather than reporting to the Agency. It is hoped that by engaging at the local level, strategic relationships would be formed and developed between these services and local government services.

A set of accessible referral guidelines would need to be developed to guide notifiers who are considering referring. These guidelines should be available online and in hard copy. Alternatives to notifying would also need to be integrated as a topic into mandatory notification training.

STRATEGIC FUNCTION

In consultation with partner agencies and other primary, secondary and tertiary services, the assessment and referral service would regularly map the needs of vulnerable families and children in its region, with a focus on areas of unmet need and unnecessary or duplicated services. This work would be formalised in an annual Local Assessment of Needs (LAN). Copies of the LAN would be forwarded to the EIRD, the proposed Children's Commissioner and the Agency. The LAN should inform future funding decisions to ensure regions have the services that they need. The EIRD would provide data to the assessment and referral service to enable it to provide this assessment.

IMPLEMENTATION CONSIDERATIONS

Child and family assessment and referral networks would be a new initiative for South Australia. The Commission recommends that consideration be given to first establishing two pilot programs: one in a metropolitan area and one in a regional area. These pilot programs should be rigorously evaluated before a service model is finalised for implementation across the state.

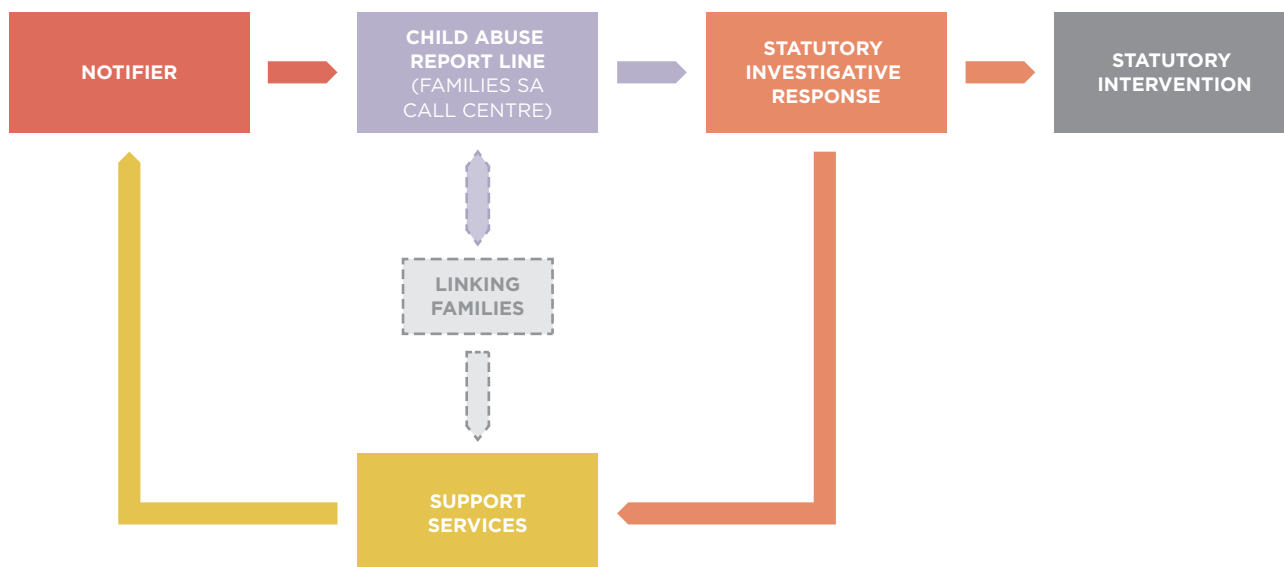


Figure 8.5: Model of the current child protection system

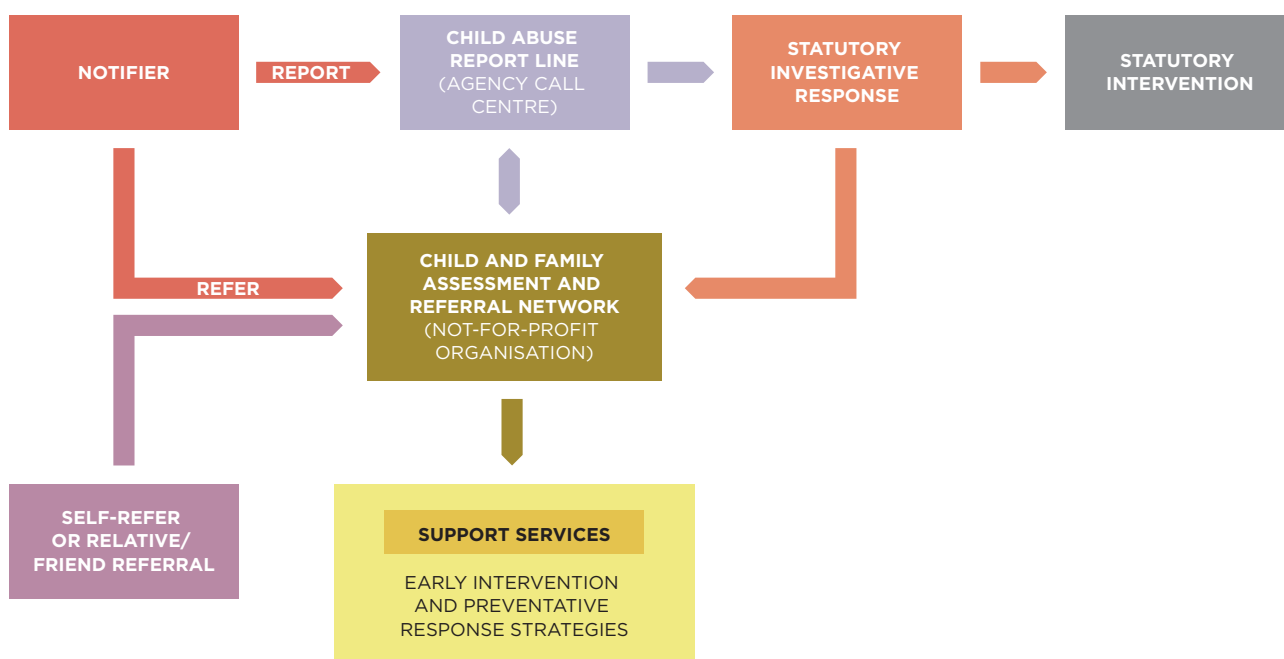


Figure 8.6: Proposed reform model of the child protection system

While it is anticipated that these networks would be developed in partnership with Families SA, they would involve divesting some work that has been the domain of the Agency to not-for-profit organisations. In the early stages of service development and piloting, it may be that the Agency takes a greater role than would be anticipated in the long term.

Because a crucial aspect of the model is that notifiers would be able to satisfy their mandatory obligations by referring to the service, quality screening and assessment would be critical to ensuring that this initiative does not endanger children by responding to their needs in an inappropriate way.

A review of the Victorian Child FIRST model (see box) concluded that it did face some challenges in meeting its aims. In particular, there were concerns about the quality of the casework being delivered, how and where risk was held in the various interconnected organisations, and inconsistent understanding of the threshold for statutory involvement.¹⁰⁰ A more recent evaluation of the Tasmanian child protection system, including the Gateway model (see box), found that a cohort of families fell between a statutory response and the lower intensity programs available through the diversionary system. These families risked being neglected until their circumstances reached a crisis point, when a statutory response was required. These observations highlight the need for programs available through the differential

pathway to offer services of differing intensity and assertive engagement with hard-to-reach families.¹⁰¹ These are matters that an evaluation would need to closely monitor.

Figure 8.5 is a model of how notifications travel in the current child protection system.

Figure 8.6 illustrates the proposed reform model, with assessment and referral networks assuming prominent roles in providing family support services.

A NEW APPROACH FOR NOTIFIERS

Under the proposed reforms, notifiers with concerns about the safety of children (whether mandated to report or not) would have two options:

- 1 *Report* to the Agency's Call Centre in the traditional way.
- 2 *Refer* to the child and family assessment and referral network where a notifier believes that a child's circumstances would be adequately attended to by a prevention or early intervention program. This decision should be guided by publicly available referral guidelines, and an awareness program that trains the biggest groups of notifiers in when and how to refer rather than report.

Common Approach

Common Approach¹ was developed for use by practitioners who have regular contact with children and families, but who may not have experience in making formal assessments. It was developed as a result of the National Framework for Protecting Australia's Children 2009–2020's first three-year action plan (2009–12) to support cross-agency shared approaches to assessment and referral.

Common Approach consists of an assessment wheel, a questionnaire for young people, a questionnaire for parents and carers, and a guidance manual. The assessment wheel visually represents the various domains of wellbeing (physical health, mental health and emotional wellbeing, relationships, material wellbeing, learning and development, and safety), with concentric circles representing the child, the family and the community. The questionnaires explore these domains in easy-to-understand language.²

In 2013, Common Approach was evaluated in four Australian sites, including Northern Connections in South Australia. Common Approach was used in multiple sectors (early childhood, health, schools, mental health, family support and family relationships) and by a wide range of practitioners (counsellors, psychologists, child health and community nurses,

teachers, family violence and drug and alcohol workers, youth workers, social workers and childcare centre managers). The evaluation found that Common Approach was a useful tool for practitioners from a range of professions and sectors. It supported relationship building with families and facilitated a more holistic understanding of a family's strengths, needs and aspirations. Specifically, it encouraged practitioners 'to identify issues they would not usually identify in their daily practice, leading to more comprehensive referrals, more integrated support and often the earlier identification of problems and difficulties'.³

Common Approach avoids clients having to retell their stories to different agencies because they can take their completed assessment wheel to the next agency to which they are referred.⁴ The child wellbeing consultant placed in northern suburbs' schools in 2012 and 2013 encouraged school staff to use Common Approach. She found that it helped staff consider issues beyond the immediate educational setting, such as children's health and safety and the wider context of family and home life. Workers were also more likely to be 'on the same page' about assessments.⁵ The expanded program of child wellbeing practitioners in South Australian schools will also use Common Approach.⁶

¹ Formerly the Common Approach to Assessment, Referral and Support.

² Oral evidence: J Davidson-Tear. Australian Research Alliance for Children & Youth (ARACY), *The Common Approach to Assessment, Referral and Support (CAARS): Working together to prevent child abuse and neglect—Final report*, Canberra, 2013, pp. 5–6, 14, 87.

³ ARACY, *The Common Approach to Assessment, Referral and Support*, pp. 6, 44.

⁴ Oral evidence: B O'Brien.

⁵ Oral evidence: Name withheld (W102); B O'Brien.

⁶ Department for Education and Child Development (DECD), *Child Wellbeing Program fact sheet*, Government of South Australia, December 2015.

A report to the Call Centre or a referral to the child and family assessment and referral network would not necessarily determine the approach to be taken to the notification. Notifications could be moved from the report pathway to the refer pathway, and vice versa, via the relationships between the Agency and each child and family assessment and referral network. To avoid double handling and potential miscommunication, calls should be transferred between the network and the Call Centre where appropriate.

Child wellbeing practitioners will offer an additional pathway to some notifiers. This is described below.

CHILD WELLBEING PRACTITIONERS

The initiative to employ child wellbeing practitioners (CWPs) in the Department is excellent. The CWPs will offer Department staff support and guidance when they are assessing the needs of children and families, and will help them to consider relevant, accessible support options in the Department and elsewhere.

Child protection concerns are greater in certain regions of Adelaide and South Australia. The Department should place most CWPs in these regions. However, all Department staff should have access to a CWP, at least by telephone. This might be achieved by having a CWP in each education local partnership¹⁰², or by establishing a central unit of CWPs to service staff who do not have an

on-site CWP. The CWPs should be able to provide advice and referral information to school staff, but also engage directly with families whose children have been identified as at risk. To avoid double handling, mandatory notifiers who work in the schools or local partnerships to which a CWP is attached, should be able to discharge their duty to notify by making a report to a CWP, where the CWP agrees that the matter is appropriate for a referral to a child and family assessment referral network.

CWPs should have on-site access to the Agency's electronic database to enable them to record notifications that are diverted to the child and family assessment and referral network, and also share information with school staff. They should have clear lines of communication to the local office of the Agency so that they can provide feedback about particular issues or cases of concern. Information about families of concern must flow both from and to notifiers in government agencies.

CWPs will have a complex, challenging role. They will serve as local child protection experts and it is intended that their knowledge and views will shape school staff. They have the potential to reinforce either good or poor professional judgement. For this reason, they should be familiar with current child protection research, including child development research and the impact of different types of abuse and neglect. They should also be experienced in assessing family needs and child safety and wellbeing.

With this in mind, CWPs should be experienced social workers. However, in some cases, it will be appropriate to recruit experienced professionals with other degree-level, tertiary qualifications, such as teachers or nurses, provided they have completed additional child protection training or have the necessary experience in the field.

CHILD WELLBEING ASSISTANTS

A range of state government agencies, including SA Health and SAPOL, have frequent contact with vulnerable children and families, as do many non-government organisations, such as independent schools, community health clinics, general practitioners and not-for-profit family support services.

These organisations should consider how they can better help their staff to make appropriate assessments and to refer vulnerable families for support. In particular, they should consider nominating an existing employee at each site to serve as a child wellbeing assistant (CWA) in addition to their usual role. The appointment of child and family sensitive practice champions in Drug and Alcohol Services South Australia is an example of a similar concept. CWAs should receive training in relation to issues such as child development and the impact of abuse and neglect, and about support services in the local area. They could provide advice and guidance

to staff in their organisation about options to support vulnerable families. Mandatory notifiers would not be able to discharge their obligations by a report to a CWA.

The Agency should convene regular cross-agency training and networking sessions for all CWAs in different regions of Adelaide or South Australia. These sessions should be seen as vital opportunities to increase the knowledge of CWAs and to encourage local inter-agency support and collaboration. There may also be opportunities for CWAs to develop links at the local level with staff from child and family assessment and referral networks.

The South Australian Government should select and fund a simple, common assessment framework, such as the Common Approach (see box), which is suitable for use by a wide range of professionals who work with vulnerable children and families. The framework should be used by government and not-for-profit services providing primary and secondary child protection services to encourage early identification of problems and more comprehensive referrals. It could also improve understanding between agencies about assessment issues and reduce the number of times that clients have to retell their stories.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

49 Institute longer term funding arrangements for prevention and early intervention services, subject to evaluation and performance criteria. 50 Establish an Early Intervention Research Directorate (EIRD) to: - a prepare a Prevention and Early Intervention Strategy that is updated at least every five years: - i to identify service models that have proved effective or show promise in promoting the health, safety and wellbeing of children in South Australia; - ii to serve as the basis of decisions by South Australian Government agencies to fund prevention and early intervention services; - iii to form the basis of negotiations with the federal and local governments, with a view to coordinating funding priorities; - b establish research partnerships and fund evaluations of innovative service models to determine their effectiveness and value for money; and - c focus on the prevention and early intervention investment priorities identified in this report. 51 Establish child and family assessment and referral networks in each region of Greater Adelaide and regional South Australia that include: - a a lead not-for-profit agency to manage, in partnership with the Agency, a local entry point to services provided by partner agencies in the region, focusing on collaborative practice and coordinated, multi-service responses, when required; - b an annual Local Assessment of Needs (LAN) prepared by the lead not-for-profit agency after mapping the needs of vulnerable families and children in each region. The LAN would inform funding decisions for services; and	c child protection practitioners in each child and family assessment and referral network to support decision making in relation to child safety including when to refer higher risk families for a statutory response by the Agency. 52 Employ qualified child wellbeing practitioners (CWPs) accessible to all staff in the Department, but focusing on locations of greatest need, to consult with staff and to work directly with vulnerable families. CWPs should have on-site access to the Agency's electronic database. 53 Equip relevant government agencies to support vulnerable families by appointing existing employees as child wellbeing assistants (CWA), in addition to their usual role, to provide staff guidance about options to support vulnerable families. 54 Implement a simple, common assessment framework, such as Common Approach, for use by government and not-for-profit services who work with vulnerable children and families. 55 Convene regular cross-agency training and networking sessions for all CWPs and CWAs in each local metropolitan and country region to increase their knowledge and support local inter-agency collaboration. 56 Amend the <i>Children's Protection Act 1993</i> to permit mandated notifiers to discharge their obligations by: reporting to the Agency's Call Centre (Child Abuse Report Line); or to designated child wellbeing practitioners, or by referral to a child and family assessment and referral network where the notifier believes a child's circumstances would be adequately attended to by a prevention or early intervention program.

NOTES

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- 4 E Munro, *The Munro Review*, p. 70.
- 5 Office of the United Nations High Commissioner for Human Rights (OHCHR), *Convention on the Rights of the Child*, entered into force 2 September 1990, article 19.
- 6 E Munro, *The Munro Review*, p. 71.
- 7 *ibid.*, p. 71.
- 8 *ibid.*, p. 69.
- 9 Office of the Guardian for Children and Young People (GCYP), *What children say about child protection and out of home care: A consultation report for the South Australian Child Protection Systems Royal Commission*, Government of South Australia, October 2015, www.agd.sa.gov.au/child-protection-systems-royal-commission
- 10 Burden of disease measures less tangible costs, such as fear, mental anguish, physical pain and disability.
- 11 P Taylor et al., *The cost of child abuse in Australia*, Australian Childhood Foundation and Child Abuse Prevention Research Australia, Melbourne, 2008, p. 135; L Segal, K Dalziel & K Papandrea, *Where to invest to reduce child maltreatment—A decision framework and evidence from the international literature*, paper prepared for the Queensland Inquiry into Child Protection, University of South Australia, 2013, p. 2.
- 12 L Segal et al., *Where to invest to reduce child maltreatment*, p. 2.
- 13 P Taylor et al., *The cost of child abuse in Australia*, p. 138.
- 14 L Segal et al., *Where to invest to reduce child maltreatment*, p. 4.
- 15 *ibid.*, p. 5.
- 16 E Munro, *The Munro Review*, p. 71.
- 17 *ibid.*, pp. 71–72.
- 18 *Children's Protection Act 1993* (SA), s. 8(1)(b).
- 19 *ibid.*, s. 8(1)(d).
- 20 *ibid.*, s. 8(1)(e).
- 21 RA Layton (Chair), *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, Department of Human Services, Government of South Australia, Adelaide, 2003.
- 22 For example, oral evidence: S Schrapel; name withheld (W35); name withheld (W107); and submissions: Bravehearts; Junction Australia; Lutheran Community Care; Baptist Care; Australian Association of Social Workers.
- 23 Australian Research Alliance for Children and Youth (ARACY), *Inverting the pyramid: Enhancing systems for protecting children*, The Allen Consulting Group, 2008, p. 5; Australian Institute of Family Studies, *Defining the public health model for the child welfare services context*, CFCA Resource Sheet, AIFS, Australian Government, 2014; Council of Australian Governments (COAG), *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Canberra, 2009, p. 8.
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- 27 K Dalziel & L Segal, 'Home visiting programmes for the prevention of child maltreatment: Cost-effectiveness of 33 programmes', *Archives of Disease in Childhood* 97, no. 9, 2012, pp. 787–798.
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- 30 P Cummins (Chair), *Report of the Protecting Victoria's Vulnerable Children Inquiry*, vol. 1, p. 147; see also, OECD, *Integrating social services for vulnerable groups: Bridging sectors for better service delivery*, OECD Publishing, Paris, 2015, p. 198.
- 31 L Segal et al., *Where to invest to reduce child maltreatment*, p. 17.
- 32 E Munro, *The Munro Review*; L Segal et al., *Where to invest to reduce child maltreatment*, p. 19.
- 33 *ibid.*; P Cummins (Chair), *Report of the Protecting Victoria's Vulnerable Children Inquiry*, vol. 1, p. 147.
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- 35 Oral evidence: C Shard. Housing SA, 'Child safety—Implementation of new service model', p. 3.
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- 37 Oral evidence: C Shard. Witness statement: J Allen. Housing SA, 'Child safety—Implementation of new service model', p. 2.
- 38 Oral evidence: C Shard. Housing SA, 'Child safety — Implementation of new service model', pp. 2–3.
- 39 Drug and Alcohol Services South Australia (DASSA) is a statewide public health service offering prevention, treatment and education services relating to alcohol and other drugs.
- 40 Roche et al., *From policy to implementation: Child and family sensitive practice in the alcohol and other drugs sector*, ANCD research paper no. 28, Australian National Council on Drugs, 2014, p. 1.
- 41 For example, Ministerial Council on Drug Strategy, National Drug Strategy 2010–2015: *A framework for action on alcohol, tobacco and other drugs*, Department of Health and Ageing, Australian Government, Canberra, 2010, p. 18; DASSA, *South Australian alcohol and other drug strategy 2011–2016*, SA Health, Government of South Australia, 2011, p. 9.
- 42 National Centre for Education and Training on Addiction (NCETA), 'Integrating prevention and early intervention responses for children in the care of the DASSA Treatment Client Group', report prepared for DASSA, Adelaide, April 2013, pp. 8, 28–33, 38.
- 43 Oral evidence: R Ali. NCETA, 'Integrating prevention and early intervention responses', pp. 10–14.
- 44 NCETA, 'Integrating prevention and early intervention responses', p. 12; R Ali, personal communication to the Child Protection Systems Royal Commission, 8 April 2016.
- 45 Oral evidence: R Ali. NCETA, 'Integrating prevention and early intervention responses', pp. 14–15.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

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- 47 Oral evidence: P Strachan.
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9 INTERVENTION WHERE THERE IS IMMINENT RISK

OVERVIEW

Working with families who come into contact with the child protection system requires persistence and skill to engage them about issues that can be traumatic and shameful. It requires presence of mind not to lose sight of the child in the midst of family interventions. While it might seem axiomatic that children's interests lie at the heart of child protection interventions, in practice the needs and anxieties of parents, practitioners and other adults too easily subsume those of the children on whom they should be focused.

This chapter discusses the Agency's response to suspected child abuse or neglect. It examines the assessment process and the statutory powers that facilitate its response. It builds on the preceding chapter by detailing circumstances in which agencies other than Families SA (the Agency) should respond to low-risk cases of suspected abuse or neglect, while affirming the need for the Agency to respond to cases involving moderate to high risk to children. It highlights the poor responses that the Agency presently delivers in many serious cases of child maltreatment.

The chapter also discusses the family preservation services offered to families at imminent risk of having their children removed, and emphasises the need for purposeful interventions that do not permit children to remain for prolonged periods in unsafe situations. It considers options for the early use of formal but voluntary interventions, including a refocusing of Family Care Meetings. It looks at the process of removing children, where necessary, from their parents' care and of obtaining orders from the court to secure children's care.

Options to support families to resume the care of their children after removal are also discussed. The chapter argues for clear timeframes to meet children's need for stability and permanence either by returning promptly to their parents' care or by being supported in a stable, long-term alternative care placement. It discusses how contact arrangements can support children's broader case plans.

This chapter principally relates to the Commission's Terms of Reference 5(a) to 5(c), in the context of Terms of Reference 1 to 4.

POWERS FOR ASSESSING AND INTERVENING IN FAMILIES

The *Children's Protection Act 1993* (SA) (the Act) provides that where the Department's Chief Executive 'suspects on reasonable grounds that a child is at risk' and 'believes that the matters causing the child to be at risk are not being adequately addressed', he or she:

Must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.¹

Effective assessment depends on practitioners having access to as much information as possible about the circumstances of children and parents in a family. Many families cooperate with assessments, and consent to information being obtained from other sources. Family members may also consent to undertake specialist assessments, such as for substance abuse or mental health.

Matters covered in an assessment are personal and potentially shaming. Some parents, including former children in care who have painful memories of the child protection system, have had poor experiences with government authorities. Not surprisingly, some families are unwilling to cooperate with Families SA. Where families are not cooperative, Families SA requires the cooperation of other agencies or the use of statutory powers or court orders (or a combination of these) to facilitate the information gathering that is critical to good assessment.

COOPERATIVE INFORMATION SHARING

The Information Sharing Guidelines (ISGs) are a 'statewide policy framework for appropriate information sharing practice'.² The ISGs apply to most South Australian Government agencies and to non-government organisations contracted by the government to provide services. The ISGs encourage agencies to share information where 'a person is at risk of harm (from others or as a result of their own actions) and adverse outcomes can be expected unless appropriate services are provided'.³ Chapter 21 outlines significant barriers that impede their effective operation. As a result, relevant information is not always forthcoming.

STATUTORY POWERS

Families SA has the power to require, by notice in writing, any person (or the agency that he or she works for) 'who has examined, assessed, carried out tests on or treated the child' to produce a written report concerning the examination, assessment, test or treatment.⁴ This power is effectively limited to information from health providers directly pertaining to the child. Information from other sources or relating to a child's parents (including their drug and alcohol use, mental health or history of domestic violence) requires a court order.

To assist child protection investigations, authorised police officers have powers of entry, search and seizure, and to require a person to answer questions. These powers must usually be authorised by warrant issued by a magistrate.⁵ Families SA and South Australia Police have agreed to confine requests for the use of these powers to matters of sexual abuse, serious neglect, physical abuse or the death of a child.⁶ In practice, Families SA rarely calls on these powers, preferring instead to seek orders from the Youth Court.

COURT ORDERS FOR INVESTIGATION AND ASSESSMENT

The Department's Chief Executive can apply to the Youth Court for investigation and assessment orders if he or she is of the opinion that⁷:

- there is information or evidence leading to a reasonable suspicion that a child is at risk;
- further investigation of the matters is warranted or a Family Care Meeting should be held; and
- the investigation cannot 'properly proceed' without an order or the child needs to be protected while the matter is investigated or a Family Care Meeting is held.

If satisfied that there are sufficient grounds and that it is in the child's best interests, the court may make orders, including⁸:

- authorising the examination and assessment of the child. For example, this power may authorise forensic medical assessments of children who may have been abused;
- authorising or directing the assessment of a parent, guardian or carer to determine their capacity to care for and protect the child. This power may be used to direct a parent to undergo a drug and alcohol, mental health or parenting assessment;
- authorising Families SA to require any person to answer questions to the best of the person's knowledge, information or belief. This power may be used to obtain a parent's history of criminal offending or a child's school attendance records;

- authorising Families SA to require any person (or the agency he or she works for) who has examined, assessed or treated a party to the proceedings (other than the child) to provide a written report of the examination, assessment or treatment. This power may be used to access a parent's drug and alcohol or mental health treatment records; and
- placing the child in the custody of the Minister.

These orders last up to 42 days, and can be extended for a further 28 days.⁹ If Families SA decides that a child should remain in the Minister's custody after this period, it must apply for care and protection orders, which last up to 12 months or until the child turns 18 years.¹⁰

POWERS TO IMPROVE INFORMATION GATHERING

Without a court order, Families SA's information-gathering powers are confined to requesting a written report from health providers who have assessed the child. It cannot access information from non-health sources, such as a child's school, childcare centre or playgroup, or about a child's parents, such as their criminal history. Nor can it seek information from the parents' landlord or mental health, drug and alcohol, or domestic violence worker.

In many cases, the only way for Families SA to obtain information of this sort is to apply for an order in the Youth Court. That application is almost invariably accompanied by an application for a custody order, a significant escalation in any intervention. The court process is adversarial. It requires parents to attend court, often with legal representation. It documents concerns in a 'concise and ... collected fashion' which can be damaging to parents struggling with poor self-esteem, and can 'get in the way of therapeutic involvement'.¹¹

In practice, proceedings for investigation and assessment orders are rarely contested; if they are, the contest concerns the custody order, not the orders to access information.¹²

Information produced as a result of a court order comes late in the intervention. Broadening the Agency's information gathering powers would permit earlier access to information concerning risks to children and the capacity of their parents. This could result in earlier, more comprehensive assessments of child safety and parental need, and better targeted support for parents. While some cases may still require a court process, increasing the Agency's powers would avoid prematurely sending parties to Court.

Widening these powers would bring South Australia into line with most other Australian jurisdictions. Table 9.1 summarises the information gathering powers of statutory child protection agencies in Australia.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Table 9.1: Information the statutory agency can require without a court order, by jurisdiction

JURISDICTION	LEGISLATIVE PROVISION	TYPE OF INFORMATION	INFORMATION PROVIDER					
			POLICE	SCHOOL	PUBLIC HOSPITAL	GP	FAMILY MEMBER	OTHER
Australian Capital Territory	<i>Children and Young People Act 2008</i> , sections 858, 859, 862.	Information relevant to the health, safety or wellbeing of a child, including his or her family or someone else.	Yes	Yes	Yes	Yes	Parent, someone with parental responsibility or out-of-home carer.	Approved kinship and foster care organisation, Minister, school-related institution, health facility, government or community-based service that provides services to, or has contact with, the child or his or her family.
New South Wales	<i>Children and Young Persons (Care and Protection) Act 1998</i> , section 248.	Information relating to the safety, welfare or wellbeing of a child or class of children.	Yes	Yes	Yes	No	No	TAFE, prescribed organisation, public health organisation, private health facility.
Northern Territory	<i>Care and Protection of Children Act 2007</i> , section 34.	Information about the child or another relevant person (for example, a family member of the child).	Yes	Yes	Yes	Yes	Yes	'Person reasonably believed to have specified information', person employed by a government agency, operator of child-related services, health practitioner.
Queensland	<i>Child Protection Act 1999</i> , sections 159C, 159D, 159N	Information to help investigate alleged harm or risk of harm to a child or to help decide the need for protection, including information about the child's family or someone else.	Yes	Yes	Yes	No	No	Chief executive of adult corrections, community, disability, education, housing and public health services, or any prescribed entity that provides a service to children or families. Person in charge of a student hostel.

South Australia	<i>Children's Protection Act 1993</i> , section 19(2).	Written report on the examination, assessment, tests or treatment of a child.	No	No	Yes	Yes	No	'Person who has examined, assessed, carried out tests on or treated the child.'
Tasmania	<i>Children, Young Persons and Their Families Act 1997</i> , section 18.	Report concerning a child, guardian, significant person, person with whom the child resides.	Yes	Yes	Yes	Yes	Yes	Person who has examined, assessed, carried out tests on or treated the child or who may have information relevant to the child's safety, welfare or wellbeing.
Tasmania	<i>Children, Young Persons and Their Families Act 1997</i> , section 53B.	Information concerning the safety, welfare or wellbeing of a 'relevant person', which includes a person in respect of whom: the Secretary or a community-based intake service has received information under the Act, or an assessment or care and protection order is in force.	Yes	Yes	Yes	Yes	No	Mandated notifiers, state service officer or employee employed in a government department or state authority, manager of a private medical establishment; controlling authority of an approved hospital, approved assessment centre or secure mental health unit; person in charge of a disability services provider funded to provide specialist disability services to a child; person in charge of an organisation funded by the Secretary to provide drug and alcohol treatment services; person in charge of an organisation that receives a referral from the Secretary or a community-based intake service.
Victoria	<i>Child, Youth and Families Act 2005</i> , sections 192, 196.	None	No	No	No	No	No	N/a
Western Australia	<i>Children and Community Services Act 2004</i> , sections 23, 24A.	None	No	No	No	No	No	N/a

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Victorian and Western Australian legislation permits, but does not require, a range of information holders to share relevant information with the statutory agency. In Victoria, the statutory agency may require certain people to provide information in relation to a child who is under a protection order.¹³ All other jurisdictions in Australia give their respective statutory agencies considerably wider powers than South Australia to require access to information.

Chapter 21 recommends legislative changes in this state to clarify the duty of a range of agencies to share information relating to the health, safety and wellbeing of children. To complement this scheme, the power of the Agency to require other agencies to provide information should be broadened. The Agency should have the power to require information relating to the health, safety and wellbeing of a child, including information relating to other people (in particular the child's parents or caregivers), where this is relevant to a child's health, safety or wellbeing. Families SA should be able to require this information from all government, for-profit and not-for profit agencies that provide services to children and young people and their families, including those organisations in health, education, policing, juvenile justice, disability, housing, mental health, family violence, drug and alcohol services, community services, multicultural services, correctional services and the screening unit. Information should be provided promptly; and within 24 hours if the Agency advises that it is an emergency.

RESPONDING TO ALLEGED ABUSE OR NEGLECT

As discussed in Chapter 7, the Families SA Call Centre (the Call Centre) applies a response priority rating (Tier 1, 2 or 3) to screened-in child protection notifications. The tier rating determines not only how quickly Families SA should respond, but also the nature of that response.

INVESTIGATIVE RESPONSE FOR TIER 1 AND 2 MATTERS

Tier 1 receives the highest priority. The Call Centre refers Tier 1 and 2 intakes to a Families SA Assessment and Support team for an investigative response. Under Families SA policy, the response must begin within 24 hours for Tier 1 cases and between three to 10 days for Tier 2 cases.¹⁴ The nature of the investigative response depends on the concerns being examined, and includes elements of investigation and assessment:

Investigation encompasses the efforts to determine if abuse or neglect has occurred. Assessment goes beyond this concept to evaluate a child's needs, safety and risk, the family situation and environmental

context, and to determine whether and what services are needed to ameliorate or prevent child abuse and neglect, or to respond to the child's needs.¹⁵

More chronic cases, such as a child who is frequently absent from school and, when he does attend, is dishevelled and hungry, tend to call for an assessment. In these cases, it is more important to determine the circumstances that are preventing the family from meeting the child's needs than identifying the specific school absences or incidents of hunger. More acute cases, such as a head injury, need an investigation to determine the circumstances surrounding the particular incident. However, an investigation is usually complemented by a broader assessment of the child's and the family's circumstances.¹⁶

There is no clear delineation between assessment and investigation. Rather, they represent a continuum. Except where it is otherwise expressed, this report uses 'the assessment process' to encompass both investigation and assessment.

STRATEGY DISCUSSIONS

Strategy Discussions help agencies coordinate responsibilities during the assessment process. They should generally be held in Tier 1 cases and, if an agency considers it necessary, in Tier 2 cases.¹⁷ Families SA generally convenes the meeting¹⁸ and invites representatives from Families SA, SA Police and Child Protection Services.¹⁹ Attendees must be sufficiently senior to plan the response and commit resources. Meetings may be in person or by teleconference. They canvass information known about a family, decide the immediate response and develop a coordinated investigation plan.²⁰ Strategy Discussions can produce good outcomes by encouraging information sharing and coordinating responses.²¹ However, limited resources mean that Families SA practitioners do not always attend, or appear rushed and poorly prepared when they do. This can waste time and result in inaccurate information being shared.²²

A prompt Strategy Discussion is crucial in cases of suspected physical trauma, where Families SA support is needed to facilitate a forensic medical assessment. Yet Families SA's response is often slow and its after-hours Crisis Care response unit sometimes refuses to convene Strategy Discussions outside business hours.²³ This risks the loss of crucial evidence.

Strategy Discussions should be held without delay when children present with physical injury. More generally, the Agency should support practitioners to give Strategy Discussions the focus that they deserve: to convene them promptly, to attend thoroughly prepared and, when required, to re-convene the meeting at appropriate stages during the assessment process.

While Strategy Discussions can include other government and non-government agencies, at present, they are invited only sporadically.²⁴ These other agencies often have much to contribute to Strategy Discussions. Families SA should train and support its practitioners to invite additional agencies in appropriate cases.

The Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect (ICP) is the guiding document not only for Strategy Discussions, but also for broader inter-agency collaboration in the investigation of suspected child abuse or neglect in South Australia. An updated ICP, due to be released in July 2016, is a significant improvement in a number of respects. Where the previous version was weighted towards sexual abuse, the revised version addresses all forms of abuse and neglect. The revised version will apply not only to government agencies, but also to non-government agencies that provide relevant services.

Collaboration is important throughout the assessment process. The revised ICP encourages Families SA to act as lead agency and to coordinate service provision with other agencies throughout the assessment process.²⁵ The Agency should perform this role, including by re-convening Strategy Discussions in appropriate cases.²⁶

ASSESSMENT TRAINING

Families SA practitioners are guided in the assessment process by the practice framework, Solution Based Casework™ (SBC). The framework aims to improve consistency through providing a 'common conceptual map' for practitioners in Families SA and its partner agencies.²⁷ To this end, not-for-profit agencies funded to provide family support services are being trained in SBC.²⁸

SBC does not purport to be a complete statement of all that child protection practitioners need to know. For example, it does not provide specific criteria for decisions about risk. Rather, it gives a structure in which professional judgement can occur.²⁹ Moreover, while SBC offers knowledge on how to do an assessment, it cannot supply the experience that leads to practice wisdom: 'You can have the knowledge, but if you ... don't have a base to build it from, then it doesn't have as much meaning'.³⁰ This calls for broader training and ongoing clinical supervision.

As outlined in Chapter 5, the rollout of SBC training beginning in mid-2013 was truncated. Many Families SA practitioners are not accredited in SBC more than two years after its introduction. Families SA also froze all non-SBC training offered by its Learning and Practice Development Unit during the initial SBC rollout. In this period, practitioners lacked both adequate SBC training and alternative training in areas such as orientation to child protection or court work.³¹ Given the accepted limitations of SBC, this was a serious error that had a

disproportionate impact on assessment and support practitioners, a high proportion of whom are recent graduates. This is most unfortunate given the particular complexities of assessment and support work and the widely accepted need for ongoing, high-quality training, particularly for recent graduates.

The 'rule of optimism' describes the tendency of practitioners to sometimes reduce, minimise or remove concerns for a child's welfare or safety 'by applying overly positive interpretations to the cases they were assessing'.³² This tendency can result in children being left in situations of significant danger and experiencing prolonged trauma.

There is a risk that practitioners using SBC are overly optimistic when working with families. However, SBC should make it difficult for practitioners to minimise a family's problems. Practitioners are encouraged to gather details of problems and to identify how they arise in the life of a family. They are urged not to accept at face value what parents say, but to seek a variety of sources of evidence and to use 'straight talk'³³ to confront problems as they really are.³⁴ However, less confident practitioners or those with cursory exposure to SBC training who have not yet applied their knowledge in practice under clinical supervision may bring insufficient rigour to assessments and lose focus on the child.³⁵

CONFLICTING PRACTICE REQUIREMENTS

In addition to SBC, an Assessment Framework helps practitioners to assess the needs of children, families and carers through different stages of contact with Families SA. The framework contains developmental domains, principles of assessment and theoretical perspectives for practitioners as a 'consistent method of gathering, organising and interpreting information to better understand a child and their world'.³⁶ Practitioners must also use a series of decision-making tools that contain questions to guide assessments of risk and safety. These tools help practitioners to make these 'critical decisions with increased validity, reliability and consistency, and, importantly, to target scarce resources to those children and families at highest risk'.³⁷

The principles underlying SBC, the Assessment Framework and the decision-making tools are similar, but they use different language. Further, practitioners must complete three sets of documentation that require different information: SBC; C3MS, Families SA's electronic case management system; and the decision-making tools. The work to reconcile and integrate this documentation remains incomplete.³⁸

These requirements unnecessarily burden practitioners and are liable to cause confusion and inconsistent practice. As a priority, policies, procedures and pro forma documentation in this area should be rationalised.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

SUBSTANTIATION

At the end of an investigation, the practitioner (in consultation with the supervisor) decides whether abuse or neglect has occurred and records this decision, which is known as 'substantiation'. Substantiation is a professional judgment that must be supported by sound rationale based on the information gathered. It does not need to be to the criminal standard of 'beyond reasonable doubt'.³⁹

Table 9.2 compares the proportion of screened-in notifications that are investigated and subsequently substantiated.

Relatively few screened-in notifications are substantiated. Table 9.3 shows this is the case throughout Australia, although the rates vary significantly.

The significance of substantiation should not be overstated. Plainly, maltreatment does not occur only in cases where abuse or neglect is substantiated. This is for a number of reasons, which include that⁴⁰:

- the case may not be investigated or may be poorly investigated, including due to a lack of agency resources;

- there may be a differential response (see Chapter 8), which does not aim to establish whether maltreatment occurred; or
- there may be insufficient evidence of maltreatment or harm, particularly in cases involving young children.

Moreover, substantiation is not a strong predictor of risk of future maltreatment or other developmental harm. Future risk is similar in substantiated and non-substantiated cases.⁴¹

SAFETY AND RISK ASSESSMENTS

Separate to whether abuse or neglect is substantiated, Families SA practitioners complete safety and risk assessments. Safety assessments focus on present danger and immediate interventions needed to protect the child. In cases where abuse or neglect is substantiated, practitioners complete risk assessments to examine the likelihood of future maltreatment and whether ongoing services are needed.⁴²

Table 9.2: Screened-in notifications investigated and substantiated, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Screened-in notifications	17,290	16,947	16,932	19,160
Investigated (% of total)	5082 (29%)	5333 (31%)	6541 (39%)	5519 (29%)
Substantiated (% of total)	2139 (12%)	2221 (13%)	2739 (16%)	2335 (12%)

Note: Screened-in notifications include those assessed as Tier 1, 2 or 3, but exclude extra-familial matters, which are referred to SA Police. Source: Data provided by Families SA.

Table 9.3: Notifications and substantiations by state and territory, 2014/15

	NSW	VIC.	QLD	WA	SA	TAS.	ACT	NT
Notifications	126,146	91,586	22,350	16,828	22,040	13,560	10,633	17,026
Substantiations (% of total)	26,424 (21%)	14,115 (15%)	6435 (29%)	3623 (22%)	2335 (11%)	904 (7%)	595 (6%)	1992 (12%)

Note: This data should be read with caution as counting rules vary between jurisdictions. It excludes notifications that the relevant statutory agencies screen out as not meeting the threshold for a child protection notification. Notifications for South Australia in this table vary from data elsewhere in this report because they include extra-familial matters that Families SA refers to SA Police and that the Commission otherwise excludes as screened-in notifications.

Source: Productivity Commission, 'Child protection services', *Report on government services 2016*, Government of Australia, 2016, table 15A.5 and p. 15.48.

SAFETY ASSESSMENTS

Practitioners complete a safety assessment immediately after the first face-to-face contact with the family. Subsequent safety assessments occur during the life of a case, including if there is change in the family's circumstances or if safety interventions are not working. A safety assessment also occurs before the child returns home and before the case is closed.⁴³

Practitioners use a safety assessment decision-making tool to identify threats that could place the child in imminent danger of serious harm and potential responses to mitigate the danger. The following responses are listed in order of escalation:

- 1 Family, neighbours or other individuals are used as safety resources.
- 2 Community agencies or services are used as safety resources.
- 3 The alleged perpetrator leaves the home, either voluntarily or with legal action.
- 4 The non-maltreating caregiver moves with the child to a safe environment.
- 5 The child is placed outside the home by a voluntary placement with extended family.
- 6 The child is placed in foster care under a parental authorisation.
- 7 The child is placed in foster care under a Voluntary Custody Agreement.⁴⁴
- 8 The child is removed under section 16 of the Children's Protection Act.

If a child needs to be removed (points 6 to 8 above), the practitioner must record why less intrusive responses would not have been appropriate.⁴⁵

If the safety assessment identifies threats that could be managed, allowing the child to remain safely at home, the practitioner completes a safety plan. Safety plans should list short-term interventions and last for up to 30 days. They should list clear behavioural goals with short timeframes, so the parties are clear about the respective obligations of the parents and Families SA. Longer-term interventions should be recorded in a child's case plan.⁴⁶

RISK ASSESSMENTS

At the end of the investigation, practitioners complete a risk assessment to determine the ongoing level of service that Families SA will provide. A risk assessment decision-making tool guides the practitioner to consider risk factors that research indicates have a significant bearing on a child's risk of further abuse or neglect. The tool contains a series of questions and assigns a rating to families as having a very high, high, moderate or low probability of further abuse or neglect in the next 12 to 24 months.⁴⁷

There are mandatory overrides for situations that Families SA determines warrant the highest level of service, regardless of risk score. A discretionary override allows practitioners (with approval of the supervisor) to increase the risk level set by the tool.⁴⁸

The risk assessment tool ranks cases according to risk, but does not dictate what level of service cases should receive. Families SA policy states how the tool's ratings should be applied to manage workload: to determine when to close files and how much service to provide.⁴⁹ Table 9.4 shows how the assessment of risk determines the level of service.

Table 9.4: Families SA service level by risk assessment

RISK LEVEL	OPEN CASE	MONTHLY FACE-TO-FACE CONTACT
Very high	Yes	4
High	Yes	3
Moderate	Yes	2
Low	Optional	1

Source: Families SA, 'Child protection manual of practice', vol. 1, internal unpublished document, Government of South Australia, 2010, p. 214.

Low risk cases may be closed. Very high or high risk cases cannot be closed until a later reassessment demonstrates that the risk is lowered. Moderate risk cases should remain open, but may be closed with a manager's approval because of resource constraints. Risk is reassessed at three-monthly intervals and immediately before closure.⁵⁰

DEFICITS IN ASSESSMENT

The Commission observed Families SA assessments of numerous cases, including individual child case studies (see Vol. 2, Case Studies 1 to 4). The Commission reviewed 19 specific cases in its Cumulative Harm review and 60 C3MS case files in its Usual Practice review (see Appendix C). Some of these assessments were reported to the Commission as being concerning and warranting review. This potential bias was offset by the Usual Practice review, which randomly sampled cases notified to Families SA in 2013/14. Among all the cases assessed, the Commission observed some common themes on the part of Families SA practitioners, including:

- excessive optimism;
- concerns viewed in isolation;
- cursory investigations;

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- a lack of focus on the child;
- too little reliance on the expertise of other practitioners;
- too much reliance on the decision-making tools;
- inappropriate referrals; and
- unrealistic safety plans.

These issues are discussed below.

EXCESSIVE OPTIMISM

Many assessments were plagued by naïve optimism about the potential for extremely disadvantaged and poorly functioning families to change. There was repeated evidence of practitioners failing to understand the difficulty for people to overcome addiction and substance abuse problems, violent behaviour and serious mental health conditions. Children often suffered the consequences of misguided efforts, and were left in unsafe situations where they sustained further harm. The files demonstrated a clear preference for family maintenance and reunification: keeping families together at all costs. There was little evidence that practitioners understood the damaging effects of trauma on child development.

Similar observations have been made in recent South Australian coronial inquests. The inquest into the death of Chloe Valentine found that Families SA practitioners made unrealistic positive assessments of the mother's insight into Chloe's needs, despite longstanding child protection concerns and serious incidents of neglectful parenting. The Coroner noted they were 'blindly searching for something optimistic in this family picture, as if to reinforce their perceived success at intervention'.⁵¹

The inquest into the death of Ebony Simone Napier criticised the failure to remove Ebony from her parents' care before her death. Families SA's closure note reported an investigation had 'cleared' her parents of causing her leg fracture when, at best, her father's explanation was a possibility only and an 'intrinsically unlikely' one.⁵² The record exaggerated the parents' engagement with a support service in spite of their tendency not to engage except when it suited them.⁵³ The Coroner also observed a tendency to downplay the dangers of marijuana consumption, in the face of evidence that the father was aggressive and violent after smoking marijuana.⁵⁴

CONCERNS VIEWED IN ISOLATION

Families SA appeared to view interventions in isolation. Notifications were treated as discrete events, rather than opportunities to build a more complete picture of the child's situation. This meant information was lost over time, rather than accumulating from one report to the next. Practitioners seemed to assume that past problems had been resolved at case closure and did not take the

opportunity to review the rationale for decisions on previous notifications, such as those coded Notifier Only Concern or Closed, Abuse Not Substantiated.

Child neglect and abuse were viewed as episodic, rather than as part of a pattern, with serious consequences for the child's development and wellbeing. Risk factors such as poor care were not viewed as serious enough to warrant assertive intervention. Evidence of past incapacity to parent, including the removal of other children, was largely ignored.

As discussed in Chapter 7, the Families SA Call Centre decision-making tools encouraged an isolated view by not assigning weight to patterns of harmful behaviour or the effects of cumulative harm. Families SA accepts the need to review these tools to respond better to cumulative harm and neglect.⁵⁵

CURSORY INVESTIGATIONS

Families SA investigations often appeared cursory and incomplete. It was common to see a report of a home visit in which parents' responses to questions were accepted uncritically, only to be followed immediately by further notifications. It was rare to see the integration of material from other relevant sources and the development of a comprehensive picture of the child and his or her needs.

Assessment of children generally appeared simplistic and incomplete, with little or no recognition of the psychological, developmental and behavioural impact of traumatic, unsafe and chaotic environments. Families SA did not request timely, comprehensive developmental assessments of a child in any of the 19 cases examined in the Cumulative Harm review. This suggests a failure to understand fully the negative effect of abuse and neglect and its cumulative damage on children and the longer-term effect on their development. The lack of focus on child wellbeing was concerning, especially where family members, neighbours and professionals continued to identify cumulative harm and a lack of safety.

LACK OF FOCUS ON THE CHILD

An essential part of the assessment process should be listening to what the child has to say. If the child is too young to speak, the assessment should include speaking to a number of adults who can reliably describe the child's experience. When children can speak, they should be supported to do so and their views heard and given appropriate weight.

Children in care who participated in the Commission's consultation said they want to be treated with respect and have their opinions valued. They want to be able to participate meaningfully in decisions about their lives.

Essential to this process is that they are spoken with and listened to. One child said, 'Hearing the opinions of young kids is the most important thing'.⁵⁶

Yet, in the cases that the Commission examined, a focus on listening to the child was the exception, not the rule. The few examples where children's views were recorded did not seem to influence practice. In one example, a 13-year-old girl appeared desperate and despairing about living at home, where she resided with a known sex offender. The file recorded without comment, 'Kayla only wants someone to listen to her'. The closure of multiple notifications suggested that no one was listening.

'Kayla only wants someone to listen to her'

An orientation towards the family, rather than the child, prevailed, which tended to minimise the voice or needs of the child. In one case, a young boy said that his black eye was caused by a punch from his father. Families SA assessed the incident as 'not substantiated'. Outcomes such as these send a clear message to the child, the father and the notifier about the acceptability of this parental behaviour.

Some practitioners struggle when talking to children⁵⁷ and would benefit from specific training. Although SBC does not contain specific tools for talking with children, there are other useful tools that can complement SBC in this area, such as Three Houses, which helps a child or family think about and discuss risks, strengths, hopes and dreams.⁵⁸

TOO LITTLE RELIANCE ON THE EXPERTISE OF OTHER PRACTITIONERS

There was limited evidence of Families SA practitioners systematically using information from external services. When referrals were made (for example, to psychological, accommodation or health services), it was difficult to determine whether the referral had been followed up or had produced an outcome. If, for example, a psychological report was received, its recommendations were not clearly evident in case planning or ongoing intervention. Observations from hospitals, Child Protection Services or mental health services were regularly ignored or discounted, although the observers were in a position to watch parent-child interactions over significant periods and were skilled in assessment. This frequently resulted in a lack of timely intervention and children sustaining further harm.

Commission witnesses reported mixed experiences of working with Families SA practitioners. While some gave evidence of excellent inter-agency collaboration, others reported instances where Families SA practitioners appeared unwilling to take on board their observations and expertise.⁵⁹

TOO MUCH RELIANCE ON DECISION-MAKING TOOLS

The decision-making tools used by practitioners in Families SA are not a replacement for knowledge and understanding. The tools contain questions based on actuarial measures that guide risk and safety assessments and help determine Families SA's response. The tools often produce completely different ratings based on the same information, depending on the Families SA practitioner. Practitioners can apply an optimistic or pessimistic spin on information to produce the rating that they want.⁶⁰ Therefore the tools must be supplemented by sound theoretical knowledge and depth of experience.⁶¹

However, in the cases reviewed in the Usual Practice review, the use of tools did not appear to support the exercise of professional judgment. There was no evidence of critical commentaries on the parameters within the tools, nor on the final rating produced by the tools. The tools often appeared to be applied inconsistently and mechanistically. It was not uncommon to see incompatible responses on decision-making tool forms, which made the final rating almost nonsensical. It was common to see negative responses to many questions on these forms in the face of obvious evidence of high-risk circumstances.

INAPPROPRIATE REFERRALS

In many cases, Families SA practitioners appeared to refer families to support services in an inappropriate manner. There was no discussion with the agency as to the services that it could provide or whether rehabilitation was likely. Nor was there any follow-up with the agency to confirm that parents had kept appointments or achieved their therapeutic goals. Cases were simply referred, and closed, often without consultation with the notifier who had made the initial report. In numerous cases, the Commission observed referrals that did not address the risk to children, who went on to suffer further harm.

UNREALISTIC SAFETY PLANS

As discussed, safety plans have been used to prematurely close cases. The plans also have lost focus: no longer directed to short-term measures to secure immediate safety, they have become case-planning documents that address longer-term concerns with parents.⁶² As a result, it is often unclear when a safety plan has been breached and what consequences should follow. For example, in the Chloe Valentine inquest, the South Australian Coroner criticised the repeated use of safety plans despite the mother breaching earlier, similar agreements without apparent consequence.⁶³

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Child safety should not be entrusted solely to people in the child's life who have been unable to secure safety in the past. Good safety plans require monitoring by trustworthy third parties, such as a friend or family member, to ensure safety is maintained. The plans should address not only the symptoms, but also the behavioural causes, of past maltreatment. For example, a safety plan for an alcoholic father who hits his children when he is drunk cannot simply rely on his commitment not to drink. It should include the specific steps that he needs to take and external monitoring to ensure that the plan is honoured and the children are safe.⁶⁴

The Commission reviewed many safety plans in the course of its enquiries and found that many embraced unacceptable levels of risk to children. They betrayed excessive optimism about the capacity of parents, many of whom were clearly leading chaotic, violent and neglectful lives. Safety plans were frequently breached, only for Families SA to initiate a further plan without regard to the litany of previous failures. For example, one plan simply required a mother with a long-term alcohol problem to stop drinking and another left the safe management of a new baby with two very young and struggling care-leaver parents, without involving a specialised support service.

A witness described recent safety plans that appeared to be used as a substitute for more formal intervention, with files promptly closed after the plan was signed. The circumstances of these plans were as follows⁶⁵:

- A two-year-old girl was brought to hospital, unable to walk, having ingested methamphetamines after she was left in a room while her father and others smoked drugs. The child had been born with traces of methamphetamines in her body and there had been six previous child protection notifications related to her parents' drug abuse and trafficking. The mother was pregnant again and still using methamphetamines. The response was a further safety plan, despite the parents taking no responsibility for the situation.
- A 14-year-old girl alleged her brother and his friends had sexually assaulted her for a number of years, including tying her up, and that her mother did not protect her. The safety plan described the problem in terms of the child's 'sexual health'.

CONCLUSIONS CONCERNING ASSESSMENTS

The Commission expected to find examples of poor assessments: this is a function of high-risk, high-volume decision making. However, it was surprising and disturbing to find that the general standard of assessment in the cases reviewed was poor.

It is tempting to respond to poor decision making by recommending additional prescriptive requirements for child protection practitioners. Child protection reviews have a tendency to blame tragic incidents on human

error and recommend new ways to control professionals so they do not make mistakes. Common measures include increased psychological pressure to try harder, reduced scope for individual judgement by adding procedures and rules, and increased monitoring to ensure compliance with the procedures and rules:

Each addition in isolation makes sense, but the cumulative effect is to create a work environment full of obstacles to keeping a clear focus on meeting the needs of children.⁶⁶

Child protection involves complex problems that call for practice wisdom and professional judgement. Rather than prescription, the focus should be on investing in the professional workforce through rich professional training and clinical supervision, and fostering a culture that promotes ongoing learning and critical reflection.⁶⁷ These themes are discussed further in Chapters 5 and 6.

The nature of the assessment process may vary depending on the type of the concerns being investigated. However, the response should generally include the following minimum elements: a face-to-face assessment of the child and the family's circumstances, including a discussion with the parents, an opportunity to sight the child and, if the child can speak, to allow the child to describe his or her experience; an independent perspective on the family's and child's wellbeing, for example, from the child's doctor, school or childcare centre, or from a family, friend or neighbour; the notifier should also be consulted to ascertain whether they can shed further light on the situation.

In the short-to-medium term, the focus of practitioner training and supervision should be on addressing the key deficits in assessment identified above. To achieve this, Families SA should:

- acknowledge that its thresholds of risk and safety are too high and invest in training and clinical supervision to recalibrate assessments over time;
- view the life of a child as a continuum, rather than as a series of isolated incidents. Practitioners should reconsider past allegations in light of fresh concerns and consider whether the combination of incidents indicates an ongoing risk of cumulative harm;
- have the appetite to pursue a thorough assessment when it is required. Practitioners should acknowledge that the complexity of issues facing many families demands a thorough assessment, in particular to determine the cumulative effect of these issues on children. In those cases, evidence should be sought from a variety of sources and integrated to give an holistic picture;

- place greater emphasis on hearing, understanding and valuing the opinions of children. The Agency should invest in a tool, such as Three Houses, to help practitioners learn how best to listen to and talk with children;
- respect the knowledge and experience of child protection experts outside Families SA, and allow their views and concerns to play a greater part in the assessment process and planning interventions. Referrals to support services should occur in the context of a genuine, therapeutic partnership, with the Agency keeping its file open until it is satisfied that the therapeutic goals are being achieved;
- review the decision-making assessment tools to give sufficient weight to issues such as neglect, cumulative harm and social isolation, and train and supervise practitioners in how to respond proactively in these areas. Practitioners should be encouraged to depart from the tools where professional judgement suggests this is required; and
- avoid using safety plans as a substitute for more formal intervention. Safety plans have a defined, but limited, role in child protection practice. Practitioners should be realistic about the parents' capacity to change, and include effective monitoring in safety plans.

COMMUNITY RESPONSES FOR TIER 3 CASES

Tier 3 intakes receive a 'community response'. Until late June 2015, this meant practitioners were supposed to invite the parents by letter to attend a family meeting to discuss the concerns, usually at the Families SA office. The letter stated that concerns raised would not be investigated. Families SA did not generally visit the home or sight the child.⁶⁸

Table 9.5 shows the proportion of Tier 3 intakes where families were invited to a meeting and the proportion of invitations which resulted in families attending the meeting.

Few Tier 3 intakes resulted in an invitation and, in the past three financial years, less than half of the invitations resulted in a meeting. The number of invitations and meetings has steadily declined during the past four financial years, with only 33 meetings held in 2014/15.

There are problems with this approach. As a voluntary system, it allows parents to determine the statutory agency's response to suspected child abuse or neglect. Where parents decline or ignore the invitation, there can be no assessment of the alleged abuse or neglect. It also alerts parents that someone has notified Families SA, while assuring them Families SA will not take action unless they want it. This could cause parents to conceal future child maltreatment. It could also cause them to isolate themselves from, and/or seek retribution against, the person they believe made the notification. If the child disclosed the abuse, for example, to a school counsellor—or if a parent believes that he or she did—it could place the child in danger. Indeed, it may be better to take no action at all, than to respond partially to child protection concerns.⁶⁹

In 2003, the Layton Review criticised Families SA for responding to Tier 3 cases in this manner, stating this 'minimalist response' had 'serious implications' for the Agency. The review observed that Tier 3 cases may not require 'a heavy-handed "forensic" style of investigation', but without some form of assessment 'there is no way of knowing the extent of the problems facing the children and the family'.⁷⁰

In 2009, the Child Death and Serious Injury Review Committee (CDSIRC) criticised Families SA's use of letters to engage with a vulnerable parents, noting 'letters and other written communication are not appropriate for parents living in circumstances of multiple disadvantage'.⁷¹

In the case of James (see Vol. 2, Case Study 1), who was removed from his mother's care aged four years, Families SA received a Tier 3 notification 18 months before his removal and responded with a letter inviting his mother to attend a meeting. The letter drew no response and there was no follow-up. In fact, when the family disengaged from a support agency that had been involved, James slipped from view. James only returned to Families SA's attention after a police visit 18 months later, when he was found confined in a room, malnourished and close to death.

Table 9.5: Proportion of Tier 3 intakes invited to Family Care Meetings and attendance rates, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Tier 3 intakes	2316	1902	1466	1312
Family Care Meeting invitations to Tier 3 intakes (% of total)	279 (12%)	228 (12%)	182 (12%)	78 (6%)
Family Care Meetings attended by Tier 3 intakes (% of total)	141 (51%)	95 (42%)	60 (33%)	33 (42%)

Source: Data provided by Families SA.

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It is impossible to determine what response the letter would have received in James's household, but merely sending the letter may have heightened the risk to James by increasing his social isolation. It would have confirmed his mother's fears: she had allowed a service into her home and Families SA became involved as a result. In this case, the sending of a letter without any accompanying investigative or support response illustrates the danger of partial involvement possibly increasing the risk to the child.

In June 2015, Families SA introduced Linking Families (LF), which responds to all Tier 3 and some lower-risk Tier 2 intakes, and some Adolescent at Risk and Report on Unborn notifications. This phone-based service aims to refer families to relevant support services. As discussed in Chapter 8, there are several problems with LF.

Among these is the fact that some more serious Tier 3 cases require an investigative response from Families SA, rather than a service referral. This response may vary depending on the concerns being investigated, but should include the minimum elements listed above for Tier 1 and 2 cases.

WHERE THERE IS NO RESPONSE

As Table 9.2 shows, in 2014/15 less than 30 per cent of screened-in notifications attracted an investigative response. In some cases, an investigation is not appropriate. However, this decision should be determined by what will keep the child safe from harm, not what resources are available.

CLOSED NO ACTION

The code Closed No Action (CNA) identifies a case that has been closed with no action being taken, because there are 'insufficient resources to conduct the required investigation or family meeting ... after having weighed the relative case risk against other incoming child protection work'.⁷² CNA is applied only to Tier 2 and Tier 3 intakes.

CNA is used in a similar way to a code used by Families SA in the late 1990s, called Resources Prevent Investigation (RPI). When RPIs rose dramatically to 1014 cases in 1999–2000, the state government provided Families SA with additional funding to abolish its use.⁷³ CNA has effectively replaced RPI—and on a much larger scale. Table 9.6 sets out the amount of CNA use during the past four financial years.

The use of the code rose to 61 per cent in 2014/15. The percentage is not uniform across the state. For example, the Northern Assessment and Support Hub at Elizabeth received 5408 screened-in notifications in 2014/15 and coded 84 per cent as CNA.⁷⁴

Families SA policy forbids the closure of Tier 1 intakes for resource reasons. However, as shown in Table 9.7 and Figure 9.1, the CNA code is widely used in relation to Tier 2 and 3 intakes. In 2014/15, 63 per cent of Tier 2 intakes and 83 per cent of Tier 3 intakes were Closed No Action.

The Commission was told that allocation meetings at Families SA's Central Assessment and Support Hub do not even consider responding to Tier 3 intakes; they are simply coded CNA.⁷⁵

Table 9.6: Screened-in notifications coded Closed No Action (CNA), 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Screened-in notifications	17,290	16,947	16,932	19,160
Screened-in notifications coded CNA (% of total)	8240 (48%)	8460 (50%)	7923 (47%)	11,661 (61%)

Note: Excludes extra-familial notifications, which are referred to SA Police.

Source: Data provided by Families SA.

Table 9.7: Tier 2 and Tier 3 intakes coded Closed No Action (CNA), 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Tier 2 intakes	13,587	13,539	14,310	16,787
Tier 2 intakes coded CNA (% of total)	6764 (50%)	7198 (53%)	6935 (48%)	10,568 (63%)
Tier 3 intakes	2316	1902	1466	1312
Tier 3 intakes coded CNA (% of total)	1476 (64%)	1262 (66%)	984 (67%)	1090 (83%)

Source: Data provided by Families SA.

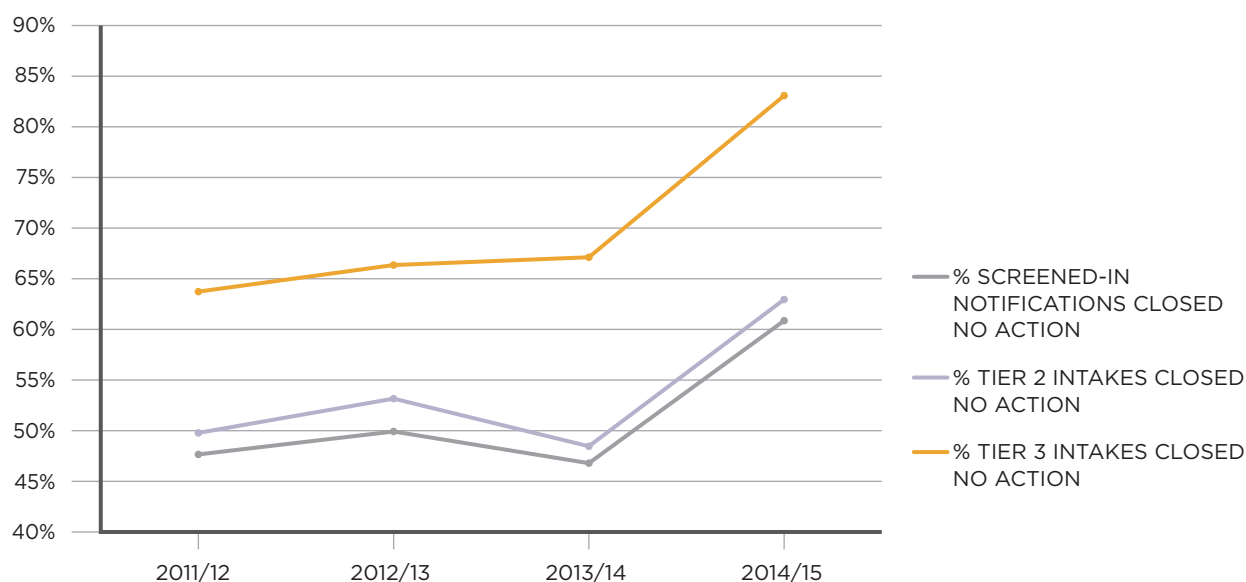


Figure 9.1: Percentage of intakes coded Closed No Action, 2011/12 to 2014/15

Source: Data provided by Families SA.

A child who is the subject of a notification that is coded CNA receives no service. In most circumstances, neither the child nor the child's family will even be aware that a notification has been made. It is curious that Families SA considers any inaction in relation to a notification of abuse and neglect to be acceptable. Once a concern has been screened-in, the agency has accepted that the information reveals a genuine child protection issue that requires a response. Any inaction on the basis of an overwhelming workload is patently unacceptable, and leaves many children living in risky and unsafe conditions.

To ignore a genuine child protection issue because of an overwhelming workload is unacceptable, and leaves many children living in risky and unsafe conditions

The response priority tool is not designed to screen notifications to determine whether a response is or is not required.⁷⁶ Rather, it is designed to assist an agency to prioritise responses. Determining how quickly a response should be provided is an entirely different matter to determining whether a service will be provided at all.

It is important to recall that Families SA Call Centre practitioners inevitably base their response priority on an incomplete picture of the child and their circumstances. There are usually significant other sources of information not available to the Call Centre, such as the child's

neighbours, extended family members, teachers or health practitioners. This information will not be captured at the point of intake, which relies only on the information from the notifier, supplemented by historical data that may be available on C3MS. To base a decision effectively to deny a response to a child with a screened-in notification on an incomplete picture is dangerous for the child.

It is no comfort that the CNA code is limited to Tier 2 and 3 cases. As noted in this chapter, the Commission has seen numerous examples of Tier 3 intakes that call for prompt assessments to determine the safety of the children involved.

Under Families SA policy, if three or more consecutive screened-in notifications in relation to a child are coded CNA, the next screened-in notification should be actioned unless a Director approves it being coded CNA.⁷⁷ Such approvals do not appear to be unusual: one witness reported having asked a Director to approve an eighth consecutive CNA in relation to one child.⁷⁸

Further, the policy is easily avoided. Screened-in notifications are not consecutive if there is an intervening screened-out notification. For example, if three consecutive Tier 2 intakes are coded CNA and the next is a Notifier Only Concern (because it does not reach the threshold to be screened in), a following Tier 2 intake can be coded CNA without approval.⁷⁹ Similarly, if Families SA codes three consecutive Tier 2 intakes as CNA, and then provides some intervention to a fourth Tier 2 intake before closing the file, a fifth Tier 2 intake could be coded CNA without the approval of a director.⁸⁰

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This is despite clear evidence that repeat notifications are a significant risk factor associated with problem behaviours, problems with peers, substance abuse, depression and anxiety, lower intelligence, poor sense of safety and stability, and reduced wellbeing.⁸¹

It is startling—and suggests acquiescence in the face of overwhelming demand—that Families SA policy would even contemplate the use of CNA in relation to four or more consecutive notifications.

OTHER CLOSURE CODES

As well as CNA, Families SA uses a range of other closure codes to justify making no response or a minimal response. They are ⁸²:

- Full Investigation Not Required (FNR)—Families SA contacts the notifier before speaking to the family and the notifier provides further information indicating an investigation is not needed.
- Refer Other Agency (ROA)—An agency working with the family agrees that an investigation is not required.
- No Grounds for Intervention (NGI)—Families SA has no role as the matter is being adequately responded to by others.
- Closed Not Located (CNL)—The family cannot be located, despite reasonable effort.
- Could Not Complete Investigation (CNCI)—Families SA initiates an investigation, but due to unexpected higher priority work, the investigation cannot be completed. Or, the investigation is stymied when the family refuses to respond.

There is reason to believe that Families SA's decision to use at least some of these codes is also based on resources, particularly CNCI. Further, the Commission heard evidence that workload generally forms part of the decision to use the FNR code, a code used even for Tier 1 intakes.⁸³

In the case of James (see Volume 2, Case Study 1), a Tier 2 intake received by Families SA soon after his birth was closed using the code FNR, on the basis that service referrals would be made by the Women's and Children's Hospital social work department. The use of the FNR code meant that the file was closed without any follow-up or monitoring of the service response. James's mother did not engage meaningfully with any of the services and there was no reduction in his level of risk.

The current use of CNA and other closure codes sends a message to children, parents, notifiers and the broader community that some concerns are not worthy of response and, by extension, that some children are not worthy of protection. The opportunity to intervene early is lost. In many cases, the opportunity to gather evidence of abuse or neglect is also lost, meaning from

an evidentiary perspective—though surely not from the *child's* perspective—it is as though the event never happened.

The current use of closure codes sends a message to children, parents, notifiers and the broader community that some concerns are not worthy of response and, by extension, that some children are not worthy of protection

The Agency should be resourced to respond to all screened-in notifications, either directly or, for low-level notifications, by referral to appropriate government and not-for-profit support agencies. This reflects the community's commitment to listen and respond to all children who are reasonably suspected of being at risk.

It is plain that the Agency's resources do not permit anything approaching this ideal. Indeed, there is reason to doubt whether the trained workforce currently available for recruitment is large enough to meet the task (see Chapter 6). The yawning gap between the commitment to respond to at-risk children and Families SA's resources has grown wider over successive years and will take time to close.

In this context, some decisions not to respond to at-risk children on the basis of resources, while unacceptable, is inevitable in the short term. Codes for the closure of files due to resources should be consolidated and practitioners given clear guidelines as to the circumstances of their use. The use of these closure codes should be tracked in accordance with consistent guidelines and the results made public at least quarterly, to allow the community to understand the limits of the Agency's capacity. The Agency should tell notifiers if it intends to use these closure codes on specific cases, to enable notifiers to take any other measures to care for and protect the child.

While the Agency should reduce the use of closure codes due to resources, it should resist measures that manipulate the rate of response without improving the health, safety and wellbeing of children. It can be tempting to deliver some services, thus avoiding the coding of a notification as a CNA, even though the nature of the service does not address the risk to the child. The Commission considers that this is all the Linking Families service does in many cases. The aim should be to improve safety, not statistics.

The Agency should aim to abolish the use of closure codes associated with resource demand within five years. To achieve this, it should project the level of demand and, together with Treasury, assess the resources required to meet this demand. This will be an inexact process to begin with as the system has been desperately under-resourced for a long period. Over time, providing improved, timely responses to vulnerable and at-risk families will moderate demand on the system. It is likely that regular reviews will be needed over successive years to ensure that resources continue to meet the task of responding assertively to at-risk children.

A MANDATORY RESPONSE?

Section 19(1) of the Children's Protection Act provides that where the Chief Executive 'suspects on reasonable grounds that a child is at risk' and 'believes that the matters causing the child to be at risk are not being adequately addressed', he or she:

Must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.⁸⁴ [Emphasis added.]

The options of 'assessment', 'investigation' or 'alternative response' mean the response may vary: a forensic investigation, a broader assessment, an alternative response from a support agency, or some combination of the three. Whatever form the response takes, the Act clearly envisages purposeful engagement to address the risk to the child. Understood in this light, section 19(1) sits uncomfortably alongside the current, widespread use of the CNA code.

Screened-in notifications are assessed by the Families SA Call Centre as meeting the definitions for abuse or neglect, and therefore they constitute suspicion 'on reasonable grounds that a child is at risk'. Section 19(1) also requires a positive belief 'that the matters causing the child to be at risk are not being adequately addressed'. This substantially reduces the provision's operation, because, without some investigation, it may not be known whether the matters are being addressed. However, in cases where the same concerns are re-notified over an extended period, it should be obvious that the concerns are not being adequately addressed. In those cases, the state of mind in section 19(1) plainly exists and the Agency should respond. Using CNA in these cases is not only dangerous, but also arguably unlawful.

Yet it should not take multiple notifications before an assertive response occurs, because in the meantime, concerns escalate and become entrenched and children experience prolonged trauma. Consistent with the aim to respond early to suspected abuse and neglect, section 19(1) should be amended to read:

(1) If the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.

The Act would continue to excuse the Agency from responding where proper arrangements exist for the care and protection of the child and the apparent abuse or neglect has been or is being adequately dealt with.⁸⁵ However, *ignorance* of whether the risk is being addressed would no longer excuse a failure to respond.

The amendment reflects the community's commitment, described above, to respond to all children who are suspected of being at risk. While the nature of that response may vary depending on the circumstances of the case, it would require an assertive response to address the risk to the child.

Consistent with the aim to initially reduce, and ultimately abolish, the use of closure codes because of resourcing issues, section 19(1) should be amended as above within five years, or earlier if resources permit.

REQUIREMENT TO SEEK ORDERS IN RELATION TO DRUG ABUSE

Section 20(2) of the Act provides that if Families SA is of the opinion that a child is at risk as a result of the abuse of a drug (including alcohol) by a parent, guardian or other person, it must apply for an order directing the person to undergo a drug assessment. An exception applies where a drug assessment of an appropriate kind has already occurred, or is occurring, and the results have been, or will be, made available to Families SA.

Section 20(2) was amended recently in response to recommendations made in the Chloe Valentine inquest. The Coroner strongly criticised Families SA for not seeking an order requiring the mother to undergo a drug assessment. He found that there was at least one occasion, and probably several, when Families SA workers must have suspected on reasonable grounds that the child was at risk due to drug abuse. This criticism was well-founded.⁸⁶

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Drug abuse rarely occurs in isolation, but in combination with other concerns, such as mental health, domestic violence, physical abuse and neglect. Nor does the court see applications for an order for drug assessment in isolation. Rather, this order is sought in conjunction with other assessment orders and invariably an application for custody.⁸⁷

The abuse of drugs poses significant risks to children. The Commission observed numerous cases where practitioners made unrealistic assessments of parents with substantial drug abuse problems, leaving children in unsafe situations where they sustained further harm. Yet this reflects the broader issue discussed above that Families SA's thresholds of risk and safety are too high and require recalibration. This approach places children at risk, not only because of drug use, but also because of other issues, including family violence, mental illness, physical abuse and neglect.

The amended section 20(2) selects drug abuse for special treatment, when what is needed is an assertive response to protect children from all types of abuse and neglect. In some cases, the response will require an application for court orders, for example, for drug assessment. In those cases, the Agency should not hesitate. However, it is unrealistic to prescribe by legislation when such an application should occur. This is a matter for professional judgment by trained, experienced practitioners under ongoing clinical supervision and supported by clear organisational policy as to the importance of responding to protect children from all types of abuse and neglect. A legislative mandate would mean that workload management efforts would focus on the need to comply with legislation to address particular kinds of risk, potentially neglecting other, equally serious, types of risk.

As this chapter observes concerning orders to access information, when Families SA seeks a court order requiring parents to undergo a drug or alcohol assessment, the application is invariably uncontested. This burdens the court with applications that are not opposed and has the potential to drive the parties into an unnecessary adversarial process.

Section 20(2) should be repealed. In its absence, section 20(1) would permit but not compel the Agency to commence proceedings to seek an order requiring a drug or alcohol assessment in appropriate cases.

Further, the Act should be amended to empower the Agency, if it suspects a child is at risk as a result of the abuse of drugs or alcohol by a parent, guardian or other person, to issue a written direction requiring them to submit to an assessment, with the results to be provided to the Agency. The direction would be binding unless the parent disputes the grounds on which the direction is made, in which case the matter would be referred to

the court for consideration. Failure to comply with a valid direction would be relevant to decision making under the Act (including in subsequent court proceedings), for example, when assessing a parent's capacity or willingness to make the changes necessary to safely care for the child. Failure to comply would not give rise to any other civil or criminal liability.

ROLE FOR SPECIALIST ASSESSMENT

In complex cases, the assessment process is aided by independent, expert assessments. Psychologists perform a range of assessments to examine a child's development, intelligence, and emotional and behavioural functions, as well as the quality of the parent-child relationship and the effect of trauma in the child. Psychiatrists diagnose mental illness or disorder in children or their parents. With additional training, supervision and mentoring, social workers can also undertake parenting capacity assessments.⁸⁸

Families SA's Psychological Services unit performs much of this assessment. It also maintains a panel of private psychologists and psychiatrists experienced in child protection, whom it engages to perform assessment work.⁸⁹

The Child Protection Services (CPS) units at Flinders Medical Centre (FMC) and the Women's and Children's Hospital (WCH) perform forensic medical assessments and forensic interviews of children. The units also employ social workers and psychologists to perform parenting assessments.⁹⁰ The assessments are labour intensive and take about six weeks to complete. The units have limited capacity and refuse many referrals each year.⁹¹ In some cases, the assessment never happens and Families SA intervenes without properly identifying the problem.⁹²

This is a particular issue in the northern suburbs. The Lyell McEwin Hospital (LMH) is South Australia's second-largest birthing hospital, and is located in an area with a very high proportion of families from low socioeconomic backgrounds.⁹³ Yet it does not have a specialist CPS unit. Although it receives support from the other CPS units, LMH lacks permanent medical staff with specific expertise in child protection, who can provide leadership and consistency in this difficult area of practice. Further, children who require forensic medical assessments, forensic interviewing and parenting assessments must travel to either WCH or FMC.⁹⁴

The government should establish a CPS unit at LMH to service the high assessment and therapy needs in the northern suburbs of Adelaide.

Families SA's Redesign process proposed to bolster assessment capacity by training social workers to undertake a range of assessments, with only the most complex cases referred to Families SA psychologists. Critically, the proposal did not address how this model would ensure independence and objectivity.⁹⁵ It is unrealistic to expect Families SA caseworkers, who have ongoing relationships with parents and children, to provide entirely independent, expert assessments.⁹⁶

Even in Families SA's Psychological Services unit, psychologists experience subtle pressure to affiliate with Families SA and to adopt its mindset.⁹⁷ The Senior Judge of the Youth Court said experts in the court sometimes appear 'a little partisan', presenting reports that resemble 'a final argument by an advocate'.⁹⁸ He said they should be 'more balanced' and better grasp their role as independent experts.⁹⁹ The judge said this applies not only to experts employed by Families SA, but also to those who depend on referrals from the agency.¹⁰⁰

As discussed below, many expert witnesses who appear in the Youth Court express concern that the court does not readily accept their evidence. The perception of partisanship described by the Senior Judge no doubt contributes to this.

The Commission recommends that the Act be amended to provide an independent model of expert assessment, similar to the Children's Court Clinic (CCC) in New South Wales,¹⁰¹ where the Children's Court may make an 'assessment order' for the assessment or physical, psychological, psychiatric or other medical examination of a child. The CCC may also appoint a person to assess the capacity of a person with, or seeking, parental responsibility (with the consent of that person). In either case, the court must appoint the CCC to prepare the assessment, unless the CCC is unable to do so or views it as more appropriate for another person to do it. The report prepared by the CCC is regarded as a report to the court, rather than as evidence tendered by a party.¹⁰²

The CCC is part of the Sydney Children's Hospitals Network, NSW Department of Health. It employs a core team of expert clinicians who conduct assessments. It also engages a panel of accredited private psychiatrists, psychologists and social workers across NSW, known as authorised clinicians, to conduct assessments. Importantly, authorised clinicians must advise of any actual or potential conflict of interest that might impair their objectivity in making assessments. Being an employee of the statutory child protection agency is stated to be a 'clear conflict of interest'.¹⁰³

In South Australia, the two existing hospital-based CPS units offer high-quality, independent assessment services. Together with a new CPS unit at LMH, these units could form the basis for an expanded independent assessment model that is similar to the CCC.

Most of the assessment function of the Families SA Psychological Services unit should be transferred to the hospital-based CPS units, with a portion remaining in Families SA to provide in-house psychological expertise for day-to-day training and practitioner advice, and to offer therapeutic support to children in the care of the state.

Court-ordered assessments would be performed either by CPS or by an approved private assessor from a panel managed by CPS. CPS should establish panels of government, private and not-for-profit organisations that could provide parenting, mental health and drug and alcohol assessments. CPS should also establish procedures and audit the work of these service providers to ensure the delivery of consistent, high-quality, child-focused assessments. This measure would improve confidence in the quality and independence of expert assessments and, in particular, remove the perception that providers might lose work if a recommendation displeases the Agency.

These changes may take some time to implement. In the meantime, the Psychological Services unit should embrace external peer mentoring and supervision, and establish professional links with experienced external psychologists in South Australia to provide this support. This will help address the pressure on staff to conform to a common mindset.¹⁰⁴

PROTECTIVE INTERVENTION

In some cases involving very serious abuse and neglect, an assessment will conclude that parents are incapable of making the changes necessary to provide safe care for the child. In these cases, Families SA seeks to place the child in alternative care according to a long-term order.

Most cases, however, are less clear cut: the assessment process may determine that the child is at risk of harm, but with intervention the parents may be able to address that risk. Protective intervention (PI) describes services provided by Families SA and other agencies that seek to address the issues that cause children to be at risk, to enable them either to remain in their parents' care or to return there safely.

There are two forms of PI: family preservation services and reunification services. Family preservation services work with families to overcome safety and risk concerns and to reduce the risk of future harm while children remain in their parents' care. Reunification services work with families whose children have been removed, seeking to address the concerns so the children can return when it is safe to do so.¹⁰⁵

9 INTERVENTION WHERE THERE IS IMMINENT RISK

REFERRALS TO PROTECTIVE INTERVENTION

As outlined in Chapter 5 Families SA's Redesign process reorganised metropolitan offices, creating specialist hubs. In this model, practitioners in assessment and support hubs respond to new cases. If the assessment process determines the family should be referred to protective intervention, the Assessment and Support hub transfers the case to a PI hub, subject to criteria.

In reunification cases, where the children have been removed, these criteria include¹⁰⁶:

- completion of the investigation and case notes;
- completion of all risk, safety, family reunification and family strengths and needs assessments; and
- the existence of a care and protection order for custody or guardianship for up to 12 months, a Voluntary Custody Agreement or a Family Care Meeting Agreement.

In family preservation cases, where the children remain at home, the criteria include¹⁰⁷:

- an assessment of risk as high or very high;
- an assessment of safety as safe or conditionally safe;
- the existence of an open child protection case with no order, a Family Care Meeting Agreement that includes family preservation services, or a supervision order with a written undertaking;
- that there is no likelihood of the children entering care in the next two to three weeks and a reasonable possibility that intervention will prevent the child entering care; and
- that there is no investigation or assessment order, care and protection custody or guardianship order, or interim court order in existence.

Under the model, PI hubs were to have specialist teams responding to either family preservation or reunification cases. In practice, high demand for reunification services has meant family preservation teams often respond to a mixture of cases.¹⁰⁸

Regional offices continue to have collocated PI, Assessment and Support, and guardianship teams. In these offices, files are transferred from an assessment and support team to a PI team at the conclusion of the assessment process.

Families SA PI practitioners work in partnership with not-for-profit service providers in the Family Support Services (FSS) program.¹⁰⁹ In 2014/15, FSS cost about \$11 million, which was distributed among six providers providing three services: targeted intervention, family preservation and reunification.¹¹⁰ The current service providers are¹¹¹:

- Centacare Catholic Family Services
- AnglicareSA
- Aboriginal Family Support Services (AFSS)
- ac.care (Anglican Community Care Inc.)
- Centacare Catholic Diocese of Port Pirie
- UnitingCare Wesley Port Pirie.

Families SA also funds some smaller PI providers, such as Connecting Families. In addition, government-run specialist reunification programs, such as the Infant Therapeutic Reunification Service and the Adolescent Late Stage Reunification (ALSR) model (see boxes), target specific age groups.

Regarding ALSR, Families SA supports the concept of late-stage adolescent reunification where children are not in stable placements or abscond to their parents, but historically this support has been limited to situations where the child already has frequent contact and a safe relationship with her or his parents, making safe return possible. By contrast, ALSR proactively builds the capacity of families so they can resume care.¹¹²

The Commission tentatively endorses the ALSR model as a pragmatic response to a small group of very vulnerable children for whom alternative care is neither safe nor nurturing. The promise of this model should not be overstated. Evidence suggests poor outcomes for older children in care who return to their parents' care.¹¹³ It will be important to closely monitor outcomes for children involved in the ALSR. Indeed, late-stage reunification arguably represents, in many cases, the system's *failure* to offer a child safe, stable out-of-home care that supports his or her development.

The Infant Therapeutic Reunification Service

The Infant Therapeutic Reunification Service (ITRS), which is located at the Women's and Children's Hospital, offers a service for children aged less than three years. It typically works with the parent and child together once a week for up to two years. The service also offers individual therapy to parents with their own trauma issues. It is intended that when the ITRS ceases working with a family and the family is reunified, another service will continue working with them in a family preservation context.

The ITRS offers therapeutic assessment to assist the court during care and protection applications, as well as long-term therapy for infants being reunified with parents. Through timely assessment the service aims to provide support before problems become entrenched or disrupt the infant's development. The ITRS also helps train staff who work for other child protection services in working with infants and supporting successful reunification.

The Adolescent Late Stage Reunification model

In November 2015, the South Australian Government announced the Adolescent Late Stage Reunification (ALSR) model, committing \$4.7 million to the service over four years. ALSR aims to respond to the rising numbers of young people residing in small and large residential care facilities under long-term orders, particularly those who abscond frequently and are reported as missing, by reunifying them with their families.

The ALSR will target 30 families a year with intensive support services for an average of six hours a week during the reunification stage and three hours a week thereafter for up to 12 months. Like other reunification services, ALSR uses Solution Based Casework (SBC) as a framework to formulate case plans. This is to ensure that plans have clearly defined goals to address the challenges facing the family that led to the adolescent's removal and that are barriers to his or her return. Parents are referred to services that will address their individual needs, such as substance abuse programs, and the young person will be linked to universal services, such as educational, vocational and medical services.¹

¹ Families SA, 'Service model proposal—Adolescent reunification', internal unpublished document, Government of South Australia, 2015, pp. 23, 27–8, 34–5.

STRONGER PARTNERSHIP IN PROTECTIVE INTERVENTION

The PI model relies on a strong partnership between Families SA and Family Support Services (FSS) providers. The Families SA PI practitioners assess whether families are ready for reunification or family preservation services and then refer them to the FSS provider. Families SA prepares the intervention goals and retains case management, while the FSS provider provides casework services specific to the family's needs. Families SA ensures regular communication between the FSS worker, the parents, the parents' support worker and any other professionals involved, including monthly review meetings to discuss progress in relation to the case plan.¹¹⁴

Families SA PI practitioners are also expected to do direct casework before referring to the FSS provider. They spend time building trust and rapport with families to assess their willingness to work with the FSS provider. They use SBC to work intensively with families to identify challenges, address safety concerns and assess parents' capacities. Indeed, the hub structure aims to allow PI practitioners to do more direct work with families before referring cases to FSS providers.¹¹⁵

In practice, sometimes it takes months before Families SA refers to an FSS provider. For the child Abby (see Vol. 2, Case Study 2), it was not until six months into the short-term order that her mother was referred to a reunification provider. This requires families to adjust to a new service team at a late stage. In reunification cases, this approach leaves limited time to work with the FSS provider before the first short-term order expires and makes it more likely that a second short-term order will be needed.¹¹⁶

Many families find it difficult to work with Families SA, particularly after it has investigated them or removed their children. The not-for-profit sector is often better placed to build rapport and to work directly with parents.¹¹⁷ Using not-for-profit agencies also means the court potentially has access to assessments independent of the Agency, as discussed above.

The Agency should confine its role in PI work to case management. Before referring to an FSS provider, The Agency needs to assess whether the family appears willing and able to address child protection concerns in a timeframe that is consistent with the child's needs. This assessment should occur promptly to allow the FSS provider time to engage meaningfully with the family. Moreover, it should be recognised that FSS providers may succeed in engaging families where the Agency cannot and that the primary therapeutic relationship for families should be with the FSS service provider, not the Agency.

Income management

Income management¹ is often presented as an option for families in the child protection system. As noted in the inquest into the death of Chloe Valentine, the Commonwealth and South Australia have entered into a bilateral agreement for the implementation of income management.² The parties have agreed to use income management as a tool to achieve the following outcomes for the care and protection of children:

- A portion of the individual's relevant welfare payments is quarantined to meet the priority needs of any dependent child.
- The wellbeing of the child is improved as a result of the intervention.
- The individual's ability to manage their income for the benefit of themselves and their children is improved.

In March 2016, the federal government started a trial of compulsory income management in Ceduna, in which 80 per cent of welfare payments was quarantined to a cashless debit card that cannot be used for alcohol or gambling.³ The results of this trial may increase knowledge about the effectiveness of compulsory income management.

There is limited evidence that income management improves financial health or has other positive outcomes for vulnerable children and families. The evidence that exists is poor in quality, meaning the conclusions should be interpreted with caution. There is some evidence that limited improvements in housing and financial stability as a result of income management allow individuals to invest in behavioural change. However, it also appears that sustainable changes may be limited because income management may increase welfare dependency. When income is no

longer quarantined, individuals often slip back into old spending habits. Income management is also easy to circumvent.

Of concern, after income management was implemented in the Northern Territory, substantiated cases of child maltreatment increased by 44.5 per cent and the proportion of child neglect cases doubled. Many people on income management reportedly experience shame, embarrassment and stigma.

Income management appears to be more successful when recipients are not compelled but volunteer to take part, and when families engage with additional services and commit to changing their behaviour. The most vulnerable families, with multiple and complex needs and prolonged involvement with the child protection system, are less likely to engage in this manner and do not appear to benefit from income management as much as might be expected.

If income management is implemented, it should form part of a package of services and supports to address the holistic needs of vulnerable children and families. Limited access to services in remote communities may limit positive outcomes. Individual assessments should be conducted before referring welfare recipients to income management to ensure it is suitable for their circumstances and that appropriate additional services can be put in place.

Considering the lack of conclusive evidence that income management has positive outcomes, as well as the practical and emotional hurdles that the program causes individuals, compulsory income management in isolation from other services and support should be avoided.⁴

¹ Further information on income management is contained in S Parkinson, *The effectiveness of child protection income management in Australia: A report to the Child Protection Systems Royal Commission*, Australian Centre for Child Protection, Adelaide, July 2015, www.agd.sa.gov.au/child-protection-systems-royal-commission.

² The Coroner criticised South Australia's lack of implementation of the Bilateral Agreement and recommended Families SA pursue compulsory income management: Coroners Court of South Australia, *Finding of the Inquest into the death of Valentine, Chloe Lee*, Inquest 17 of 2014, pp. 133-41.

³ Department of Social Services, 'Families and children: Income management', webpage, DSS, Australian Government, April 2016, www.dss.gov.au/our-responsibilities/families-and-children/programmes-services/family-finance/income-management

⁴ Oral evidence: A Elvin; K Brettig; name withheld (W11).

As case manager, the Agency should set the case goals, coordinate the ongoing interventions and, together with the other agencies involved with the family, periodically review progress towards achieving the case goals. Ultimately, Families SA should assess on the basis of the assessments of the FSS provider and any other professionals involved whether the child is safe to return to, or to remain in, the parents' care.

A CLEARER FOCUS ON THE NEEDS OF CHILDREN

If not-for-profit agencies assume a more prominent role in the delivery of PI services, it is vital that all practitioners maintain focus on the needs of children. There should be realistic, ongoing appraisals of whether arrangements continue to be in children's best interests, to ensure their needs are not forgotten amid efforts to address their parents' problems.

COMPLEX PROBLEMS

Families involved in the child protection system typically have multiple, complex problems. By the time a PI response occurs, problems have often become entrenched. Further, children who are exposed to a prolonged period of trauma tend to have more pronounced needs and require more specialised parenting. Addressing multiple, complex issues is difficult work, requiring PI services to respond to families on several fronts.¹¹⁸

A study of South Australian children who entered care for the first time between 1 January 2006 and 31 December 2007 found that 88.7 per cent had been exposed to between four and 10 social and family background risk factors. Only 9.7 per cent had between one and three risk factors.¹¹⁹ Studies of children in Victoria and Tasmania have identified similar patterns.¹²⁰

A SHORT DEVELOPMENT WINDOW

It may take parents months or years to address issues sufficiently to safely care for their children. Yet children cannot wait indefinitely:

*A 'child's time' in the crucial early years is much shorter than the 'adult's time'. A young child cannot wait for the parents to solve their persistent personality problems, childhood traumas, drug abuse and violence. A child cannot be put 'on hold'.*¹²¹

As outlined in Chapter 3, infants develop an attachment relationship towards their primary caregiver when they are between about six months and four years of age. A secure attachment supports children's physical, social and emotional development, their ability to form positive relationships, their concept of self and their ability to take risks, accept challenges and cope with failure. Conversely, an insecure attachment during infancy and early childhood makes children susceptible to a host of socio-emotional problems and future academic and psychiatric problems.¹²² Abusive or neglectful

parents expose their children to 'highly confusing and contradictory parental behaviours' that jeopardise the development of a secure attachment relationship.¹²³

Children have a small developmental window for parents to address their problems. Leaving children with abusive or neglectful parents, placing them in unstable, temporary alternative care arrangements or moving them back and forth between the two prolongs and compounds their trauma. It places them at heightened risk for attachment disorders and a 'deep incapacity to trust the adults who want to care for them'.¹²⁴

Children have a small developmental window for parents to address their problems

Purposeful family preservation and reunification services should support parents to quickly make the changes needed to safely care for their children. If parents cannot make these changes in a timeframe consistent with their children's needs, then the focus should shift to finding stable, long-term alternative carers with whom children can develop a secure attachment to support their development.¹²⁵

PURPOSEFUL FAMILY PRESERVATION

Family preservation is typically a late-stage intervention. Even at this stage, some parents are able to make use of supports to safely care for their children. For other parents, services come too late to address their difficulties in the timeframe their children need.

Evidence suggests parents who are motivated to change tend to do so quickly. A 2010 study examined 57 infants aged less than one year, who were involved in the United Kingdom child protection system. The study followed 43 children to their third birthday. Of the children who remained with their birth parents at age three, 43 per cent were considered to be at continuing risk of significant harm from parents whose situation remained largely unchanged or had deteriorated. The parents of the remaining children had made sufficient changes to be able to offer satisfactory care for the child. Significantly, all but one of these parents who made sufficient changes did so before the child was six months of age.¹²⁶

The study, although small and in another country, does illustrate that 'early action can be fair to parents as well as in the child's best interests'.¹²⁷ Parents who are motivated to change often experience a defining moment, such as the birth of a baby, the permanent removal of an older child, the death of a close relative from substance abuse, or the realisation they need to disengage from a violent relationship, which helps them to see that they must take substantial action to meet their child's needs.¹²⁸

9 INTERVENTION WHERE THERE IS IMMINENT RISK

In this chapter, the Commission has criticised Families SA's excessively optimistic assessments about parents' capacity to change, its preference for keeping families together at all costs, and its acclimatisation to abusive or neglectful family situations. The concerns apply with equal force to family preservation work. These factors cause children to be left in families where they experience ongoing abuse or neglect. The unfocused use of safety plans poses particular dangers for family preservation work, by giving the false impression that concerns are being addressed, while children remain in danger.

Family preservation services should be purposeful, with regular assessments to ensure the situation remains in the children's best interests. Cases should not be permitted to drift, allowing children to be left in dangerous situations with parents who make no or minimal effort to address the issues that place their children at risk.

Cases should not be permitted to drift, allowing children to be left in dangerous situations with parents who make no or minimal efforts to address the issues that place their children at risk

TIME-LIMITED REUNIFICATION

Reunification efforts that continue indefinitely prevent children from forming strong bonds with stable, long-term alternative caregivers. Conversely, if children are returned too early to unsafe family situations, they are at risk of further trauma in their parents' care and disruption in the event of a return to alternative care.

Reunification services should be purposeful and have a time limit. They should be guided by clear-sighted assessment to determine if the parents have made sufficient changes to allow the children to return home. If the parents do not make these changes in a relatively short timeframe, then reunification efforts should cease and the children should be maintained in a settled and permanent care arrangement.

Families SA policy recognises that timely decision making is particularly important for young children due to the critical periods of development for both the brain and attachment relationships:

Expert opinion is that for younger children in particular, a decision about reunification should not take longer than six to twelve months.¹²⁹

Families SA's evidence-based, reunification assessment tool recommends reunification efforts for infants aged under 12 months should be abandoned after they have been in care for six consecutive months, or nine of the past 12 months. For children over 12 months, reunification should cease after they have been in care for 12 consecutive months, or 15 of the past 24 months.¹³⁰ Overriding the tool requires permission from a principal social worker.¹³¹

Similar timeframes apply in New South Wales¹³² and Victoria¹³³, as well as the United Kingdom and United States of America.¹³⁴

Not only do these timeframes meet children's need for stability, they also allow for the time it takes most parents who are able to resume the care of their children to do so. As noted, most parents who do make adequate changes, do so quickly.¹³⁵

Children who go home usually do so within the first six months of entering care, with probability decreasing rapidly thereafter.¹³⁶ An Australian study tracked, over two years, 1337 children who had entered care in South Australia, Tasmania or Victoria in 2006 or 2007. Of the children who returned home within two years, 57 per cent did so within the first three months, 73 per cent by six months and 89 per cent by 12 months.¹³⁷

In practice, the recommended timeframes are routinely overridden in South Australia. One Families SA practitioner could not recall ever achieving reunification within six months.¹³⁸ Reunification efforts tend to be pursued too long, with ordinary cases taking one to two years or longer.¹³⁹

The case study of Abby (see Vol. 2, Case Study 2), an Aboriginal girl who was removed from her mother's care aged two months, is instructive on this topic. A psychological assessment warned that reunification should not be pursued for more than six months because of her attachment needs. The same assessment observed that Abby's mother faced substantial challenges in making the changes that would be necessary to resume care. Yet Families SA persisted with reunification for more than two years, despite the mother repeatedly failing drug tests and attending access with Abby under the influence of drugs. Families SA also failed to concurrently plan for Abby's long-term care needs. After she had resided in stable care with non-Aboriginal foster parents for 18 months, Families SA made the decision to move Abby to live with interstate relatives who could support her cultural needs, rather than leave her with foster parents with whom she had developed important attachments. Excessive optimism and the pursuit of reunification at all costs were clearly evident.

Table 9.8: Number of children reunified in South Australia, by time in care, 2012/13 to 2014/15

	2012/13		2013/14		2014/15	
	NO.	%	NO.	%	NO.	%
Total reunified	139	100	184	100	142	100
Reunified in first six months	60	43	95	52	71	50
Reunified after six to 12 months	63	45	51	28	44	31
Reunified after 12 to 24 months	0	0	4	2	2	1
Reunified after more than 24 months	16	12	34	18	25	18

Note: Relates to children returned to their parents after a period in care according to the Children's Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data provided by Families SA.

Table 9.8 shows how long it takes children in South Australia to be reunified with their parents.

Most children who return home do so in the first 12 months. However, in 2013/14 and 2014/15, nearly one-fifth of children took more than two years to return, which implies an extended period of instability.

RISKS CAUSED BY INAPPROPRIATE REUNIFICATION

Many children who are reunified with their parents subsequently return to care. This is troubling because children who move in and out of care tend to have 'the worst overall outcomes', facing increased risks of developmental trauma and of never finding a safe, stable alternative care placement.¹⁴⁰

Table 9.9 shows the number and percentage of South Australian children reunified over the past three financial years who returned to the Minister's care within six and 18 months.

About one-fifth of children reunified in the past two financial years returned to care within six months. Twenty-eight per cent of those who returned to care in 2013/14 did so within 18 months (data for 2014/15 is not yet available). These figures are high even over the relatively short timeframe being examined.

Table 9.9: Children reunified and subsequently re-entering care in South Australia, 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Children reunified	139	184	142
Children returned to care within six months of reunification (% of total)	20 (14%)	38 (21%)	28 (20%)
Children returned to care within 18 months of reunification (% of total)	33 (24%)	51 (28%)	Not yet available

Note: Relates to children returned to their parents after a period in care according to the Children's Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data provided by Families SA.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Another measure of reunification success is to consider the proportion of children who are returning to care. Table 9.10 shows these figures for the past three financial years.

Table 9.10: Children re-entering care in South Australia, 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Children entering care	877	761	960
Children entering care who had previously entered care (% of total)	356 (41%)	367 (48%)	347 (36%)

Note: Relates to children in the care of the state according to the Children's Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data provided by Families SA.

More than one-third of children entering care in each of the past three financial years were returning to care. In 2013/14, the figure was nearly half. These figures underscore the precarious nature of current reunification practice.

High rates of return to care are not limited to South Australia. A United Kingdom study reviewed 138 neglected children who had returned to their parents at some time in 2001.¹⁴¹ After two years, 59 per cent had been exposed to further abuse or neglect. After five years, 65 per cent were no longer in their parents' care, 67 per cent had returned to care at some stage and 72 per cent were subject to a child protection plan.¹⁴²

Another UK study tracked 149 children for an average of four years. The children had been maltreated and spent time in care at some point in 2003/04. Of the 68 children who were reunified, 59 per cent returned to care at least once and one-fifth experienced more than one reunification attempt.¹⁴³

Other British studies variously found that 37 per cent, 40 per cent and 52 per cent of children returned to care after having been reunified. Larger reviews in the USA that were based on agency database records indicate that between 19 per cent and 24 per cent of reunified children return to care within two years.¹⁴⁴

Nor should the results for children who succeed in returning permanently to their parents' care be exaggerated. Evidence from the UK and USA suggests these children tend to experience poorer emotional and behavioural outcomes and a heightened risk of further abuse or neglect than those who remain in care.¹⁴⁵

CONCLUSIONS ABOUT PROTECTIVE INTERVENTION

Family preservation and reunification services work with parents with multiple, entrenched, complex problems. Their children typically have complex behaviours and require particularly attentive care because of their exposure to unsafe circumstances. While some families can meet this challenge consistently and over the long term, it is not surprising that many cannot.

The Agency should review the quality of protective intervention services and assessment in South Australia. Its service accountability division should invest in robust and independent evaluations of the services in which they invest.

PI clearly benefits some children, but it is no panacea and should not be pursued in every case, particularly where parents are unable or unwilling to address their problems. The evidence underscores the need for purposeful, evidence-based interventions, and careful assessment to ensure PI remains in the best interests of individual children and, where children are reunified, that families receive appropriate, ongoing support.¹⁴⁶ This approach to family preservation and reunification services should be aided by the legislative reforms discussed below, which shift the balance towards settled, stable care arrangements that secure children's health, safety and wellbeing.

Protective intervention clearly benefits some children, but it is no panacea and should not be pursued in every case, particularly where parents are unable or unwilling to address their problems

FORMAL, VOLUNTARY INTERVENTIONS

Some parents are willing to address their problems, but benefit from a formal structure in which to do it.

SUPERVISION ORDERS

Families SA can apply to the court for a supervision order, which requires parents to undertake, in writing, to do or not to do certain things for up to 12 months. This allows a child to remain with his or her parents, as long as the parents agree to meet basic standards of care or to attend therapy. Under this order, the court may also require the child to be under the supervision of the Chief Executive or some other specified person.¹⁴⁷

Supervision orders are rarely used. While they require a complete, detailed court application, including the preparation of a court report, referral to the Crown Solicitor's Office, participation of a children's representative and attendance at court, they lack any effective review mechanism. The court's role is complete on making the order. If parents do not comply with undertakings, Families SA may pursue them for contempt of court (a punitive option unlikely to be helpful from a child protection perspective) or commence fresh child protection proceedings.¹⁴⁸ Yet breaching the undertaking may not be a sufficient basis on which to commence fresh proceedings. This leaves many parents effectively unaccountable for their promises and Families SA with 'a lot of responsibility, but no power to actually enforce it'.¹⁴⁹

It is also peculiar and cumbersome for the court to *direct* a person to make such promises. While there is benefit in a forum where parents may make formal, specific commitments to address the problems that place their children at risk, directing parents to make such commitments is potentially counterproductive.

Supervision orders should be abandoned in their current form. Section 38(1)(a) of the Act should be repealed. Family Care Meetings (FCMs) are a more appropriate forum for parents to make formal, specific commitments as part of a broader plan to secure the child's care and protection. FCMs involve participation from relevant agencies involved with the family and offer a more flexible review process to ensure parents, family members and support agencies follow through on their commitments.

FAMILY CARE MEETINGS

The Act provides that if Families SA is of the opinion that a child is at risk and arrangements should be made to secure his or her care and protection, a FCM should be convened.¹⁵⁰ Families SA refers the matter to the Conferencing Unit, a division of the Youth Court that employs coordinators to convene FCMs. The coordinator invites attendees and facilitates decision making at the meeting.

The FCM allows the child's family, together with the coordinator, to make informed decisions about arrangements to secure the child's care and protection.¹⁵¹ The following people may attend¹⁵²:

- The child (unless the coordinator views it is not in his or her best interests);
- The child's parents or guardians;
- Other family members who, in the opinion of the coordinator, should attend;
- A person who has a close association with the child, who should, in the opinion of the coordinator, attend the meeting;

- Support people for the child or the parents or guardians (but not a legal practitioner);
- A Families SA employee;
- If persistent absenteeism from school is involved, a school representative;
- The child's advocate, if one has been appointed;
- Any person nominated by the coordinator who has examined, assessed, counselled or treated the child in the course of the investigation into the child's circumstances;
- Any other person nominated by the coordinator for the purpose of providing expert advice or information on matters relevant to the meeting; and
- If the child is an Aboriginal or Torres Strait Islander child, a person nominated by a recognised Aboriginal or Torres Strait Islander organisation.

The FCM generally consists of three parts¹⁵³:

- 1 Information exchange—where Families SA clarifies the child protection concerns. Other professionals involved with the family may present their assessments and recommendations. The child advocate speaks to the meeting about the child's wishes and views.
- 2 Family time—where the family spends time together (without the other parties) to develop a plan to address the concerns at the meeting. Importantly, the family is asked to respond to the concerns as presented by Families SA and the professionals, rather than to minimise or debate them.
- 3 Negotiation—where the coordinator mediates between Families SA and the family to clarify the final plan and try to reach agreement.

Where possible, decisions are made by consensus. The coordinator records the decisions for signing by the parties, if they agree with the decisions. However, as the Act is construed in practice, decisions are considered valid even if Families SA does not agree, provided the coordinator considers they secure the child's care and protection.¹⁵⁴

Many witnesses told the Commission they supported FCMs as a concept. However, there was widespread dissatisfaction that they do not achieve their true potential.¹⁵⁵

FCMs are based on the family group conference (FGC) model that began in New Zealand in 1989 and exists in one form or another in more than 30 countries and several jurisdictions in Australia.¹⁵⁶ At its heart, FGC lets family members formulate a plan to address the statutory agency's concerns. When the agency's concerns are adequately addressed, preference is given to the family's plan 'over any other possible plan'.¹⁵⁷

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Research about FGC is promising, but it does not yet demonstrate improved longer-term outcomes for children. Families tend to be satisfied with the process, which usually produces an agreed plan, but only a minority of plans are fully implemented. Models of FGC also vary widely between jurisdictions, making comparison difficult.¹⁵⁸ There is a specific need for research about the use of FCMs in South Australia.¹⁵⁹

COMPULSORY REFERRALS

Under the Act, an FCM must generally be held before the Minister applies for a care and protection order for the custody or guardianship of a child.¹⁶⁰ This promotes an unhelpful link between FCMs and the commencement of legal proceedings. In 2013/14, the Youth Court Conferencing Unit held 338 FCMs and 36 reviews of FCMs. In about 83 per cent of matters referred to the Conferencing Unit there was already a court order in place.¹⁶¹ For those matters, Table 9.11 shows the time between the referral and the date on which the order was due to expire, which is commonly when the matter must return to court.

Table 9.11: Average days between referral to the Youth Court Conferencing Unit and expiry of the court order, 2010 to 2014

	2010	2011	2012	2013	2014
Days	19	19	27	20	16

Source: Data provided by the Youth Court Conferencing Unit.

The time between the referral and the expiry of the court order rose in 2012, when Families SA directed its staff to refer cases to FCMs earlier.¹⁶² However, the 2013 and 2014 figures show the impetus was not sustained. The result is that Families SA continues to refer matters to FCMs in the shadow of court proceedings. By this stage, Families SA's relationship with parents has often deteriorated and concerns have escalated to a point where it is difficult for a family plan to avoid the need for court orders.

This limits the scope for productive planning by the family to address the concerns.¹⁶³ For FCMs to be effective, they should occur at an earlier time.¹⁶⁴

The effectively compulsory nature of referrals means many matters referred are unlikely to be assisted by the process.¹⁶⁵ For example, when:

- parents dispute the basis of the child protection concerns or refuse to discuss them;
- Families SA views that the concerns are too serious to avoid a court order; and
- parents have diminished capacity and cannot make informed consent to any 'agreement'.

Further exceptions could be built into section 27(2) of the Act to excuse calling an FCM in these situations. However, the scope of the necessary exceptions emphasises that a quasi-compulsory scheme is inappropriate. Instead, the Agency should have discretion over whether a matter should be referred for an FCM.

The Layton Review made a similar recommendation, but it was not implemented.¹⁶⁶ Like the Layton Review, the Commission is of the view that section 27(2) should be deleted. Section 27(1) should be amended to reflect the principle that the Agency should consider causing an FCM to be convened when the Minister is of the opinion that a child is at risk and the apparent risk is capable of being addressed by decisions by the child's family at an FCM. Section 49 should continue to allow the court to refer matters to an FCM where appropriate.

CULTURAL SHIFT

If the Agency is to be entrusted to exercise this discretion appropriately, it should thoroughly embrace the philosophy behind FCMs. Families SA policy acknowledges cultural challenges regarding FCMs:

Although the safety of the child or young person remains paramount, the emphasis on family decision making requires relinquishment of some of the powers usually held by professionals over planning for the care of children subject to statutory intervention. This requires a willingness to acknowledge the strength families have to determine appropriate care for their children, and to accept a radically different role in supporting family decisions rather than deciding what those decisions ought to be.¹⁶⁷

However, this cultural shift has not been consistent, with some practitioners approaching FCMs as a formality before litigation, rather than as a collaborative process.¹⁶⁸ The Conferencing Unit reports that practitioners do not want to share decision-making power and rarely engage genuinely in the process.¹⁶⁹ This has possibly been compounded by minimal recent contact between Families SA and the Conferencing Unit, and Families SA's suspension of FCM training at the start of the Redesign process.¹⁷⁰

The Agency should approach FCMs collaboratively, and be willing to accept the family's plan to the exclusion of other plans, where it achieves the safety of the child. This cultural shift requires explicit training, reinforced by supervision and peer support. The relationship between the Conferencing Unit and the Agency should be improved by more frequent contact.

ROLE OF COORDINATOR

An FCM decision cannot be valid unless the Conferencing Unit's coordinator believes it properly secures the child's care and protection. There is no corresponding requirement that Families SA must agree with the decision.¹⁷¹ The Conferencing Unit considers the FCM is successful if the family has a proper opportunity to develop a plan that the coordinator considers secures the child's care and protection.¹⁷²

However, there is no point in recording an agreement which does not have the support of all the parties. There is no point in parents incorporating support from Families SA or other agencies in their plans if the agencies are not prepared to provide the support. Nor is there utility in deciding the child should remain with parents or other family members without a court order, if Families SA disagrees and proceeds to court. If an agreement is ignored and the parties proceed to court, the FCM 'could be experienced as disempowering, rather than empowering'.¹⁷³

More fundamentally, the scheme positions the Conferencing Unit's coordinator as a significant actor, the effective arbiter of the child's best interests. The coordinator can determine whether the family's plan addresses Families SA's concerns, even if Families SA is adamant that it does not. Evidence from both the Conferencing Unit and Families SA showed that coordinators and Families SA workers frequently disagree in this matter.¹⁷⁴

This places the coordinator in opposition to Families SA, as the statutory agency, and creates a process more akin to arbitration than mediation, upon which FGC is based. Yet there is reason to doubt whether coordinators, in the context of their brief, episodic involvement in FCMs, can safely form a concluded view as to a child's care and protection, if it contradicts the views of Families SA and other professionals who attend the FCM.

This more active role of the coordinator in this state represents a significant departure from the principles of FGC. In New Zealand, families lead decision making, but the statutory agency must agree with their proposed outcome:

*The family is empowered to work with the child protection worker to reach an outcome **acceptable to both**, or to choose to disagree, with the knowledge that the matter might be referred to the court.*¹⁷⁵
[Emphasis added]

Under FGC guidelines from the USA, family groups 'lead decision making and agencies agree to support family group plans *that address agency concerns*' [Emphasis added].¹⁷⁶ The coordinator 'convenes and guides' the process, but is not a 'facilitator' in the sense of a professional with 'a more elevated, active and central role

in the family meeting'. Rather, the coordinator 'minimizes his or her own voice and presence in the meeting by bringing forward significant pieces of information as quickly as possible'.¹⁷⁷ If the parties cannot agree, the coordinator asks the family how it would like to proceed, including offering to reconvene at a later date.¹⁷⁸ There is no sense that the coordinator might validate the family's plan in the face of the agency's opposition.

FCM coordinators should play a less active role, convening and facilitating meetings and encouraging a collaborative process where the family prepares a plan that satisfies the Agency's concerns. Section 36(6) of the Act should be amended so that a valid decision requires agreement of the family and the Agency, not the FCM coordinator. Ultimately, if agreement cannot be reached, the court will resolve the matter definitively. However, there should be greater willingness to adjourn FCMs where necessary, rather than to attempt to conclude an agreed plan in a single session. Families may need time to contemplate before finding a solution.¹⁷⁹ The Agency's practitioners should approach meetings well prepared and with an open mind. However, less experienced practitioners may need time to consider and consult with colleagues about more complex issues that may arise.

As the Act stands, FCMs include people with a close association with the child, who should, in the opinion of the coordinator, attend the meeting. Foster parents arguably fall within this definition, but are not usually invited. In the case of Abby (see Vol. 2, Case study 2) no one appeared to consider whether the child's foster parents should have been invited. While it is neither necessary nor appropriate for foster parents to attend every FCM, in some cases they can offer important insight into the child's circumstances. The policies of the Conferencing Unit and the Agency should be amended to include the need to consider whether in appropriate cases a child's foster parents should be invited to an FCM.

STATUS OF FCM DECISIONS

As discussed above, research concerning FGC in other jurisdictions suggests that only a minority of plans are fully implemented.¹⁸⁰ There has been no research in South Australia on the implementation of FCM decisions. However, Families SA's apparent lack of enthusiasm for the process and the fact that decisions may be imposed by the coordinator do not augur well for the implementation of the plans. Even where Families SA does support the decision in writing, it is under no express legal requirement to carry out its terms.

By contrast, legislation in New Zealand requires the statutory agency to give effect to FGC decisions, plans and recommendations, unless they are clearly impracticable or inconsistent with the principles of the legislation.¹⁸¹

9 INTERVENTION WHERE THERE IS IMMINENT RISK

Some witnesses were content with the current status of FCM decisions, viewing them as a 'working agreement'.¹⁸² In contrast, the Conferencing Unit told the Commission that FCM decisions should be filed in court and formalised as consent minutes of order.¹⁸³

Promises by family members to do or not to do specific things to address the child protection concerns should be formalised in writing and filed in court. However, such commitments should not have the status of a court order. In light of the entrenched nature of parental problems, it is likely that a proportion of commitments will not be followed, yet it would be unhelpful to prosecute parents for any such failure. Instead, the FCM decision should have the status of a formal commitment known to all the parties and to the court, upon which any of the parties may rely in future proceedings, if appropriate.

As occurs in New Zealand, the Agency should be required by legislation to give effect to FCM decisions (which would be agreed by the parties, not imposed by the coordinator), unless they are impracticable or inconsistent with the principles of the legislation. This would include the Agency providing family members with support, as agreed. If circumstances change, or the plan becomes impractical or inconsistent with the child's safety and wellbeing, then Families SA should not unilaterally abandon the agreement. Instead, it should reconvene an FCM to review the plan or commence court proceedings.

FCM decisions vary in format and are somewhat vague.¹⁸⁴ If they are to bind the parties, they should be expressed clearly so the parties understand their obligations. Template commitments should be drafted and coordinators should receive specific training regarding their use.

The Conferencing Unit can review FCMs, but this is rare. In 2013/14, it held only 36 reviews.¹⁸⁵ If the parties agree, the plan is being followed and the risks are being addressed, there may be no need for a review. However, as a general rule, FCM decisions should be reviewed after three months, with the parties able to request earlier and/or subsequent reviews, if required. This holds parties to their commitments and allows plans to be refined over time.

PARTICIPATION OF CHILDREN

When the Commission spoke to children in care, one of their key desires was to participate in processes and be heard. They identified that even young children can be asked to 'write or draw' their stories or 'paint or draw a picture on how he/she feels'.¹⁸⁶

Children are invited to FCMs only if the coordinator views it is in their interests.¹⁸⁷ In practice, children do not attend, except as babies, due to the length and structure of the meetings and concern it might cause emotional harm.¹⁸⁸

The Conferencing Unit would like children to attend more often. However, it states that even though this is rare, FCMs are still 'focused on the child's voice'.¹⁸⁹ An advocate attends the FCM to speak on the child's behalf and in the child's best interests. Advocates are paid only an honorarium and it is difficult to attract candidates. They are generally community members and do not require minimum qualifications or training.¹⁹⁰

For a time, a Legal Services Commission (LSC) children's lawyer based at the Youth Court represented children in all Adelaide-based FCMs. However, the workload became too great and this ceased.¹⁹¹

FCMs are a less formal, legal process that, with the exception of the child's advocate, excludes lawyers.¹⁹² For this reason, the child advocate need not be a lawyer. However, advocates would benefit from training about child development, the effect of abuse and neglect, and how to speak to children. They also need explicit guidelines about how to approach the task, including when to act as a best interests representative as opposed to a direct representative. In the absence of training and guidelines, the quality of representation is likely to vary substantially.¹⁹³

The Conferencing Unit should recruit, train and fund a panel of child advocates who can represent children in FCMs. All child advocates should submit a valid child-related employment screening clearance. If it is not possible to recruit sufficient suitable advocates by paying an honorarium, the Conferencing Unit should be funded to provide adequate remuneration to advocates. The Conferencing Unit should consult with the proposed Children's Commissioner and the Agency about suitable training for advocates, and prepare guidelines to assist advocates in their task. The guidelines should encourage advocates to meet with children, to help them understand the purposes of the meeting and how the child may be involved. Advocates should work with children to find safe ways for them to participate in the FCM: for example, by attending the meeting or part of it, by writing down or drawing what they want to convey, or by being videotaped offsite for screening at the meeting.¹⁹⁴ The Conferencing Unit should regularly offer performance feedback to child advocates. Poor quality advocates should be removed from the panel.

STATUTORY INTERVENTION

In some cases, the only option to secure children's safety is to remove them, at least for a time, from their parents' care.

VOLUNTARY CUSTODY AGREEMENT

A Voluntary Custody Agreement (VCA) is a short-term option. Parents agree to transfer custody of the child to the Minister for up to three months. The parties may extend this for a period up to six months. The parents may revoke the VCA at any time.¹⁹⁵

Families SA policy permits VCAs to be used in limited circumstances to resolve conflicts that threaten family breakdown, or to care for children at risk where the parents agree that there is a need for intervention. The relevant issues must be likely to be resolved within three months. VCAs are not used in cases where¹⁹⁶:

- the intent is to seek court orders at the expiration of the VCA;
- the issues are longstanding and are unlikely to be resolved within three months;
- the intent is to leave the child in the home under a safety plan;
- the parents do not acknowledge the severity of the problems or their responsibility to address them, or are unable or unwilling to work in partnership with Families SA;
- the parent has a moderate to severe intellectual disability;
- the child has sustained serious inflicted injuries.

ORDERS FOR CUSTODY OR GUARDIANSHIP

Families SA may seek a court order placing the child in the custody of the Minister. In the first place, this usually involves an application for investigation and assessment orders, described above. The court may order that the child be placed in the custody of the Minister for up to six weeks to facilitate the assessment process. If the assessment process has not been completed at the end of six weeks, Families SA can seek a four-week extension.¹⁹⁷ Applications for custody are rarely contested and are invariably successful. Between 1 July 2013 and 30 June 2014, the court granted every application for an investigation and assessment custody order.¹⁹⁸

If a child is in a situation of serious danger and it is necessary to remove the child to protect him or her from harm, Families SA has the power to do so using necessary force.¹⁹⁹ Families SA has until the end of the following working day to determine whether it is safe to return the child to parental care or whether to make an urgent application to the court for a custody order.²⁰⁰ In the 12 months to 24 February 2016, 60 per cent of investigation and assessment order applications were urgent.²⁰¹

Families SA may also bring care and protection proceedings, seeking custody or guardianship for up to 12 months (a short-term order) or for guardianship until the child turns 18 (a long-term order).²⁰²

The number of court applications made by Families SA has recently increased. Table 9.12 compares the number of child protection applications (investigation and assessment, and care and protection) commenced in two 12-month periods.

Investigation and assessment applications rose sharply, while care and protection applications increased by a relatively modest 12.3 per cent. This rise follows the Chloe Valentine inquest, which ran from 14 August 2014 to 9 April 2015. The inquest was heavily publicised and criticised Families SA's failure to seek court orders.²⁰³

Table 9.12: Number of child protection court applications commenced by Families SA

	NON-URGENT I&A APPLICATIONS	URGENT I&A APPLICATIONS	TOTAL I&A APPLICATIONS	C&P APPLICATIONS
1/7/2013 to 30/6/2014	83	125	208	326
25/2/2015 to 24/2/2016	149	221	370	366
Percentage increase	79.5%	76.8%	77.9%	12.3%

Note: I&A = investigation and assessment; C&P = care and protection

Source: Data provided by the Crown Solicitor's Office, Attorney-General's Department, South Australian Government.

THE COURT PROCESS

CHILD REPRESENTATION

Children must be represented by a lawyer in child protection proceedings unless the child makes 'an informed and independent decision' not to be represented.²⁰⁴ The Legal Services Commission (LSC) employs a lawyer who is based at the Youth Court and represents most children in child protection proceedings. This includes those who reside in metropolitan Adelaide and those who, because of age or disability, cannot be interviewed by a lawyer. Regional lawyers represent children who can be interviewed and reside outside metropolitan Adelaide.²⁰⁵

The child's representative acts on the child's instructions unless the child is not capable of properly instructing a lawyer. In that case, the lawyer acts 'according to his or her own view of the best interests of the child'.²⁰⁶ In practice, lawyers represent very young children based solely on their view of the child's best interests, informed by the evidence. Lawyers interview children who are aged about four years and over, and convey to the court both the child's wishes and the lawyer's views as to the child's best interests. As children grow in their ability to understand their situation and the court proceedings, lawyers place more emphasis on the child's instructions.²⁰⁷

There are different models of child representation in Australia. The Family Court uses a best interests model, where lawyers form an independent view based on the evidence of the child's best interests and act accordingly. The lawyer is *not* the child's representative and is not obliged to act on the child's instructions.²⁰⁸

Victoria has a direct representation model. Children aged 10 years or older must be legally represented, unless the court determines they are not mature enough to give instructions. The lawyer must follow the child's instructions 'so far as it is practicable to do so having regard to the maturity of the child'.²⁰⁹

Each model has strengths and weaknesses. Direct representation gives children an active voice in proceedings, consistent with their right to be heard.²¹⁰ It avoids role confusion as children readily understand that their wishes and instructions will be followed and the role for lawyers is clear and 'consistent with the fiduciary duties a lawyer owes to his or her client arising from the nature of the relationship'.²¹¹ However, direct representation has the potential to place pressure on children to express a wish that may put them in opposition to parents.²¹² It also assumes that children are capable of giving instructions that can be acted on, when this may not be the case:

For children whose instructions are 'I do not want to choose' or 'I will tell you, but I do not want you to tell anyone else' or 'I just do not know', the model presents

*great difficulties. It does not accommodate these children's desire to participate in the proceedings on their own terms.*²¹³

The best interests model does not prevent the views of children being communicated to the court, but allows children 'to express an opinion without feeling responsible for the ultimate decision'.²¹⁴ It need not be inconsistent with the right of children to be heard.²¹⁵ However, the role can be confusing for children when *their* lawyer does not act in accordance with their wishes and for lawyers who have no instructions and are not bound by the wishes or directions of the child.²¹⁶ The model also causes many children to feel marginalised.²¹⁷ It is a mistake to assume that children are less able to instruct a lawyer than adults: 'Many children have the maturity and judgment to direct their lawyer, just as many adults have limited maturity and poor judgment but instruct legal representatives'.²¹⁸

A review by the Australian Law Reform Commission (ALRC) in 1997 concluded:

*Ultimately the needs of children differ to such an extent that there can be no single model appropriate for all children. Children vary greatly in their capabilities, maturity and desire for involvement in litigation concerning themselves and their families. A form of representation suitable for an articulate child at 14 may not be appropriate for a younger or pre-verbal child ... The role of a child's representative should remain fluid.*²¹⁹

The model as it operates in practice in South Australia strikes the right balance. It is flexible in that it permits children to participate to the extent that they are able and willing, while allowing their representative to speak on their behalf to the extent that they are not.²²⁰

The Act would benefit from amendment to clarify this position. The current provision presents representation as a binary role: either direct representation if the child is able to instruct or best interests if not. In practice, younger children may be able to provide some instructions that may be supplemented by submissions from their lawyer as to best interests. The Act should be amended to require the child's lawyer:

- to act in accordance with the child's instructions to the extent the child is able and willing to give such instructions;
- to supplement this with his or her own view of the child's best interests to the extent the child is not able and willing to give instructions (provided that the lawyer's views do not contradict any instructions the child is able and willing to give);

- to indicate the nature of the role to the child, in accordance with the child's developmental capacity; and
- to indicate to the court on which basis submissions are made.

The ALRC recommends detailed standards for children's representatives:

*The basis of representation and the roles and functions of the representative should be clear to the court, the representative and the child concerned. This requires clear ethical and practical standards for all representatives to ensure that there is appropriate participation of and engagement with the child.*²²¹

In 2007, the Law Society of South Australia published *Guidelines for Lawyers Acting for Children*.²²² The guidelines provide that a lawyer must not act as a direct representative and a best interests' representative in relation to the same child. This is based on New South Wales guidelines, which observe that the direct representative relationship 'is established under a different set of circumstances and may have encouraged the child to be more open ... than with a best interests' representative'.²²³

This caution may make sense in jurisdictions with a clear distinction between direct representatives and best interests' representatives, particularly where lawyers act as a direct representative, for example, in criminal proceedings, and then act for the same child in a best interests' capacity. However, there is nothing unethical or inappropriate in lawyers acting in the dual role envisaged by the Children's Protection Act provided that he or she is clear with the child and the court at the outset about the nature of that role. The Law Society of SA recently withdrew the guidelines for revision. The revision should reflect the dual role envisaged by the Act.

At times, the court must consider urgent applications to secure a child's safety before a lawyer has the opportunity to interview the child. The court's practice is to appoint a lawyer to act for the child, to make interim orders and then to adjourn until the lawyer can speak to the child.²²⁴ Yet no express power authorises this practice. The Act should be amended to permit the court either to appoint a representative in such cases or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the matter so a properly instructed lawyer can represent the child. These changes were recommended by the Layton Review, but not implemented.²²⁵

The Youth Court advised the Commission that the number of hearings requiring the participation of a children's representative was rising: in 2014/15, they were almost double those in 2013/14. If this trend continues,

the state government should seriously consider increasing the resourcing of the child representative service.

DIRECT PARTICIPATION BY CHILDREN

Under the Act, children (whether represented by a legal practitioner or not) must be given a reasonable opportunity to give their views personally to the court about their ongoing care and protection, unless the court is satisfied that the child is not capable of doing so or it would pose a risk to the child's wellbeing.²²⁶ In practice, direct participation only occurs in the small number of cases that proceed to trial. One explanation for this is confusion about the process. The Legal Services Commission advises lawyers:

*As [direct participation] is done not in chambers, but in court in front of all parties, it is likely to be daunting to a child, and the child's separate representative will ask them whether they want to talk to the Court.*²²⁷

In fact, there is no requirement for children to attend open court and the court's practice is for children to speak to the judicial officer informally at the bar table, without the other parties. A transcript is prepared and retained in the event of appeal, but not routinely provided to the parties.²²⁸

While not all children are able or willing to participate directly, there is too much reluctance about their involvement. Children have a right to be heard in proceedings that concern them.²²⁹ Speaking to the judge can convey what is important to them, 'which may not otherwise be apparent'.²³⁰ Research suggests children appreciate their views being sought and involving them directly makes them feel respected, valued and involved.²³¹ When an Australian study interviewed children subject to parenting disputes, 85 per cent said children should be offered the opportunity to talk to the judge in chambers.²³²

Proceedings can be modified to allow children to communicate their views in a safe environment, including using screens or video evidence, meeting the judge outside the court in a more natural environment, or involving a trusted friend or teacher. In one model, children meet the judicial officer:

*in the presence of a family consultant (a child welfare expert), who reports back in open court on what transpired, the child consenting to the meeting at all times and it being explained to the child that anything they say may be recounted to their parents and that confidentiality cannot be guaranteed.*²³³

This role could be performed by the social workers employed at the Youth Court as Family Care Meeting coordinators, discussed above.

Whatever the model, children should have the opportunity to participate in all proceedings, not only cases that proceed to trial. The consent of the adult parties should not prevent children directly participating. Children's representatives should consider whether children are able to participate and discuss the options with them. The court should satisfy itself that children have had a reasonable opportunity to participate before finalising matters.

TRAINING FOR LAWYERS

Child protection is a specialised area of legal work. Lawyers who practice in the area need a sound understanding of areas such as child development, attachment theory, and the developmental consequences of abuse and neglect. It is tempting to view this sort of information as common sense or instinctive.²³⁴ It is a specialist area of knowledge that can be taught, but it does not commonly form part of legal training. Lawyers who act for parents would also benefit from such training because children's best interests are paramount in child protection proceedings.²³⁵

The Layton Review recommended that all children's representatives, except in emergencies, undergo training relevant to their role.²³⁶ The recommendation was not implemented.

South Australian lawyers are already required to complete 10 hours per year of mandatory continuing professional development (CPD) training as a condition of holding a practising certificate. The Commission suggests that child protection lawyers should consider spending at least three hours per year learning about areas relevant to child protection (as part of the existing mandatory CPD requirement). There are many highly skilled practitioners, such as social workers, psychologists, psychiatrists, forensic paediatricians, drug and alcohol workers and other lawyers, who are able to offer this training. The proposed Children's Commissioner, in consultation with the Legal Services Commission (LSC), the Crown Solicitor's Office (CSO), the Law Society of South Australia and the Agency, should consider developing a recommended training program.

Most child protection lawyers in South Australia are funded or employed by the LSC or employed by the CSO.²³⁷ These bodies should consider measures to encourage these lawyers to undertake child protection training, for example, by directing employed lawyers to participate in training and, for funded lawyers, by establishing a panel system with mandatory training requirements. The LSC recently established a panel for Independent Children's Lawyers (ICLs) in the Family Court. Panel lawyers must complete mandatory training, practice primarily in family law, have at least five years' recent post-admission experience in family law and hold a national police clearance.²³⁸

Lawyers representing children in state child protection proceedings are not required to submit a child-related employment screening clearance. This is concerning as they frequently meet alone with traumatised children. The LSC should require these lawyers to submit a valid clearance as a condition of funding.

TRAINING FOR JUDGES

The Layton Review also made recommendations about training for judges and the topic was a recurring theme in evidence heard by the Commission. It is widely accepted that experience as a barrister alone is insufficient preparation for many aspects of judicial work, with 'very considerable advantages to be gained from a more structured process of learning'.²³⁹ At the same time, independence of the judiciary must be safeguarded. There are powerful constitutional and philosophical reasons why Parliament cannot require judicial officers to complete training and why training should continue to be overseen by judges themselves.

The Layton Review recommended that Youth Court magistrates and judges:

*Undergo a specific education program which includes topics such as child development, the signs and symptoms of child neglect and abuse and their impact on children's behaviour, the effect of domestic violence on children and the purpose and effect of access in relation to the needs of children.*²⁴⁰

This recommendation was not implemented. The Senior Judge said that when he started at the Youth Court he and the other judicial officers would meet with various experts, including psychologists, psychiatrists and people from Families SA to cover issues such as attachment theory.²⁴¹ It would appear that these activities were not sustained over time, and in current judicial education programs there is a paucity of material relevant to child protection.

This has perhaps contributed to a perception from many experts and lawyers who appear in the court that the judiciary has an incomplete understanding of issues such as child development, attachment theory, the effect of neglect and cumulative harm, and the effect of exposure to domestic violence or drug taking. Confidence in the judiciary would be strengthened if it engaged visibly, consistently and proactively in training of this kind.

PROMOTING STABILITY AND PERMANENCY

There is tension between giving parents time to make necessary changes and making timely decisions to offer children stability and security. More time for parents often comes at the expense of children's developmental and psychological need for stability. Extended uncertainty is unsettling for children old enough to understand and also for infants, whose foster parents are left 'emotionally on hold', inevitably 'holding back a bit', not knowing if this child they love will remain with them or be removed. This risks undermining children's broader development.²⁴²

This tension plays out visibly in the Youth Court which, in relation to custody or guardianship, can make either a short-term order (up to 12 months) or a long-term order (until the child turns 18). In a bid to give parents more time, the court often decides to grant a second or third short-term order rather than a long-term order.

The Layton Review observed that multiple short-term orders 'on occasions resulted in a lack of certainty in relation to the long-term planning arrangements for children'.²⁴³ The review recommended that in most cases short-term orders last for no more than 12 months. However, where 'it was important for the child and family to have an opportunity to assess the situation before a long-term plan was put in place', the court should have the power to extend the initial order up to 18 months in total.²⁴⁴ A further period of up to 12 months could be permitted in exceptional circumstances, for example, to allow time for culturally appropriate placements to be made for Aboriginal children.²⁴⁵

However, instead of the amendments to the Act that were recommended, Parliament inserted sections 38(2) and (2a):

- (2) *Before the Court makes an order giving custody or guardianship of a child to a person who is not a parent of the child, the Court must be satisfied—*
- (a) *that there is no parent able, willing and available to provide adequate care and protection for the child; and*
 - (b) *that the order is the best available solution having regard to—*
 - (i) *the child's need for care and protection (including emotional security); and*
 - (ii) *the child's age, developmental needs and emotional attachments.*
- (2a) *If a child is to be placed in guardianship the Court must consider the importance of settled and stable living arrangements for the child and, as a general rule, a long-term guardianship order (ie an order under subsection (1)(d)) is to be preferred to a series of temporary arrangements for the custody or guardianship of the child.*

Section 38(2)(a) is problematic. A child may have had limited contact with his or her biological parents and been cared for and become attached to a foster parent for a significant period as part of a stable and loving foster family. However, if the biological parent reappears and presents as willing, capable and available, the court is prevented from making a long-term order—or any guardianship order at all—notwithstanding the child's developmental needs and emotional attachments.²⁴⁶

The Select Committee on Statutory Child Protection and Care in South Australia recently recommended that section 38(2) be expanded in operation to require the court, before making a care and protection order, to be further satisfied that there is no family member able, willing and available to provide care to a child.²⁴⁷ The Commission opposes this recommendation. This suggested amendment would create an even greater obstacle to the court making an order which prioritises the child's best interests.

The amendments have not made multiple short-term orders unusual. Table 9.13 shows the number of children under a custody or guardianship order at 30 June 2013, 30 June 2014 and 30 June 2015, who were previously the subject of two or more 12-month orders.

Many children are subject to multiple short-term orders. Two or more years may elapse before permanent care arrangements are made, suggesting that reunification is being pursued well beyond the six-to-12-month timeframe supported by research and Families SA policy. The number of such cases has grown by 53 per cent from 2013 to 2015.

Another obstacle to achieving stability for children is the number of cases where Families SA applies for a long-term order, but a short-term order results, whether by a judgement following a trial or a negotiated resolution. From 1 July 2013 to 30 June 2014 Families SA commenced 146 applications for long-term orders. Of these, 21 (14.38 per cent) were finalised by an order other than a long-term order.²⁴⁸

This proportion grows if matters resolved at trial by judgement only are considered. In the two years from 1 July 2013 to 30 June 2015, the court decided 10 applications for long-term orders by judgment. Of these, three resulted in a short-term order and three resulted in a long-term order that was burdened by a specific access order, an issue discussed below.²⁴⁹

Some witnesses criticised Families SA and the Crown Solicitor's Office for not taking a more assertive approach by applying earlier for long-term orders. However, the fact that more than half the applications for long-term orders determined by the court are either unsuccessful or burdened by a specific access order would discourage this.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

A study of reunification rates of children who entered care in 2006/07 in Tasmania, Victoria and South Australia found children were considerably slower to be reunified in South Australia. It observed that differences in legislation encourage the court in South Australia:

to impose two short-term care and protection orders before proceeding to final long-term orders. In contrast to some other states, the South Australian Courts appear to place a greater emphasis on giving families an opportunity to resolve their problems before any final decisions are made about children's long-term future [resulting in] a more gradual exit of children in South Australia.²⁵⁰

INFLUENCE OF THE COURT

Numerous witnesses from a variety of backgrounds said the Youth Court is reluctant to make long-term orders, preferring to make consecutive short-term orders.²⁵¹ There is a perception that the court adopts a 'strong pro-parent emphasis', wanting to 'give parents a go'²⁵² and asking 'what harm does it cause to the child?' if parents have 'one more chance'.²⁵³ There is a corresponding perception that the court is reluctant to accept evidence about the effect of attachment disruption on childhood development²⁵⁴, a position one witness described as 'kind of like not believing in gravity'.²⁵⁵

Witnesses commented that the court sometimes appeared sceptical about the relevance of parents' behaviour, including violence, aggression or drug taking, if the child did not witness it. They said the court appeared not to accept that this behaviour might be repeated in the children's presence, particularly if they were returned to the parents full-time. Marijuana use, in particular, was viewed as less significant. If this is the case, comments from the court to this effect impede the relationship between parents and Families SA, with parents perceiving the court as endorsing their destructive behaviours.²⁵⁶

Clearly, much depends on context. The Commission is not able to review the approach taken by the court in individual cases. However, the number of accounts from witnesses of varying backgrounds is cause for reflection.

The court determines only a small number of cases each year. However, its approach in those cases, as well as in the interlocutory stages of cases that are resolved by consent, has a significant influence on decision making throughout the child protection system. The widespread perception that this specialist tribunal gives short shrift to matters as fundamental to child development as attachment theory has the potential to undermine confidence in the court. As discussed above, it is important for the members of the Youth Court, as an expert tribunal, to engage in training that is relevant to child protection.

THE LEGISLATIVE SCHEME

While the court is bound to apply the legislative scheme, that scheme offers no explicit recognition of children's need for timely decision making, stability and the opportunity to form emotional and psychological bonds with alternative carers in the event that their parents cannot care for them. Amendments are needed to refocus decision making in these areas.

Until late April 2016, the objects of the Children's Protection Act included ensuring that all children are safe from harm and are cared for, as far as practicable, in a way that allows them to reach their full potential. The objects recognised the family 'as the primary means of providing for the nurture, care and protection of children' and accorded 'a high priority to supporting and assisting the family to carry out its responsibilities'.²⁵⁷

The Act contained fundamental principles that restated children's right to be safe from harm. It also explicitly provided for children's right to be cared for in a safe, stable family environment or, if such an environment could not be provided, in an alternative form of care that would give them every reasonable opportunity to develop to their full potential. These principles, together with the child's wellbeing and best interests, were described as 'paramount considerations'.²⁵⁸

Table 9.13: Children under custody or guardianship orders, plus those subject to two or more previous 12-month orders, 2013 to 2015

	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015
Children under a custody or guardianship order	2683	2692	2874
Children under a guardianship or custody order who were the subject of two or more previous 12-month orders (% of total)	121 (4.5%)	166 (6.2%)	185 (6.4%)

Source: Data provided by Families SA.

The Act required that consideration be given to²⁵⁹:

- the desirability of keeping the child within the child's own family and the undesirability of withdrawing the child unnecessarily from a neighbourhood or environment with which the child has an established sense of connection;
- the need to preserve and strengthen relationships between the child, the child's parents and grandparents, and other members of the child's family (whether or not the child is to reside with those parents, grandparents or other family members);
- the need to encourage, preserve and enhance the child's sense of racial, ethnic, religious, spiritual and cultural identity, and to respect the traditions and values of the community into which the child was born;
- if the child is able to form and express his or her own views as to his or her best interests—those views;
- the undesirability of unnecessarily interrupting the child's education or employment.

The Act also cautioned that children in alternative care must be allowed to maintain relationships with their family (including grandparents) and community to the extent such relationships can be maintained without risk of serious harm.²⁶⁰ The principles included no recognition of children's need for timely decision making and stability.

The inquest into the death of Chloe Valentine criticised the Act's 'heavy emphasis ... on family reunification' and highlighted the need to act early to save children, by removing them to a safe environment and so preventing cumulative harm in their parents' care.²⁶¹ It recommended amending the Act to make plain that keeping children safe from harm is the paramount consideration and maintaining children with their family must give way to this. It also recommended the inclusion of cumulative harm as a relevant factor in decisions about children's care.²⁶²

As a result, Parliament amended the Act to remove the fundamental principles and simplify the objects. The primary object of the Act—and the paramount consideration—is now to keep children safe from harm.²⁶³ Other objects include:

- to ensure as far as practicable that all children are cared for in a way that allows them to reach their full potential; and
- to recognise the importance of families to children and promote caring attitudes and responses towards children among families and all sections of the community so that the need for appropriate nurture, care and protection (including protection of the child's cultural identity) is understood; risks to a child's wellbeing are quickly identified; and any necessary support, protection or care is promptly provided.

Decision makers should also consider the views of the child, if he or she is willing and able to express them.²⁶⁴ While this much shorter list of objects gives prominence to the need for safety from harm, there is no express endorsement of the need to protect children from the harm caused by a lack of stability and permanency planning.

EMPHASISING PERMANENCE AND STABILITY

The emphasis on maintaining children in their biological families is not universal among Australian jurisdictions. In other jurisdictions, the permanency and stability of the placement are more important than the biological link between child and caregiver. In New South Wales, for example, legislation enshrines the importance of attachment relationships:

*The primary means of providing for the safety, welfare and wellbeing of children and young persons is by providing them with long-term, safe, nurturing stable and secure environments through permanent placement in accordance with permanent placement principles.*²⁶⁵

Section 9(2)(e) and (g) of the same NSW Act provide that:

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

*(g) If a child or young person is placed in out-of-home care, the permanent placement principles are to guide all actions and decisions made under this Act (whether by legal or administrative process) regarding permanent placement of the child or young person.*²⁶⁶

These provisions do not assume that the family (narrowly defined) is the best place to secure children's best interests; instead, they focus on a stable and secure environment, managed in accordance with permanency planning principles. Where a child's parents can provide a permanent placement in the child's timeframe, this is the preference. Where they cannot, an alternative permanent placement should be found. The objects and principles of the South Australian legislation should be amended to align more closely with the NSW model.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

In cases where the NSW statutory agency applies for orders for the removal of a child (other than emergency orders), the legislation requires it to assess whether there is a realistic possibility of the child being reunified with his or her parents. In so doing, the agency should consider the child's circumstances and whether the parents are likely to be able to satisfactorily address the issues that led to the child's removal.

If the agency determines there is a realistic possibility of reunification, it prepares and submits to the court for its consideration a permanency plan involving restoration, including²⁶⁷:

- minimum outcomes the agency believes must be achieved before the child may safely return to his or her parents;
- details of services the agency could provide or arrange for the child or the parents to facilitate reunification;
- details of other services the court could request that other government or non-government agencies could provide;
- a statement of the length of time during which restoration should be actively pursued.

If the agency determines there is no realistic possibility of reunification, it prepares and submits to the court for its consideration a permanency plan for another suitable long-term placement. The plan need not detail the exact placement, but must give a reasonably clear picture as to how the child's needs, welfare and wellbeing would be met in the foreseeable future.²⁶⁸

Critically, 'realistic possibility' of reunification is not an open-ended timeframe. For a child less than two years of age when the court makes its interim order, there must be a realistic possibility of reunification within six months. For older children, the timeframe is within 12 months.²⁶⁹

These timeframes are consistent with evidence about the need for stability and permanence. They focus the minds of families, the statutory agency and other support workers on achieving reunification within a defined period. The evidence indicates that most parents who can address their problems will do so in this timeframe. A child should not be left to wait indefinitely for those who cannot.

The reform measures outlined in Chapter 8 and in this chapter should help the Agency to identify and respond to family problems much earlier than is currently possible. Concerns that require a statutory response should also be identified earlier. The Agency would have additional powers to seek information, allowing earlier, more comprehensive assessments and the targeting of more intensive support. Earlier responses would also permit Family Care Meetings to be used as intended, giving families (including extended families) a genuine opportunity to develop plans to care and protect their children.

Where court orders are needed, the Agency would generally commence investigation and assessment proceedings to protect the child for up to six to 10 weeks while further expert assessment occurred. If after the assessment process the child remained at risk, the Agency would commence care and protection proceedings. The Agency would be required to assess at this time whether there is a realistic possibility of reunification in the relevant timeframe—six months for children under the age of two years and 12 months for older children. If it assessed that there was a realistic possibility of reunification, the Agency would seek a short-term order of either six or 12 months. If not, the Agency would seek a long-term order until the child turned 18 years. In most cases, at this point there would be cautious optimism for reunification, if the parents were responding to the offered support.

The Agency would be required to prepare and submit a permanency plan to the court within four weeks of filing its care and protection application. In cases where it assessed there was no realistic possibility of reunification in the timeframe, the permanency plan would propose an alternative long-term option. In cases where there was a realistic possibility of reunification, the plan would set out how this would be achieved, including the four matters listed above from the NSW scheme.

If the court were to accept the permanency plan and the parties consented to it, the court could then make final orders. If the court was not prepared to accept the permanency plan, it could direct the Agency to prepare and submit another plan.

In reunification cases, the response of the family, the Agency and the reunification service providers would need to have regard for the child's short developmental window. The Agency should expeditiously refer families to a reunification service provider, who in turn should promptly engage the family, according to the permanency plan. Parents should take the steps required to resume care of their children within the stated timeframe.

The reunification service provider should also provide regular, frank reports to the Agency to allow it to make proper, ongoing assessments of whether there remained a realistic possibility of reunification within the relevant timeframe.

If this possibility evaporated at any point, the Agency should commence proceedings for long-term orders and submit a new permanency plan no later than four weeks thereafter. The court would then determine whether it accepted the Agency's assessment. The legislation should expressly state that a parent's failure to comply with his or her commitments in the permanency plan is relevant to this decision.

In rare, exceptional circumstances (most likely to arise for older children) the court would have the discretion to extend the relevant timeframe for up to six months. In such cases, the onus should be on the parties to demonstrate why it would be necessary to extend the timeframe, *having regard to the child's best interests*, including the potential risk this poses to the child's need for stability and permanence.

Figure 9.2 shows how intervention by support agencies and the Agency could escalate to support families and to promote safety, stability and permanence.

PROMPT COURT DETERMINATIONS

An obstacle to finalising arrangements more quickly for children is the time taken to determine contested applications. The Act requires trials to start within 10 weeks of lodging a care and protection application and to be heard expeditiously. There is no time limit for a trial to be finalised.²⁷⁰

Because many trials are resolved by consent on the first hearing day, the Commission understands that the court schedules trials for a single day, with an opening address from Families SA's counsel and some initial evidence.²⁷¹ This is a pragmatic approach. However, the balance of the hearing can extend over many months, with a series of one or two hearing days interspersed by long adjournments.²⁷²

The Commission reviewed nine care and protection judgments decided by the court between 1 July 2013 and 30 June 2015 where the dates of both application and judgment could be ascertained. One judgment was delivered 1176 days after the filing of the application. Although that case was unusual as there was a delay to

allow the father's criminal charges to be finalised, there were still 392 days between listing the matter for hearing and the final judgment. The remaining eight cases were determined in an average of 200 days (more than six months) after the application was filed. Two of these were applications for long-term orders, where the court took 356 and 325 days respectively to grant *short-term* orders so that reunification efforts could continue. Lengthy delay in pursuing reunification is particularly unfortunate.²⁷³

It is curious to require trials to start quickly, yet allow them to be heard in short bursts over an extended period. Ten weeks can be a very short time to commence important proceedings and in some cases it may mean the court does not have all the relevant information to make the best decision.²⁷⁴ However, short timeframes for achieving either reunification or an alternative permanent placement mean contested matters should be resolved quickly.

At present, trials are relatively rare and the Commission's recommendations may further reduce them. Under the proposed changes, in most cases the Agency would initially seek a short-term order and then pursue reunification with guidelines in the permanency plan as to what is expected. Except where parents dispute the need for a guardianship order at all, most parents would support this approach. If reunification were unsuccessful within the relevant timeframe and the Agency returned to court for long-term orders, the legislative scheme would emphasise the need to provide children with stability and there would rarely be a basis to extend the timeframe for reunification.

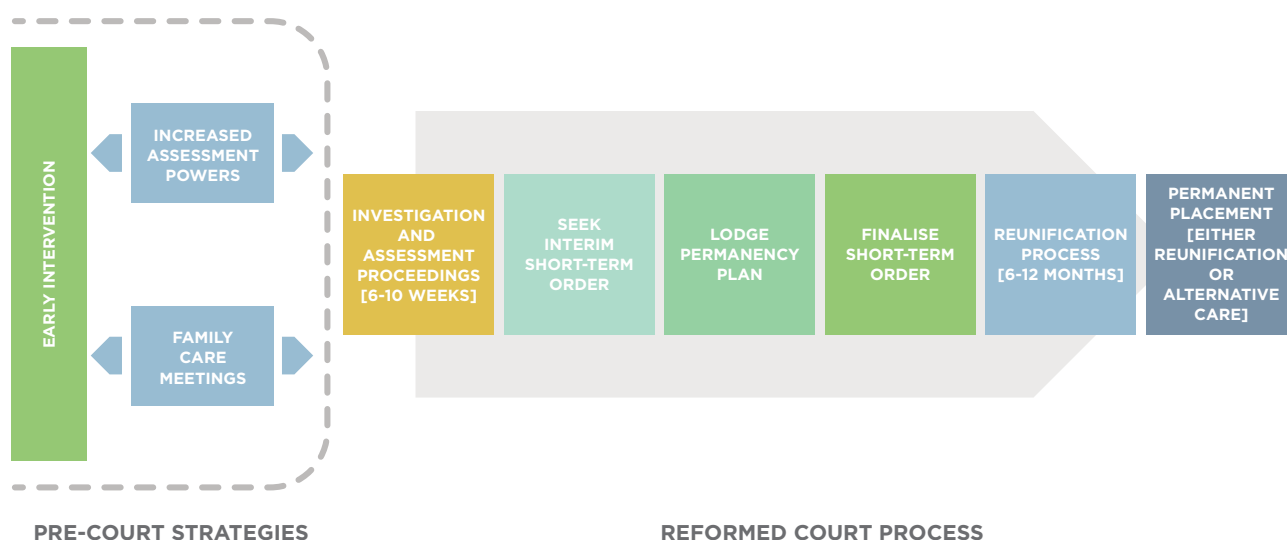


Figure 9.2: Processes for promoting safety, stability and permanence

9 INTERVENTION WHERE THERE IS IMMINENT RISK

The Act should be amended to remove the specific requirement to commence trials within 10 weeks, but it should continue to require the court to hear and determine proceedings as expeditiously as possible. It may be appropriate to call the case on for a listing conference before fixing a date for trial, but once the trial commences, without special reasons, it should continue until the conclusion of evidence with the judgment delivered as soon as practicable thereafter.

The recommendations in this chapter with respect to reducing timeframes to promote stability and permanency may have a significant impact on the number and type of matters that proceed to trial and, as a result, may require a review of listing arrangements.

CONCURRENT PLANNING

In most cases where Families SA commences care and protection proceedings there is usually a realistic possibility of reunification. As reunification work proceeds according to the proposed permanency plan, some parents are unable to address their problems in the timeframe that their children require. To meet this reality and to avoid putting children's lives on hold, practitioners should prepare either the child's return to their biological parents or their placement in stable, alternative care.

The term 'concurrent planning':

Refers to case management that comprises a family reunification case plan being pursued, while at the same time developing an alternate plan for permanent care. If the case goal changes, the alternate plan is already in place. Concurrent planning is designed to reduce case drift and to give children stability as early as possible.²⁷⁵

Families SA policy supports concurrent planning to 'reduce the time that children have to wait before longer-term plans can be made'.²⁷⁶

One form of concurrent planning is to recruit foster parents who are prepared to support the reunification process, caring for the child in the interim period, and to care for the child long-term if reunification is unsuccessful. This is emotionally demanding on foster parents, particularly where reunification is pursued indefinitely, as it requires them to love and commit to children who may or may not remain permanently in their care. While concurrent planning promises to avoid putting children's lives on hold²⁷⁷, in reality children and foster parents inevitably hold back emotionally when care arrangements remain uncertain.²⁷⁸ The emotional toll of this uncertainty makes it difficult to recruit foster parents and contributes to placement breakdown.²⁷⁹ The specific timeframes for reunification proposed above should significantly improve concurrent planning in practice and more clearly define the period of uncertainty.

FAMILY CONTACT

It is usually in the interests of children in care to continue to have some contact with their parents and siblings.²⁸⁰ However, contact should be a high-quality, shared experience for parents and children to promote the broader plans for the child and his or her development. If pursued incorrectly or for the wrong reasons, contact can undermine children's development, in particular in relation to their need for stability and permanency.

Before the Act was amended in 2016, the fundamental principles required that children placed, or about to be placed, in alternative care should be allowed to maintain contact with their family, to the extent that contact could occur without a 'serious risk of harm'.²⁸¹ This put too much emphasis on family contact by tolerating a level of risk to the child. The recent amendments to the Act do not address the issue.

CONTACT FOR THE RIGHT PURPOSE

The purpose of family contact depends on the child's circumstances, that is whether the plan is to pursue reunification or to invest in a stable, alternative placement. Where reunification is being pursued, contact aims to establish and maintain attachment relationships with biological parents to support the child's eventual return.²⁸²

Where the plan is not to reunify, children need to form new attachments with long-term carers. Contact should not, therefore, aim to maintain an attachment relationship with parents. Instead, contact should maintain a 'knowledge link' with parents, helping children integrate their parents in their mind as they grow and to view them realistically, neither as a continuing threat nor as idealised figures.²⁸³ Too frequent contact in such cases can undermine the bond with new carers by raising doubt in children's minds as to whether the placement will last and whether they should prepare emotionally to return to their parents.²⁸⁴

FREQUENCY OF CONTACT

Where reunification is envisaged and the aim is to rebuild children's attachment to their parents, contact needs to be more frequent than where it only aims to maintain a knowledge link. But care should be taken to ensure that contact does not overwhelm other aspects of the child's life. A secure attachment relationship helps children to develop other attachments. If contact arrangements:

Undermine an infant's relationship with their current carer, or are undertaken in conditions that do not ensure the infant has access to someone in their hierarchy of attachment figures available to help them regulate their emotions and behaviour, visits may in fact undermine the very goal they are trying to achieve (i.e. eventual reunion with the parents or a meaningful relationship with them while the child is in out-of-home care).²⁸⁵

Frequent contact has practical challenges. It is important for infants and small children to maintain sleep and feeding routines. Being woken and strapped into a car seat for up to an hour in each direction to attend contact visits disrupts routines and can be stressful. The effects can last long after children settle into long-term placements.²⁸⁶ Frequent contact that disregards the children's needs and routines is likely to be less satisfying for children and parents. If contact is to improve attachment relationships, it should be arranged so:

*Children feel as secure as possible, alert, awake and happy in order for them to have the curiosity and emotional energy to invest in getting to know and to interact with their parents.*²⁸⁷

Older children also have busy lives, including school, extracurricular activities, health appointments, socialising with friends and participating in the rituals of their new family. Frequent contact can cause them to miss out on these opportunities and undermine their sense of normality.²⁸⁸ Contact that disrupts education is a particular problem for children who enter care with educational deficits.

Frequent contact can also be difficult for biological parents to sustain while also attending assessments, counselling or treatment to address their problems.²⁸⁹ Frequent contact is sometimes viewed as promoting reunification. However, the evidence in this regard is mixed. A study of Victorian infants in care found that high-frequency contact schedules (four to seven visits per week) were not associated with increased rates of reunification one year later.²⁹⁰ While some research shows a relationship between more frequent contact and reunification, this link is correlative not causative and contact is only one factor among many others in reunification.²⁹¹

PROMOTING THERAPEUTIC CONTACT

Contact is a therapeutic opportunity to repair child-parent relationships and to build parenting skills.²⁹² However, parents are often only offered limited support. Access facilities and transport options also impede high-quality shared time.

One option is to hold contact in supported playgroups in Children's Centres.²⁹³ These playgroups offer a more natural, supportive environment for contact with children in care, allowing parents to interact with their children, make friends and receive practical advice and support. Many of the playgroups are run by family service coordinators (FSC), who are usually trained social workers with experience in working with vulnerable families.²⁹⁴

Families SA usually sends an access worker to supervise contact with children in care at playgroups. This is probably unnecessary where an FSC is present. With appropriate guidelines and support, FSCs should be able to supervise contact and to report progress to the Agency.²⁹⁵ To this end, contact in supported playgroups should be expanded and guidelines developed to allow FSCs to supervise where appropriate.

The person charged with supervision of the contact should be mindful of the active nature of the role. They should observe, assist, coach, intervene when necessary, and record observations and activities.

Contact spaces in Families SA often leave much to be desired: sterile office-like spaces, sometimes doubling as meeting rooms, with few toys or facilities to promote normal, positive interactions.²⁹⁶

Contact visits are sometimes held in more natural environments, such as community facilities including parks, libraries and play cafés. Where appropriate, these environments should be chosen to encourage more natural, positive parent-child interactions.²⁹⁷ However, in some cases, safety and supervision requirements mean contact cannot be held in the community. For this reason, the Agency's offices should have dedicated spaces for contact, with facilities therapeutically designed to promote high-quality time.

Many children travel long distances to contact visits, some further than their parents.²⁹⁸ In the case of Abby (see Vol. 2, Case Study 2), she was less than 12 months old and was being cared for in highly unsuitable rotational care arrangements when her caseworker declined two foster care placement offers because they would involve excessive travel for contact with Abby's mother. The caseworker responded to a suggestion that the mother should travel to Abby by saying that this would be too stressful and time consuming given other demands on the mother's time.

Children are routinely transported to contact visits by workers or volunteers who are effectively strangers. This can be 'an experience of emotional abandonment'²⁹⁹, leaving children:

*To their own emotional resources to manage the emotions evoked by separation from their carer, being accompanied by an unknown adult, travel, reunion with parents, interaction with parents, separation from parents, travel home again with unknown adult and reunion with their foster carer.*³⁰⁰

Rather than being a positive, shared experience, contact in these circumstances is 'likely to be highly stressful, counterproductive and, in fact, damaging'.³⁰¹

The Agency should review how it transports children to contact. Parents should generally be expected to travel to minimise travel by children.³⁰² An exception might be where the child is spending an extended period of time in the parent's care as part of the reunification plan. Ideally, children should be transported by their foster parents, although this will not always be a practical or safe option. In all cases, children should be transported to contact by people they know and trust.

AVOIDING HARMFUL CONTACT

For some children, contact is harmful. It can reactivate and perpetuate past trauma for children who have been assaulted by their parents. This risk is amplified when contact occurs in the absence of the child's primary caregiver. Expert therapeutic advice should be sought to weigh the benefits of contact for such children.

Young children are sensitive and perceptive. Even if they are too young to understand what is said, contact with 'a very disturbed, hostile, harsh, belittling or vengeful adult will have an emotional impact'.³⁰³ Research shows babies are frightened by parents who present a 'scary face'.³⁰⁴ Well-trained practitioners should be able to identify where children feel distressed, including identifying their non-verbal cues.³⁰⁵

Reports by carers of signs of apparent trauma before and after access are too often ignored. This destabilises the formation of an attachment between children and their carers. Children look to carers to protect them from scary situations and are confused when they do not. This puts carers in an invidious situation, unsure whether to intervene or hold back.³⁰⁶

Children's fundamental right to safety from harm extends to safety from harmful contact with their family. Children in the care of the state need to know that the caring adults around them will see and hear their distress and will protect them from harmful experiences. Practitioners involved with the child should be trained to recognise potential signs of distress, including in non-verbal children. If children experience trauma during contact or show signs of distress or anxiety, then contact should cease and only resume subject to expert, therapeutic advice.³⁰⁷

Nathan (see Vol. 2, Case study 4) entered care at 18 months following horrific abuse at the hands of his mother. For two years, Families SA pursued reunification, exposing Nathan to further trauma during contact. For example, his mother threw Nathan onto a couch and verbally abused him. At a later contact, his mother said 'fucking get into bed' and threw him roughly to the ground. Nathan showed signs of significant distress.

His experiences left Nathan uncertain about his safety at each contact and to whose home he would return:

*When children don't feel safe, they're wondering, ... When is the next access visit coming? What will she be like when I attend? It keeps them focused on their safety and not focused on the things that they should be doing as little people—learning, establishing relationships, focusing on all the things that support their more general learning.*³⁰⁸

These events had a lasting effect on Nathan's capacity to develop attachment relationships and to settle into home-based placements.³⁰⁹

The Commission also heard evidence with respect to a 10-year-old foster child whose mother abused him during telephone contact. Families SA insisted that contact continue despite repeated statements from the child that it was not what he wanted.³¹⁰

MORE FLEXIBLE CONTACT ARRANGEMENTS

Contact arrangements need to be flexible enough to adapt to the changing needs of children. In South Australia, the court determines contact arrangements. In most cases, particularly where the case is resolved by consent, the court makes a general access order, which means the child must have contact with the mother or father at such times, dates and places as may be agreed between parents and Families SA, and supervised at the discretion of Families SA. This is a somewhat curious order, because in practice it permits Families SA to determine the terms of contact.³¹¹

By contrast, if the case is contested and the court makes orders after a trial, it often makes a specific access order, which specifies the frequency and duration of access.³¹² If the child's circumstances change and the specific order is no longer in the child's best interests, a further application may be required to vary the order. This is particularly problematic where the court makes a specific access order *and* a long-term order, because the child's needs are almost certain to change across the life of the order. In some cases, the court mandates relatively frequent, long-term contact: as much as once or twice a week.³¹³ This represents a significant burden on the long-term order because it undermines the stability and permanence of that arrangement.³¹⁴

Whether the order is specific or general, it requires at least some level of contact, even if the child exhibits signs of distress that indicate contact should cease for a time.³¹⁵ The order places significant pressure on Families SA to continue to present the child for contact even if it appears not to be in the child's best interests, including where parents' attendance is poor (leaving children to wait forlornly for parents who do not attend) or where parents attend under the influence of drugs or alcohol or behave aggressively or erratically. In the case of Abby, contact between the infant and her mother proceeded even when the mother attended under the influence of drugs.

The court's preference for frequent contact—up to daily contact for some small infants³¹⁶—also places pressure on Families SA practitioners to offer frequent contact even in cases where the court does not formally order it.³¹⁷

Contact is frequently a negotiation tool in contested cases, with parents arguing for more frequent contact before agreeing to a custody or guardianship order:

*Families SA will often agree to these terms because making concessions on contact secures a safe, permanent and stable environment for the child while avoiding the uncertainty in what is often a lengthy trial. While this approach makes practical sense and is entirely understandable, it brings with it a subtle shift away from the best interests of the child and towards the interests of the parents. In other words, it becomes more about when, where and how often the parents want to see the child, rather than what orders and access arrangements are in the best interests of the child.*³¹⁸

The court's power to impose contact orders also leads to a practical consideration: where children move interstate and orders need to be transferred to another jurisdiction, the case must return to court to remove the order for contact before transfer.³¹⁹

There are effectively two processes for providing contact. Where the custody or guardianship order is made by consent, Families SA determines contact with no external oversight. Where the order is contested, the court fixes contact arrangements once and for all. It is hard to justify this distinction, which arguably gives parents a perverse incentive to contest applications.

While the court should retain power under section 38(1)(e) to direct a party to refrain from having contact or residing with, or coming within a specified distance of, the child, its power under section 38(1)(f) to make orders for contact with the child should be repealed. Instead, the Act should provide the Agency with the discretion to determine contact arrangements, having regard to the best interests of the child. In most cases, this would be determined at the local level by the Agency's caseworkers and their supervisors, in consultation with other practitioners involved with the family, in particular any reunification service providers.

Disputes will arise from time to time. If the Agency is to determine contact arrangements, it is particularly important that they reflect the best interests of the child and not resource issues in the Agency. The permanency plan submitted to the court should include a process for resolving disputes concerning contact, prioritising early mediation where possible.³²⁰

For cases where mediation is unsuccessful, a standing expert Case Review Panel (CRP) should be developed in the Agency. The panel should have three members, with the chairperson and the majority of members independent of the Agency. The members should have the skill and expertise to review contact arrangements and to direct changes where required.³²¹ All members of the panel should be independent of the case being considered. The panel should aim to review arrangements quickly and with a minimum of formality. Its decision would be final, unless there was a significant change in circumstances, in which case a matter might be reconsidered. A child's biological parents and current foster parents should have standing to use these processes. In appropriate cases, the child who is the subject of the dispute should also have the right to make application to the panel and to be heard in any dispute.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 57 Review procedures for strategy discussions to ensure they are convened promptly upon the receipt of notifications requiring investigation (and without delay when children present with physical injury). Discussions should include all relevant government and non-government participants and be re-convened as necessary.
- 58 Provide the Agency's practitioners with training, support and supervision to equip them to make realistic assessments of risks, particularly in areas of chronic maltreatment, cumulative harm, social isolation, drug and alcohol abuse, mental health, family violence, and attachment and care needs of young children, to consider the views of children and to develop appropriate safety plans.
- 59 Reconcile and integrate the Agency's assessment tools and documentation (including Solution Based Casework™, the assessment framework and decision-making tools).
- 60 Amend section 20 of the *Children's Protection Act 1993* to delete section 20(2) and (3), and include a provision which empowers the Agency to issue a written direction to parents, guardians or other persons requiring them to submit to a drug and alcohol assessment, with the results to be provided to Families SA.
- 61 Ensure the Agency responds to all screened-in notifications, either directly, or by appropriate referral, including responding promptly (including after hours) to notifications in which physical injuries are notified and the Agency's assistance is required to facilitate a forensic medical assessment.
- 62 Phase out the closure of intakes and files due to a lack of resources. This should occur over a period of no more than five years from the date of this report. In the interim, practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate. There should be quarterly reports to the public on the rate of closures that are due to a lack of resources.

63 Amend section 19(1) of the *Children's Protection Act 1993* by deleting section 19(1)(b) thereof to provide that:

- a if the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.

64 Ensure that the Agency focuses on case management of protective intervention cases and that not-for-profit agencies provide direct service delivery to families. All protective intervention programs should be evaluated on a regular basis to ensure that all such programs have an established evidence base.

65 Establish a Child Protection Service (CPS) unit at the Lyell McEwin Hospital.

66 Amend the *Children's Protection Act 1993* to provide an independent model of expert assessment in similar terms to the Children's Court Clinic in New South Wales.

67 Amend the *Children's Protection Act 1993* with respect to the procedures relating to Family Care Meetings (FCMs) as follows:

- a amend section 27(1) to provide that the Agency should consider causing an FCM to be convened whenever it is of the opinion that a child is at risk but the risk appears capable of being addressed at an FCM;
- b repeal section 27(2);
- c amends 36(6) to provide that an FCM decision would not be valid without the agreement of the relevant members of the family and the Agency;
- d require the Agency to give effect to FCM decisions, unless they are impracticable or inconsistent with the principles of the legislation, in which case the FCM should be reconvened or proceedings commenced in Court; and
- e require FCM decisions to be reviewed after three months, but provide that any party to the decision may request an earlier and/or subsequent review, if required.

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- 68 Review procedures and funding arrangements for the Youth Court Conferencing Unit:
- a to enable the Unit to recruit and train a panel of child advocates for Family Care Meetings (FCMs)—advocates should hold a valid child-related employment screening clearance; and
 - b to consider whether in an appropriate case a child’s foster parent should be invited to an FCM.
- 69 Amend the *Children’s Protection Act 1993*:
- a to require the child’s lawyer to:
 - i act in accordance with the child’s instructions to the extent the child is able and willing to give such instructions
 - ii supplement those instructions with his or her own view of the child’s best interests to the extent the child is not able and willing to give instructions (provided the lawyer’s views do not contradict any instructions the child is able and willing to give)
 - iii indicate the nature of the role to the child, in accordance with the child’s developmental capacity
 - iv indicate to the court on which basis submissions are made; and
 - b permit the court to appoint a child’s representative or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the proceedings to enable a duly instructed lawyer to represent the child.
- 70 Amend the *Children’s Protection Act 1993* as follows:
- a repeal section 38(1)(a) which concerns the making of orders for supervision and undertakings and section 38(2)(a);
 - b include as an object in the Act the importance of timely decision making to promote stability and maintenance for a child;
- c at the time of the commencement of care and protection proceedings the Agency should assess whether there is a realistic possibility of reunification:
 - i within six months for a child under two years, or
 - ii within 12 months for a child over two years; and
 - d if there is a realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should seek an order placing the child under the guardianship of the Minister for a period of either six or 12 months (depending on the age of the child), and file a permanency plan setting out the proposals for reunification;
 - e if at the commencement of care and protection proceedings, or at any time thereafter, there does not appear to be any realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should immediately apply for an order placing the child under the guardianship of the Minister until the age of 18 years and file a permanency plan setting out the proposals for the long-term placement of the child;
 - f if at any time special circumstances arise (particularly with respect to an older child) which make it necessary to extend the timeframes set out in Recommendation 70(c) hereof the Court shall have the discretion to extend the timeframe for a period no longer than six months. In any such case the onus will be on the parties to demonstrate the need for such extension having regard to the child’s best interests and the potential risk to the child’s need for stability and permanence;
 - g amend section 39(a) to delete the requirement to commence a hearing within 10 weeks, but provide that all proceedings be heard and determined expeditiously and that once the hearing commences, without special reasons, it should continue until the conclusion of evidence with the judgement delivered as soon as practicable thereafter.

RECOMMENDATIONS

- 71 Encourage lawyers employed by the Legal Services Commission and the Crown Solicitor's Office to undertake child protection training and require lawyers engaged through the Legal Services Commission to represent children in state child protection proceedings to hold a valid child-related employment screening clearance.
- 72 Ensure that contact arrangements meet the changing needs of children with respect to such matters as venue, transport arrangements and supervision and that contact never occurs when the parent is or is suspected of being affected by drugs and/or alcohol.
- 73 Amend the *Children's Protection Act 1993* to exclude contact arrangements from orders of the court and require all contact arrangements be referred to the Agency for determination in accordance with the best interests of the child. The permanency plan filed at court should include a provision as to the resolution of contact disputes, including mediation procedures wherever possible.
- 74 Establish an independent standing expert Case Review Panel to review the issue of contact when mediation is unsuccessful and it is necessary to resolve any dispute as to contact arrangements.

NOTES

- 1 *Children's Protection Act 1993* (SA), s. 19(1).
- 2 Ombudsman South Australia, *Information sharing guidelines for promoting safety and wellbeing*, Ombudsman SA, 2014, p. 9.
- 3 *ibid.*, p. 8.
- 4 *Children's Protection Act 1993*, s. 19(2).
- 5 *ibid.*, ss. 19(3) and (4).
- 6 Government of South Australia, *Interagency code of practice: Investigation of suspected child abuse or neglect*, Adelaide, South Australia, 2013, p. 45.
- 7 *Children's Protection Act 1993*, s. 20(1).
- 8 *ibid.*, s. 21(1).
- 9 *ibid.*
- 10 *ibid.*, s. 38.
- 11 Oral evidence: S Macdonald.
- 12 Oral evidence: S McEwen.
- 13 A 'protection order' includes a range of child protection court orders, including supervision, custody and guardianship orders: *Children, Youth and Families Act 2005* (Vic), ss. 196, 275.
- 14 Families SA, 'Child Abuse Report Line manual of practice,' internal unpublished document, Government of South Australia, 2010, pp. 35-44; Families SA, 'Structured decision-making response priority assessment policy and procedures' internal unpublished document, 2012, p.22; Families SA, 'Child protection manual of practice, vol. 1', internal unpublished document, 2010, pp. 149-152.
- 15 Families SA, 'Practice guide: Care and protection assessment framework — investigation and assessment', internal unpublished document, 2007, p.5.
- 16 Oral evidence: S Macdonald.
- 17 Government of South Australia, *Interagency code of practice*, p. 22; Families SA, 'Child protection manual of practice, vol. 1', pp. 145, 149-50.
- 18 SA Police convene Strategy Discussions for extra-familial matters.
- 19 Child Protection Services at the Women's and Children's Hospital and the Flinders Medical Centre perform forensic medical assessments and forensic interviews of children.
- 20 Government of South Australia, *Interagency code of practice*, p. 22; Families SA, 'Child protection manual of practice, vol. 1', pp. 145, 149-50.
- 21 Oral evidence: P Weber; R Willson; J Edwards.
- 22 Oral evidence: J Edwards.
- 23 Oral evidence: M John; J Edwards; C Keogh.
- 24 Oral evidence: B Sawyer; L Balmer.
- 25 Government of South Australia, 'Interagency code of practice: Investigation of suspected child abuse or neglect', revision of 2013 code, forthcoming, p.39.
- 26 Oral evidence: J Edwards.
- 27 DN Christensen, J Todahl & WC Barrett, *Solution-Based Casework: An introduction to clinical and case management skills in casework practice*, Aldine De Gruyter, New York, 1999, p. xii.
- 28 Oral evidence: R Starrs.
- 29 Oral evidence: D Christensen. DN Christensen et al., *Solution-Based Casework*, pp. xii, 62.
- 30 Oral evidence: S Macdonald.
- 31 Oral evidence: Name withheld (W29).
- 32 A Tomison, *Spotlight on child neglect*, NCPC Issues No. 4, Australian Institute of Family Studies, Australian Government, June 1995.
- 33 Oral evidence: D Christensen.
- 34 Oral evidence: R Starrs; D Christensen; S Macdonald. Christensen et al., *Solution-Based Casework*, p. 19.
- 35 Oral evidence: D Christensen; S Macdonald.
- 36 Families SA, 'Care and protection assessment framework', p. 1.
- 37 *ibid.*, p.2.
- 38 Oral evidence: S Macdonald.
- 39 Families SA, 'Child protection manual of practice, vol. 1'; Families SA, 'Substantiation of harm and identification of harm', internal unpublished document, 2009.
- 40 B Mathews, 'Exploring the contested role of mandatory reporting laws in the identification of severe child abuse and neglect', in M Freeman (ed.), *Current legal issues: Vol. 14. Law and childhood studies*, Oxford University Press, 2012, pp. 302, 334.
- 41 P Kohl, M Jonson-Reid & B Drake, 'Time to leave substantiation behind: Findings from a national probability study', *Child Maltreatment* 14, February 2009, pp. 17, 34; B Mathews, 'Exploring the contested role', pp. 302.
- 42 Families SA, 'Substantiation of harm and identification of harm', internal unpublished document, 2009, pp. 1-2, 6-7; Families SA, 'Structured decision-making system in child protective services: Policy and procedures manual', internal unpublished document, 2010, p. 16; Families SA, 'Child protection manual of practice, vol. 1', pp. 133, 151, 161, 177-8.
- 43 Families SA, 'Structured decision-making system', p. 16; Families SA, 'Child protection manual of practice, vol. 1', pp. 132-3; Families SA, 'Practice guide: Care and protection assessment framework', p. 10.
- 44 Under a Voluntary Custody Agreement, guardians of a child agree to transfer custody of the child to the Minister for up to two consecutive three-month periods, *Children's Protection Act 1993*, (SA) s. 9.
- 45 Families SA, 'Structured decision-making system', p. 18; Families SA 'Child protection manual of practice, vol. 1', pp. 134-5.
- 46 Oral evidence: S Macdonald. Families SA 'Structured decision making system', p. 19; Families SA, 'Safety planning', internal unpublished document, 2009, p. 2.
- 47 Families SA, 'Structured decision-making system', pp. 28-9; Families SA, 'Care and protection assessment framework', p. 10; Families SA 'Child protection manual of practice, vol. 1', p. 210.
- 48 Families SA, 'Child protection manual of practice, vol. 1', p. 213.
- 49 Oral evidence: S Macdonald.
- 50 Families SA, 'Child protection manual of practice, vol. 1', pp. 213-4.
- 51 Coroners Court of South Australia, *Finding of the inquest into the death of Valentine, Chloe Lee*, Inquest number 17 of 2014, pp. p. 41.
- 52 Coroners Court of South Australia, *Finding of the inquest into the death of Napier, Ebony Simone*, Inquest number 16 of 2015, pp. 105-6, 124.
- 53 *ibid.*, pp. 106-7.
- 54 *ibid.*, pp. 16, 121-2.
- 55 Oral evidence: S Smith; C Keogh.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

9 INTERVENTION WHERE THERE IS IMMINENT RISK

NOTES

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- 57 Talking with children is different to child interviewing, which is a specialist skill that most Families SA workers do not require given the specialist role played by Child Protection Services.
- 58 Oral evidence: S Macdonald.
- 59 Oral evidence: J Edwards. Witness statements: Name withheld (S68); L Williamson.
- 60 Oral evidence: Name withheld (W96).
- 61 Oral evidence: S Macdonald; name withheld (W96).
- 62 Oral evidence: S Macdonald; D Christensen.
- 63 Refer to EN 51, pp. 21, 103–4.
- 64 Oral evidence: S Macdonald.
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- 66 E Munro, *The Munro Review of Child Protection. Final report: A child-centred system*, Department for Education, United Kingdom Government, May 2011, p. 19.
- 67 *ibid.*, p. 20.
- 68 Yaitya Tirramangkotti, a unit formerly based at the Families SA Call Centre dedicated to Aboriginal and Torres Strait Islander children, could recommend a home visit. Families SA, 'Child protection manual of practice, vol. 1', pp. 142–3, 146.
- 69 Oral evidence: F Arney; K Taheny; S Macdonald.
- 70 RA Layton (Chair), *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, Department of Human Services, Government of South Australia, Adelaide, 2003, p. 9.41.
- 71 Submission: Child Death and Serious Injury Review Committee.
- 72 Families SA, 'Outcome codes', internal unpublished document, 2011, p. 2.
- 73 RA Layton (Chair), *Our best investment*, p. 9.23–4.
- 74 Data provided by Families SA. Excludes extra-familial notifications, which are referred to SA Police for response.
- 75 Oral evidence: K Taheny.
- 76 Oral evidence: C Keogh.
- 77 Families SA, 'Child protection manual of practice, vol. 1', pp. 153–4; Families SA, 'Outcome codes', internal unpublished document, p. 4; Families SA, 'Divisional circular no. 158', internal unpublished document, 2011.
- 78 Oral evidence: Name withheld (W58).
- 79 Oral evidence: K Taheny.
- 80 Oral evidence: Name withheld (W58).
- 81 O Octoman & L Bromfield 'Children at risk of repeated involvement with child protection services: A longitudinal study using child protection data' presentation, Australian Centre for Child Protection, no date.
- 82 Families SA, 'Child protection manual of practice, vol. 1', pp. 153–9; Families SA, 'Outcome codes', 2011.
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- 84 *Children's Protection Act 1993*, (SA) s. 19(1).
- 85 *ibid.*, s.14(b).
- 86 Refer EN 51, p. 112.
- 87 Oral evidence: R Croser.
- 88 Oral evidence: Name withheld (W61).
- 89 Oral evidence: C Simmons.
- 90 Oral evidence: J Beall; J Edwards.
- 91 Oral evidence: J Beall; K Molden; J Edwards.
- 92 Oral evidence: J Edwards.
- 93 Oral evidence: Name withheld (W16).
- 94 Oral evidence: Name withheld (W16); name withheld (W78).
- 95 Families SA, 'Redesign business case', internal unpublished document, 2013, p. 35.
- 96 Oral evidence: Name withheld (W61).
- 97 Oral evidence: C Pearce.
- 98 Oral evidence: S McEwen.
- 99 *ibid.*
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- 101 P Sandeman, correspondence to the Child Protection Systems Royal Commission, 5 January 2016 and 14 January 2016.
- 102 *Children and Young Persons (Care and Protection) Act 1998* (NSW), Division 6, Part 1, Chapter 5.
- 103 Children's Court, *Children's Court Clinic: Authorised clinicians' handbook*, New South Wales Government, 2011, pp. 18–19.
- 104 Oral evidence: C Pearce.
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- 112 Oral evidence: Name withheld (W28).
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- 115 Oral evidence: L Haddad. Families SA, 'Family preservation procedure', p. 4; Families SA, 'Family preservation work instruction', internal unpublished document, 2015, pp. 4–5; Families SA, 'Reunification work instruction', internal unpublished document, 2015, pp. 4–5.
- 116 Oral evidence: K Drew; S Hoffman; S Macdonald; name withheld (W8).
- 117 Oral evidence: F Arney; L Haddad; S Macdonald.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

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- 119 P Delfabbro, et al., 'Reunification patterns in South Australia: An analysis of social and demographic correlates', University of Adelaide, South Australia, February 2012, pp. 18–9.
- 120 P Delfabbro et al., 'An analysis of reunification from out of home care in three Australian states', *Child Indicators Research* 8, no. 2, June 2015, pp. 359, 366.
- 121 Y Gauthier, G Fortin & G Jeliu 'Clinical application of attachment theory', pp. 379, 394.
- 122 D Hetzel *What makes a good childhood: Report for the Royal Commission*, report prepared for the Child Protection Systems Royal Commission, Adelaide, March 2015, p. 16, www.agd.sa.gov.au/child-protection-systems-royal-commission
- 123 Y Gauthier, G Fortin & G Jeliu 'Clinical application of attachment theory', pp. 379, 382.
- 124 *ibid.*, pp. 379, 381; See also R Brown & H Ward, *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*, Working paper 16, second edition, Child Wellbeing Research Centre, London, February 2013, pp. 73–4.
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- 126 H Ward et al, *Infants suffering, or likely to suffer, significant harm: A prospective longitudinal study*, United Kingdom Government, October 2010.
- 127 C Davies & H Ward, *Safeguarding children across services: Messages from research*, Jessica Kingsley, London, 2012, p. 87.
- 128 *ibid.*, p. 85.
- 129 Families SA, 'Care planning policy', internal unpublished document, 2010, p. 3.
- 130 Families SA, 'Structured decision making system', p. 62.
- 131 Oral evidence: C Wood.
- 132 Within six months for children less than two years of age and within 12 months for children more than two years of age: *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 83(5).
- 133 Within 24 months: *Children, Youth and Families Act 2005* (Vic), s. 294A; Department of Human Services, 'Permanency for children', website, Government of Victoria, 2011, www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/permanency-for-children
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- 135 C Davies & H Ward, *Safeguarding children across services*, p. 87.
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9 INTERVENTION WHERE THERE IS IMMINENT RISK

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- 321 This may well be the same committee that considers applications for Other Person Guardianship, discussed in Chapter 13.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

PART IV

CHILDREN IN OUT-OF-HOME CARE

10

SERVICES FOR CHILDREN IN OUT-OF-HOME CARE

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OVERVIEW

When the state obtains a long-term order taking a child into care it assumes the heavy burden of providing for the physical, emotional, psychological and developmental safety of that child over possibly many years. Children raised in these circumstances have a right to expect a high quality of care, including priority access to health and educational services, and a high level of attention to, and investment in, helping them to recover from the experiences that brought them into care.

Families SA, the agency reporting to the Minister, is responsible for looking after these children and young people. It must meet their needs for a high standard of care and endeavour to ensure they benefit from a supportive environment and expert therapeutic support.

The Standards of Alternative Care in South Australia record the following principle of good practice¹:

Children and young people in care should be afforded the same rights and opportunities that other children in the community have. The child or young person in care may require extra efforts to redress the disadvantage they have already experienced. Extra care is required to prevent further harm through the child or young person's experiences of the process of alternative care itself.

A major challenge to providing these children and young people with a normal upbringing is the assignment of parenting responsibilities to three separate entities: the Agency, who is responsible for major decisions about their care; their carers, who attend to their day-to-day care needs; and their families of origin, with whom they often have close emotional connections and continuing contact. Good case planning and case management by the Agency is essential to meeting these challenges.

Good case management also has the potential to protect children from abuse in out-of-home care. A recent literature survey commissioned by the federal Royal Commission into Institutional Responses to Sexual Abuse highlighted the fact that creating an environment where children feel safe enough to disclose their concerns is an important aspect of keeping them safe in alternative care environments.²

For some children in care, the fracturing of relationships in their families of origin and the circumstances that brought them into care mean that they have few, if any, adults on whom they can rely. A recent audit of annual reviews conducted by the Guardian for Children and Young People (GCYP) found that of the 203 reviews audited, 14 children had no significant person in their lives outside the Agency and siblings.³ Children who are isolated from stable and trusting relationships with

adults outside the care system are especially vulnerable to exploitation: if they are exploited or abused, they may not have anyone they feel they can safely confide in.

Data consistently shows that across a number of important measures children in care experience poorer outcomes than their peers.

This chapter principally relates to the Commission's Term of Reference 5(d) in the context of Terms of Reference 1 to 4. It discusses the situation for children in care in this state, and makes recommendations for improvements.

LEGISLATION AND POLICY

Once a child is placed under a guardianship order, the Minister assumes responsibility for that child 'to the exclusion of the rights of any other person'.⁴ The powers of guardianship are broadly defined at common law⁵, although some aspects of the Minister's power are specifically set out in the *Children's Protection Act 1993* (SA) (the Act):

51—Powers of Minister in relation to children under the Minister's care and protection:

- (1) *Subject to this Act, the Minister may from time to time make provision for the care of a child who is under the guardianship of the Minister or of whom the Minister has custody pursuant to this Act, in any of the following ways:*
 - (a) *by placing the child, or permitting the child to remain, in the care of a guardian of the child or some other member of the child's family;*
 - (b) *by placing the child in the care of an approved foster parent or any other suitable person;*
 - (c) *by placing the child in a home (not being a training centre) established or licensed under the Family and Community Services Act 1972 or in any other suitable place, and by giving such directions as to the care of the child in that home or place as the Minister thinks fit;*
 - (d) *by making arrangements for the education of the child;*
 - (e) *by making arrangements (including admission to hospital) for the medical or dental examination or treatment of the child or for such other professional examination or treatment as may be necessary or desirable;*

(e) *by making such other provision for the care of the child as the circumstances of the case may require.*

(2) *In making provision for the care of a child pursuant to subsection (1), the Minister must, if appropriate, have regard to the desirability of securing settled and permanent living arrangements for the child.*

This section clearly intends that the Minister will rely on the care services of others, including foster parents or other suitable persons, to discharge the responsibility of guardianship. This includes placement of the child in a registered residential care facility.

The progress of a child under a long-term guardianship order should be kept under constant review. Section 52 of the Act mandates an annual review of the child's circumstances. The review is to be conducted by a panel appointed by the Minister for the purpose, and the conclusions of the panel must be produced in writing and provided to the child, the child's guardian and the person is whose care the child is residing.⁶

The Act requires persons exercising functions or powers under a relevant law, in any dealings with, or in relation to, a child under the guardianship or in the custody of the Minister, to have regard to and seek to implement the Charter for the Rights of Children and Young People in Care, which is developed and reviewed regularly by GCYP.⁷ The charter gives all children and young people living in care the right to be treated like other children and young people.⁸

The Standards of Alternative Care require that⁹:

Families SA caseworkers will ensure their work with children, young people, their families and carers is based upon an ongoing assessment and planning framework. Monitoring and review of casework will ensure children and young people are provided with all identified opportunities/services to allow them to realise their full potential.

Other more specific standards require that each child or young person will have an allocated caseworker who:

- maintains regular contact and is a key support¹⁰;
- will have face-to-face contact with the child at least once a month¹¹;
- will make a thorough assessment of their placement options with decisions supporting the need for settled and stable placements long term¹²;
- will have a case plan that is developed, monitored and reviewed as part of a regular six-monthly planning cycle.¹³

Education, employment, health care and other life domains must be addressed by a child's care team. The South Australian standards also encourage visionary aspirations for children in care, which are reflected in care planning.¹⁴

The National Standards for out-of-home care also require that each child and young person has an individualised plan detailing their health, education and other needs; has their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way; and accesses and participates in education and early childhood services to maximise their educational outcomes.¹⁵

It is evident that there is no shortage of guidance about the standards applicable to caring for children in out-of-home care. The challenge for the Agency lies not in identifying relevant benchmarks and principles, but rather in ensuring that the many practice and policy guidelines are translated into actions that make a difference to the lives of children and young people.

Rapid Response is a plan that was developed in 2005 as part of the government's Keeping Them Safe agenda to 'ensure that children and young people under the guardianship of the Minister ... do not miss out on the supports and services available to children with strong family networks'.¹⁶ It was developed and applied across a number of government departments, focusing on providing a coordinated approach to physical health, psychological and emotional health, developmental progress, disability needs, education, housing and post-guardianship services.¹⁷ One aspect of improved service delivery contemplated by the Rapid Response plan was priority access to services where possible. The development of the plan was overseen by a cross-government guardianship steering committee which reported quarterly to the relevant Minister.¹⁸

It is clear to the Commission that a refreshed focus is needed on the principles and actions agreed upon through Rapid Response. One young person who was approaching the age of leaving care told the Commission that she had never heard of Rapid Response, and she had not been made aware at any time of the possibility of priority access to services.¹⁹ A number of foster parents expressed frustration that their child's care status did not appear to be taken into account in assessing their eligibility for government services. The momentum for a cross-agency approach has slowed and is not receiving active attention now that the previous government structure has been dismantled.²⁰

Some specific aspects of service provision for children in care are discussed throughout this chapter.

However, the Commission considers that a more comprehensive review of Rapid Response is urgently needed, to restate the principles and practical operation of the Rapid Response plan, and reaffirm the inter-agency commitment that accompanied its initial development.

This should include the establishment of an inter-departmental group to review and reissue the plan. Any reissue should also include regular future reviews (at least biannually) to ensure that momentum is maintained.

CASE PLANNING

Case planning is an integral part of the broader service delivery approach of case management for each child or young person. Case planning is 'the process which provides the framework for making decisions about a child/young person in order to achieve identified outcomes'.²¹ This critical activity is based on an assessment of the child's needs and establishes a guide for the tasks and activities of all parties involved in the child's care. The case manager takes a leadership role in this process, and is the point of reference when issues need to be resolved.

As the parenting of a child in care is divided between the carer who provides day-to-day care and the statutory agency that represents the Minister, careful planning and consistency of focus are essential. The effectiveness of the planning depends on the collaboration of all parties, including the child or young person, their carers and other service providers.

Quality standard 2.6 of the Standards for Alternative Care requires that every child in care have a case plan that is developed, monitored and reviewed every six months.²² This document records the aims and outcomes of the case planning process, lists the activities and services that will be required to achieve those goals, and describes how and when those services will be delivered. It is a formal record which provides transparency of action for all parties who retain a legitimate interest in the child's wellbeing. The planning process also allows a child or young person to contribute their goals, aspirations and intentions in the short and long term, and to record how these contributions have been taken into account in planning.

A case plan tells all parties what is to be done, how it is to be done and why it is to be done.

The existence of a good quality case plan reflects a relationship between a child or young person and their worker which is current, active and purposeful, and reveals a level of attention to, and engagement with, the young person concerned. It also provides a measure against which to track progress and assess the utility of

services provided to a child or young person. Without a formal case plan, there is a risk that the needs of a child will be neglected, and their case left to drift.

DATA ABOUT CASE PLANNING

The Commission sought data about the number of children whose case plans are current, as a measure of the level of active engagement of caseworkers with children.

In 2011/12 the Australian Productivity Commission began tracking, for the first time, data about children in care who have a documented case plan. South Australia was not able to supply this data for financial years 2011/12, 2012/13 or 2013/14 due to recording issues. Although other jurisdictions were also unable to supply the data in the early years of reporting, by 2013/14 only South Australia and the Northern Territory were unable to report against this measure.²³ In the most recent report, for 2014/15, the Northern Territory remained unable to report due to recording issues. South Australia advised the Productivity Commission that the barrier to reporting for 2014/15 was due to system changes made to support Solution Based CaseworkTM.²⁴

When the Commission asked the Agency whether it could now report the number of children in care who had a current case plan, the Agency advised that six days of work would be required to extract the data. In light of this, the Commission did not pursue the request.²⁵ As current case plans are an important measure of quality casework and engagement with children, the lack of consistent monitoring of this data by the Agency is concerning.

The most recent data produced by the Productivity Commission for the rest of Australia for the 2014/15 financial year showed variable performance across jurisdictions. New South Wales was the lowest with 58.8 per cent of children having a current documented case plan, and Queensland was the highest with a rate of 97 per cent. The Australian average (excluding South Australia and the Northern Territory) was 75.1 per cent.

Evidence received by the Royal Commission suggests that South Australia's performance is likely to fall at the lower end, reflecting a lack of attention to formal case planning.

Life Without Barriers (LWB) reported to the Commission that of 74 children they supported in foster care placements, only nine had a current documented case plan (12 per cent).²⁶ Of those nine, LWB had been involved in the planning process for one, and foster parents had been involved in two.²⁷

Aboriginal Family Support Services (AFSS) reported a similar experience. No more than 10 per cent of the 126 children AFSS supported in foster care had current case plans.

GCYP recently audited the annual reviews of 203 children managed across 12 Families SA offices: this constituted 9 per cent of all reviews which were required in the 2014/15 year. The audit identified 33 children among that sample (16 per cent) who did not have a current case plan. Caution should be applied in extrapolating this data to all children and young people in care, however. This is because GCYP attends annual reviews for audit purposes by invitation, and the sample attended is small, and may not match the profile of the out-of-home care population overall.

However, if this evidence does indeed reflect the level of attention to case planning for children in care across the board, it is cause for considerable concern. It is unlikely that a child or young person without a formal written plan would be delivered the quality of care that they are entitled to expect from the state, nor is there any way of tracking the effectiveness of their care.

RELATIONSHIPS WITH CHILDREN

In evidence, Pam Simmons, the former GCYP, highlighted the potential conflict for caseworkers in the Agency working within a system that does not always operate to secure what is genuinely in the best interests of the child. She observed:

Caseworkers and social workers and supervisors can be very courageous, and I have seen much evidence of that, advocating for something for a child in the face of either systemic or organisational opposition. So it is certainly possible for people to advocate, and they do it all the time: advocate for the best interests of the child. There are organisational imperatives, though, which mean ... two things: one is that sometimes they are directed to either change their position, or [told] this is the way it will be. Or, secondly, people start to view what the options are for children through the lens of what is available rather than what is needed.²⁸

For children in care, caseworkers are the face of the system.²⁹ It is important that caseworkers are available and helpful in meeting children's needs. Caseworkers, where appropriate, should advocate on behalf of children, as is expected of an involved and committed parent. For some young people their caseworker will be the only adult in their life with whom they have a reliable and trusting relationship.

In 2013 CREATE Foundation conducted a major survey of 1069 children and young people across Australia, asking about their experience of out-of-home care.³⁰ Forty per cent of the respondents did not feel that they could contact their caseworker as often as they wanted, and thought that caseworkers could be more helpful. South Australia performed a little better than some other jurisdictions, with respondents more likely to report that they could see their caseworker as often as required.³¹

A common theme in responses was that children and young people wanted caseworkers to 'do what they promised, when they promised it'.³² A similar theme was observed in this Commission's consultation with young people in care, one contributor emphasising that they 'want workers to keep their promises—ask to do something and they say maybe tomorrow, maybe next week and we never get to do it'.³³

A common theme from children and young people was that they wanted caseworkers to 'do what they promised, when they promised it'

Securing the trust of children in care requires that case managers be able to make good on promises and undertakings. The CREATE survey found that a large proportion of respondents considered their carers more supportive of their interests than their caseworkers. The CREATE report concluded that if caseworkers were to work in a way that children and young people valued, they needed to focus more on advocacy rather than 'bureaucratic gatekeeping'.³⁴ To do this, caseworkers should have a well-developed understanding of the child or young person's needs.

A useful strategy is to engage children in the case planning process. This need not be attendance at formal case management meetings, but could include more creative and informal engagement strategies that make the process meaningful for the child.³⁵ The CREATE survey found that less than one-third of the children and young people surveyed knew about a case plan developed for them, and of those who knew about their case plan, only one-third had been involved in its preparation.³⁶

GCYP's audit of annual reviews for the 2014/15 financial year found that only 15 per cent of children and young people judged capable of contributing had attended in person at their annual review. A further 24 per cent had contributed by completing a survey form which had been posted to them. These levels of participation were improvements on the figures from the previous financial year³⁷, but suggest that there is room for improvement.

DEMANDS ON CASEWORKERS

A child's caseworker should be a significant and stable influence in their life. One supervisor from a country office described the intensity of the role in the following terms:

So you take them on outings, you get to know what their favourite colour is, what they like to eat, you know who their best friends are, and the point ... is that then if they have issues in placement they will disclose [them], because they trust you and they've got great confidence in you ... making sure that their health is good, their education is good, their peer social relationships, their leisure, they've got an understanding of their identity.³⁸

To provide a high quality service to a young person in care requires time; it requires an ability to collaborate and bring together all the parties who have an interest in the child or young person being their best; and it requires an understanding of the services that are available, as well as assertive advocacy on behalf of the child to ensure they gain access to those services.

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In 2008, the Children in State Care (CISC) Inquiry extensively reviewed numerous cases of sexual and physical abuse. The CISC report recommended that every child and young person should have a social worker, and that the worker should provide face-to-face contact, at least monthly, regardless of the stability or nature of the placement.³⁹ The recommendation was especially important because of the consistent theme that young people who were victims of abuse in care lacked a trusted social worker to whom they could complain, and that regular contact with a caseworker was an important protective factor.⁴⁰ This recommendation was accepted by the government, but evidence obtained by this Commission suggests that not all children are receiving a service at the required level.

A number of children in care have not been allocated a caseworker. They do not get regular visits and do not enjoy the benefits of proactive case management. Rather, they are provided services on an as-needs basis by a duty worker or a supervisor at the local office. However, casework with vulnerable children and young people in the care of the state is not an administrative function, and should not be done on this basis. These children require a relationship with someone they trust on whom they can call if a problem arises. A child who is unsafe in their placement, and who is struggling with personal relationships, health or education, is highly unlikely to contact their local office to speak to someone they do not know or seek assistance from a duty worker.

Families SA supplied data to the Commission showing that 53 children and young people subject to long-term orders were unallocated as at 22 October 2015.⁴¹ However, evidence given by a large number of workers reflected a much higher level of unallocated cases in local guardianship hubs. GCYP's audit of annual reviews for the 2014/15 year also observed a higher proportion, with 29 cases of the 203 audited not allocated to a caseworker. One possible explanation for this divergence is that the rate of allocation has changed significantly over the time in which the Commission has been gathering evidence.

However, being assigned a social worker does not guarantee children and young people a proper service response: they may receive less frequent support because of an assessment method used by the Agency to rationalise the workload when it exceeds worker capacity. A 'differential response' tool evaluates the level of attention required by each case, and the resulting rating is used to justify the provision of a lower level of service. This may include reducing visits to three-monthly, six-monthly or even yearly.⁴² Some children are listed against a caseworker's name in the C3MS database but in terms of the service response they are effectively unallocated.⁴³

The children and young people likely to receive a lower level service response are those who are in long-term stable care placements, who are surrounded by adults who are concerned for their wellbeing, and who are well engaged in the community.⁴⁴ However, this is not always the case. GCYP reported on one child who, at the age of 11, was in a placement that was considered 'not ideal'.

His case was unallocated, and he was only sighted by the Agency because other children in the same placement were allocated and social workers visiting those children happened to see him.⁴⁵

Some children do not welcome the intrusion of the Agency into their lives, as they do not wish to be identified as a child in care. Where children are in stable arrangements and an as-needs service response is appropriate, these children should be actively assessed for Other Person Guardianship (OPG) orders, which permits carers to officially, as well as practically, take responsibility for the children and or young people in their care.

Both unallocated cases and differential response cases contribute to workers' discomfort with the current system. One told the Commission about being instructed not to record resourcing issues as service barriers in case notes. She explained that she wanted to be honest and transparent with young people, who might eventually have access to these records, and show them that the lack of service response did not mean that no-one cared about them: it was simply that the office lacked the capacity.⁴⁶

The Commission attempted to identify a caseload that was professionally sustainable and would permit a service to be delivered at optimal intensity for the child. Some witnesses reported caseloads of approximately 20 children per worker in the past, although this had settled to between 14 and 16.⁴⁷ Even at that level, depending on the needs of the children, it might not be possible to deliver an adequate service to the less demanding ones. There was one experienced worker who was asked in the course of evidence what she would like to be doing if she had the time to do it:

I think, ideally, to be spending more time with the kids ... it sometimes does get to a point where it's just crisis response with certain children that are so time consuming ... some of the children that are very settled, they are just [as] entitled to your time, and [ask] 'Could you come to my school play? Are you going to come to my sports day?' You know, all these things where you want to just have that time to pick them up after school, but you're so busy chasing the children that are really, really needing us at that time ... I think some of the more settled children, unfortunately, do get a little bit pushed to one side.⁴⁸

If caseworkers are to deliver a service in accordance with the standards adopted in this state, they should be adequately resourced, and these resources deployed in a more effective way. Chapter 5 recommends providing more administrative support to workers, and reducing the administrative burden by allowing decisions to be made at lower levels. Both these reforms should permit a greater focus on face-to-face client engagement.

Children and young people can also be engaged in ways that do not require formal meetings. Mobile phone, text messages, email and other technologies that facilitate communication permit connections to be sustained without formal meetings. However, these tools should be a supplement to, never a replacement of, personal meetings held at least monthly.

Ultimately, the number of cases that constitute an acceptable level of work will depend on the complexity of needs of the children concerned. It is not possible to be prescriptive about the matter. However, the Commission makes the observation that evidence suggested that a total of 14 cases was likely to be at the upper level of acceptability, with allowances made for those cases in which a child had especially complicated needs.

The differential response tool should be abandoned insofar as it justifies a departure from the standards of care clearly identified in state and national standards. Where a less intense level of service is genuinely required, but OPG orders are inappropriate, a revised service response should be a matter of formal agreement between the child, the caseworker and the child's carer, and should reflect the best interests of the child, not the resource imperatives of the Agency. No child should be unallocated, or unaware of the identity and function of their caseworker. They should be visited on a monthly basis.

The turnover of caseworkers in the Agency also undermines children's ability to form trusting and stable relationships. The CREATE survey found that across Australia 35 per cent of respondents had been allocated more than five caseworkers over the course of their time in care.⁴⁹ GCYP's audit also showed a high turnover in caseworkers by measuring the length of time the worker had been allocated to the case at the time of the annual review. Figure 10.1 demonstrates that the overwhelming majority of children reviewed had been allocated to their worker for less than 12 months.

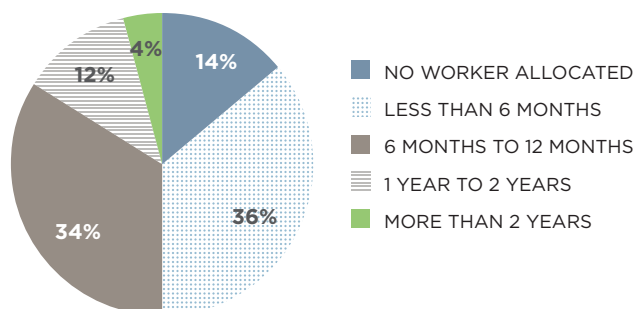


Figure 10.1: Relative lengths of time social workers had been allocated to children or young persons at their annual review, 2014/15

Source: 2014/15 audits, Office of the Guardian for Children and Young People, SA.

It is clear to the Commission that the casework staff charged with supporting the most vulnerable children in this state are not in a position to offer the best service. In order to improve the quality of response offered in this important area, staffing levels should be increased. The additional staff should be appropriately qualified, and exclude those whose experience and occupational classification is operational. Efforts should be made to ensure that, as far as possible, consistent relationships over time between children and caseworkers are promoted and supported. One way of achieving a greater level of stability is to adopt an approach within an office which matches children with both a primary and secondary worker to deliver greater continuity.

Children who are in stable placements and who do not require an active service response from the Department should be proactively assessed for OPG orders.

NON-GOVERNMENT ORGANISATION OUTSOURCING

The Child and Family Welfare Association (CAFWA), along with several other non-government organisations, has advocated outsourcing the case management of children under long-term orders to registered foster care agencies. This model has been adopted in other Australian jurisdictions.

CAFWA argues that the overlap of function between the Agency supporting the child and the registered foster care agency supporting the placement can lead to unnecessary conflicts, and that the alignment of responsibilities within one body would provide much needed clarity.⁵⁰ It contends that this outsourcing would not change the ultimate role of the Minister as guardian, but would reduce duplication of effort.⁵¹

Although there is a precedent for this model in other jurisdictions, the Commission has concluded that this level of outsourcing is inappropriate. As guardian, the Minister holds a heavy responsibility for the wellbeing of children within the care of the state. It is not appropriate that this responsibility be discharged at arm's length through a non-government agency.

Further, where children are in stable placements that permit the Agency to appropriately withdraw from its role, OPG processes should be actively pursued. However, there is a role for continuing the support of carers acting under OPG orders, and this is discussed in Chapter 13.

ANNUAL REVIEWS

According to section 52 of the Act the Minister is obliged to annually review the circumstances of children and young people on long-term orders.⁵² The review must be carried out by a panel appointed by the Minister and the panel must produce its conclusions in writing. The obligation in section 52 is key to ensuring that planning for children is regularly scrutinised and updated.

Section 52(3) requires the reviewing panel to 'keep under constant consideration whether the existing arrangements for the care and protection of the child continue to be in the best interests of the child'. GCYP described annual reviews as:

a 'pause' in the day-to-day business of parenting a child who is in care. It is a time for reflecting on the goals and ambitions, achievements and challenges for each child or young person. It can sometimes be the one time in a year when the many adults in a child's life can confer on whether they can 'parent' better.⁵³

Annual reviews are delegated by the Minister to any staff member of or above the supervisor level. This staff member chairs the panel. The panel must consist of no fewer than two people.⁵⁴ For Aboriginal or Torres Strait Islander children, there must be an appropriate cultural representative.

The discussions and considerations of the annual review panel are guided by a two-part pro forma. Part A contains relevant detail of the child's case management, including their needs, strengths and arrangements for their care, and details of the carer family and their living environment.⁵⁵ It extends over four pages.

Part B is labelled 'conclusions' and comprises only one-and-a-half pages. It requires the panel to record a brief summary of the circumstances of the child or young person, and a 'summary of the areas requiring intervention and any recommendations of the panel'.⁵⁶ The conclusion section requires a surprisingly small amount of detail. It fails to direct the attention of the panel to the statutory question of whether the existing arrangements for the child remain in their best interests. By focusing on areas requiring intervention, the form focuses discussion on deficits and does not encourage the aspirational planning that is required in the South Australian standards.

The division of the form into these two parts, whether by design or coincidence, enables the Agency to provide only a small portion of the panel's discussions and observations to the child, the child's guardian and any person who has care of the child, as it is only the review's conclusions (Part B) that must be provided.⁵⁷ The current design of the form undermines the overall intent of the legislation: to provide a transparent and open process that includes all relevant parties. The annual report pro forma should be redesigned to reflect the standards of alternative care and the legislative intent.

The GCYP's audits of annual reviews provide an important insight into the quality of casework being conducted on behalf of children and young people. Despite the fact that annual reviews are mandated in legislation, in the 2013/14 financial year the Agency completed reviews for only 53 per cent of children in care.

For the 2014/15 financial year 2100 children were entitled to an annual review. Eighty-three per cent, or 1740 children, were reviewed. This was a substantial improvement on the previous year. The Commission was advised that the Agency had brought a sharper focus to annual review responsibilities, resulting in a marked increase in compliance. However, it meant that for 2014/15 there were still 360 children in care who were not reviewed in accordance with the requirements of the legislation.

GCYP noted some examples of quality casework, including regular face-to-face contact between the child and the caseworker, and active advocacy on the child's behalf.⁵⁸ However, an inconsistency of approach was observed across different offices, with associated variations in quality. GCYP observed a greater depth of analysis and quality of discussion when external providers or panel members independent of the case were involved. Unsurprisingly, she also observed a higher quality of review when more than half an hour was allocated for discussion. It is difficult to be satisfied that an annual discussion of no more than half an hour has the capacity to deliver the comprehensive and reflective consideration required.

Very few reviews began by identifying the previous year's recommendations and reviewing progress against them. In 29 of the 203 cases audited, the caseworker had limited knowledge of the child or young person, or was not working with the child at the time of the review.⁵⁹

The poor rate of compliance with the legislative requirements should be urgently addressed. It is unsatisfactory that such high numbers of children in care are not receiving the quality of care required by legislation, let alone the quality standards dictated at the national and state level.

The Agency should take urgent action to improve the rate and quality of annual reviews. The Commission recommends that the policy guidance be reviewed to require that the annual review panel be chaired by a suitably qualified person who is independent of the case. The pro forma should also be redesigned, with the intention of providing the whole record to the parties identified in section 52 of the Act, except where this would not be in the best interests of the child. The independent chairperson should be asked to guide discussions to ensure that the review is a genuine opportunity to study the child's circumstances and plan for their future.

GCYP suggested that the following shift is required in approaching annual reviews (among other important casework functions):

The imperative for the 'corporate parent' is to shift from 'worker' thinking to 'parent' thinking to consider how the child is, what the child thinks, what brings meaning to the child's life and what the child finds funny or misses, or hopes for. To be truly informed, questions need to be asked and others who see parts of the child's life need to be closely listened to. A review has to conclude that the child has all the necessary supports to meet their needs, or identify actions and responsibilities to acquire the necessary supports.⁶⁰

The Commission adopts this as an important guiding principle.

STABILITY OF PLACEMENT

Research supports the proposition that stable care arrangements are associated with better psychosocial outcomes for children and young people.⁶¹ There are a variety of factors that appear to influence this relationship. A South Australian study looking for factors associated with placement stability identified⁶²:

- entry into care at an early age (entry as an infant under two);
- a shorter exposure to an abusive environment before coming into care;
- clear and decisive actions regarding the child's long-term future at an early stage; and
- the relative skill of the carers.

The majority of children in care in South Australia are in stable long-term arrangements. However, there is a concerning proportion who experience high levels of placement instability, as shown in Figure 10.2. Fifty children who left care in the 2014/15 financial year had experienced 11 or more placements during their period of care. A further 53 had experienced between six and 10 different placements.

The proportion of children experiencing high levels of instability is much higher in South Australia than any other jurisdiction (see Figure 10.3 and Figure 10.4). However, stability of placement can be improved by better initial planning and assessment of placements, and by better support of placements at risk.

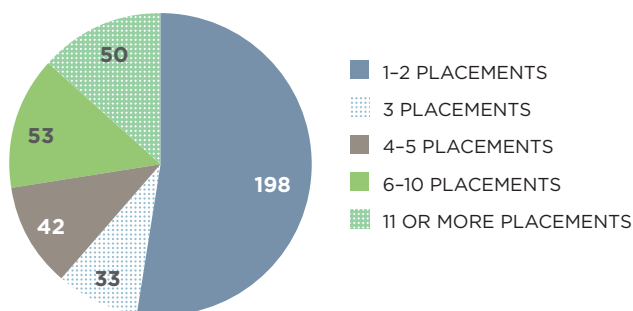


Figure 10.2: Number of placements experienced by children on a Care and Protection Order leaving out-of-home care in South Australia, 2014/15

Source: Data supplied by Families SA. The Commission was advised in response to an enquiry that data supplied by Families SA to the Productivity Commission for this measure was inaccurate. Accurate data was then supplied to the Commission. This data therefore is different from that contained in the Productivity Commission report for South Australia.

PLACEMENT DECISIONS

A decision that can have long-term consequences regarding a child's quality of care is the choice of a placement. Initial decisions are often made in pressured circumstances when a child urgently needs to be removed. At that early stage it can be challenging for Agency staff to conduct a comprehensive search for suitable family members. Agency staff often need to rely on parents from whom the child is being removed to identify alternative options for care as the parents will not always be objective about the process.

Placement decisions are at times made on the basis of short-term expediency, with limited consideration of the long-term suitability of the placement.

Where a family member or other suitable carer cannot be identified for the child, alternative care is arranged through the Agency's Placement Services Unit (PSU), also known as 'matching and allocation'. This unit receives and acts on referrals for placement by identifying what is available to best fit the child's needs. There is no doubt that the current crisis in home-based placements means that very often a child's allocation is dictated by what is available at the time rather than what is the best fit for the child.

COMPLEXITY RATINGS

Children and young people in care are scored according to a complexity assessment tool (CAT) which is then used to guide service provision. The CAT score is also used to consider eligibility for therapeutic care placements, and loadings for foster parents and kinship carers. The overall score represents a combination of ratings based on complexity measures of behaviour and special needs.

The behavioural complexity score considers substance use, sexualised behaviour, offending behaviour, school behaviour and general behaviour. The special needs complexity score considers physical health, physical development, intellectual ability, mental health and physical disability.

The overall complexity rating is determined from all these scores and informs the child's placement and service options. The CAT rating ranges from 1 (minor or no problems) to 4 (extreme problems).

The CAT score is not a formal assessment, but a guide to the severity of a child's multiple problems on presentation. It does not identify children who are at high risk of developing complex behaviours but have not as yet manifested any signs, possibly due to good quality care in a stable family environment.

In general terms, complexity assessment is a useful overall tool for identifying children with high needs, but care must be taken in placing too much reliance on an absence of identified complexity when making decisions about the appropriateness of care placements.

CONCURRENT PLANNING

Families SA's care planning policy emphasises the need to minimise instability for children in out-of-home care by concurrent planning.⁶³ Concurrent planning is a concept which recognises that care should minimise disruption to a child's attachments and relationships while reunification with their family is pursued.⁶⁴ Concurrent planning requires that, where possible, children are placed with carers who will support reunification but also be prepared to offer a long-term placement if that is required. The care planning policy emphasises that for this approach to be successful, full disclosure to the birth parents, carers and, where appropriate, the child is necessary.⁶⁵ The policy notes that concurrent planning recognises the harm that is caused by 'sequential plans to attempt reunification followed by attempts to seek a long-term placement after reunification has failed'.⁶⁶

In the Commission's case study of 'Abby' (see Vol. 2, Case Study 2), the child was removed from the care of her mother when she was two months old. Attempts to reunify her with her mother persisted until Abby was two years and seven months old. Shortly after her removal, Abby was cared for in three different foster care families. At nine months, just as Abby was entering her critical attachment phase, she was moved to a residential care facility staffed by a group of rotating carers. This situation was recognised as unacceptable by her case manager, who continued to advocate for Abby to have a home-based placement. When Abby was 14 months old she entered the care of Ms K, an experienced foster parent who was raising her own biological children together with a foster daughter on a long-term order.

10 SERVICES FOR CHILDREN IN OUT-OF-HOME CARE

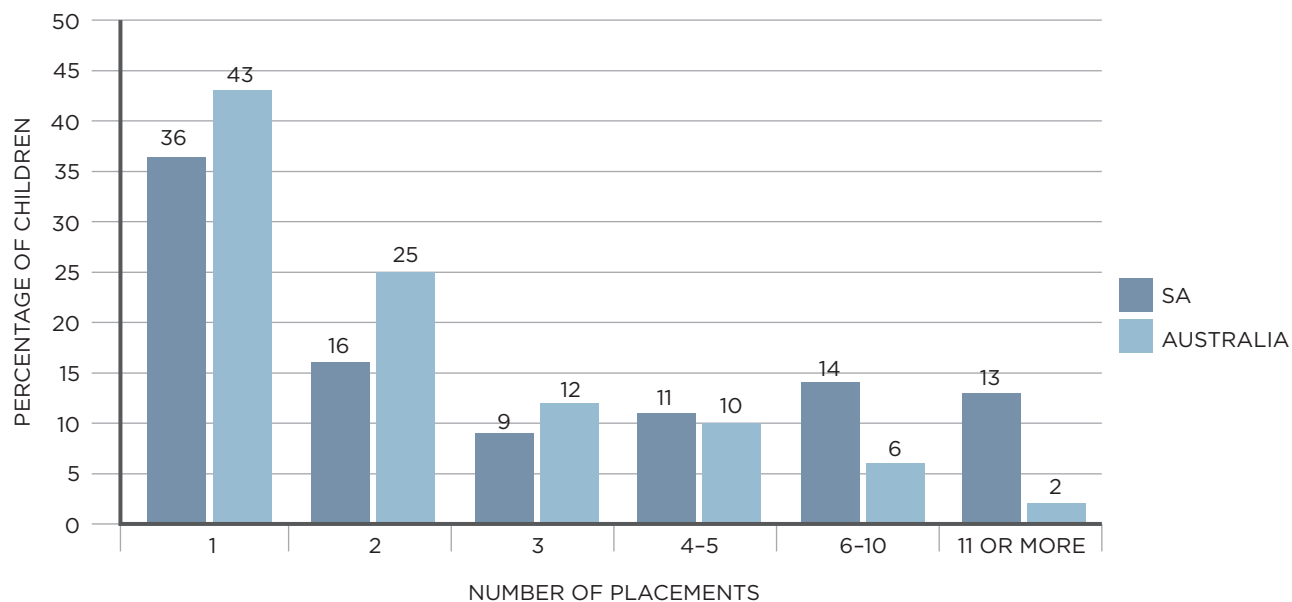


Figure 10.3: Percentage of children on a Care and Protection Order and leaving out-of-home care in 2014/15 by number of placements

Source: Data for all states except South Australia from the Productivity Commission's *Report on government services 2016*. South Australian data supplied by Families SA. The Commission was advised in response to an enquiry that data supplied by Families SA to the Productivity Commission for this measure was inaccurate. Accurate data was then supplied to the Commission. This data therefore is different from that contained in the Productivity Commission report.

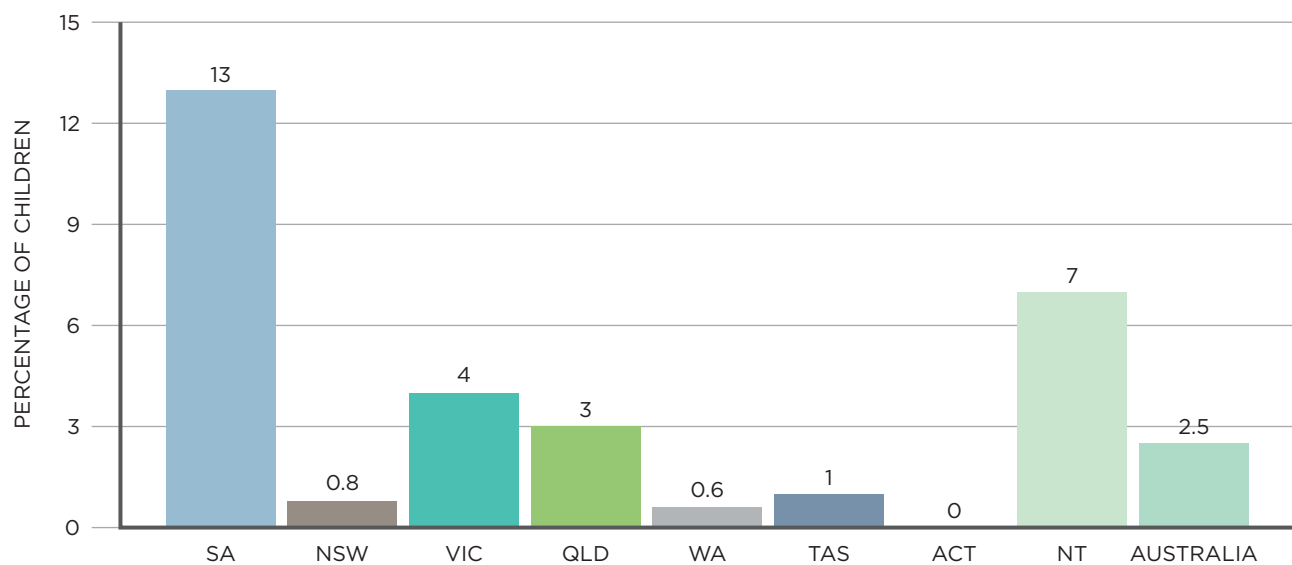


Figure 10.4: Percentage of children on a Care and Protection Order and leaving out-of-home care in 2014/15 having experienced more than 11 placements

Source: Chart compiled using data contained in the Productivity Commission's *Report on government services 2016*.

Abby remained in Ms K's care for nearly 18 months until she was two years and seven months old. This was the longest continuous attachment relationship Abby had ever enjoyed.

Unbeknownst to Ms K, very soon after Abby was taken into care, Families SA had undertaken family scoping and identified family members living interstate who were prepared to offer Abby long-term care. This was especially significant because Abby is an Aboriginal child and the Aboriginal placement principle required that great weight be given to keeping her within her cultural community. The placement interstate was not pursued because of the barriers that were perceived (incorrectly) to prevent a transfer of the court orders. In addition, no effort was made to introduce Abby to her interstate relatives although in the future she might need to be placed with them long term.

In the final stages of the failed reunification efforts, Families SA finally made contact with Abby's interstate family and assessed them for long-term care. Ms K became aware, for the first time, that she was not being considered for long-term care of Abby because of the family interstate. Given the attachment that had developed between Abby and Ms K, this transfer was not supported by the Aboriginal Family Support Service, the agency that Families SA was obliged to consult on placement decisions for Aboriginal children.

At the age of two years and seven months Abby was transferred to the care of family members over a period of five days. Before this, Abby had spent no more than an hour in their company. A number of professionals who gave evidence expressed concern about the brevity of the transition.

Quite apart from the length and quality of the transition, case planning for Abby did not place her at the centre of decision making. While considerable effort was directed towards helping Abby's mother address the issues that prevented her from safely caring for her daughter, there was a lack of focus on Abby and her long-term wellbeing, and the critical role that secure attachment relationships played in supporting her emotional, developmental and psychological wellbeing.

Abby is not an isolated case. In the hearing of the McCoolle case study, the Commission heard that one of McCoolle's victims, 'Chelsea', was subjected to a similar process of poor case planning. Chelsea had been cared for in a home-based placement with foster parents during a short-term order which contemplated reunification with her mother. When reunification failed, Chelsea was transitioned over a period of five days to the care of a relative whom she had not previously met.

Both of these cases highlight the need for comprehensive and child focused planning at an early stage, especially for infants who are in an active attachment phase, and especially vulnerable to the effects of instability and emotional trauma. Clear plans with built-in contingencies that are well known to all parties are critical to ensuring that the child's best interests dominate all case planning decisions.

Where children are on short-term orders, case plans should include clear consideration of concurrent planning, and how the child's attachment and developmental security are being assessed. For children who are not in kinship placements, careful attention should be paid to comprehensive scoping of suitable family members. A care plan should be developed and shared with all interested parties, including foster parents, which describes appropriate concurrent planning for the child's stability.

SUPPORTING PLACEMENTS AT RISK

Research supports the view that those care placements most likely to experience instability and risk breakdown can usually be identified at an early stage.⁶⁷ This highlights the importance of early intervention to prevent such a breakdown.

Children entering care in today's environment have increasingly complex behaviours and medical needs.⁶⁸ This is changing the nature of care provision.⁶⁹ When carers are not adequately supported while dealing with difficulties that children in their care are facing, placements break down. Early support should be available to identify and address issues before placements are put at risk.

Flexible support for carers is critical to identifying problems, and addressing them in a timely way. Sally Rhodes, an experienced social worker who works with families where placements are at risk, was questioned by the Commission:

- Q. What are the kind of risks that might be associated with a placement that would increase the danger that it would break down or wouldn't be sustainable?*
- A. Lack of support is the main thing, in my opinion. Lack of support is a huge issue. Lack of information, I guess, to carers around what has happened for children and therefore what to expect. Lack of training, support, and when I say 'support' I mean support that they can access 24 hours.*
- Q. What do you mean by 'support'? Is it having someone to talk to or having someone to answer questions?*

A. *I think both ... they often say carers come in with the best of intentions and they want to do the best that they can, but they don't know what they don't know, and what they don't know is what trauma looks like over a period of time and what that means to be dealing with on a day-to-day basis and the effect it has.*⁷⁰

One witness who often works with children and young people with complex developmental issues relating to trauma told the Commission he is yet to encounter a foster parent or kinship carer who, before taking on the care of a child, genuinely appreciated the complexity of the undertaking, and that instinctive notions of how to parent might not be appropriate for these children.⁷¹

Regarding trauma, another witness observed that:

*I think lots of the time it would be missed that there's a need for therapeutic support to placement. Foster carers are usually meant to have had a lot of training in childhood trauma and attachment, but quite often when we've met with them, their understanding is fairly rudimentary ... I'm constantly surprised that the information we're imparting to them about the child is usually a bit of a surprise to them.*⁷²

Home-based carers are not experts in trauma. They rely on the professionals to support them by identifying and addressing issues which emerge as the child grows. Two principal barriers to therapeutic support for placements were identified: one, that foster parents fail to communicate with support workers about the nature and severity of the problems with which they are grappling; and two, that professionals charged with supporting the placement do not refer the foster parents to appropriate support at an early stage.

Some caseworkers appeared to misunderstand the nature of therapeutic support that might be available to a placement. The Commission became aware of two instances in which caseworkers had not made referrals for psychological support, stating that the children involved were too young. This misconstrues the nature of available support. An experienced psychologist told the Commission that:

*therapy ... quite often in our context is via the caregivers because children are either too young or reluctant or what have you, [so together we try to] make this therapeutic environment for this child; so it's often around supportive work with the carers.*⁷³

The challenge of delivering therapeutic support to these children and young people is that the treatment of developmental trauma is not rapid and cannot be delivered by professional intervention alone. Therapy requires consistent long-term work, with changes to the child's care environments (home, school, therapy,

birth parents) to accommodate the distorted ways in which the child relates to the world and responds to circumstances.⁷⁴ Negotiating a path through the various services supporting a complex child was described as 'difficult and sometimes impossible' for a therapist.⁷⁵

Carers are often at the heart of delivering therapies for better outcomes for children. It is important that they understand that therapy is delivered through changes in the child's care environment, with close attention to building healthy relationships. Carers should be assured that this does not reflect shortcomings in the care they are delivering, but rather the fact that such children often need specialist care.

The need for a coherent approach underscores the importance of having an assertive and knowledgeable case manager who can lead and coordinate efforts and deliver consistency across the child's environments. Greater emphasis is needed on early intervention in placements exhibiting signs of stress.

MOVING TO A NEW PLACEMENT

There will be occasions when moving a child to a new placement is in their best interests. Where the care is inadequate or inappropriate, and the supports provided have not remedied the deficits, then often a child's interests may be better served in an alternative care environment. However, when placement changes are neither wanted nor planned, it is an important part of case planning to review the reasons for the placement breakdown, to determine what factors might prevent a recurrence in the future. Greater emphasis should be placed on reviewing these situations to identify any systemic contributors.

Children and young people should be involved wherever possible in decision making about such moves. Children whose placements end can experience a range of negative feelings:

*Without preparation for moves, children can become prone to chronic fears and anxiety and may withdraw or become overly compliant. Others may become more assertive and try to control everything. Yet others may develop chronic guilt as they hold themselves responsible.*⁷⁶

Children should understand what is happening, and be assured that someone is in control, and is planning for their future.⁷⁷ Sudden moves and abrupt loss can make it more difficult for the child to grieve even when the placement was not optimal.⁷⁸ One child involved in the Commission's consultation with children and young people observed that the relationship worked 'as long as the child is aware and the carer is a good communicator and clear with boundaries and honest.

Some say you will live with them forever and [then] you are moved'.⁷⁹ Others made the following comments about moving while in care⁸⁰:

- *When you move it sucks.*
- *I want to be consulted if I have to move.*
- *If I am moved I want visits first and I don't want to be immediately cut off.*
- *If in resi[dential] care, make sure you don't move constantly—that sucks.*

'Some say you will live with them forever
and then you are moved'

The Commission was made aware of a number of circumstances in which children were removed from placements suddenly and without warning to either the child or the carers. These matters are discussed further in Chapter 11.

When children move to a different geographic area, it can also mean a change of caseworker, to one from an office closer to the child's new home. Whether continuity of relationship with a caseworker is more important than physical proximity should be carefully considered in partnership with the child. Where possible children should be given a choice about whether or not they are allocated a new worker.

HEALTH

The Health Standards for Children and Young People under the Guardianship of the Minister govern the relationship between the Agency and SA Health in the delivery of health services to this vulnerable group.⁸¹ The standards are based on the Rapid Response framework which aims to encourage better collaboration in meeting the needs of those in care, and also give them priority access, where possible, to government services.⁸²

Rapid Response seeks to 'provide opportunities for equitable outcomes in education, health, and development' by supporting children in care with services that 'will align their level of education, health, emotional and psychological development with the population average'.⁸³

Unless funded by their carers, these children do not have the benefit of private health cover and rely on public health services.⁸⁴ They often enter care with a number of unmet health care needs, which should be properly

Nathan—Dealing with complex needs in care

(The full case study of Nathan is in Volume 2, Case Study 4: Nathan—Children with complex needs in out-of-home care.)

At the age of 10 'Nathan's' psychological and emotional problems became so great that his foster parents faced significant challenges in caring for him. On occasions, his behaviour made them fear for their safety. Families SA decided that it was no longer safe for the placement to continue, and he would be moved to a large residential care unit. Families SA decided not to tell Nathan about the decision because they feared his reaction.

When the day of the move arrived, Nathan was driven by his caseworker to the unit. On arrival, for the first time, he was informed that this would now be his home.

Nathan was highly distressed by the news. He responded by damaging property at the unit and assaulting workers. Police were called and Nathan was arrested and refused bail. He spent his first weekend away from his foster parents at the Adelaide Youth Training Centre. This was Nathan's first of many admissions to youth detention that were to follow his move to the unit.

assessed and addressed. Case managers within Families SA should actively track and coordinate children's health to ensure that these needs are met.

The South Australian Health Standards sit against a background of the National Clinical Assessment Framework for children and young people in out-of-home care.⁸⁵ The national standards emphasise the need to identify issues early so that intervention can be offered when it will be most effective.⁸⁶ The national standards therefore require a two-stage health assessment when a child enters out-of-home care. The first stage is a preliminary health check to be conducted within the first 30 days; the second stage is a more comprehensive assessment to be completed within three months.

The Standards for Alternative Care require that these children receive an initial health assessment within two months of them entering care.⁸⁷

INITIAL HEALTH ASSESSMENT CLINICS

In South Australia arrangements have been made for initial health checks of children and young people in care to be conducted at clinics constituted specifically for this purpose. Clinics are held at the Women's and Children's Hospital (WCH), the Flinders Medical Centre (FMC) and the Lyell McEwin Hospital (LMH). The initial health assessment is designed to achieve the following goals⁸⁸:

- identify any medical, psycho-behavioural or developmental conditions that require ongoing care;
- develop a health care plan that sets recommendations for the psychological health, physical health and developmental needs of the child or young person;
- make referrals to appropriate services as required;
- negotiate a process with Families SA to implement the health care plan; and
- implement the care plan and monitor the child or young person's ongoing health status.

The clinics at FMC and WCH have the better developed models. Both clinics attempt to include a psychosocial component to the assessment by having a clinical psychologist or social worker attend when most needed. A key member of the team is the clinic coordinator, who is either a psychologist or social worker. Before the child's appointment, the coordinator gathers relevant information from the Agency, SA Health (including birthing hospitals where relevant) and other health providers. The clinical skills of the coordinator are invaluable in identifying gaps in the documentation, summarising the child's health history and identifying issues of relevance for the paediatrician who conducts the medical assessment. The clinic coordinator also engages with Families SA to ensure the attendance of the caseworker and the child's carer.

The LMH clinic operates on a far more limited basis. The clinic is managed by a clinical nurse who gathers information before the appointment, and there is no psychosocial aspect to the assessment.

When undertaken comprehensively, the initial health assessment offers an opportunity to assemble all that is known about a child's health and related health needs. It will frequently identify inaccuracies in the Agency's records, which can include incorrect recording of a child's immunisation status. This, however, can be checked against the National Immunisation Register.⁸⁹ One practitioner reported that in reviewing the health history for one child she discovered that they were at risk of contracting Hepatitis C, but had not been tested. No-one had spoken to the child's foster parents about the issue.⁹⁰

Several common themes emerged when representatives from each of the clinics gave evidence to the Commission regarding the initial assessments. These included behavioural problems, sleeplessness, feeding challenges and anxiety. All practitioners reported language delay as a common developmental issue in younger children being assessed.⁹¹ An emerging issue for children in care was obesity and emotionally disordered eating.⁹²

All representatives regarded it as important that the clinics viewed problems through a trauma lens. Children who have had traumatic experiences may well present with symptoms that are consistent with conditions such as autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD). However, for some of these children, such developmental issues will right themselves when stable and supportive care with appropriate therapy is offered.⁹³

The experience of staff at both the FMC and WCH hospital clinics was that very few, if any, children referred for an initial assessment had received a health check by a general practitioner within 30 days of them entering care, as contemplated by the national standards. The purpose of the early check is to identify any health conditions that need urgent attention, but also to provide some baseline information about height and weight which will enable the child's growth to be tracked after they enter care.⁹⁴

The clinics rely on the Agency to identify children in need of assessment: they have no independent way of identifying them.⁹⁵ The clinics consistently receive referrals for children who have been in care for much longer than two to three months without having an initial health assessment.⁹⁶ The clinic coordinator for the WCH clinic told the Commission that of 45 referrals received by her, only one child had been referred within two months of coming into care. The others ranged from two months to up to 12 years.⁹⁷

Delayed referrals have consequences for children's wellbeing. Many children whose initial assessments are delayed are later identified as having issues that would have benefited from earlier intervention. Furthermore, with the recent shift in disability funding arrangements to the National Disability Insurance Scheme (NDIS), children seeking to access funds under the early intervention pathway because of a developmental delay will be excluded if they are six years of age or older. The initial health assessment can identify and document important information to establish eligibility and pathways to NDIS funding.⁹⁸

An initial health assessment concludes with the paediatrician providing a report that is to be followed up by the child's case manager. Review appointments can be scheduled as required, or referrals made back to the child's primary health provider.

The initial health assessment is an important step in a child's care journey—an opportunity to comprehensively take stock of their health history, status and future. It is an opportunity that should not be missed, particularly when there are clinics equipped to provide good quality assessments.

THERAPEUTIC SUPPORT

Medical practitioners involved in assessing children in care indicated that, in general terms, they were surprised at the low level of engagement with therapy.⁹⁹ Children in care, almost by definition, have experienced trauma in their lives. Many carers expressed frustration about the difficulties they faced accessing therapeutic help for children in their care.

In a review of unmet mental health needs of children in care, published by GCYP in February 2012, a random audit of 60 files showed that 54 of the 60 children had received a mental health assessment of some kind. However, most of these were performed to assist in court proceedings, rather than to identify and guide therapeutic services.¹⁰⁰ Many of the assessments did not meet the relevant out-of-home health care standards for a psychological assessment.¹⁰¹

There was evidence that some children for whom therapy had been recommended had not been given a referral, and for others there were long delays between a referral and the first available appointment. There were four cases in which carers were dismissive of mental health plans and actively obstructed the child's attendance for therapy.¹⁰²

Therapeutic services for children in care are scattered across a number of agencies, each of which apply their own criteria for eligibility. These include Families SA, child protection services at the WCH and FMC, Child and Adolescent Mental Health Services and private providers.

The CISC Inquiry recommended that the therapeutic services provided by these various agencies be reviewed, to increase the level of response available to children and young people.¹⁰³ This recommendation was made in the context of therapeutic responses to children who have been the victims of sexual abuse. Evidence available to the Commission suggested that, notwithstanding this recommendation, the therapeutic needs of many children in care are still being neglected. While there are some examples of very good service from the Agency, not all children with a demonstrated need are receiving assessment and support.

The Commission was made aware of a number of promising developments in service provision across the child protection system. These initiatives should be nurtured to address children in care's therapeutic needs.

FAMILIES SA PSYCHOLOGICAL SERVICES

Families SA employs clinical psychologists who provide both assessment and therapeutic services. The service structure and focus was in a state of flux at the time that evidence on the topic was taken by the Commission.

Chapter 9 recommends that eventually the assessment function for court purposes should be removed from the Agency but the assessment function for therapy be retained, enabling the Agency's psychological services to focus more strongly on providing therapy for children in care and a consultation and training service for other staff.

Psychological services would also need to retain responsibility for coordinating private providers of therapeutic services.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Child and Adolescent Mental Health Services (CAMHS) is part of SA Health's Women's and Children's Health Network. It provides community-based services for children and young people up to the age of 15; Boylan Ward, an inpatient hospital ward located at the WCH (for children between approximately 12 and 17); an emergency mental health team available at the emergency department of the WCH; and consultant liaison services at FMC and WCH. CAMHS also provides a perinatal and infant mental health service at WCH, and an infant reunification program.

At its Enfield campus, CAMHS provides an adolescent day service for young people who are struggling at school because of emotional problems or anxiety. The service is not designed, however, for young people with significant behavioural or emotional dysregulation.¹⁰⁴ A behaviour intervention service is provided at the same site for children under 12.

CAMHS has recently undergone a significant restructure in response to a comprehensive review of its services completed in November 2014.¹⁰⁵ At the same time, it has rolled out the Radical Redesign project, providing an opportunity to pilot a number of innovative service models responding to areas of need.

One of those pilots is a small inter-agency therapeutic needs panel, conceived to better coordinate the provision of therapeutic needs for children in care.¹⁰⁶ The pilot was led by Dr Prue McEvoy, the clinical director of CAMHS, who was concerned that although some children in care had been assessed many times, responses to their needs were not well coordinated. CAMHS recognised that there were occasions when there was no doubt a child required therapy, but there was a lack of thoughtfulness about the best type, and the best provider. There was also a need to coordinate children's educational needs as part of any therapeutic strategy.

The panel currently comprises senior staff from Child Protection Services (FMC or WCH), Education, Families SA and CAMHS.

The panel started by considering 20 referrals arising from initial health assessments at the WCH, FMC and LMH clinics. These included some children who had recently entered care, and others who had been in care for some time.

The panel is still at a pilot stage, but offers promise in terms of its capacity to better coordinate assessment of and action on children's therapeutic needs. It brings people together at a level of seniority that permits rapid and decisive action. Having the relevant agencies collaborate in this formal way also enables them to build a more comprehensive picture of the overall therapy needs of the population of children in care, and contribute to coordinated planning and service design. The model is especially worthwhile if it is able to also consider those highly complex young people whose needs are not always well coordinated.

EXCEPTIONAL NEEDS UNIT

The Exceptional Needs Unit in the Department for Communities and Social Inclusion (DCSI) administers (among other programs) a management assessment service, helping people who have especially complex needs.¹⁰⁷ This covers clients whose needs are challenging existing services beyond their specialist capacity; clients whose needs are beyond the collaborative capacity of existing services; and clients for whom the absence of a primary diagnosis restricts their eligibility for services.

The service provides support at various levels of intensity, from consultation and advice to other service providers, through to a management assessment panel for eligible clients, and finally, referral to the Exceptional Needs executive committee where appropriate.

Management assessment panels are convened when a referral is considered to warrant a high level of assistance. Panel members are drawn from a group of 50–60 professionals who have agreed to participate, and are appointed in accordance with the particular issues of the client. Appointees must not have previously provided services to that client as they are expected to offer a fresh perspective on the client's circumstances. The client is offered the opportunity to attend the panel or submit their views if attendance is not possible.¹⁰⁸ The management assessment service provides the panel with a report which outlines current and past service provision, including what has been tried, and what has and has not worked.

The aim of the panel is to:

*make a well informed and unconstrained consideration of what the issues are and not so much think about what service systems are available now, but [come] at it from the other end, starting out with the individual's needs and trying to come up with a sense of what is required ... developing service specifications, and then looking to what the best departments and agencies would be to provide that.*¹⁰⁹

The management assessment panel is able to expedite service provision in a creative individualised way that is not possible through established programs. It can access a small budget to fund support services and is also in a position to negotiate ongoing funding with government and non-government agencies.

The management assessment service and its panel accept referrals for young people under the age of 18 where other eligibility criteria are satisfied. This includes a number of children in care who have complex needs that are not being met by the current service systems.¹¹⁰ The panel has identified two main groups who fall into this category. The first consists of children and young people who are subject to short-term guardianship orders, but whose long-term stability has not been secured. They appear to move in and out of the child protection system in a way that is not helpful to their wellbeing. These young people are often supported by the panel advocating on their behalf with the Agency to elicit a more assertive statutory response. The second group consists of children in care approaching the age of 18 who will need additional support after the Agency withdraws.¹¹¹

At a system level, the management assessment service is in a position to identify and highlight particular system deficits that arise frequently for the clients they see. These issues can be escalated to the Exceptional Needs Unit's executive committee.

The purpose of the executive committee is 'to facilitate and lead high level, strategic oversight of contemporary government policy and service responses for people with high and exceptionally complex needs'.¹¹² Members of the committee are drawn from services including Housing SA, SA Health, Disability Services, Special Education, Office of the Public Advocate, Aboriginal Affairs and Reconciliation, Department for Correctional Services, Families SA and South Australia Police (SAPOL).

The structure and functions of the Exceptional Needs Unit prompt agencies to think beyond their service silos and cooperate at a higher level to help clients with very complex needs. This could be a model for the development of a panel and associated committee that focuses solely on the needs of children in care.

YARROW PLACE

Yarrow Place, an agency provided by SA Health through the Women's and Children's Health Network, provides services that includes forensic medical examination, follow-up therapy and counselling for anyone who has been sexually assaulted.

In response to Recommendation 42 made by the CISC Inquiry, Yarrow Place established a mobile youth team that offers a flexible and assertive outreach service to children and young people in care who are at risk of absconding and associated sexual exploitation. The team prioritises referrals for children and young people living in residential care facilities, and works closely with the residential care directorate to identify children at risk in those settings.¹¹³

Each clinician on the youth team carries a caseload of between five and six young people, permitting a more intense and flexible approach to engagement. Vanessa Kolarz, the director of the service, explained that the team's mobility enabled them to 'keep on their tail ... maintain and build rapport, and find out where they are'.¹¹⁴

Referrals to the program are received only through Families SA, although children and young people might initially be identified by other agencies, such as SAPOL. Acceptance to the program depends on the child or young person's case manager agreeing to become actively involved, as the person holding decision-making power.¹¹⁵ Importantly, once a young person is accepted, the program will continue to work with them as required to the age of 25. The program is currently limited to clients in the metropolitan area.

Flexible and assertive outreach is essential for children and young people who are commonly missing from their placement and engaging in high risk behaviour in the community.

REFORMING DELIVERY OF HEALTH AND THERAPEUTIC SERVICES

There is no doubt that many children receive high quality health and therapeutic services that are appropriately matched to their needs. However, the Commission is satisfied that some children's needs are recognised later than they should be, and there should be a greater emphasis on prevention.

HEALTH

Initial health check clinics should continue to be supported at the WCH, FMC and LMH hospitals and should adopt a consistent model of service delivery based on the one currently followed at FMC.

The scope of initial assessments should be broadened to always include a psychosocial element, even where the information available suggests that a child is unlikely to experience problems of this kind. The clinics should also investigate the contribution a consultant liaison psychiatrist might offer to the assessment.

Chapter 9 recommends the establishment of a child protection service at LMH. An initial health assessment clinic should be part of that service, modelled on the clinics currently working at FMC and WCH.

THERAPEUTIC SERVICES

A greater investment in therapeutic services is needed for children entering and living in care. The assessment of their needs, and the processes for referring them to the appropriate service, should be better coordinated. The pilot panel process currently being evaluated by CAMHS provides a valuable model for an expanded assessment panel that is connected to children and young people whose needs are assessed at the initial health check. The panel should include at a minimum representatives from:

- Child Protection Services
- Education
- CAMHS
- Yarrow Place
- the Agency's psychological services.

The panel should consider all referrals for therapeutic services that are made at initial health assessments for children entering care, and should be in a position to identify the most appropriate service, ensuring these children receive, where possible, priority access to therapeutic services.

The Commission is also attracted to aspects of the model being delivered by the Exceptional Needs Unit's management assessment service. Although that service is available to children under 18, including those in care, the Commission considers that a similar service should be developed in conjunction with the CAMHS therapeutic needs assessment panel to coordinate service delivery for children with complex needs and young people in care.

The Commission recommends that the agencies identified above work together to develop a management assessment service model that can provide coordinated intervention for children in care with complex needs. CAMHS should lead this work.

The Commission's enquiries made it clear that there are young people (especially adolescents) who are prone to risk-taking behaviour in the community.

These young people are frequently absent from their placements. Some of these young people will be at risk of both absconding behaviour and sexual exploitation, and will therefore be eligible for the Yarrow Place program. Many vulnerable young people will be at risk because of other factors, such as drug taking, self-harm or criminal behaviour. These young people also need a mobile, intensive therapeutic service to engage them. The Commission recommends that the Yarrow Place service be expanded significantly to deliver an equivalent service to children and young people in care who frequently abscond and who are at risk of harm from factors apart from sexual exploitation.

'It's hard when friends ask how many mums and dads you have—you have to say you have heaps'

EDUCATION

Education plays a critical role in helping children in care to reach their full potential. Early traumatic experiences, however, can impact on a child's ability to learn and to interact appropriately in the school environment. Children with a history of trauma and abuse may have an impaired ability to regulate their emotions and this can result in conflict with teaching staff and other students.¹¹⁶ There is also a greater risk that a child entering care will experience language delays, weakening their ability to socialise and learn.¹¹⁷ A good educational environment can contribute to overcoming children's early disadvantage. Children consulted by GCYP confirmed that the benefits of school attendance reached beyond academic learning:

They say they like school because they can mix with friends and learn new things and that there is a stability in the same place and faces. They are usually able to do the same things as everyone else their age. School can positively contribute to their social and emotional wellbeing.¹¹⁸

Osborn and Delfabbro, prominent researchers in this area, have observed that:

Education is essential for good outcomes later in life including employment and as a protective measure against risk factors such as substance abuse, homelessness and criminality. Therefore, it is essential that education is given priority within the care system so that children and young people are not placed in a position that is likely to lead to negative life outcomes.¹¹⁹

Attending school and socialising with friends who enjoy traditional family structures can be challenging. Children and young people consulted by the Commission reported varying experiences of school. The following negative aspects were identified¹²⁰:

- *It's hard when friends ask how many mums and dads you have—you have to say you have heaps.*
- *It is hard at school because you have to tell everyone; they ask why and tell everyone. Mum rocked up to OSH—I used to tell a few people and I realised Mum was telling everyone about how and why I was in foster care. It is important I get to tell people.*
- *Form signing takes time.*

Some children, however, spoke about the positive support that they have received in their educational environments¹²¹:

- *I have not been bullied, but the whole school knows—they are there for me.*
- *In primary school I told more people as I had the principal's support.*
- *Last year I had no support. The principal changed everything.*

Although there was evidence of children having very good school experiences in supportive and caring environments which understood the child's individual needs, the Commission also heard evidence of schools, including Department for Education and Child Development (DECD) schools, which were reluctant to enrol students who had challenging behaviours or special educational needs because of a history of trauma and abuse. More than one witness reported that schools had indicated a reluctance to accept enrolment of children in care, telling Families SA staff that they 'had their quota'.¹²²

School attendance can not only support educational success, it can also improve placement stability. As part of the Commission's examination of the circumstances of Nathan (Case Study 4) the Commission heard from Mr and Mrs P, foster carers who had looked after Nathan in the years immediately preceding his move to a large residential care unit. As a result of serious abuse in his infancy, Nathan suffered from reactive attachment disorder, a pervasive psychological disorder.

Mr and Mrs P worked tirelessly to engage Nathan in education, seeking a learning environment that met his needs, but Nathan's behaviour resulted in repeated suspensions and exclusions from school. These were followed by long periods of disengagement from school while protracted bureaucratic negotiations occurred about the conditions of his return.

Reactive attachment disorder

Reactive attachment disorder (RAD) is a psychological disorder that is described by reference to disturbed and developmentally inappropriate social relatedness. By definition, it originates in a child's exposure to extreme levels of insufficient care in one or more of the following:

- social neglect or deprivation in the form of a persistent lack of basic emotional needs for comfort, stimulation and affection met by caregiving adults;
- repeated changes of primary caregivers that limit opportunities to form stable attachments (for example, frequent changes in foster care);
- rearing in unusual settings that severely limit opportunities to form selective attachments (for example, institutions with high child-to-caregiver ratios).¹

Children with attachment disorders struggle with the relational skills that other people develop from loving and nurturing care. They will often struggle to be in charge as a way to deal with relational challenges, and struggle to regulate their own emotions. Children who suffer from RAD do not respond as other children to regular discipline. They experience it as rejecting, and it can take a heavy emotional toll on them.² They will approach relationships as something to be feared, or a device to manipulate to have their needs met, and act in one of two distinct ways: by using charm to control and regulate others and have their needs met, or by being hostile and distanced towards others. Attachment disorders often cause children and young people to see the world as an unsafe place, and be perpetually behaving according to the flight/fight/freeze response.³

¹ American Psychological Association (APA), *Diagnostic and statistical manual of mental disorders*, APA, 5th edn, 2013, pp. 265–266.

² Oral evidence: A Davis

³ Oral evidence: C Pearce.

When Nathan's entry into a public primary school was being negotiated by Families SA, the school imposed 16 separate conditions on his attendance. Taken together, the conditions precluded Nathan from any realistic participation in the school community. A carer from Nathan's residential unit was obliged to be present at the school at all times and Families SA was obliged to agree to implement a plan to 'build the skills to cope with relationships, change and when faced things [sic] he doesn't like and including him learning to reign in and minimise the risk he poses to others'.¹²³

This condition of itself demonstrated a misunderstanding of the chronic nature of Nathan's condition, and the role that the school had in helping Nathan to develop his skills. The Commission's examination of Nathan's educational circumstances revealed little evidence of Education being prepared to work collaboratively with the Agency and Nathan to ensure his education was not threatened by long periods of disengagement.

Mr and Mrs P, together with Families SA caseworkers and other private professionals, attempted to advocate for Nathan's access to education. These attempts were so consistently unsuccessful that Mr and Mrs P, on behalf of Nathan, filed a complaint with the Equal Opportunity Commission of South Australia. Mr and Mrs P, on behalf of Nathan, complained that the education system persisted with traditional behaviour management techniques, which had been identified by a variety of professionals involved in his care to be inappropriate and ineffective. In fact, for Nathan, a traditional disciplinary approach risked escalating his emotional dysregulation and leading him to act in even more extreme ways.

Before the complaint was resolved, arrangements were made to enrol Nathan in an independent school which, it was hoped, would offer a more suitable approach. At the time of Nathan's enrolment at that school, Mrs P told Families SA that she was convinced that if Nathan did not start attending school, the placement would fail.¹²⁴ The family could not withstand the constant pressure of Nathan's lack of educational engagement, and continue to manage him at home on a full-time basis.

Mr and Mrs P's experience is not isolated. A report prepared by UnitingCare New South Wales, a major provider of out-of-home care services in that state, observed that 'our experience is that school suspension or exclusion creates significant strains on the care placement and may lead to placement breakdown'.¹²⁵

ACCESS TO SCHOOLS

Every public school in South Australia has a notional catchment area, and some schools experiencing enrolment pressure are zoned. Any child of school age living within that zone has a right to enrol.¹²⁶ Children who are in care may be exempt from zoning restrictions. The education arm of the DECD attempts to ensure that each child in care is enrolled at an educational site appropriate to their needs. Jayne Johnston, Chief Education Officer, told the Commission that it would be unacceptable for a school principal to decline to enrol a child on the basis that they already had met their quota of children in care with trauma-related behaviours. A principal can be directed by departmental staff to enrol a student.¹²⁷

Ms Johnston expressed the 'absolute view' that if Families SA made a recommendation about the educational needs of a child who is in care, Education would facilitate that.¹²⁸ Ms Johnston acknowledged that a minority of teachers and school principals might be anxious about supporting a student like Nathan and might avoid taking on such a challenge.¹²⁹

School principals are obliged to provide a safe learning environment for school staff and students. Imposing special conditions on enrolment and providing additional support may be needed in some circumstances to mitigate risk.¹³⁰ However, conditions must not be imposed that are so onerous as to effectively exclude high needs students from participation.

The Commission received evidence that children in care sometimes struggled with the requirements of their educational environments, and were frequently suspended from school in response to behavioural issues. Data obtained by GCYP confirms that children in care are suspended at a much higher rate than their peers. The same data demonstrated a higher portion of children in care were subject to school exclusions.¹³¹

The Education Regulations 2012 (SA) provide for the suspension, exclusion¹³² or expulsion¹³³ of students. A student may be suspended by the principal for no more than five consecutive school days. A student may not be suspended for a total of more than 15 school days; or on more than four separate occasions in a calendar year without authorisation being given by a more senior officer.¹³⁴ An exclusion may only be for a period of between four and 10 weeks, unless it is at the end of a school term and there are fewer than four weeks remaining.¹³⁵ A student may not be excluded for a total of more than 20 weeks in a calendar year without authorisation being given by a more senior officer. A student cannot be excluded without first being suspended.¹³⁶ A school principal may not suspend or exclude a student indefinitely, nor are they entitled to prevent the student from returning to their school site. A decision of that kind must be made at a higher level.¹³⁷

A suspension is intended to be a 'relatively short and sharp process'.¹³⁸ Students under suspension should be provided with support to reflect on their behaviour, and schools should work towards avoiding a repeat of the conditions giving rise to it. For students who have a challenging environment outside school or a background of trauma or abuse, an important part of a principal's behaviour management repertoire is an internal or in-school suspension.¹³⁹ During exclusions a student may also be referred to a learning centre. The child should be given help managing their behaviour and serious re-engagement work should occur.¹⁴⁰ A learning centre may also be used as a stepping stone to a student attending a new mainstream school.¹⁴¹

Through the government's Rapid Response framework, DECD undertook to 'ensure that all avenues for preschool, school and post-compulsory education-based supports are explored before suspension or exclusion ... are considered'.¹⁴² Evidence before the Commission suggested that this commitment was not always being honoured in practice.

SMART TRAINING

In 2005 the Department contracted with the Australian Childhood Foundation to deliver training in Strategies for Managing Abuse Related Trauma (SMART). This training is designed to equip teaching staff to respond more effectively to children and young people who struggle with the educational environment because of abuse-related trauma. The Department has recently renewed this commitment for a further three years.¹⁴³

A number of teachers across the Department have completed the SMART training, and some have completed training to train others.¹⁴⁴ The Commission considers this an important step towards changing the attitude of teachers to children facing educational challenges of this type. However, unless the training changes teaching practice, it is a hollow endeavour. The Department has held a contract to deliver this training since 2005, but evidence indicated that there remained a high level of misunderstanding of the needs of children in care.

The Department's learning centres take advantage of a much higher teacher-student ratio than conventional schools and provide education for periods up to 10 weeks to students who have been excluded from their schools. Behaviour centres operate on a similarly intense level and provide intervention for students who are at risk of disengaging from schooling.

SMART training is a foundational skill for all learning and behaviour centre staff; they are also expected to have a greater understanding of students with trauma backgrounds.¹⁴⁵ Nathan attended a learning centre during one period of disengagement from school. Staff at the centre described Nathan as a psychotic monster, calculating and dangerous, an evaluation contrary to their SMART training, which should have given them a more sophisticated understanding of Nathan's challenges.¹⁴⁶ At one time Nathan was locked in a classroom following an incident with a teacher, a strategy that was completely counterproductive in the face of Nathan's limited emotional regulation abilities in that environment.¹⁴⁷ The time Nathan spent at learning centres did not lead to his reengagement in mainstream education.

Patricia Strachan, the former executive director of the Office for Children and Young People within the Department, was asked about the value in having schools specifically identified as 'SMART' friendly schools, or as schools with a high proportion of SMART competent teaching staff. Ms Strachan expressed caution about such an approach, observing that:

it would be very difficult to label all our schools with ... names [such as] autism friendly, dyslexia friendly. Really, schools need to be able to provide inclusive education to meet the needs of their students, irrespective of the profile of disabilities, challenging behaviour, children who have been traumatised. So they need to be able to do all elements, really.¹⁴⁸

Ms Johnston agreed with these observations, noting that while the Department had taken an important first step towards embracing trauma-friendly principles, there was a need to lift the level of understanding within all schools to better meet the needs of students. Ms Johnston considered that greater investment in these skills in pre-service training was required, and that this would be achieved by greater engagement with the tertiary sector. Graduate teaching programs for teachers in their first three years also needed to include a greater emphasis on supporting students who came from a trauma background. Ms Johnston observed that many teachers entered the profession with very little appreciation of the complexity of problems some children at school might be facing.¹⁴⁹

IN-SCHOOL SUPPORT

Where a child who is not in care has additional needs, school services officers may provide extra support. This support is not paid for by the child's parents and is funded by the Department.¹⁵⁰ The Commission was told that where a child is in care, the Education arm of the Department frequently expects Families SA to fund this support.¹⁵¹ Negotiations about these issues can delay a child's enrolment or return to school. There is no reason to treat children in care any differently from other children when considering funding responsibilities for their in-school support. Delays concerning funding should never contribute to a child's absence from school.

REDUCED HOURS OF ATTENDANCE

It is helpful to some students experiencing challenges in the school environment to have their hours of attendance varied for a limited period of time. If a student is attending school less than full time, specific exemptions are required. Variation of hours for less than a month can be authorised by the school principal. For longer periods the exemption must be approved above principal level¹⁵² and must be recorded in writing. Given that school attendance is compulsory, arrangements for reduced

attendance should be strictly tracked and not allowed to drift. The Commission heard evidence which suggested that these requirements were not always met.

Nathan attended school on the basis of reduced hours at a number of departmental sites for a number of years. Departmental records obtained by the Commission, however, did not indicate that relevant exemptions were always in place. The Office for Education held only two exemptions for Nathan covering July to December 2014.

Part-time attendance to address behavioural challenges should always be regarded as transitional. Any exemption should be supported by a clear plan for return to full-time engagement. As a process, it should be rarely used.¹⁵³ However, the evidence obtained by the Commission suggests that there has been inconsistent compliance with the necessary safeguards on a wide scale. Wendy Dale, the manager of Families SA's School Engagement Program, reported that children in care who are referred to that program attending less than full time generally do not have part-time exemptions or plans for educational re-engagement in place.¹⁵⁴

INDIVIDUAL EDUCATION PLANS

Individual education plans should be in place for all children in care. The government's Rapid Response action plan recommended that all preschools, primary schools and high schools develop an individual education plan for students in care.¹⁵⁵ An individual education plan should anticipate the challenges that might arise and identify in advance what support is to be provided, by who and to what end. It should include specific measures to address educational disadvantage and, where appropriate, promote an environment of care that supports recovery from trauma.

REFORMS IN EDUCATION

It is critical that Education regards itself as a partner of the Agency in delivering appropriate services to children in care. As outlined earlier, remediation of psychological damage sustained when a child is abused or neglected is achieved through cohesive and consistent care across a child's environments. A child's education should be approached as a part of the therapeutic solution.

Ms Johnston recognised that the flexibility needed within the system was not always evident.¹⁵⁶ A culture of preparedness to engage with vulnerable students should be fostered within Education.

Professional development as well as practical supports are necessary. The level of understanding of students with significant trauma backgrounds needs to be improved within all schools. All schools need to be 'trauma friendly'.¹⁵⁷ To this end, Education should continue to encourage staff to undertake SMART training, and should ensure that these skills have a high profile in professional development programs.

At an individual school level, there is scope for the child wellbeing practitioners referred to in Chapter 8 to also play a role in sharing knowledge about the needs of children in care, and contribute to training on these topics.

Policies relating to suspension, exclusion, expulsion and reduced hours should be reviewed for their appropriateness for children with trauma backgrounds. In particular, greater effort should be made to deal with their behaviour by providing in-school options that have a learning component. These children should also be given opportunities to reflect on their behaviour, and helped with strategies to avoid such behaviour in the future.¹⁵⁸ All other options should be explored before suspensions or exclusions are utilised.

Records should be regularly audited by Education to ensure that the necessary authorities are in place for students on reduced hours of attendance and, most importantly, that there is a current plan to return them to full-time schooling.

Funding arrangements should be clarified to show that Education remains responsible for funding any additional school support required for children in care. Funding should be allocated on the basis of the needs of the child, as guided by expert assessment and input from Families SA and the child's carer. Policy guidance for funding should reflect the special duty that the state owes to children in care to address the disadvantages of their early experiences.

Specifically trained school support officers may provide one aspect of the assistance required. Education should recruit and train people who have skills in helping children with these behaviours, and who can deliver services where needed.¹⁵⁹

CHILDREN WHO GO MISSING

The CISC Inquiry exposed the plight of vulnerable children who were frequently missing from their care placements and made a number of recommendations to improve the safety of children and young people who behaved in that way.

This Commission is aware that the problem of missing children is a continuing one, but is also concerned that some of the tools and strategies recommended in the CISC Inquiry have not yet been deployed to their full extent.

The Commission examined records of children missing from their placements during the 2013/14 financial year. One 16-year-old male during that year had been missing from his placement a total of 178 times. The longest continuous period was five-and-a-half days. A 13-year-old female during the same period had been missing 96 times. The longest sequential period for her was 19 days. Absences of this frequency and length were not uncommon.¹⁶⁰

Children who leave their placements are influenced by factors that can be broadly described as 'push and pull'. Push factors are reasons the child wants to leave, perhaps because they do not feel happy in or connected to their placement or they don't like other young people with whom they have been placed.¹⁶¹ Pull factors are the features of the world outside the placement that attract them. For some children this will be cigarettes or alcohol and illicit drugs; for others it will be relationships with adults with whom they cannot associate in their placement. Often these two matters will be interrelated.

There is no simple solution to the problem. Keeping more children safely in their placements depends on improving the quality of their care environment, coupled with efforts to reduce the pull from outside.

These challenges are not unknown in conventional family structures. There, however, established relationships of trust and feelings of belonging help the young person explore their world in a safer way.

For children who live in less nurturing circumstances, there are greater challenges. Laura Kelly, a program manager within the residential care directorate with particular experience in this area, told the Commission:

It's all good and well to have fantastic workers and staff and clinicians and services and care teams and practice guides and procedures, but if children aren't there, you can't use them. And if you're competing with drug dealers and people in the community because the children are desperate to make connections and, you know, try as they will—the staff are mostly really excellent people—the children will choose people with whom they can continue an ongoing relationship post-care, so they will connect with anyone and everyone in the community, quite often, and I think that's such a problem that probably just needs more time and resources, not just from child protection, but from other agencies.¹⁶²

Since the CISC Inquiry, the Agency has developed a risk assessment to be completed for all children in residential care which identifies their risk in the community should they go missing. It takes into account factors such as their age, their connections in the community, and the chance of them engaging in risk-taking activities. The assessment is intended to be actively reviewed and guides the response that the Agency takes to children and young people who go missing. It advises whether a formal missing persons report should be lodged with SAPOL, and what level of response from the police is sought.¹⁶³

The use of this tool, and the associated guidance on responding to absences, has resulted in a significant drop in the number of children and young people being reported to SAPOL as missing. There has been a corresponding change to the way in which SAPOL is engaged when there is a low risk associated with their absence.¹⁶⁴ There was also evidence that a greater level of cooperation and collaboration has been possible between the Agency and SAPOL; for example, training has been delivered jointly by the Agency and SAPOL to residential care staff as well as some staff at guardianship hubs. The training includes using the risk assessment tool, but also provides staff with greater knowledge and understanding of the triggers that cause children to go missing as well as better skills to deal with them.¹⁶⁵ The training has been delivered in a more limited way to non-government organisations and commercial care providers.¹⁶⁶ This process should continue.

The use of the risk assessment tool and greater collaboration with SAPOL will not change the behaviour of children who wish to leave their placement. Training workers in understanding children's triggers, and how to manage them, are an important part of the training, and should continue to receive emphasis.

REGULATING EXPLOITATIVE RELATIONSHIPS

One tool that is available to Families SA that is not available in traditional family structures is the legislative power to give written directives to adults in certain circumstances. This power enables Families SA to intervene between young people in care and unsuitable adults who would seek to exploit them.

The power to give written directives originated in recommendations made by the CISC Inquiry¹⁶⁷, which observed that although there was a range of criminal offences that could be employed against adults who exploit young children in care, proof of those offences usually depended on the willingness of the child concerned to give evidence. Young people who are vulnerable will frequently be unwilling to speak against exploitative adults. This may be due to fear and intimidation, or gifts and bribery.¹⁶⁸ The value of written

directives lies in placing the onus to manage contact on the adult rather than the young person, and reducing the places to which a young person could run if they decided to leave their placement.¹⁶⁹

Section 52AAB of the Children's Protection Act permits a written directive to be issued by the chief executive of the relevant department prohibiting a person from:

- communicating or attempting to communicate with a specified child during a specified period; or
- harbouring or concealing or attempting to harbour or conceal a specified child during a specified period.¹⁷⁰

The chief executive must not issue such a notice unless they believe that it is reasonably necessary:

- to avert a risk that the child specified in the notice will—*
 - be abused or neglected, or be exposed to the abuse or neglect of another child; or*
 - engage in, or be exposed to, conduct that is an offence against Part 5 of the Controlled Substances Act 1984; or*
- to otherwise prevent harm to the child.*¹⁷¹

An offence against Part 5 of the Controlled Substances Act includes the trafficking, manufacture or cultivation of controlled drugs and the trafficking or cultivation of controlled plants.

The scope for the deployment of a written directive is wide. It can be applied where there are concerns about physical abuse, sexual abuse, self-neglect or neglect of other children, and involvement in, or exposure to, the trafficking, manufacture, cultivation, possession or use of controlled drugs, including cannabis. The words of the section assume that exposure to drug possession or use will be harmful to a young person.

The Families SA fact sheet on written directives was examined by the Commission.¹⁷² It inaccurately advises that 'a written directive is appropriate in circumstances where there are reasonable grounds to suspect that the child or young person in care has been abused or is likely to be at risk of harm by an adult'.¹⁷³ The fact sheet replaces the words of the legislation with concepts that are not consistent with, and are more stringent than, the test set out in the legislation.

The fact sheet further advises that '[when] considering whether to issue a written directive, the case manager and supervisor must have made an assessment that issuing the directive is reasonably necessary to avert a risk that the child or young person will be abused, neglected or harmed by an adult'.¹⁷⁴

The notion of future harm is repeated later when the fact sheet states that 'evidence or proof that the child or young person has already been harmed is not required as the aim of a written directive is to prevent further known or potential harm from occurring'.¹⁷⁵ These statements introduce to the test the additional requirement that the state of mind must include a risk of harm to the child. In fact, a written directive can be lawfully issued to prevent a risk that the child will engage in, or be exposed to, offences against Part 5 of the Controlled Substances Act without any belief or state of mind about specific harm that might follow from that engagement or exposure.

Further, the fact sheet refers to conduct against Part 5 of the Controlled Substances Act and specifies concerns about the use, manufacture or sale of drugs and/or firearms. Part 5 encompasses a much wider range of drug-related conduct, which may well occur in the presence of a young person or be engaged in by a young person. Importantly, it includes possession of drugs even for personal use, supply of drugs (for example, sharing drugs with young people), cultivation of controlled plants, and possession of equipment to smoke cannabis. Part 5, contrary to the fact sheet, makes no reference to firearms whatsoever. Any written directive based on a risk associated with firearms would need to be justified under section 52AAB(3)(b) 'to otherwise prevent harm to a child'.

Any staff member who considers the fact sheet without reference to the applicable legislation may well be left with the impression that the scope of written directives is restrictive. The nature of the risk in fact required could be as low as exposure to a person possessing drugs for their personal use, sharing cannabis or possessing a pipe to smoke it. Properly understood, the power to issue a written directive to control an adult's access to a young person in care has a wide application to a variety of situations. The Families SA fact sheet presents an unnecessarily restrictive picture of that power.

In the Commission case study into the circumstances of Hannah (see Vol. 2, Case Study 3), a distinct reluctance to employ the tools was evident. Hannah was frequently absent from her placement, and there was a legitimate fear that she was at risk of abuse and exploitation from adults with whom she associated during those absences. Despite this, caseworkers exhibited a poor understanding of the utility of written directions, and were reluctant to assertively use them to keep Hannah safe. This is surprising given that the power to issue written directives has been available to Families SA staff since June 2010.¹⁷⁶

There should be a review of Families SA's guidelines for written directions. Accurate guidance should be provided about their scope and application, and staff should be encouraged to use them proactively in appropriate situations to keep children in care safe.

PRIORITISING THE EXPERIENCE OF CHILDREN IN CARE

In the Commission's case studies of Hannah and Nathan (see Vol. 2, Case Studies 3 and 4 respectively), neither young person's voice was strongly apparent in making decisions about their welfare. Each young person was at an age where they were capable of contributing to decision making, and although their preferences could not always be accommodated, they should have been given clearer opportunities to contribute.

The low rate of young people's participation in case planning and annual review planning is concerning, and suggests practice that does not value their contribution in determining the course of their own lives, and understanding their own experiences. The Commission came across many examples of decisions being made about children without their consultation.

National out-of-home care standards require that children and young people in care participate in decisions that have an impact on their lives, in accordance with their age and developmental stage. One of the overriding principles identified in the South Australian standards is that children and young people are given 'a voice in decision making and [are] involved in the design and delivery of services'.¹⁷⁷ More specific policy guidance or unenforceable standards have, to date, made few differences to practice.

The Commission recommends that the entitlement of children and young people in care to contribute to decision making should be enshrined in legislation, in a more direct way than is currently provided.

The current Children's Protection Act section 3(3) requires that the views of that child (if the child is willing and able to express such views) must be taken into account by any person making a decision under the Act. This includes decisions made by the Youth Court regarding guardianship of the child. The way in which these views are provided to the Court are discussed in Chapter 9. 'Taking into account' a child's views is not the same as involving them in decision making. For some decisions, including decisions made by the Youth Court, 'involvement' would not be appropriate. However, for some decisions, there is greater scope for involvement of a child, in addition to simply providing their views.

Many decisions made by the Agency according to the guardianship order and the powers of care and control inherent in that order are identified (although not exhaustively) in section 51 of the Act. In the Commission's view it is appropriate to go further than simply having regard to children's views and insert a requirement that they be included in decision making in those circumstances.

GCYP's submission to the Commission recommended an express legislative amendment to provide that:

- in all decisions that affect the child, the child will be included in the decision making to the extent that they are capable and willing; and
- the views of the child will be given due weight in accordance with the age and maturity of the child.¹⁷⁸

The Commission agrees with that proposal. An amendment should be made to section 51 of the Act to reflect this.

MONITORING THE QUALITY OF CARE

As is noted elsewhere in this report, the South Australian Standards for Alternative Care are not actively monitored or reported upon. At this stage, it would be cumbersome and counterproductive to require the Agency to report performance against all of the standards. However, these children are the responsibility of the state, and the Minister should be regularly informed about the quality of care being offered to them as a group.

For this reason, the Commission considers it necessary that the Agency report to the Minister quarterly on the following Standards of Alternative Care:

- Standard 2.1—A caseworker is allocated to each child and young person in alternative care.
- Standard 2.2—Each child and young person will have face-to-face contact with their allocated worker a minimum of once a month.
- Standard 2.6—Each child in long-term care has a case plan that is developed, monitored and reviewed every six months.

The Agency should also report quarterly on the proportion of children who enter care who have their medical and psychosocial needs assessed in accordance with the relevant health standards for children entering care, and the proportion who are reviewed pursuant to section 52 of the Act at the time that the annual review falls due.

This data should also be provided, at the same time, to GCYP for monitoring purposes.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		86	Invest in the ongoing development of a therapeutic needs assessment panel led by Child and Adolescent Mental Health Services for children in care whose therapeutic needs are identified in their initial health assessment.
75	Review and republish Rapid Response with updated guidance as to the extent of priority access for children in care.		
76	Reinstate the inter-departmental committee overseeing Rapid Response to review its operation, at least biannually.	87	Develop an inter-agency panel modelled on the Exceptional Needs Unit's management assessment panel to support case management of those children in care with complex needs who are not appropriately managed by existing services.
77	Ensure that every child or young person in care has an allocated caseworker who has face-to-face contact with them once a month at a minimum.	88	Develop a mobile outreach service modelled on Yarrow Place's mobile youth team for children and young people who frequently abscond from placement, and who are at risk because of factors other than sexual exploitation.
78	Assess all children who are currently receiving a differential response for eligibility for Other Person Guardianship.	89	Improve the profile of Strategies for Managing Abuse Related Trauma (SMART) training for educational staff, requiring that to be part of professional development where appropriate.
79	Assess whether allocation of a primary and secondary worker to deliver guardianship case management would improve the continuity of relationships with children.	90	Review and promote Education's policies regarding school suspension, exclusion and expulsion to ensure that they are used as strategies of last resort for children in care.
80	Review the policy guidance and all other documents used for annual reviews to ensure compliance with section 52 of the <i>Children's Protection Act 1993</i> , including requiring greater sharing of the information discussed at annual reviews.	91	Regularly conduct an audit of children in care who are on reduced hours of attendance at school and ensure they have plans to re-engage them in mainstream education.
81	Require that all annual reviews be chaired by a suitably qualified person who is independent of the case.	92	Require Education to fund any in-school support needed by children in care.
82	Give concurrent planning greater emphasis in case planning, especially for children during their active attachment period.	93	Recruit and train a panel of school services officers to support children with trauma-related behavioural challenges.
83	Review all placement breakdowns to determine and correct identified system deficits.	94	Amend the practice guidelines regarding written directives to comply with the provisions of the <i>Children's Protection Act 1993</i> and provide training to child protection workers to ensure that they understand them.
84	Provide therapeutic support to placements that are identified as being at risk or under stress.	95	Amend section 51 of the <i>Children's Protection Act 1993</i> to include a requirement that in all decisions affecting the child that are made in accordance with an order for guardianship, the child must be included in the decision making to the extent that they are capable and willing, and that the views of the child are given due weight in accordance with the age and maturity of the child.
85	Fund initial health assessment clinics at the Women's and Children's Hospital, Flinders Medical Centre (FMC) and Lyell McEwin Hospital to operate in accordance with the service model employed at FMC. This includes funding clinics at a level that enables a psychosocial component to be offered at every initial health assessment.		

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- 96** **Require the Agency to report quarterly to the Minister and to the Guardian for Children and Young People, and make public a report as to the following matters:**
- a** **compliance with the Standards of Alternative Care in South Australia 2.1, 2.2 and 2.6;**
 - b** **the proportion of children entering care whose health needs are assessed in accordance with the requirements of the relevant health standards; and**
 - c** **the number and proportion of children and young people who have been reviewed in accordance with section 52 of the *Children's Protection Act 1993* at the time the review falls due.**

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- 38 Oral evidence: Name withheld (W51).
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- 119 A Osborn & P Delfabbro, *National comparative study of children and young people with high support needs in Australian out-of-home care*, University of Adelaide, 2006, p. 65.
- 120 GCYP, *What children say about child protection and out-of-home care*.
- 121 *ibid.*
- 122 Oral evidence: C Simmons.
- 123 D Kevesevic, email to J Lamont, 23 September 2013.
- 124 Oral evidence: Mrs P. (see Case Study 4)
- 125 T Beauchamp, *Addressing high rates of school suspension*, p. 7.
- 126 Oral evidence: J Johnston.
- 127 *ibid.* Each school principal or preschool director is line managed by an Education director who generally has responsibility for three partnerships. Within each partnership there are 15 to 25 sites, including both preschools and schools. The education directors report to the Executive Director for Pre-school and School Improvements, who reports directly to Ms Johnston. Ms Johnston pointed out that she had never heard a principal say they would not accept an enrolment on the basis they had their quota of children under guardianship with trauma-related behaviours and if they did it would be 'absolutely' contested.
- 128 Oral evidence: J Johnston.
- 129 *ibid.*
- 130 *ibid.*

NOTES

- 131 GCYP, *Children and young people in state care in South Australian government schools 2008–2015*, pp. 6, 8.
- 132 Education Regulations 2012 (SA), r. 45.
- 133 *ibid.*, rr. 46, 47: A student may not be expelled from a school by the head teacher (a principal) for less than six consecutive months, unless the exclusion is for the remainder of the school semester, or for more than 18 consecutive months. The Director-General may expel a student from all schools and other specified facilities for not less than one year, unless the expulsion is for the remainder of the school year, and for not more than five years. A student cannot be expelled without first being suspended.
- 134 *ibid.*, r. 44.
- 135 *ibid.*, r. 45.
- 136 *ibid.*
- 137 Oral evidence: J Johnston.
- 138 *ibid.*
- 139 *ibid.*
- 140 Oral evidence: J Johnston; P Strachan.
- 141 Oral evidence: P Strachan.
- 142 DFC, *Rapid Response: Whole of government services for children and young people*, p. 28, recommendation 3.7.3.
- 143 Oral evidence: P Strachan.
- 144 Oral evidence: J Johnston.
- 145 *ibid.*
- 146 GCYP, 'Record of meeting', internal unpublished document, September 2012, pp. 11, 64.
- 147 Oral evidence: Mr and Mrs P (Vol.2, Case Study 4: Nathan)
- 148 Oral evidence: P Strachan.
- 149 Oral evidence: J Johnston.
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- 151 Oral evidence: Name withheld (W73); J Johnston.
- 152 Oral evidence: J Johnston; W Dale.
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- 156 Oral evidence: J Johnston.
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- 158 T Beauchamp, *Addressing high rates of school suspension*, p. 11.
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OVERVIEW

There is no doubt that in most circumstances the best care for children who cannot live at home is in an alternative home-based environment.

In South Australia, people who open their homes to care for children who have been removed, do so on a voluntary basis, with reimbursement of the estimated cost of caring for the child or children. One witness referred to the enterprise as ‘extreme volunteering’, a description that captures the challenges and rewards conveyed to the Commission in the course of hearing from foster and kinship carers.¹

A healthy and robust foster and kinship care system is critical to the functioning of the child protection system for the following reasons:

- Children in out-of-home care do best in ongoing, stable environments where their emotional, relational and developmental needs are met.
- Where the supply of foster and kinship carers is insufficient, children who cannot live at home are cared for in rotational styles of care. These care arrangements often deliver poor quality care, at a higher cost, and do not satisfy a child’s emotional and relational needs.
- Heavy reliance on rotational care burdens the child protection budget and makes it more difficult to fund prevention and family preservation activities.
- Child protection workers might be reluctant to remove children from unsafe environments when they are not convinced that placing the child in the alternative situation would be any better.

Investment in growing home-based care options for children removed from their families is a critical step in reforming the current system. The system must get foster and kinship care right to make inroads in other areas. A number of barriers currently exist to growing the sector. Some are within the control of Families SA (the Agency), but others reflect wider social and economic conditions which are not easily addressed. The system should also invest in looking after existing carers. Supporting carers to parent children well should be seen as strengthening protective factors for children in care.

However, home-based care options must not be grown by risking children’s safety in accepting less than satisfactory placements. Inappropriate or unsafe care can compound existing trauma, and increases the risk that children will suffer long-term psychological, emotional and relational difficulties.

In 2008 the Office of the Guardian for Children and Young People (GCYP) asked their youth advisors what made a good foster parent.

One contributor said ‘the focus for someone considering becoming a carer should be on wanting to provide a home and a heart for a child who can’t live with their family’.² Young people who participated in the consultation for the Commission also emphasised these aspects of belonging:

That the foster carers treat me like they love me, and like I’m their actual kid.

*I don’t call her mum but she is my mum. She is now my guardian.*³

‘The focus for someone considering becoming a carer should be on wanting to provide a home and a heart for a child who can’t live with their family.’

The Agency cannot parent a child. It cannot provide the sustained and consistent relational safety that many children entering out-of-home care desperately need. The Agency can endeavour to find the best people to carry out this important task, and support and monitor them to make sure they do it in the best possible way.

This chapter considers how the numbers of home-based carers can be increased, and how the quality of the care offered can be improved, consistent with keeping children in home-based care safe.

This chapter principally relates to the Commission’s Term of Reference 5(d), in the context of Terms of Reference 1 to 4.

WHAT THE DATA TELLS US

The rate of children in care has risen steadily over the past decade for both Aboriginal and non-Aboriginal children, (see Figure 11.1) and consequently substantially more children need out-of-home care. These rates are unlikely to decrease significantly in the short term, and they have not been matched by a commensurate increase in available home-based care placements.

Most South Australian children in care live in stable, long-term placements, most, if not all, of which are home based. GCYP reported that a 2013/14 audit of 208 annual reviews revealed that 81 per cent of children were living in stable, long-term placements.⁴ The most recent figures show that 85 per cent of children in care live in home-based care (see Figure 11.2). The number of children in home-based care is steadily increasing, but has not increased proportionally because the population requiring care has also grown overall.

The proportion of children in home-based placement has remained steady since 2007, maintained by a large increase in reliance on kinship care, not by substantial growth in recruitment and retention of foster parents (see Figure 11.3 and Figure 11.4). The last decade has seen a 350 per cent increase in the numbers of children being cared for in this way.

South Australia's spending on out-of-home care per child per night is among the highest in the nation, until 2013/14 outpaced only by WA and the NT (see Figure 11.5). The 2013/14 financial year saw a sharp increase in the costs of out-of-home care, attributable to the high costs of residential and commercial care placements. As at 30 June 2015 the annual cost per child of residential care in South Australia was \$275,903. Non-residential care (including home-based care) was less than a fifth of that figure at \$48,736.00.⁵ Foster and kinship care is not only the best quality care for children, in most circumstances, it is the most economical type of placement.

LEGISLATION AND POLICY

The categories 'foster care' and 'kinship care' are departmental operational categories which do not align with the legislative definition of foster parent set out in the *Family and Community Services Act 1972* (SA). The term 'foster care' is not defined in the Act at all. Rather, section 4 of the Act defines a 'foster parent' and 'a foster care agency'. Foster care is referred to in subdivision 3, section 40, where the purpose of foster care and the foster care system is set out.

In Specific Child Only (SCO) care, approval is restricted to foster care of a specific child by a person with whom the child has an existing relationship, although the carer might not be a relative. Kinship carers, and some SCO carers, are subject to assessment, support and supervision regimes which differ from those which apply to foster parents.

The provision of foster care is regulated by legislation which mandates regular monitoring and review. By contrast, kinship care is largely unregulated, the growth in numbers not having been matched by a growth in formal regulation.



Figure 11.1: Children in out-of-home care: rate per 1000 South Australian children aged 0-17 years

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

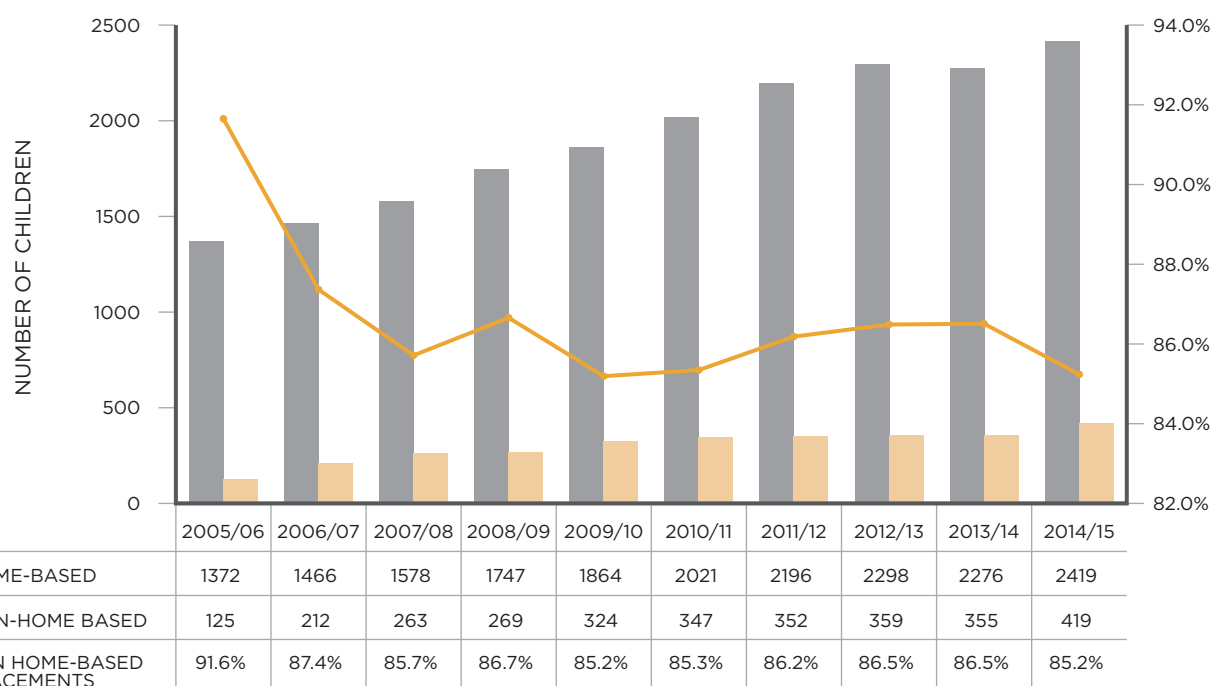


Figure 11.2: Children in out-of-home care in South Australia by home-based or non-home-based care

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

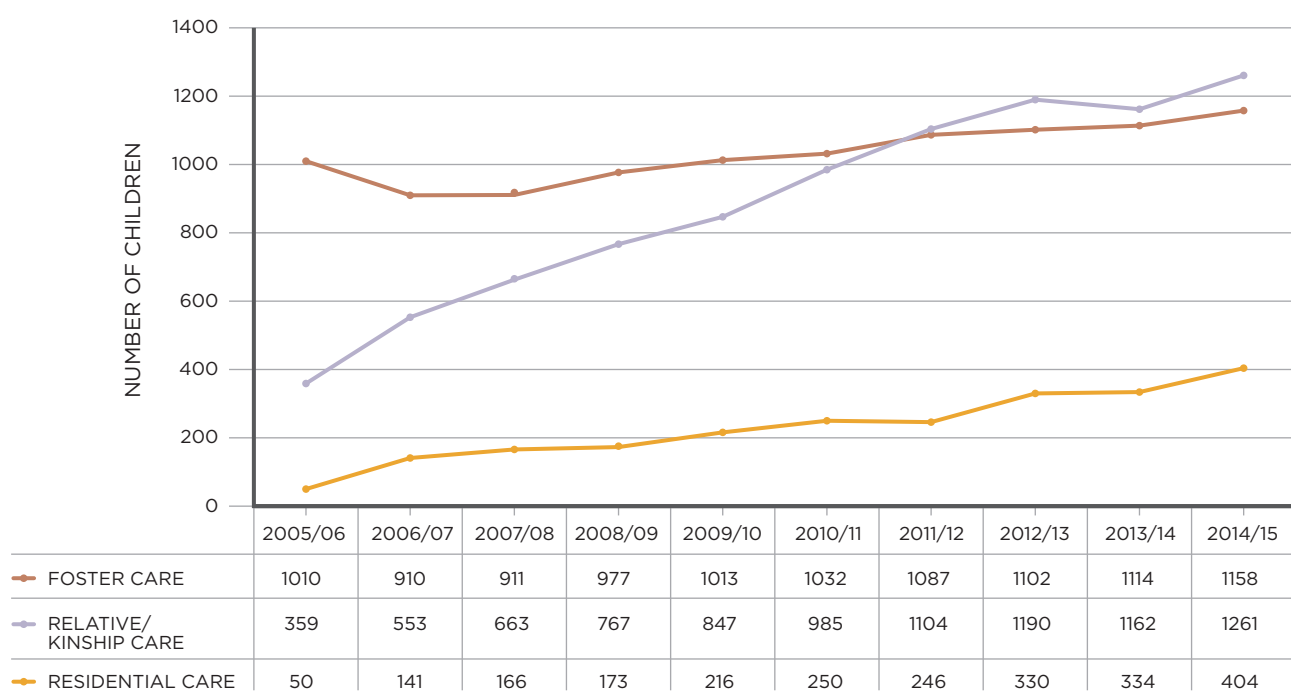


Figure 11.3: Number of children in home-based care and residential care

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

11 CARING FOR CHILDREN IN HOME-BASED CARE

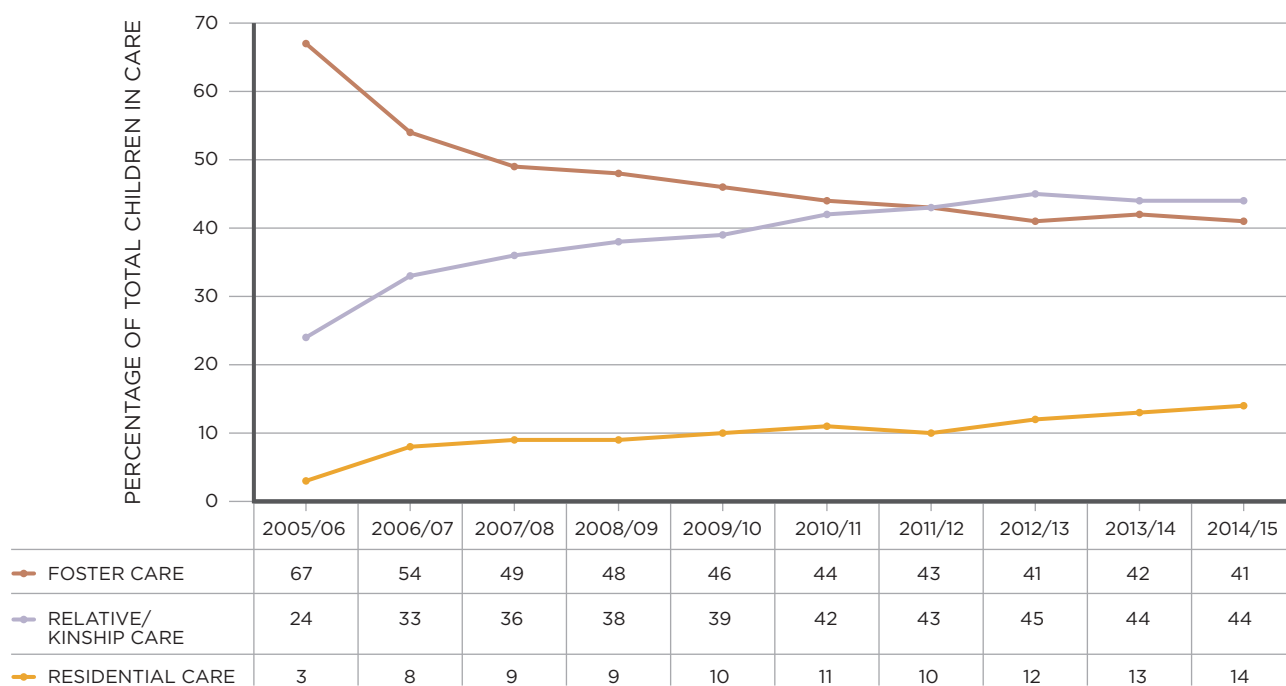


Figure 11.4: Percentage of children in home-based care and residential care

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

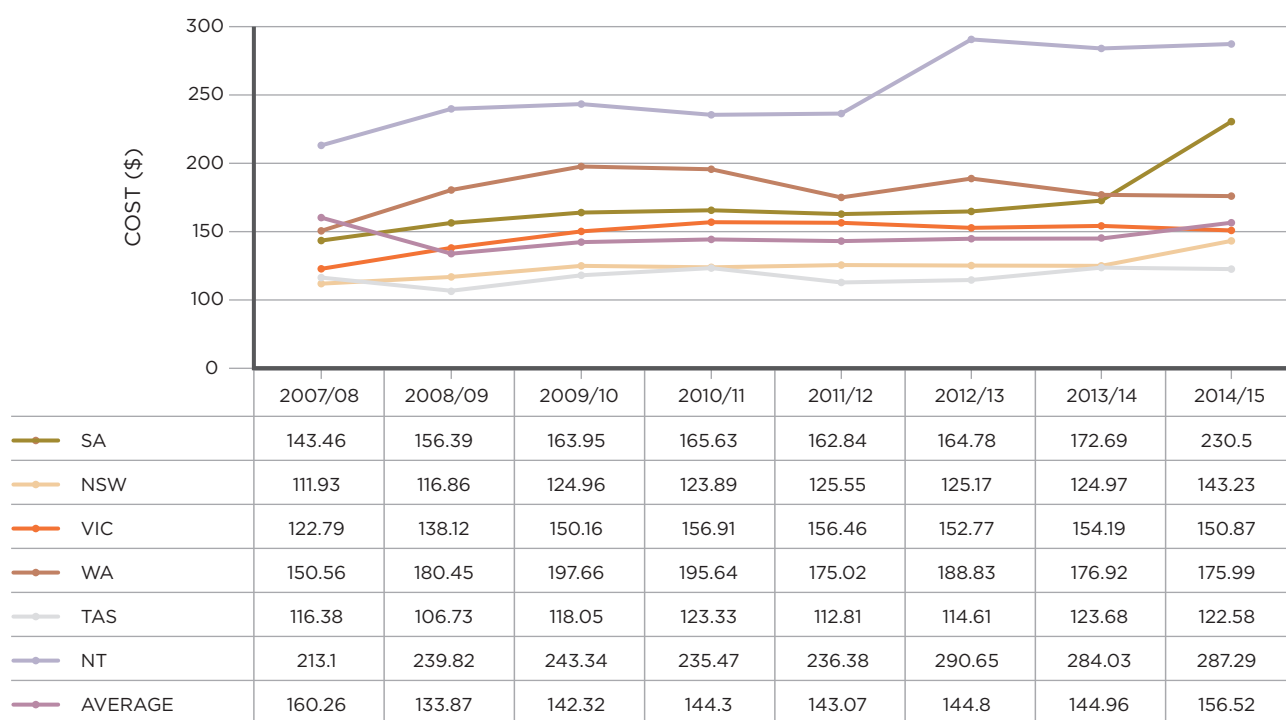


Figure 11.5: Out-of-home care placement expenditure per night

Notes: ACT and Queensland data omitted. These figures fall in the range below South Australia, but above Tasmania.

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

DEFINITIONS

The Family and Community Services Act governs the manner in which some types of family and community services are delivered. The Department for Education and Child Development (Department; DECD) administers various aspects of this Act including licensing agencies which provide foster care, approving persons who wish to be foster parents, and the ongoing review of the agencies and individuals involved in that service provision.

The Act applies only to foster parents, who are defined as:

a person (not being a guardian or relative of the child) who, for monetary or other consideration, maintains and cares for a child on a residential basis, but does not include the licensee of a children's residential facility.⁶

'Relative' is further defined to mean a step-parent, brother, sister, uncle, aunt, grandfather or grandmother.⁷

The requirements of the Family and Community Services Act therefore apply to care which is provided in the circumstances described above and which is not provided by a step-parent, brother, sister, uncle, aunt, grandfather or grandmother. This means that the various powers provided in the Act do not apply to relative carers, even where the care is provided on behalf of the Minister as the Guardian of the child, and attracts a reimbursement for providing that care.

Families SA practice definitions do not align with legislative definitions. Kinship care is defined to include a much wider category of people than the legislation contemplates. The Relative, Kinship and Specific Child Only Care: Practice Guideline and Procedure defines a relative or kinship carer as a person who:

- *The child is related to by blood or marriage.*
- *Is a member of the child's community, clan, skin or language group who is bound by a defined relationship that is in accordance with traditional practice or custom.⁸*

An SCO carer is defined as a person who:

Has a significant relationship with the child based on identity, cultural connection or emotional attachment.⁹

A Families SA internal audit of kinship care processes observed a lack of clarity about the defining features of kinship and SCO carers. This is important because carers who fit the categories of kinship or SCO carer are assessed and supported in a way that is very different from foster parents. The specific differences are discussed later in this chapter.

THE LEGISLATIVE FRAMEWORK

A person is not entitled to act as a foster parent to a child unless they have been approved in accordance with sections 41 and 42 of the Family and Community Services Act.¹⁰ The Chief Executive of the Department is authorised to grant approvals, once satisfied that a series of criteria have been met.¹¹ Any approval granted must specify the number of children the carer is permitted to care for at any one time, and is subject to an overall limit of three children except in special circumstances approved by the Chief Executive.¹²

Licensed foster care agencies are also defined and regulated in the Family and Community Services Act. Foster care agency is defined as 'the business of placing children in the care and control of foster parents'.¹³ A person must not carry on the business of a foster care agency unless they are licensed.¹⁴ In order to grant a licence to an agency the Chief Executive of the Department must be satisfied of a number of criteria.¹⁵ The agency must retain certain records, and must conduct regular reviews of the foster parents supported by that agency.¹⁶

None of these provisions apply to persons who come within the definition of a relative in the Family and Community Services Act. They do apply to carers who, although related or known to the child in some way, stand outside the narrow definition of 'relative' in the Act. Therefore, some carers who are treated by the Department as 'kinship carers' come within the legislative definition of a 'foster' parent in the Act.

QUALITY STANDARDS

South Australia's provision of alternative care is subject to the Standards of Alternative Care in South Australia¹⁷ which were developed in conjunction with the not-for-profit sector, and organisations concerned with promoting the voice of children in alternative care. The standards refer to entry into care, case management, provision of care, participation of children and young people, care records, and transition planning. Standard 1.1 requires that 'all children and young people requiring alternative care will be matched to a suitable placement and provided with services that meet their specific needs'.¹⁸ There is currently no requirement that service delivery organisations report against these standards.¹⁹ The impact of the standards on the quality of service delivery has therefore been difficult to track.

National Standards for Out-of-Home Care were developed as a project of the National Framework for Protecting Australia's Children 2009–2020.²⁰ Standard 1 emphasises stability and security for children in care.²¹ It requires that 'children and young people are to be matched with the most suitable carers and the care environment according to their assessed needs', noting that 'research shows that stability, connectedness and security are essential to achieving successful transition to adulthood and are strong predictors of outcomes for children and young people in out-of-home care'.²² Performance reporting against these standards is in development.²³

In a submission to the Commission, GCYP observed that the current system gives little choice in placements for children, and serious compromises are frequently made in placement decisions.²⁴ Decisions are often made on the basis of what is available rather than what is the best fit.

The state's ability to meet quality standards depends, to a large extent, on improving the way in which home-based care is sourced and managed.

CHALLENGES IN KINSHIP CARE

Families SA has a strong policy preference for placing children in need of out-of-home care with kinship carers. The Families SA Care Planning Policy provides that:

*The first preference is for a child to be cared for safely within their own family and community. Where this is not possible, placement within the child's community with significant others is next preferred. The placement of children must be based on their assessed needs and children will be matched with the best option possible. Placement within a family, preferably from the child's cultural group, is preferred over non-family based care. Where non-family based care is necessary, it will be provided in the least restrictive and most normalised manner possible.*²⁵

The Relative, Kinship and Specific Child Only Care: Practice Guideline and Procedure refers to a 'child placement principle', which outlines a hierarchy of care options for children in need of out-of-home care. The hierarchy identifies placement with relatives or kin as the first preference, closely followed by placement with significant others in the child's social network. Home-based foster care is the next preference, followed by rotational and other types of care.²⁶ The practice guide represents the child placement principle as underpinned by the objects and principles enshrined in the *Children's Protection Act 1993* (SA), which before the 2016 amendments emphasised the desirability of a child remaining within established familial and neighbourhood networks, or in an environment where they have an

established sense of connection. These references were removed by amendments to the Act made by the Children's Protection (Implementation of Coroner's Recommendations) Amendment Bill, which came into force in 2016. The guide does not yet reflect these amendments.

However, the child placement principle as described in practice guidance which places a relative or kin placement at its apex has no legislative basis or force (nor did it at the time that the practice guide was written). Contrary to the strong implication in the practice guide, it does not have the same status as the Aboriginal placement principle which has a basis in legislation.²⁷

Notwithstanding these legislative changes, kinship care is likely to continue as the preferred care option for many children who enter the child protection system. It is a natural outcome of placement decisions being made in the best interests of each child.

The submission made to the Commission by the Australian Association of Social Workers argued that many social workers were concerned that there is an uncritical promotion of kinship care as necessarily in the best interests of children. They argue that there is a 'limited acknowledgement that complex and poorly functioning families may be the result of generations of poor parenting and that removal of a child to grandparents may still leave them exposed'.²⁸

A recent survey of relevant literature from Australia, Canada and the US²⁹ summarised the respective demographic characteristics of foster parents as most likely to be:

- female;
- white;
- married in two-parent household;
- earning a mid-range income;
- without post-school education;
- in a household in which one person in the house is in paid employment;
- aged between 35 and 54;
- parents of their own birth children;
- in homes with under-utilised space; and
- wanting more children.

Kinship carers, by contrast were more likely to be:

- grandparents;
- from minority ethnic backgrounds;
- single;
- older;

- have less formal education;
- in poorer health than foster parents;
- live in poorer accommodation with overcrowding; and
- working.

Research has highlighted that kinship carers often enter the arrangement out of a sense of obligation to members of the family. Carers face the additional challenge of having to negotiate altered family relationships including that with the child's birth parents. This can be especially difficult for Grandparents who may experience a sense of responsibility for their child's personal difficulties.³⁰ In South Australia, 41 per cent of kinship carers are grandparents.³¹

For some carers, generational changes in parenting style can be challenging. Some research has highlighted that kinship carers are more likely than foster parents to resort to physical forms of punishment and overall harsher discipline styles. Punitive care styles are unlikely to address underlying psychological and emotional consequences of trauma and abuse.³²

This is not to blame kinship carers or suggest that they cannot deliver appropriate care. The likelihood that kinship carers enter the caring arrangement at greater social disadvantage, with less training, and potentially more complicated family relationships to negotiate, highlights the need to provide a more, rather than less, rigorous assessment and support program.

WHOSE RESPONSIBILITY?

Recruitment, assessment, training and support of foster parents in South Australia is managed exclusively by foster care agencies. Each agency is funded in accordance with a service agreement with Families SA, and their delivery of these services is reviewed at regular intervals.

Over time, funding for each agency has been negotiated individually, and then rolled over contract to contract. The result is inconsistent funding across agencies delivering the same service.³³ In the past, some agencies received as little as \$4000 per placement per year; others were paid \$15,000 for the same service. Recently, the gap was reduced to bring the lowest cost agencies to \$8000 per placement.³⁴ The historical gap might be seen as reflecting prudent use of public funds to obtain a service at the lowest cost to the taxpayer, but the evidence suggests that the lowest cost placements were associated with poorer quality carer assessment, and higher rates of care concerns for children in care.³⁵ Agencies who delivered services at the lowest cost were unable to provide a quality service at the intensity necessary to support carers to do their job well.

An agency funded at a high rate has a greater capacity to deliver a quality service to foster parents. However, there is no transparency about these funding discrepancies to enable carers to make an informed choice of agency. The fact that contractual details are negotiated confidentially, and considered commercial in confidence, also prevents the agencies knowing where their funding level sits in the applicable range.

Fundamental service parameters require an agency to complete home visits with their foster parents and track their progress on a regular basis. Some agencies are able to provide additional services. For example, Life Without Barriers provides psychological support, and other programs such as a mentor program for children in care. Lutheran Community Care has available the Marte Meo attachment-based program to develop strength in caring for children, which is funded from a non-government source.³⁶

Families SA's Service and Accountability Unit retains and tracks regular performance data from each agency. They also receive feedback about agency performance on an ad hoc basis from departmental staff in service delivery hubs. Feedback mechanisms are being improved with development of an electronic survey for local office managers to complete before agency service contracts are renewed.³⁷ The unit does become aware of patterns in the complaints made about particular agencies. The Commission also became aware of some patterns which highlighted concerns about particular agencies.

The agencies identified as problematic were typically among those funded at the lowest level. Any critical assessment of their performance relative to other agencies should therefore take account their comparatively poor funding for delivering appropriate services.

Ultimately, if an agency is expected to deliver a comparative service, it should be funded at a comparative rate, especially when they are not profit-making ventures, but are funded to deliver critical services. If agencies underperform even when funded at an equivalent level, then action should be taken to address the deficits or else decline the renewal of service agreements. Comparative funding and performance should be reviewed to bring greater equity to services being provided to foster parents.

FOSTER CARE AGENCIES

In South Australia, 12 agencies hold licences to operate as foster care agencies:

- Aboriginal Family Support Services
- Anglican Community Care
- Anglicare
- Baptist Care SA
- Centacare
- Centacare Catholic Diocese Port Pirie
- Key Assets
- Life Without Barriers
- Lutheran Community Care
- Time for Kids
- UnitingCare Wesley Adelaide Homelink SA
- UnitingCare Wesley Country.

Each operates across different geographical areas. In some areas more than one agency operates. Key Assets, Life Without Barriers and UnitingCare Wesley Adelaide Homelink SA provide specialist foster care services for children with high needs. Each agency is funded by Families SA to provide services to recruit, train, assess and support foster parents. A prospective foster parent approaches the agency of their choice and is recruited, trained and assessed by that agency. The final registration is undertaken by Families SA.

RECRUITMENT

As numbers of children in care grow, so does the need for appropriate foster and kinship care placements. However, transformative social changes since World War II have undermined some fundamental social assumptions on which foster care was based:

The problem with this growing reliance on foster care is that it is at odds with the most dramatic social trend to have occurred in Australia since the Second World War—the torrent of women entering the workforce. Both in its scale and implications for society, Australia has witnessed few other movements like it ... With women traditionally filling the role of carer, their increased workforce participation has meant that there is a shrinking pool of volunteer carers, and there has been a continual struggle to attract new ones into areas such as foster care.

The problem is compounded by the ageing of Australian society which has meant that working women and men are increasingly called upon to care for elderly relatives. In fact in the 21st century, more employees will have dependent elders than dependent children.³⁸

These changes to the social landscape are permanent and the traditional foster care model should be reviewed in this light. A major challenge is whether the role should continue to be conceived as a voluntary endeavour, or whether changing social conditions, and changes in the needs of children coming into care, mean the role should be reconsidered as a profession with associated wages and conditions.

In South Australia, the number of foster parents entering the sector has been far outstripped by the number leaving. In the 2014/15 financial year, 82 households entered and 138 left. In the preceding financial year, 145 entered and 241 left. Over the same period, Victoria, Queensland and the NT recorded more foster parents entering than exiting the system³⁹, suggesting that a different recruitment approach might help, and that the overall loss is not due to social conditions alone.

Research has identified other barriers to a greater level of foster care in the community. Reasons include the disruption to family circumstances with fostering, and the associated financial cost.⁴⁰ A 2014 study found that the two reasons most frequently cited for not becoming a foster parent were that the person had never been asked, and fostering a child was too big a commitment. The researchers argued that the prominence of the first reason highlights an opportunity for good communication to increase numbers.⁴¹

Broad-based media campaigns have been employed in the past to address the low level of knowledge in the community about fostering. Such campaigns raised awareness and created initial interest in fostering, but show limited return in recruiting carers.⁴² Greater success has been shown in localised recruitment campaigns, especially word of mouth.⁴³ The same results were identified in the recruitment of Aboriginal carers, with success being influenced by the involvement of Aboriginal people.⁴⁴

In South Australia registered foster care agencies are funded to recruit carers. Each agency chooses how and when to recruit to suit their target market, funding level and numbers of existing carers. Evidence to the Commission from these agencies confirmed that word of mouth remained the most powerful and effective recruitment tool. Foster parents who speak about their experience and model the difference their service can make in the life of a child have proved to be the best motivator for other families.

The Child and Family Welfare Association (CAFWA) is the peak body in South Australia which represents not-for-profit organisations that provide child protection services for children, young people and families (especially out-of-home care services).⁴⁵ CAFWA has argued for a role in developing a centralised marketing and recruitment process for foster parents, eliminating

potential double handing of current enquiries made to Families SA and or foster care agencies.⁴⁶ The interim report of the Select Committee on Statutory Child Protection and Care in South Australia, published on 23 September 2015, recommended that this centralised function be pursued.⁴⁷ A collaborative approach to marketing foster care would undoubtedly generate benefits in accessing the economies of scale.

One agency, Lutheran Community Care, sounded a note of caution about this centralised approach. They ran a centralised recruitment process between 2004 and 2006, but now recruit carers only for their own agency. They observed that recruitment marks the start of a relationship with potential foster parents and the continuity of relationship from first contact can be beneficial to the overall process. Agencies managing their own enquiries have more opportunities to screen out unsuitable applicants early in the process by exploring initial enquiries in greater detail.⁴⁸

An independent evaluation in 2007, of the centralised recruitment service managed by Lutheran Community Care, found that of 900 calls received, only 55 parties were referred on to other agencies for assessment. The review concluded that recruitment, training and assessment could be more effectively undertaken at one location and potentially by a single agency. They emphasised the importance of consistency of relationships, and reduced duplication of information throughout the process.⁴⁹

In South Australia, a large number of enquiries about fostering received by agencies do not convert to applications for registration. These numbers should not necessarily be interpreted as lost opportunities; a well-functioning system should aim to identify candidates who are ill suited to the role at an early stage. However, the large gap between enquiries and applications arguably highlights a level of interest that should be tapped more effectively (see Figure 11.6).

Figure 11.6 shows a reasonably steady level of interest in foster care, evidenced by the number of enquiries fielded by agencies. However, the number of applications and subsequent approvals show a substantial decline over the last three financial years.⁵⁰

Recruitment efforts need to present flexible options in foster caring. The 2007 review of centralised recruitment in South Australia observed a shift towards young and more highly educated candidates.⁵¹ These candidates tend to be more interested in short-term care options. Greater take-up of this type of care would not address the dearth of long-term foster parents, but candidates prepared to undertake short-term roles might consider a more long-term commitment when circumstances allow. Carers who offer respite only are also critical to reducing stress on long-term carers, contributing to the sustainability of existing long-term arrangements.⁵² The need for carers to support the system in flexible ways should be identified in promotions.

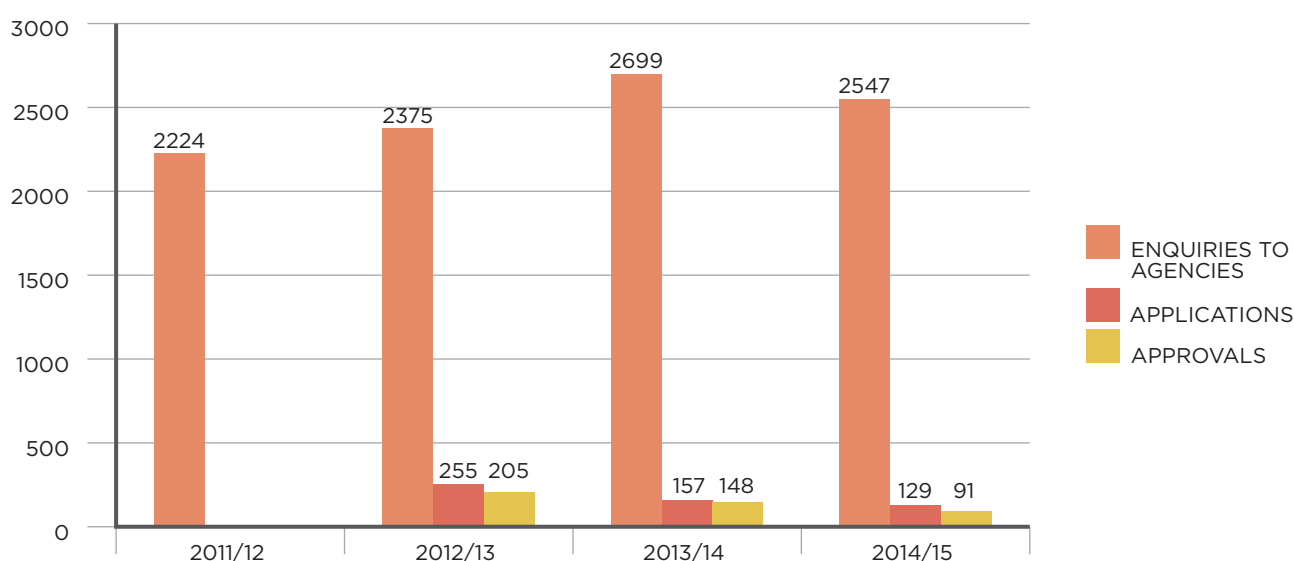


Figure 11.6: Foster parent applications, assessments and approvals in South Australia 2011/12 to 2014/15

Note: Data for applications and approvals for 2011/12 not available.

Source: Data provided by Families SA.

Information provided at recruitment is critical to ensuring that candidates understand the rigours and challenges of the role. To attract and retain the right carers it is critical that a realistic and honest message is delivered, balanced with promotion of the associated rewards.⁵³

Broad-based media campaigns could promote a heightened awareness of foster care in the community. However, the required high numbers of new foster parents are more likely to be delivered by local targeted strategies—using existing word of mouth networks and existing carers to help identify potential new carers. There is evidence that using existing carers in the recruitment process improves credibility.⁵⁴

There is good reason, therefore, to be cautious about moving to a centralised recruitment model. Unless carefully structured, such a model could take a generic focus with a media campaign improve knowledge generally, but not delivering a large number of new carers. Local agencies with community knowledge and access to existing carer networks may well be in a better position to conduct the kind of recruitment that research shows is effective.

Recruitment should remain the responsibility of individual agencies, and could be complemented by collaboration on worthwhile and cost-effective individual campaigns.

A number of foster parents told the Commission that the recruitment and assessment process did not equip them for the reality of foster care. One witness said the information provided was delivered in an inexperienced way, was out of date and presented an inaccurate picture of the relationship with the Department.⁵⁵ Had the witness not had independent knowledge of the reality of the foster care system from other sources, she may well have been dissuaded from taking on the role.⁵⁶

Departmental workers should participate in information sessions for potential foster parents to ensure that information is accurate and up to date. Current carers should also contribute their perspective on the challenges of the task. This combined range of perspectives would be more likely to give potential carers a realistic picture of the challenges and rewards involved. Children in care should also participate in these endeavours, to provide a child's perspective on the rewards and challenges of foster care.

ASSESSMENT AND REGISTRATION

FOSTER CARE

Foster parents are assessed through the Step by Step competency-based program, developed interstate and widely used across Australia. The program prescribes a series of five to six interviews with the family (as well as individual interviews which may be conducted with

family members who may stay or board in the home from time to time), with time in between to allow potential carers to consolidate information, and for reports to be prepared. Families SA tracks registered agencies against key performance indicators, which include how many assessments are completed within five months, the minimum period prescribed for assessment.⁵⁷

CAFWA advised that the Step by Step process was seen as unnecessarily restrictive, repetitive and 'tick box' focused. The timeframe anticipated by the program itself can be expanded by delays in obtaining screening clearances, and the time it takes for Families SA to consider the assessment and application for registration. Some contributors thought that delays in registration contributed to a loss of momentum for families, who might thus lose interest in fostering.

Some agencies have discussed with the Families SA Carer Assessment and Registration Unit (CARU) innovative ways to shorten the time between assessment visits, with a view to shortening the overall assessment time.⁵⁸

Peter Sandeman, Chief Executive Officer of Anglicare, the largest registered foster care agency operating in South Australia, told the Commission that his agency preferred to take a longer time to assess a family, because gaining an understanding of the family's relationships brings more information to the assessment.⁵⁹ He observed that:

the issue for us is we use the 12 month process to winnow out people who shouldn't be there. So what's the nightmare for an organisation like ours? Being infiltrated by a paedophile ... So we're very careful to make sure that recruitment processes are a little bit arduous and people have lots of option for self-referring out, and we have a lot of opportunity to get to know these people really, really well. So yes, it takes a long time. The conversion rate is low and the people we get are really good.⁶⁰

A carer's decision to open their home to an unrelated and unknown child is not to be taken on a whim. It is a life-changing decision, particularly for families interested in providing long-term care. For the sake of the child, it should not be subject to the vagaries of a changed mind because an assessment 'takes too long'. There is a balance to be struck between, on the one hand, developing efficiencies to ensure time is not wasted and, on the other, recognising the value of relationship building over time. The Commission considers the current balance of a minimum five-month period is appropriate.

The Parliamentary Select Committee report published on 23 September 2015 recommended that a fast track option be developed for training foster parents, including a full-time intensive program.⁶¹ In light of the advantages

of an assessment that takes place over a lengthier time period, the Commission does not support a full-time intensive foster care assessment process.

Some contributors directed criticism at delays once an assessment was lodged for registration with CARU. A complete review of documentation for registration purposes takes a staff member three days. However, the Commission heard evidence that there was a backlog of six to ten weeks in the CARU process. Many applications have to be returned to the assessing agency seeking further information—expanding the review process towards 10 weeks. Priority assessments (where a child has been identified for placement with the applicants) are fast tracked, but this delays other work.⁶²

The Redesign process of reform (discussed in Chapter 5), which began in 2013, made changes to processes and structures across the Agency. Before Redesign, CARU was staffed by four licensing officers, each social work qualified (AHP 2 classification). After Redesign, social work staff were reduced to two, and seven ASO5 staff were employed (ASO being the administrative stream which does not require any formal tertiary qualification).⁶³ The reduced overall expertise in the section has resulted in a greater load for the remaining professional staff and supervisors.⁶⁴

The task of assessing foster care applications for registration is not administrative. It requires more than a satisfaction that documentation is in order. A robust consideration of the issues raised requires critical thinking and an ability to look behind the information provided to identify gaps:

an example would be the applicant has a history of depression, and that's fine, because many people in the community can manage their depression, but the

information to mitigate that risk hasn't been provided. So we have to go back and make further enquiries, and say 'can you provide additional information?'. So it is going through the competencies and making sure all the key competencies are met and if there are any indicators, we go back and ask for further information.⁶⁵

That is not to say that the position necessarily requires social work qualifications. The Commission understands that there is a move back towards requiring tertiary qualifications for appointment to the position.⁶⁶ The Commission supports a move towards requiring higher level formal qualifications for analytical work of this kind. The unit should also be resourced to provide a timely response to completed assessments. Where children are waiting in unsuitable emergency accommodation for a home-based placement, it is critical that the availability of that home is not delayed by resourcing constraints. Staffing levels should be maintained on the basis of a service benchmark of 14 days for an uncomplicated application.

Obtaining screening clearances also unnecessarily delays the registration process. The carer registration process applied by Families SA anticipates a screening clearance will be obtained by the assessing agency before beginning the Step by Step program.⁶⁷ In practice, many agencies begin assessment before clearance based on information from an applicant.⁶⁸ On occasion, concerning information comes to light after the assessment has begun, and time invested has been wasted.⁶⁹

A screening clearance is not the end of probity checks for a foster parent. Once a completed assessment is returned to CARU, they search a number of internal databases, checking for adverse information about carers and other adults frequently in their household.

The need for early preliminary assessment¹

Case one: A foster care agency conducted a full assessment of a couple and forwarded the documentation, together with the relevant screening clearance for approval. CARU's database search found that the female applicant had a history of childhood abuse, and a history of seeking financial assistance from Families SA after being raped as an adult. The male applicant had a history of seeking financial support from Families SA and a history of schizophrenia and contact with mental health services, and was reported to have attempted suicide on more than one occasion. Neither applicant had disclosed these matters to the foster care agency in any detail, when questions in the assessment specifically raised

the issues. These matters were relevant to (although not decisive of) the applicant's capacity to provide foster care. They should have been investigated before undertaking any thorough assessment.

Case two: A couple completed the full Step by Step assessment and identified their daughter as in regular daily contact with them and their household. Any child placed with them would also have a close relationship with their daughter. Their daughter had a lengthy child protection history including serious physical abuse of her own children. This information, if known, would have disqualified the couple at an early stage.

¹ Foster care assessment files provided by Families SA.

Information is sometimes identified during this search that makes registration inappropriate, and renders the lengthy assessment futile.

Applicants for assessment as a foster parent should therefore supply sufficient preliminary information to enable CARU to search the databases at an earlier stage in the process. This will prevent resources being expended on applicants whose circumstances or relationships make them unsuitable to provide foster care in any capacity. The separate screening clearance remains essential.

A number of foster care agencies, with the support of CAFWA, recommended that final registration of foster parents should be delegated to the agencies themselves.⁷⁰ It was suggested that this move would better clarify the separation of functions between Families SA as funder and regulator, and the registered agency as provider, with not-for-profit agencies responsible for all functions from recruitment, through assessment and registration.⁷¹ This model is used in other states.⁷²

The CARU registration assessment is more than a rubber stamp. The current placement of final registration with the Department provides a quality assurance process. CARU commonly identifies gaps in assessment, and seeks further information from assessing agencies.⁷³

Only a small proportion of carers who are recommended for registration by agencies are not subsequently registered by Families SA. The Commission examined all applications for registration as a foster parent made to CARU between 1 July 2011 and 1 December 2014, a period of approximately three and a half years. Over this period there were 553 applications, 17 of which were not approved. Of those 17 non-approvals, 15 were not recommended for approval by the assessing agency, but were submitted to CARU to make the final decision. Two applications in the period were recommended for registration by the agency, but were not registered by CARU. The number of applications which were not recommended by the agency, and yet still forwarded for a decision by Families SA highlights the continuing function of separate quality assurance. Clearly some agencies would prefer Families SA to make the final decision to exclude unsuitable candidates rather than themselves having difficult conversations with such applicants.⁷⁴

To put the above numbers in context, agencies do screen out applicants in the course of the process when it becomes clear that they are unsuitable. Many unsuitable applicants never reach Families SA for a registration decision. The Step by Step guide clearly identifies a number of 'screen outs' or factors which identify an

applicant as unsuitable.⁷⁵ CARU does, from time to time, receive applications which should have been screened out at a much earlier stage in accordance with the guide. The Commission was advised that CARU now asks agencies to notify them about applicants who have been screened out without a formal registration decision being made, so they can be tracked centrally in case they choose to approach another agency for assessment.⁷⁶

The Commission recommends that the Department be notified of applicants who are screened out, or withdraw from assessment for any other reason, in order to track applicants who might be tempted to 'agency shop'. This requirement should be formalised as a part of service agreements with registered agencies.

In the Commission's review of applications for registration, themes such as domestic violence within households, and mental or physical health challenges, were identified. In general, there was a greater tolerance for issues of these kinds when the applicant was seeking to provide care to a specific identified child. In one case, the strengths of a couple were seen to outweigh serious health concerns of the female applicant, who was in such poor health she would be unable to lift a child. In another, current domestic violence risks were not considered as sufficiently serious to disqualify an applicant seeking registration to provide respite care to a known child. These issues also emerge strongly in considering the standards applied to the assessment of kinship carers. There was an overall sense that carers with an existing relationship to the child were approached with a greater tolerance of circumstances that ought to have raised concerns. It was not clear whether this was a result of different assessment processes, or an overall greater tolerance of risk in kinship placements.

INTERIM REGISTRATION PROCESSES

Where children are subject to an unplanned removal there is rarely time to conduct a comprehensive assessment of the adults who are available to provide care. The child's best interests are usually served by them remaining in a familiar environment, with adults who are known to them. In these circumstances, carers who fit the definition of SCO or kin may be registered quickly using an initial registration process called the 'iREG'.

The iREG is intended as a preliminary assessment of suitability. The applicable practice guide provides that 'iREG does not endorse the child/ren remaining with the carer on a long term basis or mean that kinship carer registration will automatically occur. Kinship carer registration requires further assessment and decision making within the early months of the care arrangement to ensure registration occurs within three months of iREG endorsement'.⁷⁷

To complete an iREG, the following details must be considered⁷⁸:

- personal details;
- details of children under 18 also living at the premises;
- details of any adults also living at the premises;
- two referee reports;
- a safety assessment which indicates whether immediate safety risks have been identified, and whether identified risks can be managed with the use of a safety plan; and
- consent forms for Families SA to search the Client Information System and the connected client and case management system (C3MS) databases and obtain a criminal history check.

Health assessment of a potential carer relies on a self-report rather than an expert medical opinion,⁷⁹ and no screening clearance is required.

The iREG process is designed to provide sufficient information to place a child for no longer than three months, and is insufficiently rigorous to ensure a child's safety in the long term. However, it is evident that significant delays in kinship assessments mean children are placed on these limited assessments for much longer than three months. The iREG process requires that referrals of these registrations must be made to Placement Services Unit (PSU) for a full assessment within 14 days. This timeframe gives PSU the best chance of completing the necessary assessment within three months. However, recent data showed that only 27 per cent were referred within that timeframe; the rest were referred between 14 days and three years later.⁸⁰

As at 9 October 2015, 967 children in the care of the Minister were residing in kinship placements. They were being cared for by 899 carers in 633 households (some households contain more than one registered carer). Of those 967 children, 376 were living with carers who had not been formally assessed, but were registered on the basis of an initial registration. This is approximately 39 per cent of all children in kinship placements. Removing from consideration children who have been in placements for less than three months, approximately 34 per cent of the children are in kinship care placements that have not been assessed according to Families SA's own guidelines. Table 11.1 shows the applicable time delays.

iREG does not require a carer to present a current screening clearance, which is ultimately necessary to obtain full registration as a kinship carer. Some assessments lodged with PSU for consideration reveal serious issues with the suitability of the carers, which is particularly problematic when the child has been in a placement for an extended period of time.

Table 11.1: Children in placements registered only on iREG status

TIME IN PLACEMENT	NUMBER OF CHILDREN
Less than 2 weeks	4
Between 2 weeks and 1 month	8
Between 1 month and 3 months	30
Between 3 months and 6 months	68
Between 6 months and 9 months	65
Between 9 months and 12 months	52
More than 12 months	149
Total	376

Source: Data provided by Families SA.

Garry Matschoss, Acting Manager of the PSU, observed:

*Sometimes, it gets very contentious, because having done the full assessment, and this is where I sign off ... we don't recommend approval, which ... can be very problematic if the child has been in placement for some time, but it does happen.*⁸¹

A proportion of the overdue assessments might be awaiting a screening clearance. There is no point conducting a comprehensive assessment of a kinship carer until the clearance is available because they will not be approved without a screening clearance.⁸² Screening clearances must therefore be given a high priority within the Department for Communities and Social Inclusion, particularly where a child is being cared for in circumstances which may turn out to be unsuitable. An administrative arrangement should be established to provide priority screening checks for carers with whom a child has been placed pursuant to an iREG process.

The use of iREG processes requires urgent clarification. The longer a child remains in a placement which proves to be unsuitable, the greater the potential for further adverse impact on them. If issues arise during the course of assessment that cannot be overcome by working with the family, the child faces the uncertainty and disruption of a move from a placement with which they have grown familiar and carers to whom they may have grown attached. Placement of vulnerable children in alternative care which is not assessed to be safe or suitable also exposes the child to continuing risk.

Delays in full assessment arguably expose some carers (who are not related in the terms defined in the Family and Community Services Act but who are acting on the authority of the iREG) to liability under that Act. Section 41 prohibits a person from acting as a foster parent, unless they have been so approved. Section 42 requires that a carer be assessed according to a range of criteria:

In considering any application for approval as a foster parent the Chief Executive Officer must attempt to assess the capacity and willingness of the applicant to care for a child according to adequate principles and standards of child care, and must, in such manner as the Chief Executive Officer thinks fit, satisfy himself or herself as far as reasonably possible—

- (a) that the applicant will have adequate interest in, and affection and respect for, a child placed in his or her care; and*
- (b) that the applicant will treat the child in a consistent manner and will provide a safe and stable family environment for the child; and*
- (c) that the applicant will understand adequately the developing personality of the child, and will provide opportunities to develop the abilities of the child; and*
- (d) that the applicant will provide adequate accommodation for the child and any other material provision necessary for the welfare of the child; and*
- (e) that, where appropriate, the applicant will provide opportunities for the child to maintain or recover his or her identity as a member of his or her own family and will allow the child reasonable access to his or her own family; and*
- (f) that, where appropriate, the applicant will assist the child to return to his or her own family; and*
- (g) that the applicant is in sound health and is able to withstand the demands of providing foster care; and*
- (h) that the applicant is otherwise a fit and proper person to provide foster care; and*
- (i) on any other matters that the Chief Executive Officer may consider relevant.⁸³*

A person is an approved foster parent if they have been approved as such, in writing, by the Chief Executive of the Department. The iREG process does not assess in detail the breadth of matters described in section 42,⁸⁴ and it is unlikely that the Chief Executive would regard that process as an appropriate basis on which to grant registration as a foster parent. There is therefore a serious question about whether a proportion of kinship carers and SCO carers are regarded by the Department as registered foster parents under the Family and Community Services Act. If they are not, then there is a potential liability for acting as an unregistered foster parent. This issue does not apply to kinship carers who are step-parents, brothers, sisters, uncles, aunts, grandfathers or grandmothers.⁸⁵

SPECIFIC CHILD ONLY CARE

Formal assessment of SCO carers is currently referred to foster care agencies for assessment according to the Step by Step program. Historically, there has been ambiguity about how these carers should be assessed. The requirement that SCOs be assessed according to the Step by Step tool was introduced because of a historically high rate of placement failure. Children were being rushed into placements with adults who had little understanding of the demands involved.⁸⁶ The Step by Step assessment program over time focuses the adults on the significance of their undertaking.

However, unlike a foster care assessment, SCO carers are assessed with the child already provisionally in the placement under an iREG.

Provisional placement of the child can make it difficult to negotiate with carers about changes to the physical environment such as placing a pool fence or removing unsafe clutter. It can also be difficult to convince carers of the need to work cooperatively with the Department.⁸⁷ Foster care agencies can be tempted to prioritise the assessment of carers who do not yet have children placed in their care (who are awaiting registration and are not eligible for iREG), to cope with the numbers of children awaiting placement. Some foster parents are working towards eligibility to care for more than one child, and there is an understandable desire to prioritise those assessments.

The Commission understands that the placement of children with SCO carers using the iREG process has been the subject of some discussion within the Agency. There are benefits to children being able to be placed, with full assessment following quickly. On the other hand, if full assessment does not quickly follow (the impetus for which can fall away once a child is placed) there is a risk that the child's stability will later be disrupted.

One solution would be to fund foster care agencies where necessary to contract out SCO assessments to ensure their efficient completion. Experts in private practice could be funded to complete those assessments 'as needed'. A panel of private practitioners authorised to conduct these assessments should be developed so that urgent assessments can be outsourced for priority attention where appropriate.

KINSHIP CARE

Kinship carers are not assessed according to the Step by Step program. They can be assessed by staff in the local office or by specialist assessment PSU staff. Kinship assessments are strength based and do not focus on the key competencies central to the Step by Step program. Assessment also focuses on identifying and mitigating risk to a child.⁸⁸ Assessments are conducted against documentation which has not yet been approved at an executive level in the Department.⁸⁹ There remains a level of uncertainty about the applicable policies and procedures.⁹⁰

The Commission heard that in practice there is an inherent conflict in kinship placement assessment sitting with the local office. A worker faced with an emergency removal has a stark and difficult choice: place a child in emergency care which carries with it a high administrative burden and a great deal of pressure from management to move the child to a cheaper arrangement, or write up a substandard kinship care placement to justify placement in a family environment. An experienced social worker told the Commission of one environment:

It was like Steptoe and Son. There was rubbish from floor to ceiling; from the front fence to the back fence of the property. It was shocking. Inside the house wasn't unhygienic per se, but there was so much clutter and stuff in it, there was no room for anybody, let alone for children. There was no yard space. There was scrap metal, car bodies, ovens and fridges and all sorts of stuff out there. Yet the staff had said that it was an appropriate house in order for the carers to be registered to care for these children. It was hideous. So that's the sort of situation that can potentially occur when staff are desperate to place children.⁹¹

There is no doubt that kinship care placements are subject to a different standard of assessment than foster parent placements. There is an obvious case for adopting a flexible approach to account for the benefits of the child remaining in a familiar environment with connections to their family, but there is a danger that, on occasions, keeping the children with family has justified a placement which is inappropriate and potentially unsafe.

Inter-generational abuse¹

'Felicity' is a teenager who was removed from the care of her mother Patricia in 2000, following a large number of child protection notifications about her and her siblings. Patricia had also been removed from the care of her mother as a child following allegations that she had been sexually abused by her stepfather, and that her mother had not been protective or supportive of her daughter. Criminal charges were laid, but were later withdrawn. Families SA recorded a finding that Patricia had been sexually abused by her stepfather.

In 2000 when Felicity was removed, she was placed with her grandmother and step-grandfather, against whom abuse had previously been substantiated by Families SA. This placement choice was by court order, and against the objection of Families SA.

By 2014 the placement was under considerable stress, with allegations that Felicity may now have been the victim of abuse at the hands of the step-grandfather.

¹ DECD, Care concern documentation.

Mr Matschoss the Manager of the PSU, observed that there was ongoing pressure to reduce the complexity and scope of the assessment of kinship carers, in an effort to address the growing backlog of assessments.⁹²

In October 2013 amendments to kinship carer assessment processes were authorised at the executive level which removed the obligation on potential carers to provide a medical report from a general practitioner as to their capacity to provide care. The change was a response to the observation that medical reports could take months and delay the carer assessment process. The replacement medical self-assessment requires potential carers to self-report any medical issues for which they need support with or which might impede their capacity to provide care.⁹³ This is especially concerning against the background that almost half of kinship carers are grandparents, many of whom have health issues affecting their capacity to care for children, especially in the longer term.⁹⁴

Once a child is placed with a kinship carer and medical issues arise, Families SA has no power to insist on an independent expert medical report. The Commission heard of one situation where a grandparent kinship carer had an obvious serious medical condition, but refused permission for Families SA to obtain independent evidence about it. In those circumstances, Families SA regarded themselves as powerless.⁹⁵ Conversely, foster parents in a similar position can be obliged to supply

medical information pursuant to section 47 of the Family and Community Services Act (under threat of a pecuniary penalty).

In November 2013 the Department introduced a priority response assessment (PRA) which further diluted the assessment process for some kinship carers. This short-form assessment is conducted when the carers are identified through initial triage as low or no risk. No documentation guides this triage decision, which relies heavily on professional judgement. The PRA does not assess parenting capacity, family history and environmental factors, all of which are part of a full assessment. When the abbreviated assessment was implemented, the potential risks of not covering parenting capacity and family history were identified. A requirement was then imposed to check potential carers on C3MS in order to identify issues. An internal audit of 43 PRAs found three cases of care concerns about potential carers which had not been identified through the PRA process.⁹⁶

The same internal audit identified a number of carers registered on the basis of iREG documentation, with no evidence of police checks. There was uncertainty about the person responsible for conducting the police check and where the results should be recorded on C3MS.⁹⁷ A high proportion also demonstrated evidence of only one referee check having been completed.⁹⁸ There is no requirement that the referee have any standing or professional relationship to the child or carers. In some instances the referee was a close relative.⁹⁹ Greater objectivity is needed in selection of referees, or a greater range of informants should be relied upon to build a picture of the carer's suitability.

Helen Kay, Manager of the Families SA kinship care support program, told the Commission that some kinship carers have a history of adverse involvement with Families SA. Where such a history exists, the carer might be reluctant to engage with the Agency, and resist accepting intervention that might help them care for children.¹⁰⁰ Some carers, the Commission was told, 'prefer not to be contacted at all'.¹⁰¹ As with SCO carers, once a child is placed, there can be less motivation to cooperate with departmental processes. Some family members dismiss the assessment process as unnecessary bureaucracy and become difficult to engage.¹⁰² All these factors contribute to kinship care potentially being a 'high risk program'.¹⁰³

The Commission was told in clear terms of a feeling that in many circumstances a poor kinship care placement is a better option for a child than emergency care.¹⁰⁴ Notwithstanding the risks inherent in some arrangements, the possible management of those risks is a pragmatic response to the current crisis in alternative care placements. It also acknowledges the benefits of a child being maintained within a familiar family structure.

These observations highlight the need for comprehensive assessment, to achieve an informed balance between risk and the best interests of the child.

The existence of family ties is not a guarantee that a child will be safe in a kinship care placement. In Victoria in 2010, an Ombudsman investigation of out-of-home care concluded that less rigorous assessment standards, and the regular failure to check even those basic standards, had children remaining in dangerous placements for long periods of time.¹⁰⁵ Departmental records were examined after two Victorian examples of children complaining of sexual abuse. There was no evidence that relevant assessments and criminal record checks had been properly done.¹⁰⁶ Evidence before the Commission suggests that the same risk exists in this state.

DECISION MAKING

The Commission heard of inconsistencies in the level of decision making independence permitted to home-based carers. The departmental Consents and Decisions Practice Guide acknowledges that decision making in long-term home-based care will be delegated as part of a natural part of the parenting process.¹⁰⁷ Section 80 of the Family and Community Services Act permits the Department to formally delegate in writing certain areas of decision making to foster parents who have cared for a child for three years or more.

Section 80 is rarely used. Rosemary Whitten, Executive Director for Metropolitan Services and Residential Care Services, was asked why formal delegations could not be made more frequently to enable families to make decisions about certain areas of children's lives, such as health, education or travel. Ms Whitten believed that a barrier to greater delegation of decision making was the Department's ongoing fiscal responsibility in some areas.¹⁰⁸ This could be relevant where a child has high health needs, and decisions lead to significant financial implications. However, areas such as education and travel could be delegated to carers, with negotiation about financial responsibility dealt with as a separate issue. Section 80 provides a method for carers to be helped to gradually take over decision making, culminating in the making of Other Person Guardianship (OPG) orders in their favour. This is discussed further in Chapter 13.

Ultimately, a greater emphasis on OPG processes may render section 80 delegations of less relevance. However, it is a tool that must not be overlooked in considering ways in which home-based carers can be more empowered to care for children.

Amendments should be made to section 80 to repeal the current minimum requirement of three years and replace it with 12 months. To promote its use, a practice guide

should be developed to identify the types of delegations which might be made, and the circumstances in which they should be considered.

RELATIONS WITH THE STATUTORY AGENCY

Thirteen years ago the Layton Review observed that the state must acknowledge that it cannot itself parent, but it can facilitate and support parenting done by others. That report highlighted that the purchased services and contracts model often reduced foster parents to the cost of accommodation and nutrition of children without resourcing or acknowledging the role that these adults perform in developing children's sense of belonging, sense of worth and self-esteem.¹⁰⁹

Notwithstanding the force of this observation, foster parents and kinship carers continue to feel undervalued and sidelined in decision making about children they care for 24 hours a day, seven days a week. Carers seeking a voice in decision making about their child frequently reported having their status dismissed as 'only the carer'.

Foster parents reported wanting to give a child in their care a secure sense of belonging, that they were part of a family with all the rights and responsibilities that entails. One foster parent explained, 'I want my children to know they're part of a family, not part of the system'.¹¹⁰ Many children in alternative care remain psychologically 'caught between two families' and foster parents and kinship carers play an important role in helping children to negotiate this.¹¹¹ They do so uncertain about the security of their own emotional position. Foster parents in particular described the challenge of committing themselves to the care of a child who could be removed by the Agency at any point. One carer, who had cared for her now six-year old foster child since he was three-weeks old, described herself as living with the sword of Damocles hanging over her head.¹¹² Many foster parents find themselves unable to function in that emotional environment. Good carers are pushed out, and the ones that remain are encouraged to care just a little less.¹¹³

'I want my children to know they're part of a family, not part of the system'

The Commission heard evidence from a large number of foster parents in hearings and considered the experience of others as part of three case studies: Abby, Nathan and Shannon McCoolle (see Vol. 2). While there was some evidence of functional, consistent relationships between foster parents and Agency staff, overall carers were dissatisfied with the lack of respect shown to them, and lack of interest in their contribution to case management.

The case studies identified instances where foster parents had been poorly treated and the value of their contribution dismissed.

The best recruitment strategies for foster care might rely on word of mouth, but their success is very much dependent on the message being delivered by existing carers. Some foster parents told the Commission that although they loved their foster children, they would not recommend the experience to others. Overwhelmingly, the reason for this was the challenges they faced in dealing with the Agency.

One experienced social worker summarised the complaints consistently heard from carers¹¹⁴:

- they are not reimbursed for the real cost of providing care;
- they do not get enough information about children placed in their care;
- they are not automatically given a seat at the table when meetings are held, and their parenting role is not acknowledged in decision making;
- they are mistrusted for their motives, and normal advocacy for children in their care was made to seem abnormal;
- they get insufficient support to care for highly challenging children; and
- when they complain, the response is at best ineffectual, and at worst punitive.

These themes were consistently reflected in the evidence heard by the Commission, and in observations made in the course of case studies about the lack of respect shown to foster parents.

Registered agencies were also frustrated about the level of support available from the Agency. Aboriginal Family Support Services described a growing frustration with promises made at the start of placements, which were not made good. They said that expectations of carers were high, but at times the support to meet these expectations fell short:

Some of our placements can be really quite difficult, and we're asking carers, who are volunteers, to take on very complex children at times ... and yet we are asking them to do this with little to no additional resources, and sometimes to keep this placement alive we have to put in the extra yards, and whether it's the additional visits by support workers or some additional resources by Families SA, it keeps this placement in care, and stability for the child.¹¹⁵

The Commission is satisfied that if recruitment and retention of home-based carers is to improve, a shift in the way they are treated is essential. The child protection system cannot continue to exploit the goodwill of volunteers who turn their lives upside-down for children without giving them the respect and dignity that their position demands.

The Agency must clarify the role that it plays in caring for children who are in home-based placements. They must support the family to parent well, rather than intruding into every aspect of decision making as representatives of the Minister. This does not mean stepping away from the statutory responsibility, including the responsibility to develop a relationship of trust with the child and visit regularly. One submission argued that Families SA have confused their role, saying 'the state can never be the parent, as the state is always a terrible parent and can never make up for the security of that daily care from a consistent, committed and loving caregiver ... Foster families are often inappropriately intruded upon in terms of decision making, but abandoned in terms of support to deal with the child's needs'.¹¹⁶

'Foster families are often inappropriately intruded upon in terms of decision making, but abandoned in terms of support to deal with the child's needs'

INFORMATION SHARING

There is a high level of concern that the Agency does not freely share information which is relevant to the care of a child with potential carers. This concern is not isolated to the information required at the start of a placement; it applies to information relevant on an ongoing basis to the carer's capacity to parent.¹¹⁷ In particular carers felt excluded from comprehensive information about children's trauma histories. This left carers to their own devices to navigate the child's special needs. One worker explained that in determining whether to share information with foster parents she was mindful of the confidentiality of the child's family of origin. 'It's a fine line between providing them enough so as to not, you know, go against the family's confidentiality'.¹¹⁸

The balance of how much information is shared with carers, including potential carers, should be drawn in favour of more rather than less. Providing less than the full picture to carers is counter-productive and undermines carers' capacity to deliver good quality care. It results in placement instability or the child's needs not being met.¹¹⁹ Carers also may not receive sufficient

information about case direction for the child, or about court dates and outcomes when a child is subject to ongoing proceedings.

An alternative approach which provides greater clarity about foster parents' rights has been taken in NSW. The *Children and Young Persons (Care and Protection) Act 1998* (NSW) sections 143-146 specifically refers to carers having a right to particular types of information, and rights to participate in decision making about children in their care. These provisions clarify the rights of carers to make informed decisions about placements and to receive the information they need to provide care. The provisions also emphasise a child's entitlement to have information about carers before being placed with them.

Abby: Poor communication with foster parents

(The full case study of Abby is at Volume 2, Case Study 2: Abby—Intervening in high-risk families.)

In the case of 'Abby', her foster parent was made aware that the placement of the 18-month old child in her home might not be long term. Efforts to reunify Abby with her mother became increasingly futile. Abby's caseworker made statements to the foster mother which gave her the impression that her family would be closely considered for long-term care if that need arose. However, the truth of the matter was that, at a very early stage, kinship carers interstate were being scoped. The complexities of an interstate transfer of orders meant that Abby remained in temporary foster care while reunification was attempted. Abby was in a critical developmental phase where satisfying her attachment needs was especially important, and home-based care was the best place for those needs to be satisfied.

Abby's foster family hoped that she would become a permanent part of their family if reunification failed. When Abby was two-and-a-half years old her foster mother was asked to take her to a meeting at a playground with relatives who had travelled from interstate, which she did. At the meeting, Abby's foster mother discovered that those relatives were being considered as long-term carers for Abby. She was not informed of this development by Families SA staff, but rather overheard it from one of Abby's relatives. This was the first time Abby's foster mother was made aware that other carers were being scoped for Abby.

Table 11.2: Base subsidy rates by age of child (weekly)

CHILD'S AGE	TAS (\$)	WA	NT	VIC	ACT	QLD	NSW	SA	FCE [†]
1	190	172	211	159	231	221	218	155	218
3	190	172	211	159	231	221	218	155	218
6	217	225	226	159	259	238	245	172	234
10	217	225	266	171	259	238	245	172	274
14	251	277	329	252	348	259	329	248	345/337

[†] FCE = foster care estimates, the approximated costs associated with caring for a child or young person developed by the Social Policy Research Centre at the University of New South Wales.

Note: Figures are 2013 for all jurisdictions except South Australia. SA's figure is based on data from carer payment schedules applicable from 1 October 2014, rounded up to the nearest dollar.

Source: Adapted from Acil Allen Consulting, *Professional foster care: Barriers, opportunities and options*, October 2013, p. 6, referring to M McHugh, *Updating developments across Australian jurisdictions, New directions in policy and planning for foster care in Australia*, Keynote Address, Centre for Excellence in Child and Family Welfare Inc. Victoria, Foster Care Futures 11 September 2013.

FINANCIAL ARRANGEMENTS

Payments are made to foster parents and kinship carers in accordance with carer payment rates tied to the age and complexities of the child in their care. The payment is a reimbursement of the cost of caring for the child. It is not a wage and is not considered as income for the purpose of determining eligibility for federal income support payments or for tax purposes.

Table 11.2 shows that South Australia's payment levels are among the lowest.

A direct comparison of these rates may be misleading because of the variety of ways in which loadings and additional costs are accounted for in different jurisdictions. A more useful guide to the adequacy of reimbursement is obtained by comparing the South Australian reimbursement rates to the foster care estimates, developed by the Social Policy Research Centre at the University of New South Wales. Foster care estimates represent the approximated costs associated with caring for a child or young person. While many foster parents are reluctant to refer to the financial burdens of caring, worried that they will be accused of 'being in it for the money'¹²⁰, a comparison of these figures show that the contribution of carers to raising children is often financial as well as psychological and emotional.

In South Australia, a series of loadings apply to recognise the higher cost of caring for a child with higher needs. The rate of carer reimbursement can be adjusted in accordance with the needs of the child at any particular time. However, this flexibility moves the rate payable both up and down. Good quality care which reduces

psychological distress and the associated behavioural symptoms can result in carers having their payments reduced.

Some children attend school irregularly because of behavioural challenges that result in frequent suspension. Other children require regular medical and psychological appointments. Foster carers tasked with meeting these needs, especially where they have more than one child in their care, are prevented from or limited in engaging in the paid workforce. Foster care becomes a full-time occupation.¹²¹ In these circumstances, any changes to the reimbursement payable are felt acutely.

Carers who register through specialist agencies including Life Without Barriers and Key Assets are more highly paid than general foster parents, and the fortnightly payment does not change according to the complexities of the child. Children who are placed with these carers have already been identified as having higher needs, and have often already endured at least one failed placement. Even across the specialist agencies the carer payments are inconsistent. Reimbursements across the specialist agencies vary by up to \$200 per fortnight per child.¹²²

The discrepancy between a foster parent receiving a base rate and one registered with a specialist agency is well understood in the foster care community:

That disparity is incredibly unfair, and for carers who talk to each other ... well, I get \$850 a week through Key Assets, and I've got this kid who actually looks like his behaviours are worse than yours, and I'm getting \$200 per fortnight.¹²³

A carer who is registered as a general carer does not have access to the highest level of reimbursements available through a specialist agency, even if their child develops especially high needs. Only by transferring to a specialist agency and completing additional training will that carer be able to access the additional reimbursement. Additional benefits can encourage carers in that situation to take that course. Specialist agencies are funded to deliver more intensive support to carers, and are better equipped to deliver therapeutic support to those placements.

The Agency should address the discrepancies across general carer rates. Some flexibility is reasonable in the rates payable for children with higher needs, but the gap must be reduced by bringing basic payment rates upwards. In particular, there must be an acknowledgement that loadings which support a family's ability to provide intensive and consistent care can prevent escalation of difficult behaviours and subsequent placement breakdown. The rates payable to specialist foster parents should also be standardised across agencies. Where general foster parents have children whose needs escalate and the care of those children would be better provided through a specialist agency, carers should be helped to move their registration to the specialist agency.

In addition to carer payments, Families SA is responsible for payment of other miscellaneous costs as they arise. An Alternative Care Support Payments: Manual of Practice guides decision making.¹²⁴ Squabbling about financial responsibility for children's hobbies and activities still causes tension between foster parents and Families SA staff. One carer reported that funding for a child's music lessons was stopped after 18 months because of financial constraints.¹²⁵

Among the most contentious of these issues is payment for private school fees. Some families incur many thousands of dollars over a child's schooling. The Manual of Practice provides guidelines for this decision making and clearly sets out the circumstances in which fees will be paid. However, these guidelines are subject to the circumstances of each child.¹²⁶ Discretionary overrides of guidelines by senior executive staff asked to review particular cases become problematic when more persistent or assertive carers are treated more favourably than carers who accept a decision made at the local office level. Inequities become well known and promote resentment among carers.

Transparency is lacking about foster care entitlements and decision making. The two principal guides to decision making and entitlements, Alternative Care Support Payments: Manual of Practice and Consents and Decisions Practice Guide, are not available as a matter of course to foster parents. A version of the Consents and Decisions Practice Guide, which was specifically

developed for release to carers, is available.¹²⁷ An up-to-date version of the Alternative Care Support Payments: Manual of Practice should be produced and made freely available to registered carers, whether online or in hard copy. If a specific guide is produced for carers, it should contain the same information, to the same level of detail as the internal manual.

ADVOCACY

Connecting Foster Carers (CFC) is the peak independent body representing foster parents and kinship carers. It is funded through a service agreement with the Department, which requires CFC to provide a variety of services, including a newsletter at least twice a year, a telephone advice service staffed 9–5 with call back function after hours, and an internet site.

Funding, which for the 2015/16 financial year totalled \$92,396, also covers: a small honorarium and reimbursement for excess mileage for CFC board members; training and information exchange forums; and corporate expenses such as the operation of a mobile telephone free-call service. CFC pays no wages, and the free-call line and other services are staffed by volunteers.¹²⁸

CFC has 560 member households and delivers newsletters three times a year. Board members rotate staffing the telephone service and answering enquiries via the internet site.

The objects of CFC include:

- assisting carers to provide a loving and stable family home environment to foster children;
- advocating, representing and lobbying on behalf of carers and foster children; and
- bringing greater recognition to carers and foster children.¹²⁹

Advocacy at a system level is well established, and CFC attends more than 30 meetings per quarter with government and non-government agencies. The service specifications in the agreement with the Department refers to advocacy, although it is not clear whether this refers to advocacy for foster parents and kinship carers as a group, or also on behalf of individual carers. It is difficult for CFC to offer an individual advocacy service to foster parents.

Many carers, especially kinship carers, are not used to dealing with large bureaucracies and lack the skills to assert themselves in dealings with Families SA. Other carers feel overwhelmed by the power imbalance between them and Families SA, which has the ultimate power to remove the child from their care.¹³⁰

CFC volunteers are carers themselves and many have good reason to be reluctant to develop an adversarial relationship with Families SA. They are also at a disadvantage in that they are usually not in possession of all relevant information.

An independent advocacy service that helps carers negotiate with the Agency should be established. CFC volunteers cannot be expected to provide an individual advocacy service in circumstances where their own relations with the Agency may suffer as a result. The appropriate site for such an advocacy service needs consideration. Such services might be provided through CFC, existing community legal centres or the Legal Services Commission. Educational materials for carers should be developed by the same service to clearly identify their rights to contribute to decision making in the Youth Court and in the Agency, and what rights of review exist inside and outside the Agency.

MANAGING RISK

PLACEMENT SUPPORT

Providing proper support to carers can reduce the risk of placement breakdown and improve stability for children in care. In a comprehensive survey in New South Wales, foster parents were asked to rate five statements for their relative importance in retaining foster parents. The three most important factors were:¹³¹

- receiving more support from a caseworker;
- getting respect from workers; and
- getting regular respite from caring.

Financial considerations were viewed as much less relevant. These observations suggest that for carers the quality of the experience is much more important to them than the costs.

The level of foster parent satisfaction in their parenting role has been linked to them feeling competent in managing the behaviour of the children for whom they care. These feelings have been linked to an intention to continue to foster children in the future.¹³² Helping carers do their job well not only improves the current quality of care but could offer other benefits through improved carer retention.

Registered foster care agencies are required to employ supporters of carers (SOCs). The SOC role, as described in the service contract with DECD, is to 'support, supervise and manage carers to ensure compliance with the requirements of this Service Agreement'.¹³³ The role as described is broad ranging and ill defined. A consistent theme in evidence about this relationship was a lack of clarity about the role. Some Families SA workers were uncertain about exactly what SOCs were contracted to do, and perceived that SOCs were unwilling to take on difficult aspects of the work.

Foster parents are also confused about the role of the SOC. Many foster parents believe that the SOC is a support for the carer, as the title of the position implies. In fact, on occasion the performance of an SOC's contracted duties requires them to act contrary to the carer's interests. Josephine Jarvis, the chairperson of CFC, told the Commission there was a lack of clarity about whether the SOC was there to provide support to the carer or to the placement.¹³⁴ If the support is to the placement, then questions arise about who is there to support carers who provide care intermittently, or who are awaiting a placement.¹³⁵

Many foster parents are under the impression that an SOC will advocate on their behalf in dealings with Families SA. In practice, carers are often disappointed about a lack of support in this regard. Foster parents report that SOCs appear cautious about engaging in true advocacy because they are afraid to 'rock the boat' and feel constrained by the contractual relationship between the registered agency and Families SA. There are also occasions when concerns about the placement originate with the SOC, and advocacy by them would be a conflict of interest.

Mr Sandeman of Anglicare suggested one way of thinking about the role:

my view is more that we're supporting a family, a family system, and that means somebody outside the family who is able to help that family resolve tensions and conflict. You're not there to support ... the carers against the child, though that could be a construction. I think it's much more about supporting families to function better, which means having the capacity to work both with the child, the other siblings, and the parents, and sometimes between the parents ... When it comes to investigation of a concern about abuse of that child within the foster family, that's when the department needs to step in. That's not our role ... If they're case managing the child and they need to step in to decide whether to take the child away ... we do have a responsibility to report abuse if we see it, but the decision making about what happens as a result of those reports needs to be with the department.¹³⁶

There is an urgent need to clearly define the respective roles of the SOC and the child's caseworker. Although it is critical that they work together, with the child's best interests at the forefront of their working relationship, it is inevitable that their perspectives will not always align. Some caseworkers employed by Families SA complained that they were not permitted access to the service agreements which they believed would define the duties of the SOC. There is no reason why there could not be greater transparency about the terms of the service agreement (although aspects of costs arrangements might need to remain confidential). However, it must be understood that the service agreements also lack specificity. Families SA and the registered agencies must work together to develop clear specifications as to the respective roles of the SOC and Families SA caseworker. Such specifications must be freely available (including to carers) and must inform service delivery to families. Foster parents must also receive accurate information about the precise nature of the SOC role. The current role title has a clear potential to mislead.

The Family and Community Services Act requires foster parents to be regularly reviewed. Reviews are conducted by registered agencies.¹³⁷ Support and review of foster parents in accordance with these provisions is accomplished by contractual relationships with registered agencies. The Chief Executive of the Department has compulsory powers for managing foster parents. These include the power to enter any place or premises for the purpose of providing foster parents with support or guidance on the care of a child, and to ascertain whether a child is being provided with adequate care.¹³⁸ Foster carers are also required to furnish the Chief Executive with 'such information in relation to the foster parent or a child in his or her care as the Chief Executive Officer may require'.¹³⁹ Penalties exist for the enforcement of these provisions.

Kinship care by a step-parent, brother, sister, uncle, aunt, grandfather or grandmother is not subject to the requirements of the Family and Community Services Act.¹⁴⁰ When the Department places children in these arrangements, it does not have the statutory powers and obligations that would govern a foster care placement. This includes the power to delegate decision making under section 80. There is no logical reason to exempt related persons providing care to children from these provisions.

Kinship carers are supported by kinship care workers who are non-social work qualified operational staff employed by the Agency (under the supervision of social work staff). Kinship care workers work with a child's case manager to ensure that the placement is safe and appropriate.

Evidence indicated that kinship carers can be reluctant to engage with the program and accept support. For some kinship carers, contact must be negotiated.¹⁴¹ The Agency's capacity to support and supervise the care delivered to children in the care of the Minister is not a matter for negotiation.

The Agency's carer registration procedure requires that kinship carers be reviewed every 12 months to provide opportunities for mutual feedback about areas for development, or areas where further support is needed.¹⁴² Mr Matschoss, of PSU, which is responsible for the initial assessment, believed these reviews were the responsibility of kinship support workers or caseworkers from the local office.¹⁴³ Ms Kay, of the kinship care support program, believed that responsibility sat with the PSU.¹⁴⁴ What is clear is that kinship carers are not being reviewed on a regular basis in the same way as foster parents.

The kinship care program applies a workload management tool known as 'differential service response', which identifies workload priorities for kinship care support. It was described as ensuring that 'some carers would receive more intensive support than others, depending on their current circumstances and need'.¹⁴⁵ Some kinship carers do not have a support worker at all, and others only receive a minimal service.

Without legislative powers, Agency staff must negotiate to obtain the information for assessing and monitoring a placement. Mr Matschoss, talking about assertively pursuing a formal assessment of kinship carers, made the observation:

I guess about the closest we get is writing to them and saying that there will be a review ... of the placement ... which is, I guess, a veiled threat. We do things like looking at who's got the relationship; is there a kinship care support worker involved; what's the relationship there; is the local office involved? So we look at other avenues of how we can get in there. We also try to talk to the people, to find out what is the problem, and work around it, and accommodate. We are very, very flexible. In my time being involved, there is not one yet where we haven't succeeded in actually being able to complete the assessment, but some, a couple of them, have been quite challenging.¹⁴⁶

A coercive approach is not suggested for securing the cooperation of reluctant kinship carers, but the existence of formal statutory powers to enable the Agency to keep children in care safe should provide clarity and boundaries in the relationship between the Agency and carers.

THERAPEUTIC SUPPORT

Children entering care in today's environment have increasingly complex behaviours and medical needs.¹⁴⁷ Thus, the nature of care provision in home-based environments is changing.¹⁴⁸ When carers are not adequately helped to deal with difficulties of children in their care, placements break down. Early support should be available to identify and address issues before placements are put at risk. Flexible support for carers is critical to identifying problems which might arise, and dealing with them in a timely way.

Home-based carers are not experts in trauma.¹⁴⁹ They rely on the professionals to help them identify and deal with issues that emerge as the child grows. Two main barriers were identified to delivering therapeutic support: foster parents fail to communicate with support workers about the nature and severity of the problems; and professionals charged with supporting the placement do not refer them to appropriate support at an early stage.

The relationship between carers and the Agency is critical. A number of carers reported a reluctance to speak candidly to caseworkers about the challenges of caring, because they were afraid that their capacity to cope would be questioned. Some carers reported a reluctance even to seek reimbursement for property damage caused by their foster child because of a fear that their capacity to control the child's behaviour would be brought into question.¹⁵⁰

Greater access to therapeutic support must be made available. This support can be delivered where it is most needed, only if the relationship of trust between carers and the Agency is improved.

TRAINING

The compulsory training delivered to foster parents for initial and continued registration is limited to:

- orientation training through the 'Shared Stories, Shared Lives' package;
- Apply First Aid (3 yearly);
- Safe Infant Care (for carers registered for infant care); and
- Child Safe Environments (3 yearly).¹⁵¹

Ongoing training for foster parents is the responsibility of the contracted support agency. Barriers to attracting carers to complete more training include foster parents being put off by the poor quality training offered, or becoming frustrated by training being arranged then frequently cancelled because of a lack of interest.¹⁵² Staff from one registered agency observed a low uptake of non-mandatory training.¹⁵³ Carers should be helped to develop their knowledge and skill. However, while foster care remains a voluntary undertaking, there is a limit to how much training can be legitimately imposed on busy carers.

A structured training program for general carers should be developed and skills recognised through a skills loading that acknowledges the preventative value of high quality therapeutic care. Carers with complex children, or children at risk of developing complex behaviours, could be targeted and helped to complete the program without needing to change their registration status to specialist therapeutic carer.

Foster care agencies currently deliver training independent of each other. There has been some local inter-agency cooperation, but more opportunities should be investigated. CAFWA is well placed to lead discussions for improved coordination, which could be supported by the government as a priority project.

RESPIRE

Each agency enters into arrangements with carers to provide respite in the course of a placement. Respite can help carers who need a break from their caring role, and foster children who would benefit from different environments and a greater variety of role models.¹⁵⁴

Respite care can also be used between carer households to enable siblings in separate houses to enjoy weekends together. Children in care could thus develop a range of long-term relationships to their lasting benefit as they move into adulthood.

Foster care agencies recruit and register carers specifically interested in providing respite care only. Respite care is then provided to long-term carers on the basis of a match with a respite carer registered with that particular agency. There is no flexibility across agencies of access to respite care.

The need for respite care

Ms M is a 65-year-old retired woman who at the age of 60 decided to provide respite care to a child or young person in need. Soon after she was registered she was convinced by her registered agency to take on full-time care of an infant on an emergency basis. The infant remained with Ms M for 18 months while efforts were made to reunify him with his mother. In this time the child became attached to Ms M and a psychological assessment concluded that the child would suffer psychological damage if those ties were severed. Ms M was convinced to take on care of the child long term. Ms M lives in an area where the registered agency has no respite carers, but other agencies have carers in the area. Although Ms M was able to arrange some respite through personal friends, the lack of a respite carer in her local area who could provide respite during the school term puts pressure on Ms M.

11 CARING FOR CHILDREN IN HOME-BASED CARE

Time for Kids is a not-for-profit service that provides respite carers for kinship placements.¹⁵⁵ The fragmentation of services across different agencies, and between registered agencies and the Department means that kinship carers do not have access to respite carers who are registered with foster care agencies.

Greater coordination of respite care provision is urgently needed. The current fragmentation undermines the capacity of the system to respond adequately to carer needs. As with training, CAFWA is well positioned to lead greater agency coordination for respite, and should be supported by the government as a priority project.

RISK OF ABUSE AND NEGLECT

Just as children are at risk of abuse from their own families, so are they sometimes at risk in home-based placements.

Some children in care have particular needs and behaviours which make them especially vulnerable to abuse and neglect. A child whose psychological and emotional distress is expressed in behavioural dysfunction may test even the most patient carer. Carers who are not helped to manage these complexities may find themselves resorting to inappropriate and damaging methods to cope.

Foster parents may have allegations of abuse and neglect made about them because¹⁵⁶:

- abuse has occurred;
- children misinterpret actions because of a past history of abuse;
- foster parents are expected to deliver a higher standard of care than that expected of other parents; and
- the risk of emotional and physical abuse increases where carers are not trained adequately to cope with a child's challenging behaviour.

South Australian data about the rate of substantiations of abuse in out-of-home care does not differentiate between home-based and residential care environments. The available evidence suggests that out-of-home care for some children continues to be unsafe. In the 2014/15 financial year 80 children were the subject of a substantiation of sexual abuse, physical abuse, emotional abuse or neglect in out-of-home care. This almost 400 per cent increase from the previous financial year suggests a dramatic change in approach to allegations of abuse (see Chapter 15).

Table 11.3: Number of children in out-of-home care who were the subject of a substantiation of sexual abuse, physical abuse, emotional abuse or neglect

	2012/13	2013/14	2013/14
Number of children	8	21	80
Proportion of total children in out-of-home care	0.3%	0.7%	2.4%

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.

The Commission obtained data from the Office of the Guardian for Children and Young People which monitors allegations of serious sexual abuse in care. Its capacity to do so is limited by the extent to which Families SA complies with its obligation to report all such matters to the Guardian.¹⁵⁷ There is good reason to think the level of under-reporting from the Agency is significant. Between November 2008 and 31 October 2014 (six years) the Guardian received a total of 236 notifications, affecting¹⁵⁸ 422 children and young people. Of that figure, 182 children (109 females and 73 males) affected were in home-based care, and 196 (140 males and 56 females) were in residential or commercial care. In drawing conclusions about the respective risk in each care arrangement, it is well to remember that 85 per cent of children in out-of-home care are in home-based arrangements (see Figure 11.2).

The risk of sexual abuse does not come from adults alone. Awareness is growing of the risk of child-child sexual abuse in out-of-home care environments, and the need for adults monitoring the environment to be vigilant to this possibility. Of the 236 total incidents reported to the Guardian, 95 were allegations of sexual abuse committed by another child.

Foster parents reported to the Commission that information about children's history of sexualised behaviours was not always shared with them. Some carers felt this information was withheld at times to obtain a placement.¹⁵⁹ The Commission was made aware of one case where children in a kinship placement exhibited difficult sexualised and trauma-related behaviours. These behaviours, including sexualised behaviours involving other children, were reported to the Agency and the kinship carers repeatedly sought support for the children. Ultimately the behaviours became unmanageable and the placement was at risk of ending. A request for an alternative placement recorded that the children's behaviour was compatible with being placed with other children, and there were no

challenging behaviours which would place other children in the placement at risk of harm. This was a dangerously inaccurate representation of the situation.¹⁶⁰

A scoping review commissioned by the Federal Royal Commission into Institutional Responses to Child Sexual Abuse identified 16 evaluations which considered the prevention of child sexual abuse in out-of-home care.¹⁶¹ The following practices were identified from the literature as contributing to the prevention of child-child sexual abuse in out-of-home care¹⁶²:

- providing adequate information to caregivers at the time of placement;
- strongly considering the appropriateness of placements at the outset;
- establishing a plan to maintain safety of all children in the placement;
- developing specific and well-articulated supervisions procedures; and
- providing effective treatment for children which specifically addressed their behaviour.

Where children are known to exhibit sexualised behaviours, this information must be shared openly with potential carers. Carers should have an opportunity to consider the appropriateness of the placement, and whether they are equipped to maintain the safety of all children in the placement.

Caregivers should also be offered training in how to address the needs of children who have been sexually abused, and to support them to keep their environment safe.¹⁶³ Training should include how to respond to children who behave in inappropriate ways to minimise the risk that innocent conduct might be misinterpreted.

Factors identified as contributing to the prevention of carer-child sexual abuse are:

- completing rigorous screening checks, including having regard to information beyond criminal background checks;
- anticipating and checking applications for the use of pseudonyms;
- removing organisational features which can facilitate sexual abuse (power differential, unsupervised access to children, carers sharing bedrooms with children); and
- developing an environment where children feel safe enough to disclose.¹⁶⁴

Reforms to screening practices and organisational features are discussed in Chapter 20. Perhaps of greatest importance for children in home-based placements is creating an environment where they feel safe enough to disclose. This requires the maintenance of consistent and continuous relationships of trust with important adults outside the placement, such as the child's caseworker or other trusted adults (see Chapter 10).

RESPONDING TO RISK

DECISIONS TO REMOVE

The media recently reported a number of removals of children from foster care placements. In these cases, Families SA needs to protect the privacy of the children concerned. Media reporting of these situations can present a picture of Agency operations which is incomplete or inaccurate. Reporting of that kind feeds the fear experienced by foster parents that their children might also be removed.

Removal of a child from a settled foster or kinship care placement is governed by a document described as a 'Divisional Circular'. The removal of a child is a controlled by section 51 of the Children's Protection Act which provides a general power to the Minister to make arrangements for the care of a child under guardianship, including placing them in the care of an approved foster parent. The Agency's discretion about where to place a child in care is unfettered, and carers have very limited rights of review.

Divisional Circular 131, issued on 29 July 2013, sets out a mandatory process of consultation and communication before a decision to remove. In particular, the circular requires that where concerns are serious enough to require placement termination to be considered, the caseworker must have communicated about those issues with relevant stakeholders, including anyone engaged to support the placement, professionals working with the child and, critically, the carer.¹⁶⁵

If the Agency considers that the matters of concern are unlikely to be resolved, and there is a high risk of placement breakdown, a case conference must be held and the carer must be invited. A decision to remove can only be made at that conference if all parties agree to that outcome. If consensus cannot be reached, the decision is made by a director or assistant director, taking into account all relevant information, and consulting with relevant experts.¹⁶⁶

The prescribed process, if followed, should leave a carer in no doubt about the seriousness of the situation before a decision to end the placement is made.

On occasions a removal must be undertaken in emergency circumstances, and it is not appropriate to engage the carer in a case conference. The circumstances include the Agency believing there is a real immediate risk to the child, and giving carers advance warning of the intended action may place the child at risk (for example, by being removed to an unknown location).¹⁶⁷ Where such circumstances genuinely exist emergency removal is the only option. However, a very detailed assessment of the nature of that risk must precede any decision to proceed with an emergency removal. When a placement has to end, a cooperative and well planned process is to be preferred wherever possible. The impact of the removal on the child's sense of security and wellbeing must be carefully considered. The impact of such action on the carer's willingness to engage in a cooperative and planned transition process should also be weighed. These are not easy decisions, but evidence suggests that the balance has not been appropriately struck in recent times.

The Commission considered independent reviews of a number of decisions made by the Agency to remove children from placements. Some common themes were that:

- the Agency held genuine concerns about the quality of care being offered in the placements;
- the nature of the concerns made removal an appropriate response;
- the implementation of the decision to remove was poorly managed;
- there was a lack of consideration of whether the alternative available to the child would deliver a superior quality care; and
- the child's perspective or view was not sought.

The seriousness of a decision to remove a child from a long-term placement, with the associated interruption to their security and attachment relationships, cannot be overstated. The Divisional Circular records:

*the decision to remove children from families with whom they are living, including the removal of children who are settled with foster, relative or kinship carers, is a critical decision in the life of a child: removal of a child from placement may have a lifelong impact on the health, wellbeing and future of the child. The carer family may also be severely impacted. Such decisions must be made with the utmost consideration of the child's safety, life-long security and future emotional wellbeing, as well as the natural justice rights of carers and their emotional wellbeing.*¹⁶⁸

Decisions that have such wide reaching implications should be attended by a greater level of transparency and formality than is currently available. Foster parents

must be supported to present their point of view and, where appropriate, participate in child-focused transition planning.

CARE CONCERN PROCESSES

Allegations that children in care have been abused or neglected, or that an appropriate standard of care has otherwise not been met, are referred to within the Department as 'care concerns'. Management of these matters is described and analysed in greater detail in Chapter 15.

The management of care concerns has an impact on carers against whom such allegations are levelled. No doubt, the swift and rigorous investigation of such allegations is a fundamental safeguard for children living in out-of-home care. Some allegations are so serious that a child cannot be permitted to remain in the placement while the investigation proceeds. In some circumstances, that will require removal of the child without prior notification to a carer. These are situations which may arise with limited time to plan a response, and the safety of the child must be the focus of decision making.

However, if investigations are unnecessarily prolonged and conclude that concerns are not substantiated, or can be addressed without the removal of the child, then valuable security and continuity for the child will have been unnecessarily lost. For this reason, investigations must proceed as quickly as possible. Subject to investigational demands, carers must be given clear information about the allegations against them and how long investigations will take. Children also must receive appropriate and honest information about why their circumstances have changed, and what is likely to happen in the future.

REFORMING HOME-BASED CARE

Both the legislative and policy framework for home-based care needs significant overhaul. Governance has not kept pace with the growth in kinship care and this deficit should be urgently addressed. Carers need greater clarity about their rights to information and participation in decision making, and major decisions made by Agency staff that affect carers should be more transparent.

Legislative amendments are needed to ensure that all carers providing care to a child in the custody or guardianship of the Minister are subject to a consistent legislative regime, whether or not they are related to the child in their care. Legislative governance should therefore be expanded to include family members (including the groups currently excluded from the operation of the Family and Community Services Act) who care for children in arrangements where they receive a payment from the state government for that care.

This could be achieved by prescribing a second category of carer to which the provisions of Part 4, Subdivision 3 of the Family and Community Services Act would apply. This category would include step-parents, brothers, sisters, uncles, aunts, grandfathers and grandmothers who provide care for children who are in the custody or guardianship of the Minister, but who are currently excluded from the definition of foster parent. Amendments would also be necessary to section 80 in Subdivision 8 of the Family and Community Services Act to include reference to decision-making power being delegated to these relative carers as well as foster parents.

It is appropriate that kinship carers who care for children in private arrangements remain unregulated by the Family and Community Services Act.

The governance structures currently prescribed by the Family and Community Services Act are premised on a division of function between Families SA and registered agencies. The reforms to bring kinship care into alignment with foster care should extend to outsourcing kinship care assessment and support to appropriately qualified registered agencies. iREG processes would continue to be completed by Agency staff involved in the initial identification and assessment of the placement, but the final assessment would be delegated to the non-government agency tasked with providing ongoing support for the placement.

If possible the number of agencies delivering these services should not be expanded. Greater coordination and collaboration between agencies is valuable for providing training and respite care in particular. The recommendations made in that regard would be more easily achieved with the current modest number of agencies providing services.

The higher risks that may require management in kinship placements require highly skilled and knowledgeable staff helping carers to deliver quality care. Contractual conditions in service agreements with registered agencies must specify tertiary level qualifications for employed support staff.

Section 42 of the Family and Community Services Act sets out a range of matters the Department's Chief Executive must consider before registering a foster parent. The Commission considers that these matters are equally appropriate to kinship carers. However, the Step by Step program used to assess foster parents is not designed to assess kinship carers.

A standardisation in the legislative regime does not assume standardised assessment. The criteria in section 42 are sufficiently broad to support a variety of assessment methods, appropriate to the circumstances of the particular carer. The current assessment tools have

not been approved at an executive level, and remain in an unapproved form. There must be an investment in a rigorous evidence-based assessment tool to be used by registered agencies to assess kinship carers.

Standardisation of registration processes should deliver greater rigour to the current kinship registration processes. It would require regular reviews, and the Chief Executive of the Department would, if necessary, have the power to require compliance. It would also bring all carers within section 80, enabling decision making to be delegated to relative carers in appropriate cases.

The Commission acknowledges that there may be challenges in outsourcing kinship assessment and support in some regional and remote areas. This would need to be carefully monitored, and actioned only when an appropriate agency is able to demonstrate a capacity to provide a service at the required standard.

The Commission recommends that registration of kinship carers sit with CARU rather than the PSU, because of the anticipated standardisation of processes and stakeholders. CARU is in the best position to provide the comprehensive check of applications for registration that must apply to kinship carers.

The changes proposed would see a significant contraction in departmental kinship support services. However, it would bring a greater role for the CARU in reviewing and approving registrations.

CARU would need a significant injection of resources to deliver these expanded services. To assess the staff levels required, a service benchmark of a 14-day turnaround for completed assessments should be imposed (completed meaning that they do not need to be returned to the agency for further information). In considering how resources should best be deployed, emphasis should be placed on the analytical and professional, rather than administrative, aspects of the registration task.

The backlog in kinship carers who are caring for children without having been subjected to a comprehensive assessment should be addressed as a matter of urgency. A specific project team should be engaged to address the situation, and ensure that no kinship carer has a child in their care under an iREG process for longer than three months.

Practices that dilute the assessment for kinship carers, such as medical self-report processes and the priority response assessment, should be abandoned. There is a real danger that risks that remain unknown cannot be managed appropriately and children will be at risk.

PARTICIPATION IN DECISION MAKING

Foster parents at present have very little power to challenge decisions made which affect children in their care. Current practice in the Youth Court does not normally include contributions from children's home-based carers. Section 47 of the Children's Protection Act permits the court to join a person who is not a party, where the order to be made will be binding on that person. This power has limited application to persons who care for the child under an administrative agreement with the Agency.

Section 47A permits the Youth Court to hear submissions from a variety of persons who are not party to the proceedings. The range contemplated includes a person who at any time has had care of the child.¹⁶⁹

The right to make submissions does not give a carer the same rights as a party to proceedings. However, it does give carers a voice in the proceedings that is independent of the Agency. A carer's ability to exercise this right is limited by the information they are given about the nature and timing of legal proceedings regarding the child. It also depends on them being made aware of the right, and being equipped with the skill and knowledge to present submissions. The independent advocacy service referred to earlier could help carers make submissions where appropriate, and promote awareness of this provision.

Currently, there is no legislative requirement that carers be permitted to contribute to decision making that affects children in their care. The evidence before the Commission suggests that the Agency has not always made their contribution a priority. The degree to which relevant information is shared also continues to be a source of dissatisfaction. It is appropriate that provisions for each of these matters be enshrined in legislation. The Commission recommends that the Family and Community Services Act be amended to include provisions in similar terms to section 143 to 146 of the Children and Young Persons (Care and Protection) Act (NSW), which refer to:

- a carer's right to certain information to enable them to make an informed decision whether or not to accept a placement;
- a carer's right to all information reasonably necessary for them to provide appropriate care to the child and keep other members of the household safe; and
- a child or young person's right to information about a proposed carer before placement.

Section 146 provides that a carer is entitled to participate in decision making going 'beyond those relating to daily care and control, concerning safety, welfare and wellbeing of a child or young person in the care of the authorised carer'.¹⁷⁰

TRANSPARENT DECISION MAKING

The Commission considers that the seriousness of the decision to remove a child from a long-term placement requires a more transparent process than is currently available. Professional voices outside the Agency must be heard in these decisions. It is the view of the Commission that the quality of decision making could be improved by implementation of a panel process which considers all removal decisions where the Agency and carers are not agreed that removal is in the child's best interests. An independent panel would consider not only the concerns about the placement, but the quality of the alternative placement on offer. The panel would also consider the plans for a sensitive and child-focused transition if a decision is made that the placement should be terminated.

Where possible, the panel should also consider in advance removals conducted without prior notice to carers. Such removals should be considered interim only, until the independent panel has considered any submissions made by, or on behalf of, the carer.

The panel should have at least three members, including an expert member independent of the Agency. Emergency decisions, when necessary, should be made on an interim basis, and reviewed within a fortnight by the panel. The panel should also obtain and consider the views of the children and young people involved in the most appropriate way.

COMPLAINTS MANAGEMENT

CFC reported that carers find making complaints about Families SA difficult. They are uncertain about the appropriate process, and fear the consequences to their relationship with the Agency and their position as carers.¹⁷¹ The Agency should develop a centralised complaints process for carers, to investigate complaints independently. It need not be a formalised investigation, but it should respond promptly in writing to complaints. The availability of the process should be well publicised.

The process should not require as a matter of course that the first approach with the complaint to be to the local office or worker concerned. Although usually complaints should be raised initially at the local level, this should not be a prerequisite to raising the matter through a complaints office. The complaints office should however encourage, in appropriate cases, attempts to resolve issues through informal mediation between the parties.

RETHINKING HOME-BASED CARE

Many contributors emphasised the need to give serious consideration to a move towards professionalising foster care. This is a concept that is gaining momentum in both research literature and across the out-of-home care sector. Two key drivers have been identified for this trend: children with increasingly complex needs entering care, and recruitment and retention challenges in home-based care.¹⁷²

A key action from the Second Three Year Action Plan of the National Framework for Protecting Australia's Children was to investigate barriers and opportunities for developing professional models of home-based care.¹⁷³ A report by consultancy Acil Allen was commissioned to review these barriers and opportunities, and provides a basis from which further work can be undertaken.

The term 'professionalisation' is commonly used without clear definition. Across Australia, models of foster care already exist which aim to recruit skilled and qualified carers to foster children with high needs. These programs offer a higher reimbursement rate, sometimes with an expectation that full-time care will be available to the child. These have been described as 'enhanced foster care models'.¹⁷⁴

ENHANCED FOSTER CARE MODELS IN SOUTH AUSTRALIA

A number of enhanced models currently operate in South Australia. Life Without Barriers, and Key Assets run the largest therapeutic service agencies which provide a higher level of support and reimbursement to carers who take on the care of children with high needs. There is a strong argument for an expansion of these specialised models to children with less complex needs, but for whom specialist care is nevertheless appropriate to prevent issues arising.

Centacare was recently contracted to establish a specialist reunification foster care service. Carers are recruited specifically to care for children while work is done to support reunification with their families of origin. Kirsty Drew, Executive Manager, Family Outreach and Relationship Services at Centacare, told the Commission that carers recruited to this role are expected to deliver a more intensive service involving:

*a certain level of professionalism and commitment from the carers. So this is their job, they don't have another job. The child doesn't go to childcare, they are with the carer. With that acknowledgment around the payment, they are a lot more involved.*¹⁷⁵

Carers in this program are helped to engage on a more natural basis with birth families, to transport children to access, and build what can become a mentoring role for the birth family developing skills to regain care of their children. The foster parent is described as part of a care team.

The original model hoped to recruit foster parents who were interested in delivering the short-term therapeutic work, and respite carers who would be prepared to provide long-term care if reunification has failed. This has not proved successful, as it has not been possible to recruit carers who are interested in offering both respite and long-term care.¹⁷⁶

This means that where reunification is not successful, a child who may have formed attachment relationships with the reunification carer goes back into the system for placement with long-term carers. This disruption is unhelpful for the child's psychological and emotional development.

The program shows promise in delivering a more holistic reunification service which puts the care of children at its centre. However, where reunification fails, there are potentially emotional and psychological consequences for the child.

The Centacare model inches closer to a professional model but does not meet the definition of a truly professional model.

BARRIERS TO A PROFESSIONAL MODEL

The Acil Allen report describes professional foster care as:

a model of home-base foster care whereby carers are employed in a professional capacity to care for children and young people with complex needs, who are unable to be placed in more traditional less intensive forms of out-of-home care.

*Under professional care models, carers would be paid a salary that is commensurate with their level of skill; would be required to hold a relevant qualification and/or undertake ongoing competency based learning and development; and would provide, or have access to, therapeutic clinical support and other specialist services.*¹⁷⁷

The key barriers to a true professional model arise from fact that professional foster care sits at the intersection of the separate worlds of work and family. Negotiating industrial relations, occupational health and welfare, and tax implications of shifting a volunteer home-based endeavour to a professional remunerated model is complex.

Unintended consequences might also follow such a move. The following possible consequences are of concern:¹⁷⁸

- Professionalisation might drive up rates of payment for services traditionally provided on the voluntary model. Carers already caring for children with complex needs under the voluntary model may be understandably dissatisfied with the resulting disparity.
- If professionalisation does not result in the recruitment of additional carers, but merely shifts existing carers into the professional model, the overall cost of care would increase without changing the number of providers.
- It is unclear how a for-fee service relationship would impact on the development of stable attachment relationships between children and carers. This relationship might well be affected by the child being aware that their carers is being paid to care for them.

As at 2013 there was no precedent for a truly professional model of foster care being successfully implemented in Australia. Models developed in both Victoria and Queensland were not advanced into operation because of the complexities of shifting the underlying model from volunteers to employees.¹⁷⁹

In its interim report, the Select Committee on Statutory Child Protection and Care in South Australia recommended that the Agency establish a trial of professional foster care in an area of identified need.¹⁸⁰ Against the background of the complexity of issues needing to be resolved to develop such a model, the Commission does not regard professional foster care as a current priority. To date neither Queensland nor Victoria has been able to negotiate these complexities, indicating caution is needed about this state expending significant resources in developing a model.

The Commission considers that at present there is greater potential for the expansion of enhanced models rather than attempting to negotiate and expend resources on developing a professional model with all its inherent complexities.

However, the Agency should closely monitor developments in other states, to identify successful models elsewhere that might guide future service developments in this state.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		
97	Amend the <i>Family and Community Services Act 1972</i> to include relative carers within the regulatory provisions of Part 4, Subdivision 3 and section 80. The definition of relative carers should include the categories of relatives who are currently excluded from the definition of foster parent in section 4 (step-parent, brother, sister, uncle, aunt, grandfather or grandmother), who care for children in the custody of, or under the guardianship of, the Minister.	105 Establish a Families SA Carer Assessment and Registration Unit service benchmark for assessment and registration decisions of 14 days where the assessment is complete and further information is not required from the assessing agency.
98	Amend the <i>Family and Community Services Act 1972</i> to provide approved carers with a right to information for the purposes of caring for children in the same terms as in sections 143–145 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> (NSW).	106 Develop a process for carers seeking approval (foster parents and kinship carers) to provide preliminary information about themselves and other adults who frequent their home to enable comprehensive C3MS checks to be done before a full Step by Step or other appropriate assessment is completed.
99	Amend the <i>Family and Community Services Act 1972</i> to provide for approved carers to be involved in decision making concerning a child in their care, in the same terms as in section 146 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> (NSW).	107 Include in the service agreement with all registered agencies the requirement that Families SA Carer Assessment and Registration Unit be notified of any person who begins an assessment process for carer registration (by Step by Step or another appropriate process) who is screened out, or, for whatever reason, subsequently withdraws from the assessment.
100	Amend the <i>Family and Community Services Act 1972</i> to provide a specific right to approved carers to contribute to a child's annual review pursuant to section 52 of the <i>Children's Protection Act 1993</i> .	108 Develop an approved panel of practitioners authorised to provide priority assessments of specific child only carers on behalf of registered agencies.
101	Amend section 80 of the <i>Family and Community Services Act 1972</i> to repeal the current requirement that foster parents care for a child for three years or more before delegations of powers can be made, and instead prescribe a minimum period of 12 months.	109 Create a project team to address the backlog in assessments of kinship carers and comprehensively review carers whose assessment is limited to an iREG assessment where the child has been living in the placement for more than three months.
102	Outsource assessment and support of kinship carers to appropriately qualified non-government organisations in accordance with the service models which currently apply to foster care.	110 Cease reliance on medical self-assessment forms and response priority assessments for kinship carers.
103	Develop or purchase a comprehensive kinship assessment tool for assessing the safety and appropriateness of kinship placements.	111 Enter an administrative arrangement with the Department for Communities and Social Inclusion to provide priority screening clearances for carers where a child has been placed pursuant to an iREG process.
104	Invest resources in the Department's Carer Assessment and Registration Unit to expand services to include consideration of applications for registration by kinship carers. These registrations would be in accordance with an appropriate assessment tool, and would authorise the carer to provide care to a specific child or children only.	112 Review initial orientation training for carers seeking approval to include training on recognising and managing trauma related behaviours, together with information as to availability of, and access to, therapeutic assistance if required.
		113 Include Agency staff, children in care and existing foster parents and kinship carers in the delivery of preliminary information and training for new and prospective approved carers.

RECOMMENDATIONS

114 Develop a practice guide identifying the circumstances in which delegations pursuant to the amended section 80 of the <i>Family and Community Services Act 1972</i> should be made. 115 Develop a written document which sets out the role and duties of the supporter of carers (SOC), including their role if care concerns arise, and to whom various duties are owed. This document should be freely available to home-based carers. 116 Fund Connecting Foster Carers, or an appropriate alternative agency, to deliver an advocacy service with paid staff to support carers to access and exercise their rights. 117 Fund the advocacy service to develop education material which clearly describes foster parents rights to contribute to decision making, and their rights of review regarding decisions which affect them. 118 Create an expert panel within the Agency to consider the removal of children from long-term home-based placements. 119 Review reimbursement rates to bring general foster rates with loadings for children with complex needs closer to rates payable to therapeutic carers. 120 Develop a specific package of training for general foster parents which can lead to payment of additional skills based loadings. 121 Support carers who are registered to general agencies to transfer to therapeutic agencies where the needs of children in their care require it. 122 Conduct a review of contractual conditions and payments to registered agencies to promote greater consistency of payments to agencies which support foster parents. 123 Update the Alternative Care Support Payments: Manual of Practice and make it available to all approved foster parents and kinship or relative carers. 124 Monitor developments in professional models of foster care in other states with a view to adopting or adapting a proven model. 125 Engage and support the Child and Family Welfare Association to develop more coordinated provision of training to carers.	126 Engage and support CAFWA to improve the coordination of respite provision to carers. 127 Develop a centralised system for receiving and resolving complaints from carers, including informal mediation or escalation to executive staff where appropriate. Timely written responses should be made to complaints.

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12

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OVERVIEW

Children for whom a home-based care environment cannot be found, or is not appropriate, find themselves being placed in a range of settings which can broadly be described as 'rotational care'. This chapter considers the care that is available to those children, in terms of the quality of their experience and their protection from abuse.

Rotational care is a poor substitute for a loving family. It does not satisfy children's attachment or developmental needs and for children who have experienced trauma and abuse, it rarely provides an environment which helps them to heal. Rotational care divides knowledge about the child across three shifts of workers a day, and fragments their childhood into observations recorded in a handwritten log.

Rotational care is provided to children who require care on an emergency basis (referred to as emergency or commercial care) or on a longer term basis in facilities which are either operated, or licensed by, Families SA (the Agency).

Residential care has traditionally been reserved for young people whose high needs make them unsuitable for a home care environment. However, recent growth in the number of children entering care has not been matched by a growth in home-based placements. Over the past decade the widening gap has been filled with rotational care arrangements which have developed in an unplanned and uncoordinated way.

The growth in demand for home-based placements has also seen young children and infants placed into rotational care, including children in their active attachment phase where consistent care supporting preferential attachment relationships is crucial to their development.

The plight of these children came to the forefront of public consciousness with the arrest of Shannon McCooles for sexual offences against the youngest and most vulnerable children (see Volume 2, Case Study 5: Shannon McCooles). The community was shocked and horrified about the extent of McCooles's offending, and wondered how such depravity could have gone undiscovered for so long. The Commission's inquiries into this question reveal a system of care that was failing children both in terms of the quality of care that was available to them and the protection from abuse that the system was equipped to provide.

One experienced former Families SA employee encapsulated the crisis in rotational care that preceded the arrest of McCooles, observing that:

Having so few placement options for children who cannot return home that we now have babies and toddlers in residential care should be a scandal. The baby in residential care is the dead canary in the coalmine; and the baby sexually abused in care is the mine explosion.¹

Drawing on evidence from the case studies of McCooles and 'Nathan' (see Volume 2, Case Study 4: Nathan), and other evidence, this chapter explores the reforms that are needed to the system of rotational care. It identifies systemic and operational deficiencies in facilities and considers the manner in which the system can be reformed to deliver a purposeful and high quality care environment, for children for whom home-based care is inappropriate.

The matters raised in this chapter are urgent and critical. Reforms discussed in this chapter must be prioritised to keep children in the care of the state safe.

This chapter principally relates to the Commission's Terms of Reference 5(d), 5(e), 5(f) and 5(h), in the context of Terms of Reference 1 to 4.

ROTATIONAL CARE

In this chapter, the overall concept of rotational care describes any care arrangement that involves children being cared for by adults who are employees, and who work according to a shift structure which divides the day across three or more shifts, with changing staff attending to children's care needs across each shift. Many of these arrangements have the same staff working on shifts, which gives children a greater sense of certainty and connection to those charged with caring for them. The Commission heard evidence that the number of carers varies between placements but could be as high as 30 over a week. The lowest number of carers in a placement reported to the Commission was three.²

Rotational care of two main types is delivered in South Australia: emergency care (also referred to as commercial care) and residential care.

Emergency care is a response to an urgent situation and is provided in a range of settings, including homes owned by the Families SA (the Agency), short-term holiday rentals, hotel rooms, bed and breakfast establishments, and caravan parks.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

Emergency care is delivered by casual staff, engaged via private agencies who maintain panels of carers. There are no minimum qualifications for staff engaged in this way, and they frequently care for children in unsupervised environments. As these arrangements are 'established' by the Minister, they are not subject to the registration requirements of the *Family and Community Services Act 1972* (SA).³

Residential care is delivered by the Agency and by not-for-profit organisations. It is provided in a house or unit that is established on an ongoing basis for the care of children. As children move on, another child is placed. Facilities that are established and operated by not-for-profit organisations must be licensed, and the facilities are subject to 12-monthly reviews of their licence.⁴

Residential care is also staffed on a rotational basis, although there is frequently a greater level of consistency across the staff engaged at any particular site than is possible in emergency care.

CHILDREN'S EXPERIENCES OF ROTATIONAL CARE

The Guardian for Children and Young People (GCYP or the guardian) recorded various statements that children made about living in residential care during their 2013–2014 visits. Some children spoke well of the staff who provided care and were positive about their ability to listen and spend time with them. Others had concerns about the physical environment and the relationship challenges that can accompany living with a large number of other unrelated young people.⁵

A lack of familiarity with the staff can be especially challenging for younger residents. Children sometimes wake up in the morning to meet for the first time a carer who will be responsible for toileting, bathing and feeding them. Other children go off to sleep not knowing who will be there the next morning, and whether they know the person who will be there if they wake up during the middle of the night. One carer working in a rotational care setting described a child asking a senior worker, 'Can you just come in and ... be there tomorrow morning so that I know that, when I wake up in the morning, there's someone there that I know'.⁶

A number of children and young people who lived in rotational care attended the Commission's consultation. They said the following about their experiences⁷:

One worker has been on night shift for three years. I trust her. The carers are always awake. There is an alarm around the house. There are certain rules—you have your own bedroom, it's not a jail.

In resi[dential]-care the night time carers are loud. They watch TV and wake you up, and then tell you to go back to sleep.

Shift changes are hard—you wake up with a different person there. Not sure who will be there in the morning.

When we went to the Royal Show we could only stay for an hour and a half because of the shift change. Other kids got to stay for the whole day.

For children in rotational care the impact of trauma can be compounded by inconsistencies in their care environment and inconsistent oversight of their behavioural and emotional wellbeing. Rotational carers can struggle to manage these difficult behaviours. Disruptive behaviour and aggression in rotational care environments often receive the greatest attention because of the effect they have on others, while other important indicators about a child's wellbeing may go unnoticed.⁸

'People don't want teenagers much, they want little babies and five-year-olds. All the people who aren't picked go in a home together'

For some children, ending up in rotational care brings a connotation of not being wanted. One child told the Commission, 'People don't want teenagers much, they want little babies and five-year-olds. All the people who aren't picked go in a home together'.⁹

INFANTS AND VERY YOUNG CHILDREN IN ROTATIONAL CARE

The Commission heard from a number of professionals with a high level of concern about infants and young children being cared for in rotational arrangements. Patricia O'Rourke, Advanced Clinical Practitioner with the CAMHS Infant Therapeutic Reunification Service, told the Commission:

*A healthy baby will be a wreck at the end of a week of rotational care, let alone our babies ... So never is rotational care okay. I don't even think it's okay for disturbed older children.*¹⁰

There is a consistent body of evidence which establishes that rotational care is not an appropriate environment for the care of young children.¹¹ A necessary condition for infant development is the availability of attachment relationships. Children who experience maltreatment in these relationships have reduced opportunities to develop trust, security and emotional regulation. At sensitive stages in brain development, the absence of healthy attachment relationships can undermine neurological development, potentially disadvantaging children throughout their lives.¹² Disrupted care experiences may result in attachment insecurity including reactive attachment disorder, a serious disturbance in social and emotional relatedness and behaviour, or disinhibited attachment disorder, which is characterised by diffuse and non-selectively focused attachment behaviour, attention seeking behaviour and indiscriminately friendly behaviour.¹³

Placing infants and very young children in rotational care restricts the opportunity for children to develop relationships with a confined group of caregivers who are consistently available and emotionally engaged. Dr Sarah Mares, an infant, child and family psychiatrist, explained:

*In a rotational care situation the child is having to adapt to the institutional environment whereas actually what children under three need is that the environment adapts to them.*¹⁴

In this environment children miss out on the developmental benefit of emotional engagement and play in everyday activities:

*It is about the baby being enjoyed or the toddler being enjoyed, not just being cared for like a machine, like a body. They are not just a body, they are a person with an experience, a little person with an experience.*¹⁵

The impact of rotational care on young children

(The full case study of Nathan is at Volume 2, Case Study 4: Nathan—Children with complex needs in out-of-home care.)

The Commission heard that Nathan was cared for in emergency care between the ages of six and eight, following a series of placement breakdowns. At the age of six it was clear that he had high therapeutic needs as a result of having experienced serious childhood abuse. Nathan was housed in rental premises and his care was provided by staff employed through a commercial agency. Nathan's psychologist reported to Families SA, in the course of a regular report about his progress:

*Notwithstanding his charming manner Nathan's behaviour is no longer regulated by a concern for maintaining close emotional ties with significant people in his life. He is not being properly socialised ... In the absence of him being afforded the opportunity to form and maintain close emotional ties with a consistent caregiver or caregivers, he is almost certain to experience poor outcomes in most if not all aspects of his life. He is also a significant risk to the welfare and wellbeing of others. He is eight years old.*¹

The psychologists who gave evidence in the case study agreed that Nathan's time in rotational care contributed to his dysfunction. There is no doubt that the inability of the Agency to provide a placement setting which allowed him to settle and develop healthy relationship skills has undermined his recovery from a traumatic start.

¹ Email to P Parkin, 12 January 2010.

Recently, there has been a growth in placement of infants and young children in rotational care. Data produced to the Commission by Families SA identifies the number of children in care aged three years and under accommodated in rotational care (residential care and emergency care) from 2011/12 to 2014/15:

- 2011/12—50
- 2012/13—63
- 2013/14—32
- 2014/15—48.

BARRIERS TO MONITORING CHILDREN'S BEHAVIOUR

Rotational care diminishes the capacity of an organisation to recognise changes in children's behaviour which may indicate that they are experiencing distress.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

Unexplained changes in the behaviour or development of a child should raise concern that a child is distressed by an event or a change in their environment. In children who are non-verbal the ability to stay attuned to their behaviour is especially important.¹⁶

In a home-based care environment, there is usually a very small group of people who are intimately involved in the care of the child and are attuned to changes in their child's behaviours. When care of a child is shared between multiple carers, accompanying supervisory and management personnel, and a case manager, knowledge about the child is also fragmented, as is the responsibility of staying attuned to changes and of acting upon that knowledge.

Procedures in rotational care facilities attempt to provide continuity in monitoring a child's behaviour. Handwritten logs record daily activities and observations. A 10-minute changeover provides some opportunity for workers to discuss what is happening for the various children. Procedures require reporting of concerning observations to senior staff. However, the Commission heard during the McCooles case study that the effectiveness of these procedures is variable and dependent on a number of factors:

- an environment existing where carers are supported in the implementation of the procedures;
- consistent practices surrounding what should be recorded;
- a high level of knowledge regarding the significance of certain types of behaviours;
- competent oversight and analysis of the information reported;
- clear practices to escalate information to an investigation or other action where appropriate.

The Commission identified significant failings in the residential care directorate in all of these areas and observed that opportunities were lost to take action that might have prevented or detected offending by McCooles.

EMERGENCY CARE

Emergency accommodation was established to provide short-term care for children who could not be put in any other placement, in circumstances of pressing need.¹⁷

Children are placed in accommodation which is sourced by Families SA but staffed by carers employed casually by private agencies, according to service agreements. Three agencies currently provide staff under these agreements: nannySA, Hendercare and a for-profit arm of Baptist Care.¹⁸ Approximately 75 per cent of care is provided in premises that are leased or otherwise obtained by Families SA; the remaining 25 per cent

occurs in houses that are owned or managed internally.¹⁹ In late 2015 a total of 31 houses were being used for emergency accommodation.²⁰

Emergency placements are often established to respond to a demand at short notice, to remove a child into care at short notice, or to deal with the unanticipated breakdown of a placement. They can be established as well as cancelled at short notice. Families SA's placement services unit (PSU) arranges the premises and contacts a commercial agency to arrange for staff. Approval is required from the Families SA executive to place a child on these terms.²¹ Children are collected from their social worker by the worker sent by the commercial agency, who then travels to the property and sets up the placement.²²

A LONGSTANDING PROBLEM

Since the early days of placing children in motels and hotels, various bodies have agitated for the development of strategies to ensure that care of this kind is not required.

By 2007, children as young as 10 were being placed in hotels and motels, being cared for by agency staff on a 24/7 basis. This was the unplanned infancy of emergency care provision by commercial carers. Service contracts were then negotiated with the commercial care sector to staff these placements. Emergency care was only ever intended to be a short-term measure and there has been a lack of considered planning for its future use.²³

From a figure of zero in 2002/03, the number of children in commercial care placements rose to four in 2004/05, then to 106 in 2005/06. This sharp increase was the result of many more children being placed in state care coupled with the failure of home-based care placements to keep pace.²⁴ One witness told the Commission that in some cases, children's extended stays in emergency placements were not because nothing else was available, but because other pressing priorities occupied the scarce time case managers had available: 'Case managers would almost park the kids there while they tried to cope with the other load they had on board, so [the children] would, by default, stay there'.²⁵

For a number of years attempts at planning have been made, without any significant inroads into the growing number of children in these arrangements. In 2011, the Agency released Directions for Alternative Care in South Australia, which promised a more robust out-of-home care system. However, the action plan which was to follow did not eventuate.²⁶ The document proposed:

exploring a developmental and differential program of supported, residential and intensive group care environments providing a spectrum of residential care opportunities, including:

- *emergency and short-term care*
- *respite and assessment options*
- *general group home care*
- *high support and special needs residential opportunities.*²⁷

Building the out-of-home care system remains the overarching theme of contributions made to the Commission on addressing the high level of reliance on emergency care. One contributor commented that the challenge had remained the same for some years: to ‘build a sustainable alternative care system while concurrently managing the crisis’.²⁸

WHO IS CARED FOR IN EMERGENCY CARE?

Figure 12.1 sets out the number of children who have been placed in emergency care in the 2012/13 to 2014/15 financial years, by placement type. The number of children who are placed in emergency care each year has fluctuated but there is an overall increase during the past three financial years.

This data corresponds with evidence heard by the Commission that there had been a steady drop in the number of children in emergency care, followed in 2015 by a substantial rise. It coincided with an increase in the number of children being removed coupled with a decrease in the number of available foster parents and residential carers—many of the latter being unavailable while a broad review of staff was under way following the Hyde review. The Commission heard that most weekends the service was close to running out of commercial carers who could care for the number of children who required placement.²⁹

At one stage the situation was so dire that children were placed in other children’s rooms in residential care when that child was missing from their placement or staying elsewhere for the weekend.³⁰

Although emergency accommodation developed as a mode of short-term care, the Commission heard evidence that children are spending extended periods, sometimes years, in emergency care. One emergency care worker said she could not think of any child with whom she had come into contact who had remained fewer than eight weeks.³¹ As a consequence, children live for extended periods in placements which are established at short notice with little regard to placement matching.³²

Table 12.1 sets out the number of children placed in emergency care for three or more consecutive months, by placement type. It demonstrates some fluctuation in the number of placements, but no real decrease over time. Service agreements with agencies who provide staff in emergency care are structured on the assumption that the care is genuinely short term. The service model, budget and programming is not intended to provide

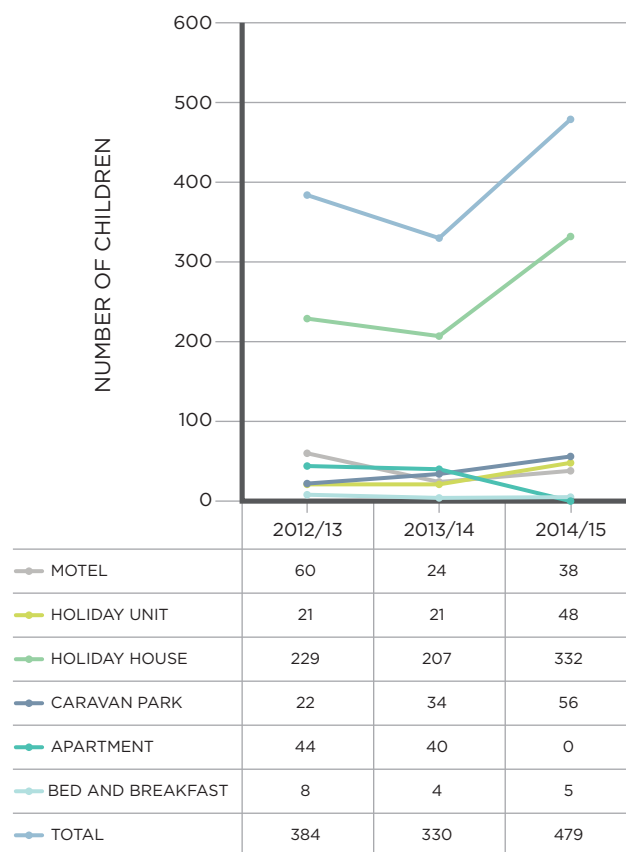


Figure 12.1: Number of children in emergency care by placement type, 2012/13 to 2014/15

Note: The terms ‘holiday house’ and ‘holiday units’ refer to short-term rental accommodation in these housing types.

Source: Data from Families SA.

long-term care and there is little consideration of anything more than basic 24/7 care.³³

GCYP monitors the number of children placed in emergency care. In a January 2015 report, GCYP observed that at any one time, there are between 15 and 20 children in the state living in interim emergency care for extended periods. Many of these are children and young people who have complex needs.³⁴

The reality of the current situation is that children who are easiest to place in other arrangements will remain in emergency care for the shortest periods of time. Consequently, it is children with high and complex needs who are likely to find themselves languishing for long periods of time in this poor quality care. Yet it is these children who require high levels of support and therapeutic assistance, which emergency care is not designed to provide.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

Table 12.1: Number of children in emergency care for three or more consecutive months, 2011/12 to 2014/15

	NUMBER OF CHILDREN	FEMALES	MALES	AVERAGE AGE	OLDEST CHILD	YOUNGEST CHILD
2011/12	175	64	111	12	18	0–6 months
2012/13	114	49	65	10	17	0–6 months
2013/14	128	50	78	10	17	6 months to 1 year
2014/15	165	67	98	10	18	6 months to 1 year

Source: Data from Families SA.

WHERE DO CHILDREN IN EMERGENCY CARE LIVE?

Despite a strong recommendation against the practice from the Children in State Care (CISC) Commission of Inquiry, children in care continue to be housed in motels, caravan parks and bed and breakfast arrangements (see Figure 12.1).³⁵ The majority of children in emergency care placements are housed in holiday houses. The term 'holiday house' does not refer to the facilities or the nature of the environment, rather the fact that the property is secured on a short-term, sometimes week to week, lease arrangement. In a report about emergency care in January 2015, GCYP noted that placement of children in settings like motels is rare in other states and territories.³⁶ By contrast, in the 2014/15 financial year in this state, 38 children were cared for in motels, and 56 in caravan parks.

Children in commercial emergency placements can face unplanned and disruptive changes of residence in short-term rental accommodation. During busy periods, such as the Clipsal car race, the Fringe Festival and Christmas holidays, children are sometimes moved out to make way for other tenants.³⁷

The fact that the properties are physically designed as family homes does not necessarily mean they are suitable for emergency care. They are not required to be routinely inspected in the same way as licensed residential care facilities.

The Commission has heard evidence that houses used by Families SA for emergency care are sometimes unfit for purpose and at times unsafe. One carer spoke of a placement arranged for a four-year-old boy in an area that was unsafe at night, had inadequate locks, no front fencing and no safe place for a child to play. In the same placement, a female child was required to share a room with carers. Families SA changed the location of the placement only after persistent complaints from carers.³⁸

In Volume 2, Case Study 3, Hannah's emergency care placement ended when a complaint was made by staff to the Health Department which resulted in the placement being shut down.

The continued housing of children in inappropriate accommodation places the safety of children and carers at risk, and fails to provide an appropriate environment for the ongoing care of children.³⁹

The challenges of motel accommodation

A female carer was required to care for a 15-year-old boy in a motel located at a busy intersection. The boy had just been released from youth detention and had a history of psychological issues and violence against women. Another worker, who was rostered to work a passive shift (sleeping overnight), refused to sleep in the adjoining room to the child as the door did not lock. The substitute carer had little information about the young person: the placement was new and she could not access any information. The child was distressed and upset. He wanted to leave the motel room but knew he had to stay or he would be returned to detention. He repeatedly left the room to search for cigarette butts to smoke, with the carer attempting to supervise him from a safe distance throughout the motel premises. He left the placement the next day and was arrested.¹

¹ Oral evidence: Name withheld (W40)

STAFFING EMERGENCY CARE PLACEMENTS

Placements are staffed by commercial carers from one of the three agencies contracted to Families SA. Staff are rostered over three shifts per day, usually of about eight hours each shift, with a 10-minute handover.⁴⁰

An ongoing challenge in emergency care has been to develop consistent teams of carers for particular children. As the carers are engaged via an agency, and are employed on casual conditions, continuity can be challenging. In one instance, the Commission heard that a 13-year-old child in emergency care had seen 90 different carers rotate through her placement in 12 months.⁴¹

Compared with residential care which is staffed by Families SA, emergency care has a much higher turnover of staff.⁴² This can be attributed to the casual conditions of employment offered by agencies (although some carers are employed on contract by Baptist Care⁴³), to the agency's desire to share work equitably among staff⁴⁴, and to the emergency nature of the placements which are by definition created at very short notice.

That is not to say that stability cannot be achieved in commercial emergency care arrangements. The Commission heard of one placement in which a core group of five carers was rostered. This was achieved through careful carer selection and close monitoring by the agency manager. However, this example is the exception rather than the rule, and it must be noted that the child concerned has been in the 'emergency' placement for more than 1200 days.⁴⁵

RECRUITMENT AND TRAINING

Service agreements govern the relationship between Families SA and the commercial agencies providing emergency care. These agreements stipulate mandatory requirements for employment, including current child-related employment screening checks, police clearances and a range of training.

The selection process for staff engaged through agencies is unregulated. There is no standard job and person specification for the role and no minimum qualifications required, as evidenced in the McCoolle case study. The processes adopted by the three agencies vary. nannySA conducts an interview and then checks references over the telephone.⁴⁶

Baptist Care recruitment involves a preliminary screening for prerequisite conditions, followed by the applicant's attendance at an assessment centre to participate in an interview, role play and group scenario. Reference checks are then conducted. Baptist Care is presently considering introducing psychometric testing.⁴⁷

Prerequisite qualifications for commercial care agencies also differ. Baptist Care, for example, mandates that staff hold a Certificate IV relevant to the field, or equivalent tertiary study, before employment.⁴⁸ nannySA does not require any qualification (see Volume 2, Case Study 5: Shannon McCoolle). Candidates who are unqualified to work in nannySA's child care centres, where a Certificate III in Children's Services is a minimum requirement, are nevertheless employed as emergency care workers deployed to care for the state's most vulnerable children.

The processes used by commercial agencies are significantly less rigorous than those used in Families SA's residential care directorate. However, applicants who fail to meet Families SA requirements often seek and obtain positions with private agencies.⁴⁹ This is especially concerning where carers are engaged on anything but a very short-term basis, because commercial carers receive less training than Families SA employees as well as a lower level of ongoing support and supervision.

Training of commercial carers is delivered by the contracting agency. The level of training provided depends on the care agency. nannySA provides approximately two days of training, includes child-safe environments training and one day of training relating to Families SA practices. The training is delivered by employees who have attended 'train the trainer' courses provided by Families SA.⁵⁰ The Commission heard that currently Baptist Care provides six days of training which includes non-violent crisis intervention training, and components relating to disability, positive behaviour support, confidentiality, information sharing, working with families, grief and loss.⁵¹

While the Commission has heard evidence of commercial carers who are child focused and perform their duties in a diligent and skilled manner, the opposite is sometimes the case. One supervisor tasked with overseeing aspects of commercial care placements observed that 'we ... found very quickly that the agencies were often just getting anybody they could possibly find to come and work'.⁵²

SUPERVISION

The Intensive Placement Support Team, based in Families SA, oversees emergency care placements. This service, which is staffed by youth workers, aims to supervise and build the capacity of the commercial care team. It reports any deficiencies in the performance of individual carers to the commercial agency and consults with Family SA's PSU about placements.⁵³ The team also visits placements and tries to build relationships with children.

Emergency placements are administered by the local Families SA office, which is responsible for tracking and approving the necessary expenditure.⁵⁴ Because of the high costs involved in maintaining emergency care placements, any approval to extend them is escalated to the executive level.⁵⁵

The consequences of a lack of rigour in recruitment processes

In May 2011, a commercial agency contracted to provide emergency care workers applied for a screening clearance for a potential employee, 'Russell Yorke'. In assessing Mr Yorke's suitability to work with children, the screening unit accessed his criminal and child protection history. A clearance was granted. Mr Yorke began work as an emergency carer in June 2011.

Unbeknown to the screening unit, Mr Yorke had worked with vulnerable children in Victoria, and Victorian authorities had recorded allegations that between 2005 and 2010 he had consistently engaged in inappropriate behaviour around children he accessed in a variety of care-giving roles. This behaviour including sexual grooming and sexual assault. None of these allegations had been substantiated, and no criminal charges had been laid. In August 2011, the Victorian Department for Human Services became aware that Mr Yorke was working in child protection in South Australia but did nothing to advise authorities in this state about his history.¹

Two months after he began work as an emergency carer, Mr Yorke applied to be registered as a foster parent. A psychological assessment commissioned by the assessing foster care agency concluded that he was unsuitable to become a carer *'in any capacity'*.

These facts were reported to Families SA in September 2011. Notwithstanding that report Mr Yorke continued

to deliver care to vulnerable children until 27 April 2012, when Families SA finally advised the private agency that Mr Yorke was considered unsuitable to work in emergency care.

In May 2012 Families SA were advised that Mr Yorke was in a romantic relationship with a young person who had formerly been in care, but had recently turned 18. The young person was now under the Guardianship of the Public Advocate because he had an intellectual disability and poor daily living skills. Mr Yorke had been engaged to care for this young person while he was still under the care of Families SA.

A 2013 review concluded that there was 'prima facie evidence that [Mr Yorke] has engaged in sexual and other inappropriate behaviour with children in the Minister's care', and that there is 'evidence that he presents an unacceptable risk to children'. The same review highlighted that five months had passed between the clear identification of concerns about Mr Yorke and the termination of his services. A national child protection warning has now been recorded against Mr Yorke.

¹ Families SA, 'Review into whether [Russell Yorke] has engaged in any inappropriate behaviour with children in the Minister's care', internal unpublished document, Families SA Statewide Services directorate, no date.

The guardian observed in her January 2015 report that the level of monitoring of emergency care placements appeared to depend substantially on the 'availability and attentiveness of the social worker allocated to the child'.⁵⁶ The variability in the quality of casework being delivered by the Agency, which is discussed in Chapter 10, gives little reason for confidence that an appropriate level of monitoring is being consistently sustained.

Families SA staff who engage with contract carers or agencies, including the Intensive Placement Support Team, are not provided with copies of the service agreements, nor do they have access to information about the terms of their engagement. Families SA employees complained that they were unable to identify whether carers or commercial agencies were adhering to contractual conditions or standards of care.⁵⁷ In the McCoolle case study it emerged that service agreements stipulated a carer to child ratio of 1:1. In practice, emergency care placements were being staffed at a carer to child ratio of 1:3, at the behest of local Families SA staff.

Unless a child has especially high needs, emergency care is currently staffed at a level of one carer to up to three children, or two carers to four children. Even with numbers of children higher than three, night shifts are generally staffed by a single worker. This undermines workers' capacity to deliver the required quality of care to children who have high needs, and also regularly leaves emergency care workers alone with vulnerable children, increasing the risk of abuse.

The responsibility for supervision and performance management of commercial carers lies with the agency that employs them.⁵⁸ Evidence heard as part of the McCoolle case study revealed that the nannySA supervisors responsible for staff performance cannot maintain a consistent physical presence at houses. While they have some capacity to respond when complaints are raised, their capacity to identify issues is limited.⁵⁹ nannySA is reliant on information being passed to it by other carers or Families SA, and supervision occurs only in reaction to complaints.

MOBILITY BETWEEN AGENCIES

Families SA does not provide any overall approval or registration process for agency staff who are rostered into emergency placements. Staff members may work casually for more than one agency at the same time, or, in some circumstances, for Families SA and for an agency. This means that no single organisation is responsible for monitoring the overall performance of that staff member. This can lead to circumvention of the requirements restricting the number of hours that carers work per week, and the number of consecutive hours that can be worked⁶⁰, provisions that are aimed at occupational health and safety considerations, but also the delivery of quality care to children.

Through an examination of documents produced in the McCoolle case study, the Commission discovered that during one period McCoolle was working shifts while employed by Families SA and shifts while also employed by nannySA. These shifts were sequential, leading to continuous shifts which lasted over 18 hours, and were sometimes as long as 24 hours. There was no oversight of the total hours worked continuously or the total hours worked over a week because of the split between shifts conducted through Families SA and shifts conducted through nannySA.

No senior staff member was able to provide a satisfactory explanation as to why a staff member who was employed by Families SA on their casual list would, at the same time, be engaged through an agency at substantial additional cost. The Commission was left with the impression that these arrangements had developed with little close consideration of the effect on the quality of care available to children, and the economic inefficiencies for Families SA.

Similarly, Families SA does not track the movement of emergency care workers from one agency to another. If a carer's engagement with one agency is terminated or suspended, that carer may apply to another agency. Whether the agency to which the carer applies becomes aware of their history depends on the new agency conducting rigorous checks, and the willingness of the other agency to share information.

The Commission became aware of one instance where an emergency care worker was directed by Families SA not to work in Nation Building houses (small home-like residential care facilities) due to concerns about her interaction with children in care. The carer subsequently obtained a position with Families SA as a youth worker. It did not appear that her earlier poor performance was considered during the application process.⁶¹

This systematic lack of oversight poses an unacceptable risk to the safety of children in rotational care.

PLACING CHILDREN AND CARERS AT RISK

The Commission is concerned that the amount of information given to emergency care workers about children who come into their care is frequently inadequate.⁶² This results in part from the nature of emergency care, where the emergency circumstances can mean that Families SA has little information to share.

In response to this, one commercial care agency exercised extreme caution about the developmental condition of infants coming into their care. Carers were trained to start all infants on formula, even those who were over 12 months, because they simply did not know whether or not the child could eat solid food.⁶³ Requiring carers to apply this sort of caution because of a lack of basic information is unacceptable, and greater care should be taken to obtain such details at the time children are removed from their birth families.

The lack of information persists beyond the initial placement. The same carer said the following about the experience of older children:

They've got to explain to every support worker who comes through the door what their deal is and why they're here. Not that we ask that information but the kids have got their own rundown—they're getting frustrated because the support workers don't know where to take them to school or where to go with them next.

This lack of information has placed carers at risk of harm. In one instance carers were not informed of a child's history of self-harm and harming others.⁶⁴ Absence of appropriate supervision within houses also contributes to the risk to children's safety. One carer told the Commission that they had observed staff asleep on active night shifts⁶⁵ and a number of carers spoke of inadequate support when first placed at houses, conducting their first shifts without adequate supervision.⁶⁶ On some occasions, the police have been called to assist with the control of children. A review of C3MS records conducted by the Commission's expert panel identified an occasion when emergency care workers called for police assistance to deal with a non-compliant seven-year-old.⁶⁷

An inability to access Families SA records regarding children via C3MS, infrequent visits by social workers to placements and a failure to update information exacerbate these problems (see Volume 2, Case Study 5: Shannon McCoolle).

The challenges of caring for high needs children in emergency care

A sibling group entered a placement staffed by emergency care workers engaged through a private agency. Some of the children had wounds which required monitoring. The youngest child was still in nappies. Families SA staff mentioned to emergency carers that some of the children had MRSA, a bacterial infection which is resistant to many antibiotics, but gave no information about what that was or how carers ought to manage it. Carers did their own research and obtained some pamphlets to guide their approach.

Due to the size of the sibling group, the children were split between two adjacent houses. Children would frequently run to the other house to see their siblings. The residence was unsafe as the children could access the roof and jump between the roofs of adjoining properties.

At the direction of Families SA and the care agency, carers were required to separate the youngest child from his siblings to settle him to sleep. This resulted in the child screaming, scratching and biting carers. At one point his behaviour escalated to the point that carers barricaded themselves in a carers' room and called the police to defuse the situation. The philosophy of the particular agency prevented carers from physically separating the children to calm them.¹

This placement was staffed by only a single carer overnight.

¹ Oral evidence: Name withheld (W40)

THE FINANCIAL BURDEN OF EMERGENCY CARE

Emergency care is the most expensive option in South Australia's out-of-home care system.⁶⁸ In mid-2013 the cost of caring for a child in emergency care was \$322,600 per year, compared to residential care by Families SA staff which cost \$180,500 per year.⁶⁹

With emergency care now accommodating children for extended periods, these costs are a significant drain on the child protection budget. For example, Families SA spent over \$460,000 in 2013/14 to provide 11 months of emergency care to one teenage girl. At that time, it had already spent more than \$1 million on emergency care for that young person. These costs are considered normal for such packages of care.⁷⁰ In recent times commercial care placements per child cost about \$10,000 per week dependent on the level of service required, for example,

whether one or two carers are on shift during daytime shifts, and whether an active (awake) or passive (asleep) staff member is required for night shifts.⁷¹

At present, the use of 'emergency' refers not to the need to accommodate children in any truly unforeseen situation, but rather to an inability of the current care structures to accommodate demand. The higher cost of emergency care corresponds with a lower standard of service provision and safety for children. As one social worker who supervised children in commercial emergency care placements observed, 'You could buy a couple of houses and staff them with people with the amount of money [it costs for] these kids in rotational care—it makes no sense'.⁷²

At present, the use of 'emergency' refers not to the need to accommodate children in any truly unforeseen situation, rather to an inability of the current care structures to accommodate demand.

Continuing reliance on such an expensive model of care has contributed to the very high average cost per night of providing out-of-home care in South Australia. As discussed in Chapter 11 (Figure 11.5), South Australia's average cost per night in 2014/15 was \$230.50, outpaced only by the Northern Territory which recorded an average cost per night of \$287.29. The most economical service delivery was in New South Wales, which was paying only \$143.23 per night.

Out-of-home care continues to consume the vast majority of child protection spending (see Chapter 8, Figure 8.4). Spending rose sharply after 2013/14 and continues to climb (see Figure 8.3). While such a heavy reliance on costly and poor quality emergency care continues, there is little chance of funds being available for investment in other important services.

THE AGENCY'S AWARENESS OF EMERGENCY CARE RISKS

Since at least 2011, senior executives in Families SA have been on notice that continuing to rely on the employment of emergency care workers on shifts where they work alone with vulnerable children carries a heavy risk.

In February 2009 brothers 'Jake' and 'Nicholas Butler' were placed in the care of emergency carers engaged through nannySA. On 21 February 2009 five-year-old Jake disclosed that he had been sexually abused by a worker by the name of 'Colin Norton'.⁷³

An investigation was launched which concluded that Jake had been sexually abused by Norton, and there were significant concerns that three-year-old Nicholas had also been abused. Norton denied the allegations but admitted masturbating once while he was working a shift caring for the boys.⁷⁴

Criminal charges were laid but did not ultimately proceed to trial. The internal care concern investigation concluded that the allegation of abuse was substantiated.⁷⁵

An adverse events review report was completed in October 2011. The reviewer emphasised that the current service model which commonly left poorly trained agency workers alone with vulnerable children was inviting a high level of risk. The reviewer observed:

*It has been shown that younger, more vulnerable children are entering Families SA's care and staying longer. Notwithstanding developments within the Nation Building program, the use of emergency placements is unlikely to cease in the medium term. These circumstances would seem to create an even greater imperative to minimise the opportunities for child sex offenders. **It is the judgement of the reviewer that emergency care arrangements necessitate a minimum of two staff for both overnight and daytime care. Not to do so is for Families SA to take a calculated risk which, as was seen with Jake and Nicholas, can have dire outcomes.***⁷⁶ [Emphasis in original]

The reviewer went further:

It is the opinion of the reviewer that Families SA has little effective knowledge of or operational control of quality of staff that are provided by the commercial carers. In the absence of such oversight Families SA has little demonstrable evidence of carer competency to care for vulnerable children. Families SA is exposed to significant organisational risk in continuing arrangements which are clearly inadequate for meeting the needs of children in care.⁷⁷ [Emphasis in original]

David Waterford became aware of these matters soon after commencing as Executive Director. He was concerned about the continued use of single-handed shifts. Mr Waterford observed that most systems in the developed world had moved away from single-handed models by the 21st century.⁷⁸ Notwithstanding these remarks, the use of commercial care and staffing of using single-handed shifts has continued.

MCCOOLE'S ACCESS TO CHILDREN THROUGH EMERGENCY CARE

Shannon McCoolle began his career caring for vulnerable children through casual employment with the agency nannySA. He was recruited to the agency on the basis of a single interview and only cursory reference checks. Although McCoolle had no experience caring for infants or young children, a half-day training session on infant care and child nutrition was considered sufficient to equip him to care for babies and young children, even on shifts where he worked alone.

Very soon after he started, McCoolle was engaged to care for a sibling group of three children: 'Kevin', 'Amy' and 'Ricky Jones'. Ricky Jones was three-and-a-half years old and suffered developmental delays which restricted his ability to communicate. McCoolle worked a number of shifts which gave him unsupervised access to the children, access which he exploited to commit several sexual offences against Ricky.

These offences were committed at a time when the review into the circumstances of the abuse of Jake and Nicholas Butler had not yet been finalised. However, the review delivered in October 2011 did not result in any changes to the level of training required of emergency care workers, nor the practice of engaging them on single-handed shifts to care for children with very little oversight or supervision.

CEASING RELIANCE ON EMERGENCY CARE

The continued reliance in this state on poor quality emergency care is placing infants and young children in environments that are developmentally damaging and sometimes unsafe. Young children are being removed from the care of their parents following an assessment that they are at risk of harm or neglect, only to be placed in an environment which also carries a risk of harm. This risk is not restricted to the long-term harm of spending extended periods of time in rotational care, which undermines the development of critical attachment relationships, but extends to the risk of abuse at the hands of workers who are not adequately scrutinised when they are employed, and not adequately supervised while they have access to children.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

There is conceivably a role for well supervised commercial care in true emergency situations or to fill short-term roster gaps. However, the current services are inadequate and should be reviewed as a matter of urgency.

Families SA is examining the viability of incorporating those emergency care placements provided from Families SA properties into the residential care directorate. There is some potential for extending that project to include emergency care being provided in other short-term sites, such as motels and short-term rentals.⁷⁹ The Commission suggests the various functions of setting up placements, supervising and supporting them be consolidated in the directorate.

While these proposals would potentially deliver the structure and oversight that has been lacking, they would not address the high level of reliance on this form of care, which has arisen because of a crisis in more suitable out-of-home care placements. Resolving these matters requires a great deal more forethought and planning, including a high level of investment in improving home-based care options through the reforms discussed in Chapter 11, and preventing the movement of children into out-of-home care through greater investment in early intervention and protective intervention, discussed in Chapters 7 and 8 respectively.

The reforms proposed will take time. In the meantime, arrangements should be made to improve the quality of care being delivered in emergency care. Those arrangements should include:

- reviewing service agreements with private agencies to ensure that their recruitment and training requirements are appropriate for carers who are delivering emergency care;
- developing a job and person specification and selection criteria for emergency carers to be appointed to casual pools. Agencies should be contractually obliged to have such documents approved by Families SA;
- enabling Families SA staff who have contact with and supervise agency staff to examine the agency's service conditions;
- registering emergency care workers with Families SA, identifying the agency with whom they are listed. Workers should not be permitted to register for work with more than one agency, or to register for agency work when they are a Families SA casual staff member. Prior to registration Families SA should review whether it holds any information which raises concerns about the suitability of the worker;
- terminating single-handed shifts in emergency care.

The Agency should aim to bring all emergency care in house. There are practical challenges to achieving this in the short term, including recruiting sufficient suitable staff and developing infrastructure to manage it.

However, emergency care has long been neglected on the assumption that the heavy reliance on it is temporary and will resolve when other aspects of the system begin to work more efficiently. Greater investment should be made in bringing this form of care in the Agency's structures, and it should be delivered by staff with a much higher level of skill than is currently available.

The guardian observed that reliance on emergency care will not reduce until other alternative options are established. She observed that this will not be achieved without substantial additional funds, at least on a temporary basis.⁸⁰ The Commission agrees with this observation.

RESIDENTIAL CARE

Families SA runs a variety of residential care facilities, with varying physical configurations and staffing ratios. Residential care is also provided by not-for-profit, non-government organisations (NGOs) which are licensed by the Minister for that purpose.

South Australia relies more heavily on residential care than any other jurisdiction. Figure 12.2 shows the reliance on this form of care across the various Australian jurisdictions. Families SA reported that at 5 August 2014 there were 156 children being cared for in 64 residential care facilities. Usually an additional 65 children would be cared for in residential care facilities operated by NGOs.⁸¹

THE GROWTH OF RESIDENTIAL CARE

The current state of residential care is the result of growth over many years without the necessary oversight and planning. As the former guardian observed of the current state of affairs:

*Nobody would want this to happen. Nobody planned for it to happen. It was probably rather that the implementation of the good intentions from years past was lacking.*⁸²

In the 1970s government policy focused on the deinstitutionalisation of residential facilities. Non-government providers were encouraged to close large institutions and offer cottage or foster care.⁸³ A greater emphasis on family-like settings, with foster care being the preferred placement choice, saw residential care conceived as the placement of 'last resort' when other placement options had failed.⁸⁴

A shortage of placements in residential care arose as overall capacity could not meet demand. There was concern about inappropriate placement decisions and children being placed long term in units designed for short-term accommodation. Younger children were at risk from the behaviours of older children, and it was felt that units became a 'dumping ground' for children.⁸⁵

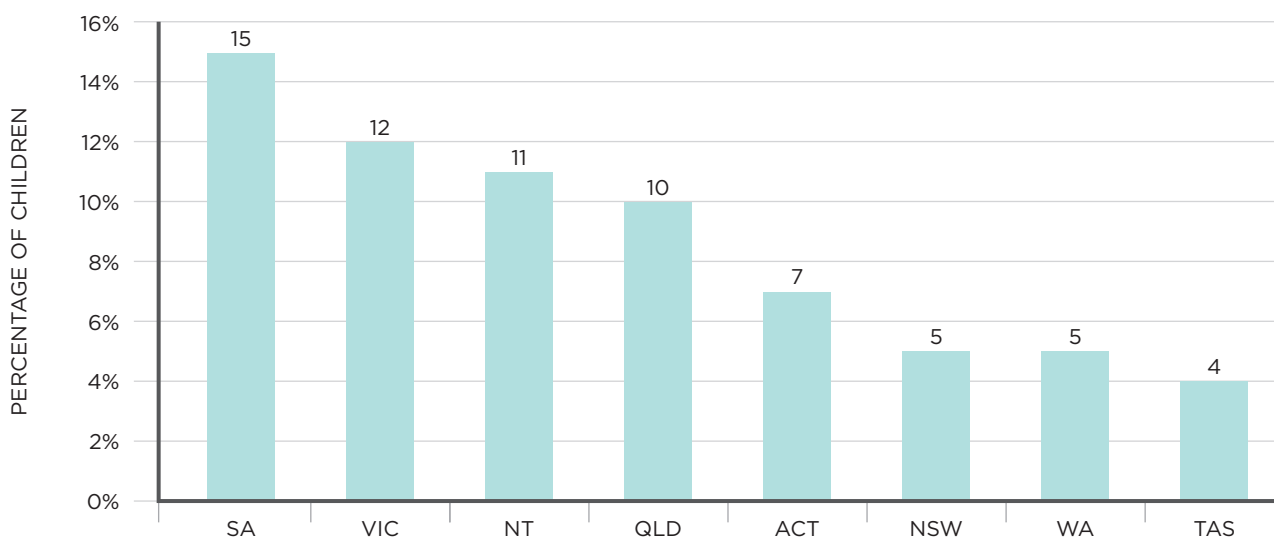


Figure 12.2: Percentage of children in care placed in residential care, 2014/15

Source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, January–February 2016.

During the 1990s, the Campbelltown and Enfield community residential units and Gilles Plains and Sturt assessment units began operation. However, the accommodation shortage persisted, with children as young as eight being placed in units, and concerns about inappropriate placements remaining.⁸⁶

In 2004 approval was granted to establish 10 transitional accommodation houses, which were designed to provide short-term housing to children who were hard to place in home-based care, with a view to reducing reliance on emergency care.⁸⁷

In September 2009, Families SA underwent a restructure which shifted the management of transitional accommodation and community residential care. At the same time, there was a growing tension between strategic planning for the growth of the sector, and managing the crisis of the increasing numbers of children entering care. There was a push in the Agency for competitive tendering, which was hindered by the absence of a procurement strategy.⁸⁸

In 2010 the federal government's Nation Building stimulus package made available a large number of new houses, providing a unique opportunity to transform the way residential care and emergency care were being delivered. The challenge was twofold: to develop a workforce strategy to staff the houses, and identify children currently in emergency care to transition into Nation Building facilities. At the same time, Families SA also planned to recruit sufficient youth work staff to take back the delivery of emergency care services from private agencies.

Families SA set up a Nation Building housing project to use the new housing stock to reduce reliance on emergency care. The project envisaged residential care being provided by Families SA youth workers in a proportion of the houses, supplying differentiated services to address children's individual therapeutic needs.⁸⁹ At the time, however, South Australia's capacity to find appropriate foster care placements for children was decreasing. Based on the premise that, for the majority of children, placement in foster care remained the preferred option, there was concern that a focus on growing residential care would detract from the attention given to foster care.

The aim for the Agency, as described by the former deputy chief executive, was to 'have the best residential care system on a very small scale and somewhere for most of those children in foster placements'.⁹⁰

In mid-2011 the residential care directorate of Families SA was created. Later that year, the new Department of Education and Child Development was announced, which would include Families SA. In the same month the Nation Building houses became available. The plan to staff these houses with youth workers employed by Families SA was, however, stymied by delays in obtaining Cabinet approval to raise the fulltime employment (FTE) cap, so premises were staffed entirely by commercial carers engaged at a premium cost through private agencies. The differentiated services for children with high needs that were originally anticipated were not provided.⁹¹

By May 2012 the approval to increase the FTE cap had still not been granted. As a result of Cabinet concern about the increase in the number of public sector employees, Families SA was asked to consider a model that would run for no more than three years, during which time an assessment would be made about transferring residential care provided in Nation Building houses to the not-for-profit sector.⁹²

The delay in progressing Cabinet approval for funding was felt acutely in the Agency. A high level of concern existed that continuing to care for children in settings that failed to meet their attachment and therapeutic needs would result in children being further damaged. In an internal communication, the Deputy Chief Executive noted that the number of highly complex children who could not be properly cared for in any of the existing service models, described as 'unplaceable children', had increased from six to nine during the period of delay in advancing the Nation Building proposal. This number was anticipated to increase further in the time it would take to implement change. In the meantime care for each of these children was costing the state between half a million and one million dollars per year.⁹³

In the early phases of planning for the Nation Building project, the concept of developing a greater occupational mix in the residential care workforce was canvassed. Mr Waterford supported the development of a mix of professionally qualified staff (social workers, psychologists and other appropriately qualified professionals) and operational staff (staff focussed on operational care functions) to deliver a higher quality care than had been possible with a homogenous operational group. Ultimately this idea was not embraced, and recruitment to operational positions continued.

Between 2011 and 2013, the delay in Cabinet approval for the increase in FTE positions prevented the recruitment of new youth workers into ongoing positions, and employment was being offered on short-term contracts. Evidence available to the Commission supports the conclusion that the nature of the offering to the marketplace affected the quality of applicant that the recruitment processes were able to attract.⁹⁴

In June 2013 Cabinet approval was finally granted to commence the recruitment of 369 FTE youth workers. Approval was granted on the basis that the Nation Building housing model would be built, owned and operated until an appropriate non-government agency could be identified to take over its operation. Between 2011 and 2013, while the approval was outstanding, the Nation Building houses had been staffed by carers engaged through commercial agencies, providing a compromised standard of care at a premium price.⁹⁵

In a media release issued on 11 June 2013, the then Minister, Jennifer Rankine, said:

*Replacing commercial carers with professional, highly qualified Families SA staff means that our most troubled young people will get the long-term therapeutic and consistent care that they require ... the positions will be three-year contracts and recruitment will be rolled out until 2015. There will be a specific recruitment campaign that will target potential staff in related employment and attract new workers.*⁹⁶

The release made no reference to the fact that the strategy was conceived as a temporary one and devolvement to the non-government sector was its ultimate aim.

Efforts still continue today to recruit adequate numbers of youth workers to the Nation Building houses. Lack of preparedness within Families SA to commence recruitment⁹⁷, inadequate consideration of the overhead costs of recruitment within the Cabinet submission⁹⁸, challenges resulting from the move to the Department for Education and Child Development (the Department), the arrest of Shannon McCool and subsequent reviews of recruitment processes have all contributed to delay.⁹⁹ To date, reliance on commercial care remains high and the demand for residential care placements remains strong.

RESIDENTIAL CARE DIRECTORATE

The residential care directorate sits within the Families SA Metropolitan Operations and Residential Care section of the Office for Child Protection.¹⁰⁰ At March 2015, the directorate was responsible for 41 houses providing residential care, and five larger community residential units.¹⁰¹ Most facilities are located in the metropolitan area, with two properties in regional centres. The directorate is divided into regions and a manager is appointed to each. Each region or large residential care unit is managed by a supervisor employed at operational services (OPS) 5 level who provides oversight and management. Senior youth workers manage small groups of houses. The day-to-day care of children is delivered by child and youth workers employed at OPS2 and OPS3 classifications on rotating shifts and, where required, commercial carers engaged by Families SA.

Residential care is provided according to two main models: small houses caring for between one and four residents, and community residential units designed to house up to 12 residents. There are some variations on these two distinct models, including some facilities which are collocated small homes which can accommodate large sibling groups and maximise staff flexibility across the houses.

WHO LIVES IN RESIDENTIAL CARE

Children who enter care often have developmental disadvantages associated with being raised in abusive and neglectful environments. They have often been exposed to or witnessed physical or sexual abuse and have missed out on consistent and nurturing care. Their development may have been undermined by these experiences and they may present as challenging and confusing individuals to caregivers.¹⁰²

Children in residential care are more likely to suffer behavioural and emotional difficulties and experience problems in other areas, including physical health, learning and language and educational outcomes.¹⁰³ Approximately 15–20 per cent of children in out-of-home care who exhibit significant behavioural and emotional difficulties are at high risk of repeated placement instability and further psychosocial harm¹⁰⁴ and are more likely to be placed in residential care.¹⁰⁵

In 2008 Howard Bath, the then Northern Territory Children's Commissioner, observed that:

*residential care is generally only considered after multiple foster care failures ... Unfortunately, these more needy and behaviourally troubled young people are placed into a care modality that has been run down and neglected and thus struggles to respond to the demands placed on it.*¹⁰⁶

Bath noted that the behavioural, developmental and psychiatric problems of the population of young people in residential care were varied and complex. He emphasised the need for these complexities to be considered in the design of residential care environments. Drawing on other research, he made the following observations about the characteristics of young people cared for in residential care facilities¹⁰⁷:

- aggressive behaviour is often a defining characteristic of young people classified as 'high needs' whether or not those behaviours are identified by a formal diagnosis;
- the majority of children have some trauma related symptomology;
- between 14 per cent and 40 per cent have an intellectual disability, often in the 'mild' range;
- a significant proportion have neuro-development problems, including autism spectrum disorder, foetal alcohol syndrome, attention deficit hyperactivity disorder, Tourette's disorder, and other chromosomal disorders and learning disabilities; and
- some young people have formally diagnosed mental illnesses, including mood disorders, anxiety disorders and early onset schizophrenia.

Infants in residential care

'Chelsea' and 'Rose' were both infants when they were placed in residential care houses. Both placements were inappropriate and the rotational style of care provided was not suitable for either child's developmental or safety needs. Chelsea was initially placed in a house with one other infant before being transitioned to a placement with two teenage girls. The house where Chelsea lived did not even have a bath, and she was washed in a tub placed in the bottom of the shower.

Chelsea had entered care from hospital as an underweight child with developmental delay resulting from neglect, who had also been physically abused. Both Chelsea and Rose were sexually abused by Shannon McCooles¹ when each was under two years of age. Neither of them was capable of making a verbal complaint, or protecting themselves from the abuse. In both instances there were observations by other carers in the house of concerning physical indicators of sexual abuse or sexualised behaviours that were indicative of abuse. These observations were either not acted on by the carers, or were not followed up by Families SA staff when reports were made.

¹ See Volume 2, Case Study 5: Shannon McCooles.

A report to the Community Services Ministers Advisory Council in June 2005 concluded that adolescents with mental health problems are the least likely to display improved psychological adjustment in the care environment. The same cohort was the least likely to achieve the placement stability that appears to be a predictive factor in after-care success.¹⁰⁸ In alternative care systems where some young people 'fail their way into residential care' it is frequently this cohort of complex high-needs young people who find their way to residential care.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

In South Australia, the residential care population is expanding to include much younger children than has previously been the case. Often these children should be placed in home-based care, but this is prevented by a lack of options. The residential care population is no longer confined to older adolescents who cannot be accommodated in home-based care, but now also is being relied on to care for infants and young children. South Australia has a higher reliance on residential care for children aged four and under, and for children aged between five and nine than anywhere else in Australia, where placement of children under four in residential care is especially rare (see Figure 12.3).

Earlier in this chapter, the particular dangers associated with caring for infants and young children in rotational arrangements have been discussed. For these reasons the placement of children under 10 in residential care should cease. This is especially urgent with respect to children under three.

The CISC Inquiry recommended that adequate resources be directed toward placing children and young people according to suitability of placement rather than

availability.¹⁰⁹ Not unlike the present time, the state was experiencing a chronic shortage in home-based placements, and the Inquiry was concerned about the growing reliance on emergency and residential care. There is no evidence that the Agency's capacity to place children according to their needs has improved since that recommendation. Evidence rather indicates that a chronic shortage in available placements persists, restricting the capacity of placement services to choose according to the child's needs, rather than to availability.

The importance of providing placements that address children's needs has been emphasised throughout this chapter. The appropriate method of 'matching' is not to search for the least poor match of a child to an existing placement, but rather to tailor a placement to suit a child's needs. The Commission accepts that this is not always possible within the present residential care environment within South Australia. Recommendations in relation to this process are addressed later in the section 'Reforming residential care'.

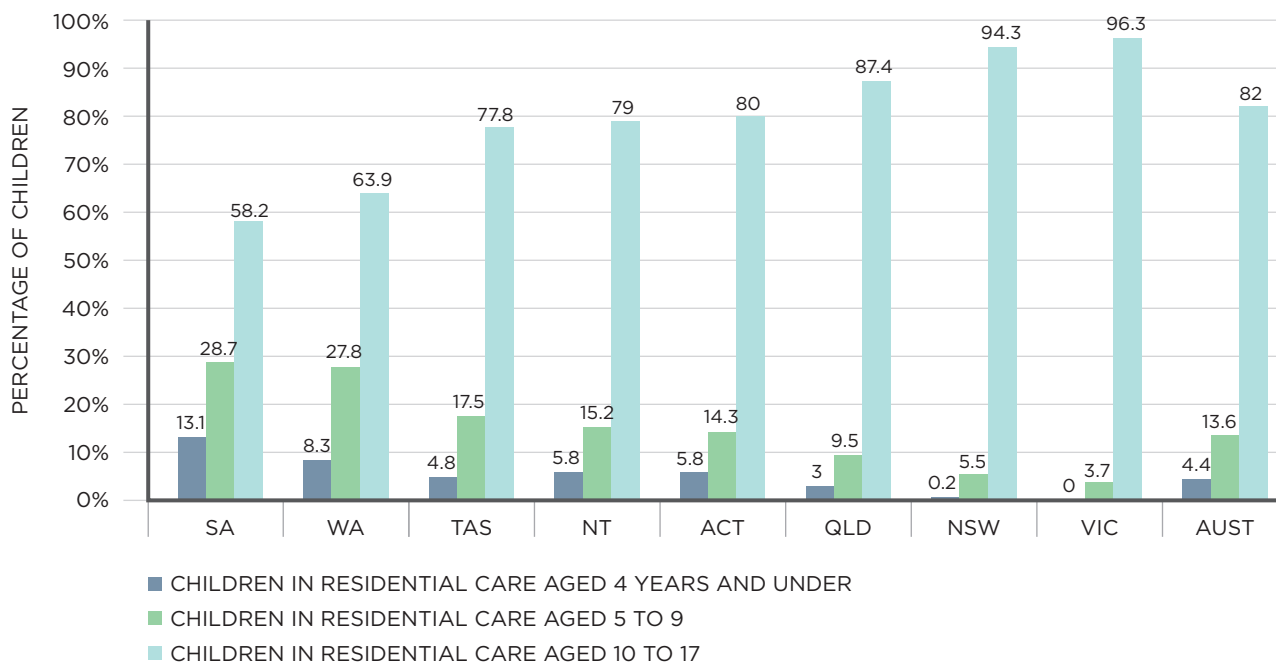


Figure 12.3: Percentage of residential care population by age, 30 June 2015

Note: Percentages may not add up to 100 due to rounding.

Source: Data from Australian Institute of Health and Welfare, *Child protection Australia 2014-15*, Child Welfare Series No. 63, 2016, Table A36, p. 103.

COMMUNITY RESIDENTIAL CARE UNITS

Community residential care, referred to as units, have been in use since the 1980s. There are five currently in operation.

At June 2014, between 62 and 66 children, or about one-quarter of children in residential care, lived in units.¹¹⁰ At that time, the youngest child placed in a unit was nine, although the primary focus is children and young people 10 and above. Recently, a new 12-bed unit was opened in the southern suburbs: it has the capacity to house sibling groups together in a wing, and has been used to place some children younger than ten.¹¹¹

In general, large units have bedrooms separated across three wings with an office and communal living area. Newer units have kitchens in each of the wings and each room has its own ensuite facilities.¹¹² There is a greater emphasis on security in the larger units than in other placements: youth workers lock the doors to children's bedrooms to prevent theft, and systems are in place that allow youth workers to isolate power to bedrooms as a behaviour management tool and lock kitchens.¹¹³ This increases the institutional feel of the environment.

During day shifts there are three OPS2-level carers rostered, one working in each wing caring for up to four residents. A fourth carer provides support across the unit. During business hours on weekdays a senior youth worker and a supervisor are also available. Care is provided solely by employees of Families SA.¹¹⁴ Over the course of a week, children will be exposed to a large number of carers rotating across the two-day and one-night shifts.

Until recently, units were staffed overnight by a single youth worker.¹¹⁵ However, the Commission understands that approval for two youth workers to work overnight has now been granted but Families SA has had difficulty filling the positions.¹¹⁶

Twelve-bed units are the most economical method of providing residential care. By housing greater numbers of children in the facility, fewer resources are required. In particular, savings can be made in staffing levels compared to some smaller facilities.¹¹⁷ However, these cost-savings have been at the expense of the quality of care available.

WHO LIVES IN COMMUNITY RESIDENTIAL CARE

Over time, the kind of children being placed into larger units has changed. While these units were originally designed to accommodate children with comparatively moderate needs, they have gradually developed into a population of children with high needs.¹¹⁸ Often the residents are children or young people with complex behaviours and histories of failed home-based care experiences, who may often demonstrate highly

traumatised behaviour. They may be violent towards carers and other children, take drugs, be truant from school and behave in inappropriately sexualised ways. Children with these high needs are placed in units because of the higher numbers of staff available on site at any time, compared to a smaller home. These changes have impacted greatly on the capacity of units to provide a safe environment for children.

The Commission heard almost universal condemnation of large units. Claire Simmons, a principal clinical psychologist with Families SA, told the Commission that the chronic placement shortage meant that once a child was placed in a unit, there was less chance of them being considered for a more appropriate placement. Under the 'triage' system, children in emergency care receive higher priority than those in large units.

Even design features such as the separation of children into separate wings, has not addressed the problem.¹¹⁹ The problem is exacerbated by the demand for beds, which gives little scope to consider whether the placement of a particular child is an appropriate fit for the child, or for other residents. One supervisor recalled objecting to placements on the basis of inappropriate matching, including the placement of a child on the autism spectrum at the unit. He was informed that the unit was the 'best of all the worst options that there are'.¹²⁰

'You have 12 kids who are all scared, confused and angry, and if the behaviour starts here, it just spreads around the unit and they're just in a constant sort of state of fear and confusion and uncertainty'

Rosemary Whitten, the Executive Director of Metropolitan Services and Residential Care, was the only witness who identified any redeeming features of large units. She argued that large units allowed for 'a balance of caring for individual children, [and] some group environment so that the young children don't get lonely, because that's a significant issue, but it also allows for organisational systems and efficiencies so that Government gets good value for money'.¹²¹ In the long term, the harm that is done to children in these environments does not support the contention that they are providing 'value for money'.

Placing a child into a large unit carries with it a risk that the child is exposed to further trauma, or will develop antisocial behaviours, from their interaction with other residents. One experienced supervisor from a large unit observed that he often witnessed ‘cross-contamination’ of negative behaviours between children, as they spread through the unit ‘like a virus’:

*You have 12 kids who are all scared, confused and angry, and if the behaviour starts here, it just spreads around the unit and they’re just in a constant sort of state of fear and confusion and uncertainty.*¹²²

Ms Simmons made a similar observation:

*The ones I really worry about going into units are the kids who haven’t picked up the absconding or the sexualised stuff or the drug and alcohol. I always feel devastated, I think [this] is not overstating it, when we have to place a child in that environment who hasn’t got those behaviours yet, because it really does feel like the system’s just ... adding ... another problem for these kids.*¹²³

In addition to the spread of negative behaviours in the unit setting, there is a corresponding spread of high-risk behaviours among residents when outside facilities. When residents with volatile behaviours are colocated they persuade or coerce each other into engaging in high-risk activity away from the units. In a report provided to the Minister in 2007, the guardian drew attention to evidence that children residing in units frequently absconded and were at high risk of harm, including drug taking and prostitution:

*Young people are inviting or coercing other children in care to join them in their risky activity and associations. Adults are involved in recruitment and are adept at identifying vulnerable people.*¹²⁴

LIFE IN LARGE UNITS

The rate of critical incidents, and the degree of harm which results, are indicators of how safe a residential facility is for its residents. The guardian analysed critical incident data from eight units as part of a report on larger residential care facilities.¹²⁵ While 20 per cent of children in residential care are housed in residential units, 33 per cent of the critical incidents considered by the guardian occurred in them. At least two-thirds of the occasions where physical restraint was used on children occurred in units.¹²⁶ Over a six-month period, 266 critical incidents were reported within units, with almost half occurring within two particular units.

Behavioural contamination

In 2013, at the age of just 11, ‘Nathan’¹ entered a large residential care unit. Nathan had no history of being arrested by the police, nor any history of absconding from his home-based care placement. Every professional involved in Nathan’s care agreed that a large unit was an inappropriate placement to address his needs, but it was presented as a short-term option until something more suitable became available. Within the first six months of Nathan’s placement at the unit he had committed 22 separate criminal offences, had been incarcerated in youth detention on five occasions and had been missing from the unit on 40 occasions, the longest period for four nights. He was also the victim of a serious assault at the hands of an older resident.

The former supervisor at Nathan’s unit said:

*Personally, I’m totally opposed to large units. I believe that we shouldn’t be building them and if I could have permission to bulldoze my own I would do it tomorrow. If you think about it, you’re putting 12 highly complex young people under the same roof, and what do you expect is going to happen?*²

¹ See Volume 2, Case Study 4: Nathan.

² Oral evidence: D Kevesevic.

The following issues were recorded as triggers for children involved in those incidents¹²⁷:

- dissatisfaction with where they live;
- intoxication by alcohol and other drugs;
- residents facing challenges at school;
- inactive supervision by staff and not intervening as tensions rose;
- bullying by other residents; and
- residents reacting to staff who they did not know or did not like.

The guardian's report identified that critical incidents had an impact on children apart from those who were directly involved: other children who were present felt scared and missed out on positive engagement with staff who were occupied dealing with the immediate crisis. Workers experienced particular difficulty managing residents with disabilities and younger residents who were more vulnerable.¹²⁸

For the purposes of a case study, the Commission examined monitoring reports prepared for a specific unit where Nathan was placed. The report was produced from residents' self-evaluation surveys, a review of documentation, and a visit to the unit. One resident suggested that house dinners could occur where all 12 residents could eat a meal together. Residents associated such an event with being 'more like a real family'.¹²⁹ A dinner was arranged on the evening that a staff member from the guardian's office attended. Residential care staff observed that the dinner would not be possible if all the residents had been home at the time because it would 'not be safe to have them all together'.¹³⁰

At Nathan's unit each resident had their own ensuite bathroom and toilet facilities, which are accessed through their bedroom. Each resident's bedroom is locked both when they are inside and outside the room.¹³¹ Residents must ask a staff member to unlock their bedroom if they wish to enter or use the bathroom or toilet facilities.¹³² Without this process valuables 'go missing' and residents' safety and security can be undermined.

One supervisor gave the Commission an example of how quickly adverse events can unfold when young people with complex behaviours are left unsupervised:

*In this case, a staff member was in the kitchen in the wing and there's a corridor and while she was cleaning the plates after dinner she sort of had a look and saw a young person sitting at the door, so half of his body was visible from the outside, his legs were sort of inside. She found that strange... So she had a look and this young person had ... his pants down and was masturbating while the other person was in the room completely petrified watching TV ... So this is how quickly this can happen.*¹³³

If staff are busy dealing with a critical incident, or are otherwise engaged, residents must wait if they need their rooms unlocked including to use their bathroom. At the time of the monitoring visit conducted by staff from the office of the guardian, residents were observed knocking on the observation window to the office to get staff attention to access their bedrooms or go outside.

Staff have high levels of administrative responsibility. Everything that occurs is logged, including movement, telephone calls, and daily events both positive and negative. Food is stored in the kitchen of each wing. Kitchens are locked and food is not freely available to

the residents. Many critical incidents occur in kitchens and the kitchens present many hazards during such incidents.¹³⁴

It is clear that the processes which operate to keep children and young people safe also undermine the homeliness of the environment. Striking a balance between keeping residents and property safe and extending the freedoms that might be expected in a home environment is challenging. This conflict is very much a result of the collocation of children and young people with complex issues and the paucity of staff available to supervise their interactions.

The Commission heard evidence that within some community units youth workers use police intervention, criminal charges and bail conditions to control children's behaviour.¹³⁵ The use of police as a tool to deter children from engaging in particular behaviours is undesirable. It reflects the high level of routinely aggressive behaviour within units and the failure to equip carers with tools to manage children's behaviour more effectively.

On some occasions, police are called when a young person or young people begin to act aggressively or in a way that might involve a danger to themselves, and there are insufficient numbers of staff in attendance to contain the situation. Calling the police is one strategy which results in urgent support for an escalating situation. But it is an approach that brings young traumatised children into contact with the justice system, which is not always helpful to the management of their behaviour in the long term.

This is a particular problem during night shifts when a single youth worker is expected to supervise and care for up to 12 children and young people across three wings of the unit. Many contributors argued for the rostering of a second night officer in larger units. The addition of a second staff member is not simply a question of preventing inappropriate or exploitative behaviours within the facility or having an extra pair of hands in the event of a crisis: it can help stabilise behaviour before a crisis occurs. Danijel Kevesevic observed that management of these complex children was all about relationships:

*If you had another person, the kid would be reassured there's enough people to take care of me, I'm not scared anymore, and it would be good to have people who actually saw Joe was to be the night officer instead of a revolving door of people they don't even know ... So the kids usually ask you 'Who's on tonight?' and if you say 'Danijel', 'Oh, OK, I know where I'm standing, I know where the line is. I know this person will take care of me'. If you say 'John' who is casual, that creates another level of anxiety. 'Who is John? He's brand new. He doesn't know the rules. Will he be able to protect me? Will he make this placement safe? Does he know the job?'*¹³⁶

GCYP monitors the investigation of sexual abuse allegations as a result of Recommendation 20 of the CISC Inquiry. In an unpublished memorandum to the Minister for Families and Communities in 2011, GCYP drew attention to the disproportionately high percentage of notifications of sexual abuse arising from units. Twenty-three per cent of notifications which were reported to GCYP involved a child in a unit when such children represented three per cent of the total care population. Peer-on-peer sexual abuse allegations were made 1.3 times more frequently in a unit than in other residential care, and 4.5 times more frequently than in home-based care.¹³⁷ It is accepted that the rate of reporting of sexual abuse does not correspond to actual events of sexual abuse, and that concerns have been raised about the accuracy of data provided to the guardian by Families SA;¹³⁸ nevertheless, this data adds yet more weight to the already overwhelming argument in favour of ceasing reliance on this form of care.

ADVOCATING FOR THE CLOSURE OF UNITS

Recommendations to the state government to close large 12-bed residential care units have been made repeatedly. Their continued use conflicts directly with the recommendations of independent inquiries and repeated recommendations made by the guardian. Families SA also recognises the inappropriateness of the model and would prefer not to further invest in it.

The 2003 Layton Review identified that children in care had expressed a need for 'flexible accommodation that does not place two highly at risk adolescents together, in the same accommodation, particularly if there are drug and alcohol problems'.¹³⁹ Since 2005 GCYP has advocated for the closure of units due to the high risk to safety and wellbeing of children placed therein.¹⁴⁰ The CISC Inquiry recommended that adequate resources be directed towards placing children and young people according to suitability of placement rather than availability, and accommodating a maximum of three children in residential care facilities.¹⁴¹

Notwithstanding the unity of voices against the model, in the 2011/12 budget Families SA received funding to build and operate two more 12-bed units to address the growing need for out-of-home care placements. Mr Waterford told the Commission that the Agency did not support the model and did not want to invest in it, but that the view of Treasury was that this was the cheapest way of dealing with the issue.¹⁴²

The placement of children in residential units operating in South Australia should cease. The environment is unsafe. The collocation of multiple high-needs children and young people spreads risk-taking behaviour, endangers children and fails to meet their therapeutic needs.

No more than four children should be housed in any one residential care facility, except when necessary to accommodate large sibling groups. The decision to continue to invest in these facilities because of short-term economies of scale fails to consider the long-term cost to both the children being cared for, and society more generally, when the results of drug use, criminal behaviour, violence and sexual abuse of already disadvantaged children are considered. Economic rationalisation misses the point of child protection.

Economic rationalisation misses the point of child protection

SMALLER RESIDENTIAL FACILITIES

Smaller residential care facilities are managed through two programs: transitional accommodation and Nation Building accommodation. The variation in description of these two programs reflects the historical origins of the properties in each, and the only difference that remains between the two forms is how they are staffed. In transitional accommodation, day-to-day care is provided principally by OPS3 youth workers with staff from commercial agencies engaged only when Families SA youth workers are unavailable (see Volume 2, Case Study 5: Shannon McCoolle). By contrast, Nation Building houses were originally staffed entirely by commercial staff; however, Families SA has for some time been engaged in the process of moving towards staffing those properties with Families SA youth workers.¹⁴³ Supervision is provided by departmental senior youth workers.

Transitional accommodation and Nation Building houses operate on a different staffing model to the larger units. This is possible because of the smaller number of residents and the lower complexity of their individual behaviours. Staff in smaller houses are responsible for cooking and cleaning as well as caring for children, while in the larger units cooks and cleaners are contracted for those functions.¹⁴⁴ In transitional accommodation and Nation Building houses, staff to children ratios are set between 1:3 and 1:4. Where the young people in the house have high or complex needs, the ratio is more likely to be set at 2:3 or 2:4. That staffing level is augmented by a senior youth worker who circulates between four houses on a rotating shift basis. A supervisor is also responsible for four houses and is available during business hours.¹⁴⁵

One experienced supervisor who had spent time in both the larger units and the smaller houses described the contrast he observed:

It [the smaller residential care facility] is a normal looking house among all other normal looking houses... So when you come in, you do get a feel of a house

... However, instead of 12 kids and 20 something workers, you have two to three kids that are ... matched properly, and you would have one or two staff members, depending on the dynamics that are happening. The staff member would be cooking with the kids literally rather than cooking the food and then staff ... heating it up and dishing it [up] ... you can't compare it. It just looks like a home and feels like a home. And definitely the doors wouldn't be locked ... It was a completely different experience for me, an eye-opening experience.¹⁴⁶

USE OF FORCE AGAINST CHILDREN IN RESIDENTIAL CARE

The use of force against children and young people who reside in residential care facilities is permitted by Regulation 14 of the Family and Community Services Regulations 2009 in the following circumstances:

- (1) *An employee in a residential care facility may only use such force against a child placed in the facility as is reasonably necessary in any particular case—*
 - (a) *to prevent the child from harming himself or herself or another person; or*
 - (b) *to prevent the child from causing significant damage to property; or*
 - (c) *as a last resort after other strategies have failed—to ensure that the child complies with a reasonable direction given by an employee of the facility; or*
 - (d) *to maintain order in the facility.¹⁴⁷*

This regulation applies to Families SA facilities, including emergency care, but not to licensed residential care facilities maintained by not-for-profit organisations.¹⁴⁸

The Agency trains youth workers in non-violent crisis intervention which is a behaviour management program that focuses on preventing disruptive behaviour. The program includes a model of physical intervention, which is used only as a last resort. The restraints involved are not intended to be painful, and are applied with the child's dignity firmly in mind.

Commercial carers engaged through private agencies who work in residential care are not trained in the use of the physical restraint.¹⁴⁹ In fact, in some cases, physical contact of any kind is prohibited by the commercial agency. This includes occasions when physical contact is needed to protect children from danger or harm, or to comfort or nurture a young child. Some commercial carers are directed that they cannot have any physical contact with children. Families SA staff have been obliged to instruct carers that certain contact, such as holding a child's hand when crossing the road, is not only appropriate but necessary to keep children safe.

Evidence was also given that when children were at risk of harming themselves, agency staff were directed to lock themselves in the office rather than intervene.¹⁵⁰

Where force is used against a child in residential care, each employee involved must ensure a written report is made to the supervisor of the facility. The report must contain the name of the child and that of every employee who was involved in or witnessed the use of force; the date, time and location of the incident; and the nature of the force, its purpose and the circumstances in which it was applied.¹⁵¹ In practice, these obligations are satisfied by the completion of a pro-forma critical incident report which is submitted to a supervisor for approval.

The completion of written records documenting occasions involving the use of force is a critical safeguard for both the child and for workers involved. Written records provide transparency which permits others to review the incident. These reviews can help to improve skill and knowledge, with a view to preventing future use of force. Critical incident reports are also used by the guardian to monitor residential care environments, in particular to assess the safety of children in those settings.¹⁵²

ACCURACY IN RECORDING THE USE OF FORCE

The Commission heard evidence during the McCoole case study that reports about the use of force were commonly prepared by one employee who was involved in an incident, without input from others who were involved or witnessed it. The pro forma used to record these incidents can mislead the reader into believing that other carers have endorsed the account when in fact they have neither seen nor considered it. The Commission viewed three critical incident reports prepared by McCoole in which he described the use of force against a child. On each occasion, the account provided by McCoole in the report conflicted with evidence from other carers who observed his conduct as well as that given by the children involved. None of McCoole's colleagues had been asked to contribute or endorse the version being promoted by him in the report.

The supervisor who was asked to endorse two of the three reports, however, assumed that the witnesses named in the report had contributed to its preparation, and assumed that the account recorded was accurate. This meant that McCoole was able to avoid including dissenting voices about the use of force in the official record.

The regulations should be amended to require all witnesses involved in or present during the use of force to endorse the report as an accurate record of events, or, if they do not agree, to prepare and submit their own report. An electronic signature would be adequate to indicate agreement with the terms of the report.

THE CHILD'S ACCOUNT OF THE USE OF FORCE

Regulation 14 requires that along with the written record prepared by staff, a child must be given an opportunity to contribute their account:

- (3) *An account of an incident leading to the use of force against a child placed in a residential care facility must be—*
- (a) *written, signed and dated by the child; or*
 - (b) *if the child cannot write—*
 - (i) *written on the instructions of the child, and signed and dated, by a person nominated for the purpose by the child; and*
 - (ii) *signed by the child,*

(and such account must be kept together with the record required to be kept under subregulation (2)).

- (4) *A child may nominate any of the following persons for the purposes of subregulation (3)(b):*
- (a) *the child's case manager or caseworker;*
 - (b) *a lawyer;*
 - (c) *a cultural advisor;*
 - (d) *any other adult person,*

(but any such person nominated may not be an employee of the facility nor have been present during the relevant incident that led to the use of force against the child). [Emphasis added]

Critical incident reports considered by the Commission in case studies have systematically failed to comply with Regulation 14(3). The manager of one guardianship hub had never seen a critical incident report which complied with Regulation 14(3).¹⁵³ The Commission issued a summons for all records prepared pursuant to Regulation 14(3) for the 2014/15 financial year and received records prepared by children from two incidents, neither of which satisfied the requirements of Regulation 14(3). It is apparent that there has been a complete and systematic failure to comply with this critical safeguard on the use of force in residential care. The former guardian told the Commission that her monitoring had revealed a longstanding failure to comply, and she had raised her concerns at a management level within the directorate.¹⁵⁴

Nicole Stasiak, the Director of Residential Care, conceded that there had been a failure to educate carers about these obligations.¹⁵⁵ After the matter was raised in Commission hearings, Families SA amended its procedures to reflect the legislative requirements and has begun to train supervisors and senior youth workers. An ongoing barrier to compliance has been the ability

to identify a person within the categories of Regulation 14(4) who is not employed by the facility to assist the child.¹⁵⁶

The pro-forma critical incident report should be amended to make clear the regulatory requirement that the child's perspective of events be obtained. Reports should not be signed off by supervisors where these requirements have not been met unless a sound and convincing reason is available to explain the deficit.

It is critical that children living in residential care are aware of their rights under Regulation 14. GCYP should develop an education campaign aimed at ensuring children and young people are aware of their rights and understand how to ensure their views are recorded in these circumstances.

LISTENING TO CHILDREN IN RESIDENTIAL CARE

GCYP monitors the circumstances of children in residential care to ensure that their voices and experiences are heard, and influence agency practice. GCYP has monitored residential care environments since 2004, and the current regime includes monitoring visits to selected facilities, visiting residents, and writing reports and summaries.

GCYP has the capacity to enquire into the circumstances of children in residential care and provide advocacy. The GCYP's capacity to deliver this advocacy depends on children and young people knowing their rights, and having access to GCYP. In this regard, GCYP has observed significant variation in children and young people's knowledge. It publishes the Charter of Rights for Children and Young People in Care as a means of publicising these rights. Within residential care facilities, children have varying levels of understanding of the charter.¹⁵⁷

The GCYP's monitoring noted that few residential care houses have formal complaint or feedback processes and residents are not aware of how to raise complaints.¹⁵⁸ Within some, an informal complaints process is in place, but residents hold varying views about its effectiveness. Some children told the guardian that they did not feel listened to and questioned the value of speaking up. All children agreed that a more formal process which required complaints and responses to be documented would be a good idea.¹⁵⁹

GCYP made a similar observation about house meetings. Meetings did not occur in houses where children under 10 lived, and while some carers reported that meetings occurred informally, children in those houses did not always agree. Within community residential units, most supervisors reported that fortnightly meetings took place. Residents expressed conflicting views about the usefulness of the meetings.¹⁶⁰ Children in units

generally complained to GCYP that there were limited opportunities to participate in decisions that affected their lives.¹⁶¹

COMMUNITY VISITORS SCHEME

The Layton Review recommended that functions be included within GCYP¹⁶² similar to the ‘community visitors’ that were then provided for in Queensland within the *Commission for Children and Young People Act 2000*.¹⁶³

South Australia has not legislated for a community visitors scheme for children in care. Community visitors schemes operate within the state providing services to other vulnerable groups. Since 2011 there has been a community visitors scheme for people with mental illness who are admitted to treatment centres, including emergency departments and forensic settings.¹⁶⁴ This service was recently expanded to include people with a disability and now provides support to those living in state-funded disability accommodation or supported residential facilities.¹⁶⁵ It is an independent statutory scheme with reporting lines to the relevant Minister and includes a Principal Community Visitor and an advisory committee. The scheme’s volunteer community visitors must undergo role-specific training.¹⁶⁶

A Bill to implement a Training Centre Visitor Scheme has passed both Houses of Parliament. It provides for the creation of the Training Centre Visitor, an independent statutory position, who is equipped with powers of visiting, inspecting, advocacy and promotion of residents’ best interests. There is also a power to inquire into and provide advice on matters referred by the Minister. GCYP can be appointed to this role, in addition to its present functions.¹⁶⁷

These community visitors provide important services for vulnerable populations who are accommodated in out-of-home environments. They provide a range of services that include inspecting facilities, advocacy, improving the patients/residents’ experiences, identifying gaps in service provision, increasing accountability and transparency within service provision, helping resolve complaints, and acting as a link between frontline service delivery and policy and service development. Their aim is to ensure the consistent delivery of best practice services, and improve overall health and wellbeing outcomes.¹⁶⁸

The former guardian supported the development of a targeted community visitor scheme for children in residential care, recognising that although social workers did their best to visit children regularly, they faced competing organisational demands. A business case put forward by GCYP in 2014 proposed that a community visitor scheme target children who were new to care—the time of greatest instability and uncertainty. The business case also supported extending the service to all children in non-home-based care, in view of their position

of particular disadvantage.¹⁶⁹ The former guardian expressed the view that whereas a community visitor could focus solely on the child’s views and interests, a social worker had to balance other interests.¹⁷⁰

The estimated cost of a scheme which targeted services to all children who had newly entered care (including those in home-based placements) exceeded \$2 million a year; providing the service to children in residential care only was estimated at \$1.7 million.¹⁷¹ The preference for a targeted model—that is, providing a community visitor service for the first years of a child’s time in care—was based on the cost. The cost of a community visitor service to *all* children in care was calculated to be at least \$11 million per annum.¹⁷²

In contrast with the mental health and disability model, the former guardian recommended the paid employment of community visitors, in order to recruit individuals with a background of engaging and working with children, and thereby achieve high quality reporting and advocacy.¹⁷³

The Commission supports the implementation of a community visitors scheme for all children in residential care. The powers that community visitors will require to effectively perform their function will depend on the model adopted. Any scheme should grant community visitors the ability to access the children to whom they provide a service.

COMPLAINTS MECHANISMS

Section 56 of the Family and Community Services Act requires the Department’s Chief Executive to hear and investigate complaints made by a child with respect to their care or control. However this section applies only to children residing in licensed residential care facilities. There is no corresponding obligation on the Chief Executive in relation to children in facilities established by the Agency.

Ms Stasiak told the Commission that she supported the inclusion of Families SA facilities in this regime. She observed that some staff in residential care feared that helping children to make complaints about their circumstances would encourage them to make false allegations which would result in staff being removed from the workplace. Workers with this attitude express caution about improving complaints mechanisms. Ms Stasiak’s view was that children usually have an underlying reason for making a complaint, even on the occasions where it is not well founded, and processes must allow children to do so.¹⁷⁴ Ms Stasiak’s evidence reflected a sophisticated awareness of the challenges which face the residential care directorate and a child-focused view of the potential solutions.

Section 56 of the Family and Community Services Act should be amended to require the Department's Chief Executive to also hear complaints from children residing in their own facilities. A clear pathway to this mechanism should be available to children and young people in residential care. In order to track the effectiveness of the mechanisms established, quarterly reports which describe the number of complaints received and any emerging themes should be made to the Minister and GCYP.

Earlier reference is made to GCYP developing an awareness campaign for children and young people in residential care regarding their rights pursuant to Regulation 14. This campaign should also include promoting rights according to section 56, and how to access these complaint pathways.

STAFFING

Working in residential care is a difficult job. Carers must demonstrate understanding and empathy towards children of differing ages, ethnicity, culture, socioeconomic background and development. They must have an extensive knowledge of children's psychological and emotional difficulties, and a high level of skill to address them. The challenge for workers was encapsulated by Mr Waterford, discussing the difficulties of recruiting workers to the role:

For [some children] within this population, the level of trauma they had experienced I think necessitated a higher level of expertise. The challenge ... is that a lot of the work is cleaning, cooking, bottom wiping, and getting the right mix of operationally classified staff and professionally classified staff is vexed.¹⁷⁵

Child and youth workers are employed under the OPS stream, with salary ranges from \$49,576–\$53,661 for OPS2 to \$57,738–\$61,822 for OPS3.¹⁷⁶ Applicants must hold a child-related employment clearance, a current first aid certificate and full drivers licence.¹⁷⁷ In the course of hearing evidence about residential care, the Commission heard from many committed and knowledgeable workers, providing high quality care in very difficult circumstances. Retaining good staff is a critical part of developing residential care services as a positive placement option.

SELECTING CARERS

Following the arrest of Shannon McCoolle, the Agency's recruitment processes for youth workers have been closely reviewed both within the Department and externally. The evidence about this topic as it applies to McCoolle is described in more detail in the McCoolle case study.

The process by which McCoolle was recruited to Families SA was typical of the practices in operation at the time. A merit-based selection process was undertaken by a panel comprising the recruitment coordinator, who was employed within the residential care directorate, and two youth workers. The process included the following steps:

- initial application via a web-based site;
- shortlisting of applicants on the basis of their written application;
- the administration of an employment suitability test package offered by the Australian Institute of Forensic Psychology (AIFP), rebranded in 2013 as the Safeselect® Psychometric Testing System. Safeselect is a later version of the AIFP test suite;
- exclusion of some applicants on the basis of the test results;
- an observation shift in a residential facility;
- a medical assessment; and
- a face-to-face interview by the panel.

Safeselect testing includes an IQ component as well as a literacy, numeracy and writing component and a series of personality measures which are said to produce a result indicating the applicant's potential suitability for the position. The test did not make a specific claim to test for a risk that the applicant would commit abuse against a child. The tests were administered by the recruitment coordinator, with results processed interstate by the AIFP, who produced a series of documents describing the results for all candidates.

This documentation provided to the Agency included results for each candidate for the IQ, reading, writing and numeracy assessments. Safeselect also identified whether candidates were recommended for further evaluation and an interview, and whether caution should be exercised in advancing a candidate when results indicated they were 'high risk'. Candidates might be advanced notwithstanding their test scores where, for example, English was not their first language, and the test may have unfairly discriminated against them.

The panel was required to interpret the test results as part of the shortlisting process before the interview and during the interview process.

THE HYDE REVIEW

Following McCoolle's arrest, Mal Hyde, the former Commissioner of the South Australian Police, was appointed by the Minister for Education and Child Development to conduct a residential care workforce review. Its purposes were to ¹⁷⁸:

- assess whether the residential care workforce was fit for role by conducting a full evaluation of the recruitment and selection process for each employee;

- review and make recommendations to improve the effectiveness of the selection policy and processes and assess the operational risks in staffing residential care facilities; and
- identify strategies to maintain adequate staffing levels.

Mr Hyde worked with departmental staff and psychologists from Broomhall Young Psychology to complete the review in September 2014. A number of deficits within Families SA policies and practices were identified.

Before the review could begin its work evaluating individual employees, the available records had to be gathered. There was no simple and accurate way to identify all residential care directorate employees. Inconsistent information was obtained from payroll records, databases and onsite records provided by managers. Eventually after cross-checking the data from a number of sources, 467 employees were identified.

The review then faced challenges gathering documents relating to the employment and supervision of each employee including their initial application, psychometric test results, observation shift reports, evidence of valid child-related employment screening, supervision reports and performance plans. No single file contained all relevant documents about an employee's recruitment and performance. Paper records were scattered throughout the Department, and psychometric tests for some employees had to be obtained from Safeselect. The review was obliged to recreate its own employee files from available documents.

These challenges highlighted an ongoing failure by the Department to establish basic human resources (HR) systems and processes. The capacity to effectively monitor the conduct of employees, particularly in a workforce of this size, requires systems that permit the employer to readily access corporate information. At its most basic, an employer should be able to identify who is working for the organisation. The effect of this systematic failure is further described in the McCoole case study, where his performance deficits were never fully understood by any single person in the directorate as he moved between areas which were separately managed.

The review observed that management within residential care was not fully integrated into the broader Department for Education and Child Development, resulting in ineffective and inefficient duplication of policies and procedures, siloed systems and a reduced level of support from that which had been available when the Agency had been part of the Department for Families and Communities. Processes and arrangements reflected a reactive management style, concentrating decision making in key executives and managers, with no business

plan. A number of broad reforms were under way with few completed, and policy documents did not reflect the reality of Agency practice.¹⁷⁹

The review examined how the recruitment process used the Safeselect test results. It observed that understanding the test results and interpreting them in a recruitment process required expertise and training. Panel members involved in recruitment between 2011 and 2013 were not trained in the interpretation of the tests and the review found evidence which suggested that they took little notice of the results.¹⁸⁰

This conclusion is consistent with evidence before the Commission. Panel members who were asked to consider the Safeselect results recognised that they were untrained and therefore unable to properly understand test results. This, it seems, led to the results that were available being disregarded.¹⁸¹ A number of applicants who returned high-risk ratings were advanced, as the interview process either failed to highlight areas of concern, or if concerns were identified and an attempt made to follow them up, panel members were not qualified to interpret the candidate's response¹⁸² (see Volume 2, Case Study 5: Shannon McCoole).

The findings of the review included that:

- the selection process had not been applied reliably, consistently and effectively, leading to significant weaknesses;
- recruitment and selection had not been planned and managed in a structured way at senior levels and there was no workforce plan;
- the selection process was being managed without expertise, resources and capability; and
- there was a lack of rigour applied to the selection process generally, and the quality control, performance management and accountability for the recruiting and selection processes were inadequate.

The Commission agrees with these findings.

The review concluded that the residential care directorate had no workforce management plan with a strategic approach to recruitment, selection, training and retention. The directorate's systems could not even identify the number of vacancies.

Of the 467 employees examined by the review, 102 workers were identified as being of high or very high concern.¹⁸³ The review could not locate sufficient information on which to make a suitability assessment for 86 employees, or 18 per cent of the workforce. These results reinforce issues raised about recruitment and selection processes, and how the Agency assesses an employee's ongoing suitability for the role.¹⁸⁴

The review made a total of 49 recommendations, and an implementation project commenced in early 2015. The project team was staffed by employees outside the Office for Child Protection but within the Department. It was intended that the project team would complete the work necessary to embed the responses to the recommendations within the practice of the Agency.¹⁸⁵

The issue of the 102 employees identified as high or very high risk had to be addressed as a matter of priority. A panel worked through those employees to consider the viability of their future employment. Each employee was interviewed by a panel which included an organisational psychologist, a senior residential care directorate employee and a senior HR professional. As a result of these interviews, 25 employees were directed away from the workplace, pending further action.¹⁸⁶

The project team then took on responsibility for recruiting and selecting youth workers¹⁸⁷ given the urgent need to fill vacant positions. Approximately 100 youth workers employed on temporary contracts were transferred to ongoing contracts¹⁸⁸, vacancies were identified and a recruitment process commenced. This initial recruitment process utilised the Safeselect suite of tests with two additional tests added to secure information identified by registered psychologists as important.¹⁸⁹

The project developed systems and processes that should be incorporated into Families SA standard processes. Dr Jane Richards, the Project Director, expressed a level of concern that the Agency does not currently have the expertise needed to manage the systems required, and that no plan existed to address or resource this.¹⁹⁰

The Deputy Chief Executive, Office of Child Protection, Etienne Scheepers, gave evidence before the Commission in October 2015. He told the Commission that he had only recently received a copy of the Hyde review. When asked if he had read it, he said:

*I skimmed it. I have an idea what's in there. I have not read it in-depth because the world has moved on significantly from then.*¹⁹¹

The Commission is concerned that these comments demonstrate a lack of understanding of the entrenched issues facing the Agency and the extent to which these will continue to challenge the Agency in the immediate future. While improvements have been made through the work of the implementation project, 'given the previous history on selections and the management approach, there is no guarantee that the changes will remain'.¹⁹²

CURRENT RECRUITMENT PROCESSES

In 2016, recruitment for residential care was placed within a dedicated Families SA team. The current process is coordinated by a recruitment officer with HR expertise. This officer chairs the selection panel which also comprises two supervisors from the directorate. The panel report is prepared by another HR specialist.

The panel prepares an initial shortlist, after which a suitability test is conducted by a clinical psychologist. A series of psychometric tests, approved by the review implementation steering committee¹⁹³, are conducted by the psychologist in a one-to-one setting, and the applicant is either screened in or out. There is no follow-up of this assessment in the panel interview.¹⁹⁴ The Safeselect testing regime is no longer used by Families SA as part of its recruitment of youth workers.

The Commission supports the continued use of the 2016 recruitment processes. The utilisation of HR expertise in conjunction with highly experienced operational staff provides necessary experience on the selection panel. It is appropriate that a suite of psychometric tests is utilised which reflect the specific role of youth workers within South Australia, and reflect the characteristics sought in applicants for this role. Both the Hyde review and the McCoolle case study identified that a crucial failing of previous recruitment processes was the use of untrained and unqualified staff to interpret Safeselect test results. It is important to acknowledge that while Safeselect asserts that its reports are designed to be read by non-psychologists, it also asserts that at least one person on a selection panel should be trained in the use of the system.¹⁹⁵ Even though Safeselect offers training to selection panel members, this was not utilised by the Agency.

The Commission is satisfied that individual testing conducted by qualified experts in organisational psychology is an appropriate and necessary strategy. This method is key to undertaking a holistic assessment of an individual to properly assess their potential suitability for a role in the residential care setting. The Commission emphasises that psychometric or psychological assessment should only be conducted by experts with appropriate qualifications.

The Commission does not recommend a return to using the Safeselect tool as part of the recruitment process. Experience in this state has demonstrated that expecting people without expertise in the field of occupational psychology to interpret test results, and ask questions of applicants in an interview which requires further interpretation of test results, has led to a misuse of the tests and leaves the Agency open to significant errors of interpretation.

In addition, the Commission is of the view that the Safeselect tests are not appropriate for use in residential care recruitment.

Safeselect asserts it provides clients with 'a group of tools designed to assess the risk associated with hiring staff who will work in a public safety role'.¹⁹⁶ The term 'public safety officer' is used by Safeselect to 'refer to anyone working in a job where the decisions they make will affect the safety of other people'.¹⁹⁷ Under this wide descriptor, Safeselect provides psychological assessment services for roles such as police, correctional services, fire, ambulance, fisheries and security officers. Working in child protection is viewed by Safeselect as a public safety role.¹⁹⁸

Further, the complete suite of tests is not viewed as reliable for Aboriginal and Torres Strait Islander (ATSI) applicants. Advice to Families SA from Kenneth Byrne, the Managing Director of the AIFP, was that reliance on the test results could unfairly disadvantage such applicants. While the test was administered to ATSI applicants, they were automatically recommended to advance.¹⁹⁹

The Agency has been reviewing the appropriateness of using the Safeselect suite of tools in its selection of residential care workers since at least 2010, and the need to use a psychological screening test that identified desirable characteristics and core competencies of the actual role in the Agency has been highlighted.²⁰⁰

The use of the Safeselect profiling system in the selection of residential care workers has not been specifically evaluated. There is no evidence which establishes that the suite of tests is an appropriate measure of risk or indicator of desirable personality traits in relation to the specific role of youth workers employed in residential care. It is questionable whether the Agency should have viewed its residential care workers, who care for children with trauma histories in a residential environment, as working in a public safety role.

Assessment of the suitability of an employee for the youth worker role should not cease at the point of employment. Evidence given during the McCoolle case study consistently demonstrated that carers working with McCoolle had concerns about his personality fit and style of care, and that they observed inappropriate interactions by him with children and carers. To a degree, senior staff were aware of these concerns. An ongoing process of assessment of the suitability of carers should continue past initial employment. It is recommended that the employment of all new employees be subject to an initial probationary period of at least six months. A comprehensive review of performance should occur immediately before the conclusion of the probationary period and an assessment made about the suitability of the employee for continued employment.

It is important to note that commercial carers are not subject to the same standards of engagement required of the directorate's youth workers.²⁰¹ People who are viewed as unsuitable for employment according to standards set within Families SA may nevertheless work

within Families SA by gaining entry through commercial care arrangements, either within Families SA housing or in emergency care.²⁰²

TRAINING

When skilled care is delivered by qualified and committed carers, children and young people can do well in residential settings. However, evidence suggests that there are significant gaps in training provided to carers in Families SA facilities, which leave children at risk of physical and emotional harm.

The demands of the youth worker role require a high level of knowledge. This demand can be met either by recruiting appropriately skilled people or by intensively training employees once they are engaged. While there is an argument that the basic level of knowledge might be improved by requiring applicants to hold a formal relevant qualification prior to appointment, such a requirement would restrict the pool from which selections are made. In view of the pay structure and the operational aspects of much of the work, it is unlikely that sufficient numbers of applicants with appropriate qualifications would be attracted to the position in the long term. The Commission also heard that personal characteristics such as resilience and life experience can be as important as formal qualifications in the selection of good child and youth workers.²⁰³

The Commission accepts that mandating qualifications at a degree or certificate level, prior to employment, is inappropriate. The quality of training offered to employees after their appointment therefore becomes particularly important.

Youth workers currently undertake a full-time six-week course upon commencement, which includes class-based teaching and practical experience shadowing other youth workers (see Volume 2, Case Study 5: Shannon McCoolle). Workers are then required to complete a Certificate IV in Child, Youth and Family Intervention within 12 months. This training is funded by the Agency.²⁰⁴ The certificate requirement has not always been a condition of employment and there is a proportion of the workforce who hold no formal qualification. The Agency is in the process of consultation about how to now engage these employees in training towards the certificate.²⁰⁵

Training should continue beyond the basic matters covered in the six-week course and the Certificate IV.²⁰⁶ The Commission is aware that a number of carers felt ill-equipped to respond to the basic needs of young children in their care. Workers who were rostered to care for infants were not provided with training specific to infants' needs or development. While some had experience caring for their own children, this was not always the case. One youth worker said that when an infant was first placed at the house where he was employed only one worker within his team had previous personal experience caring for infants. No-one in the team had any training or employment experience caring for infants.²⁰⁷

Child and youth workers should be engaged in compulsory professional development which acknowledges the importance of their role in delivering therapeutic care to children and young people—one that transcends caring for the basic physical needs of a child. This professional development should endeavour to ensure that these workers gain the skills needed to contribute to a healing environment which is responsive to children in care.

THE CARE OF YOUNGER CHILDREN AND INFANTS

With the exception of circumstances where it is in the best interests of children to keep sibling groups together, the Commission does not support the placement of children under 10 in residential care. The reality is that until the home-based care sector can be expanded to accommodate the number of infants and younger children coming into care, or the number of such children requiring placement decreases, younger children will continue to be accommodated in these environments.

It is therefore necessary to consider how the directorate will provide quality care to those children. Youth workers who care for young children and infants must acquire the skills that are needed for that task.²⁰⁸ One option would be to develop a specific class of residential care worker with specialist training in early years care and child development. In view of the long-term aim of removing that group of children from the residential care population, recruiting specific workers for that purpose is short-sighted. In order to improve skills of the workforce in early years care, but retain the flexibility in the workforce to accommodate anticipated changes in the residential care population, suitable workers within the directorate should be identified for specific training in early child development and early years care.

SUPERVISION

In addition to appropriate ongoing training, workers should receive regular *professional* supervision. Evidence from the McCoolle case study indicated that supervision was predominantly used as a means of addressing undesirable behaviours. Treating supervisory practices as relevant only to correcting workers' conduct contributes to the perception that supervision is a pejorative process: it misses entirely the positive uses of supervision as a means for staff to raise topics of concern in their observations of children, to discuss their own development, and relay the observations of other staff.

Youth workers may operate in an isolated environment, without close oversight by their immediate supervisors. Supervision can provide an opportunity for supervisors to assess their wellbeing. Workers should have regular supervision which reviews their behaviour and performance and identifies learning opportunities. In some instances group supervision will be appropriate to raise common issues and constructively address team functioning. The supervision should be conducted

by someone who has a high level of knowledge about child development and trauma, and can contribute knowledgeably to discussions about particular children.

Supervision notes are an important record of the Agency's assessment of staff members' performance. They should be kept in a manner that enables continuity of supervision across a worker's engagement in different areas and different houses. The McCoolle case study highlighted that as McCoolle moved between different areas of the directorate, his supervision records were not accessed by his new supervisors, and a consistent knowledge of his performance deficits was never gained.

SEXUAL ABUSE IN RESIDENTIAL CARE

There is no doubt that children who are cared for in institutional environments (including residential care) are vulnerable to abuse, including sexual abuse. The reasons for this are attracting research attention as the disturbing rate of child abuse in religious and secular institutions is uncovered. In 2013 the National Crime Agency in the United Kingdom published a paper identifying themes in the sexual abuse of children by adults in institutions. The analysis considered residential care homes and secure units, among other institutional settings. An examination of the data gathered led the authors to observe:

*Learning from institutional sexual abuse cases indicates that there is something about institutions, as environments for child sexual abuse, which appears to aggravate the vulnerability of potential victims and amplifies the power over them that abusers can exercise. This means that institutions are high risk environments for children, young people, and indeed other vulnerable people. Such a high risk, coupled with the vulnerability of potential victims, requires a higher investment in mitigation.*²⁰⁹

The analysis concluded that:

*[Institutional child sexual abuse] is a product of a malign culture within an organisation which colludes with an offender's propensity to abuse. The culture is set by poor leadership with rigid and closed structures; ineffective and unmonitored policies where staff are reluctant to report or discouraged from reporting their concerns; and where the interests of the institution are valued above the interests of the child.*²¹⁰

A child who has been the victim of abuse is more vulnerable to being re-abused. Children who enter care already have developmental disadvantages associated with being raised in abusive and neglectful environments. When they are removed from their families to rotational care settings these disadvantages are compounded.

Children who have been abused sometimes become accustomed to these experiences and may also become used to their experiences not being given any priority. Children have the capacity to learn from a very early age to manage this in a way that enables them to remain close to their caregiver who is also the source of the abuse. The ability to manage and mask their own needs is then taken into subsequent relationships.²¹¹ These children do not assume adults will be interested in, or believe, what they have to say. They may learn to lie as a coping mechanism in their flawed care environment.²¹²

Some children who have been maltreated or neglected are especially vulnerable to adults who pay them particular attention and make them feel special. Children become attached to their abusers, and when abuse is also associated with attention, it can feel special for a child who is detached from other relationships that should be sustaining them.²¹³ One of the challenges for identifying and addressing this risk in the residential care environment is that the creation of a special relationship with a vulnerable child can, in most circumstances, be highly beneficial: 'many people have had a special relationship with a teacher or other adult that has been hugely beneficial, raising their ambition, confidence and skills'.²¹⁴

Some children who have been abused before coming into care develop behaviours which a potential offender can interpret as provocative. This is, of course, a self-serving interpretation. Nevertheless, it does render those children more vulnerable to a repeat of the abuse that might have brought them into care.²¹⁵

GCYP collects data relevant to allegations of sexual abuse in care. The data collected relies on reports being forwarded from the Care Concern Investigations Unit, and the data gathered must be considered with the caveat that GCYP may not receive all relevant notifications from the unit. There is good reason to think not all reports were forwarded to GCYP. A total of 236 reports of allegations of sexual abuse made between November 2008 and October 2014 were received,²¹⁶ including a small number of reports from the Adelaide Youth Training Centre (AYTC), the secure care facility for children and young people serving periods of detention or remanded in custody.

Of the 236 total, 116 related to children living in family-based care, and 79 to children in residential care. The remaining 41 related to children in respite care, emergency care or the AYTC. Approximately 10 per cent of children in out-of-home care during the relevant period lived in residential care settings, and yet 79 (34 per cent) of the 236 reports came from children in that environment. Children in residential care are significantly over-represented in the rate of sexual abuse allegations being made.²¹⁷

GCYP observed that the higher rate in residential care may result from a number of factors: a greater external scrutiny of residential care; the higher needs of children in those settings; and a greater vulnerability in residential care to sexual abuse, including abuse from other children and young people.²¹⁸

While the focus of the Commission's inquiry has been the risk of sexual abuse of children in residential care by carers (Volume 2, Case Study 5: Shannon McCoolle), statistically there is greater risk to a child in residential care of sexual abuse by people outside the care facility as well as by other children within. A report of the Victorian Commission for Children and Young People identified that external predators committed 63 per cent of the sexual abuse identified within the period of the Inquiry. It was of equal significance that 31 per cent of the acts were committed by children against other children.²¹⁹ Residential care environments should acknowledge the risk of sexual abuse of all forms to children and actively protect children against such offending. This is of particular significance in considering the future for the 12-bed community residential units.

WHO ABUSES CHILDREN?

DEFINING PAEDOPHILIA

Paedophilia is a term that is commonly, and often inappropriately, used to describe adults who engage in sexual behaviour with children who are under the statutory age of consent. Properly applied, however, the term 'paedophile' has a far more restricted meaning. The clinical definition of paedophilia is a person who has '[a] sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age'. The diagnostic criteria for paedophilic disorders, as set out in DSM-5, require that:

- 1 Over at least six months, there have been recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child or children (generally aged 13 years or younger);
- 2 The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty; and
- 3 The individual is at least age 16 years and at least five years older than the child or children in criterion 1.²²⁰

As is evident from these criteria, 'not all paedophiles commit sexual offences and not all people who commit child sexual offences are paedophiles'.²²¹ The research supports the conclusion that there are adults who experience paedophilic urges who do not offend against children and many adults who offend against children but do not satisfy the diagnostic criteria for paedophilia.²²² It is a dangerous and pervasive stereotype that all adults who offend against children have a specific and exclusive sexual interest in children.

It is a dangerous and pervasive stereotype that all adults who offend against children have a specific and exclusive sexual interest in children

PREDATORY, OPPORTUNISTIC AND SITUATIONAL OFFENDERS

Researchers Stephen Smallbone and Richard Wortley conceive child sex offenders as falling into one of three types: predatory, opportunistic or situational offenders. Predatory offenders are stereotypical paedophiles and can be described as 'high-frequency, chronic offenders'. They indulge in more frequent and extended sexual contact, suggesting they are interested in forming a relationship with the child. They are persistent and calculating in identifying vulnerable children to pursue.²²³

Not all child sexual offenders are predatory in their approach. Professor James Ogloff told the Commission that 'most child sexual offences have been found to be opportunistic, situationally determined, or involve victims who, while still being children, are post-pubescent'.²²⁴

Opportunistic offenders may or may not satisfy the diagnostic criteria for paedophilia. Their offending generally exploits existing circumstances.²²⁵ Opportunistic offenders:

*will tend not to actively create opportunities to abuse children, particularly if doing so would require any sustained effort. In simple terms, where the committed offender is the opportunity-maker, the opportunistic offender is the opportunity-taker.*²²⁶

Situational offenders offend in circumstances where the situation amplifies the level of temptation. The environmental circumstances create an impulsive decision to offend to satisfy a sexual need that does not necessarily originate in an attraction to children. Situational offenders are generally law-abiding citizens with no other criminal involvement. Their sexual offending will be relatively isolated.²²⁷ They are unlikely to create an opportunity to offend. The offending may result from environmental stressors:

*While they are generally able to exercise self-restraint, a momentary lapse may be enough to turn what is probably at first a sense of emotional congruence with a child into a sexual incident.*²²⁸

Situational offenders are likely to be older at the time of the first sexual contact with a child, and they usually select female victims and victims within their family circle.²²⁹ A situational offender is more likely to be a person in a caregiver role or an authority figure who abuses their position of trust.²³⁰

Child sex offenders are a heterogeneous group and it is not possible to identify any particular features that mark out a person who is more likely to sexually offend against a child.²³¹ Frequently, even people who have the closest relationships with child sex offenders have no knowledge they are so inclined and are even less likely to know they have acted on the inclinations.²³²

There are many adults whose potential to offend against children can be controlled by making changes to the environment in which they operate. That is, an opportunistic offender who is not presented with an opportunity to access a child will not manipulate circumstances to create such an opportunity. A situational offender who is not placed in a high risk situation may never commit an offence.

MANIPULATION OF ENVIRONMENTAL FACTORS

Institutional settings have generally concentrated on screening to exclude unsuitable adults from working with children. Modern approaches emphasise that the manipulation of environmental factors has the potential to be a much more powerful way to protect children from sexual abuse. It is important to acknowledge, however, that predatory offenders, who manipulate their environment to create opportunities to offend, will not be completely deterred by changes to their operating environment.²³³

Wortley and Smallbone nominate four strategies for changing operating environments: increasing effort, controlling prompts, increasing risk and reducing permissibility.

INCREASING EFFORT

The 'increasing effort' strategy relies on the assumption that offenders will usually choose a victim who requires the least effort and deviation from their usual routine. Increasing effort for potential child sex offenders involves making access to victims more difficult.²³⁴ This strategy includes screening and recruitment processes that exclude high risk people.

Increasing effort also requires 'target hardening'. This focuses on strategies such as teaching children protective strategies. This might include prevention programs that provide generalised upskilling in assertiveness and self-confidence for vulnerable children rather than education about adult concepts such as sexuality or sexual acts.²³⁵

CONTROLLING PROMPTS

For some offenders, the situations in which they find themselves may prompt them to offend. Some sexual offences are committed in circumstances where the child has been in a 'provocative' (from the point of view of the offender) or vulnerable situation.²³⁶ In residential care settings, tasks such as bathing, nappy changing or changing clothes may present prompts which tempt offending.

INCREASING RISK

In child sexual abuse, the presence of a responsible and alert parent or caregiver plays a central role in protecting the child from abuse. In institutional settings, effective supervision of employees combined with protocols that govern the way in which employees engage with children are critical.²³⁷

Protocols such as prohibiting workers from being alone with children or modifying the physical environment to increase natural surveillance opportunities may be necessary.²³⁸ Ambiguity in rules and regulations as to what interactions are and are not prohibited provide fertile ground for exploitation by a potential child sex offender, who will push boundaries to engage in grooming behaviour.²³⁹

In a residential care environment the presence of other staff members who are well trained and attuned to behaviours which raise concern is potentially one of the most powerful strategies to reduce the risk of child sexual abuse.

The effectiveness of the supervision of other adults, however, depends on the ability and willingness of those adults to recognise problematic behaviours. This can be challenging. Professor Ogloff explained in evidence that the starting point for most adults is that they experience no sexual attraction to children. It is easy to assume adults who appear in other respects to be like us also have the same absence of sexual attraction to children.

This is particularly so for adults who are part of our own social or friendship groups.²⁴⁰ This thinking supports the pervasive and dangerous belief that a child sex offender will be so different to us they will be easily identifiable. The more the community perpetuates the stereotype that sex offenders are sleazy predatory strangers, the more the real danger to children is overlooked. The real danger often lies with people who seem most like us: 'monsters don't get close to children, nice men do'.²⁴¹

To recognise problematic behaviours, people working in an environment with children must understand that people who are motivated to offend against children will not always fit their preconceived notions of what an offender looks like.

REDUCING PERMISSIBILITY

For some offenders, a psychological capacity to justify their offending enables them to overcome the community message that sexual behaviour with children is unacceptable. This may be through distortions of thinking such as 'I was educating the child', 'the child was not harmed' or 'the child enjoyed the act'.²⁴² Distortions might include thinking about children in sexual ways or considering children's behaviour to be deliberately provocative.

In institutional settings, justification of behaviours of this kind may be achieved by a de-personalisation of the victims, divesting them of human qualities and individuality. Staff anonymity and collective responsibility can minimise the staff member's sense of personal responsibility.²⁴³ Institutions that have firm rules and expectations of staff (including clarity of behavioural standards and expectations), and which personalise and individualise the children they care for, can address the distortions that offenders might employ to justify their offending.

Smallbone and Wortley set out the following features of institutional environments that minimise the risk of sexual abuse:

*Strategies include ensuring that residents receive adequate levels of physical care that affords them human dignity; minimising institutional features of the environment and unnecessary regimentation; introducing explicit codes of conduct and induction procedures for staff that clearly spell out acceptable and unacceptable behaviour and leave no room for the exploitation of ambiguity; provide formal opportunities for residents to make complaints if abuse occurs; and opening the institution to outside scrutiny, including instituting a process of regular independent inspections and reviews.*²⁴⁴

The National Crime Authority report referred to earlier drew a number of conclusions about improving the conditions in institutional settings to prevent abuse:

Children in institutions are at risk not only from the offenders who seek to exploit them, but also from adults who fail to see or fail to report abuse;

Organisational culture, structure and processes can be used to manage situations where offenders might be tempted to abuse. There is greater capacity for the protection of children through the management of opportunity and situations, than through the exclusion of potential offenders from the environment;

Rigid hierarchical organisations and closed organisations can operate to de-personalise staff and children within them. This disempowers children in their relationships with adults and staff in their relationships with managers. Staff who see signs of abuse and report them are often ostracised and excluded; and

Quality leadership and strong governance in an organisation which has the safeguarding of children as a high priority, and which regularly monitors and evaluates relevant policies and processes, influences the development of a healthy, open culture which supports the reporting of concerns.²⁴⁵

These observations resonate heavily in the Commission's consideration of the organisational dysfunction that was the background to McCoole's offending. These matters are discussed in greater detail in that case study (Volume 2, Case Study 5: Shannon McCoole).

RECOGNISING THE SIGNS OF SEXUAL ABUSE

Sexual abuse can have both an immediate and long-term impact on a child's physical, emotional and mental wellbeing. Children who are too young to retain a narrative memory of the abuse perpetrated upon them may nonetheless retain the experience in procedural memory, such that the associated distress and anxiety can be later triggered.²⁴⁶ It is a misconception to think that abuse a child does not remember will not have an effect on their psychological wellbeing and development.

The impact of child sexual abuse depends on a range of factors including the age of the child, the age of the perpetrator, and the frequency, duration and type of abuse.²⁴⁷ Infants and young children are particularly vulnerable to the impact of abuse as the early years are a critical period for biological, psychological and social development. It is a time when infants and young children are completely reliant on their caregivers for emotional and physical protection.²⁴⁸ The younger the child the more likely the impact of abuse will be inscribed on neurological processes, affecting memory, attention

span, self-regulation and physical health.²⁴⁹ Infants and young children are also especially vulnerable to abuse as they are unable to understand or communicate the nature of their experience in a way the adults around them will understand.

For these children, the existence of a close and consistent caregiver who is attuned to small changes in their behaviour and wellbeing is critical to their protection. In a traditional family environment with a small number of consistent caregivers, behavioural issues are more easily identified and addressed in a timely way. For children in rotational care, the impact of trauma can be compounded by inconsistencies in their care environment and inconsistent oversight of their behavioural and emotional wellbeing.

BEHAVIOURAL INDICATORS

There are a range of behaviours that may indicate past or current abuse or trauma, but which do not specifically indicate sexual abuse. In the short term, infants and young children may respond to trauma with non-specific distress such as being more unsettled or demanding. Trauma also manifests in language delay, regression in previously achieved developmental goals, clinginess, sleep difficulties and toileting issues. Specific phobias related to the abuse might develop such as a fear of bathing, toileting or being in the dark. Some children may re-enact frightening events during play, with toys or sometimes with other children, or in drawings.²⁵⁰

Children may also internalise symptoms, becoming withdrawn, anxious or stressed, or exhibiting a number of behavioural changes all at once. Other children may externalise symptoms, becoming upset and displaying tantrums and aggression. The child may self-harm through behaviours such as head banging, excessive rocking, rubbing hair off their head or risk taking.²⁵¹

A number of children who have experienced trauma will develop behaviours which can be described as 'self-soothing'. For children who have been abused the usual methods of self-soothing, such as thumb sucking, may become persistent or extreme. Some children will develop genitally focused soothing behaviours or begin to deliberately defecate or urinate in socially unacceptable locations. They may engage in faecal smearing outside normal toileting mishaps. Where these behaviours are persistent, or develop after continence has been achieved, they indicate that the child is experiencing an extreme level of distress. Children may also play with faecal matter to distract them from their distress or replicate their trauma in some way.²⁵²

Toileting issues of this kind, particularly if they are persistent, raise questions of sexual abuse and should be closely assessed with other contextual information including the existence of other specific trauma behaviours.²⁵³

MORE SPECIFIC INDICATORS OF SEXUAL ABUSE

There are some behaviours which raise a specific level of concern about sexual abuse rather than other kinds of abuse or trauma. In younger children, any penetrative behaviour (inserting things into their own or other children's genitals) raises a high level of concern about sexual abuse.²⁵⁴ Any behaviour that has coercive features, including pressuring other children into sexual acts or exposing themselves, is of particular concern. Behaviours that mimic adult sexual behaviour should raise serious questions about the origin of the knowledge on display. Touching the genital areas of others outside what is incidental or accidental should also raise concerns.²⁵⁵

Some behaviours raise a level of concern about sexual abuse, but need to be closely examined in their particular context. These include a child persistently or provocatively exposing their body to others beyond what is contextually appropriate, and masturbating in a way that has a driven or compulsive aspect to it and appears to be motivated by something other than exploration.²⁵⁶

APPRECIATING THE SIGNIFICANCE OF A CHILD'S BEHAVIOUR

Assessing the significance of behaviours exhibited by children who have been removed from their birth families can be complicated by their sometimes unknown trauma histories. The extent and type of trauma a child in care has been exposed to in their past may never be fully understood. The identification of behaviours, and the assessment of their significance, is further complicated by inconsistencies in the rotational care environment and the lack of knowledge held by staff about the potential significance of the behaviours they observe.

Traumatic behaviours can intensify in the rotational care environment because there is no consistent adult in the child's life. A carer's capacity to perform their role can also be impaired by an absence of information about the child's background before coming into care. This, combined with inadequate logging and reviewing of child behaviours at a supervisory level, results in a lack of careful and detailed tracking of behavioural changes.

NOTICING THE BEHAVIOUR OF ADULTS

In a paper prepared for the federal Royal Commission into Institutional Responses to Child Sexual Abuse, Professor Eileen Munro and Dr Sheila Fish analysed the failure of adults to identify and report child sexual abuse in institutions.²⁵⁷ This analysis accepted as a starting point that a worker's judgment about the behaviour of other adults in their environment is subject to cognitive biases. Organisations have a major part to play in addressing these conditions to make adults more sensitive to the behaviours they observe that might indicate child sexual abuse.²⁵⁸

Confirmation bias is a concept that describes the human tendency to be slow to revise an opinion once it has been formed. When a point of view or opinion has been reached, we more easily notice evidence confirming it, and tend to explain or interpret other evidence in a way that supports our original thinking.²⁵⁹ The overwhelming majority of workers in residential care are well intentioned in their interactions with children, and when faced with an example of concerning behaviour, they are likely to apply an explanation for the behaviour which is consistent with their existing opinions and biases.

Sexual abuse of a child in the workplace is rare. In circumstances where workers do not expect or anticipate the occurrence of a rare event, child sex offenders may be more easily able to convince their colleagues they are overly suspicious or have misinterpreted an individual incident.²⁶⁰

The ability to identify problem behaviours can also be challenged by the need to bring together a large number of minor pieces of information to give them meaning.²⁶¹ If each individual piece of information is interpreted benignly, it is unlikely to be reported or be available for analysis in any holistic way. This may be particularly problematic when a worker is frequently moved across various sites working with different people, such that a pattern in their behaviour is never identified with certainty by their colleagues.

Finally, it must be remembered that it is far easier in hindsight to attribute behaviours to grooming when it is known they led to abuse. In hindsight, behaviours can be divorced from the environment in which they occurred, and from sometimes competing indications of good behaviour, which may have influenced the interpretation at the time.²⁶²

ORGANISATIONAL CULTURE

Organisational factors have a powerful part to play in helping workers make the best decisions when they observe concerning behaviours. The underlying organisational culture is a critical factor in determining how people behave within the workplace. It transcends policies, procedures and training and informs how people behave. Some aspects of organisational culture can be created by the *perception* of a matter which becomes so pervasive that it informs the behaviour of the workers within the organisation.

Professor Munro and Dr Fish make the following observations about the significance of organisational culture in keeping children safe:

*Culture is partly created by explicit strategies and messages from senior managers but is also strongly influenced by the covert messages that run through the organisation and influence behaviour ... workers need not only a formal mechanism for making reports but some guidance on the threshold for action. Thresholds are rarely explicitly put in writing; workers tend to develop an understanding of them through the feedback they get themselves or the feedback they see given to others who report concerns. The feedback can either encourage or discourage workers to report concerns.*²⁶³

Their report identified examples of workers declining to make complaints about behaviour because they did not trust managers and believed nothing would be done, or because they were concerned that a colleague who was the subject of the complaint would learn that it had been made.²⁶⁴ Some workers fear being ostracised by colleagues if they report concerns. Resolving to allege that a colleague is behaving in an inappropriate way with children is a difficult decision, particularly when workers have regard to the potential consequences of such an accusation if it turns out to be unfounded.²⁶⁵

Workers might also be dissuaded from making reports because of an absence of clear reporting pathways or a lack of clarity about who is responsible for raising concerns. An organisational environment in which concerns do not appear to be listened to, or actioned, will discourage workers from making a report, as well as lead them to believe they will be ostracised or punished, rather than supported, for doing so.

The policies and procedures of an organisation, in particular the rigour and consistency with which they are applied, are important to the prevention of child abuse in institutional settings. Where behavioural expectations are clear and consistently enforced there is less room for an offender to groom their environment to normalise breaches of acceptable boundaries with children and young people. Ambiguity in behavioural expectations in an environment can allow potential offenders to exploit situations to their own advantage. Offenders can build an identity as someone who regularly flouts the expected behavioural norms, leading their colleagues to ignore occasions when their interactions with children cross appropriate boundaries.²⁶⁶ A workplace where inappropriate behaviour is regularly tolerated fosters an unwillingness to report and act on concerns.²⁶⁷

APPLYING THEORY TO PRACTICE

Evidence given in the McCoolle case study highlighted gaps in carers' knowledge of child development, sexualised behaviours and indicators of distress, and an underdeveloped understanding of the dynamics of child sexual abuse. It also revealed a dangerous naivety about the risk of sexual abuse in the residential care environment. This was particularly concerning, given the rapidly developing knowledge base about the risks to children in institutional care.

Evidence also exposed an inconsistent understanding of policies and procedures. Guiding policies were difficult to locate and applied inconsistently, even by those at senior levels. The enforcement of clear boundaries and standards in the workplace has been identified as an important strategy to reduce the risk of sexual offending.²⁶⁸ The Agency should clearly identify operational policies, and train the workforce in their operation. Senior members of staff should model and enforce strict adherence.

Carers should be provided with training to help them understand and respond to children who exhibit behaviours that may indicate trauma or sexual abuse. This is a complex task when caring for children who will commonly have experienced serious abuse or neglect in their past, and causal conclusions might be difficult to draw. Case study 5 notes that carers received insufficient training in the identification and understanding of these behaviours; furthermore, when these behaviours were observed, their significance was not understood, or when they were understood, they were not actioned. Identifying and understanding these behaviours is not just about preventing sexual abuse in care, but is also critical to identifying children who need additional help or professional intervention.

Training should be accompanied by opportunities for workers to discuss the application of theory to their own practice. They should be encouraged to discuss children in their care whose behaviours are of concern and regularly review learning through applied discussions.²⁶⁹

Carers should understand and accept that children in residential care are vulnerable to sexual abuse and should be vigilant in monitoring the conduct of others. Training should be provided to address dangerous assumptions and stereotypes of child sexual offenders, and provide information about the complex dynamics of grooming.²⁷⁰ This training should be designed not to alarm, but to challenge the current stereotyped thinking and encourage workers to have an open mind about the risks to children.

Training should be delivered by experts in the field and be followed by opportunities to openly discuss the application of learning to the residential care environment. The provision of such training would be

in line with Recommendation 17 of the CISC Inquiry, which recommended that all carers receive training in aspects of child sexual abuse.²⁷¹ All employees should acknowledge their responsibility for reporting matters that raise concerns about the conduct of colleagues towards children as part of the conditions of their employment. This should extend to observations and information which do not meet the threshold for mandatory reporting. Their responsibilities in this regard should be discussed and workshopped through training.

Some carers have been discouraged from enquiring into and addressing behaviours which are trauma based, or indicate the possibility of abuse. They were told that enquiring into such matters was inappropriate because they were not sufficiently trained, and that any exploration of such issues would need to be undertaken in the context of an expert forensic interview. This approach potentially denies children opportunities to share their concerns and worries, and talk about their experiences in a way that promoted a better understanding. It could also emphasise the institutional nature of the environment and undermine the development of healthy nurturing relationships.

Residential care workers should not be prevented from engaging with children to explore the meaning behind children's statements and behaviours, in a way that is supported by their training. The child and youth worker job description requires workers to 'sensitively ascertain information from children or young people about their health, education, family and cultural background, and their understanding of their situation'.²⁷² This aspect of the role is critical, and the workers should be equipped to do it. The role description for their position should also include (in addition to the matters referred to above) *ascertaining information about the child or young person's feelings of safety in the residential care environment*. Additional practice guidance and training should be provided to ensure workers understand the limits of their responsibilities in this regard.

THE DANGERS OF SINGLE-HANDED SHIFTS

Inadequate staffing creates a risk to child safety. A number of youth workers and carers told the Commission that they were concerned that they would not be able to safely care for children because too many were being placed in their care, or because they were unable to manage children's behaviour. Staffing a shift with a single carer magnifies that risk.

The risk of sexual abuse posed by single-handed shifts has been addressed within the McCoole case study. While working double-handed shifts does not remove all opportunities to offend, and there are necessarily times when a child will be alone with a carer, the physical presence of another staff member on a shift would plainly deter most offending.

In addition, engaging carers who are well trained and attuned to behaviours which raise concern is a potentially powerful strategy to lessen the risk of child sexual abuse.²⁷³ The capacity of good workers to provide effective monitoring is reduced if they are overworked and unable to spend quality time engaging with children.

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Single-handed shifts also limit opportunities for therapeutic work with children. To satisfy their needs beyond basic physical care, spending time with them to develop relationships of trust is necessary. Single-handed shifts also sometimes impair the capacity of a carer to attend to all the children's needs. Where multiple children reside at a placement, children sometimes miss out on attending activities if only one worker is available. Carers may be obliged to focus attention on a child with high behavioural or care needs, at the expense of less demanding children.²⁷⁴

The risks to children of single-handed shifts have been well known at a senior level for some time. The Agency's capacity to deliver any higher staff to child ratio has however been undermined by a lack of funding.²⁷⁵

A move away from single-handed shifts is needed to aid in crime prevention and to provide workers the time and space they require to attend to children's basic care needs. Such a move would call for a substantial investment to expand the workforce, and it is accepted that this cannot happen quickly or without thorough planning. However, removal of single-handed shifts should be a serious medium-term aim for Families SA.

SUPPORTING AND SUPERVISING CARERS

Support to carers is provided during working hours by senior youth workers, with on-call support available overnight. A mobile night team offers additional support, but this resource is as yet unable to provide thorough supervision or monitoring due to the multiple houses and units it services, which are spread across large distances within metropolitan Adelaide.²⁷⁶

A large proportion of youth workers who gave evidence during the McCoole case study raised concerns about the level of support and supervision they received from a particular cohort of senior youth workers and supervisors who were operating in the southern area. The Commission observed inconsistent supervisory practices and a toxic workplace culture which, at least in part, can be attributed to poor relationships and a chronic lack of trust between senior and operational staff.

The capacity to monitor children's behaviour in a rotational care environment, where observations are split between carers, is undermined where carers fail to communicate with one another, either because they do not get along or because the culture does not support it.²⁷⁷

The combination of a toxic workplace culture and inconsistent operational practices within residential care properties affected the willingness of carers to raise concerns about the behaviour of children and staff, to the extent that carers were deterred from reporting for fear of personal repercussions. These concerns were not unfounded. In the course of the McCooles case study, the Commission heard of numerous instances when senior staff responded inappropriately to complaints.

The directorate's organisational culture has led to a situation in which obtaining accurate information about children and workers is compromised. The culture of mistrust deters many good workers from speaking out about concerns they have about the safety of children and the behaviour of their colleagues. These factors contributed to McCooles's conduct going undetected for so long. The inconsistent approach to standards similarly enabled McCooles to take advantage of lax practices to normalise some of his inappropriate conduct.

It is critical that the Agency remain vigilant about the risk of child sexual abuse. While the scope and frequency of McCooles's offending marked it as especially heinous, his arrest did not mark the end of risk to children in rotational care. The Agency is in need of substantial reforms to its structures, organisational culture, staffing and policies in order to reduce the risk of abuse in the future.

REFORMING RESIDENTIAL CARE

CAN RESIDENTIAL CARE BE GOOD FOR CHILDREN?

Residential care is not the first choice of care for many children. Because it is depicted as an unattractive, last chance option, it implies to children that their placement there is their fault and removes any sense that it might be a positive option.²⁷⁸

Such a characterisation fails to recognise that residential care can be the right option for *some* children. The challenge lies in developing a system that reflects the different needs of children who come into residential care, as the provision of homogenous service models will almost invariably fail to meet the needs of some.

In his book *Pain, normality and the struggle for congruence*, Professor James Anglin identifies situations in which residential care might be recommended²⁷⁹:

- to accommodate children who do not want to be placed in home-based care, or for whom home-based care is not appropriate. This may be due to previous abuse in such environments, or a child's behaviour posing a risk to their own safety or that of others;
- to keep family groups together, when siblings would have to be separated to obtain a placement in home-based care;
- to maintain stability of a home-based placement by providing respite care;
- to provide intensive therapeutic services; and
- to assess a child's needs, in preparation for a long-term placement.

A single service model will be incapable of meeting all of those needs. A differentiated system has the capacity to better address individual needs, both in relation to the nature and duration of care.

An important aspect of a reformed system is a clear understanding of the *purpose* of the placement. For every child, care provision should be informed by that purpose, with strategies in place to achieve it over the timeframe identified.

Despite the potential benefits of targeted and well-resourced residential care, there are many children for whom it will not be an appropriate placement option. It should not be a dumping ground for children in the absence of better options. Strategies that improve the recruitment and retention of foster parents and other home-based options remain essential to the development of a healthy out-of-home care system.

Residential care is not a replacement for a child's family or their home. It should however provide a home-like environment that is nurturing, supportive and stable. It should develop the child's sense of culture and community, and encourage, where appropriate, ongoing contact with birth families and other important people. Children should not be isolated, but have access to social, sporting and educational opportunities. They should be encouraged to express their views about matters that affect them, and have these views heard.

Given the length of time children reside within residential care, there should be capacity to plan for the future, including after care. Children should be encouraged to be aspirational about their futures, and should have someone walking beside them in planning for the future, providing guidance and helping to shape their goals. Children and young people need carers who they can relate to and trust, and systems that can help them to achieve their goals.

Above all, the residential care environment should provide a safe place for children and young people. This principle is recognised in the National Framework for Protecting Australia's Children, which identifies as one of its six supporting outcomes that 'Children who have been abused or neglected receive the support and care they need for their safety and wellbeing'.²⁸⁰

The concept of safety includes an environment that is physically safe for a child to live: that is, facilities that are safe, in locations that are safe, with adequate staff who are equipped with the knowledge and skills to provide appropriate care. Safety also extends to providing an environment that is free from physical and sexual abuse and neglect.²⁸¹

REFORMING STAFFING

Professor Anglin, conducting research about best practice in residential care settings, observed that there is a tendency for the philosophies and practice orientation of supervisors to permeate the conduct of carers, and affect the experiences and thoughts of children in their care.²⁸² This observation underlines the need for management and supervisory staff to embody best practice in their endeavours. This includes adopting practices which reflect a philosophy of care, adhering strictly to operational standards and procedures, and leading and modelling a healthy and cohesive working environment.

Currently senior staff in residential care are appointed to the OPS classifications, which focus heavily on operational requirements. Supervisors play a strong hands-on role in everyday decision making, including approval of expenses, and staffing.

Supervision of youth workers should stem from a greater professional knowledge base and have a greater emphasis on child development and wellbeing, to promote the care of vulnerable children as a professional endeavour. To achieve the shift the Commission recommends the appointment of allied health professional (AHP) or professional officer (PO) stream employees as supervisors, above senior youth workers. The AHP stream is the one used by Families SA to employ social workers and requires a degree qualification. The PO stream is not widely used within Families SA but is utilised to employ people with a broader range of qualifications, although it also requires at the minimum a degree. If this recommendation were implemented, senior youth workers would be required to assume a greater responsibility for operational tasks such as rostering and administration to permit supervisors to engage with the development and care needs of the children.

Supervisors appointed at the AHP or PO classifications should be able to demonstrate a knowledge of child development. The McCoolle case study identified significant gaps in the capacity of the Agency to understand the significance of information about the behaviour of children in residential care. The primary focus of supervisors should be the therapeutic care of children, including tracking information about their experiences and behaviour in care. Their purpose should be to obtain an accurate picture of the child's psychosocial status, to identify any behavioural concerns and coordinate their observations with the district office, psychological services and youth workers to tailor a consistent, cohesive response. Where concerns held by residential care staff about children are not being addressed, supervisors should raise the issue with the district office, and where necessary, with other services.

The change in the supervisor function would mean additional responsibilities for senior youth workers, including the authority for some routine decisions. In long-established care teams, where youth workers understand a child's care needs and background, it would be appropriate to reflect their greater understanding by granting them authority to make decisions about certain day-to-day activities. This would help overcome delays in decision making which can cause children to miss out on opportunities.

The McCoolle case study demonstrated significant distrust and organisational dysfunction within the residential care directorate. Evidence heard by the Commission about the conduct of some senior staff cast doubt on their ongoing suitability for employment in a role caring for vulnerable children. While the behaviour of a number of staff members failed to meet the standards that should apply to such important work, the Commission is obliged to refer in particular to the conduct of Katherine Decoster, Shane Sterzl and Lee Norman, and recommend that the Agency consider their conduct, as described in the case study, against the relevant ethical standards and consider what, if any, action should be taken with respect to them.

Apart from these individuals, the Commission observed a number of occasions when staff were discouraged from raising concerns. There was a pervasive perception held at a senior level that concerns about inappropriate conduct by one staff member towards another, including bullying, racist jokes and sexist conduct, could be dealt with by 'mediation'. This meant the staff member making the complaint had to come face to face with the other in an attempt to resolve the issue. This was applied even in situations where significant power imbalances existed, and had the effect of dissuading staff from voicing complaints when they were not prepared to engage in such a process. This was especially so where concerns were genuinely performance or disciplinary matters, and not appropriate for a 'mediated' response.

An open door policy should be promoted at all levels of management to encourage staff to raise legitimate concerns about the behaviour of colleagues and the wellbeing of children. While there is a role for mediation, it is an unsuitable mechanism for dealing with allegations of inappropriate workplace conduct. Policy and procedure should make it clear that raising concerns about the conduct of other carers is a condition of employment, and that staff should err on the side of reporting. There should be a clear process for a worker to make a complaint or report the conduct of other workers. Such a process must support workers who wish to complain to senior staff outside their usual reporting lines.

TRACKING THE BEHAVIOUR OF WORKERS

During the course of the McCoolle case study it became apparent that there are a number of ways in which information about the conduct of a worker is recorded, but there is no system to bring together or analyse that information. Observations about McCoolle's conduct were potentially available from care concern reports, supervision records, complaints about him from fellow workers to supervisors, and critical incident reports. Had all these sources been formalised and analysed, it is *possible* that the themes identified by the Commission might have been identified during the time he was employed.

This chapter has already considered the need to ensure that workers report observations of their colleagues that concern them, and the need to reform the quality of recording critical incident reports. Information from all sources should be compiled in a single location, with staff specifically tasked with tracking and monitoring workers who are identified as potentially problematic, or who justify close enquiry.

The Commission recommends that a unit be established either within the residential care directorate or in the HR services unit to bring together information about employees and contracted staff working in rotational care (both emergency and residential). This unit must also be freely accessible to staff and contracted carers who wish to share concerns but who feel constrained from doing so within their direct lines of management. Evidence in the McCoolle case study highlighted the existence of multiple barriers to workers raising complaints, not the least of which was a lack of clarity about the appropriate pathway.

This unit should track matters relevant to employees of the Agency and workers who are contracted through commercial agencies. The registration of these workers discussed earlier should simplify this process.

To bring together all the different information which should flow into this unit, the Commission recommends that the Agency invest in software that facilitates the capture of care concerns, critical incident reports, concerns reported by colleagues and other sources of information. As an example, a program currently in use by SA Police, IA Pro, provides suitable recording, tracking and reporting functionality. The Commission was impressed by the functionality of this program, and its potential applications in child protection.

In the course of analysing data, this unit should also conduct regular audits of reports on the use of force against children in residential care facilities, to ensure compliance with the Family and Community Services Regulations.

THERAPEUTIC CARE

The CISC Inquiry recommended that therapeutic and other intensive services be developed as a matter of urgency for children in care who abscond. It further recommended the establishment of a group of care workers with suitable training and experience to deliver intensive therapeutic services for children with complex needs who frequently abscond from placements, and the engagement of a team to examine the benefits of establishing a specific therapeutic intervention program to identify, assess, assist and treat children at high risk.²⁸³

At the time, it was recognised by the government that there were children in care with complex needs who required greater therapeutic support. The development and implementation of initiatives which expanded the therapeutic component in care services, such as residential care, were also under consideration at that time. The CISC Inquiry noted the need to adequately resource, monitor and evaluate such programs, in order for them to be effective:

*Evidence to the Inquiry establishes, without question, that there should be a range of placement options for each child and young person in state care. Each should be placed in the most suitable option available.*²⁸⁴

Notwithstanding this recommendation, therapeutic services have not been developed consistently.²⁸⁵ Families SA has attempted, with varying success, to provide intensive therapeutic care to a small number of children with high needs. This has included establishing a relatively stable workforce in some placements, and locating a social worker at the house where care was provided. Training and support was provided by psychological services and psychologists attended meetings to discuss progress.²⁸⁶ Care has been provided to one or two children at a time, with variable

outcomes. Some children found the process intense and frightening.²⁸⁷ Despite this model having been used in the past, its current availability, and how such a placement might be obtained for a child or young person with high needs, was not clearly apparent (see also Volume 2, Case Study 3: Nathan).²⁸⁸

THEORIES AND MODES OF THERAPEUTIC RESIDENTIAL CARE

Care provision within Australia can be generally categorised as 'standard' and 'therapeutic'. The distinction lies in the ideology of care and the practical aspects of the daily care of children. There is no single model or mode of therapeutic residential care. A definition which continues to inform practice is that therapeutic care is:

*intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.*²⁸⁹

What is meant by working 'therapeutically' with children is not well defined and is left to the interpretation of those who work with children.²⁹⁰ There is also debate on the reference to the care being 'time limited' given the length of time many children and young people remain in residential care.²⁹¹

A report prepared by the Australian Centre for Child Protection (ACCP) for the Commission provides an analysis of overseas and Australian use of therapeutic care and a review of relevant literature. This report has informed much of the Commission's consideration of therapeutic care.

The bulk of published research has been conducted in international residential treatment programs, which are generally delivered very differently to therapeutic care in Australia. Residential treatment programs in North America, in particular, tend to be delivered in large facilities or clusters of satellite homes, supported by multidisciplinary services and guided by a program of intervention. The focus is generally on time-limited interventions, and services aim to support the child and their family or wider network. Australian models of therapeutic residential care relate to models of group care, which are tailored to meet the needs of children who have experienced trauma, abuse and removal from family of origin. Practice frameworks in Australia which guide services are not strictly 'models of care'; rather they are broad therapeutic frameworks which address organisational culture and guide individual practice.²⁹²

Notwithstanding the differences in the models, adoption of some of the characteristics of residential treatment care models would improve the quality of care being delivered in residential care. Relevant literature supports the following conclusions²⁹³:

- Success of residential care is related to matching interventions to properly assessed needs; however, much more work needs to be done to determine what works for whom.
- Long-term effectiveness appears related to the capacity of the service to engage with the child's support network. Consideration of how to engage with a child's family and other supports, including those situations where returning the child to their biological parents is not contemplated, will be a challenge in residential care settings, particularly where parental abuse or neglect has occurred.
- The impact of any residential program may be time limited, unless ongoing support is provided. Program design should therefore consider ongoing contact with program staff and post-care support.

The ACCP suggests that exploring the potential for larger congregate care models, as opposed to houses, may help to develop a broader range of models for children in out-of-home care.²⁹⁴ The Commission cautions against developing such models based on the present structure of large units within the state. While it is conceivable that, in the future, such models might be appropriate to meet the therapeutic needs of specific groups of children, add-on therapeutic care under the present structure would not resolve the present issues experienced in large residential care units.

THERAPEUTIC RESIDENTIAL CARE IN AUSTRALIA

Since 2008 Victoria has provided therapeutic residential care to children with intermediate or complex needs. In contrast to South Australia, non-government organisations provide the majority of residential care in Victoria. Additional funding is provided to NGOs for each therapeutic residential care placement to fund additional staff, and published guidelines set out comprehensive practice expectations. Carers are required to have or obtain minimum qualifications and receive core training. Therapeutic specialists are employed in the residential environment and provide assessment and therapeutic plans for children and support for staff in maintaining therapeutic responses to children. Therapeutic plans provide for the involvement of the service provider and other government agencies. Referrals to placement are initiated by a panel process.²⁹⁵

The Victorian system is worthy of consideration as it appears to be the only Australian model that has been evaluated against standard residential care. A review of therapeutic care pilot sites in Victoria conducted in 2011 suggested that the presence of a therapeutic specialist and increased staffing were important in developing quality relationships with children. The report noted positive signs for improved placement stability and engagement with community, as well as progress towards case planning goals, when compared with standard residential care. A reduction in risk taking and secure care admissions was also noted.²⁹⁶

The report's cost analysis indicated that the additional cost involved in a therapeutic residential care placement was likely justified when considering longer term outcomes for children. A report of the Victorian Auditor General in 2014 came to a similar conclusion.²⁹⁷

In Australia two frameworks have been most influential in shaping practice and policy: the Sanctuary® and Children and Residential Experiences Model (CARE) models. There is limited evidence evaluating either model. The Sanctuary model aims to create a trauma-informed and sensitive organisational environment within which specific trauma-focused interventions can be delivered. Importantly, it aims to develop an organisational culture in which staff teach important skills, but also model those skills in their interactions with children.²⁹⁸ The CARE model is a practice framework which focuses on organisational competencies and consistency across team members in the way in which they understand and respond to children's behaviours. It aims to strengthen attachments, build competencies, involve families in children's care, enrich environments, and enable staff to adjust their expectations to take into account children's development and experience of trauma.²⁹⁹

Thus while there is an absence of comprehensive evaluative data establishing the effectiveness of intensive therapeutic care service provision within the Australian context, there are indicators that therapeutic care can achieve positive outcomes. There is currently insufficient evidence to distinguish between the two models in terms of their effectiveness. It may be that having a clear model of practice is as important as the particular model that is selected.³⁰⁰

Both models³⁰¹:

- address organisational culture and advocate agency wide change in knowledge, attitudes and behaviour towards children;
- recognise that children have suffered a variety of traumatic experiences, and focus on staff developing a common understanding of the reasons behind behaviour, rather than simply responding to the behaviour itself;

- focus on the development of competencies through strategies that are developmentally appropriate; and
- offer extensive training to develop common understandings of children's challenges.

CONSIDERATION OF THERAPEUTIC CARE IN SOUTH AUSTRALIA

The Layton Review recommended that a range of flexible care options be developed for children and young people who were in care. Recommendation 14 stated that 'placement services must include specialised professional care options particularly for children and young people who have significant needs'.³⁰²

In 2012, when therapeutic residential care was a relatively new concept, the Agency proposed a specialised residential care model that involved a focus on tailored care, with service provision delivered according to individual needs. It was considered particularly appropriate for children with physical, mental or intellectual disabilities. The proposal noted that 'the number of children and young people with complex and/or extreme levels of need entering out-of-home care is escalating and therefore the need to develop more effective and proactive specialised delivery models is increasing'.³⁰³

Provision of therapeutic services also formed part of the Agency's planning for residential care in the Nation Building program. A differentiated system was envisaged comprised of an assessment unit as well as streamed services that included therapeutic residential care offering clinical support from experienced practitioners and youth workers. The streamed system recognises that children will have variable durations of care depending on the identified aim of their stay: for some the targeted support would allow children to return to their family; for others long-term care will be appropriate. This model was strongly supported by Dana Shen, the former director of residential care.³⁰⁴

A 2014 recommendations paper which considered the future of residential care built on these ideas. It proposed reducing commercial care, creating induction and assessment units for short-term care, and subsequently matching children with home-based placements. Where longer term placement within residential care was appropriate, a streamed model of care was proposed. The model anticipated differentiated services matched to the needs of children with physical health, mental health, disability and behavioural problems.³⁰⁵

THE NEED FOR A THERAPEUTIC FRAMEWORK

The absence of a model or framework of therapeutic care in South Australia has resulted in carers relying on their own experience and preferences, or learning on the job from other carers. As many carers do not have

a high level of knowledge about caring for children with trauma behaviours, variation in styles with disparate and inconsistent practices within and between facilities is evident. In the absence of overarching principles it can be difficult for staff to assess the appropriateness of some conduct towards children. Differences of opinion can arise, which are adjudicated by senior staff based on their own personal preferences or styles of care. Inconsistency is confusing for children and undermines stability. Inconsistency can also be exploited by abusers who seek to normalise conduct which is questioned.

A therapeutic framework should provide a theoretical background for all care decisions, to improve consistency and reduce reliance on individual philosophies. The framework should provide the added benefit of establishing a solid basis for the supervision and performance management of workers who do not follow the endorsed approach.

A framework should be applied in all facilities providing residential care to children in care: its application should not be restricted to facilities which care for children with high needs. A framework which promotes consistency, a growth in knowledge, and a more sophisticated understanding of, and response to, behavioural challenges is relevant to the entire directorate.

A model of therapeutic care should provide:

- services within a homely environment;
- multidisciplinary staffing at a level that permits effective application of therapeutic principles;
- structures to promote interdisciplinary engagement, including caseworkers, psychological services and external services such as education, police and health;
- consultation and engagement about the construction, implementation and review of a child's therapeutic plan;
- strategies to engage other adults who are important to the child;
- a means to evaluate the service's effectiveness.

STREAMED SERVICES

The Commission understands that the Agency is currently considering a restructure of the residential care directorate, including the development of specialised therapeutic care facilities which house small numbers of complex young people.³⁰⁶ Three streams of care are proposed:

- short-term assessment over eight weeks. Assessment would include the viability of reunification with parents where appropriate;
- care for children on long-term guardianship orders, who are assessed as complexity levels 1 and 2 (according to the complexity assessment tool which is described in greater detail in Chapter 10); and

- care for children with high needs, whether physical, psychological or behavioural.

The current proposals do not rely on large residential care units as long-term homes for children and young people. The new model envisages no children under the age of 10 housed in residential care.

These proposals are appropriate and well informed. However, it will take a great deal of commitment and political will to implement the model.

To ensure that children and young people in residential care are kept safe it is most important to match them to the facilities, including the other residents. Children should not be placed in homes on the basis of the staffing levels that are available; rather, staffing levels should be determined on the basis of the needs of the children in that facility. The current situation which exists in large residential care units, where complex young people are grouped together for ease of management and efficiency of staff deployment, should not be permitted to continue.

A therapeutic framework, once selected, should be applied across all three streams of care. The Commission recognises that all children and young people living in residential care facilities will benefit from a consistent therapeutic approach.

STRUCTURAL REFORMS

The management and supervision of residential and emergency facilities is currently spread across different divisions of the Agency. Control of all residential facilities, and the management of emergency care placements, should be centralised within the residential care directorate to allow consistent management, oversight and supervision of all forms of rotational care.

In the course of the McCoole case study, evidence was given about a 'build, own, operate and transfer' model (BOOT), which was a condition of the approval which was granted to hire residential care staff to the Nation Building project. The BOOT proposal required the Nation Building service to be built, operated, and then transferred to the non-government sector once an appropriate candidate had been identified. The Commission does not support this plan. The residential care directorate requires extensive reform to stabilise and upskill the workforce. It needs substantial attention to address the toxic organisational culture and establish enforceable and consistent performance requirements. The serious process of reform cannot be accomplished if the endeavour is seen as temporary. The provision of residential care requires skill, experience and close oversight. For the foreseeable future, this should be done from within government.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

A necessary corollary of this position is that the directorate should continue efforts to build a stable long-term workforce in residential care. The implementation of differentiated services, and the adoption of therapeutic models of care and secure care, will continue to require a highly skilled, stable and knowledgeable workforce.

MEASURING OUTCOMES

The Agency should also commit to developing and implementing outcome measures for children who live in residential care.³⁰⁷ The Commission recommends that the Agency consult with a credible research body to identify appropriate criteria against which to measure the effectiveness of reform efforts. These measures should concentrate on outcomes for children who live in residential care. In particular, consideration should be given to achieving consistency between outcomes measured by the Agency and those measured as part of monitoring the 'Outcomes Framework'³⁰⁸ and any interstate residential care services which engage in similar monitoring, to permit data to be compared across populations. This process would place the Agency in a better position to monitor the wellbeing of children in residential care and to assess the efficacy of programs.

ACHIEVING HIGH RELIABILITY

The arrest and prosecution of Shannon McCoolle highlighted the vulnerability of young children in residential care to sexual abuse. The Commission's enquiries have demonstrated that no single failing enabled McCoolle to offend in such a devastating way. There is no simple remedy to address the overall risk of sexual abuse in residential care. The system should be structured and staffed by people who understand the importance of ongoing, vigilant observation, informed by knowledge about sexual abuse, trauma, child development and child behaviour.

The problems facing children in residential care go far beyond the risk posed by McCoolle. Some two years after McCoolle's arrest, and despite attempts by the directorate to address a number of the issues identified, children in residential care are still at risk of harm in the system that has been entrusted to care for them.

While the reforms discussed in this chapter should improve the safety of the residential care environment, ultimately it is the quality of staff who are engaged to care for children that will provide the greatest deterrent to adults who seek to prey on vulnerable children in their care.

Organisations that are structured and managed so as to prioritise the safety of children have been referred to as 'high reliability' organisations. They:

share a fundamental belief that mistakes will happen and their goal is to spot them quickly. They encourage an open culture where people can discuss difficult judgements and report mistakes so that the organisation can learn. Organisations seeking to be safe places for children must encourage frequent, open and supportive supervision of staff to help counteract the difficulties people face in making sense of ambiguous information about colleagues. A shared acknowledgement of how difficult it can be to detect and respond effectively to abuse contributes to a culture that keeps the issue high on the agenda.³⁰⁹

Organisational change to recast the residential care directorate as a high reliability organisation should be prioritised. It is essential that this occur to protect those most vulnerable children who the state has taken into its own care. The offending by McCoolle was of a gravity beyond what could have been contemplated by the Agency. However, it cannot be assumed that it was a one-off. The system must protect against its reoccurrence.

SECURE THERAPEUTIC CARE

Secure therapeutic care is a model of care that generally involves the statutory confinement of children in care who are at significant and substantial risk of harm either to themselves or others. This form of care aims to address the therapeutic needs of such children where they are unable to be addressed in a less intensive environment. Children are placed in secure therapeutic care for a period of time during which they receive intensive therapy to address their underlying issues.

The model is generally aimed at children and young people in care with complex needs who:

- place themselves and/or others at significant risk of harm;
- abscond on a regular basis, placing themselves at risk;
- have complex trauma symptoms and behaviours;
- undertake risk taking behaviour that results in serious abuse and exploitation, in particular sexual exploitation; and
- abscond from placements, meaning it is not possible to address their underlying trauma or attachment problems with therapy.

The needs of this group of children vary. They may include issues such as mental health concerns, cognitive impairment, neuro-disabilities (such as foetal alcohol spectrum disorder), communication disorders and learning disabilities, or any combination of these.

The key feature of *secure* therapeutic care as opposed to other forms of therapeutic care is the restriction of a child's liberty. This aspect of it has made the use of secure therapeutic care a controversial topic in South Australia for some years.

In 2003 the Layton Review recognised a cohort of 'young people caught in a vicious cycle of drug addiction, sex abuse and prostitution ... [who] needed a place where they could be taken to have a chance to 'dry out' and assess their future lives with professional assistance'. The Layton Review identified a need for therapeutic safe-keeping with secure short-term accommodation and appropriate services, acknowledging that 'safe-keeping arrangements are a significant and intensive interaction' but for some young people, there were no other effective options. As a result, secure therapeutic care was recommended.³¹⁰ This recommendation was not implemented.

In 2008, the CISC Inquiry identified a similar need.³¹¹ In considering the question of a secure facility, the views of the Agency were sought. The Agency informed the CISC Inquiry it had considered such a model at different times but was currently 'working to identify a suite of services and system changes required to provide stability and certainty for children who may be an ongoing risk as runaways'. The response further stated that:

*once an adequate suite of prevention-focused therapeutic support and placement options is in place, we will be better positioned to consider any potential role that an intensive short-term mandated treatment model could play as a part of a continuum of responses.*³¹²

The Agency's preferred option was to 'enhance and improve current systems, inter-agency accountability, service delivery models and multidisciplinary approaches to address the complex needs of the children'.³¹³

Nonetheless, the CISC Inquiry recommended a secure therapeutic care facility. The recommendation was initially supported by the government. In 2010 a change of mind followed advice from GCYP and the development of a secure therapeutic care facility was abandoned.

Instead the government indicated that a number of other strategies would be developed to protect children, including³¹⁴:

- improved intensive therapeutic services for children in existing residential and home-based care, including those in youth training centres;

- protective behaviour training and sexual health education available to all residents of residential facilities; and
- an amendment to the *Summary Procedure Act 1921* (SA) to restrain adults who exploit children by offering them shelter, drugs or other goods in return for sexual services.

Of these three strategies highlighted by the government only the legislative change to provide for written directions has been actioned.³¹⁵ Protective behaviours training and sexual health education have not been provided. While a small number of places have been created for intensive therapeutic care, therapeutic care services have not been improved to the required level.

In South Australia children and young people are held in a secure setting only for youth justice and mental health purposes.

The Adelaide Youth Training Centre (AYTC) is a facility for the detention of children and young people who have come into contact with the criminal justice system. A sentence of detention can only be imposed in very limited circumstances, such as where the child or youth is a recidivist offender, a serious firearm offender, or one for whom the court is satisfied a non-custodial sentence would be inadequate because of the gravity or circumstances of the offence, or because the offence is part of a pattern of repeated offending.³¹⁶

Boylan Ward (part of the Women's and Children's Hospital) is a 12-bed mental health facility for children and young people. While it is not a secure unit, a young person subject to an involuntary treatment order may be held securely.³¹⁷ The ward's focus is to provide inpatient services for young people who are experiencing the early stages of a psychotic illness, suffering severe mental disorder (including depression) with a suicidal component, or have complex and coexisting disorders requiring multiple assessments and specialised care.

Secure therapeutic care models currently operate in New South Wales, Western Australia, the Northern Territory and Victoria to meet the needs of children whose safety and therapeutic needs cannot be met in any other way. Each of the models operates slightly differently although there are some common themes.³¹⁸

While Queensland does not operate a secure therapeutic facility, the 2013 Child Protection Commission of Inquiry in Queensland recognised the need for such a facility and recommended the development of a model when finances permitted.

THE NEED IN SOUTH AUSTRALIA

Evidence before the Commission indicates that the need for secure therapeutic care, identified by the Layton Review in 2004 and the CISC Inquiry in 2008, still exists.³¹⁹ Witnesses reported that the needs of a particularly complex group of children remain unmet.³²⁰

The evidence suggests that the size and complexity of this cohort of children has increased since the CISC Inquiry.³²¹ The Agency's Director of Quality and Practice, Sue Macdonald, acknowledged that the danger is 'off the scale' for some children. The inability to contain these children and young people is an ongoing challenge to the system, not only for Families SA but also for SA Health.³²²

INAPPROPRIATE USE OF THE ADELAIDE YOUTH TRAINING CENTRE

The Commission understands that high-risk children sometimes engage in offending behaviour with the aim of being detained in the AYTC. Some children feel safer in the contained environment that it provides.³²³ In the Nathan case study, the Commission became aware that Nathan had repeatedly expressed the view that he would rather be at AYTC than his residential care unit. In the opinion of Claire Simmons, a principal clinical psychologist, this was because he knew he could not keep himself safe and wanted someone else to take that responsibility.³²⁴

It is a matter of concern that children are indulging in criminal offending to find safety. These children are at risk of developing recidivist criminal behaviours and becoming institutionalised. Detention of children in AYTC provides short-term safety, but no long-term solution, nor does it help a child to resolve underlying issues. Failure to provide more appropriate alternative environments for these children perpetuates the disadvantages they face.

CHILDREN IN NEED OF SECURE THERAPEUTIC CARE

Some children desperately need intensive therapeutic care, but the intensity associated with that process is challenging. Ms Simmons described:

*[a] cohort of children [who] ... abscond because they are frightened ... of a relationship with anyone, so ... [without] the capacity to contain them, you can't work with them because they're simply not there.*³²⁵

Children who have experienced significant abuse in their home environment can find being in a home-type placement painful and run away.³²⁶ One child who was placed in intensive therapeutic care remained four nights out of 65. While therapeutic services were available, her persistent absconding prevented her benefiting from services to address her underlying trauma issues. While absent the child was placing herself at risk through drug taking, prostitution, association with outlaw motorcycle criminal gangs, and engaging in criminal activity

including threatening to harm others. Staff were at a loss as to how to keep the child safe when no alternatives were available.³²⁷ This child's circumstances are not unique.

A CAUTIOUS APPROACH

Secure therapeutic care is not without controversy. While some witnesses identified the need for secure care in carefully identified circumstances as a last resort, others were not convinced.³²⁸ Many people highlighted the need for caution and careful consideration. Some emphasised that if a secure therapeutic care service were developed it would need to be well resourced and purpose built, and provide adequate therapeutic services as well as a suite of step-up and step-down services (flexible levels of care according to need). One witness thought that 'entry, maintenance and exit of children with the facility should sit separately to Families SA'.³²⁹

In terms of step-up and step-down services, the Commission heard evidence highlighting the lack of services for the drug and alcohol problems experienced by children and young people in care. In particular there is no drug and alcohol detoxification service available to adolescents.³³⁰

A cautious approach is needed. Secure therapeutic care is resource intensive and without a planned and structured approach, with clear guidelines and principles, it could easily be abused.

Ms Macdonald told the Commission that any secure therapeutic care model would need to be chosen carefully, with oversight which ensured that children were not allowed to drift. Further, it would need to admit children for a sufficient time to be able to address entrenched issues. It should not be used simply as a circuit breaker and it should deliver an appropriate therapeutic service.³³¹

SECURE THERAPEUTIC CARE IN SOUTH AUSTRALIA

A report prepared by Dr Sara McLean, based at the Australian Centre for Child Protection has informed the Commission's consideration of secure therapeutic care in the child protection system. Dr McLean concludes that there is a 'paucity of evidence about the effectiveness and the practice parameters of secure care, despite anecdotal support for its use'.³³² While acknowledging the paucity of evidence, the Commission is mindful of the urgent circumstances that a number of children and young people find themselves in, and the absence of any other effective options.

The Commission recommends that a secure therapeutic care model and facility be established in South Australia for children in care. The Commission is mindful of the costs involved, but considers there is a demonstrated need for such a service.

The service's creation and implementation would require careful consideration. It should be flexible enough to meet the needs of children who are at risk from a variety of factors and should be part of a suite of options available for children in care, with appropriate and well-resourced step-up and step-down services. These may include semi-secure care, mental health facilities and outreach programs, and specialised flexible foster placements. The aim is to help children to reintegrate without overwhelming them.

Secure therapeutic care would provide the most intensive model of care available and be supported by streamed residential care services, all operating under a consistent therapeutic model of care.

A number of key messages are highlighted in Dr McLean's report that should guide the design of a model³³³:

- Children placed in secure care are likely to have complex needs, including communication disorders, mental health disorders, post-traumatic stress disorder, neuro-disabilities and learning disabilities.
- Its effectiveness will depend on the quality of therapeutic input, skilled interactions with staff and transition planning.
- The model should include:
 - positive relationships between staff and young people;
 - an ability to match therapeutic input to client needs;
 - significant input from mental health services;
 - the capacity to engage children with services for long enough to benefit; and
 - appropriate and comprehensive transition planning.

In addition to these considerations, the Commission has also identified a need for a drug and alcohol service for adolescents as part of the streamed model of care (including detoxification services).

GOVERNANCE

There is potential for abuse of a secure therapeutic care model, and strong external oversight is necessary. The best way to achieve oversight is to place decision making in the hands of the Judiciary. In New South Wales, applications must be made to the Supreme Court, while in Victoria and Western Australia the Children's Court determines applications.

The commission favours the NSW approach. An application is made to the Supreme Court and the length of the stay is determined by the court. Typically a one-week order is initially made, allowing time for more intensive assessment and the gathering of additional

evidence.³³⁴ The decision to restrict a child or young person's liberty in these circumstances is one that should have high level oversight. It is not appropriate to place oversight with the Youth Court jurisdiction which also hears and responds to criminal charges, and may lead children and young people to think the process is a punitive one.

The legislative framework for this state should require application to the Supreme Court of South Australia before an admission. The length of admission should be governed by the court (subject to a maximum prescribed by legislation), with regular judicial reviews to oversee the effectiveness of the orders.

As part of the application process evidence should satisfy the court that a service is available to meet the needs of the child while in secure therapeutic care. A case plan should outline the following matters:

- the reason and purpose of admission;
- the case plan; and
- the plan for transitioning the child back into the community using step-down services.

TIMING AND DURATION OF SECURE THERAPEUTIC CARE

Careful consideration should be given to the circumstances in which a child is placed in secure therapeutic care. In some jurisdictions it is used as a last resort. However, this approach raises the risk of dangerous behaviours continuing while other inappropriate options are explored, and may mean the opportunity to provide worthwhile therapeutic intervention is lost. The appropriate test should be whether secure therapeutic care is the most appropriate option available to the child, weighing up the risk of harm to the child if there is no intervention versus the seriousness of restricting the child's liberty.

The available length of admission varies across Australia. Longer term programs are often required to respond to such issues as mental health, disability and social needs.³³⁵ Children should be admitted for a sufficient time to address any of these underlying concerns.³³⁶

CHILD'S RIGHTS

Secure therapeutic care must grapple with the tension between a child's right to freedom and self-determination and the need for the state to take appropriate steps to protect them from danger and aid their psychological recovery.

If a child elects or wishes to be placed in secure therapeutic care and this is supported by the Agency, the application process should follow the same path as an involuntary application. The Supreme Court should make the decision and provide continuous oversight.

The representation of children subject to an application should also be considered. Children should be provided independent legal representation which is free of charge throughout the period of the order. They should also be able to contact their legal representative and/or GCYP at any time during the period of the order.

OTHER CONSIDERATIONS

Delivering therapeutic services is a crucial part of the secure therapeutic care model. A high level of inter-agency cooperation between the Agency and service providers such as SA Health and Education is required to deliver services.

Dr McLean reports that staff who adopt a wellbeing oriented approach to working with young people are more likely to be effective than those who adopt a punitive approach.³³⁷ She maintains that knowledge about child development, family dynamics, conflict resolution and responses to challenging behaviour arising from trauma and disability are important.³³⁸ Staff should have specialist skills in these areas. A model of secure care should in no way be conceived as a punitive response.

Staff should be able to draw on the expertise of others as required. Youth workers will need to be highly trained with regular ongoing professional development and supervision. They will need to work closely with and be supervised by professionals across a variety of areas, including mental health, trauma, social work and education.

EVALUATION OF THE MODEL

Any secure therapeutic care model which is established should be regularly evaluated against key performance indicators that measure outcomes for children. The model should be constantly assessed against evidence provided by such evaluations.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

128 Phase out the use of commercial carers in any rotational care arrangements except in genuine short-term emergencies. 129 Review service agreements with commercial agencies who supply emergency care staff to: a require the commercial agency to develop job and person specification and selection criteria which must be approved by Families SA; b prohibit workers from undertaking shifts through more than one commercial care agency at a time when engaged by Families SA to look after children in care. This includes a prohibition on undertaking shifts for a commercial care agency at the same time as undertaking shifts for Families SA; c require commercial care workers to be registered and approved by Families SA before their employment begins; and d require commercial agencies to report any information that reflects on the suitability of a care worker, to initiate tracking via the system outlined at Recommendation 142. 130 Provide Families SA staff who work with commercial carers with access to relevant portions of service agreements to clarify work expectations and specific conditions of engagement. 131 Provide the residential care directorate with sole responsibility for engaging, supervising and supporting emergency care placements. 132 Forthwith abandon single-handed shifts by commercial carers engaged through commercial agencies. 133 Reform the manner in which the use of force against children in residential care facilities is recorded and tracked by: a amending regulation 14 of the Family and Community Services Regulations to require any worker who participates in or witnesses an incident involving or leading to the use of force against a child to verify the accuracy of the written report of the incident or, in the alternative, where the accuracy of the	written report is not verified, provide an independent written account with respect to the incident; b amending the pro forma of the report to clarify the requirements of regulation 14(3); c requiring supervisors to reject any report that does not comply with regulation 14(3) in the absence of any adequate explanation for non-compliance. If a non-compliant report is accepted, the supervisor should specify the reason for acceptance in the absence of compliance; and d regularly audit reports to ensure compliance with the regulations. 134 Amend section 56 of the <i>Family and Community Services Act 1972</i> to extend the operation of the section to children in all facilities (including emergency care) established by the Minister, and develop a specific and identifiable pathway to enable a child to make a complaint to the Chief Executive pursuant to that section. 135 Require the Chief Executive to provide a quarterly report to the Guardian for Children and Young People (GCYP) and the Minister with respect to the number of complaints received, and any recurring themes which emerge from those reports. 136 Request GCYP to develop an education program for children in facilities run by the Agency or non-government organisations (emergency and residential) to explain and promote their rights pursuant to regulation 14(3) of the Family and Community Services Regulations 2009 and section 56 of the <i>Family and Community Services Act 1972</i>. 137 Legislate to provide for the development of a community visitors' scheme for children in all residential and emergency care facilities. 138 Recruit child and youth support workers in accordance with the 2016 recruitment model, including a requirement that all applicants for those positions undergo individual psychological assessment. 139 Require all new child and youth support workers to complete a minimum six-month probationary period, to be followed by a rigorous performance review before approval for further employment.

RECOMMENDATIONS

140 Require all child and youth support workers to complete ongoing professional development and training, particularly in the following areas: - a the dynamics of abuse in institutional environments; - b understanding children who are at risk from institutional environments; - c the way in which children react and respond to abuse; - d how to respond to children whose behaviour or statements may indicate the possibility of abuse; and - e the early years child development, and caring for infants and young children (for selected workers).	143 Create a specific unit and database to receive and track information about the conduct of staff from: - a care concerns; - b critical incident reports; - c information from other staff; and - d complaints made by children. This process should apply to staff employed by the directorate and those engaged through commercial agencies. Staff should be permitted to provide information directly to that unit.
141 Review and clarify policies that guide the behaviour of workers, particularly in relation to: - a physical contact with children (to provide clear and unambiguous guidance); - b recording observations in observation logs; and - c reporting lines for information about the wellbeing of children.	144 Review the conduct of the specific staff identified in Volume 2, Case Study 5: Shannon McCooie and consider their ongoing suitability for employment in their role.
142 Develop a clear process for workers in the residential care directorate which: - a obliges workers to report any concerning behaviours from other workers, including those behaviours that do not necessarily meet the requirements for a mandatory report; - b obliges workers to report concerning behaviours from children in the absence of action by case management staff; and - c clarifies the availability of reporting pathways external to workers' immediate line of supervision.	145 Develop a streamed model of residential care with the following elements: - a short-term assessment; - b long-term care for children who are not suitable for home-based care; - c care for children with high therapeutic needs; and - d built-in measures of outcomes that can be used to evaluate performance of the model on a regular basis.
	146 Identify and adopt a model of therapeutic care which is sufficiently flexible to be applied across all categories of residential care, and which promotes a consistency of approach and standard of care for all children.
	147 Replace operational services (OPS) 5 supervisors in residential care with allied health professional (AHP) or professional officer (PO) degree qualified staff, and recast the job and person specification to focus on the provision of staff with high level expert knowledge.
	148 Ensure that all youth workers in residential care have regular supervision as a means to promote their professional development and, where necessary, manage deficits in their performance.

- 149** **Apply the following standards across residential care:**
- a** **no child under 10 years to be housed in a residential care facility except where necessary to keep a sibling group together; and**
 - b** **no child to be housed in a facility with more than four children, except where necessary to keep a sibling group together.**
- 150** **Recruit a sufficient complement of staff to:**
- a** **cease using commercial carers in residential care facilities;**
 - b** **develop a casual list to provide staff who are available on a flexible basis; and**
 - c** **abandon single-handed shifts.**
- 151** **Abandon any plan to outsource any residential or emergency care service that is currently delivered by the Agency.**
- 152** **Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.**

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

NOTES

- 1 Submission: Name withheld (S84).
- 2 Oral evidence: Name withheld (W61).
- 3 *Family and Community Services Act 1972*, s. 51(6).
- 4 *ibid.*, s. 51(4).
- 5 Guardian for Children and Young People (GCYP), 'Some things we heard from young people in residential care when we visited during 2013–2014', Office of the Guardian for Children and Young People, website, www.theguardian.sa.gov.au/2015/03/voices-of-young-people-from-residential-care/
- 6 Oral evidence: S Goss.
- 7 GCYP, *What children say about child protection and out of home care: A consultation report for the South Australian Child Protection Systems Royal Commission*, GCYP, Government of South Australia, October 2015, p. 30, www.agd.sa.gov.au/child-protection-systems-royal-commission
- 8 S Mares, 'Report for the Child Protection Systems Royal Commission: Shannon McCoole Case Study', unpublished document, 2016, p. 7.
- 9 GCYP, *What children say about child protection and out of home care*, p. 32.
- 10 Oral evidence: P O'Rourke.
- 11 Oral evidence: S Mares.
- 12 *ibid.*
- 13 C Pearce, 'Repairing attachments', *BACP Children and Young People*, December 2012, p. 28; C Pearce, 'An integration of theory, science and reflective clinical practice in the care and management of attachment-disordered children: A triple-A approach', *Educational & Child Psychology* 27, no. 3, 2010, pp. 73, 75.
- 14 Oral evidence: S Mares.
- 15 *ibid.*
- 16 S Mares, 'Report for the Child Protection Systems Royal Commission', p. 8.
- 17 Families SA, 'Nation Building houses relocation project', project brief, draft internal unpublished document, Government of South Australia, October 2010, p. 6.
- 18 Oral evidence: L Kelly.
- 19 Oral evidence: G Matschoss.
- 20 Oral evidence: N Stasiak.
- 21 Oral evidence: G Matschoss.
- 22 Oral evidence: Ms K (Vol. 2, Case Study 5: Shannon McCoole).
- 23 Oral evidence: J Walker. Submission: J Walker.
- 24 EP Mullighan, *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct*, Children in State Care (CISC) Commission of Inquiry, Adelaide, 2008, p. 399.
- 25 Oral evidence: J Walker.
- 26 GCYP, *Report on interim emergency care for children under guardianship*, 2015, p. 4, cfc-sa.org.au/wp-content/.../45_Interim-Emergency-Care-Public-Report-2015.pdf
- 27 Families SA, *Directions for alternative care in South Australia 2011–2015*, Government of South Australia, 2011, p. 8.
- 28 Submission: J Walker.
- 29 Oral evidence: G Matschoss.
- 30 *ibid.*
- 31 Oral evidence: Name withheld (W40).
- 32 Oral evidence: J Walker.
- 33 Submission: J Walker.
- 34 GCYP, *Report on interim emergency care*, p. 3.
- 35 EP Mullighan, *Children in State Care Commission of Inquiry*, p. 402.
- 36 GCYP, *Report on interim emergency care*, p. 6.
- 37 Oral evidence: S Turvey.
- 38 Oral evidence: Name withheld (W40).
- 39 S McDougall et al., *The implementation of recommendations made by independent child protection inquiries in South Australia: A report to the Child Protection Systems Royal Commission*, Australian Centre for Child Protection (ACCP), Adelaide, April 2016, www.agd.sa.gov.au/child-protection-systems-royal-commission. This report records that the government response largely satisfies the intent of the CISC Inquiry recommendation. The report does not refer to the continued placement of children in motels, serviced apartments and B&B accommodation. It is likely that the Commission has access to additional data not considered by the ACCP.
- 40 Oral evidence: N Stasiak.
- 41 Oral evidence: S Turvey.
- 42 Oral evidence: D Shen.
- 43 Oral evidence: J Creek; T Santillo.
- 44 Oral evidence: J Creek.
- 45 Oral evidence: S Turvey.
- 46 Oral evidence: A Abela.
- 47 Oral evidence: T Santillo.
- 48 *ibid.*
- 49 Oral evidence: Ms L (Vol. 2, Case Study 5: Shannon McCoole).
- 50 Oral evidence: S Turvey; L Kelly; T Santillo.
- 51 Oral evidence: T Santillo.
- 52 Oral evidence: S Turvey.
- 53 Oral evidence: S Turvey.
- 54 Oral evidence: G Matschoss.
- 55 *ibid.*
- 56 GCYP, *Report on interim emergency care*, p. 9.
- 57 Oral evidence: S Turvey; name withheld (W67).
- 58 Oral evidence: S Turvey.
- 59 Oral evidence: P Cross.
- 60 Oral evidence: D Shen; P Cross.
- 61 Oral evidence: Mr F (Vol. 2, Case Study 5: Shannon McCoole). M Yeoll, email to P Elliott, Subject: RE: Trainee, 26 November 2013; Families SA, 'July 2012 intake: Child & Youth Worker external OPS2: Summary', internal unpublished document, no date, p. 43.
- 62 Oral evidence: P Cross.
- 63 Oral evidence: Name withheld (W40).
- 64 *ibid.*
- 65 *ibid.*
- 66 *ibid.*; S Goss
- 67 For the methodology of the Commission's usual practice review see Appendix C
- 68 Oral evidence: Name withheld (W107).

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

- 69 J Rankine (Minister for Education and Child Development and Minister for Multicultural Affairs), *Highly trained Families SA staff boost—Helping our most vulnerable*, media release, Parliament House, Adelaide, 11 June 2013.
- 70 Oral evidence: Name withheld (W34).
- 71 Oral evidence: Name withheld (W59).
- 72 Oral evidence: Name withheld (W34).
- 73 DECD, Special Investigations Unit serious care concern investigation report, SIU/00427—C Norton, internal unpublished document, 9 January 2012.
- 74 *ibid.*
- 75 *ibid.*
- 76 Families SA, 'Adverse events review report—Jake and Nicholas Butler', internal unpublished document, 25 October 2011.
- 77 *ibid.*
- 78 Oral evidence: D Waterford.
- 79 Oral evidence: N Stasiak.
- 80 GCYP, *Report on interim emergency care*, p. 9.
- 81 Families SA, 'Residential care workforce review', internal unpublished document, 2014, p. 1.
- 82 Oral evidence: P Simmons.
- 83 EP Mullighan, *Children in State Care Commission of Inquiry*, p. 192.
- 84 Families SA, 'Reclaiming residential care: A positive placement option for children and young people', internal unpublished document, no date, p. 1.
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OVERVIEW

The importance of children being provided with stable and nurturing family relationships to support their wellbeing and future development is emphasised throughout this report. This chapter specifically examines the role and function of adoption and Other Person Guardianship (OPG) as options for the permanent care of children who cannot be safely cared for in their families of origin.

In South Australia, many children in care remain in foster, kinship or residential care placements long after it is clear that there is no chance of returning them to the care of their parents. In some instances, for example where a child's parents are deceased, acknowledgement of this will be swift. In other situations tension may arise between the child's best interests and a birth family's desire for reconciliation.

There is no doubt that care arrangements which provide stability, certainty and normalcy give children the best chance to meet their full potential. Placing decision-making power with families who know the child best, and who have day-to-day care for the child should be pursued wherever possible and safe.

In South Australia, there are two legal provisions that clarify family relationships and decision-making power and increase feelings of stability and belonging for a child. These are orders for OPG and orders for adoption.

It is evident that both options have been seriously neglected in South Australia. As a result, Families SA (the Agency) continues to retain responsibility for the monitoring and case management of some children who have become, for all intents and purposes, part of a new family. Many contributors to the Commission expressed disappointment that the Agency had not embraced these options to advance the interests of children in care.

In August 2015, the release of the Coroner's report into the death of Chloe Valentine brought the issue of adoption of children from the child protection system to the forefront of public debate. This debate has proceeded, at times, on the mistaken belief that the need to provide children requiring care with a loving and stable family can be met by matching those children with those families who wish to adopt a child. This fails to understand adoption as a mechanism to advance the best interests of the child by recognising and negotiating the relational complexities of their situation, as opposed to a means to satisfy the desire of adults to create or expand their families.

Adoption and OPG mechanisms should be engaged in a more systematic way to meet the needs of children for stability and certainty. Although these arrangements will not be suitable for every child, greater consideration

should be given to their potential to provide a safe home for those children who would benefit from such an opportunity.

This chapter principally relates to the Commission's Term of Reference 5(d), in the context of Terms of Reference 1 to 4.

ADOPTION RATES

Since the 1960s, adoption Australia wide has decreased steadily. In 2014/15 there were 292 adoptions registered across Australia, the lowest number on record, and a 74 per cent fall from 1142 in 1990/92.¹ The neglect of adoption as an option for children in care undoubtedly relates, at least in part, to issues arising out of the Stolen Generations as well as past practices of forced adoption.

Notwithstanding this general trend, in recent years there have been a growing number of adoptions of children from care. In particular, legislative changes in Western Australia and New South Wales have elevated the status of this kind of arrangement. During 2014/15 across Australia there were 94 adoptions by carers, the highest figure in a decade. Of these, 87 occurred in New South Wales.²

Amendments to the NSW *Children and Young Persons (Care and Protection) Act 1998* provide what has colloquially been described as 'fast track adoption'. The legislation states that where there is no realistic possibility of restoring a child to their biological parents within a period of six months for a child under two or 12 months for a child over two, then the permanency plan for that child's long-term placement must consider whether adoption is the preferred option.³ Those amendments did not receive universal support. Although Aboriginal children are exempted, concerns were expressed by some health, legal and community groups that making adoption easier risked creating a new generation of Stolen Children.

In South Australia only one 'known child adoption' occurred in 2014/15. That adoption was not necessarily by a carer, as 'known child adoption' includes adoptions by step-parents and other relatives outside the child protection system.⁴

Patricia Rayment and Claire Simmons, experienced clinical psychologists employed by Families SA, confirmed that adoption as a permanency option had been neglected in South Australia for many years. They argue that this neglect has:

effectively robbed children under the guardianship of the Minister of an option which would see them exit state care and be given the opportunity to belong to families throughout their life spans.⁵

They estimated that if adoption were supported in South Australia at a rate equivalent to that observed internationally, some 200 non-Aboriginal children in care might be able to leave the system.⁶

THE HALLAHAN REPORT

In January 2015 the South Australian Government commissioned Professor Lorna Hallahan to undertake an independent review of the *Adoption Act 1988*. She was tasked with considering the following issues⁷:

- adoption information vetoes
- adoption of a person over the age of 18 years
- retention of the child's birth name
- same sex couples adoption
- single person adoption
- discharge of adoption orders in certain circumstances
- adoption of children in care
- inter-country adoption.

Professor Hallahan's report (the report) makes a number of recommendations for changes to the Adoption Act and to consequential policies and practices. This chapter is only concerned with that part of the report which relates to the adoption of children in care.

The wide range of views on this topic that are cited in the report mirror submissions received and research undertaken by this Commission, with the dominant theme being that the rights of the child must be paramount, and the needs and best interests of the child must be prioritised.⁸

Section 9(1) of the Adoption Act (which defines 'adoption' in South Australia) provides that:

where an adoption order is made, the adopted child becomes in contemplation of law the child of the adoptive parents and ceases to be the child of any previous birth or adoptive parents.

In considering the relevant issues, Professor Hallahan applied a broader definition of adoption, taken from the Report of the Senate Committee into the Commonwealth Contribution to Former Forced Adoption Policies and Practices:

Adoption is a legal process by which a person becomes in law, a child of the adopting parents and ceases to be a child of the birth parents. All the legal consequences of parenthood are transferred from birth parents to the adoptive parents. The adopted child obtains a new birth certificate showing the adopters as the parents, and acquires rights of support and rights of inheritance from the adopting parents. The adopting parents acquire rights to guardianship

and custody of the child. Normally the child takes the adopters' surname. The birth parents cease to have any legal obligations towards the child and lose their rights to custody and guardianship. Inheritance rights between the child and the birth parents also disappear.⁹

BEST INTERESTS ARE PARAMOUNT

In discussing the issue of adoption generally, Professor Hallahan makes the point that adoption does not exist primarily for family formation, so the selection of adoptive parents cannot be based on the desire of some people to have children. It must be based on a profound understanding of the rights, needs, best interests and welfare of the child or children.¹⁰

Her report emphasises that in any adoption process the paramount consideration must be the best interests of the child. Professor Hallahan refers to Article 21 of the United Nations Convention on the Rights of the Child (UNCRC), which states that:

Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorised only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary¹¹

Professor Hallahan comments that adoption is:

*one of the possible options available to ensure that children receive the care to attend to their needs, interests and well-being... In adoption, Article 21 specifies that the best interests of the child must be 'the paramount consideration' whereas in Article 3, the best interests of the child is 'a primary' consideration. The paramountcy principle in Article 21 'establishes that no other interests whether economic, political, state security or those of the adopters should take precedence over, or be considered equal to, the child's' ... Archard (2003) elaborates on the distinction. A consideration that is to be paramount 'outranks and trumps' all other considerations and, in the context of adoption it means that the child's welfare and best interests are **the most important consideration** and must determine the outcome.*

Within the UNCRC 1990 while the best interests of children are the paramount consideration there is a presumption that children's best interests are served by the following:

- *Living with their biological parents where possible; however, adoption can only occur if parents are unwilling or unable to discharge their parental responsibility;*
- *Each potential adoption requires proper investigation and assessment with full reports 'by independent professionals to the authorities considering the adoption application';*
- *Children's rights must not be violated;*
- *Child's views must be inclusive of the process where possible which is in the spirit of the Convention; and*
- *Adopted children have the right to know that they are adopted and to know the identity of their biological parents.¹²*

Professor Hallahan discusses the research into outcomes for children adopted from care and those that compare adoption with other permanency options. She says that:

the studies suggest, unsurprisingly, that children fare better when they do not have prolonged exposure to highly inadequate parenting, poor living conditions, sustained neglect and abuse. They also fare better when their living arrangements are safe, stable and maintained over their childhood. Whether or not adoption adds that bit more that really helps a child settle and belong is not entirely clear. Early action is important, especially to reduce the impact of poor attachment, and cumulative harms and trauma along with birth-related developmental issues.¹³

and:

Any decision to proceed with adoption from care needs to be made with intensive assessment, a commitment to explore and exhaust other options without allowing drift to occur in the child's life and providing an opportunity for key family members, including the father if he is known, to have input into the decision. All this must occur within a commitment to preserve the safety of the child.

This approach to planning for long-term stable care and belonging for a child requires an approach to case recording, data keeping and sharing an internal communication within the child protection authority (Families SA) that is an expectation of professional practice, and facilitated within the department. An integrated case management approach that has highly trained social workers involved with the child and his/her world (including school), the child's family, foster carers, and other child and family support services

could produce a comprehensive plan to which all parties agree. This builds on the notion of surrounding the parent, child and foster carer with pre- and post-placement resources that enhance every opportunity for a placement to survive and thrive.¹⁴

PARENTAL CONSENT

The Act provides that an adoption order will not be made unless each person who is a parent or guardian of the child has consented to the adoption (whether the parent or guardian is present in Australia or not).¹⁵ While there may be some parents who are prepared to relinquish their rights and consent to the order for adoption, there are others who will be reluctant, even if the children have been removed from them due to their abuse or neglect. The Act provides for the dispensation of consent where it appears to the court¹⁶:

- (a) *That the person cannot, after reasonable inquiry, be found or identified; or*
- (b) *That the person is in such physical or mental condition as not to be capable of properly considering the question of consent; or*
- (c) *That the person has abandoned, deserted or persistently neglected or ill-treated the child; or*
- (d) *That the person has, for a period of not less than one year, failed, without reasonable excuse, to discharge the obligations of a parent or guardian of the child; or*
- (e) *That there are other circumstances by reason of which the consent may properly be dispensed with.*

In South Australia, therefore, there is no legal impediment to the adoption of a child who is in care, even in the absence of parental consent, where any of the preconditions above are satisfied.

Professor Hallahan referred to these existing provisions, noting that in the course of consultations she was 'struck by the number of practitioners in the field who were not aware that these provisions exist in the Act and confidently asserted that adoption from care is impossible'.¹⁷ She thought this reflected a long-standing policy suggesting that adoption from care may not be the solution for many children who come to the attention of the child protection system.

REASON FOR CAUTION

The Guardian for Children and Young People (GCYP) in a submission to the Hallahan review emphasised that in most cases children in care want to identify with both their family of origin and the family that provides care to them.¹⁸ The Charter of Rights for Children and Young People in Care underscores the right of children in care to maintain a connection with their families, culture and community, including contact with people who help them

feel good about themselves.¹⁹ These rights, the GCYP reminds us, should apply equally to children who have been in care and are subsequently adopted. Adoption should not be considered where there is doubt about whether these rights will continue to be respected.

Professor Hallahan refers to adoption of children from care as a 'last resort option'. Specifically, she indicates that adoption is not to be approached as the solution to solving immediate issues of safety for a child, at the potential expense of their 'longer term needs around belonging and identity formation'.²⁰

The report observes that children in the care system are not uncomplicated. They may have developmental issues and complex family circumstances; they may have siblings who are an important part of their identity and sense of belonging.²¹

The Commission is concerned that some of those who advocate adoption as the solution to the lack of suitable long-term placements for guardianship children may underestimate the extent of trauma and consequent complex behaviours of children who have been mistreated by their biological parents. Foster parents who undertake the care of such children need not just financial support but help from a range of relevant services to manage their problems. Many foster parents are reluctant to contemplate adoption because of the associated loss of these supports.²²

Further, the Commission heard evidence about long-term placements with caring and loving foster families which broke down as a result of the extreme behaviour of children relating to their earlier mistreatment. In some cases, the children had to be removed because their behaviour placed the safety of the foster parents at risk. The removal of these children from a caring foster placement to yet another placement, possibly into residential care, is distressing for carers who have become attached to them. It also has an obvious adverse impact on already traumatised children and is likely to reinforce their belief in their lack of worth.

Adoption is no panacea for the current shortage of suitable care placements for children who cannot remain with their families of origin. The fact that there is a cohort of families who are interested in starting or growing their families through local adoption, and who may relieve placement pressure in the care system, is irrelevant to the question of a child's best interests.

By keeping the child's best interests at the centre of all decision making, it is apparent that there is currently another option available in South Australia that will satisfy a child's need for permanency and stability. This is Other Person Guardianship, commonly referred to as OPG. This form of guardianship delegates greater decision-making power to the family that is caring for

the child without affecting the legal status of the birth parents. It anticipates the continuity of some assistance from the government for a child's special needs.

Professor Hallahan supports the use of OPG and observes that the government has not made wide use of this provision to date. She urges the allocation of additional resources, together with a comprehensive evaluation of the program over a period of about 10 to 20 years.

Professor Hallahan concludes that existing arrangements in the *Children's Protection Act 1993* (SA) relating to OPG are adequate in terms of ensuring security and stability without undermining long-term identity formation, and further considers that the court should be satisfied that OPG is not an option for a child before proceeding to adoption.

The Commission considers that greater use should be made of OPG. Many families will be content with the security that OPG provides; for others, a successful OPG placement will provide strong support for a subsequent application to adopt. However, OPG should not be used to exclude the possibility of adoption in appropriate cases, nor should it be treated as a mandatory prerequisite to an application for the adoption of a child in care. In every case, the option exercised must be that which is in the best interests of the child.

ADOPTION AND ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

The long-term negative ramifications of forced adoption on Aboriginal and Torres Strait Islander families cannot be overstated. However, the possibility of adoption should not be denied to Aboriginal children as a result. The adoption of Aboriginal children is not excluded by the Act, but is subject to the following important conditions set out in section 11²³:

- (1) *The Court will not make an order for the adoption of an Aboriginal child unless satisfied that adoption is clearly preferable in the interests of the child to any alternative order that may be made under the laws of the State or Commonwealth.*
- (2) *Subject to subsection (3) an order for the adoption of an Aboriginal child will not be made except in favour of a member of the child's Aboriginal community who has the correct relationship with the child in accordance with Aboriginal customary law or, if there is no such person seeking to adopt the child, some other Aboriginal person.*

The more contentious issue is where adoption by a non-Aboriginal person of an Aboriginal child is contemplated. The Act does not prohibit this, but sets out conditions that must be satisfied before such an order may be made under section 11(3):

- (a) *that there are special circumstances justifying the making of the order; and*
- (b) *that the child's cultural identity with Aboriginal people would not be lost in consequence of the adoption.*²⁴

The GCYP, in a submission to the adoption review, pointed out that there is no requirement in section 11 of the Act to consult with an Aboriginal organisation in relation to adoption of Aboriginal children: this is at odds with the consultation requirements in the Children's Protection Act. The Commission considers it appropriate to include such a provision in the Adoption Act to reflect the Aboriginal placement principle and its underlying philosophies.

The Commission otherwise considers that the current legislative framework strikes an appropriate balance in terms of the adoption of Aboriginal children.

OTHER PERSON GUARDIANSHIP

Other Person Guardianship is assigned by order of the Youth Court, which appoints up to two persons as the legal guardians of a child. In practice, orders are made until the child attains the age of 18 years²⁵, although the court has the power to make shorter orders if appropriate. OPG is an alternative to adoption for a foster or kinship carer with respect to a child who is placed under the guardianship of the Minister. In cases in which a child is already under the guardianship of the Minister, the guardianship is transferred from the Minister to the child's carers.

The aim of OPG is to provide a child with a normal care environment that is stable, consistent and loving, in which the child has the opportunity to fulfil their developmental potential. Placing decision making about the child within the family that is caring for them promotes an environment that is more consistent with that of a traditional biological family and empowers carers to make decisions based on what they perceive as being in the best interests of the child. The responsibility of an Other Person (OP) guardian is greater than that of a foster or kinship carer who is obliged to act according to the prescriptive decision-making authority given to them by the Minister.

OP guardians are able to make decisions about most aspects of a child's life, such as education and schooling, haircuts, medical procedures, and school excursions. They can also make decisions about interstate or

overseas travel, provided that such arrangements do not contravene any fixed contact arrangements with birth parents. Any continuing involvement with Families SA is on a voluntary or as-needs basis.

Legal arrangements similar to OPG exist in other jurisdictions within Australia and internationally. In the United Kingdom, the nearest legal equivalent of OPG is called a Special Guardianship Order. It is a private law order made under the UK Children Act 1989 and is intended for children who do not live with their birth parents who would benefit from a legal and secure placement. That order does not end the legal relationship between the child and their birth parents. Those who can apply for Special Guardianship Orders include anyone with whom the child has lived for at least three years out of the last five, and a local authority foster parent with whom the child has lived for at least one year preceding the application.²⁶

In South Australia there are three entry points to OPG:

- variation of a long-term guardianship order to an OPG order;
- application for OPG as an alternative long-term guardianship order following unsuccessful attempts at reunification; and
- application for OPG without prior long-term guardianship or Custody of the Minister court orders.

The most common entry point for OPG is variation of an existing long-term guardianship order.²⁷

Although an OP guardian is not obliged to acquiesce to the Minister's ultimate authority when making decisions that affect the child, the OPG order is not unconditional and the OP guardian must comply with the conditions that are affixed to the order of the court.²⁸ These are most commonly articulated in what is referred to as the 'care plan'. The court can revoke the OPG order if there is failure to comply.

The OPG practice guide sets out the areas which Families SA considers should be covered in the care plan. They are²⁹:

- how the child's health, educational and social needs will be met;
- how this child's special needs (trauma or disability) will be met;
- how the child's identity as a member of two families will be developed;
- how the child will maintain connection to their family of origin, community and culture. In particular, for Aboriginal children:
 - how the child will gain knowledge and understanding of their Aboriginal history;

- how the child will be assisted to learn, understand and build their Aboriginal identity;
 - how the child will gain more knowledge and understanding of their extended family and community;
 - how the child's cultural expression will be developed;
 - how the child will gain more knowledge and understanding about their Aboriginal cultural values, beliefs and practices;
- how the child will have regular family contact/access visits and how this will be facilitated by the new guardian, birth family and, where necessary, Families SA;
 - what level of Families SA financial support (i.e. alternative care support payments, loadings and incidentals) will be needed and when/how such payments will be reviewed;
 - what level of ongoing Families SA support and/or services are required and how these services will be reviewed;
 - how any future disputes between the parties will be resolved; and
 - how and when the child's care plan will be reviewed.

The practice guide also provides that³⁰:

- Aboriginal and Torres Strait Islander children must be appropriately assessed for OPG arrangements in accordance with the Aboriginal and Torres Strait

Islander Child Placement Principle. Initial assessment for such children will be based on the criteria outlined in the OPG practice guide with particular focus on the carer's demonstrated commitment to maintain the child's connection to their family of origin, community and culture;

- All assessments for OPG involving Aboriginal children will require consultation with the Regional Principal Aboriginal Consultant and, where appropriate, extended family and community members; and
- OPG assessments must also consider individual cultural issues relating to culturally and linguistically diverse communities as an integral part of the formal assessment planning process.

RATES OF OTHER PERSON GUARDIANSHIP

The Commission was advised that all OPG applications finalised by the Youth Court between July 2011 and December 2014 were granted.³¹ However, in recent times, there appears to have been a dramatic drop in the number of applications made. The number has dropped from 27 in 2012/13 and 29 in 2013/14 to three in the first six months of 2014/15.³² The Commission has not been provided with any explanation, although it understands that there is a large backlog of OPG applications awaiting assessment by Families SA. Whatever the reason, South Australia lags substantially behind other states with respect to OPG, as demonstrated in Figure 13.1 below.

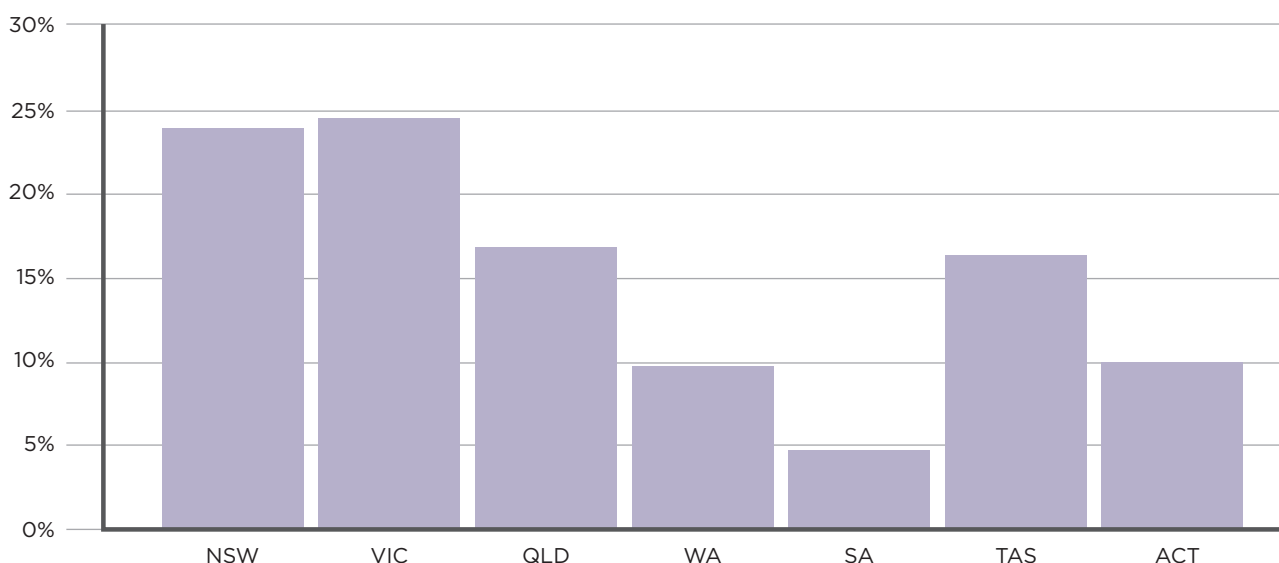


Figure 13.1 Percentage of children in third-party guardianship across Australia, 30 June 2014

Source: Australian Institute of Health and Welfare, *Child Protection Australia 2013–2014*, Australian Government, p. 35
(Note: Data for Northern Territory unavailable).

WHAT DOES OPG MEAN FOR A CHILD?

Through OPG it is hoped that children will develop a stronger sense of belonging and personal identity by being connected with a family that they can call their own. The order demonstrates the guardian's permanent commitment to the child—recognising the child as part of their family and promoting feelings of safety and security. The Commission was told of one case in which an OPG order was sought by Families SA three weeks before the child turned 18 to recognise the child's place within the family and to foster a greater sense of belonging.³³

A shift to OPG, with reduced contact with Families SA, should also help remove the stigma of a child being labelled as someone in state care. Research that shows the improved developmental outcomes of adopted children, as compared to those who have been maltreated by biological parents or have been in simple foster or residential care, also supports the benefits of an OPG order.

WHAT DOES OPG MEAN FOR A CARER?

The making of an OPG order acknowledges the contribution a carer has made to a child's life. It grants them greater decision-making capacity and responsibility than that which can be exercised by simply being a foster or kinship carer. OP guardians have the benefit of exercising their decision-making power free from regular oversight by Families SA caseworkers.

However, children subject to an OPG order have usually experienced abuse or neglect in their early lives and are likely to have ongoing needs that can render parenting difficult. It is therefore important that such children and their guardians are afforded some continuing support by the state, if it is required.

It is expected that access arrangements between the child and the biological parents existing before an OPG order will continue while the child is in the care of an OP guardian. Those arrangements should be included in the care plan.³⁴ In some instances there is need for support by Families SA, such as where there are complicated internal family dynamics: this may be the case when kinship carers become OP guardians or where the birth parents of a child have behavioural or psychological problems which make unsupervised access inappropriate.

An OP guardian also benefits from a greater degree of certainty that the child will remain in their care over the long term. The fear of a child being removed is a significant issue for some foster parents. A Families SA worker said that potential foster parents were dissuaded from taking on the role by the perception that 'at the end of the day the biological family have all the rights. Families SA make all the decisions and you are simply a

volunteer'.³⁵ An OPG order has the potential to reduce that anxiety and assist the carer to make a long-term commitment in which they can permit themselves to love and care for the child unreservedly:

*[you care for a child] with a guarded heart because there is always a risk that the child could be removed.*³⁶

'(You care for a child) with a guarded heart because there is always a risk that the child could be removed'

WHEN IS IT APPROPRIATE FOR AN OPG ORDER TO BE MADE?

The practice guide sets out five conditions identified by Families SA for a carer to be eligible to be appointed the child's guardian³⁷:

- The carer has demonstrated capacity to provide a high level of care for the child;
- The carer has sufficient personal and professional support and resources to provide care for the child now and into the future;
- The carer family is committed to the child maintaining connection to their family of origin, community and culture;
- The carer has made a lifelong commitment to the child; and
- A preferential relationship exists between the child and the carer.

These are appropriate matters to be considered with respect to an OPG application, but they should not be inflexibly applied. They are not mandated by legislation nor by direction of the court. For example, notwithstanding these criteria, OPG may be appropriate for a child who is particularly traumatised and is unable to develop a preferential relationship, but the OP guardian recognises and understands the situation and provides high quality care for that child's special needs.

THE CURRENT APPLICATION PROCESS

The current application process generally starts with a referral to the OPG Assessment Panel (the Assessment Panel) from a Families SA worker and/or a carer (who may be assisted by their support agency).³⁸ The Assessment Panel is located within the Placement Services Unit of Families SA. In some instances carers have directly approached an Executive Director of the Agency when their application has not been endorsed by Families SA at the local level.³⁹ For an OPG application to be successful, however, it generally requires the support of Families SA.⁴⁰

The Assessment Panel meets on a monthly basis and usually consists of two principal social workers, an Aboriginal Family Support Services (AFSS) representative, a representative of the Child and Family Welfare Association (CAFWA) plus any professional person that the panel deems to be relevant to an assessment. For example, when the application relates to a child with a disability, the panel may engage the help of a disability services expert.⁴¹

A worker in the Placement Services Unit undertakes an assessment of the application by applying the five criteria. The worker must consider the child's long-term prospects up to and beyond the age of 18.⁴² The Commission heard evidence indicating that this particular aspect of the assessment was potentially complex as it required the assessor to look at a child's life well past the age of 18. For example, a worker assessing a toddler must consider the impact of issues which might arise in adolescence—a complicated task which becomes even more difficult with children who have a background of trauma.⁴³

About half of all applications are referred back to the initiating caseworker with a request for more information. The Assessment Panel will then either approve or refuse the application. If the application is approved, the child's caseworker prepares a care plan which then serves as a 'roadmap' of the child's care needs over the short and long term.

TIMING OF THE APPLICATION

There is no timeframe prescribed by legislation with respect to an OPG application. In practice, the decision to apply for an OPG order is based on the needs and circumstances of the individual child rather than the length of time in which the child has been in a particular placement.⁴⁴ However, there is clearly a large degree of uncertainty surrounding the time at which an application can be pursued.

One carer said she had been advised that she would have to wait for two years before the issue was raised⁴⁵ and another mentioned a period of at least three years.⁴⁶ Garry Matschoss, Acting Manager of the Placement Services Unit, identified a 'rule of thumb' for the Placement Services Unit of the child having been in the placement at least a year.⁴⁷

The level of confusion regarding the time at which an application for OPG can be made should be resolved. The Commission recommends an amendment to the Children's Protection Act to permit applications for OPG to be made for a child who has been in the care of a foster parent under a long-term order for not less than two years. However there will be some situations in which the best interests of the child will dictate a lesser

period of time in care. Accordingly, the legislation should also provide the court with an unfettered discretion, in appropriate circumstances, to make an OPG order for a child who has been in care for less than two years.

DELAYS

The Commissioner heard a number of complaints about delays in the processing of OPG applications. The Commission was told that at one stage, the waiting list was between 18 months and two years.⁴⁸ Mr Matschoss said some assessments were completed in as little as four months but generally took more than six. In some cases carers opted not to proceed when they fully understood the responsibilities.⁴⁹ The delays may in part be due to the restricted number of workers assigned to undertake OPG assessments: currently there are only two staff dealing with applications. Mr Matschoss estimated that there were there about 36 cases on the waiting list.⁵⁰

There is also the complex and time-consuming nature of the assessments themselves. These are especially difficult when complicated access arrangements or other disputed matters need to be resolved for inclusion in the case plan. The process is further complicated by the need to refer the final decision to the Executive Director of the Agency for approval.

THE APPLICATION TO THE YOUTH COURT

The application is then forwarded to the Crown Solicitor, as the legal representative of the Minister, to make an application to the Youth Court.⁵¹

The child's biological parents are parties to the original guardianship order and are therefore served with a copy of the application. Although there is no legislative requirement for them to consent to the application, the Act requires the court to be satisfied that before making an OPG order there is no parent able, willing and available to provide adequate care and protection for the child.⁵² As discussed in Chapter 9 this provision is problematic and should be repealed. It has the potential to stand in the way of a long-term order in the best interests of the child.

Evidence suggested that there were delays in listing OPG applications for hearing in the Youth Court. The Commission has not investigated that aspect but it may be that OPG applications are regarded as less urgent than other applications made to the court in which the safety of a child is at risk. It is also possible that neither the applicant/carers, nor the child, has a particularly strong voice in presenting such applications and that may be a factor in the lack of expedition.

BARRIERS TO OPG

Evidence given to the Commission suggested that OPG placements were not a priority for the Agency from a case management perspective. Ms Rayment and Ms Simmons commented that:

Practitioners seem to be resistant to transfer children's guardianship from the Minister, possibly due to factors including historical concerns regarding OPG, lack of parental consent, concerns regarding the quality of care provided by foster carers or a carer's ability to manage issues such as contact with birth families. The vexed issue of children being placed under the guardianship of carers from a different cultural group has also led to delays in progressing OPG.⁵³

A foster parent told the Commission that some 18 months earlier carers had been undertaking the assessment process but it was stopped without explanation.⁵⁴ On 19 October 2015 an article in the *Advertiser* under the heading 'More stability for children in state care' reported the Education and Child Development Minister, Susan Close, as saying that she wanted to raise awareness of OPG among those who had long-term care of children. The article advised that the Agency would be writing to 788 families who had been caring for a foster child for two years or more, encouraging them to consider OPG, which would give them more control over everyday decisions. A sum of \$475,000 a year in the state budget was mentioned to fund the initiative.⁵⁵

Mr Matschoss was asked about the matters contained in this article (which had been published just a few days before he gave evidence). The article had apparently taken him by surprise. He was unable to assist with any detail as to how the sum of \$475,000 would be allocated⁵⁶ and he was concerned about whether the staff could cope with a substantial influx of applications.⁵⁷ Mr Matschoss thought there would be fewer than the 788 families mentioned in the article but that 150 to 200 families would be eligible.⁵⁸ However, he cautioned that some of the carers most eager to apply were not necessarily the most suitable. The unsuitability appeared to relate principally to difficulty with access arrangements with birth parents. There was also some confusion about the level of ongoing financial support that would be available, but Mr Matschoss's personal view was that financial reasons alone would not justify rejecting an application for OPG.⁵⁹

The proposal contained in the announcement by the Minister is consistent with the recommendation in the Hallahan report for greater use of OPG. It suggested a change of attitude by Families SA and was welcomed by foster parents who had been advocating for this form of legal permanency for many years.

On 19 April 2016 the Commission wrote to the Department to ascertain progress with respect to the OPG applications foreshadowed by the Minister. The Commission sought the following information:

- how many families were contacted;
- how many families responded;
- how many families indicated they would like to pursue an OPG application; and
- what progress has been made in relation to those applications.

By letter dated 28 April 2016 the Commission received a reply under the signature of the Deputy Chief Executive for Child Protection as follows:

In October 2015 the Growing Other Person Guardianship project was still in its early planning. The number of carers to be contacted depended on the determination of preliminary screening criteria which were not yet established. The figure provided to the Advertiser was based only on the number of children in foster care placements for two years or more and did not consider any other relevant factor relevant for OPG.

The preliminary screening criteria used to identify the carers to receive an invitation to attend to the OPG information sessions were:

- carers who have been caring for children for longer than three years
- carers who have no current care concerns
- carers who are a fully registered carer
- carers who have not accessed payment other than carer payments aligned to the child's age and complexity
- carers who are caring for children under the age of eight.

Using the above criteria as a guide, 213 families were contacted and 84 families responded.

A total of 59 families and four non-government organisations' representatives attended the sessions as follows:

- Northern location, Mawson Lakes: 20
- Central location, Hindmarsh: 11
- Southern location, Marion: 20
- Port Augusta: 4
- Whyalla: 8.

Of the 63 families who attended the sessions, four were neither sent an invitation letter nor made previous contact to advise of their attendance.

The information sessions were intended to provide information to carers about the OPG process and not to gauge or seek opinions of those attending about their interest to pursue OPG.

The OPG process begins when carers express their interest in OPG with their caseworker at the office or hub. This may occur during the child's annual review, or as part of casework case management practice. Information recorded in case notes cannot be extracted for reporting. Therefore at this stage the number of people interested in OPG is not possible to ascertain and report on. Following discussions about the criteria and process for OPG with the carer, if the hub/office and carer feel that OPG is the appropriate path to take, a referral is made to the OPG team and discussed with the OPG panel that approve the commencement of the OPG assessment.

The OPG project is reviewing how each step in the OPG process can be improved to capture information for the purpose of improving reporting. Currently, based on those who attended the information sessions, referrals have come through as follows:

- *One family has been referred and approved for assessment; this carer is caring for three grandchildren.*
- *One other family is in the process of being referred.⁶⁰*

The information contained in this letter raises several matters of concern:

- The criteria for consideration as an OP guardian are set out in the Department's OPG practice guide⁶¹ and do not include any of the matters used by the OPG project team to identify those carers who were entitled to receive an invitation to the proposed information session.
- There is no explanation for limiting the invitation to those carers who had been caring for children for longer than three years. Section 80 of the *Family and Community Services Act 1972* allows the Minister to delegate powers to a foster parent who has had the care of a child for three years or more, but that is different from OPG. In any event, the statement by the Minister as reported in the press contemplated those who had been caring for a child for two years or more, and Mr Matschoss mentioned a period of one year.⁶²
- Reference to 'carers who have not accessed payment other than carer payments aligned to the child's age and complexity' suggests that carers who are receiving anything more than the basic subsidy were to be excluded. The OPG practice guide sets out the areas that Families SA considers should be covered in the care plan and states what level of Families SA financial support may be required. If Families SA

considers there is a need to monitor such payments to avoid misuse, appropriate provisions can be included in the care plan.

- The limitation to carers of children under eight years of age is curious. There is no apparent rationale for this criterion, which may exclude many families, including some whose children may have passed that age while they were waiting for the Agency to consider and/or process their application. There is no reason to exclude a child from OPG on the basis of age if the OPG placement is in the child's best interests. Some applications may in fact be facilitated by the ability of older children to more readily express their views about the application.
- The letter sent to families who were not excluded by the preliminary screening advised that it was for an information session only. That may account for the relatively low number of persons who responded to the invitation. It appears that there was no attempt at these sessions to gauge or seek opinions from those attending about their interest in becoming an OP guardian. The Agency indicates in its letter that there is difficulty in extracting relevant data from the case notes to ascertain the number of people who might be interested in OPG. It would have been helpful to use these sessions to ascertain the level of interest from those present and give them some clear direction on how to advance an application.
- Although some carers might have decided not to proceed once the responsibilities had been explained to them, it is unlikely that reluctance accounts for the alarmingly low level of assessments that followed the promising announcement by the Minister.

The Commission can only conclude that the intransigent attitude of Families SA identified earlier continues. The intention of the criteria applied on this occasion appears to have had more to do with limiting the number of applications flowing into the Department, rather than making a concerted effort to increase the numbers of carers who might be suitable OP guardians.

THE RIGHTS OF THE BIRTH PARENTS

Although there is no requirement that birth parents consent to an OPG application, they are entitled to be notified and, where appropriate, their views obtained with respect to it. This process can cause delays. In one case the Commission was told of efforts to locate a child's parents being so thorough that a birth parent was found who was unaware that he was the father of the teenage child concerned. Mr Matschoss observed however that many birth parents did consent: they may say, 'I hate your Department, but I know it's best for my child'.⁶³ Others, despite their relationship and history, struggled with the idea that they might be seen to be giving their child away.

Although dealing with such issues was the responsibility of the workers in the Placement Services Unit, Mr Matschoss thought there might be an advantage in having someone independent who had not been previously involved working through issues with the child's parents.⁶⁴ Some foster parents refrain from pursuing an OPG application to avoid stirring up issues with birth parents who were having minimal, if any, contact with the child.

The Commission considers that the rights of birth parents with respect to an OPG application should be clarified. Although they are not required to consent, they do have a right to be heard. However, if they wish to oppose the order, the onus should be upon them to establish on the balance of probabilities why the order should not be made. This may be a less confronting position for birth parents, and remove a level of anxiety associated with 'giving the child away'.

PROMOTING OPG

Families SA should make a genuine commitment to OPG as part of permanency planning for children in care. The suitability of an OP arrangement should be identified as early possible in a child's placement, with records maintained about the progress of the child, and the carer's suitability for OP guardianship. That information should be readily accessible at the time of the OPG application and assessment.

There is a need to clarify and expedite the current procedure with respect to OPG assessments. Where a child has been in care under a long-term order for a period of not less than two years (or in other special circumstances less than two years), a foster parent should be entitled to make an application to the OPG Assessment Panel to be appointed the OP guardian of that child. The application should usually be made with the support of the Families SA caseworker or the foster care support worker, but that support should *not* be a prerequisite to the foster parent or kinship carer making the application.

The application should briefly address the five relevant conditions. The applicant may wish to nominate a person or persons to assist with the assessment of their suitability, such as a caseworker, teacher, disability support worker, therapist or other expert concerned with the care of the child. In that case, the application should include a written authority for information to be made available to the panel.

The Assessment Panel's membership should be reviewed. It should be composed of members with appropriate expertise who are independent of Families SA, although Families SA should be represented, provided the person concerned is not connected to the case in question. Depending on the case, the Assessment Panel could include representatives from CAFWA or AFFS, a disability support worker and a psychologist or other professional. For administrative convenience, this panel could be the same one that is constituted as the Case Review Panel to consider disputed issues of family contact, which is discussed further in Chapter 9.

When an application is lodged, the Assessment Panel should conduct an initial screening. If the application is 'screened in' (as having the capacity on the face of it to satisfy the five criteria), it should then be referred for formal assessment and preparation of a care plan. The person preparing the assessment and developing the care plan would need to consult with the child, the carers, the birth parents and other professionals. In the case of Aboriginal and Torres Strait Islander children, the principal Aboriginal consultant and AFSS would need to be consulted.

In some cases, the Assessment Panel might consider the child's caseworker to be the best person to perform the assessment. Where the caseworker has maintained a close relationship with the child and the foster family and has kept the required records, the assessment and care plan should be able to be completed in a timely manner. Otherwise, the application should be referred to a practitioner within the Placement Services Unit. If there is no-one available to perform the assessment in a timely way, it should be outsourced to a private practitioner. Any costs incurred as a result of outsourcing should be offset by the advantages and potential cost-saving of moving a foster parent to OP guardianship. Figure 13.2 shows the suggested process for applying for Other Person Guardianship.

Following the assessment and preparation of the care plan, the matter should then be referred back to the Assessment Panel for final determination. Upon approval by the panel the application should be referred to the Crown Solicitor to prepare the requisite application to the Youth Court. There should be no need to refer the matter to the Executive Director for final approval, as that will be given by the Youth Court on the hearing of the application.

The OPG application should then be served upon the birth parents with advice that if they oppose the making of the order they will be required to prove to the court on the balance of probabilities why the order should not be made.

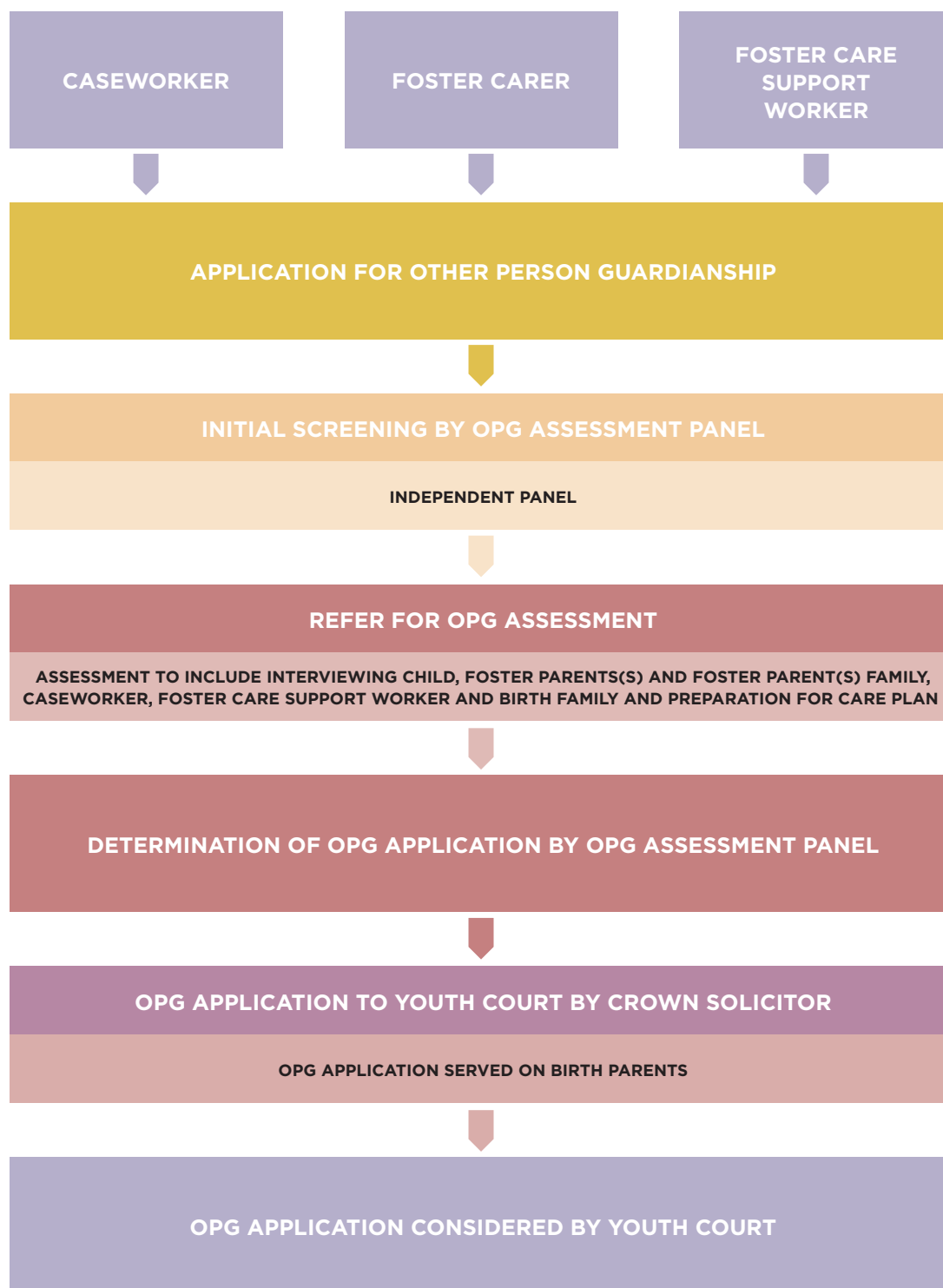


Figure 13.2: Proposed process for applying for Other Person Guardianship

STANDING TO MAKE AN OPG APPLICATION

Evidence was given by some carers that they would like to act on their own behalf with respect to lodging an OPG application in the Youth Court.⁶⁵

The ability to initiate proceedings in court would assist those persons whose applications are not currently supported by Families SA. However, such applications are likely to have limited chance of success and have the potential to result in protracted proceedings by creating an adversarial relationship with the Minister as the guardian of the child. There is also a danger that granting carers the ability to take their own action could have a number of unintended consequences. It could lead to a change of practice whereby carers were encouraged and/or expected to make applications on their own behalf, saving the resources of Families SA. This would be a significant disadvantage to carers, particularly those who do not have the intellectual or financial ability to deal with complex court procedures. Carers are unlikely to be well placed to undertake potentially difficult negotiations with biological parents with respect to access or other arrangements, which must be included in the care plan. It could also make it difficult for the court to obtain properly sourced objective evidence as to the suitability of the proposed OP guardian, which would inevitably result in further delays to the application.

The wish to act in person appears to be borne out of frustration with the current attitude of Families SA to OPG applications as well as the extended delays in processing. The question of delay can be resolved by Families SA promptly addressing the current backlog. The Commission believes that the ability of a carer to make an application to an independent panel, as outlined above, should allay the concerns of those carers whose applications, for whatever reason, are not supported by their caseworker. If an application is not approved by the Assessment Panel, it is unlikely that it would succeed in court. The Commission does not therefore currently support carers being permitted to apply directly for an OPG order. However, this issue may need to be revisited if the current problems persist despite the recommendations contained in this chapter.

POST-OPG SUPPORT

The strength of the relationship between the child's carers and the biological parents is an important part of the success of any OPG arrangement.⁶⁶ The transparent exchange of information between parents and carers should be encouraged whenever it is possible.⁶⁷ In the long term, fostering good relations between birth families and carers may result in a reduced need for resources to support contact. A more natural relationship between the birth family and carers is also good for the children.

In the Commission's consultation with children, one child said, 'Where I am now we organise the access ourselves—without Families SA being involved. It is great'.⁶⁸

'Where I am now we organise the access ourselves—without Families SA being involved. It is great.'

Mr Matschoss told the Commission that it was initially intended that post-OPG support to families would be provided by a non-government organisation such as the post-adoption support service provided by Relationships Australia. Many families would benefit from continuing support after OPG, although at a much reduced intensity. It is appropriate that a continued as-needs support service be made available to them. In line with recommendations in Chapter 11 about extending the role for the non-government sector in supporting home-based placements (specifically kinship care), the Commission recommends that post-OPG support also be provided by non-government agencies. There is no reason that support could not be provided, at a reduced level, by the registered foster care agency responsible for originally placing the child in the care of the family. Where no agency has previously been involved (kinship carers are supported by the statutory Agency) a referral should be made to a non-government agency providing services in the appropriate region.

PARTIAL DELEGATION OF AUTHORITY

Section 80 of the *Families and Community Services Act 1972* provides that where a child who is in care has been in the care of a foster parent for three or more years, the Minister may delegate to the foster parent such powers as the Minister thinks fit. A delegation under this section may be varied or revoked at any time by the Minister. The power is limited to delegation to approved foster parents and does not include kinship carers who fall outside the definition of a foster parent.

A gradual and sequential delegation of powers pursuant to section 80, to transfer decision making to carers who have been identified as potential OP guardians, should occur as part of day-to-day case planning. The manner in which carers then exercise those powers will be highly relevant to the later assessment of their suitability as an OP guardian.

This delegation of power could also occur during the period in which the OPG application was pending and would help to allay some of the present anxiety about delays in processing those applications.

The barriers to greater reliance on section 80 are discussed in greater detail in Chapter 11. Recommendations are made in that chapter to amend section 80 to expand its operation to include relative carers (according to the definition suggested in that chapter), and make section 80 delegations available when the child has been with the carer for 12 months or more. These amendments should provide greater flexibility in the use of section 80 delegations as a tool to work towards OP guardianship applications.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 153 Amend the *Children's Protection Act 1993* to enable carers to apply to be appointed an Other Person guardian where children who are subject to long term orders have been in their care for a minimum period of two years, or such lesser period as the court in its absolute discretion determines is appropriate in the circumstances.
- 154 Amend the *Children's Protection Act 1993* to provide that biological parents who oppose an application for the appointment of an Other Person Guardian bear the onus of proving to the court on the balance of probabilities why the order should not be made.
- 155 Establish an independent assessment panel to consider applications for Other Person Guardianship, in accordance with the following procedures:
 - a the application to be made by a foster parent in person or by a caseworker or foster care support worker on behalf of the carer;
 - b an initial review be carried out by the Assessment Panel to determine the utility of referring the application for a full assessment;
 - c the application to be referred to the caseworker or such other appropriate person as is available to carry out the assessment and prepare the case plan in a timely manner;
 - d when the assessment has been completed and case plan prepared, the application to be referred back to the Assessment Panel for final determination;
 - e all decisions of the Assessment Panel are to be final.
- 156 Promote the use of section 80 of the *Family and Community Services Act 1972* for the delegation of decision making to support potential applications for Other Person Guardianship.
- 157 Consider the question of adoption where that is in the best interests of the child and an Other Person Guardianship order would not be appropriate.

NOTES

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- 3 *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 83.
- 4 AIHW, *Adoptions Australia 2014–2015*, p. 27.
- 5 Submission: P Rayment and C Simmons.
- 6 *ibid.*
- 7 L Hallahan, *Adoption Act 1988 (SA) review*, 2015, p. 7.
- 8 *ibid.*, pp. 57–60.
- 9 *ibid.*, p. 19.
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- 11 Office of the United Nations High Commissioner for Human Rights (OHCHR), Convention on the Rights of the Child, entered into force 2 September 1990, Article 21.
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- 18 Guardian for Children and Young People (GCYP), submission to the L Hallahan review of the *Adoption Act 1988 (SA)*, February 2015, p. 2.
- 19 *ibid.*, p. 3.
- 20 L Hallahan, *Adoption Act 1988 (SA) review*, p. 54.
- 21 *ibid.*, p. 55.
- 22 *ibid.*
- 23 *Adoption Act*, s. 11.
- 24 *ibid.*, s. 11(3).
- 25 *Children's Protection Act 1993 (SA)*, s. 38(1)(d).
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- 28 *Children's Protection Act*, s. 38(1)(f).
- 29 Families SA, 'Other Person Guardianship practice guide', internal unpublished document, Government of South Australia, October 2013, pp. 6–7.
- 30 *ibid.*, p. 3.
- 31 Families SA, data provided to the Child Protection Systems Royal Commission.
- 32 *ibid.*
- 33 Oral evidence: G Matschoss.
- 34 Families SA, 'Other Person Guardianship practice guide', pp. 6–7.
- 35 Oral evidence: T Hutson.
- 36 Oral evidence: K Ryan.
- 37 Families SA, 'Other Person Guardianship practice guide', p. 4.
- 38 Oral evidence: G Matschoss.
- 39 *ibid.*
- 40 *ibid.*
- 41 *ibid.*
- 42 *ibid.*
- 43 *ibid.*
- 44 Families SA, 'Other Person Guardianship practice guide', p. 3.
- 45 Oral evidence: S Lane.
- 46 Oral evidence: Name withheld (W10).
- 47 Oral evidence: G Matschoss.
- 48 Oral evidence: Name withheld (W59).
- 49 Oral evidence: G Matschoss.
- 50 *ibid.*
- 51 *ibid.*
- 52 *Children's Protection Act*, s. 38(2)(a).
- 53 Submission: P Rayment and C Simmons.
- 54 Oral evidence: J Jarvis.
- 55 L Novak, 'More stability for children in state care', *Advertiser*, 19 October 2015, www.adelaidenow.com.au/news/south-australia/sa-foster-parents-asked-to-take-on-guardianship-roles-for-their-foster-children/news-story/58f5caa2eee5e16c33a75d2880705e9e
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- 62 Oral evidence: G Matschoss.
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Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

14

LEAVING CARE

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OVERVIEW

In order to conduct a thorough analysis of the child protection system it is necessary to examine how the state prepares and plans for a young person's exit from the system and how it supports their transition to an independent life. The manner in which they are supported through this transition is a measure of the success of those who have been charged with raising them.

Children and young people leave the child protection system in a number of ways, often depending on why and how they were initially placed in care.¹ This chapter focuses on young people whose case is closed on the expiry of their guardianship order at the age of 18, or who, before reaching the expiry of their order, are transitioned into independent living arrangements.

Leaving care is 'a major life event and process that involves transitioning from dependence on state accommodation and supports to so-called self-sufficiency'.² It can mean significant changes to caring relationships that have sustained young people throughout their childhood. Turning 18 marks the beginning of an expectation that the young person will be responsible for their own pathway, negotiating the government systems and services that might be available to support them, and bearing responsibility for the consequences of the decisions they make.

Unlike young people in the general population, care leavers embark on the challenges of adulthood without the safety net offered by a traditional family structure. While reaching the end of their care journey is a highly anticipated occasion for some, for others it can generate a sense of abandonment and anxiety.

Preparation before transition and support after it are critical to care leavers if they are to develop the skills needed to reach their full potential. Previous reports concerning the South Australian child protection system have identified gaps and advocated for the state to provide young people leaving care with appropriate resources and recognition. The Layton Review discussed the need for³:

- specific legislation for young people leaving care;
- transition planning that involves all key agencies and stakeholders including significant others and the young person; and
- a reorientation of existing systems and policies towards a model that incorporates permanency planning.

Despite the acknowledged need for a more comprehensive approach, major challenges persist for young people leaving care. The end of their care journey represents an opportunity to transition into adulthood on their own terms. A supportive transition that nurtures their independence in a way that parallels parental care should be regarded as a central component of a quality child protection system.

This chapter principally relates to the Commission's Terms of Reference 1 and 2.

CHALLENGES FOR YOUNG PEOPLE LEAVING CARE

Young people leaving care represent one of society's most vulnerable and socially excluded groups.⁴ By comparison to the general population, care leavers are more likely to suffer disadvantages in several key areas as a consequence of their out-of-home care experience.⁵

For any young person, the transition from adolescence to adulthood can be a challenging period marked by changes across many aspects of life. For children leaving care, it can present greater obstacles than those experienced by other young people in the general population. Transitioning to independence requires already disadvantaged young people, who are coping with a greater number of life stresses, to enter adulthood at a far younger age and over a shorter timeframe than their peers.⁶

The circumstances leading to placement in the child protection system, such as a parent's mental health issues or substance abuse, violent family relationships, poverty, neglect, and physical, sexual or emotional abuse, all leave their mark. Irrespective of the period of time a child spends in out-of-home care, the loss, interruption or absence of secure caregiver relationships usually makes the experience a traumatic one and can contribute to ongoing difficulties with social adjustment and challenges maintaining stable and adaptive relationships. Children and young people in care very often develop problems with behavioural and emotional regulation arising from traumatic experiences or disruptions in early attachments. They are more likely to have developmental delays and intellectual or physical disabilities compared to the general population. These difficulties all impact on their ability to engage effectively with the adult world.

Children and young people may encounter a range of inadequacies in out-of-home care including poor quality care; abuse; a constant shifting of placements, schools and social workers; and a lack of stability and security over time. This lack of continuity and consistency is likely to undermine their social and educational progress and hinder their capacity to successfully move towards independence.⁷

Any transition that occurs abruptly at a critical stage of a young person's development brings another experience of loss and abandonment. Young people frequently leave care without stable family support or a well-established social circle on which to rely. Some may return to the support of their birth families, but not infrequently those families are still experiencing the challenges and behaviours that led to the child being taken into care. Such young people are reluctant to seek out services, engage in therapy or develop community networks because their experiences in out-of-home care have led them to distrust the system. Many young people perceive the system as a source of instability and frustration, and seek to distance themselves from it. Those who have experienced trauma and abuse may also find it difficult to articulate their problems and feel uncomfortable engaging with conventional service models. This in turn leads to them feeling disconnected from society and becoming even more isolated.⁸

Internationally, research consistently reports that care leavers are more likely to⁹:

- not complete high school;
- be unemployed or underemployed;
- earn low wages if employed;
- become parents at a young age;
- be incarcerated or involved with the criminal justice system;
- be homeless at some stage;
- live in unstable living arrangements;
- be dependent on social assistance;
- experience mental health issues; and
- be at higher risk of substance abuse difficulties.

EDUCATION AND EMPLOYMENT

Australia-wide data obtained from an extensive survey of care leavers found that of the respondents who had left care (and were over 18 years of age) only 35.3 per cent of them had completed Year 12 studies. The figure for the general population of 19-year-olds who had completed Year 12 studies was 74 per cent. In the same population, 28.5 per cent of care leavers were unemployed, compared to 9.7 per cent of youth in the general population.¹⁰

When young people leave care with an inadequate education they have a lower prospect of obtaining employment, which is an essential step towards securing independence. A variety of factors may contribute to young people in care suffering poor educational outcomes. One factor is likely to be that young people in care are required to complete their final years of schooling at the same time as they are moved out of the care system.

Claudine Scalzi, the state coordinator of the CREATE Foundation, observed:

*Children and young people ...17, 18, doing Year 12 ... have to work out where to live. It's near impossible. But ... that's probably why children and young people don't go on to further education, because it's stressful to be completing that, trying to work out where to live.*¹¹

A young person who has the commitment and intelligence to succeed academically and engage in higher education is hardly well served by balancing the demands of Year 12 with managing a household, a budget, independent living, and the fear that support will soon cease. Young people living in care through their final years of schooling and striving for a place in higher education are simply not competing on a level playing field with their peers.

LIFE SKILLS AND HOUSING

Many young people leaving care do not have the developmental maturity or life skills to allow them to live independently. For example, few know how to budget to meet periodic payments, and built-up debt can prevent them from meeting their daily living expenses. Gaps in life skills such as accessing transport can limit employment opportunities, which in turn contribute to financial problems.¹²

Finding and retaining suitable housing is difficult for care leavers.¹³ Apart from the limited supply of accessible housing, many young people lack the skills or maturity to live alone and find it difficult to tolerate the social isolation. If they are placed with others, they may lack the skills to live harmoniously. Care leavers are at a heightened risk of homelessness: CREATE's 2009 survey found that 34.7 per cent had experienced periods of homelessness in the first year of leaving care.¹⁴

RELATIONSHIPS AND SOCIAL CONNECTION

Some care leavers experience difficulties forming relationships and gravitate towards negative peer groups. Keeping such company can increase the risk of offending and set the young person on a path towards the correctional system.¹⁵

Lacking adequate social supports, information about their rights and access to services, care leavers are at risk of exploitation. They are also more likely to experience low self-esteem, increasing their vulnerability.

Alice Thompson-Francis, the manager of a non-government run independent living program providing supported accommodation to care leavers, told the Commission:

I think ... it's a case by case basis for each client, but what runs through them all is just their need to be loved and their need to be wanted, and they will risk that for anything, no matter how unsavoury these people are. ... Part of our job with all of our clients, and this is male and female, is how we build that self-worth, how we use praise and positive reinforcement, making sure that no matter what they do, there is success in everything, to build that self-esteem, [which] will then hopefully also build that self-worth. That being said, sometimes the self-worth of our kids ... is that ... it takes more than ... praise and nice words sometimes to fix what's happened. And our kids are taught from a really young age attention—positive or negative, it's still attention, so sometimes that's one of the hardest things ... to really ... move on from.¹⁶

'It takes more than praise and nice words sometimes to fix what's happened'

HEALTH

Young people leaving care are more likely to have health problems than those in the general population. In South Australia, the demographic profile of young people accessing post-care services indicates that, compared to the general population, nearly two-thirds meet the criterion of psychologically distressed.¹⁷ A 2010 investigation of 77 care leavers aged between 18 and 25 concluded that 53 per cent had a problem with substance abuse.¹⁸ These issues are frequently related, and some young people may consume substances as a way of dealing with psychological issues. This in turn contributes to the development of antisocial behaviour.¹⁹

With health services delivered separately for adults and children, and not well integrated, care leavers can find the journey to adulthood complex and difficult to negotiate.²⁰

INTER-GENERATIONAL CHILD PROTECTION ISSUES

Young people who leave care are significantly more likely to become parents at a younger age.²¹ Unfortunately, for some care leavers, a history of trauma and unstable or poor quality out-of-home care compromises their parenting capacity.

A survey conducted by Relationships Australia Post Care Support Services in South Australia found that nearly half of a 40-parent sample reported facing significant impairment in this regard.²²

Young people who have left care are also far more likely to have children who are placed in out-of-home care.²³ Helping young people to transition successfully out of care can circumvent the inter-generational nature of child protection issues. Preparing young people for their future parenting role can act as a form of early intervention to protect future generations of children from risk of harm.

As one witness observed:

It should never be assumed that [children with a history of out-of-home care] ... know how to make good and healthy choices about when they want to be parents, about what they need to provide for their children, about how many children they can care for at the one time, and there are such simple steps that can be taken to support children under guardianship so that they can make good choices about their own health and their own circumstances that will lead to better outcomes for their children.²⁴

SMOOTH TRANSITIONS MAKE SOCIAL AND ECONOMIC SENSE

A holistic and accessible system of support for young people transitioning out of care has the potential to interrupt patterns of disadvantage and help young people develop the foundation for greater wellbeing. In the 2009 CREATE Report Card, *Transitioning from care: Tracking progress*, Dr Joseph McDowall observed:

Many acute issues must be addressed within the system; but it is how effectively the young people in care transition to become valued and productive members of the community that is the benchmark of success ... For far too long young people transitioning from care have been 'invisible', largely absorbed into the disadvantaged sector of the nation. While they may wish to be treated 'like everybody else', they should occupy a special place in the collective mind of their 'corporate parents' who need to be sure that their young people have realised their maximum potential as human beings.²⁵

SOCIAL CONSIDERATIONS

Individualised, aspirational transitions from care empower young people to move into adulthood on their own terms and in a manner that allows them to best take advantage of their individual skills and talents.

Care leavers are not a homogenous group. A 2008 study grouped care leavers into three clusters, each of which required a different type and amount of support. The 'moving on' young people welcomed the challenge and made effective use of help they had been offered. The 'survivors' tended to include younger care leavers who had experienced disrupted placements and higher levels of homelessness and unemployment after exiting care; they benefited from specialist caseworkers and mentors. The most disadvantaged group, the 'strugglers', required the most post-care support, despite the fact that they seemed to benefit the least from it.²⁶

Transition planning should be flexible enough to cater for individual needs and circumstances. A successful transition for some young people will be measured by the achievement of stable housing, an income, and reliable social supports which enable them to engage effectively in their community. For others, a successful transition will be measured not only by having basic needs met, but by having opportunities provided for engagement in higher education, and the private housing and job market.

Researchers have observed that many care leavers display remarkable resilience in recovering from trauma.²⁷ The quality of the care provided in out-of-home environments correlates closely with the development of this resilience. In particular, placements that promote secure attachment, provide good educational experiences, advance living skills and career plans, are supportive of social experiences and nurture a positive identity have been found to be associated with higher levels of resilience.²⁸

Stereotyping care leavers around concepts of disadvantage, unemployment and poor levels of education has a tendency to lead to a one-size-fits-all policy which overlooks the potential of care leavers who do not fit this model. When low expectations are held of them, and reduced outcomes are considered acceptable, care leavers come to behave as disadvantaged because they believe that to be inevitable.²⁹

A study conducted of care leavers who had gone on to higher education, or aspired to do so, noted a series of common themes, which included³⁰:

- the existence of a person to inspire and walk alongside the care leaver, and a person who took an interest in their education and career planning;
- the existence of multiple pathways into higher education where direct entry from school was not possible;

- the existence of someone to support educational aspirations, and to overcome the pessimism of others; and
- preparation in transitioning from care, including financial support for higher education.

Faced with such a diverse population, it is incumbent on the state to ensure that care leavers have a transition out of care that is individualised and aspirational, and which gives each young person their best chance of fulfilling their life potential.

ECONOMIC CONSIDERATIONS

There is a powerful economic argument for investing in a system that provides support to young people so that they may successfully transition out of care. A study conducted in 2006 tracked the pathways of 1150 young people who left the child protection system in Australia between 2003 and 2004 and assessed the extent of their service usage over time. The research found that there are substantial potential cost savings to government if care leavers are helped to achieve more aspirational pathways.³¹

The research assigned care leavers to one of five pathways, according to their level of usage of eight service systems (alcohol and other drugs; employment support; family support; income support; health; housing support; justice; and mental health services). Those in Level 1 had similar service usage to the general population, while those in Level 5 had very high and complex patterns of service usage, including frequent use of mental health crisis services and hospitals, drug detoxification, income support, terms of incarceration and long-term income support.

The report estimated that 55 per cent of care leavers fell into high cost service usage pathways and that the children of people leaving care were also likely to end up on that pathway. By tracking the combined cohort of young care leavers, the research estimated the net cost to government over the course of 44 years from age 16 to 60 to be \$1.9 billion, or \$43 million per year. The net cost was calculated as the gap between the estimated costs of a cohort in the general community and this cohort.³²

The analysis suggested that even if no more than 10 per cent of individual care leavers in each service usage level were supported so they could move to the next less intensive level, gross savings in the order of \$128 million over the course of 44 years could be realised. Even a conservative level of additional support, aimed at improving the pathway of a modest proportion of care leavers, has the potential, over time, to result in substantial savings, not to mention the improvement to the lives of those individuals.

Jodie: A promising student set up to fail

Jodie was under the guardianship of the Minister from the age of 14. She lived initially with friends of her family, but that arrangement broke down when she was 16. At the age of 16, Jodie was placed in an independent living program run by a non-government organisation which provided supervision and support. She was attending high school and had goals to pursue higher education.

One week into her Year 12 studies, Jodie was informed that she would be moving to an independent living unit. The prospect of living on her own frightened her. She told the Commission:

On the day that they told me that I had to move out, I was hysterical ... what 17 year-old girl wants to live on their own, how am I supposed to afford it, I'm starting Year 12, how the hell do you think I'm going to get my good grades, and then I kept saying, 'This is why everyone in Families SA fails'.

The unit was located in a troublesome neighbourhood and was not close to Jodie's high school. Jodie was required to cover rent and all living expenses, including the internet which was necessary for her studies, from a Centrelink youth allowance. Jodie said that it was not uncommon for young people to live by candlelight or to go without food because they could not make ends meet on their youth allowance. However, Jodie managed to find a part-time job and saved the money to buy herself a car to drive to school.

As a result of the pressures of independent living, she cut back her studies to four days a week. Families SA offered no additional assistance such as tutoring to help her complete Year 12. She obtained a laptop computer through the non-government organisation after multiple requests to Families SA brought no action.

Jodie told the Commission that the decision to move her into independent living had:

set me back in Year 12, having to worry about paying bills, having food to eat, having a car to get to school, paying insurance, and still achieving high grades in school. This is nearly impossible ... I feel I have not been prepared and they have failed to do their job completely.

Jodie reported that it took her over 12 months to obtain her birth certificate from Families SA, when she needed it to apply for a tax file number. During a Year 12 retreat run by her high school, parents wrote letters of encouragement to their children; all Jodie received was a very short letter from a social worker.

Despite these barriers Jodie displayed remarkable resilience and ambition. She told the Commission in evidence that she had not abandoned her dream of going on to higher education and she had a clear path in mind of how she would achieve this. She knew this

would become even more difficult once Families SA withdrew its support altogether.

After moving into her independent living unit, Jodie was told that Families SA intended to close her case on her 18th birthday, which fell in the middle of her Year 12 exams. Jodie negotiated with Families SA to keep her case open until after her graduation from Year 12, but no support, including financial support, would be provided after that time. Jodie enquired about the possibility of leasing the second bedroom of another young person's independent living unit for a short period after her lease ended, hoping this arrangement would provide her with short-term accommodation and would assist the other young person financially. However, she was told that this was against policy.

Jodie told the Commission she felt let down by Families SA. She said:

The day [my 18th birthday] hits I have nowhere to live as they have said I will no longer 'need' their help. I feel that they have failed me and really set me up to fail. I will do the best I can; however I have no financial, physical, emotional help at all from any adult figure ... I feel I am just a number on the system who gets ticked off and then they move on to the next number.

I really believe this is why the per cent of children under the guardianship of the Minister who do not achieve ... in life is significantly high, as the support they received while in care was very minimal. Social workers only 'care' between the hours of nine to five.

Turning 18 is meant to be a highlight of your life and be an exciting time ... however for me it is not that at all. I am worried about what is next for me, where I go next, how I continue to live and pay for everything.

The Commission has recently learnt that Jodie managed to gain a scholarship to help fund her further studies.

Given Jodie's personal drive and motivation, adults around her might have assumed her capable of handling the challenges of independent living. But the resources of the state should stretch beyond basic assistance. Care leavers who are high achievers and have aspirational goals should not be neglected, but should be celebrated and given help to achieve their goals.

Jodie needed a transition-from-care plan that provided stability and support during her critical senior school years. She needed ongoing financial assistance after she turned 18 to help her find accommodation and meet the costs of tertiary education. Jodie would have benefited from tutoring to help her fulfil her educational goals as well as mentoring and guidance appropriate to her individual needs.

MODELS OF TRANSITION CARE

THE NATIONAL APPROACH

The importance of transition planning has been recognised through a priority project established under the National Framework for Protecting Australia's Children.³³ *Transitioning from out-of-home care to independence: A nationally consistent approach to planning* (the National Approach) was published in 2011.³⁴

Also published in 2011 were the National Standards for Out of Home Care, which refer to standards for young people transitioning out of care. Standard 13 requires that these young people have a transition-from-care plan from the age of 15 that details the level of support to be provided after leaving care.³⁵ Performance against Standard 13 is measured by:

- the proportion of young people aged 15 and over who have a current leaving care plan; and
- the proportion of young people who, at the time of leaving out-of-home care, report they are receiving adequate assistance to prepare for adult life.

The National Approach to transitioning from care seeks to produce broad consistency across the states and territories as to how the transition planning is achieved, as well as promote stronger links and better coordination of government and non-government services. The vision for the National Approach is described as follows:

*All young people transitioning from out-of-home care to independence receive support from governments, non-government organisations, family members and/or carers, business and the community to experience an effective transition and reach their full potential for social and economic participation.*³⁶

The National Approach offers a holistic perspective, requiring the following needs to be considered³⁷:

- housing/accommodation;
- health (physical, emotional—including self-esteem, mental, sexual and dental);
- education and training, employment or other suitable activity;
- financial security;
- social relationships and support networks;
- life (and after care) skills; and
- legal matters.

It endorses the inclusion of all relevant participants in planning, including the young person, their caseworker, foster parents, family members, other agencies and significant others in the young person's life. It sets out a three-phase approach which assumes a continuity of

effort from the preparation phase through transition to after care, with the key goals for each phase building on and consolidating work from the previous one.

At each phase essential elements are identified which have their origins in the evidence base relating to transition planning.³⁸

Preparation

- A transition plan is in place that meets the needs of both the young person and the agency.
- The young person knows their entitlements and how to access them.
- Personalised support is in place.
- Practical support is in place.
- General and preventative health needs are being addressed.

Transition

- The transition plan is implemented, is being overseen by a key person and is modified when required.
- The young person is accessing specialist and mainstream services for ongoing assistance.
- Personalised support is in place and information is being shared across agencies as appropriate.
- Practical support is in place and is ongoing as needed.
- Ongoing needs are being addressed to support participation, relationship building and stability.

After-care independence

- Independent living skills are consolidated.
- Support is ongoing.
- The individual is participating socially and/or economically.

The National Approach provides a best practice standard from which states and territories are asked to develop their own service models. It is expected that adherence to a broad, evidence-based approach will result in an improvement to the outcomes of care leavers across the nation.

INTERSTATE APPROACHES

In Australia, post-care support is legislated in New South Wales, Victoria, the Northern Territory and Western Australia.

In New South Wales the *Children and Young Person's (Care and Protection) Act 1998* mandated that the Minister provide or arrange for assistance for young people in care and care leavers between the ages of 15 and 25. The Minister is to provide such assistance as he or she considers necessary, having regard to their safety, welfare and wellbeing.³⁹

Assistance includes⁴⁰:

- the provision of information about available resources and services;
- based on an assessment of need, financial support and help with finding accommodation, setting up house, pursuing education and training, securing employment, and accessing legal advice and health services; and
- counselling and support.

Ministerial guidelines for the provision of assistance after leaving care were published in 2008.⁴¹ They state that a leaving-care plan should be informed by a needs assessment⁴², and that designated agencies must be involved in the transition planning as well as offer follow-up support at regular intervals in the years after the young person's exit from care.⁴³ The guidelines also recommend extra assistance based on an assessment of the person's needs and consideration of whether they are at risk of not successfully transitioning to independent living.⁴⁴ The young person should where practicable be referred to an existing service which may include a funded specialist after-care service.⁴⁵

In Victoria, section 16(1)(g) of the *Children, Youth and Families Act 2005* provides that the secretary of the relevant department has a responsibility to help young people under the age of 21 make the transition to independent living. However, this is a non-enforceable responsibility. A comprehensive framework for transition planning that refers to, and is consistent with, the National Approach is set out in the *Care and transition planning for leaving care in Victoria: A framework and guide*.⁴⁶

In Western Australia, the *Children and Community Services Act 2004* makes provision for services to young people under the age of 25 who at some time after the age of 15 were subject to a protection order or a negotiated placement, or were provided with a placement service for a period exceeding six months.⁴⁷ The chief executive officer (CEO) must ensure that qualifying persons receive help obtaining accommodation, undertaking education and training, obtaining employment, gaining legal advice, and accessing health and counselling services.⁴⁸ The CEO may also provide financial assistance (including a loan) to obtain, furnish or equip accommodation, cover moving costs or living expenses, or access employment, education or training.⁴⁹ Grants towards education and training costs may also be made.

The Northern Territory provides that the CEO of the department may provide assistance to young people who have left the care of the department and are between the ages of 15 and 25.⁵⁰ That assistance relates to obtaining accommodation, education or training, employment,

legal services, health services or counselling services. Financial assistance may be provided for education or training, obtaining and furnishing accommodation, or enabling a person to live near their education, training or employment.⁵¹

THE SOUTH AUSTRALIAN APPROACH

South Australian legislation does not impose any obligation on the Minister to continue supporting young people past 18 years of age. The *Children's Protection Act 1993* states:

The objects of this Act are–

- (a) *to ensure that all children are safe from harm; and*
- (b) *to ensure as far as practicable that all children are cared for in a way that allows them to reach their full potential ...*⁵²

When a child is placed under guardianship, the Minister assumes a heavy responsibility. Major decisions about the manner in which the child will be raised, their health care, their educational and recreational opportunities, where they will live, and who they will live with are all assigned by a guardianship order to the discretion of the Minister.⁵³ However, the *Children's Protection Act* contemplates that these guardianship orders operate only until the child is 18.

In response to the recommendations made by the Layton Review, the Act was amended in 2006 to include under the Minister's general functions a requirement that the Minister must endeavour:

- (h) *to provide, or to assist in the provision of, services*
- (i) *to assist children who are under the guardianship or in the custody of the Minister; and*
- (ii) *to assist persons who, as children, have been under the guardianship or in the custody of the Minister, to prepare for transition to adulthood.*⁵⁴

The Minister's responsibility for ensuring that 'all children are cared for in a way that allows them to reach their full potential'⁵⁵ extends only as far as requiring that the Minister 'endeavour' to assist care leavers and young people under guardianship to prepare for transition to adulthood. There is no obligation imposed on the Minister to provide services past the age of 18, nor is there any prescriptive explanation of what this assistance might actually entail. At present, the legislation does not adequately reflect the attention that should be given to this critical aspect of a young person's journey from care.

Neurological research indicates that achievement of the legal age of majority does not coincide with complete maturation of the frontal lobes of the brain—the part of the brain responsible for high-level decision making and reasoning. Rather, these structures appear to fully mature in early adulthood, after the age of 20.⁵⁶ Research also suggests self-regulatory competence is not fully developed until early adulthood. The functional modern family structure implicitly accounts for this, and is usually flexible enough to respond to the various rates at which a young person will be ready to take on the responsibilities of adulthood.

In the current social environment, it is a rare family that requires a child to leave home and relinquish family support at the age of 18. Educationally, socially and financially, many young people benefit from receiving the support and guidance offered by caring adults well beyond this age.

The lack of a prescriptive obligation on the Minister to provide support past the age of 18 stands in stark contrast to the approach taken in modern families. The current legislative regime remains a 'surgical cut at age 18'⁵⁷, which occurs irrespective of the young person's readiness for independence. Research conducted in South Australia found that almost all service providers interviewed believed that care leavers were not developmentally mature enough to independently negotiate the adult world without the support of a caseworker.⁵⁸ Many considered it unreasonable that these young people were expected to face these challenges much earlier and more abruptly than their peers. Comments in the submissions received by the Commission reflected similar concerns:

*Young adult care-leavers are often without any form of safety net to soften their inevitable falls and guide them through the challenges independence presents. This absence of support means that young adult care leavers are also denied the recognition and comfort of affirmation for their achievements and strengths.*⁵⁹

'Young adult care leavers are often without a safety net to soften their inevitable falls and guide them through the challenges that independence presents'

Data from Families SA indicates that 269 of the 301 young people who transitioned from care in the two years between 1 January 2013 and 31 December 2014 had their files kept open for a period of 30 or more days following the expiry of their court order. Of this cohort, approximately 10 per cent had cases that remained open

with Families SA as at 23 April 2015. These relatively low figures are not surprising given the Commission found that the Agency has a very limited capacity to deliver meaningful post-care services to young people.⁶⁰ In the absence of a legislative mandate, any work after the young person turns 18 is ad hoc and is at the discretion of the individual caseworker and the district centre manager who must approve it.⁶¹ The Commission was advised that while there was evidence of local managers being prepared to extend services to young people beyond 18, executive level approval was infrequently given, meaning very few young people were supported beyond 18 for more than a short three-month period.⁶²

TRANSITION PLANNING POLICY

The Standards of Alternative Care in South Australia recognise the need for transition planning.⁶³ Core Standard 7 of that document requires that transition planning for young people leaving care begin when they are 15 years of age and 'gain clarity and intensity'⁶⁴ as the young person approaches 18 (or the time of their planned exit from care). The Redesign process in Families SA has resulted in a number of policy changes to the way in which young people transitioning out of care are being supported. It has also changed the way in which cases are managed in local offices.

Transitioning from care in South Australia is governed by the Transition from Care Service Model⁶⁵ and the Transition from Care Work Instruction.⁶⁶ The service model records its objectives as follows⁶⁷:

- to provide case management services to young people who meet the eligibility criteria;
- to maximise young people's capacity to live independently in the community;
- to assist young people to obtain and retain accommodation; and
- to improve social, emotional and economic outcomes for young people leaving care.

It records desired outcomes as follows:

- Young people experience a well-planned gradual transition to independence.
- Young people are adequately prepared with the full range of practical skills they need to live independently.
- Young people are better informed of community services/supports available post care.
- Young people transition from care to stable accommodation and are able to meet the obligations of a tenancy agreement.

Neither the service model nor the work instruction make any reference to the National Approach, nor do either appear to be modelled according to its underlying principles, which endorse a holistic approach to transition planning with continuous assessment of the young person, identifying strengths and goals in each of their life domains. The worker is required to refer back at all times to the life domains, including health, education, training or employment, and identity and culture. This ensures that the focus is wider than simply the development of practical skills, and challenges young people to consider a more aspirational trajectory.

This wider focus is missing from the service model and work instruction currently operating in Families SA. The service model is focused on the attainment of practical goals. It makes no reference to the three phases of transitioning (planning, transition and after-care) nor does it consider how those three phases might be translated into practical case management. In order to improve the trajectory for care leavers, a service model should be developed that is consistent with the National Approach and incorporates its principles of best practice.

The service model also requires that on reaching the age of 15, all young people with a complexity assessment rating (CAT) of 1 or 2 will have their case management transferred from a case manager (generally a qualified social worker) to a transition-from-care youth worker. This model replaces the previous one where the child's existing caseworker would be responsible for supporting the child's transition.

ROLE OF TRANSITION-FROM-CARE YOUTH WORKERS

The service model requires the following:

Adequately qualified and trained staff will provide a Transition from Care service that supports the achievement of the objectives and outcomes as stated above. All staff will be required to have a qualification (i.e. Certificate III, IV, Diploma, Advanced Diploma(s) or Degree [in a relevant field]).⁶⁸

Transition-from-care youth workers are employed at an OPS3 classification. Appointment to the position does not require any minimum qualifications.⁶⁹ The OPS3 classification is remunerated at an annual salary of between \$56,330 and \$60,314. By comparison, a base level social worker employed at the AHP1 classification would be remunerated at an annual salary of between \$57,127 and \$70,111.⁷⁰ The employment of OPS3 youth workers in a case management role is inconsistent with the requirements of the service model.

The policy decision to employ OPS3 workers to case manage young people at a critical phase in their care journey is short-sighted. Built into the process is a change of caseworker at a critical time for the young person. For many, this will be another in a long series of changes that mar their out-of-home experience. Continuity of relationships throughout a child or young person's care journey is frequently ruptured by workers moving on, by young people changing placements to different geographical areas and by other events which may be unavoidable. Good service planning works to minimise those changes as much as possible.

As different circumstances arise, an adolescent may move rapidly from being a low complexity case to one of higher complexity, due to complications such as drug taking, or other risky behaviours.⁷¹ This highlights the dangers of allocating case management responsibilities to less qualified workers on the basis that their skills will be adequate to manage cases of lower complexity. The current service model for transitioning from care places young people entirely in the hands of workers who lack the level of skill and knowledge that is acknowledged in the Allied Health Professional (AHP) classification, which requires social work qualifications as a minimum standard. This strategy gives little weight to the importance of continuity of case management relationships for young people, particularly at a very difficult and potentially complex time in their lives.

The transfer of the whole case management responsibility to transition-from-care youth workers at the age of 15 also sends a potentially frightening message to a young person: the focus of work will now be on moving them out of care, rather than incorporating the transition service as an add-on to standard case management relationships.⁷²

INTER-AGENCY COLLABORATION

The fragmented nature of services for young people leaving care was a consistent theme throughout the Commission's investigations. In South Australia services appear to be siloed, and impeded by compartmentalisation.⁷³ The lack of integration, particularly between children and adult health care services, makes the transition difficult for care leavers with mental health problems or disabilities. There is a disparity between the services offered by the Child and Adolescent Mental Health Service (CAMHS) and the services available in the adult mental health system. The Commission also heard that attempts are occasionally made to coordinate or share the management of young people who might have a combination of problems. A young person may be deemed eligible for only one service based on an assessment of that being the more pressing problem, when in fact a wrap-around approach from a combination of service providers would be more useful.⁷⁴

A collaborative approach would help provide care leavers with efficient and effective support.⁷⁵ A more integrated system for transitioning from care should be developed which allows for better service coordination and information sharing among government agencies and the non-government sector. While it is beyond the Commission's terms of reference to make recommendations regarding the manner in which the state's health care services are coordinated, it is noted that there should be a greater focus on the needs of the individual over time so that the same agency can provide a continuous service from adolescence into adulthood.⁷⁶

CASE PLANNING

In line with the National Standards, the Transition from Care Service Model requires that planning for a young person's transition commence at the age of 15.⁷⁷ As noted above, a key indicator against which performance is measured is the proportion of young people in out-of-home care aged 15 and above who have a current leaving care plan.

Table 14.1 sets out the percentages of young people in the care of Families SA who were entitled to transition planning according to the National Standards and who had a current transition-from-care plan for the relevant financial year:

Table 14.1: Young people under the guardianship of the Minister entitled to transition planning and who had a current transition-from-care plan

YEAR	ENTITLED TO PLANNING	RECEIVED PLANNING	PERCENTAGE
2011/12	611	199	32.6
2012/13	645	213	33.0
2013/14	617	206	33.4
1.7.2014 – 31.12.2014	553	135	24.4

Source: Data from Department for Education and Child Development.

The fact that fewer than one-third of young people who were entitled to transition planning actually received that service demonstrates that insufficient attention is being paid to it.

Young people more generally report receiving limited career planning and little information about what training and employment options may be available to them.⁷⁸ All too frequently, young people approach the age of 18 without a clear understanding of how they will access adult services and accommodation.⁷⁹

The Commission examined one young person's transition from care in Vol. 2, Case Study 3: 'Hannah'. It found that Hannah's planning lacked acknowledgment that 'independent living' is a multifaceted concept, and its attainment requires more than securing a house and an income and developing the skills to manage each of those things. There was limited consideration of Hannah's goals, and the skills she would need to achieve those goals.

Hannah was not provided with adequate opportunities to participate in case planning, or identify the goals of the transition plan. There was little evidence that the case planning by Families SA sought input from other significant adults or service providers in Hannah's life, including the independent living program in which she was involved. Hannah's voice was also excluded from consideration of planning for her future. Hannah's experience highlighted the need to prioritise the engagement of young people in planning their future. Not only does such an approach reflect best practice, but it also reflects the important expectation that young people will start to take responsibility for their own life paths.

Standard 4.1 of the Standards of Alternative Care require that a young person be an active participant in all decision making that relates to them.⁸⁰ This is reflected in the Transition from Care Work Instruction which requires that case management engage the young person in developing their plan and working towards achieving their goals.⁸¹ The case study of Hannah revealed that in practice she was not consulted sufficiently about important decisions that affected her transition.

The lack of planning for young people's transition from care is unacceptable: it is an area in which South Australia should work to meet the National Standards. It is hoped that Families SA's recent introduction of a transition-from-care plan template and a checklist of actions to be completed prior to a young person's exit from care will lead to an improvement in this area. However, a more fundamental shift is required—from the current case management approach which is reactive, piecemeal and crisis focused, towards one that is forward thinking, holistic and person-centred.

LIFE SKILLS

Before the changes imposed by Redesign, teams of youth workers specialising in supporting young people transitioning out of care delivered life skill development programs in money management, food management, safety in the home, tenancy training and accessing community resources.⁸² Under the new service model these programs are no longer operational.

The Commission heard evidence that residential care units and commercial care settings are particularly poor at equipping young people with the skills required for self-sufficiency. A former youth worker in a residential care facility told the Commission that a culture shift in combination with a change to service principles has led to young people not being encouraged to take responsibility for themselves:

When it came to going to school, going to medical appointments, keeping money aside so you've got bus tickets to get around—all of that changed ... they weren't being set up with the right skills because we were just doing everything for them, and there was no accountability if they didn't do anything for themselves. So they go from literally one extreme to the other, of being in a unit with fulltime staff, there's always food there, there's always a warm bed; everything is there for them ... to moving into a house on their own with no budgeting skills, don't know how to cook a meal, don't know how to wash their clothes, don't know how to keep the room tidy, and then they're expected to just live there with a worker that will come and see them every two to three times a week.⁸³

One residential care unit supervisor spoke about the limited capacity of residential care facilities to cater for young people developing skills such as driving.⁸⁴ There was no clearly identified process about how lessons would be funded, and who would be responsible for taking the young person out to achieve the necessary driving hours.⁸⁵ The Commission also heard evidence about commercial care environments where young people approaching their transition from care are being cared for around the clock with no consideration given to the need to develop their life skills.⁸⁶

There is scope for life skills programs to be outsourced to the non-government sector. Existing programs run by the CREATE Foundation as well as several independent living programs are discussed below. The key role for the specialist transition-from-care youth workers in that case would be to ensure that young people are engaged in the program that is best suited to their overall goals.

In addition to formalised programs, however, a young person's progress should be tracked to ensure that they are being helped to develop the necessary life skills in their out-of-home care environment. For many young people in stable foster or kinship care environments, this may involve the transition-from-care youth worker helping the main carer with a range of tools for modelling independent living skills.⁸⁷

FINANCIAL ASSISTANCE

The Families SA Financial Counselling and Support Program has the capacity to provide a range of financial support services for young people over the age of 15 who are transitioning from care or moving into independent living and for adults who have spent a period of six months or more in care.⁸⁸

In practice, this generally involves helping young people to set up a bank account and tax file number, and apply for Centrelink payments and any transition to independent living grants that may be available.⁸⁹ It might also involve paying for driving lessons for the young person. While there is potential for financial counsellors to work with young people to develop their financial planning and budgeting skills, this is an ad hoc service which relies on a referral being made by the young person's caseworker.⁹⁰ Post-care financial services are provided on the basis of self-referrals and vary depending on individual needs, but may include help managing utilities bills, for instance.⁹¹

Young people moving from care to independent living are eligible for adolescent community brokerage money which is funded from the Commonwealth/State National Affordable Housing Agreement.⁹² The payment is not available for young people who remain in home-based care at the time of their exit. Brokerage is paid to a maximum of \$5000 for purchasing furniture and household items. Although it is intended that the funding be 'innovative and flexible in meeting the specific and individual needs of the young person'⁹³ there are restrictions on what can and cannot be bought. An itemised account including quotes for goods to be purchased must be provided to Families SA.⁹⁴ A young person cannot use brokerage funds to purchase furniture informally, although second-hand goods can be purchased as long as the vendor has an ABN.⁹⁵

The transition to independent living allowance (TILA) is an allowance of up to \$1500 funded by the federal government, which may be used in a variety of ways. The TILA is available for young people aged between 15 and 25 and can be applied for in addition to any other assistance that may be available from other sources.

Carer subsidy payments made by Families SA cease when a young person turns 18, making many foster parents unable to continue looking after young people due to additional financial pressures. To address this issue, the Layton Review recommended that funds be made available to extend care payments to foster families if the young person remains in their care.⁹⁶

In 2006, Families SA introduced a limited subsidy for carers when a young person is over the age of 18 and still engaged in secondary education. It does not continue if the young person goes on to tertiary education, nor is it sufficiently flexible to support the variety of other

legitimate pathways that young people may wish to pursue, such as vocational traineeships or entry to the job market. Importantly, the subsidy ceases in the case of young people who are arguably the most in need of ongoing support and stability—those who are disengaged from education and at risk of choosing less desirable pathways.

Financial assistance available for young people transitioning from care lacks a cohesive delivery strategy. The benefits of the Financial Counselling and Support Program are gained only by young people whose caseworkers proactively seek it out. By contrast, jurisdictions such as New South Wales, Western Australia and the Northern Territory have legislated the responsibility of the Minister to provide broad ranging financial assistance to care leavers. The CREATE Foundation's Ms Scalzi advised the Commission that in this state it remains the case that many care leavers are simply not aware of their entitlements under grants such as TILA and the Dame Roma Mitchell Fund.⁹⁷

Once a young person is moved into an independent living arrangement, they are expected to manage their finances with minimal support, including negotiating complex systems such as Centrelink.⁹⁸ While this approach may be considered good practice for adulthood, it is necessary to recognise that frequently these young people:

*come from a trauma background ... and quite often there can be intellectual delays, so ... they wouldn't have the mental capacity to be able to deal with someone at Centrelink. And they haven't got the resources to be able to provide the information Centrelink want at the time, like tax file numbers, and things like that, at that age.*⁹⁹

A NEW APPROACH TO SUPPORTING CARE LEAVERS

The Commission recommends that the Children's Protection Act be amended to impose a specific obligation on the Minister to provide or arrange assistance to care leavers up to the age of 25 years. Such assistance should specifically include the provision of information about services and resources (especially financial grants and assistance for care leavers); financial and other assistance to obtain housing, education, training and employment; and access to legal advice, health services, counselling and support. Consistent with the NSW model, the specific details of the assistance should be articulated in ministerial guidelines. The assistance provided should include, in appropriate cases, extension of payments to foster and kinship carers to help them continue to care for young people who are pursuing post-high school education or training, including TAFE and apprenticeship-based qualifications.

Some improvements in service accessibility for care leavers may also be accomplished by reinvigorating Rapid Response prioritisation policies, and extending their application specifically to people leaving care up to the age of 25.¹⁰⁰

The current service model and work instruction do not give sufficient emphasis to the best practice elements clearly set out in the National Approach. The service model and process documents should adopt a more sophisticated approach to transition planning, consistent with the National Approach. Specific reference should be given to how to support young people who wish to engage in post-high school education and training.

Transition-from-care youth workers should not be used as case managers. Instead, they should be developed as an add-on service, available to support a young person's transition from care throughout the planning, transition and after-care independence phases. The service should be offered to young people for whom continuous support by Families SA is likely to be appropriate. This would enable caseworkers to access the specialised knowledge and community networks of the transition from care youth workers, while maintaining the high standard of case management that is expected of tertiary qualified case workers. Young people may also be encouraged to engage with services if they can turn to the youth workers for additional support and consultation:

*Often when you're doing casework there's conflict between the caseworker and our young people from time to time. The ... major role of a youth worker should be engagement with young people and, if they're not doing the case management, it's a lot easier to engage with young people, even at that complex level, over a period of time starting at 15.*¹⁰¹

*So, depending on the young person, that could be as simple as initially starting more of a mentor role, really, until you've engaged, and then start setting goals with that young person towards independence.*¹⁰²

All young people transitioning from care should receive sufficient help from the Financial Counselling and Support Service to enable them to develop their financial management skills and take advantage of any financial support to which they are entitled. Following the lead of other jurisdictions, the Minister's capacity to provide financial assistance after a young person leaves care should be expanded to include contributions towards accommodation, living expenses, and education and training costs.

SUPPORT SERVICES FOR CARE LEAVERS

There are a number of non-government agencies which provide support to young people leaving care, and which have contractual relationships with Families SA.

THE CREATE FOUNDATION

The CREATE Foundation is the national peak consumer body representing children and young people with out-of-home care experiences. In South Australia it is funded by Families SA to provide a number of programs and services that support young people transitioning from care.

The CREATE Your Future program delivers a series of practical workshops to support young people aged 15 to 25 across seven life domains: education, training and employment; identity; relationships; health and wellbeing; finance; housing; and life skills.¹⁰³ The program aims to provide young people with 'that stuff you miss around the kitchen table'¹⁰⁴ as a consequence of growing up in care. The workshops are held alongside recreational activities, including camps, to encourage attendance. Young people can attend as many of the modules as they like, and can consolidate their skills through advanced sessions.¹⁰⁵

The program includes an annual scheme providing grants of up to \$3000 to members of clubCREATE for items such as laptops, driving lessons, educational resources, and accommodation and living expenses.¹⁰⁶

The running of such programs is not without challenges. Running camps in particular is a costly exercise which is encumbered by the difficulty of finding suitable volunteers to assist.¹⁰⁷ The ability to offer such programs to children and young people living in rural regions is especially limited by budgetary constraints.¹⁰⁸ These programs also have a limited capacity to cater for young people with high or complex needs.¹⁰⁹ Group-based activities that bring together young people who have complex trauma and abuse histories can be challenging and require a high degree of risk management.¹¹⁰

Despite their limitations, programs such as CREATE Your Future offer young people 'an opportunity to connect ... with other young people with the care experience, make them feel that they're not alone, and connects them with their community'.¹¹¹ Importantly, these programs are not restricted to those under the age of 18, meaning that care leavers can continue to benefit from these programs after transitioning to independence. Additional funding to allow programs to cater for young people with a range of needs, through one-on-one sessions where necessary, would ensure that all young people leaving care are properly equipped with the life skills required for independence.

Research by the CREATE Foundation has found that information and resources about transitioning from care are fragmented and difficult to navigate.¹¹² The CREATE Go Your Own Way kit is a recently developed resource for young people aged 15 and above who are starting to plan their transition to independence.¹¹³ The kit includes information across the seven life domains covered in the CREATE Your Future program and is supported by a website where young people can find further resources. The kit is currently being piloted in South Australia, with an evaluation under way of 84 kits that were distributed to young people turning 17 in 2014.¹¹⁴

CREATE is also interested in developing a smartphone application for care leavers.¹¹⁵ The relevant department in Queensland has piloted such a tool, and in Victoria care leavers have access to a dedicated leaving care helpline which they can call for social support, for advice or for a referral to local support services.¹¹⁶ Many children and young people respond to strategies that use social media and technology based tools to keep them informed of available services.¹¹⁷ Research suggests that the use of smartphone applications has the potential to enhance social networks and 'give young people an opportunity to engage in their own time and at their own speed, and help resolve distrust in services or organisations'.¹¹⁸ Innovations of this kind, where supported by an evidence base, should be embraced.

CREATE's Speak Up program is available to young people aged 14 to 25 who are interested in becoming CREATE young consultants. Participants learn about the care sector, and develop advocacy, leadership and public speaking skills through a three-level training program. As young consultants, they use their stories and experiences to represent CREATE at local, state and national events and forums.¹¹⁹ Aside from the obvious benefit of giving young people the opportunity to have their voices heard, the program builds participants' confidence and provides them with skills that will empower them into adulthood. Ms Scalzi told the Commission of one young person who:

*was unaware of CREATE while being in care, but postcare, she was engaged in education at TAFE, and needed to do a community module, and found out about CREATE that way. And since then, she's done all levels of Speak Up; she's been to Ministers' meetings; she's been to CREATE conferences. She's applied for grants. She's kind of cofacilitated on camps. She's highly engaged—it's given her a purpose.*¹²⁰

In South Australia membership of clubCREATE is not automatic on a child or young person's entry into care. The organisation is obliged to spend its limited resources on locating and attempting to engage children and young people. Reaching out to care leavers who may be interested in participating in programs such as Speak Up

is particularly challenging as neither Families SA nor the post-care services provider, Relationships Australia, are able to share the contact details of young people.

Young people should be signed up to clubCREATE as a matter of course on entering care, with the choice of opting out should they choose. This would ensure that all children and young people in care are made aware of the programs on offer and would free up resources to be utilised where they are needed most.

The CREATE Foundation provides a unique service and has established credibility with young people with an out-of-home care experience. They should be assisted in utilising their funding in the most efficient way. The Commission recommends that the Department reach an administrative arrangement with the CREATE Foundation to provide details of children when they enter care. This arrangement should strictly control the use to which such data can be put, and also require CREATE to provide an easily accessed exit option from membership.

The Commission also recommends funding the development of a smartphone application to provide young people with up to date information about programs and services.

SUPPORTED INDEPENDENT LIVING PROGRAMS

Families SA has contracted with non-government agencies including The Salvation Army, Anglicare and Baptist Care (SA) Inc. for the provision of programs that support young people transitioning from care. These services are generally bundled with independent living accommodation.

Young people are referred to these programs through the Families SA Placement Services Unit. Once a referral is received, program managers meet with the young person and their caseworker to identify whether the young person wishes to engage with the program. They also assess the suitability and readiness of that young person to move towards independent living.

However, it appears that many young people are referred to independent living programs not because they are ready to take that step, but because it is the only viable placement option once home-based care and residential care are no longer suitable for them (see Volume 2, Case Study 3: Hannah).

Each program offers a range of practical supports for young people including, but not limited to:

- developing life skills such as cooking, cleaning, budgeting, shopping or accessing public transport;
- applying for and engaging in education or employment;
- managing and maintaining health;
- developing community and social connections;
- addressing legal issues;
- developing and maintaining positive relationships; and
- learning to access long-term housing options.

As the approach adopted and the capacity to provide support vary somewhat across the programs, each service model is outlined briefly below.

MUGGY'S ACCOMMODATION SERVICES, THE SALVATION ARMY

The Salvation Army runs three Muggy's programs servicing the north and south metropolitan areas, as well as multiple north-western country locations, which are managed from offices at Port Pirie and Whyalla.¹²¹ Each program has the capacity to work with 20 young people.

Each program leases houses to young people transitioning from care. Some properties are owned by Families SA, some by The Salvation Army and others by Housing SA. A young person can be referred to the program from the age of 15, but they will not usually be allocated a property until they are at least 16 years old, which is when they become eligible for a youth allowance payable through Centrelink. Young people in the Muggy's program agree to pay for food and \$85 a week in rent from that allowance, although the costs of utilities are paid by the program.¹²² They are able to furnish the home using brokerage funds available to care leavers, and the goods purchased remain theirs to keep when they leave the program.

Staff are available 24 hours a day at a centrally located office which is also equipped to provide temporary accommodation and intensive support to a young person prior to their transition into a property or during times of crisis.

In order to remain in Muggy's accommodation, the young person is expected to engage with workers and maintain regular attendance at appointments. These may take place two to three times a week at either the Muggy's office or, more commonly, at the young person's home. The appointments are scheduled in accordance with a case plan, renewed every three months, which incorporates goals that the young person, in conjunction with their key workers, wishes to work on based on identified support needs and interests.¹²³

YOUTH 180, ANGLICARE

Anglicare's Youth 180 program offers nine independent living placements throughout metropolitan Adelaide in properties owned by Housing SA. These properties are usually available to young people once they turn 16. While the program does accept referrals of young people older than 16, the fact that participants must transition out of their placement at the age of 18 means that any young person referred after the age of 16 will have less time in which to develop independent living skills in a supported environment. Youth 180 can continue to offer outreach support up to the age of 19.

Young people have an individual care plan which is developed around eight independent living skills domains.¹²⁴ The care plan is updated monthly by the youth caseworker following consultation with the young person, their youth carers, their Families SA case manager, and any others who may be involved in the care team.

It is not an essential requirement of the Youth 180 program that young people be in receipt of a youth allowance from Centrelink. However, if they do receive an allowance, a contribution of \$40 a week towards rent is expected. Groceries and utilities are covered by the program because these are shared with the youth carers. Youth 180 properties are furnished, although Youth 180 provides the young person with some financial support to decorate the property.

STABILISATION AND TRANSITION SERVICE AND SUPPORTED INDEPENDENT LIVING PROGRAM, BAPTIST CARE SA

Baptist Care SA (Inc.) is contracted to offer two transitioning-from-care services to young people under guardianship.

The Stabilisation and Transition Service (SATS) assists young people from the age of 14 to 18 to build independent living skills in a congregate care environment. The program operates at two properties, one of which accommodates up to four males and a second which accommodates up to six females. The properties are split into units, each with two bedrooms, their own living area and kitchen. The facilities are staffed 24 hours a day by one or two support workers who assist young people with the development of independent living skills. Each young person is assigned a case manager who is tasked with tracking the young person's progress.¹²⁵

The SATS program is commonly used as a stepping stone to programs such as Muggy's or Youth 180.¹²⁶ Young people may start out in the SATS program at age 14, and after developing their independent living skills in a supported congregate care environment for two

years, will transition into one of the independent living programs.¹²⁷ The SATS program has limited outreach capacity once a young person has left the program.

The Supported Independent Living Service (SILS) can accommodate up to seven young people aged between 15 and 18. The program is an extension of the SATS program with an added independent living component. There are four properties in Murray Bridge and three in Mount Gambier where young people live independently and receive case management support. A fourth property in Mount Gambier which acts as a stabilisation house, can accommodate up to two young people. The properties are owned by Housing SA but are allocated to Families SA and provided to Baptist Care for use in the SILS program.

Baptist Care has an arrangement whereby Junction Australia, under the supervision of Baptist Care, administers the lease of the independent living unit to a young person. This is intended to separate the support provision role undertaken by Baptist Care from Junction's tenancy management function, encouraging a more collaborative approach between the young person and Baptist Care.¹²⁸ Once a young person is eligible for a Centrelink youth allowance, they are expected pay for their living expenses as well as \$50 a week in rent. However, there is a degree of flexibility whereby Baptist Care can instruct Junction Australia not to collect rent for a certain period if, for example, the young person is waiting for their youth allowance to be approved by Centrelink. Similarly, as with the Muggy's program, young people must furnish their independent living unit using their brokerage funds.

Young people in the SILS program can remain in their independent living unit for as long as their file remains open with Families SA. In practice, this generally means that young people are transitioned out at about the time of their 18th birthday.

A NEED FOR GREATER PROGRAM FLEXIBILITY

Each program offers a slightly different service model, with variations in the level of support offered. The Muggy's program, for instance, suits young people with a higher level of independence because there is not the live-in support available in some other models. The availability of a variety of service models makes it more likely that a young person will be able to be matched to a program that suits their particular needs. Some programs, however, have been criticised for expecting too much of young people who are trying to live independently for the first time.

Some witnesses believed that some programs had rules that were too rigid for the needs of young people.¹²⁹ For example, different programs had different rules about young people sharing accommodation. In some cases, housing together those with complex needs may

be detrimental to their successful transition from care. For some, having their own space is a welcome change from congregate care arrangements.¹³⁰ Others, however, may be highly fearful of living alone. Service flexibility is needed to ensure that the varied needs of young people are appropriately met.

The principles of the Muggy's program require young people to experience the natural consequences of their actions. This means that if a young person consistently fails to meet their rental obligation, or fails to abide by tenancy rules or program expectations, their housing lease will be at risk, and ultimately may be terminated. However, these expectations are balanced with a high level of staff persistence, and a high degree of flexibility in service delivery. As the program operates on a 24-hour staffing roster, appointments are scheduled around young people's commitments. The fact that appointments are usually held in the young person's own home is consistent with research suggesting that meeting young people in their own environment can help to facilitate engagement and alleviate levels of discomfort and anxiety.¹³¹

Services should be wary of imposing expectations that ignore the underlying trauma history of some young people which may impact on their willingness or capacity to engage, particularly where services operate on traditional appointment structures.¹³² As in a modern family, services should be sufficiently flexible to help young people learn from mistakes by not closing the door on assistance and by offering multiple chances for re-engagement.¹³³ The Muggy's program has a strong commitment to continuity of care, which means that even if a young person loses their tenancy, Muggy's remains open to working with them towards another tenancy.¹³⁴

The Youth 180 program uses a trauma focused therapeutic approach that is strengths based.¹³⁵ This is particularly relevant when working with adolescents, which is often the age at which the complexities of a trauma background become more evident. Youth 180 emphasises relationship building and providing young people with a sense of belonging.¹³⁶ Ms Jo Press, the Manager of Anglicare's residential care programs, told the Commission that:

The best opportunities for young people to be able to have the best outcomes they can have ... is really primarily not through whether or not they know how to budget or they can wash dishes or they can go grocery shopping. Those things are important, I'm not meaning to dismiss them, but it's more about how they feel a sense of worth and a sense of belonging and how they understand how to have, you know, healthy relationships. So my primary concern in Youth 180 is that it always comes back down to the relationship and maintaining the relationship with the young person

*over and above all the other things that fit into that. You do those alongside it, but the relationship's got to be central to everything that you do.*¹³⁷

In line with research highlighting the importance of stability and positive relationships in building resilience, independent living programs should aim to do more than just equip young people with basic life skills. Building relationships with young people needs time and flexibility but requiring young people to transition out of independent living programs at the age of 18 limits the capacity of the programs to develop these links. This becomes particularly problematic when referrals are received after the young person's sixteenth birthday, and the time available to work together is reduced:

*We don't have as much luxury to nurture them in their homes, because it's ... kind of all business when they come in ... later ... we do have to try and move them on a little bit quicker.*¹³⁸

The Commission heard of only a few examples where contractual conditions with service providers had been relaxed so they could keep working with young people after the age of 18, when circumstances required continued support. However, there are strong arguments in favour of the state funding independent living programs run by the non-government sector to provide formalised support and accommodation to young people beyond the age of 18.

In accordance with best practice principles, transition to independence should occur at a pace determined by the young person. Extending the support offered by these programs past the age of 18 may remove the pressure to make the initial referral before the young person is ready. It would give programs greater flexibility to work with young people for as long as required to ensure a successful transition.

The non-government sector may be better placed than Families SA to continue working with young people after this age.¹³⁹ One witness observed:

*What I do notice in Youth 180 is that young people in care are jumping at the bit to get themselves out of care once they turn 18. So I think that we would need to think about how we do that. I don't think that young people want to be stuck in care, or they would consider to be stuck in care, until they are 25. My preference would be that the guardian was able to perhaps step aside at 18, but those services that held a relationship with those young people ... could continue to provide services mostly again of an emotional and relational support for that young person up to a much greater age.*¹⁴⁰

There may also be an advantage in spreading the responsibility and accountability across sectors and services. Positive experiences with non-government services could be used as the vehicle to develop trust and gradually introduce mainstream government services.¹⁴¹

One of the primary criticisms of the current system is that young people lose relationships they have formed with carers and caseworkers on turning 18, leading to renewed feelings of abandonment and rejection.¹⁴² When relationships constantly change it becomes difficult for consistent plans to be developed. The young person is more likely to lose trust in services and relationships, making them reluctant to seek out services in future. The ability to maintain continuity of care and relationships is all the more important for young people who have difficulty with building trust and relationships in the first place.

A working model exists in New South Wales, where designated agencies that supervised the young person's last placement must provide follow-up support at regular intervals in the years following their exit from care.¹⁴³ Such a model should be considered as an alternative, in appropriate cases, to Families SA's approach in which a transition-from-care worker extends their supports to a young person beyond the age of 18.

If such a model is to be workable, existing independent living programs would need to expand. Both Youth 180 and the SILS programs have waiting lists for a limited number of placements.¹⁴⁴ Although the Muggy's program has greater capacity with funding for 20 young people in each of its north, south and country programs, a waiting list still applies. All the programs are limited by the discrete locations in which they operate. Greater investment in such programs is likely to make economic sense. Evidence suggests that these sorts of programs are more cost effective than commercial or residential care.¹⁴⁵

The Department should review its contractual conditions with independent living programs with a view to developing a more flexible approach to the age of admission and the circumstances in which a young person leaves. Particular consideration should be given to continuing accommodation support for young people who wish to engage in higher education or after high school training.

HOUSING SA INITIATIVES

In recognition of the difficulties that care leavers face in securing accommodation, Housing SA has committed, under its Rapid Response–Whole of Government Services

policy¹⁴⁶, to provide eligible young people leaving guardianship with timely access to housing advice and assistance.

Where public housing is identified during transition planning as the most suitable option, young people should be given priority allocation, most commonly through the Direct Lease Youth Priority Scheme. This scheme offers short-term housing (typically for a period of two years) to young people aged between 16 and 25 who have had difficulties accessing other accommodation.

Despite the Rapid Response policy, securing suitable housing remains one of the biggest challenges for young people transitioning from care.¹⁴⁷ The waiting time for an allocation can be so long that referrals must be put in to Housing SA around a young person's sixteenth birthday.¹⁴⁸ Too often housing and accommodation options are not explored early enough, resulting in limited housing options at the point of transition. This places increased pressure on Housing SA and creates a high level of anxiety in young people about where they are going to live.¹⁴⁹ The shortage in public housing also places pressure on Families SA to move young people as soon as they are allocated a property, irrespective of the readiness of the young person to make that move.¹⁵⁰

Inter-agency collaboration is not always as effective as it should be. Referrals provided by Families SA to Housing SA can lack critical background information. This means that Housing SA is unable to fully assess risk or put in place appropriate supports for young people moving into public housing.¹⁵¹ There has also been a lack of active support from Families SA once a young person moves to a Housing SA property. The manager of the Southern Region of Housing SA, Danielle Bament, told the Commission that a lack of support can result in young people getting 'into trouble with their tenancies early on, whether it's debt, or disruption, or just putting their tenancies at risk'.¹⁵²

Housing SA data showed that, as at 30 June 2014, 20.3 per cent of active public housing tenancies in South Australia contained at least one occupant who was currently, or had previously been, under the guardianship of the Minister.¹⁵³ Once in the public housing system, a large proportion of young people become entrenched and go on to some other form of public housing at the end of their direct lease.¹⁵⁴ Young people who transition from care can face challenges in breaking this pattern.¹⁵⁵

Public housing is not always the best option for vulnerable young people exiting guardianship: it often groups together in one area people with a variety of complex needs¹⁵⁶ and it is often located in low-income, high unemployment areas.¹⁵⁷

Public housing lease conditions, which permit only one leaseholder, also restrict young people from entering share housing arrangements. Although tenants can apply to have another person live with them, they retain responsibility for maintaining the tenancy. This can be difficult for young people to manage if the person with whom they are sharing causes problems or disruptions.¹⁵⁸ Ms Bament said:

*A lot of the tenancies in public housing among young people were going badly because ... they wanted to be more social. They reported to [Housing SA] and Families SA they don't like living by themselves, it's the first time they've ever lived by themselves, so they have friends around, and get into a bit of trouble.*¹⁵⁹

Young people seeking to enter the private rental market face a number of barriers including a lack of a rental history, and most pertinently, housing affordability.¹⁶⁰ An analysis conducted by Housing SA found that there were 'virtually no opportunities to live independently in private housing' for young people on a Centrelink income.¹⁶¹

In light of the significant housing issues that continue to confront young people leaving care, Housing SA has trialled a series of initiatives in the southern Adelaide region to find ways to better support them. A new assessment form to accompany the referral to Housing SA has been developed to gather more detailed information about the young person's needs, including risk factors and what supports exist or are needed.

The southern region of Housing SA has also been trialling an approach in which young people who have a long-term chronic condition that prevents them from accessing or maintaining other forms of housing are offered a Category 1 lease as opposed to a direct lease when a property becomes available.¹⁶² The advantage of a Category 1 lease is that it is a long-term lease which extends for a period of five to ten years, potentially providing greater stability to young people who are unlikely to be able to access other options.

The Commission understands that Housing SA is intending to roll out the initiatives trialled in the southern region across the whole state in the coming months. A memorandum of understanding¹⁶³ and an updated operational protocol¹⁶⁴ are being finalised to set out agreed agency roles and responsibilities.

The Southern Region Housing SA office, in collaboration with the Southern Guardianship hub of Families SA, has also been developing a model that provides more aspirational pathways for young people leaving care. The intention is to replicate the pathways that most young people in the general community take when moving out of home, which involves entering the private rental market through shared housing, while also engaging in study, training or employment:

This model aims to set up a more common—a more mainstream pathway that most young people experience, and provide those opportunities for young people exiting care, so that they can live in a household with reasonable amenities, certainly higher than public housing, and ... live with their peers, but in a way that ... they are receiving support.

*There will be households of two or three young people sharing, and ... each young person would have their own case manager. That case manager would be common to the household, and as well as providing one-on-one support, that case manager will provide support to the household to maintain, you know, good household relationships.*¹⁶⁵

The model envisions young people being housed for six to 12 months, ensuring continuity of care and intensive support from Families SA in the early stages of living independently. As a young person approaches the leaving care age, a case conference would be held and a plan put in place for transitioning them to Housing SA supports.

The project is still in its infancy. Through the 90-day change program run by the South Australian Government, an intensive team has been brought together from Housing SA, Families SA and the Department of State Development to refine the details of the service model.¹⁶⁶ Housing SA and Junction Australia have also committed to providing high amenity houses in good transport corridors. A funding source is now being sought to support a two-year pilot project in the southern metropolitan region.

The initiatives taken by Housing SA in collaboration with other agencies reflect an acknowledgement that approaches under the Rapid Response policy were failing to produce the desired outcomes for care leavers. There is a need to re-emphasise the objects of that policy. There is also a need to develop, pilot, evaluate and promote innovative services that specifically address the trajectory of transience that is too common among care leavers. Research also supports the use of lead-tenant models such as the Ladder St Vincent Street program to assist care leavers in their transition to independence.

The Government should support the innovations being developed by Housing SA that involve expanding the range of housing options for independent living past the age of 18, and which attempt to model more closely the natural journeys of young people moving gradually towards independence. Housing SA is a vital partner in these reforms.

Ladder St Vincent Street

The Ladder St Vincent Street program is an innovative youth housing and support program, located in Port Adelaide. It was developed by Housing SA, St John's Youth Services and Ladder to provide sustainable housing for young people who have experienced or are at risk of homelessness. Ladder is a not-for-profit organisation established by Australian Football League players to tackle youth homelessness.

The program applies a model of service provision which draws together access to secure housing, an expectation of engagement in education, training and employment opportunities, and participation in community. Young people are provided with independent apartments in the one purpose-built complex which is staffed 24 hours a day. They are provided with case management, which includes a focus on training and employment, and receive mentoring from former and current elite sportspeople and others associated with sport.

POST-CARE SERVICES

RELATIONSHIPS AUSTRALIA SA

Since July 2012, Families SA has contracted Relationships Australia SA to provide post-care services. Support is available to anyone over the age of 18 who has spent six months or more in out-of-home care in South Australia. The services are offered out of an office called Elm Place, which concurrently runs the Commonwealth-funded Find and Connect program.¹⁶⁷

The services available through Relationships Australia are limited by funds and staffing. With a current annual budget of \$326,104 and 2.58 fulltime equivalent staff to provide support services to meet the multitude of needs of care leavers across the entire state, Relationships Australia faces issues that appear to be the result of a lack of funding for post-care services, as opposed to a lack of skill in the organisation.¹⁶⁸

At present the service relies on clients self-referring. Since the service's inception in 2012, only 9 per cent of clients have been under the age of 20, with the highest percentage of clients waiting until their mid-twenties to seek support.¹⁶⁹ The longer care leavers wait to access services, the more entrenched their issues tend to become. There is a lack of clear referral pathways between Families SA and post-care services, and there are concerns that not all care leavers are made aware of post-care services.¹⁷⁰ CREATE Foundation's Ms Scalzi told the Commission:

*Relationships Australia postcare services are underfunded to be able to provide a decent postcare service for children and young people in care ... from 18 to about 26, they're not engaging, and they'll come back, [in their] 30s, 40s, to postcare services, so ... there's that big gap, where we ... lose them.*¹⁷¹

Although some recent improvements have been made in links between Families SA and post-care services, there remains a need for a more integrated referral system, where young people are systematically referred to the service by Families SA at an earlier age, and with an accompanying risk assessment.¹⁷²

The current method of promoting the post-care service is by way of a brochure. Post-care services require resourcing to support an assertive outreach program targeting individuals who are not currently engaged.¹⁷³ The service would also benefit from strategies of engagement that are based on feedback from young people and utilise social media and other methods that appeal to this particular cohort. This is consistent with research which recommends a greater focus on outreach programs and the use of social media and technology to engage vulnerable care leavers.¹⁷⁴ The smartphone application referred to earlier would help here.

The current funding for post-care service delivery is not enough to address the complex issues faced by care leavers, which include major health, dental and educational disadvantages.¹⁷⁵ Where Elm Place was initially able to offer a drop-in service, resource limitations have now reduced the service to an appointment-based one. Many young people in this cohort find appointment keeping difficult and conversations in an office setting intimidating.¹⁷⁶ Relationships Australia SA should be funded to deliver innovative and flexible post-care services which engage young people at times and in locations where they are more likely to be receptive. Several interstate examples of mobile youth outreach services exist that would provide suitable models for South Australia. The Chatterbox Bus run by Open Family Australia, for example, amalgamates outreach with drop-in services and links longer term support to informal frontline assistance including access to the internet as well as food, clothing and health supplies.¹⁷⁷

There is a long overdue need for service provision to shift away from compartmentalised programs to an integrated approach that both prepares young people to transition from care and assists them after the age of 18. Such an approach would also build and capitalise on relationships formed with a child prior to them leaving care:

My thinking is that, really, it is the ongoing emotional support as any other family would provide for their young people that is needed for young people post 18. As I said before, my preference for that would be that that service is tied in to the service where that young person already has strong relationships.¹⁷⁸

BEST PRACTICE IN POST-CARE SERVICE

An example of a comprehensive leaving care program that incorporates best practice principles is the Stand By Me pilot program developed by Berry Street in Victoria. The program is based on the UK's personal adviser model and provides intensive general casework support. Recognising that trust is a major issue for these young people, the program emphasises continuity of worker-client relationships throughout the pre- and post-care phases. It offers medium to long-term support after care through an assertive outreach model that follows the young person and matches resources to their identified need at the time.

The program is adaptable and flexible, appreciating that the first few years after leaving care can be a time of multiple crises and evolving needs. A key focus is on activities likely to reduce homelessness such as working with young people to plan their accommodation, helping to negotiate retention of foster care or kinship care placements, and establishing and maintaining transitional or independent living options. The program also works with young people to address trauma, improve access to mental health supports, facilitate access to financial assistance, and establish links to employment, education and training services.

An interim evaluation of the first year of the pilot program that ran from December 2012 to December 2013 was recently conducted.¹⁷⁹ The review found that the program was developing effective ways of working with care leavers and that the program's approaches and methods were consistent with research into effective practice for supporting young people leaving care who have complex needs, and who are at risk of homelessness.¹⁸⁰ Significant positive outcomes have been found as a result of¹⁸¹:

- the program's focus on building relationships over time while the young person is still in care;
- work done to re-establish and support young people's contact with family; and

- assistance with maintaining links with out-of-home care supports including foster parents or residential carers in order to reduce the possibility of further trauma and disrupted attachments.

Similar programs have been funded in New Zealand. Young people can be allocated an adviser from two non-government service providers at the age of 15 to assist with planning the transition from care, empowering them to make informed decisions and modelling positive social behaviours. The service providers can then become the lead agency supporting the young person in the community after they leave care.¹⁸²

There is a need to move away from the notion that post-care services are an 'add-on' to the core work of the child protection system. The state should follow through on its responsibilities and make significant investment towards providing comprehensive support for young people after they leave care.

Evidence suggests that this will be best achieved by funding programs delivered by the non-government sector that commence working with young people well before they turn 18 years of age and continue providing support during the transition from state care and throughout the person's adult life.

Greater effort needs to be made to integrate post-care service provision to the agencies supporting young people during care, to capitalise on relationships and connections which should be well established. The Commission recommends the piloting of an intensive post-care support service for those young people who are identified as especially vulnerable in the post-care period. Preference should be given to an agency that currently provides support services to this group.

For other generic post-care services, there should be a significant injection of funds to enable services to be delivered more flexibly, and more assertively. A review of the needs of the population currently accessing Relationships Australia services should be conducted to identify areas of specific need.

FAMILIES SA PROVISION OF ACCESS TO RECORDS

Families SA responds to requests from care leavers for access to records held by the Department. Items such as birth certificates, immunisation records and other legal documents may be required in adulthood, but for many care leavers, accessing the information held in their file is also an important aspect of developing a sense of self and piecing together memories that they are unable to clarify from other sources.

In order for care leavers to access their file, they must complete a freedom of information request.¹⁸³ This presents a hurdle for many young people who are often also dealing with the stress of negotiating with a number of other bureaucratic processes. Once a care leaver is granted access, they are given a brochure for Relationships Australia should they require counselling to help them review their file.¹⁸⁴ Providing support to care leavers to access their records is essential given the potentially confronting material that they may encounter. A brochure with contact details for a service that the care leaver may not otherwise have any connection with is unsatisfactory.

Other jurisdictions have specific legislative provisions giving care leavers the right to access a range of documents, without charge, relevant to their care journey (including birth certificate, school reports, medical reports and personal photographs). New South Wales has the most generous provisions, granting care leavers a right to access any personal information that relates to them from the departmental files, his or her authorised carer or carer agency.¹⁸⁵ The care leaver can elect to have the requested information orally or in writing. The care leaver is also entitled to original versions of documents held on a file, free of charge. The carer agency is required to provide an appropriate person to support and assist the care leaver in seeking access to the information.

The Children's Protection Act should be amended to permit care leavers to access, free of charge, original and copy documents relating to them which are held by the Department, registered carers, registered care agencies (foster or kinship care), or non-government organisations who have been contracted to provide them with out-of-home care. Support should be provided to any young person so accessing their records to help them make sense of the records and understand their implications.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

158 Amend the <i>Children's Protection Act 1993</i> to require the Minister to provide or arrange assistance to care leavers aged between 18 and 25 years. Assistance should specifically include the provision of information about services and resources; financial and other support to obtain housing, education, training and employment; and access to legal advice and health care. 159 Expand financial counselling services to manage access to post-care financial support from the Agency provided in accordance with Recommendation 158. 160 Amend the <i>Children's Protection Act 1993</i> to permit care leavers to access, free of charge, original and copy documents that relate to them from the Agency, approved carers, and any non-government agencies contracted to provide care to them. 161 Continue to make modified payments to foster and kinship carers where the care leaver is engaged in tertiary education, apprenticeship, or any post-high school training, and where their best interests would be served by remaining in foster or kinship care until the qualification is completed. 162 Review the Rapid Response policy to identify opportunities to expand priority services to care leavers up to the age of 25. 163 Prepare a new service model and work instruction for leaving care that incorporates the relevant elements of the National Approach, including specific reference to supporting care leavers who want to access further education and training. 164 Redeploy transition-from-care caseworkers to provide an add-on service for young people planning their move to independence. 165 Reach an administrative arrangement with the CREATE Foundation to provide it with the names and contact details of children entering care and/or their carers (as appropriate). 166 Fund the development of a smartphone application that provides young people with up-to-date information about services and entitlements when leaving care.	167 Review contractual conditions governing service specifications for non-government independent living programs to develop greater flexibility in the age of admission and the age of discharge from programs. 168 Fund Housing SA to develop innovative housing models, particularly those that use supported share housing where appropriate for care leavers. 169 Fund a pilot program of intensive case management assistance for vulnerable care leavers, to be delivered by an agency with established relationships with vulnerable children in care. 170 Conduct a review of the needs of the population currently accessing Relationships Australia's services to identify the specific needs of service users. 171 Make a significant injection of funds into post-care services currently provided by Relationships Australia, to enable these to be delivered more flexibly and more assertively.

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15

INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME-CARE

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OVERVIEW

Children who have been removed from their families and placed in out-of-home care have the same right to be safe as all other children. It should be expected that children in the care of the state will be given a higher standard of care than they would otherwise receive in the community. Despite safeguards, the perpetration of abuse against children in the care of the state, and deficits in care standards, are unfortunate realities. The child protection system must be equipped to respond to these challenges.

It is essential that the system investigate abuse and neglect in care for it to evaluate and improve its standards of service delivery. Appropriate and transparent mechanisms for reporting, investigating and responding to allegations of abuse are integral to this goal. These need to be complemented by sophisticated monitoring practices that evaluate responses and inform necessary system change, not only to respond to children who experience abuse in care, but also to prevent such abuse recurring.

An allegation that a child has been abused or neglected in their care environment, or that there is a deficit in their standard of care, is referred to as a *care concern*. After securing the immediate safety of the child, the purpose of responding to a care concern should be twofold: first, to identify the contribution of an individual's actions (or inactions) to any deficiencies in the standard of care, or any abuse or neglect experienced by the child, and second, to identify whether any systemic issues contributed to the child's adverse experiences.

This chapter discusses how the abuse and neglect of children in care is reported, investigated and responded to by the child protection system. The Commission has examined the challenges faced by the Department in fulfilling these responsibilities and identified improvements that should be made to this important aspect of service delivery.

The chapter principally relates to the Commission's Terms of Reference 5(g), in the context of Terms of Reference 1 to 4.

WHAT THE RESEARCH TELLS US

At the outset, it is important to acknowledge that the majority of care environments are safe. Most carers and employees are committed to providing safe care.¹ However, there may be occasions when a child in care is maltreated, or the care provided falls below an acceptable standard. The reasons for this may be varied, and the result of the interaction of a number of factors. For example, poor recruitment practices and training,

inadequate support and monitoring of placements, and the high care needs of a child may all contribute to abuse or neglect in care.

The child protection system must have in place robust mechanisms that support the identification, reporting and investigation of these care concerns.

There is no clearly defined model of best practice for investigating the abuse and neglect of children in care. However, research identifies a number of themes or principles that receive relatively widespread approval as 'good practice', summarised as follows²:

- the need for a specialist independent investigations unit;
- the need for the child's voice to be heard before, during and after the process;
- the need for accurate record-keeping during investigations;
- the importance of adequate training and support for staff; and
- a recognition that resource limitations can influence decision making during investigations.

Research highlights the need for investigators to have a diverse range of skills, which may be broader than those held by child protection practitioners. This should be considered when designing job descriptions and training. Investigators should also have no prior relationship with the carers or staff members they are investigating.³ Clear, specialised procedures, policies and guidelines should be developed and shared with stakeholders.⁴ It is essential that this includes guidance in relation to coordination and cooperation between government agencies and other stakeholders. In particular, there should be close coordination between investigators and law enforcement such that investigations can be conducted jointly or in parallel where appropriate.⁵ Clear definitions are also critical. Variable and ambiguous definitions of maltreatment and risk undermine an investigator's ability to make findings about abuse or neglect.⁶

Research also suggests that one of the best predictors of child maltreatment is a prior history of child maltreatment by the carer or staff member. As part of the investigation, the investigator should therefore have access to, and review, all previous reports of child abuse and neglect.⁷

Timely investigations are essential, not only to protect the child but to capture evidence before it is compromised or memories fade. Findings need to be promptly made and communicated to those responsible for managing change and to other stakeholders, to ensure corrective actions are taken.⁸

Significantly, research suggests that the availability of services or resources can affect the substantiation of an allegation. If resources are not available to respond to the child's needs, maltreatment may not be substantiated even if it exists. The workload of an investigations unit can also be a major barrier to appropriate analysis and decision making, and the completion of investigations.⁹

THE DUAL PURPOSE

When responding to allegations of abuse or neglect in care, a properly functioning care concern system will identify both inappropriate conduct by an individual and failings of the system. This is because the state owes a particular duty of care to children who have been removed from their families and placed in the care of the state:

Incidents or situations of harm to a child in care need to be viewed and responded to not just as an abusive action by an individual, but as a breach or dereliction of the duty of care at individual, program and agency levels. The concept of extended responsibility involves seeing beyond the individual to the range of individuals, agencies and departments involved in the care of the child or young person.

Harm to a child or young person in care will be seen as different to intra-familial abuse. The operational definition of harm and risk of harm for children and young people in care is expanded to include the state's duty of care, and thus will have a dual focus on the action or inaction of an individual and the systemic context in which it occurred.¹⁰

Identifying and responding to systemic issues is an important mechanism through which the experience of children in care can be improved. Understanding how the system has failed one child should allow for changes to be made to prevent or minimise the recurrence of abuse or neglect to other children.

While in some circumstances the outcome of an investigation may apportion blame to an individual, the actions (or inactions) of an individual should not overshadow possible system deficits as contributing to the issue. It is of critical importance that every investigation is viewed as 'an opportunity to educate others about prevention'.¹¹

In addition, a care concern investigation should not be viewed as a mechanism to punish an individual carer or staff member. The findings of an investigation may lead to consequences for an individual, such as deregistration as a carer or the termination of their employment. However, an investigation should not be aimed at giving effect to those consequences or be distracted by them. The overarching aim should be to keep children in the care of the state safe.

ESTABLISHING AN INDEPENDENT INVESTIGATIONS UNIT

The Layton Review in 2003 recommended an accountable, independent and transparent review mechanism for complaints about case management and allegations of abuse or neglect of children in care. It proposed the establishment of a specialist review and investigations unit, independent from the statutory agency Families SA (the Agency).¹²

Independence was an important aspect of this recommendation. Investigation of its own decisions could leave the Agency open to criticism of bias or cover-up. However, a unit in the same department as the Agency, but removed from its operations, was considered sufficient to provide independence, transparency and integrity. The unit was to afford a high level of procedural fairness, have database recording capabilities to ensure appropriate tracking of allegations and scrutiny of the system, and be subject to an external appeal process.¹³

A specialist unit was established in the Department for Families and Communities and tasked with the investigation of abuse and neglect of children in care. The unit reported directly to the Chief Executive, and sat within the Office of the Chief Executive. It also undertook investigations into care concerns arising in the context of disability services and youth training centres.¹⁴

In 2012, the unit in part moved with the Agency to the newly formed Department for Education and Child Development (DECD, or the Department), and became known as the Care Concern Investigations Unit (CCIU). Since that time, the Department has struggled to find an appropriate place for CCIU within its organisational structure.¹⁵ Apart from the Office for Child Protection¹⁶, the Department had little experience or expertise in statutory child protection, and more specifically the investigation of abuse and neglect in care. The CCIU was initially located in the Office for Corporate Services (formerly the Office for Resources, Operations and Assurance), a section of the Department that had never undertaken statutory child protection work.

In mid-2014 the Chief Executive of the Department approved the move of CCIU into the Office for Child Protection, in the Agency's Service Accountability Unit.¹⁷ This arrangement would have provided a direct reporting relationship to the Deputy Chief Executive responsible for Families SA, while maintaining the independence of CCIU from the Agency's day-to-day operations. It was intended that this would better enable any system deficits identified through investigations to be fed into practice and policy improvement.¹⁸

The move of CCIU into the Office for Child Protection never eventuated. The destabilisation in the Department that occurred following the arrest of Shannon McCoole (see Volume 2, Case Study 5: Shannon McCoole) and the subsequent focus on the functioning of CCIU in that matter may have contributed to this.

Eventually, the Department opted to shift responsibility for conducting serious care concern investigations to the Department's Incident Management Division (IMD).¹⁹ All investigators in the IMD have a law enforcement background.²⁰ Concerns had previously been expressed that the approach of the IMD was 'more focused on individual culpability, which although important is not the priority for the management of care concerns in the child protection context'.²¹

The lack of clarity about the placement of CCIU has been accompanied by confusion as to the scope of CCIU's role and its limited integration with associated functions in the Department. This has been particularly evident in circumstances where the care concern has involved allegations of employee misconduct. Within the Department, the investigation of employee misconduct was generally the responsibility of the Special Investigations Unit (SIU). Despite the potential for the overlap of responsibilities, no planning took place and no document existed governing the respective roles of the two investigative bodies. They operated independently of each other. At times this led to an ineffective use of the Department's investigatory resources. The efficacy of the relationship between CCIU and the human resources functions of the Department has also been questionable.

CCIU has continued to rely on outdated and unendorsed practice manuals developed before the Department was formed in 2012.²² It has mostly been left to its own devices without strategic guidance. Consequently, the day-to-day functioning of CCIU has been largely subject to the professional judgement of whoever happens to be the unit's manager.²³

A report commissioned by the Department to review CCIU in March 2015 found there was 'an inconsistent understanding of the purpose, objectives and role of the CCIU'.²⁴ This finding is consistent with those of the Commission.

During the past four years, the functioning and relevance of CCIU have been compromised by its instability and lack of integration into the Department. There appears to have been an insufficient understanding of the important role of CCIU in the child protection system. Much work of CCIU has been delayed. The outcomes of its investigations have made little contribution to improving systems issues facing Families SA and the experiences of children in care.²⁵

The lack of understanding of CCIU's role and purpose extends to many stakeholders in the child protection system, including Families SA staff, foster parents and

residential care workers.²⁶ The Commission was told 'the whole area of care concerns is just a nightmare ... people are not necessarily very clear on all the processes'.²⁷ The procedures and practice surrounding care concerns were described as a 'minefield'²⁸ and the lack of documented guidance available to Families SA staff is a huge gap in the field.²⁹ Many carers were completely unaware of the care concern process, not knowing what CCIU was, what care concerns were or how investigations were conducted.³⁰

The investigation of abuse and neglect in care is a function that the proposed new department would need to perform. While independence is important, it is equally important that there is sufficient clarity regarding the purpose and integration of the investigative body within the department to ensure its dual purposes are effectively achieved.

REPORTING CARE CONCERNS

A care concern arises when a child who is in the care of the state³¹:

- is allegedly abused or neglected; or
- there is allegedly a deficit in the standard of care provided to the child; and
- the allegations relate to the care provided by a Families SA employee or volunteer, an out-of-home care employee or volunteer, a foster parent, a kinship carer or a Specific Child Only (SCO) carer.

Care concerns are raised with the Department through a report to the Families SA Call Centre (commonly known as the Child Abuse Report Line, or CARL). They are received in the same way as other child protection notifications. If the notification meets the above criteria, it should be classified as a care concern referral (CCR) and referred to the manager of CCIU.³²

Unlike notifications relating to children who are not in care, the Call Centre practitioner is not required to assess whether a notification should be screened in for a response. The practitioner is also not required to give a response priority (tier) rating to the concern: at the point of intake, the level of concern or seriousness expressed by the notifier is irrelevant.³³

The guidance given to Call Centre practitioners about receiving care concern notifications is limited and outdated. The care concern criteria are not clearly set out in their practice manual, and there is no definition of what amounts to a care concern.³⁴ Consequently, Call Centre practitioners sometimes incorrectly classify care concerns as a general child protection notification (referred to a Families SA local office) or an extra-familial notification (referred to South Australia Police). As a result, they are not referred to CCIU.³⁵

The reporting of a care concern may also be frustrated by limitations in the functionality of C3MS, the Agency's electronic case management system, which leads to 'inaccurate, inconsistent or absent case recording'.³⁶ The Commission was told a care concern may not be recorded on C3MS, and therefore not referred to CCIU, if the notifier can only provide the name of the carer or employee, and not the name of the child. This is because C3MS requires notifications to be recorded against a child's name. If the functionality of C3MS is obstructing the recording of care concerns in this way, it is a significant gap in the reporting system.³⁷

LISTENING TO CHILDREN IN CARE

Children in care may report concerns regarding their care, or that of another child, to the Families SA Call Centre. However, there is no special mechanism to support this, and in reality few children self-report abuse or neglect concerns to the Call Centre. From 2011/12 to 2014/15 there were more than 190,000 notifications to the Call Centre but only 200 (0.1 per cent) of those were from children making a report about their own circumstances (see Chapter 7, Tables 7.6 and 7.7). Less than half of those (89 notifications) were screened in for a response from the Agency.³⁸ It is unknown if any of the 200 notifications came from children in care.

Children in care are particularly vulnerable to abuse or neglect by a carer. They may have limited support networks beyond their primary carers. In particular, children in rotational care do not have the advantage of a consistent caregiver who will listen to them and advocate on their behalf. Due to their past experiences, children in care may be reluctant to build trusting relationships with other adults, and may feel further isolated by their adverse experiences in care.

Perpetrators of abuse may target children with a history of dishonesty as they are less likely to be believed by adults if they complain. If an organisation, or the broader system, does not value the voice of children, they are especially vulnerable.³⁹ Unfortunately, children in care are less likely to be believed if they make a disclosure than other children in the community.⁴⁰

This was demonstrated in the McCoole case study. A senior youth worker was faced with an accusation made by a 13-year-old girl in residential care that McCoole had walked into the bathroom without warning when she was on the toilet with her pants down. She called McCoole a paedophile. The senior youth worker dismissed her complaint about McCoole's behaviour and accepted his explanation of innocence, partly because the young person had a history of telling lies.

Children who have experienced abuse and neglect may develop unhelpful behavioural habits such as telling lies. However, it is dangerous to systematically prefer to believe adults over children when the respective versions of events collide.

There should be formal and informal mechanisms in place to ensure a child's experiences of care are both heard and understood. Children should feel able to report concerns about their circumstances and believe that their complaints will be heard and responded to appropriately.

It is also important for a child to have trusting relationships with adults other than their primary carer: they need regular contact with both their caseworker and other caring adults.⁴¹

ADULTS' FAILURE TO REPORT

It is likely there is an under-reporting of abuse and neglect in care⁴², not only because children feel unable to report, but also because adults fail to report.

A child in care may raise an issue with a carer or another adult. If that person is a mandated notifier, they are obliged to report the concern. However, this does not always occur. Some people may believe a report is unnecessary because the child is already in care and they assume that those in the Department who are involved in the child's case management will already be aware of any such concerns.

The Commission was told that if a concern was raised directly with a Families SA office, rather than the Call Centre, it was possible the issue would be addressed locally instead of through CCIU.⁴³

There is a lack of clear guidance as to the circumstances in which a person who is in contact with a child in care must make a notification. This has contributed to Agency staff and other stakeholders having a varied understanding about when such a notification should be made.

However, the value of any reporting guidelines, or the reinforcement of mandatory notification obligations, will be directly influenced by the way in which the system values the voice of children in care:

*Unless the organisational culture supports the power of children and young people, emphasises their rights and has a positive child-focused orientation, any obligatory procedures such as complaints mechanisms are tokenistic and ineffective.*⁴⁴

‘Unless the organisational culture supports the power of children and young people, emphasises their rights and has a positive child-focused orientation, any obligatory procedures such as complaints mechanisms are tokenistic and ineffective’

While supporting children to disclose concerns and report them is of fundamental importance, the Commission’s inquiries into McCoole’s conduct demonstrated that organisational culture can also create a barrier for adults, silencing potential notifiers.⁴⁵ How the system responds to a child or adult who makes a notification can affect their willingness, and that of others, to report in the future.

PRACTICAL STRATEGIES TO IMPROVE REPORTING

Within the Agency, staff must be able to identify a care concern and understand their obligation to report it.⁴⁶ The Commission was told that there was little contact between CCIU and front-line staff, impairing CCIU’s ability to perform an educative role.⁴⁷ Providing guidance to staff should be a responsibility shared by CCIU and the Agency. Staff, including residential care workers, should be trained to identify and notify any conduct that may amount to a care concern, and should be supported by clear, easily accessible documentation.

A better understanding of responsibilities on the part of staff should help foster an environment in which children see value in disclosing or reporting concerns about their own circumstances. There is also scope to consider how technology can help provide children in care with a voice. It is unlikely that a child in care would telephone the Call Centre, wait on the line for their call to be answered and then disclose their concerns to a stranger. Although there is an online notification system (eCARL), it does not have a user-friendly interface for children.

A number of local authorities in England and Northern Ireland use a computer application (accessible through the internet, and on smartphones and tablets) to help children communicate their circumstances or concerns to people involved in their care. The application, Mind of My Own or MoMo, is described as a ‘self-advocacy app’. It is not an application dedicated to the reporting of child protection notifications. Rather it facilitates engagement between a child and their caseworker, and gives them a tool to express their views.⁴⁸ There is merit in exploring such technology to ensure children in care feel able to voice their views and, importantly, know how to engage

with a concerned adult if they experience abuse or neglect, or are concerned about the standard of care being provided to them.

It is also necessary to ensure adequate guidance and training are provided to carers who are engaged through contracted service providers (whether in a home-based setting or a rotational care setting) about their role in identifying and reporting conduct that may amount to a care concern, and the process that follows. While there is a general contractual requirement to this effect, the Department appears to have provided little guidance as to the content or expected outcomes of this training.

DETERMINING THE CATEGORY

All care concern referrals are sent from the Call Centre to CCIU, where they are determined to be one of four categories: serious, moderate, minor or no action. This determination is made by either one of the two most senior staff, namely the manager or the principal investigations officer. The category determines the response pathway, as shown in Table 15.1. Minor and moderate care concerns are referred from CCIU to Families SA, where it is expected that front-line staff would undertake an appropriate response.

Table 15.1: Care concern response pathways

DETERMINATION CATEGORY	RESPONSE
Serious care concern	Serious care concern investigation conducted by the CCIU, and more recently the Incident Management Division
Moderate care concern	Families SA inquiry
Minor care concern	Families SA case management
No action	No further action taken

Source: Oral evidence, S Macdonald, and witness statement, P Adams.

Serious care concerns are serious breaches of accepted care standards, where the child is suspected to be in immediate danger, has already suffered serious harm or is at significant risk of serious harm, as a result of the carer’s or staff member’s actions, inactions or impaired capacity to act in their designated role. The investigative response—a serious care concern investigation—should involve evidence gathering and an assessment of individual culpability and the contribution of systemic factors.⁴⁹

Moderate care concerns are moderate breaches of accepted care standards, which give cause for concern that the child is at risk of harm, and their safety and wellbeing would be in jeopardy if intervention did not occur. The response should focus on the attitude, behaviour, skills and capabilities of the carer or staff member and the supports and resources available to them. This process is conducted by way of an inquiry and a formal outcome should be recorded.⁵⁰

Minor care concerns are minor breaches of accepted care standards that pose a minor risk to the safety and wellbeing of the child. The response is expected to be part of general case management, with attention given to the supervision, development and training of the carer, staff member or volunteer by way of discussion.⁵¹

If, despite the referral, a child was not in care at the time the concerns were raised, or they involved a person other than a caregiver, CCIU will not take any action.⁵² It may also be determined that no further action is required if, for example, there is insufficient information in the referral, no breach of a standard of care is identified, or the allegations are already being addressed by Families SA or a service provider.⁵³

RELYING ON PROFESSIONAL JUDGEMENT

The determination process on occasion leads to inappropriate decisions and an underestimation of potential risk.⁵⁴

In making a determination as to category, the manager of CCIU and the principal investigations officer rely on their professional judgement. Other than the broad definitions described above, there are no clearly defined assessment criteria to guide this process or help the decision maker to weigh the various factors.⁵⁵

Professional judgement is important, but making determinations on that basis alone can be fallible. Decision making may be straightforward when a child is 'clearly safe or clearly unsafe'.⁵⁶ However, care concern referrals often do not present a definite picture of a child's circumstances and safety.⁵⁷

Difficulties in applying a consistent approach to decision making seem inevitable. The absence of articulated thresholds for each of the categories has led to a situation in which:

*the same allegations or concerns could go to one worker and be assessed as serious, and go to a different worker and be assessed as moderate, or even ... as no action.*⁵⁸

THE INFORMATION-GATHERING PROCESS

During the determination process a range of information is considered, including⁵⁹:

- the age of the child and their vulnerability;
- the effects of the alleged abuse or neglect on the child;
- whether the child sustained any injuries;
- the behaviour of the child in the context of the notification;
- whether there is more than one child involved;
- the credibility of the notifier or any witnesses;
- actions already taken in response to the care concern referral (CCR);
- prior notifications or care concerns relating to the child or the person who is the subject of the concern, and if so whether they are similar in nature;
- whether there are any supports in place for the person who is the subject of the concern; and
- whether the allegations are criminal in nature.

Some of this information will be available on the face of the referral. Some of it will not.

Depending on complexity, determinations may take as little as an hour or as long as two weeks.⁶⁰ Timeframes extending beyond 48 hours to determine the response pathway for an allegation relating to the suspected abuse or neglect of a child in care are unacceptable. Initial delays only serve to contribute to the more extensive delays experienced in care concern investigations. Lengthy determinations are also indicative of the inappropriate processes for gathering and assessing information during this early stage.

INVESTIGATING, NOT DETERMINING

CCIU's intention in gathering more information than is presented on the face of the referral is to help the decision maker reach the most appropriate determination.⁶¹

The initial task of CCIU is to determine an appropriate category based on the seriousness of the allegations contained in the referral. While there is a role for gathering limited basic and incontrovertible information, caution must be taken not to give undue weight to information received from other sources. For example, it is appropriate for the decision maker to confirm an employee was on shift at the time of the allegations, or that a child was in a particular placement. It may also be appropriate to review prior care concerns relating to the person who is the subject of the concern. However, having regard to information beyond these basic details can lead to a quasi-investigation being conducted before a determination is made.

To develop an understanding of the circumstances surrounding the child's care, CCIU will often consult with Families SA senior staff who are involved in the child's case management, who are supporting the placement or responsible for managing the employee who is the subject of the concern.⁶² However, this process can undermine the independence of CCIU and compromise good decision making.

For example, about 12 months before McCoolle's arrest, a care concern was raised regarding his conduct involving a six-year-old female child, 'Mikayla Bates'. The observations of the notifier led to the circumstantial inference that McCoolle had sexually assaulted Mikayla. Nevertheless, this was determined to be a minor care concern. This was inappropriate and a gross error. Before the determination was made, Catherine Harman, who was then the manager of CCIU, consulted with a manager and supervisor in Families SA's residential care directorate. Ms Harman was advised that McCoolle was an agency worker and that in all circumstances it was unlikely that he would be given any more shifts. Ms Harman acknowledged that this advice may have influenced her decision to categorise the matter in a way that would not require a comprehensive CCIU investigation.⁶³

The information gathering that occurs before a determination is made is indicative of CCIU conflating what should be clearly defined stages of determination and investigation. The tendency to seek further contextual information blurs the distinction between assessing the seriousness of the care concern based on the information in the CCR and assessing the veracity of the allegations.

The Commission reviewed a number of determinations that, on the basis of the information provided in the CCR, appeared serious in nature. Nevertheless they were classified as minor or moderate following extraneous information being taken into account.

For example, CCIU may allow information regarding the notifier's circumstances to influence determinations. Families SA may advise CCIU that the notifier is experiencing drug or mental health issues, or is involved in court proceedings to have their child returned to their care, or there is an acrimonious relationship between the notifier and the carer or employee who is the subject of the care concern.⁶⁴ Some determination rationales highlighted the identity of the notifier as being 'significant in relation to the matter'.⁶⁵ A determination rationale relating to allegations of emotional abuse in a foster care placement questioned 'the agenda of the notifier'.⁶⁶ In another matter, information from a Families SA caseworker indicating they had no concerns regarding the placement, led CCIU to determine that 'no action [was] required'.⁶⁷

By placing weight on the identity and credibility of the notifier during the determination phase, *determining* the seriousness of the allegations is conflated with *investigating* the veracity of the allegations.

CONDITIONAL SAFETY

The raising of a care concern does not shift responsibility for the immediate safety and wellbeing of a child in care from Families SA. It is for Families SA to decide if a child will be removed from their placement, or whether an employee will be shifted to another position, placed on alternative duties or suspended.

At the time a determination is made, it is expected that Families SA will have already acted to ensure the child's safety. This can result in undue emphasis being placed on the fact that the child is already out of harm's way, and therefore conditionally safe. The determination may be influenced by the level of response thought necessary given the child's or carer's current circumstances, rather than focusing on the seriousness of the allegations. An otherwise serious incident may be categorised as minor or moderate because the child is conditionally safe.⁶⁸

Conditional safety does not mean a child's experiences do not warrant proper investigation. A failure to investigate could lead to the child being returned to an unsafe care situation, or another child in the future being placed in the same unsafe environment.

The Commission reviewed a CCR that alleged the child's foster parents took him outside and made him jump on a trampoline without stopping when he would not sleep at night. While he was jumping, the carers cracked a whip underneath his feet. This was determined to be a moderate care concern. However, at least nine prior CCRs had been raised in relation to this child's placement with the foster parents. On a previous occasion, one of the carers had broken the child's arm when attempting to discipline him. Efforts by Families SA to address the behavioural management techniques of the foster parents had failed.

The rationale for the determination concluded by noting the child no longer resided in the placement and called for Families SA to investigate the appropriateness of placing a child with those foster parents in the future.

Given the previous CCRs and the failed attempts by Families SA to address the concerns, an independent investigation was warranted. Requiring a child to jump on a trampoline at night while cracking up whip is at the very least emotional if not physical abuse. The allegations suggested the foster parents had intentionally jeopardised the child's safety and wellbeing. The conditional safety of the child should rarely be given weight in the determination, particularly against a significant history of CCRs.⁶⁹

THE RELEVANCE OF ACTION TAKEN BY FAMILIES SA

The Commission was told that if Families SA advises CCIU that the matter is already being addressed, a determination may not reflect that which would be appropriate based on the information in the CCR alone.⁷⁰ Concerning examples of this practice include the following⁷¹:

- It was alleged a child residing in a kinship placement had not attended school regularly for three years, was not fed enough food, was constantly presenting as dirty and smelly, and was not having his medical needs met. This was determined to be a minor care concern. The issues were said to be longstanding, but being addressed by case management.

If issues of persistent neglect had not been resolved after three years, despite case management efforts, it is difficult to view the allegations as being anything other than serious. The minor categorisation simply sent the concerns on the same ineffective response pathway. This case required an independent investigation with consideration of broader issues including whether the placement had been appropriately supported and whether the placement should have continued in the face of such ongoing issues.

- Concerns were raised about the physical and emotional abuse and neglect of a child in a kinship care placement. Before the carers were registered⁷², 35 child protection notifications had been made relating to the care they provided to their own children. The CCR was categorised as minor. It was noted that 'there [was] a comprehensive management strategy in place to which an investigation by the CCIU is unlikely to "value add"'. There were a number of ways in which an investigation could have added value to the child's experiences or contributed to broader systems issues. CCIU could have reviewed the effectiveness of the approach to put in place a management strategy. An investigation could have shed light on any deficiencies in the process that led to the persons becoming kinship carers despite their significant number of child protection notifications.
- It was alleged that a child was forced to jump on a trampoline while it had bricks on it. A number of previous care concerns had been raised against the child's foster parents in relation to both abuse and deficiencies in their standard of care. On a previous occasion, the foster parents had openly stated that they did not want to care for the child. Nevertheless the child remained in the placement. It was determined no action was required because, after the trampoline/brick event, the child no longer had any contact with the foster parents and the foster care agency was likely to recommend deregistration. However, no follow-up action was taken to ensure they were deregistered. An investigation may have

identified systems deficits that had enabled the foster parents to continue in their role, despite their inability to provide a safe care environment.

- Allegations of sexual abuse by a carer were categorised as minor. It was noted that although the allegations were serious, appropriate supports were in place for the child and the carer had been deregistered.

Having regard to actions taken by Families SA in these sorts of cases can result in CCIU missing important opportunities to inform future practice improvements. It also does little to address the risk to other children who may be placed in such adverse care environments.

RESOURCE CONSTRAINTS

CCIU's capacity to undertake investigations is limited by its staffing complement of only four investigators.⁷³

Philip Adams, Manager of CCIU, acknowledged that resource constraints in CCIU should not be considered at the determination stage. However, it appeared that in some matters they had led to a lower than appropriate categorisation.⁷⁴ This was evident in a referral involving the neglect of an Aboriginal child by a kinship carer in a remote community. Concerns about the care of the child had been prevalent over a significant period of time. Families SA's previous attempts to address the issues had not improved the child's circumstances. It was a matter that required independent investigation. Nevertheless, it was categorised as a moderate care concern, citing, among other considerations, distance and timing.

CCIU should respond appropriately to concerns in all regions across South Australia, not only those that are financially or geographically convenient.

The capacity to resource an investigation may be a factor that is difficult for CCIU to ignore at the determination stage. It raises the question of whether the determination of care concerns should be undertaken independent of CCIU as the investigative body.

A very troubling determination

The care concern referral (CCR) alleged a residential care worker (the carer) entered Oliver's room yelling and Oliver accidentally slapped the carer in the face. The carer dragged Oliver by the feet into the hall, where, using Oliver's own hands, he hit Oliver in the head 10 times. The carer laughed and put washing powder in Oliver's mouth. This was witnessed by two other children. It was alleged that this was not the first time the carer had hurt Oliver or other children in the house. Oliver was reportedly scared of the carer.

This was categorised as a minor care concern. CCIU consulted with the carer's manager, who advised that the carer had experienced stressful events in his life, but there had been no cause for concern during his employment. Further, the carer was to be moved to another residence and would no longer provide care for Oliver. CCIU concluded that 'given the consistent account provided by the boys and [the manager's] response to this CCR to date there is little value a formal investigation by the Office or the CCIU can add'. The residential care directorate and human resources were to respond to any specific issues identified regarding the carer's behaviour.

This is a troubling determination. The allegations were serious and potentially criminal in nature. It is difficult to comprehend how the alleged physical abuse of a child in residential care, particularly when deliberate and degrading, could be determined to be a minor care concern. The discussions with the carer's manager appear to have resulted in the CCR being determined as less serious than it should have been. While Oliver was conditionally safe from the carer, the intention was to expose another group of children to the risk of having him care for them. There was no independent examination of the circumstances surrounding the incident or whether broader systems issues contributed, such as carer training, the use of behaviour management techniques or lack of managerial oversight.¹

¹ Department for Education and Child Development, Care concern documentation, internal unpublished documents, Government of South Australia.

THE CONSEQUENCES OF AN INCORRECT DETERMINATION

The determination of serious allegations as minor care concerns has broad implications. A departure from an appropriate categorisation of conduct because of influence from extraneous information or by persons who are not independent leads to a lack of clarity and common understanding of the process. Families SA staff and other stakeholders are left without a clear understanding of the criteria to be applied when determining a CCR or the rationale for a decision.⁷⁵

The use of the term 'minor' can be misleading. Those who rely on a determination that does not accurately reflect the seriousness of the concerns are unlikely to give the matter the weight it deserves. Staff or other agencies who are asked to respond to the care concern may not believe it is necessary to gather further information because they are mistakenly reassured by the minor label. It may also send conflicting messages about what conduct is considered appropriate and what is not.

As revealed by the McCoole case study, categorising serious allegations as minor or moderate can lead to the mismanagement of care concerns and inadequate responses to legitimate concerns. For example, no inter-agency strategy or planning meeting will be held, investigative tasks may be allocated to staff lacking appropriate skills, efforts may be made to manage serious matters collaboratively with service providers, and processes and outcomes may be influenced inappropriately by staff who have a vested interest in the matter. Some of these topics are discussed below.

IMPLEMENTING THE STRUCTURED DECISION MAKING® TOOL

Determinations must be made in a way that is transparent and accountable, and not undermined by external influences or idiosyncrasies of the decision maker.

In 2013, in response to deficiencies identified in the determination process, a project was undertaken to develop a Structured Decision Making® (SDM) assessment tool to provide criteria and thresholds for assessing care concern notifications. The SDM care concern screening criteria tool was developed by Families SA in partnership with the Children's Research Centre in the United States, the creators of the SDM system. It was anticipated that this tool would 'offer the same objectivity, consistency, validity, transparency and rigour that SDM has been demonstrated to deliver for intra-familial child protection'.⁷⁶

15 INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CARE

It was proposed that the care concern screening tool would be used by practitioners in the Families SA Call Centre to assess notifications of alleged care concerns and classify them into one of three response pathways: investigation and review, standard of care review or response not required. This proposal was a marked change from the system of relying on professional judgement alone, and would replace the unhelpful minor, moderate and serious categorisations.

The care concern screening tool includes clearly defined criteria as to what constitutes a care concern, the circumstances under which a care concern response is required and, as shown in Table 15.2, defined thresholds for practitioners to assess the notification against.

The tool applies the same thresholds to abuse or neglect, and risk of harm, for children in care as for other children in the community. This ensures that abuse in care is not measured differently, and that there is not a greater tolerance of inappropriate conduct or unsafe care environments.

Recognising the high duty of care owed by the state to children in care, the standards of care assessment criteria include a broad range of circumstances, such as⁷⁷:

- minimum case management requirements are unsupported or unmet;
- the child's health care, emotional wellbeing or therapeutic needs are unmet;
- the child's indigenous, cultural, spiritual or religious identity is unsupported;
- confidentiality or the privacy of the child are breached;
- negative behaviour is directed towards the child;

- the child's problematic sexual behaviour is normalised or minimised;
- appropriate relationships between the child and his or her family or kin are undermined; and
- the child's participation in decision making is inhibited or refused.

Testing of the care concern screening tool demonstrated that it produced consistent assessment decisions, and would have a negligible effect on the workload of Call Centre practitioners, who were familiar with the application of structured decision-making tools, and accustomed to interpreting and applying definitions. While the tool reduced the scope for individual interpretation and unusual or inappropriate assessments, the practitioner would still be required to apply professional judgement to determine if the concerns raised in the notification met the clearly defined criteria. This is to be expected. As discussed in Chapter 7, SDM tools support but do not replace professional judgement.⁷⁸

A constructive care concern response is one that not only promotes the wellbeing of the child, but also improves the quality of out-of-home care service delivery, strengthens care team relationships and helps conserve valuable foster care resources.⁷⁹ The screening criteria tool puts renewed focus on program and system level concerns and recognises that:

*Care concern responses cannot contribute to the improvement of [out-of-home care] until they move from a focus on individual culpability in causing harm to a child to a focus on the total care system and its expected standards of care.*⁸⁰

Table 15.2: SDM care concern screening criteria assessment thresholds and response pathways

ASSESSMENT	THRESHOLD	RESPONSE PATHWAY
Abuse or neglect, or significant risk of serious harm	Same threshold as for intra-familial child protection. Relies on the definitions of abuse, neglect and risk in the <i>Children's Protection Act 1993</i> (SA).	Investigation and review
Standard of care unmet	Different threshold to intra-familial child protection to acknowledge the higher standard of care expected for children in care. The standards are informed by: • the Standards of Alternative Care in South Australia (revised 2009) • the National Standards for Out-of-Home Care (2011) • a literature review.	Standard of care review
Criteria unmet		Case management consideration

Source: Department for Education and Child Development (DECD), memorandum, 'To head of Child Safety for executive decision re: Structured Decision Making care concern screening criteria', internal unpublished document, no date, pp. 8–9; DECD, 'SDM policy and procedures manual care concern screening criteria', internal unpublished document, July 2014, p. 51.

The investigation and review response pathway emphasises that a care concern response must be holistic, not only investigating individual culpability, but also reviewing the context in which the conduct occurred and identifying the contribution of program and system deficits.

In August 2014, the care concern screening tool was approved by the Families SA Executive for use in the Call Centre, with endorsement from the Chief Executive of the Department.⁸¹ Nevertheless the tool was not implemented. At October 2015, CCRs continued to be determined in the same manner, punctuated by confused and flawed processes. Several possible reasons were put forward, including a change in leadership in the Office for Child Protection, the likelihood that the tool would screen in more care concerns for an investigative response, and the approval coming at a time when the Department was in significant crisis.⁸²

The Commission asked a qualified and experienced Families SA practitioner to use the care concern screening tool to assess the care concern referral raised against McCooles that had been determined to be minor. This assessment identified that the allegations raised the suspicion of a sexual act with, or exploitation of, a child in care, and a significant risk of sexual abuse of the child: all grounds for screening in the notification for an investigative response and referral to CCIU. However, at the time and in the absence of the tool to guide professional judgement, the McCooles care concern was incorrectly classified. Consequently, an investigation did not occur.

The care concern screening tool should be implemented, and screening decisions regarding notifications of care concerns should be made by Call Centre practitioners. Determinations as to the categorisation of care concerns should no longer be made based only on professional judgement. However, before implementation, the care concern screening tool should be reviewed, particularly in light of what has been learned from the McCooles case study. For example, a defect in the tool is that it may not give weight to new suspicious indicators of sexual abuse if the child has been sexually abused in the past, which could lead to an inappropriate screening decision.⁸³ A history of sexual abuse should not be used to discount current concerns. The review should also ensure the tool does not allow for allegations that demonstrate relevant facts circumstantially to be overlooked.

INVESTIGATING A SERIOUS CARE CONCERN

When investigating a serious care concern, CCIU will attempt to gather information from a range of departmental, government and non-government sources. CCIU has access to C3MS and other records held by the Agency, such as carer registration files. Records may be sourced from other government agencies with the cooperation of the Agency as the child's guardian or, if they relate to another person, with that individual's consent. CCIU investigators may also interview witnesses, including Families SA staff members, carers, the child and the person who is the subject of the concern.⁸⁴

THE POWER TO INVESTIGATE

The authority, including any statutory power, for CCIU to conduct investigations is uncertain, even within CCIU.⁸⁵

A DELEGATION FROM THE CHIEF EXECUTIVE

The Chief Executive of the Department purported to delegate authority to individual CCIU staff to conduct, manage and plan investigations for and on behalf of the Department, by sending letters to them. The letters did not refer to any legislative powers. Nor did they indicate what an investigator was actually authorised to do in the conduct of an investigation.⁸⁶

The Commission sought clarification of this issue. The Chief Executive advised the Commission that the letters were not intended to act as a delegation of statutory powers or authorities. Rather they served as evidence of his authorisation to CCIU staff to conduct investigations. The letters were subsequently reissued. The concept of delegated authority was removed.⁸⁷

POSSIBLE STATUTORY POWERS

The 2015 report commissioned by the Department to review aspects of CCIU suggested that the unit acted according to the authority of section 19 of the *Children's Protection Act 1993* (SA).⁸⁸ The Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect also states that according to section 19, 'CCIU has legislated authority to access relevant information as articulated under [the Act]'.⁸⁹ However, CCIU Manager Mr Adams told the Commission that CCIU did not rely on this section as a source of authority or power to conduct a care concern investigation.⁹⁰ With an appropriate delegation, section 19 could provide a basis for the conduct of *some* care concern investigations.

Section 45 of the *Family and Community Services Act 1972* (SA) empowers authorised officers to enter premises for the purpose of ascertaining whether a child in foster care is being adequately cared for. However, Mr Adams said that this section had not been applied directly while he was manager of CCIU.

Section 47 of the Family and Community Services Act requires foster parents to provide the Chief Executive with information about themselves, or a child in their care. These two sections currently provide a source of power in relation to the investigation of foster parents. Proposed legislative reforms (discussed in Chapter 11) would result in all relative or kinship carers (who are caring for a child on a care and protection order) also being subject to these provisions.

Reliance on sections 45 and 47 would give investigators more scope to gather and obtain information, and result in better informed findings.

CONTRACTUAL OBLIGATIONS

Contractual arrangements with foster care and emergency care agencies require service providers to cooperate with care concern investigation processes and to follow up assigned tasks. These arrangements should provide very effective support to CCIU when gathering information during an investigation.

Mr Adams thought that there was a need for a much closer relationship between CCIU and those areas of the Agency responsible for licensing, contracting and service accountability, to complement the role of CCIU.⁹¹ That is clearly desirable. If investigation processes are being compromised because of a lack of cooperation from service providers, the Agency should address these issues through contractual mechanisms.

LIMITED POWERS OF INVESTIGATION COMPROMISE OUTCOMES

The scope of CCIU's investigatory powers is limited. Apart from contractual obligations, and information obtained from within the Department and through inter-agency mechanisms, investigators cannot compel persons or organisations to provide information, nor speak with them. Consequently there will be cases where key witnesses decline to provide information, and other potentially relevant evidence cannot be obtained. This can result in findings based on an assessment of incomplete evidence.

At the conclusion of an investigation (putting aside the identification of systemic issues), the outcomes that may be reached are⁹²:

- abuse or neglect is substantiated or not substantiated; and
- a deficit in the quality of care is substantiated or not substantiated.

When an investigation is constrained by a lack of evidence, the appropriateness of recording a definitive outcome of 'substantiated' or 'not substantiated' is questionable.

For example, an investigation was conducted into sexual abuse allegations levelled against a kinship carer who was providing care to his teenage step-granddaughter. It had been substantiated that a number of years earlier the carer had sexually abused the teenager's mother. Information gathered during the investigation revealed that there was evidence potentially supportive of the present allegation of abuse. However, key witnesses declined to speak with the investigator and did not cooperate with the investigation. The outcome of this investigation was then recorded as 'abuse not substantiated'.⁹³ In the circumstances the more appropriate result should have been the recording of an inability to resolve the allegation due to an insufficiency of evidence.

The Commission considers an outcome such as 'undetermined—insufficient evidence' should be available to investigators and would make it clear to those who subsequently review or rely on a record of the care concern that a finding was unable to be made due to evidential limitations.

OTHER DEFICIENCIES IN THE PROCESS

NO CLEAR SCOPE OR PURPOSE

Stakeholders have described some investigations as 'a fishing expedition, a trawling exercise, to pull together as much as they can to throw at their defendant in some hope that something would stick'.⁹⁴ One experienced practitioner told the Commission the approach can be to look under every rock and explore everything, rather than conducting an investigation with clear scope and purpose.⁹⁵ If this is the prevailing approach, it may be a consequence of a lack of documented guidance and clarity as to the role and purpose of an investigation. An outdated manual of practice (2010) provides limited direction to investigators, and some aspects of the manual are irrelevant to the current functioning of CCIU. CCIU attempts to fill these deficits through the use of internal guidelines and procedures, but they are not comprehensive, nor endorsed by the Executive.⁹⁶

PROCEDURAL FAIRNESS

The Layton Review was clear that investigations must ensure that:

all persons investigated have a right to a high level of procedural fairness, given that one of the potential outcomes of such an investigation may be a person losing their livelihood (in the case of an employee) or having a child in their care removed permanently and, in turn, being deregistered.⁹⁷

Procedural fairness requires the decision maker to use fair and proper procedures when making a decision that affects a person's rights, interests or legitimate expectations. It has a number of elements including the requirement to inform a person of the case against them and to give them a reasonable opportunity to respond.

Investigators have not been given guidance as to how to afford a person procedural fairness throughout an investigation process. They have been left to develop their own understanding of this indispensable concept. One practitioner with experience in care concern investigations told the Commission that they only became aware of the concept after working in CCIU for a number of years.⁹⁸

Procedural fairness can be a difficult concept to understand and apply. It should not be left to the responsibility of an individual investigator to determine what it is and its application to investigations.

ASSESSMENT OF THE EVIDENCE

At the conclusion of the investigation, the investigator must decide the outcome on the balance of probabilities.⁹⁹ However, this is another area in which limited guidance is provided and there is a possibility that this standard of proof is being applied inconsistently.¹⁰⁰

Drawing together the available information and assessing the weight to be placed on items of evidence is a difficult task. Unendorsed frameworks may be used to guide this process, but investigators generally approach the task in an individualised manner.¹⁰¹ While the principal investigations officer reads draft investigation reports and consults with investigators about their findings¹⁰², the lack of documented guidance raises the potential for the officer to be misinformed during this process. Ensuring that investigators understand how to assess evidence and apply the standard of proof are essential to achieving consistency in decision making.

THE APPLICABLE STANDARDS OF CARE

The standards against which an investigator should assess the level of care provided to the child are not defined.¹⁰³ The principal reference should be the Standards of Alternative Care in South Australia.¹⁰⁴ However, the standards relied on in practice vary between investigators and there is no common understanding as to when a care standard is unmet.¹⁰⁵ Service providers also considered there was a lack of clear objective standards of care against which deficits could be measured.¹⁰⁶

ACHIEVING THE TWO INVESTIGATORY AIMS

Because an investigator is tasked with examining abuse, neglect and care standards, as well as identifying broader systems issues, the effectiveness of each function can be compromised. The dual purposes of an investigation require distinct approaches. Identifying and analysing systems issues affecting a placement will

usually require a more holistic assessment of the child's care, compared with an incident-focused approach questioning whether a particular episode of abuse has occurred. Achieving these two investigatory aims is challenging in the absence of up-to-date, comprehensive and endorsed policies and procedures.

The outcome of a serious care concern investigation can have far-reaching consequences. The investigator's decision can have significant repercussions for a child's placement and for an individual. Guidelines should be developed to address important aspects of an investigator's role. These should include how to define the scope of an investigation and achieve its dual purposes, how to afford a person procedural fairness, and how to assess evidence and apply the appropriate standard of proof. The standards against which a child's care is measured should also be defined.

PROTRACTED INVESTIGATIONS

Service providers and carers identified the time investigations took as a significant source of frustration.¹⁰⁷ The Commission reviewed all 26 serious care concern investigations that were finalised between 1 July 2013 and 1 December 2014. The average time taken to finalise an investigation was two years and two months. This is obviously substantial, not only for the child but also the person who is the subject of the concern.

THE EFFECT OF DELAYS

Evidence before the Commission suggests CCIU is inadequately staffed, but delays cannot be entirely attributed to resourcing pressures.¹⁰⁸ There are a number of factors which may contribute to the length of time investigations take to complete, including:

- initial delays in the determination of a care concern referral and allocation to an investigator¹⁰⁹;
- insufficient clarity as to the purpose and scope of an investigation;
- a lack of adequate policies, procedures and guidelines;
- insufficient training provided to investigators¹¹⁰;
- no timeframes for an investigation to be completed¹¹¹;
- investigations not commencing until after any criminal proceedings have been finalised¹¹²;
- attention being diverted from progressing the investigation to keeping stakeholders up to date¹¹³;
- the time-consuming process of generating investigation reports. They are often lengthy (about 20–50 pages), digressive and unfocused. This is a likely result of investigations being confused and unconstrained¹¹⁴; and
- the process of giving stakeholders and the subject of concern an opportunity to provide feedback during the finalisation of the report.¹¹⁵

Investigative delays can have an adverse effect on the permanency of placements of children in care and contribute to carers either leaving, or not joining, the out-of-home care system.¹¹⁶

For a child in care, the delay in finalising an investigation may result in the irretrievable breakdown of their placement. When responding to a serious care concern, removing the child from the placement will often be in their best interests. However, protracted investigations can effectively end any prospect of the child's return. In some cases removal may have been the eventual outcome but in others the child may have been reunified with their carers if the investigation had occurred promptly. This has significant consequences for a child in care, particularly given the challenges of finding other suitable out-of-home placements. Delay may also result in a child being asked about an incident long after the event, when they have limited recollection or may be re-traumatised by the questioning process.

A protracted investigation can also be stressful for an individual and have a significant consequence on their livelihood. An employee may be stood down for an extended period or a carer may be unable to obtain a screening clearance to undertake other roles. For example, a foster parent was unable to work in his role as a bus driver pending the outcome of an investigation that took more than two years to be finalised.¹¹⁷

Delays undermine the relevance of CCIU. In many cases, by the time a report is finalised the situation of the child in care is completely different to that which prevailed when the concern was raised. Systems issues that may have been identified may no longer be relevant to the policies or practices of Families SA or the service provider. As a result, Families SA may not draw on the conclusions of an investigation.¹¹⁸

Delays in investigating serious care concerns are unacceptable. The care concern process should minimise the potential for further harm to children by ensuring responses are timely.¹¹⁹ Previous reviews have also highlighted the importance of the prompt resolution of concerns, particularly from a procedural fairness perspective.¹²⁰

THE EFFECT OF CRIMINAL PROCEEDINGS

When a care concern referral contains an allegation that, if proven, would amount to criminal conduct, it is referred to South Australia Police (SAPOL) to consider whether a criminal investigation should be conducted. Until recently, CCIU would defer its own investigation pending the finalisation of any criminal investigation and proceedings. Consequently in some circumstances the care concern investigation would be delayed for more than a year.¹²¹

This practice appears to have developed as a result of the recommendation in the CISC Inquiry that the unit's guidelines include that¹²²:

[the unit is to] take no action that would prejudice a police investigation or potential prosecution. In particular, the [unit] must not speak to the child, alleged perpetrator, potential witnesses or other potential complainants without seeking, and then gaining, approval in writing from SA Police.

However, the Commission has not been able to identify any written policy or guideline that incorporates this recommendation.

The intent of the recommendation was to prevent CCIU from taking action that would prejudice a police investigation or prosecution: it did not require a care concern investigation to be placed completely on hold as has become the practice. In recent times, there appears to have been some progress with respect to this issue. With written permission from SAPOL, limited aspects of a care concern investigation may be undertaken while criminal proceedings are under way. However, there is no clarity as to the circumstances in which this may occur, and the decision appears to be made on an ad hoc basis.¹²³

Complications that may arise if investigations are conducted in parallel can be overcome by staff with specialist investigatory skills, clear lines of communication, and an understanding of the respective roles of CCIU and SAPOL.

An investigation by CCIU into whether or not an incident has occurred, and the apportionment of blame, will usually prejudice criminal proceedings. However, if there is clear communication between the two agencies, the examination of program or system deficits that may have contributed to the incident should be able to be undertaken in parallel with a criminal investigation.

When compared with the interface between law enforcement and child protection agencies in other jurisdictions, the practice in South Australia of delaying the commencement of a care concern investigation is uncommon.¹²⁴

In Victoria, staff members of the statutory child protection agency, employed as Quality of Care Coordinators, are specifically tasked with coordinating responses to care concerns, including joint responses with the Victoria Police. This enables matters to be more easily progressed without compromising ongoing criminal proceedings.¹²⁵ Similar arrangements would be valuable in South Australia, given the contribution of pending criminal proceedings to the issue of delay. However, it would be important for those coordinating a joint response to have the requisite skills and expertise.

RESPONDING TO A SERIOUS CARE CONCERN INVESTIGATION

The process that follows the completion of an investigation involves a number of layers of authority. Investigation reports are approved by the manager of CCIU and provided to the Deputy Chief Executive of the Office for Corporate Services, who is required to approve the report. The report is then forwarded to the Chief Executive of the Department for endorsement and final approval. CCIU has no further involvement in the matter.¹²⁶

The Chief Executive then refers the report to the Deputy Chief Executive of the Office for Child Protection, who is expected to provide the Chief Executive with a response briefing, including an 'action plan' responding to the report's findings, within three months.

The processes followed by the Agency to produce the response briefing are unclear. Documentation outlining inconsistent processes is in circulation in the Agency. It appears the manager of the Families SA office where the child's case file is held is expected to complete the response briefing and provide it to the manager of the Agency's adverse events program. The briefing is then provided to the Deputy Chief Executive of the Office for Child Protection who forwards the approved briefing to the Chief Executive of the Department.¹²⁷

DELAYS AND DEFICITS IN THE AGENCY'S RESPONSE

Between 2013 and 2015 the Agency's adverse events program lapsed due to a lack of staff. This affected the Agency's oversight of the completion of response briefings and the attention given to systemic issues raised by CCIU.¹²⁸

At April 2015, the Commission examined the response of Families SA to 16 of 26 investigation reports finalised between 1 July 2013 and 1 December 2014. The Chief Executive did not receive a response briefing within the designated three-month timeframe in any of the 16 matters. Ten responses had been completed, but the average time taken was five months, with the longest time being just over nine months.¹²⁹ The Chief Executive was still waiting for responses for six reports that had been approved between May and November 2014. In the case of the report approved in May, 11 months had passed without a written response by the Agency.¹³⁰

These delays in the Agency's response time, coupled with protracted investigations, undermine the utility of a process aimed at addressing systems issues and improving practices within Families SA.¹³¹

An investigation report does not outline recommendations or actions to be taken by the Agency when addressing issues: that task appears to be left to the local office managers. However, their capacity to consider systems issues and effect change is limited.

Given the resource pressures within Families SA, it is overly optimistic to expect office managers to respond to investigation reports in a considered and strategic manner. It may be difficult for them to detach themselves from their local responsibilities and adopt a more strategic outlook when addressing the findings of a report. In addition, an office manager may not appreciate broader issues affecting the Agency.

Managers do not receive specific guidance or training as to how they should respond to investigation reports, particularly what may be expected of them regarding systems issues that may have been identified.

Even if a manager does complete a response briefing, there is no clear or routine mechanism in place thereafter to identify and act on the lessons learned from the investigation process. This suggests the outcomes of serious care concerns investigations are not used effectively to guide system-wide reform.

COLLABORATION TO INFORM SYSTEM CHANGE

While some responses may need a local focus, senior front-line staff should collaborate with staff who have roles dedicated to the oversight of agency-level responses and the promotion of system change. Such collaboration would allow effective local level responses to inform the Agency's practices more broadly, with the overall aim of improving the experiences of other children in care who could be adversely affected by similar systems deficits. Local staff should be given clear guidance as to their responsibilities in this collaborative process. They also need to be given time to dedicate to the task.

RESPONDING TO MINOR AND MODERATE CARE CONCERNS

Minor and moderate care concerns are not investigated by CCIU: they are returned to Families SA for response.

There is some documentation that provides limited guidance to Agency front-line staff. However, it is outdated and not disseminated in any systemic way. There is also confusion and a lack of understanding about roles and responsibilities.¹³² Staff do not receive formal training in responding to care concerns.¹³³ The system relied on experienced staff to provide support and guidance to new staff. However, with the loss of experienced staff, even this informal training mechanism has become difficult to sustain. The knowledge and rigour relating to responding to minor and moderate care concerns have diminished over time. The process is subject to individual interpretation and different approaches across offices.¹³⁴

MINOR CARE CONCERNS

Minor care concerns should generally be allocated by the relevant office manager to the child's caseworker to be dealt with as part of their normal case management. It is expected they would work with other agencies if necessary to determine how best to address the concern.¹³⁵ Responses are expected to be collaborative and supportive. Case management actions may include¹³⁶:

- more regular contact with the child and carer;
- a review of the child's care plan;
- clarification of expectations, roles and responsibilities;
- the provision of information or training to carers; and
- development of strategies with carers to address challenging aspects of the placement.

The focus is on supporting and maintaining the placement—it is not about laying blame.¹³⁷

Such actions reinforce the inappropriateness of categorising the care concern raised against McCooles as minor. Allegations that are suggestive of sexual abuse, or any incident of abuse or harm, could not be adequately addressed through a case management response.

Care concerns that are suitable for a case management response should genuinely be minor. They should pose very limited risk to the child continuing in the placement, or to other children who may come into contact with the employee or carer.

MODERATE CARE CONCERNS

Although the focus of moderate care concerns is on providing support and maintaining the placement, they call for a more formal response than minor care concerns.¹³⁸ An element of the response should be investigatory. However, there is little clarity as to who should be responsible for that aspect of the matter. This can result in an inadequate or delayed response. For example, senior staff in different directorates of the Agency allowed a moderate care concern involving an employee to languish for 20 months as they were confused about who was responsible for responding to the matter.¹³⁹

The prevailing practice appears to be that the office manager who is responsible for the child's caseworker is the person who is ultimately responsible for responding to the care concern. However, if the person who is the subject of concern is an employee, there is an expectation that their manager will be involved in addressing them, and helping to identify systems issues.¹⁴⁰

Previously, the response to a moderate care concern was to be completed within 42 days. This included submitting a report to the manager of the investigations unit. Such a report is no longer provided: the outcome is simply recorded on C3MS.¹⁴¹ The staff member responsible, usually the office manager, is expected to decide whether abuse or neglect, or a deficit in the standard of care, is substantiated. More recent documentation obtained by the Commission indicates there is no set timeframe to complete a response.¹⁴²

COLLABORATION WITH STAKEHOLDERS

The Commission reviewed 100 minor and moderate determinations made between 1 July 2013 and 1 December 2014. Approximately 85 per cent related to a foster parent, a kinship carer or an emergency carer.¹⁴³

If a minor or moderate care concern relates to a foster parent, kinship carer or emergency carer, the responsible section of Families SA (for example, the kinship support program) or the relevant non-government organisation should be informed. It is expected the care concern will be addressed collaboratively by the various stakeholders.¹⁴⁴ However, what is expected of them, and where the division of responsibility lies, are not well defined.

The approach to collaboration is inconsistent across the state.¹⁴⁵ There is a lack of documentation to guide how the Families SA office involved in the response process and the stakeholder should work together. Communication issues are frequently cited.¹⁴⁶ The stakeholder may not be included in the response process at all, or invited to participate as an afterthought.

Excluding stakeholders from the process, regardless of the reason, undermines the effectiveness of the care concern system and in turn jeopardises outcomes for children in care. Decisions may be based on incomplete information. Plans or strategies that are being implemented in an effort to support and maintain a placement may be compromised if the foster care agency is not actively involved. Meaningful collaboration should form part of a functioning and valuable care concern system.

However, there are some cases, such as the care concern raised against McCooles, where the seriousness of the allegations and a potential conflict of interest on the part of the service provider, would preclude a collaborative approach during the response to the care concern. In those cases, agencies should be obliged to cooperate rather than collaborate with the investigation.

THE NEED FOR SPECIALIST SKILLS AND OBJECTIVITY

Responding to care concerns can be complex, and the inappropriate determination of serious allegations as minor or moderate unnecessarily contributes to the

challenges that confront Families SA front-line staff.¹⁴⁷ It is a departure from the recommendations of the Layton Review, which contemplated a unit independent from the operations of the Agency to investigate serious allegations of abuse and neglect involving children in care. The system is not designed for the Agency's front-line staff to deal with serious allegations. They often will lack the necessary skills or independence.

Agency front-line staff have a role to play in responding to care concerns, but only where care concern referrals are properly categorised.

AN EXAMPLE OF AN INADEQUATE RESPONSE

The Commission's inquiries revealed that the inadequate response to the care concern raised against McCoole was not an isolated occurrence.

For example, a CCR alleged a male foster parent was watching his teenage female foster child dress and undress. This was determined to be a moderate care concern. The determination led to a process that was not in the best interests of the child and did not sufficiently address the concerns.¹⁴⁸

The allegations were referred to SAPOL but it was not clear from the records obtained by the Commission whether Families SA ascertained if a criminal investigation was to be conducted before it proceeded with the care concern response. A strategy discussion between Families SA and SAPOL should have occurred in this case soon after the allegations were raised in order to plan how the matter should proceed and ensure there was clarity about the responsibilities of each agency. There is no record on C3MS that this occurred.¹⁴⁹

Families SA responded to the allegation by arranging for the child's caseworker to speak with both the child and the foster parents. This occurred in the home of the foster parents. The conversations with the child and the foster parents took place in separate rooms but within about 15 minutes of each other. Having a conversation with the child in the home and with the foster parents nearby was inappropriate. The child may have been reluctant to talk about the allegations in that environment. Given the conversations were conducted so closely in time, it is also unlikely that the caseworker had the opportunity to reflect on the child's responses before speaking with the foster parents.¹⁵⁰

Further, the information in the CCR was limited. If the foster parents had been interviewed before the child, they may have been able to provide some context to the allegations being made and the child's circumstances. The record of the conversation with the child evidenced a lack of preparation. The purpose of speaking with the child and the issues explored were not clear. The record suggests the concerns raised in the CCR were not sufficiently addressed.¹⁵¹

A more considered and specialised response was required to this matter than that which occurred. Caseworkers who do not possess the necessary skills to conduct an investigation can undermine the care concern process and threaten the outcome, particularly in circumstances when they are inappropriately tasked to manage serious allegations.

ENGAGING WITH A CHILD DURING AN INVESTIGATION

There is an important difference between *talking to*, and *interviewing*, a child. Forensic interviews of children are conducted for a specific purpose, such as investigating an incident of abuse or conducting an assessment of a child and their family.¹⁵²

Caseworkers will often talk to a child about their placement in general terms to find out about their progress and experiences. This is part of standard case management and does not require an in-depth understanding of interviewing techniques. A proper forensic interview is more targeted. The interviewer gains an insight into the child's world through understanding the way the child's day is structured and experienced. The interviewer can explore allegations in context and, if necessary, focus the child's attention on areas of particular importance. An appropriate balance will be reached between the avoidance of leading questions and enabling the child to understand the experiences of interest to the interviewer.¹⁵³

As was highlighted by the McCoole case study, when investigating allegations of abuse, in particular sexual abuse, interviewers need to be aware of a number of factors which may affect whether or not a child discloses their experiences, such as¹⁵⁴:

- a child may not feel comfortable talking about their experiences when the interview is held in the same environment in which the abuse occurred;
- if a child is not certain whether they will have ongoing contact with the person responsible for the abuse, they may be reluctant to disclose;
- a child is not necessarily more likely to disclose to someone with whom they have an existing relationship; and
- sexual abuse can be particularly difficult for children to disclose as they have a sense of the secrecy surrounding it.

Central to the investigation of an allegation of abuse or neglect is providing the child with sufficient opportunity to disclose their experiences during a properly planned interview. Purposefully providing a child with that opportunity is a complex task. Generally, Families SA caseworkers have very limited, if any, training and expertise in this specialist skill.¹⁵⁵

15 INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CARE

THE INFLUENCE OF OTHER FACTORS

Resource limitations and operational pressures within the child protection system can compromise the decision making of practitioners when responding to care concerns. It may be difficult for Families SA staff to detach themselves from these issues. Staff responding to care concerns cannot help but be aware of the 'very stretched and overburdened' nature of the system.¹⁵⁶ Factors that should not be given precedence over the child's safety, such as limited alternative placements for the child, may be given too much weight. The staff member may have an established relationship with the carer who is the subject of the concern and find it difficult to set aside their pre-existing views when deciding the outcome. In these circumstances, they may be less likely to make a decision that would require the child to be removed from the placement or make a finding of substantiated abuse against the carer.¹⁵⁷

Similarly, where the subject of concern is an employee, the conduct of staff may improperly influence the course of the investigation. This was clearly demonstrated in the response to the care concern raised against McCoolle. Staff members who knew McCoolle made incorrect assertions about him and about the notifier of the care concern. This conduct influenced the staff who were tasked with investigating the allegations.

All of these issues reinforce the need for the investigation of serious allegations to be undertaken independently of Families SA operations.

TRENDS IN CARE CONCERNS

Table 15.3 shows the number, and determined category, of CCRs received by CCIU each financial year from 2011/12 to 2014/15. From 2011/12 to 2013/14, the total number of CCRs declined. This changed in 2014/15, with a four-year peak of 1002 referrals.

For three years until 1 July 2014, the proportions of CCRs determined as minor, moderate and serious were relatively constant. The vast majority of CCRs, on average 78 per cent across three financial years, were determined to be minor care concerns. As shown by Figure 15.1, in 2014/15 there was a dramatic decrease in the number of CCRs determined to be minor. The proportion was less than half of the previous year, falling from 77 per cent in 2013/14 to 37 per cent in 2014/15. There was a corresponding increase in the proportions of CCRs determined to be moderate and no action required.

The trends show that there was a clear change in the work of CCIU in 2014/15. It raises for consideration whether this is a reflection of a change in how care is delivered to children, in reporter behaviour or in the determination practices of CCIU.

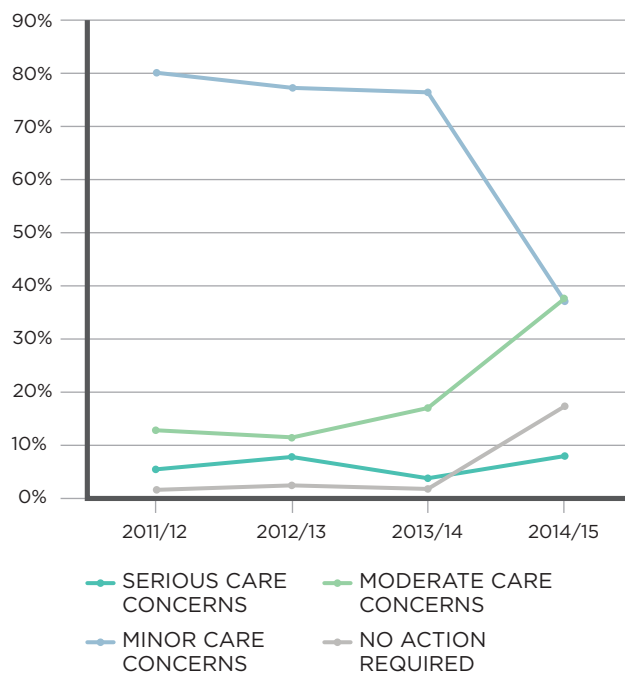


Figure 15.1: Trends in determinations of care concern referrals, 2011/12 to 2014/15

THE RELEVANCE OF THE ARREST OF MCCOOLE

Before McCoolle's arrest in June 2014, the number of CCRs was steadily declining. Conversely, the number of children in care increased from 2368 at 30 June 2011 to 2631 at 30 June 2014.¹⁵⁸ It is unlikely the decrease in CCRs was due to the growing number of children in care generally being provided with a better standard of care. Rather, a number of deficiencies in the care concern system have likely contributed to the decline in CCRs over this time, including:

- an inadequate understanding of what constitutes a care concern;
- a lack of clarity about when the conduct of a person caring for a child in care should be reported;
- a mistaken belief that because a child is in care a notification is not required; and
- the lack of appropriate response to some CCRs, leading to notifiers believing reporting is futile.

THE INCREASE IN DETERMINATIONS OF 'NO ACTION REQUIRED'

McCoolle's arrest, and the publicity which ensued, may have had an influence on reporting behaviours. The increase in reports in 2014/15 was accompanied by a ninefold increase in the proportion of CCRs determined to require no action. Given the impact of McCoolle's

Table 15.3: The number and determination of care concern referrals, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Total care concern referrals	975	874	830	1002
Serious care concerns (percentage of total)	57 (6%)	70 (8%)	33 (4%)	83 (8%)
Moderate care concerns (percentage of total)	122 (13%)	104 (12%)	143 (17%)	375 (37%)
Minor care concerns (percentage of total)	780 (80%)	675 (77%)	636 (77%)	368 (37%)
No action required (percentage of total)	16 (2%)	25 (3%)	18 (2%)	176 (18%)

Source: Data from Care Concern Investigations Unit.

conduct, adults in contact with children in care may have become hyper-vigilant and reported less serious behaviour not previously regarded as warranting notification.

While adults should be observant and attentive at all times to the safety and wellbeing of children in care, better guidance and support following McCoolle's arrest may have helped to limit this reporting of unnecessary concerns.

The Commission was told that many care concerns could be more appropriately responded to in the first instance at the case management level, rather than the matter being reported to CCIU.¹⁵⁹

FEWER MINOR DETERMINATIONS

The steep decline in the proportion of minor care concerns in 2014/15 reflects the shortcomings in the determination process and a risk-averse culture. There is no evidence CCIU purposefully changed the determination thresholds following McCoolle's arrest. However, it is likely greater caution was employed when determining which CCRs required an investigative response, as opposed to a case management response. This seems particularly likely given that the notification in relation to McCoolle's conduct had been erroneously categorised as minor.

THE PROPORTION OF CARE CONCERNS TO BE RESPONDED TO BY FAMILIES SA

Families SA is expected to respond to the overwhelming majority of care concerns raised. As shown in Table 15.4, on average from 2011/12 to 2014/15 Families SA was required to respond to 801 care concerns each year. In 2013/14, 96 per cent of CCRs determined by CCIU to require a response were classified as either a minor or moderate care concern. In 2014/15 this proportion fell slightly to 90 per cent. Only a very small proportion of

CCRs, on average 7 per cent from 2011/12 to 2014/15, receive an investigation by CCIU independent of Families SA operations.

There is a role for Families SA to play in responding to less serious care concerns, particularly those where there is a real prospect of a case management response improving the outcomes for the child. However, it is questionable whether the present balance whereby CCIU only responds to about one in 10 care concern referrals is appropriate.

Testing of the SDM care concern screening criteria indicated that between 420 and 520 care concerns would be screened in for an investigation and review response each year. However, not all care concerns meeting the threshold of abuse, neglect or significant risk of serious harm would require an investigation independent of Families SA operations. It was determined through applying draft criteria that between 170 and 200 care concerns required an independent investigation by CCIU.¹⁶⁰ This is more than double the number of care concerns that were retained by CCIU for investigation in 2014/15. An increase in the workload of CCIU is not unexpected. The Commission's inquiries revealed serious allegations of abuse or neglect in out-of-home care were being referred to Families SA offices for response. This practice should cease.

Over an 18-month period to July 2015, CCIU finalised only about one investigation per month. At this rate of finalisation, it would take CCIU a number of years to complete current outstanding matters, not accounting for new investigations. The productivity of the CCIU should increase, to meet the greater workload. In part this would require better resourcing.

15 INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CARE

Table 15.4: Total care concern referrals determined to require a response, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Total care concerns determined to require a response ^a	959	849	812	826
Care concerns to be responded to by Families SA ^b (percentage of total)	902 (94%)	779 (92%)	779 (96%)	743 (90%)
Serious care concerns (to be investigated by CCIU) (percentage of total)	57 (6%)	70 (8%)	33 (4%)	83 (10%)

^a The total number of care concern referrals, not including those determined to require No Action.

^b The total number of minor and moderate care concerns.

Source: Data from Care Concern Investigations Unit.

MANAGEMENT OF PRIOR CARE CONCERNS

The Commission reviewed selected documentation relating to more than 300 CCRs received by CCIU between July 2013 and December 2014. The Commission was able to identify clear trends in relation to carers and staff members with histories of prior care concerns and placements with ongoing difficulties.

A significant proportion of CCRs originated within placements in which Families SA was already aware of ongoing problems. For example, in a sample of 50 CCRs which had received a determination of 'no action required', approximately 30 per cent related to placements that were the subject of a prior care concern. The rationale for this decision often indicated that Families SA was aware of ongoing issues in the placement and was making efforts to address them through case management. Little consideration appears to have been given to the ineffectiveness of that as a remedial action. Similarly, in a sample of 50 CCRs which had received a determination of 'moderate', approximately 42 per cent related to placements in which Families SA was aware that issues existed and again 'case management' was being undertaken to address the problems.

Approximately 50 per cent of all care concerns determined to be serious in the review period related to placements in which Families SA was aware of prior or ongoing issues.

Kinship care accounted for 41 per cent of placements with a history of care concerns (across a sample of 200 CCRs relating to subjects who had at least one previous CCR). Sixty-five per cent of these kinship placements involved Aboriginal and Torres Strait Islander children.

In approximately 50 per cent of serious care concern investigation reports reviewed by the Commission, the subject of concern had a history of prior CCRs.

These trends suggest the response of CCIU and the Agency to troubled placements often appears to be ineffective, and decision making often gives insufficient weight to the relevance of a history of care concerns. A history of child maltreatment on the part of a carer or staff member is a useful predictor of future maltreatment. However, the Agency does not make use of the trends that can be identified by analysing the history of prior care concerns to address systems issues.

DEFICITS IN RECORDS MANAGEMENT

Care concern data is recorded on two distinct systems: Objective and C3MS. Objective is the central recording database for care concerns used by CCIU, and C3MS is Families SA's electronic case management system. Data is not automatically shared across the two systems, and neither system has a complete picture of a care concern. Table 15.5 sets out the data saved on each system. To understand what has taken place from the time of the care concern notification through to Families SA's eventual response, both systems need to be accessed.¹⁶¹

The paper files used by CCIU prior to Objective have not been completely transferred onto the system due to a lack of resources. In some cases, in order to ascertain a complete picture of a person's care concern history, four different databases or systems need to be reviewed: Objective, C3MS, CIS (the system predating C3MS) and hard copy files.¹⁶² This is a time-consuming exercise and crucial information could be missed.

C3MS stores care concern information under a child's name. It is therefore difficult to ascertain through that system alone if the person the subject of concern has a care concern history. To search for their history, the name of any child previously involved must be known. Often it will not be.¹⁶³

Table 15.5: The storage of care concern information on Objective and C3MS

OBJECTIVE	C3MS
• Care concern referral • Determination rationale • Information gathered and correspondence during a serious care concern investigation • Serious care concern investigation report	• Care concern referral • Determination rationale • Details of minor or moderate care concern response • Outcome of moderate care concern investigation • Serious care concern investigation report • Response to serious care concern investigation report including details of actions taken

Source: Witness statements, P Adams; A Dimusevska.

Care concern histories can be more easily obtained through searching Objective, as information is stored under the name of the person who is the subject of the concern. However, Families SA staff do not have access to the Objective system.¹⁶⁴

Extracting data from both C3MS and Objective is a difficult task, as neither system has adequate reporting capabilities.¹⁶⁵ This contributes to care concern data not being used in a strategic way to identify where there may be consistent problems in out-of-home care service delivery.

The Layton Review contemplated that care concern data would be used by Families SA and CCIU to improve systems deficits, assist in the oversight of staff and achieve better outcomes for children in care. This has not occurred.

Currently, CCIU is entirely reactive: it waits to receive allegations before conducting the investigations. However, analysing themes and patterns in care concern referrals and outcomes would be a potent tool for the Agency, enabling them to be more proactive and targeted in addressing abuse and neglect in care. For example, data analysis may reveal that a particular residential care facility or foster care agency is responsible for a disproportionate number of CCRs; clear themes may emerge as to the type of care concerns arising in a particular area, or reveal a troubling pattern of behaviour in an individual. Analyses of this type are not undertaken.

Care concern data should be used in a more proactive way. Data analysis may lead to the early detection of systems issues and assist the Agency to take a strategic approach to the management of their staff and carers. The implementation of a database that permits the tracking of care concerns, critical incidents and other complaints, particularly in residential care, is discussed in Chapter 12.

A REFORMED CARE CONCERN SYSTEM

The creation of a new, stand-alone child protection department brings with it an opportunity to reform the approach to investigating abuse and neglect in care and establish an effective care concern system. The following elements will be critical to its success:

- clear policies, procedures and guidelines, accessible to all Agency staff and communicated to all stakeholders;
- specific training for Agency staff and service providers, detailing roles and responsibilities in the care concern system;
- a panel responsible for determining which matters should be investigated independent of the Agency's operations;
- a unit, independent of the Agency's operations, responsible for investigating serious allegations (the investigations unit);
- a unit, within a directorate responsible for quality and practice, that has oversight of the care concern system (the response unit);
- integration between the care concern function and the Agency's human resources unit;
- benchmarks for the completion of investigations and responses to care concerns; and
- an accountability mechanism external to the department.

The approach to responding to care concerns in the future should be informed by the discussion throughout this chapter, and the specific features identified below.

THE NEED FOR TWO SEPARATE UNITS

The deficits identified in the care concern system prove the need for two separate units to be established in the new department. This is to ensure that sufficient attention and expertise are given to investigating serious allegations (the investigations unit), as well as responding to less serious matters. There is also a need for a dedicated unit to have clear responsibility for oversight of the care concern system (the response unit).

The investigations unit should be independent from the operations arm of the new department. Its focus should be the investigation of all allegations of serious abuse or neglect and significant risk of serious harm. In some circumstances, this unit may also be called upon to investigate serious care standard deficits. The unit would need to be sufficiently resourced to fulfil this mandate, and provide a statewide service. The limited staffing levels that have been in place in CCIU in recent times are unlikely to be adequate. The placement of the investigations unit in the new department should ensure that clear links are established with the human resources unit, and in particular with those staff members responsible for addressing employee misconduct.

The response unit should form part of the new department's quality and practice directorate. This unit would be an integral part of the reformed care concern system and would have oversight of all care concerns, with particular responsibility for advising and liaising with front-line staff, monitoring care concerns, collating care concern data and informing system change.

Links between both units and the section of the department responsible for the licensing and accountability of service providers would also be essential.

DETERMINING THE INVESTIGATION PATHWAY

Chapter 8 proposes reforms that would give notifiers with concerns about the safety of children (whether mandated to report or not) two options: to report their concerns to the Agency's Call Centre, or alternatively refer the matter to a child and family assessment and referral network in cases where a notifier believes that a child's circumstances would be adequately addressed by a prevention and early intervention program. However, guidelines and training should make it clear that care concerns should always be reported to the Call Centre. If a care concern notification is made to a referral network, the call should be transferred to the Call Centre. If a notifier is not willing to wait while their call is transferred, the referral network should promptly relay the information to the Call Centre.

The Agency's Call Centre should be responsible for assessing care concern notifications using the SDM care concern screening criteria tool. The immediate safety and wellbeing of the child should remain the responsibility of the local office who has case management responsibility for the child.

To fulfil its monitoring and analysis role, the response unit should also be advised of all care concern notifications received.

Care concern notifications assessed by the Call Centre as requiring an investigation and review response should be referred to a three-person panel. This is necessary to guard against the professional judgement of a single decision maker inappropriately determining that front-line staff should respond to serious allegations, as opposed to referring the matter to the investigations unit. The panel should include experienced staff members from the investigations unit and the response unit, and a senior staff member from the quality and practice directorate—either the director or the Agency's principal practitioner.

The panel would need to meet regularly to ensure investigations start within 48 hours of receiving the notification. Consultation between the panel and operational staff or other stakeholders before determining the investigation pathway should be rare, and if necessary limited to information such as whether the person who is the subject of concern was on shift at the relevant time. The panel should not be responsible for taking any investigative steps.

The panel should be guided by clear criteria when determining whether the care concern is more appropriately investigated by the investigations unit, or front-line staff. Consideration may be given to factors such as¹⁶⁶:

- the extent and type of alleged harm;
- the number and age of children involved;
- whether a criminal investigation is likely;
- whether the person who is the subject of the concern is a staff member;
- whether there is a history of care concerns; and
- the nature of any systems issues that may be identified.

Given the potential sensitivities and specialist skills required, all allegations that raise the suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) should be investigated by the investigations unit.

The panel should also consider the potential for a child to be forensically interviewed during the investigation, and the likelihood for this interview to be conducted by the Agency, as opposed to SAPOL or Child Protection Services (CPS). It is likely that the investigations unit would conduct the investigation, as front-line staff are unlikely to have the specialist skills required to conduct the interview.

If the panel decides that the allegations can be appropriately investigated by front-line staff, there should be a flexible approach as to who has the responsibility for that investigation. For example, the panel may consider

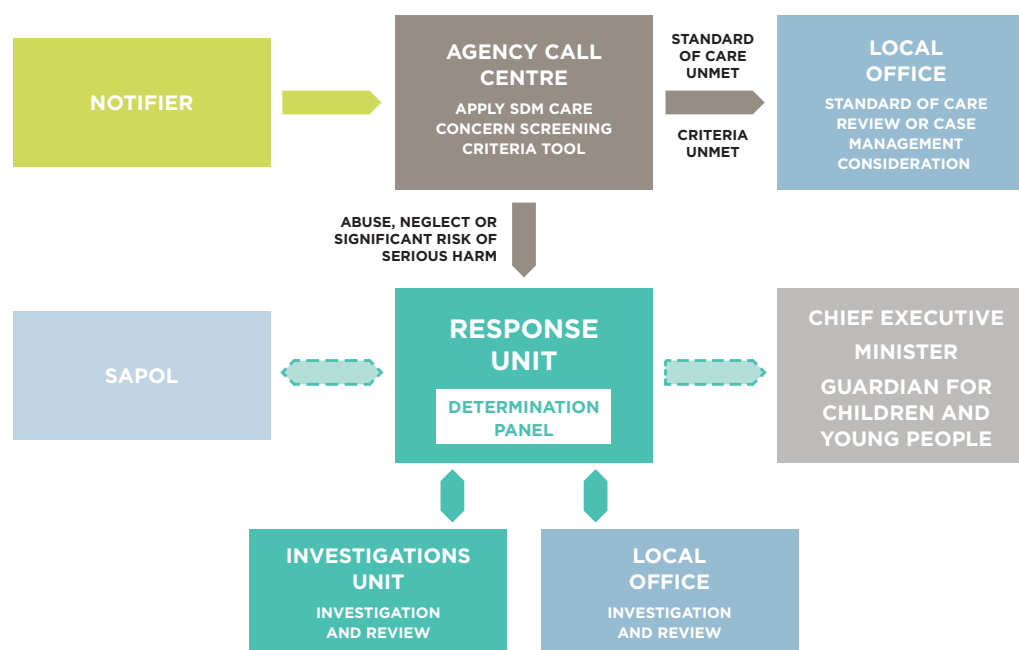


Figure 15.2: Reformed care concern system

some independence from the office responsible for the child's case management is necessary and allocate the matter to another local office for investigation.

The meeting requirements of the panel should not delay a matter being referred to SAPOL if the allegations are criminal in nature. In the first instance the response unit should be responsible for referring a matter to SAPOL but the panel may also consider the matter if it has not yet been referred.

Figure 15.2 sets out the proposed response pathways of a care concern notification through the reformed system. The reporting function of the response unit (discussed later in this chapter) is also shown.

STRATEGY DISCUSSIONS

All investigations undertaken by the investigations unit should start with a strategy discussion, bringing together expertise from the unit and other relevant agencies such as SAPOL and CPS. As part of its monitoring role, the response unit should also be represented. Depending on the nature of the allegations, it may also be appropriate to include human resources expertise, representation from the relevant local office, and the Agency's licensing and service accountability section.

The strategy discussion should provide an opportunity for agencies to genuinely engage, share information and develop an investigation plan. Each agency needs a clear awareness of the planned activities and responses of all other agencies.¹⁶⁷

Chapter 9 acknowledges the importance of inviting other agencies, including non-government agencies, to strategy discussions in appropriate cases. However, inviting a non-government organisation to a care concern strategy discussion requires caution, taking into account different considerations than those when responding to allegations of abuse or neglect in a child's birth family. This is because in a care concern investigation, the non-government organisation may have a potential conflict of interest. For example, they may be called on to advocate on behalf of an employee or foster carer.

Strategy discussions may also be an important tool for care concerns that the panel has determined appropriate to be investigated by front-line staff.

In some cases, a strategy discussion would need to be held without delay following the care concern notification. It may be necessary, for example, to respond promptly to suspected physical trauma with a forensic medical assessment. Obviously, determining the investigation pathway should not stand in the way of an urgent response, and a further strategy discussion could be convened if appropriate.

SPECIALIST INVESTIGATORS

The investigations unit should be staffed by specialist investigators, in a multidisciplinary team encompassing both child protection and law enforcement expertise. All investigators should be trained in areas such as the Agency's processes, the purposes of conducting an investigation, investigative techniques, child development, trauma-related behaviours and indicators of abuse and neglect.

Each investigation should be allocated to a primary investigator. However, the combined expertise available in a multidisciplinary team should provide a collaborative environment where investigations and decision making are informed both by child protection principles and the investigative principles used in law enforcement. This should ensure investigations do not become overly incident-focused, without consideration of other contextual factors that may have contributed to the child's adverse experiences and the carer's or employee's conduct.

Investigators should understand the importance of affording procedural fairness to the person under investigation. The investigator should have authority under section 58(3) of the Children's Protection Act to divulge information so that procedural fairness is not unduly frustrated by a duty to maintain confidentiality. The subject of the concern should be advised in writing of at least the general nature of the allegations within seven days of the notification. However, if a matter has been referred to SAPOL, communication with the subject of concern should not occur without police approval.

Investigators should have authority to gather information under sections 45 and 47 of the Family and Community Services Act and to conduct an investigation under section 19 of the Children's Protection Act in appropriate circumstances. Contractual arrangements with service providers and conditions of employment should also provide mechanisms through which investigators gather information.

Chapter 21 proposes amendments to the Children's Protection Act to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies with responsibilities for the health, safety or wellbeing of children, where it would promote those responsibilities. These amendments could be relied on by investigators to gather information during a care concern investigation.

An update to the Interagency Code of Practice was due to be released in July 2016. At the time of writing, it was expected the updated code would make it clear that it applied to the investigation of abuse and

neglect of children in care, and this is endorsed by the Commission.¹⁶⁸ There is no reason why inter-agency practices should be less robust because a child is in care.

INTERVIEWING CHILDREN

In many circumstances an investigation of serious allegations will include an interview of the child who is the subject of the concern, and possibly other children in the placement who may be able to provide relevant information. Depending on the nature of the allegations, trained interviewers from CPS or SAPOL may interview the child for the purposes of a criminal investigation, and this can subsequently be relied on for the care concern investigation.

In determining who should conduct an interview with a child, regard should be had to the recent amendments to the *Evidence Act 1929* (SA) and the *Summary Offences Act 1953* (SA). The legislation now sets out certain preconditions for the admissibility of a recorded interview with a child under the age of 14 years in certain criminal proceedings.¹⁶⁹

Further, section 104 of the *Summary Procedure Act 1921* (SA) requires that an investigating officer, generally a police officer, attend the recorded interview of a child under the age of 14 years, for that interview to be admissible during committal proceedings in the Magistrates Court. (The term 'investigating officer' would not include a staff member of the Agency investigating a care concern.) This is because the recording must be accompanied by a transcript verified by the police officer as being a complete record of the interview. This is an important safeguard to ensure the accuracy of documentary evidence.

However, there may be occasions when SAPOL is not involved in a care concern investigation, but CPS considers it appropriate to conduct a forensic interview. The absence of SAPOL should not be viewed as an impediment to CPS conducting a forensic interview. If a child discloses their experiences during that interview, the resulting transcript should be admissible. Section 104 of the Summary Procedure Act should therefore be amended to permit the transcript to be verified by a person in attendance at the interview, other than an investigating officer as defined in the Act. It is not intended that the power to have someone other than a police officer verify the transcript be used in practice except in special circumstances.

Against this background, investigators in the investigations unit need to exercise caution when deciding to interview or re-interview a child. The decision to re-interview a child should always be made in consultation with a senior staff member. If a child has already been interviewed about the allegations by SAPOL or CPS, they should only be re-interviewed if further specific information has been identified as being

necessary for a complete investigation. Any interview needs to have a clear purpose, and should not be approached in an unstructured way.

If an interview is to be conducted, the nature of the allegations investigated by the investigations unit will, in most cases, require the child to be forensically interviewed by an appropriately trained interviewer. There should be investigators in the investigations unit trained in the forensic interviewing of children. The inter-agency training offered through TAFE is not sufficient for this purpose.¹⁷⁰

If a child needs to be interviewed during an investigation being conducted by front-line staff, careful consideration should be given to who will conduct that interview, and its purpose, including whether a forensic interview is necessary.

FLEXIBILITY IN THE APPROACH

An effective care concern system should provide for both flexibility and review in decision making. The response unit should serve as a liaison point and pivot in the system. When the Agency's Call Centre assesses a matter as Standard of Care Unmet, it is ordinarily allocated to the local office for review. In some cases, the response unit may regard such a matter as requiring an independent investigation by the investigations unit. In those circumstances, the response unit should refer the matter to the panel for consideration.

There may also be some cases in which the local office considers a matter too serious to be investigated or addressed locally, or that it lacks the necessary expertise to conduct the investigation. In those cases, the office should also have the option of having the response pathway reviewed.

Providing some flexibility in the response pathways will only be beneficial to the care concern system if it is not misused. It should not be viewed as a mechanism to have care concerns reallocated without a genuine reason. It should also not interfere with the timeliness of investigations or responses.

THE BROADER ROLE OF THE RESPONSE UNIT

Staff in the response unit should generally have expertise in child protection; experience in conducting investigations would also be desirable.

The response unit should provide an advisory and consultative role for front-line staff who are tasked with responding to care concerns. The unit should also be responsible for ensuring there are clear and up-to-date policies, procedures and guidelines in place covering the various functions of the care concern system. This information should be accessible to staff

across the Agency, and disseminated to stakeholders. Documentation relevant to carers should be available online in a clear, accessible format.

The response unit should liaise between the Agency and SAPOL. Matters referred to SAPOL for criminal investigation should generally not be actioned by the investigations unit or front-line staff until the criminal investigation and related proceedings are finalised, to ensure the actions of the Agency do not prejudice any criminal investigation or prosecution. Through liaising with SAPOL, the response unit should advise the investigations unit or front-line staff when an investigation or other review of allegations can begin. In collaboration with SAPOL, the response unit should determine whether there are any aspects of the allegations that may be addressed while the criminal proceedings are still under way without prejudicing the criminal process.

The investigation of care concerns (and standard of care reviews), whether undertaken by the investigations unit or by front-line staff, should be subject to specific timeframes. In Western Australia an investigation is expected to be completed within 30 days¹⁷¹; in Victoria, it should be completed within 28 working days of receipt of the care concern.¹⁷² The Commission considers that in the absence of ongoing criminal proceedings or special circumstances, a period of no more than six weeks should be sufficient to complete the investigation of a care concern.

COORDINATING RESPONSES TO INVESTIGATIONS

On completion of an investigation, the investigations unit should produce a report outlining its findings and the rationale for them. The report should then be provided to the Chief Executive of the new child protection department and the response unit.

The response unit would be responsible for notifying other relevant sections of the department of the investigation outcomes, for example the human resources unit, service accountability, carer registration or the local office. The response unit would also be responsible for coordinating their responses. Responses and intended actions of each section should be sought, and reported to the Chief Executive, within four weeks.

During this four-week period, the response unit would play an important role in ensuring the responses of each section were consistent. The unit may also work with the various sections to help develop actions to respond to issues specific to that practice area as well as broader systemic issues.

It is expected the response unit would use effective local level responses to guide broader systems improvements.

THE MONITORING ROLE

Crucial to the effectiveness of the care concern system would be a monitoring and analysis role to be performed by the response unit, including:

- monitoring the timeliness of investigations;
- reviewing systems issues identified during investigations and making recommendations to the Chief Executive in response;
- monitoring the implementation and effectiveness of these recommendations;
- analysing trends in care concerns and systems issues; and
- fulfilling the Agency's external accountability responsibilities (discussed below).

The response unit would need full access to all records relating to care concerns. As discussed earlier, this information is spread across a number of systems. At present, Objective is likely to be the most useful system but the Agency should consider whether there is a better system that would permit the more effective tracking and analysis of care concern information. The Agency should also dedicate resources to uploading hard copy files of historical care concerns onto an electronic records management system so they are readily searchable and accessible.

A CASE MANAGEMENT RESPONSE

Care concern notifications assessed as Criteria Unmet should be referred to the relevant local office for a case management response, and the child's caseworker should work collaboratively with the care team to address the concerns. While the response unit should be advised of the notification for the purpose of data analysis, the unit is not expected to have an active consultative role. Senior staff in the local office should be sufficiently equipped to help less experienced staff undertake an appropriate case management response.

EXTERNAL OVERSIGHT AND ACCOUNTABILITY

In 2008, the CISC Inquiry recommended reporting lines be established from the investigations unit (now CCIU) to the Guardian for Children and Young People (GCYP) when allegations of sexual abuse were raised involving children in care. In particular that¹⁷³:

- the unit advise the GCYP (and SAPOL) of the notification of an allegation of sexual abuse of a child in care immediately, or within 24 hours;
- the GCYP be invited to attend strategy discussions, and be provided with a written record of discussions and intended actions within 24 hours; and

- the GCYP be kept informed of the progress of investigations and, on request, be provided with information about an investigation within 24 hours.

It was also recommended that the GCYP have an advocacy role for children in care who had disclosed sexual abuse, and that it be mandatory for the Chief Executive of the Department or Commissioner of Police to notify the GCYP when a child in care made such a disclosure.¹⁷⁴

The recommendations were accepted, and agreed practices were put in place between CCIU and GCYP. The extent to which CCIU has complied with this agreement has varied over time and has been dependent on the approach taken by the various managers of CCIU. Trends in the number of matters referred demonstrate that it is likely GCYP has not been advised of all relevant matters as agreed. This has been of particular concern since 2010. From November 2008 to October 2014, only 43 per cent of notifications were referred to GCYP within the timeframe recommended by the CISC Inquiry, and promptness has diminished over the years. In 2013, only five per cent of notifications were received within 24 hours.¹⁷⁵

The inconsistencies in CCIU's reporting practices mean that the intent of the recommendations has not been achieved. The GCYP's capacity to perform an effective monitoring and advocacy role has been diminished.¹⁷⁶

The care concern system in South Australia has not been subject to an external accountability mechanism, and that which was put in place in relation to allegations of sexual abuse in care has not been particularly effective.

Implementing external oversight in South Australia should lead to a more transparent and accountable care concern system. Regularly providing data about care concerns to the GCYP would provide a mechanism for deficiencies in the system, which are affecting the experiences of children in care, to be highlighted and addressed.

Consistent with recommendations in Chapters 10 and 16 requiring the reporting of key data to the Minister and GCYP, the Chief Executive of the new department should report quarterly to the Minister and GCYP on matters including:

- the number of care concern notifications received and their response pathway;
- how many care concern investigations have been completed;
- whether investigation timeframes were met and the reasons for timeframes not being met;
- the outcomes of investigations; and
- how identified systems issues are being addressed.

This mechanism is not intended to replace the specific reporting structures recommended by the CISC Inquiry in relation to allegations of sexual abuse.

As administrative actions, complaints or concerns that an individual may have regarding the conduct or outcome of an investigation, may be subject to the jurisdiction of the Ombudsman. The role of the Ombudsman is discussed in Chapter 22.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		179	Define the standards against which deficiencies in the care provided to a child in care should be assessed.
172	Provide specialist training and documented guidance to staff within the Agency, as well as home-based carers and carers engaged through commercial agencies, as to their roles and responsibilities with respect to identifying and reporting conduct that may amount to a care concern, and the processes that follow such a report.	180	Clarify the powers available to investigators, including putting in place appropriate delegations and authorities pursuant to sections 45 and 47 of the <i>Family and Community Services Act 1972</i> and section 19 of the <i>Children's Protection Act 1993</i> .
173	Consider developing technology to provide children in care with a user-friendly mechanism to engage with caseworkers in the care team and other responsible adults about their experiences and concerns.	181	Ensure that staff are available in the investigations unit who are trained in forensic interviewing of children when this service is required.
174	Review and implement the Structured Decision Making' care concern screening criteria tool for use by Call Centre practitioners.	182	Amend section 104 of the <i>Summary Procedure Act 1921</i> to permit the filing in committal proceedings of a transcript of a recorded interview with a child under the age of 14 years that has been verified by a person in attendance at the interview, other than an investigating officer as defined in the Act.
175	Establish a panel in the Agency to determine the appropriate response pathway with respect to a care concern that is not diverted by the Call Centre to the field, but noting that all allegations that raise a suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) must be investigated by the investigations unit.	183	Require investigators to record an outcome as 'undetermined' in any case in which there is insufficient evidence to make a definitive finding.
176	Establish in the Agency an investigations unit independent of the operations of the Agency to investigate matters referred to it by the panel, and staff that unit with a multidisciplinary team of investigators with expertise in child protection and law enforcement, and provide training and guidelines as to the scope of their roles.	184	Establish a response unit within the directorate responsible for quality and practice to: - a provide advice to front-line staff about care concerns; - b provide a report to the Chief Executive of the Agency outlining responses and intended actions to issues identified in an investigation report. This should be provided within four weeks of the response unit receiving the investigation report; - c undertake a monitoring role in respect of all care concern notifications; - d analyse trends in care concern data to proactively address systems issues and inform the management of staff and carers; and - e make recommendations to the Chief Executive of the Agency as to proposed improvements in response to identified systems issues.
177	Ensure that all care concern notifications are investigated in a timely manner: - a investigations should commence within 48 hours of the receipt of a notification; and - b in the absence of ongoing criminal proceedings or special reasons, investigations should be completed within six weeks from receipt of the notification.		
178	Require a strategy meeting to be held at the start of all investigations undertaken by the investigations unit.		

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- 185** Establish a liaison function between the response unit and SAPOL, particularly with respect to identification of aspects of a care concern investigation that may be commenced by the Agency while criminal proceedings are pending.
- 186** Require the Agency to provide quarterly data to the Minister and the Guardian for Children and Young People about care concerns, including:
- a** the number of care concern notifications received and their response pathway;
 - b** how many care concern investigations have been completed;
 - c** whether investigation timeframes have been met and the reasons for timeframes not being met;
 - d** the outcomes of investigations; and
 - e** how identified systems issues are being addressed.

NOTES

- 1 Office of the Guardian for Children and Young People (GCYP), *Preventing sexual abuse of children and young people in state care in South Australia*, information paper, Government of South Australia, May 2006, p. 3.
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PART V

CHILDREN WITH DIVERSE NEEDS

ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

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OVERVIEW

The discussion of child protection for Aboriginal children is a difficult topic. Past policies, including forced removals, forced assimilation and dispossession of land and culture, continue to have significant negative impacts on Aboriginal peoples. This legacy casts a long shadow over child protection services. Aboriginal children and families are over-represented at every stage of the child protection system. While the removal of children from their parents is disruptive and painful no matter the cultural group, it has profound historical echoes for Aboriginal people.

All children, including Aboriginal children, are entitled to enjoy a range of rights, including the right to a full life, care and protection and an adequate standard of living. Aboriginal children also have specific rights to enjoy their culture, religion and language in their community. While there is potential for tension between these rights, the better view is to see them as mutually beneficial and interdependent: Aboriginal children flourish best when they can *safely* enjoy their land, language, community and culture.

Practitioners should be trained and supported to ensure that assessments of risk to children consider Aboriginal culture and parenting practices. However, culture should never be used to excuse situations where children are abused or neglected: all children are entitled to the same standards of health, safety and wellbeing.

Like other families, some Aboriginal families need support. There should be more investment in early intervention support services and more intensive support, including by services run by Aboriginal organisations.

As with many other families, some Aboriginal children cannot safely live with their family. In accordance with the Aboriginal and Torres Strait Islander Child Placement Principle, Aboriginal children who are taken into care should be placed wherever possible with other Aboriginal carers, preferably those from the same family, community or culture. More support is needed to identify these carers. A limited pool of potential Aboriginal carers means a growing number of children are placed with non-Aboriginal carers. These carers need support to preserve and strengthen the children's cultural links.

The child protection system should build its Aboriginal workforce. It should also consult meaningfully with the Aboriginal community to draw on Aboriginal knowledge and skills to address the needs of children. At the same time, the system should equip its non-Aboriginal workforce, through training and support, to respond effectively to the needs of Aboriginal children and families. There is a need to re-focus cultural support in

Families SA (the Agency) to ensure that all practitioners have access to advice and support in specific cases, as well as more strategic guidance and training.

There are particular challenges in many remote Aboriginal communities, where many children are highly vulnerable and continue to be exposed to all forms of maltreatment. Practitioners require specific training, support and clinical supervision to equip them to work effectively with children and families in these communities. They need sound knowledge of Aboriginal culture and parenting practices and should give due weight to children's connection to land, language, community and culture. However, they should not lose sight of the fact that children in remote communities have the same rights to health, safety and wellbeing as other children.

This chapter surveys a range of recent initiatives by government and not-for-profit agencies in remote communities to support children, families and the broader community. It discusses how these services could operate more effectively and more collaboratively. Because the support and involvement of Aboriginal communities are central to the success of child protection initiatives, the Commission recommends that the South Australian Government consult meaningfully with communities about these recommendations as it considers their implementation. In future, agencies should work collaboratively with remote communities to develop a common vision for child safety and wellbeing.

This chapter principally relates to the Commission's Terms of Reference 5(a) to (h), in the context of Terms of Reference 1 to 4.

HUMAN RIGHTS

The United Nations Convention on the Rights of the Child recognises the right of children to a full life, care and protection, and a standard of living adequate to allow their physical, mental, spiritual, moral and social development. These rights apply to all children, irrespective of race, language or ethnic origin. The Convention makes special provision for indigenous children, recognising their right, in community with their indigenous people, to enjoy their culture, profess and practice their religion, and use their language.²

The United Nations Declaration on the Rights of Indigenous Peoples recognises further rights for indigenous peoples, including³:

- to practise and revitalise their cultural traditions and customs;
- to manifest, practise, develop and teach their spiritual and religious traditions, customs and ceremonies;

- to revitalise, use, develop and transmit to future generations their histories, languages, oral traditions, philosophies, writing systems and literatures; and
- to participate in decision making in matters which affect their rights.

There is potential for tension between the right of Aboriginal children to life, care and protection, and healthy development, and 'the collective rights of Indigenous peoples to know who they are, where they come from and maintain contact with their culture and family'.⁴ Clearly, children's right to life and safety is paramount: no right for a community to remain intact can trump a child's right to be safe. Yet this should not overlook the fact that Aboriginal children flourish in their community, where they remain connected to family and culture and can draw on their cultural and spiritual heritage. The better view is not to regard individual and collective rights in 'simple competition', but as mutually beneficial and interdependent.⁵

*Cultural rights directly impact on a child's ability to meaningfully enjoy every other human right and freedom, let alone their health. Like all human rights, they are universal, indivisible and interdependent.*⁶

LEGACIES OF THE PAST

Aboriginal people continue to bear the effect of past policies. There remains a significant gap between Aboriginal and non-Aboriginal people across a wide range of measures, including life expectancy, child and infant mortality, infant birth weight, incarceration, family and community violence, alcohol and substance use and related harm, and a range of health and education measures.⁷

Forced removals, in particular, cast a long shadow over child protection services in Australia. From 'the very first days of the European occupation of Australia', Aboriginal children were forcibly removed from families and communities.⁸ From about 1910 to 1970, between one in three and one in 10 Aboriginal children were forcibly removed. Not one Aboriginal family escaped the effects and most families were 'affected, in one or more generations, by the forcible removal of one or more children'.⁹ Most children removed 'suffered multiple and disabling effects'.¹⁰

This continues to have a profound impact. Inter-generational trauma manifests itself 'through issues such as family violence and excessive drug and alcohol use, as well as knowledge of parenting itself'.¹¹ Many who were forcibly removed grew up without positive parenting role models, leading some to develop poor parenting skills and to pass these on to their children, creating a negative inter-generational cycle.¹²

ABORIGINAL APPROACHES TO PARENTING

It is important to recognise the strengths in Aboriginal parenting. While there is no single approach¹³, it is possible to identify general themes, including¹⁴:

- a collective approach, where families and communities together care for and protect their children;
- increased freedom and autonomy for children to explore their world and to learn their responsibilities for protecting one another;
- the integral contribution of elders to family functioning; and
- the sharing of culture and spirituality with children as part of their broad family and community.

These themes offer a useful counterpoint to individualistic, overly protective modes of parenting, which may burden parents and undermine a child's resilience and independence.¹⁵

As discussed in Chapter 3, attachment theory describes the need of all children to form selective attachment relationships with their primary caregiver to support their physical, social and emotional development. However, cultural differences may apply to how these needs are satisfied in a particular context. Collective caregiving can support the formation of multiple attachment relationships that provide the child with emotional security.¹⁶ Aboriginal peoples' conception of a 'competent' child may place more emphasis on communal responsibility than individual autonomy and assertiveness.¹⁷

While all children are entitled to the same standards of health, safety and wellbeing, assessments should 'take particular cultural expressions of safety, sensitivity and competence into consideration'.¹⁸ Poor knowledge of culture and parenting practices may lead non-Aboriginal practitioners to identify child protection concerns where there are none.

Cultural explanations do not necessarily mean a child is not being maltreated. Nor do they mean that an attachment bond is secure in instances when it may not be.¹⁹ The child protection system should not permit culture to excuse genuine risk or absence of safety.

Practitioners need training and support to draw the distinction 'between parent/caregiver behaviour which harms or impedes a child's development and that which ... is considered within Aboriginal culture to be appropriate and responsible parenting practice'.²⁰ Put another way, practitioners need to know 'what constitutes "good-enough parenting" for Aboriginal families, from the standpoint of the state's interest in child development'.²¹

16 ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

OVER-REPRESENTATION

Aboriginal children and families are vastly over-represented in all parts of the South Australian child protection system. Figure 16.1 compares the rate of Aboriginal children in South Australia who have had screened-in notifications with the rate for non-Aboriginal children.

As Figure 16.1 shows, in 2014/15 Aboriginal children were 6.6 times more likely to be the subject of a screened-in notification. This over-representation occurs throughout the state's child protection system. Figure 16.2 and Figure 16.3 compare the rate of Aboriginal children who have finalised child protection investigations and substantiations of abuse or neglect with the rate for non-Aboriginal children.

In 2014/15, Aboriginal children were 9.8 times more likely to be the subject of a finalised child protection investigation and 9.9 times more likely to be the subject of a substantiated finding of abuse or neglect than non-Aboriginal children.

Figure 16.4 shows that this over-representation carries through to children in out-of-home care.

In 2014/15, Aboriginal children were 9.2 times more likely to enter out-of-home care than non-Aboriginal children.

Aboriginal people make up about 2.4 per cent of South Australia's population and about 4.5 per cent of the state's child population.²² Yet in 2014/15, 26 per cent of children with screened-in notifications and about 30 per cent of children with finalised investigations and substantiated abuse or neglect findings were Aboriginal. They represented 28 per cent of children admitted to care in 2014/15 and 30 per cent of children who were under a care and protection order at 30 June 2015.²³ Similar over-representations are found in all jurisdictions in Australia.²⁴

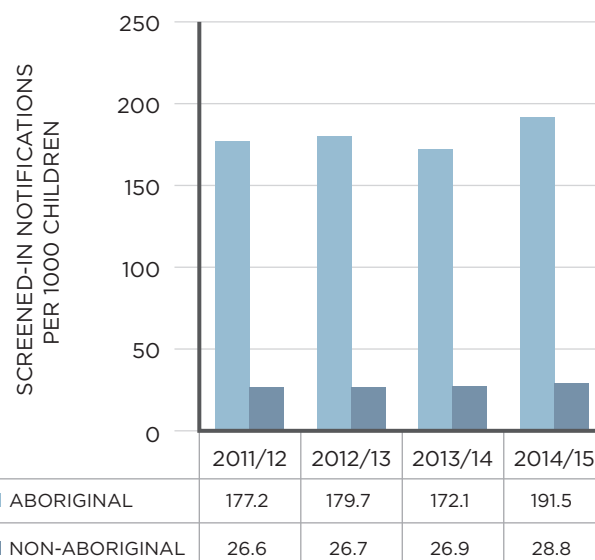


Figure 16.1: Rate of South Australian Aboriginal and non-Aboriginal children who have had screened-in notifications per 1000 children

Note: Includes extra-familial (EXF) cases, which South Australia Police respond to.

Source: Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, table 15A.8.

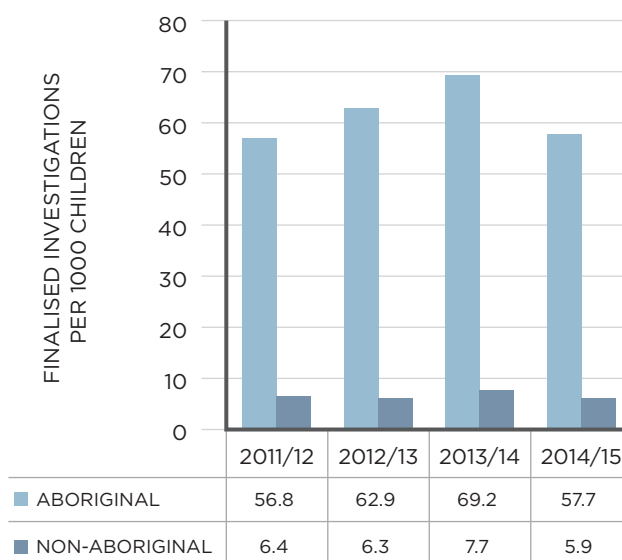


Figure 16.2: Rate of South Australian Aboriginal and non-Aboriginal children with finalised child protection investigations per 1000 children

Note: Finalised investigations include investigations finalised by 31 August in the following financial year.

Source: Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, table 15A.8.



Figure 16.3: Rate of South Australian Aboriginal and non-Aboriginal children with a substantiated finding of abuse or neglect per 1000 children

Source: Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, table 15A.8.



Figure 16.4: Rate of South Australian Aboriginal and non-Aboriginal children in out-of-home care per 1000 children

Source: Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, table 15A.8

This over-representation has profound, cumulative effects on many Aboriginal childhoods. A 2010 longitudinal study followed South Australian children born in 1991, adding comparative data for children born in 1998 and 2002. By 2007, 57-76 per cent of Aboriginal children born in 1991 had been the subject of at least one notification (the figure was 23 per cent for children generally). Forty per cent of Aboriginal children had four or more notifications (23 per cent for non-Aboriginal children). The study found that the over-representation appears to be increasing: 16 per cent of Aboriginal children born in 1991 were the subject of at least one notification by 1995 (5 per cent for non-Aboriginal children), whereas 56 per cent of Aboriginal children born in 2002 were the subject of at least one notification by 2006 (11 per cent for non-Aboriginal children).²⁵

UNDER-REPORTING OF ABUSE AND NEGLECT

There is reason to believe official notification and substantiation records understate the number of children, both Aboriginal and non-Aboriginal, who experience abuse and neglect.²⁶ In some Aboriginal communities, past inquiries have found sexual abuse in particular is grossly under-reported.²⁷ The reasons for under-reporting all types of abuse and neglect of Aboriginal children include²⁸:

- fear, mistrust and loss of confidence in the police, justice system, government agencies and the media;
- fear of racism;
- fear the child may be removed from the community;
- community silence and denial;
- social and cultural pressure from other members of the family or community not to report abuse or violence and the belief that reporting is a betrayal of the culture and community;
- a belief in the need to protect the perpetrator because of the high number of Indigenous deaths in custody;
- fear of repercussions or retaliation from the perpetrator or their family;
- personal and cultural factors of shame, guilt and fear;
- lack of understanding about what child abuse and neglect is generally, and lack of understanding about what constitutes child sexual abuse specifically;
- language and communication barriers, lack of knowledge about legal rights and the services available, and lack of services for Aboriginal victims; and
- geographical isolation (that is, nobody to report to, no means of reporting and minimal contact with child welfare professionals).

EFFECTIVE RESPONSES TO CHILDREN AT RISK

Chapter 9 outlines concerns that Families SA assessments are often compromised by excessive optimism and tolerate situations that are plainly abusive or neglectful. These concerns also apply to assessments concerning Aboriginal children. The Commission observed many assessments of Aboriginal children, including in the case study of Abby (see Vol. 2, Case Study 2) and in the course of the Commission's Cumulative Harm, Usual Practice and Intake reviews (see Appendix C). The Commission observed many examples of Aboriginal children who were exposed to prolonged abuse and neglect with little or no effective response, including the following:

- At the time of Erin's birth, her parents had ongoing issues with drug and alcohol abuse and domestic violence, and they refused to work with Families SA. Her two older siblings were already in long-term care. Over the next three years, there were repeated notifications involving homelessness, domestic violence, substance abuse and poor supervision. On one occasion, Erin was found, aged three years, wandering the streets unsupervised in hot weather without water, shelter or shoes. A safety plan was agreed, yet a few days later she was again found wandering unsupervised. The response was another safety plan. Notifications continued, including an incident where the father beat Erin and dragged her down the street. Finally, aged four years, Erin was placed in care. She bore the effects of neglect: delayed development, poor dental health and needing surgery for a condition which could have been treated had she not missed multiple medical appointments while in her parents' care.
- All five of Errol's older siblings were removed from his parents' care owing to concerns of chronic neglect, domestic violence, lack of supervision, and drug and alcohol abuse. When Errol was born, his mother signed a safety plan agreeing to abstain from drinking around the child. At least 11 notifications followed, relating to ongoing domestic violence, substance abuse and his mother's deteriorating mental health. When he was nearly five years, Errol was admitted to hospital under the pretence he had fallen from a cupboard at home, when in fact he had ingested his mother's anti-psychotic medication.
- Gemma has six children. Over 14 years, Families SA received more than 40 notifications featuring persistent concerns of domestic violence, lack of supervision, non-attendance at school, attending school without food or clean clothes, and presenting with minor physical injuries. On occasions, Families SA visited the family and referred them to various Aboriginal support services, but the responses

appeared uncoordinated and did not break the cycle of maltreatment. The children were not listened to, such as when Graham, aged eight, told his teacher:

'My fucking mum doesn't have any food in the house. I'm hungry and my tummy hurts'. Families SA assessed that this was too 'vague' to require a response. Signs of cumulative harm to the children appeared to receive little weight. The children remain in their mother's care and, without significant escalation of issues, appear likely to stay there.²⁹

It is not possible to conclude that these cases received a poor response, or that practitioners applied a different standard because the families were Aboriginal. However, the Commission observed a pattern across many cases of vulnerable Aboriginal families with children at significant risk who received no adequate response.

Witnesses described a reluctance on the part of Families SA and other agencies to intervene in Aboriginal families, noting that higher thresholds of risk and safety appeared to be applied for Aboriginal children.³⁰ One experienced practitioner stated:

Reluctance to recreate another stolen generation, and the very real risk of being accused of racism, have resulted in child protection workers adopting a two-tier risk threshold for Aboriginal and non-Aboriginal children, with the level of risk needing to be much higher for Aboriginal children before intervention occurs. Yet Aboriginal senior consultants and executives can still be heard to say that Aboriginal families are being unfairly targeted by the child protection system with issues of poverty being mislabelled as abuse or neglect. There may be occasional cases of this, but I have never seen one. What is overwhelmingly evident is a bias to not intervene. This means that when intervention finally occurs, the families' difficulties are usually extreme. When intervention occurs, there is also a very high tolerance for family conditions still mired in trauma.³¹

In 2012, the South Australian Child Death and Serious Injury Review Committee reviewed the circumstances surrounding six children who sustained serious injuries. Its recommendations emphasised the need for all agencies in the child protection system to be culturally appropriate, but to apply the same standards of risk and safety for both Aboriginal and non-Aboriginal children.³²

All practitioners in the child protection system should have training, support and clinical supervision in working effectively with Aboriginal children and families, including knowledge of culture and parenting practices, but should apply the same standards of risk and safety to all children.

ABORIGINAL SERVICES IN FAMILIES SA

Families SA has a range of roles and services that work specifically with Aboriginal children and families. These are discussed below.

PRINCIPAL ABORIGINAL CONSULTANTS

The Agency employs four principal Aboriginal consultants (PACs), each of whom has a geographical area of responsibility. These senior practice roles provide strategic guidance to help the Agency respond more effectively to Aboriginal children and families, including strategies to maintain the cultural identity of children in care and training for staff in how to work more effectively with Aboriginal families. They also consult about specific cases, for example, concerning the cultural implications of a placement decision or the needs of particular Aboriginal families and communities.³³

ABORIGINAL FAMILY PRACTITIONERS

Some offices of the Agency employ Aboriginal family practitioners (AFPs), who have flexible roles. They perform direct casework with Aboriginal families and help non-Aboriginal staff to more effectively engage Aboriginal families in a culturally appropriate way. They often co-work cases with non-Aboriginal practitioners, assisting and advising in casework and identifying resources in the community that families can access.³⁴

Each Families SA Call Centre team has at least one AFP. Most regional offices also have at least one, although the Mount Barker office and most metropolitan offices have none.³⁵ The Northern Protective Intervention hub and the Central Assessment and Support hub host AFPs from the northern Kanggarendi and Yaitya Tirramangkotti teams (discussed below). Instead of AFPs, Port Augusta has an Aboriginal services team of three staff.³⁶

KANGGARENDI

The Agency has two Kanggarendi teams. The teams respond to Tier 2 and Tier 3 intakes relating to Aboriginal children and families where a non-investigative, community-based response is appropriate.³⁷ One team responds to cases in northern and western metropolitan Adelaide and the other to cases in southern metropolitan Adelaide. The teams consist of AFPs and a supervisor.³⁸

As described in Chapter 9, resource constraints mean most Tier 2 and 3 intakes are Closed No Action (CNA). Therefore, the cases to which Kanggarendi responds might otherwise receive no response. The service works with families on a voluntary basis, offering support for up to 12 months, including practical in-home assistance, parenting skills development, referrals to community supports and intensive case management.³⁹

If risks escalate and the child needs to be removed, Kanggarendi closes the file and re-notifies the Call Centre.⁴⁰

YAITYA TIRRAMANGKOTTI

Until recently, Yaitya Tirramangkotti⁴¹ (Yaitya) was a unit in the Call Centre. It assessed notifications about Aboriginal children and families and supported other Call Centre staff to make culturally appropriate assessments. Its 'guiding principle' was that the Agency 'should not respond to reports on Aboriginal children without first taking advice from staff with sufficient knowledge of the relevant family and community'.⁴² The Layton Review in 2003 strongly supported Yaitya's role⁴³, as did an internal review in 2012.⁴⁴ By 2014, Yaitya consisted of a supervisor, a senior practitioner and eight social workers, supported by six AFPs, divided between the other teams in the Call Centre.⁴⁵

In 2014, Families SA moved Yaitya to its Central Assessment and Support hub. An internal report relating to the Call Centre supported the move but did not give a rationale for it and the Commission has not been able to establish why it occurred.⁴⁶ In practice, there is little contact between Yaitya and Call Centre staff.⁴⁷

CHALLENGES OF RECRUITING AN ABORIGINAL WORKFORCE

The challenges to recruitment outlined in Chapter 6 are much greater for Aboriginal employees. Many Aboriginal people are reluctant to work in the child protection system, particularly in Families SA. Many Aboriginal employees find Families SA a challenging, stressful workplace. Witnesses identified a number of challenges, including:

- poor cultural understanding and insensitivity among some non-Aboriginal colleagues;
- negative reactions in the Aboriginal community to a person working with 'welfare', which is accentuated in South Australia by the state's small Aboriginal community, where many people know each other; and
- conflict between providing support and advice to the Aboriginal community and advising Families SA about the removal of children.⁴⁸

The internal review in 2012 identified that Aboriginal staff in Families SA are not well supported. This affects performance, recruitment and retention.⁴⁹ The review recommended measures to make the Agency safer and more attractive for Aboriginal employees, including:

- development of a central Aboriginal recruitment and retention strategy;
- tailored support for the professional and personal needs of Aboriginal staff, many of whom experience significant pressure, particularly in front-line roles;
- improved induction and recruitment processes, including information to prepare employees for the complexities of working in a system where Aboriginal children are significantly over-represented;
- improved professional development and support for Aboriginal staff in leadership roles and those identified as future leaders; and
- improved personal and professional development opportunities, including access to training and qualifications.⁵⁰

The Commission was also told of commendable practices in the Agency, including a scholarship program that enables Aboriginal staff to study social work with course fees fully reimbursed.

Families SA developed a document titled, Aboriginal Recruitment and Retention Strategy, which addresses many of these issues.⁵¹ However, the Commission was told it is not a formal strategy, but rather a 'work in progress'⁵² designed to 'inform discussion'.⁵³ In October 2015, the Agency appointed a strategic Aboriginal advisor, whose role includes developing an Aboriginal recruitment strategy.⁵⁴ Four years after the internal review, the Agency should finalise this strategy as a priority. The strategy should reflect the recommendations listed above and should also complement the Agency's broader workforce strategy.

Despite these challenges, the Agency has had some success in recruiting an Aboriginal workforce. Aboriginal people represent about 5 per cent of employees (at June 2015), exceeding the state government's strategic target of 2 per cent Aboriginal employment across the public sector.⁵⁵ The vast majority of Aboriginal employees are full-time (88.5 per cent), permanent (78.2 per cent) employees. Most of those employed full time are in human service roles, as either allied health professionals (46.8 per cent) or occupational services officers (27.3 per cent).⁵⁶ The measures described above will help build on this representation.

Community-based, not-for-profit agencies in the broader child protection system face many of the same barriers to recruiting Aboriginal employees. While these agencies carry less stigma than Families SA, they face a retention

challenge in that Aboriginal staff with experience in the sector are often attracted to more senior roles, such as PACs, in the Agency.⁵⁷

TRAINING THE NON-ABORIGINAL WORKFORCE

Given the over-representation of Aboriginal children and families, it is important for the child protection system to build its Aboriginal workforce over time. However, it is not feasible in the foreseeable future for all Aboriginal children and families to be responded to by Aboriginal staff. It is essential that the Agency build the skills of its non-Aboriginal workforce to work effectively with Aboriginal children and families.⁵⁸

PACs, AFPs and staff from Yaitya and Kanggarendi are important sources of cultural advice to the broader Agency workforce. However:

*over-reliance among some non-Aboriginal staff on the assistance [Aboriginal staff] provide ... has resulted in a lack of effort exerted by some non-Aboriginal staff to expand their own skills and knowledge in respect of best cultural practice and to gain experience in working with Aboriginal children.*⁵⁹

Working effectively with Aboriginal children and families is core business for all staff of the Agency. Training, supervision and support programs should reflect this. Witnesses identified that many non-Aboriginal workers have poor understanding of Aboriginal culture. Not only does this affect the quality of their work, but the gulf in understanding is a significant challenge for their Aboriginal colleagues.⁶⁰ Existing cultural training is poorly attended and typically consists of a single, day-long session, sitting in a training room.⁶¹ One Aboriginal practitioner noted:

*You can't go to a culturally appropriate training session and think, well, I'm appropriate at the end of the day, because I've done one session.*⁶²

Witnesses suggested alternative training models, such as exposing practitioners to culture by taking them 'out bush' on camps, and asking them to participate in Aboriginal cultural events or co-work with Aboriginal workers.⁶³

The 2012 internal review found that Families SA's cultural training was too brief and offered little guidance about practical service delivery. Training should extend beyond the history of Aboriginal mistreatment and disadvantage—although this provides important context—to offer practical skills, techniques and advice. It needs to include information about the complexity and diversity of Aboriginal communities, including topics such as Aboriginal parenting practices and the role of extended family in Aboriginal communities.⁶⁴ Importantly, it should equip practitioners to distinguish practices that

are considered appropriate and responsible in Aboriginal culture from behaviour that harms or impedes a child's development and warrants a response.⁶⁵

In terms of tertiary training, the Commission heard that Deakin University gives a particularly good overview on Aboriginal culture and its relationship with child protection and that many Families SA practitioners have benefited from this course.⁶⁶

REFOCUSING CULTURAL SUPPORT IN FAMILIES SA

Because PACs, AFPs and staff from Yaitya and Kanggarendi offer cultural advice within Families SA, it can be confusing for staff to know to whom to turn.⁶⁷ There is also the potential for conflicting advice.

PRINCIPAL ABORIGINAL CONSULTANTS

PACs continue to spend most of their time consulting in relation to specific cases⁶⁸, despite a 2012 review concluding that this was 'unsustainable'. PACs should focus on:

*knowledge sharing, training and on-the-job skill transfer to non-Aboriginal staff [and] becoming disseminators of knowledge in best practice Aboriginal business, not merely a source for answers to specific questions and case-by-case assistance.*⁶⁹

PACs should serve as case consultants only in complex cases. They should use this opportunity 'to train and educate staff on the processes and knowledge that brought them to give the specific advice offered' and to identify where the workforce may require training.⁷⁰

ABORIGINAL FAMILY PRACTITIONERS

AFPs are well placed to provide cultural advice to practitioners in less complex cases, although their aim over time should be to build the knowledge and skills of non-Aboriginal staff. Complex cases that exceed their knowledge should continue to be referred to a PAC.

Some AFPs cannot provide cultural support in certain cases. Many AFPs negotiate informal arrangements about the types of work that they will perform. Some respond only to chronic neglect and family support cases. Many are reluctant to be involved directly in higher risk cases that may lead to removal, but are happy to co-work cases, providing assistance from the background to a non-Aboriginal primary worker.⁷¹ These arrangements often reflect the legacy of past policies and the close relationships between many Aboriginal people. They avoid placing practitioners in 'conflicting or personally compromising situations'⁷²:

*It is pivotal to have Aboriginal staff only undertaking work with client groups with which they are both comfortable and have the skills and aptitude with which to work therapeutically. Misplaced or misfit role allocation may lead to negative outcomes for clients.*⁷³

Consultation arrangements should be flexible enough to accommodate this, while ensuring practitioners have access to the support they need.

KANGGARENDI AND YAITYA TIRRAMANGKOTTI

As discussed below, Kanggarendi's functions should be transferred to the not-for-profit sector. Its staff should no longer offer internal cultural advice to Families SA practitioners.

For Yaitya, one option is to return to the Call Centre. Table 16.1 shows the total number of notifications received by the Call Centre during the past four financial years, by the child's Aboriginality.

Table 16.1: Number of Aboriginal and non-Aboriginal notifications, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Aboriginal notifications	8583	8972	10,159	11,878
Non-Aboriginal notifications	30,699	32,879	35,786	41,562
Notifications where Aboriginality is unknown	1225	1688	2892	4370

Source: Data from Families SA.

In 2014/15, the Agency received 11,878 notifications concerning Aboriginal children, comprising 21 per cent of all notifications. The number of notifications concerning Aboriginal children rose 38 per cent between 2011/12 and 2014/15 (35 per cent for non-Aboriginal children).

It would take a dedicated team of about 10 AFPs, assessing five notifications a day, to assess all the notifications concerning Aboriginal children received in 2014/15.⁷⁴ If notifications for Aboriginal children rise during the next three years at the same rate as the preceding three years, a team of about 14 Aboriginal practitioners would be needed in the Call Centre by 2017/18. By comparison, in February 2016 the Agency had a total of 17 AFPs (one vacant) and four senior AFPs across the whole of metropolitan Adelaide.⁷⁵

While the Agency should decide how much of its Aboriginal workforce to devote to the Call Centre, it is one area among many that would benefit from cultural advice. While the Call Centre has less Aboriginal cultural input since Yaitya's departure⁷⁶, it retains six AFP positions, including at least one in each Call Centre team.

As with other functions in the Agency, the over-representation of Aboriginal children means it may not be feasible for Aboriginal practitioners to process all notifications concerning Aboriginal children. Further, building a sufficiently large Aboriginal workforce to respond to all such notifications could leave other parts of the Agency without adequate access to cultural advice and support. For this reason, notifications may need to be processed by non-Aboriginal practitioners, who are trained in Aboriginal culture and parenting practices and can draw on assistance from on-site AFPs.

Call Centre practitioners receive information by telephone or the internet and assess the level of risk using decision-making tools and their professional judgment. In some cases cultural considerations will help to distinguish appropriate, responsible Aboriginal parenting practices from behaviour that is harmful and requires a response. However, much depends on the context of the family and the child, which may be difficult to assess remotely. In many cases, some form of face-to-face assessment by practitioners who are informed by culture may be needed.

As noted, most metropolitan practitioners, as well as those in the Mount Barker office, have no on-site access to AFPs. This is a barrier, notwithstanding that staff in these offices can seek input from Kanggarendi or Yaitya.⁷⁷ An alternative to returning Yaitya to the Call Centre would be to reallocate its staff so that all Agency offices have on-site AFPs. The Agency should consult its Aboriginal practitioners and the broader workforce about the best model for providing cultural advice and support.

SUPPORT SERVICES FOR ABORIGINAL CHILDREN AND FAMILIES

Aboriginal children and families have access to a range of mainstream support services, including those described in Chapter 8. There are also many services specifically for Aboriginal children and families:

- The Aboriginal Family Birthing Program is available to many Aboriginal women in country and metropolitan South Australia. They receive care during pregnancy, labour, birth and the postnatal period from Aboriginal maternal and infant care workers, in partnership with midwives, obstetricians and general practitioners. A recent evaluation indicates that the program is helping to meet targets for reducing Aboriginal disadvantage

by increasing the proportion of mothers receiving antenatal care and reducing the proportion of infants with low birth weight.⁷⁸

- The Metropolitan Aboriginal Youth and Family Services (MAYFS) offers targeted early intervention services to Aboriginal young people (aged 10–18 years), including a mentoring program and programs to learn about culture and skills for life.⁷⁹
- Nunkuwarrin Yunti provides a range of allied health and specialist services to promote the physical, social and emotional wellbeing of Aboriginal children and families.⁸⁰
- Nanko-walun Po:rlar Nomawi is an early intervention service operated by Child and Adolescent Mental Health Service (CAMHS) in Murray Bridge. It offers support services to Aboriginal children and families throughout Ngarrindjeri country, including helping families involved with the child protection system.⁸¹
- Aboriginal Family Support Services (AFSS) offers a range of services at 17 sites in South Australia, including family support, gambling help, residential services for children in care, home-based foster care services, and a community safety and wellbeing program.⁸²

Aboriginal people should have the choice to use either mainstream support services or Aboriginal-specific services. Aboriginal services often more readily incorporate Aboriginal parenting practices and world views, tapping into their clients' cultural and normative assumptions and making it easier to engage with families and motivate them to change.⁸³

Many mainstream parenting programs, for example, simply aim to impart 'good parenting', modelling how parents should respond to challenging behaviours with strategies such as ignoring, use of rewards and time out. While potentially useful, these strategies contain basic assumptions about parenting that may conflict with Aboriginal practices⁸⁴:

*Seemingly straightforward ideas about household or family boundaries or the primacy of parents in supervision and monitoring of children may not transfer to Aboriginal family processes. When practitioners try to promote positive models, they may talk past and fail to engage with the experience of Aboriginal parents, with whom they find little resonance. As a result, parents remain unengaged, uninterested and do not acknowledge the pertinence of the messages for them.*⁸⁵

Chapter 8 recommends the establishment of an Early Intervention Research Directorate (EIRD) to identify evidence-based service models and invest in robust evaluations of new service models. Given the over-representation of Aboriginal people in the child protection system, EIRD should give particular attention

to service models that meet the needs of Aboriginal children and families. While some research exists concerning effective Aboriginal service models, more research is needed.⁸⁶ EIRD should specifically aim to build this research base.

Existing services for Aboriginal people should be equipped to identify families with complex needs, and refer them to services that have the capacity to meet those needs. Universal health services and services that are aimed specifically at Aboriginal people are particularly well placed to link these families to more intensive services. In particular the Aboriginal Family Birthing Program is well placed to identify families with high needs and ensure that they are referred to appropriate programs.

Where eligibility criteria exclude families with complex needs from universal services, alternative services should be available, with clear referral pathways to ensure that these families are not left to negotiate complicated service systems unassisted.

In particular, services should adopt an approach which ensures that if a family is identified as needing assistance, they are given it, whether by the service provider or through a referral to an appropriate service.

MOVING KANGGARENDI

Kanggarendi is intended as an early intervention service, responding predominantly to Tier 3 intakes and some lower risk Tier 2 intakes.⁸⁷ In practice, it responds predominantly to Tier 2 intakes, particularly higher risk Tier 2 (five days) intakes.⁸⁸ This no doubt reflects resource pressures in Families SA. However, as discussed in Chapter 9, higher risk cases require assessment and a voluntary response is inadequate and dangerous.

A 2013 evaluation found Kanggarendi's presence within Families SA was an obstacle for some clients, although this was somewhat offset by its voluntary service model, Aboriginal workforce and distinct identity:

*Families see that as welfare and you're going to get an automatic shutdown reaction.*⁸⁹

As outlined in Chapter 8, the not-for-profit sector is best placed to offer support of this kind. Consistent with its role as an early intervention service, Kanggarendi should be repositioned to respond to genuinely lower risk cases, including some Tier 3 intakes and notifications currently screened out as Notifier Only Concern, Adolescent at Risk or Report on the Unborn. The South Australian Government should fund one or more not-for-profit agencies—preferably Aboriginal organisations—to offer these services to Aboriginal children and families.

BETTER INTENSIVE FAMILY SUPPORT

A significant service gap remains for higher risk Tier 2 and 3 cases involving Aboriginal children and families.⁹⁰ Kanggarendi's service model was never intended to respond to cases of this kind.

Chapter 9 details how not-for-profit agencies provide more intensive support for families through the targeted intervention, family preservation and reunification programs. AFSS offers these services to Aboriginal people in Adelaide (except for targeted intervention), Berri, Ceduna, Coober Pedy, Port Augusta and Port Lincoln.⁹¹ The other agencies also have a significant proportion of Aboriginal clients.

A 2012 evaluation of these programs found that Aboriginal children comprised 38 per cent of targeted intervention clients, 26 per cent of family preservation clients and 33 per cent of reunification service clients. Aboriginal families were less likely to complete the programs successfully: only 27 per cent of Aboriginal families who were referred to targeted intervention completed the program successfully (compared with 48 per cent for non-Aboriginal families), with similar trends for the other programs.⁹²

Aboriginal clients of targeted intervention experienced reduced notifications, investigations and substantiations over time, but a much higher proportion of them remained involved in the child protection system after leaving the program than non-Aboriginal clients:

- 57.0 per cent had a notification (48.3 per cent for non-Aboriginal clients);
- 28.9 per cent had a Tier 1 intake (22.1 per cent);
- 31.6 per cent had an investigation (25.1 per cent);
- 17.7 per cent had a substantiated notification (11.8 per cent); and
- 19.0 per cent had a child in care after exit (13.0 per cent).⁹³

In other words, over-representation persisted after involvement in the programs.

As do other families, Aboriginal clients referred to these programs increasingly face complex combinations of child protection issues. The service models have not adjusted to this complexity. They tend to offer practical support and are not equipped to respond to complex, interrelated problems.⁹⁴

For higher risk families there is a need for evidence-based service models that are sensitively adapted for Aboriginal culture and parenting practices. The South Australian Government should fund not-for-profit agencies—preferably Aboriginal organisations—to develop service models that respond to higher risk Aboriginal families with multiple, complex problems.

COORDINATING SERVICES

Aboriginal support service providers face many of the same challenges in coordinating services as outlined in Chapter 8, including matching local services to the needs of children and families and integrating services into a cohesive system that is easily accessible.

The measures recommended in Chapter 8 will help Aboriginal service providers to meet these challenges. First, the annual Local Assessment of Needs (LAN) prepared in each local area should consult with Aboriginal people and service providers about the needs of local Aboriginal families and children and the most effective service response.

Second, local Aboriginal support services should be placed in child and family assessment and referral networks. This would allow a visible entry point for Aboriginal children and families to access Aboriginal and mainstream services. It would also encourage improved service coordination, including stronger referral pathways, consistent referral criteria, better information sharing and integrated, multi-service responses where required. As a result, more Aboriginal people would be able to access the support they need, when they need it.

REUNIFICATION SERVICES

As discussed in Chapter 9, many children reunified with their parents after a period in care subsequently return to care. Table 16.2 and Table 16.3 show that Aboriginal children are also generally over-represented in this area. Table 16.2 compares the numbers of Aboriginal and non-Aboriginal children who were reunified and who re-entered care between 2012/13 and 2014/15.

Some caution is needed in assessing these statistics, given the relatively small number of cases and the volatility from year to year. However, nearly one-third of Aboriginal children reunified with their parents in 2014/15 re-entered care within six months, which is a very short time given a child's need for stability. This is twice the rate of non-Aboriginal children.

Table 16.3 shows the proportion of children entering care under the *Children's Protection Act 1993* (SA) (the Act) who had previously entered care, that is, the proportion who were returning to care.

In each of the past three financial years, the percentage of children returning to care was higher for Aboriginal children than non-Aboriginal children, peaking at 57 per cent in 2013/14.

Aboriginal children have the same developmental needs for stability and permanency as other children. Children who move in and out of care face increased risks of developmental trauma and may never find a safe, stable care placement. Aboriginal children's experience of care as unstable and precarious is likely to contribute to poorer outcomes. As recommended in Chapter 9, Families SA practitioners should be trained and supported to make realistic assessments about the viability of reunification, conscious of the developmental risks of unsuccessful reunification efforts.

ABORIGINAL CHILDREN IN CARE

Some Aboriginal children need to be in care. The Agency should work to preserve and strengthen the connection of these children to land, language, community and culture.

CULTURAL CONSULTATION

Section 5(1) of the Children's Protection Act provides that:

No decision or order may be made under this Act as to where or with whom an Aboriginal or Torres Strait Islander child will reside unless consultation has first been had with a recognised Aboriginal organisation, or a recognised Torres Strait Islander organisation, as the case may require.

The Minister may declare an organisation a recognised Aboriginal organisation. During the past two decades, 24 organisations have been declared⁹⁵; however, many are now defunct. When Families SA tried to contact the organisations recently, only nine responded that they wanted to continue in the role.⁹⁶

Only one recognised organisation, Aboriginal Family Support Services (AFSS), is funded to perform the role. In practice, AFSS is the only organisation that Families SA consults under Section 5(1). Until recently, AFSS was funded for only one cultural consultant for the state.⁹⁷ This has now increased to two consultants and a coordinator.⁹⁸

As observed in the case study of Abby, Families SA interprets the Act to require consultation with a recognised organisation only in relation to court applications, not subsequent decisions about where a child in care should reside.⁹⁹

Table 16.2: Aboriginal and non-Aboriginal children reunified and re-entering care in South Australia, 2012/13 to 2014/15

	2012/13		2013/14		2014/15	
	ABORIGINAL	NON-ABORIGINAL	ABORIGINAL	NON-ABORIGINAL	ABORIGINAL	NON-ABORIGINAL
Reunified	32	102	62	117	47	93
Re-entered care within six months (percentage of total reunified)	9 (28%)	8 (8%)	10 (16%)	25 (21%)	15 (32%)	15 (16%)
Re-entered care within 18 months (percentage of total reunified)	9 (28%)	19 (19%)	13 (21%)	35 (30%)	N/a	N/a

Note: Relates to children returning to their parents after a period in care in accordance with the Children's Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order, and to those re-entering care in accordance with the Children's Protection Act.

Source: Data from Families SA.

Table 16.3: Aboriginal and non-Aboriginal children entering care and those re-entering care, 2012/13 to 2014/15

	2012/13		2013/14		2014/15	
	ABORIGINAL	NON-ABORIGINAL	ABORIGINAL	NON-ABORIGINAL	ABORIGINAL	NON-ABORIGINAL
Children entering care	263	614	244	517	264	696
Children re-entering care (percentage re-entering care)	115 (44%)	237 (39%)	139 (57%)	218 (42%)	107 (41%)	235 (34%)

Note: Relates to children in care in accordance with the Children's Protection Act, including under a Voluntary Custody Agreement or a custody or guardianship order.

Source: Data from Families SA.

This is an unduly narrow interpretation. The Act requires consultation for any decision or order made under it as to where and with whom an Aboriginal child may reside. The Act gives the Minister power to make arrangements for the placement of children (whether with a guardian, a member of the child's family, an approved foster parent, or a facility suitable for that purpose).¹⁰⁰ Placement decisions for Aboriginal children in care are therefore made under the Act and trigger the consultation requirements. AFSS also considers that it should be consulted in relation to placement decisions.¹⁰¹

In Abby's case, Families SA practitioners did not consult with AFSS apart from in court applications, but they did seek additional guidance from a principal Aboriginal consultant (PAC), an employee of Families SA. PACs are an important source of internal advice, but they are no substitute for consultation with a recognised organisation.

At 30 June 2015, there were 840 Aboriginal children in care.¹⁰² The Agency should consult with a recognised Aboriginal organisation in relation to all placement decisions for these children. This would require a significant increase in staffing and resources for declared organisations.

Many Aboriginal communities in South Australia have a distinct language and culture. It would be difficult for one organisation to connect with all these communities and offer advice for all Aboriginal children and families. The South Australian Government should consider funding several Aboriginal organisations, including those with strong links to specific communities, to provide more specific consultation.

For example, the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council (NPY Women's Council) is an Aboriginal organisation based in Alice Springs with extensive experience and connections in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in the far north of South Australia. It has been a recognised organisation since 1994, but was unaware of this until Families SA wrote to it in March 2014.¹⁰³ The NPY Women's Council is nevertheless well placed to perform this role in the APY Lands and would be willing to do so, if funded appropriately.¹⁰⁴

The Agency is reviewing the list of recognised organisations.¹⁰⁵ Organisations that are defunct or otherwise unwilling to perform this role should have their designation revoked.

ABORIGINAL AND TORRES STRAIT ISLANDER CHILD PLACEMENT PRINCIPLE

The Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) was developed in the 1980s. It has been implemented in all Australian states and territories and is recognised in the National Framework for Protecting Australia's Children 2009–2020.¹⁰⁶ The principle:

*establishes the basis for keeping children within their families and communities to provide the link between the past and the future for Aboriginal and Torres Strait Islander cultures and the assurance that if separation or removal is necessary, the child's links with their family, community and culture are actively maintained.*¹⁰⁷

The Children's Protection Act requires Families SA to apply ATSICPP when making placement decisions for Aboriginal children, giving a hierarchy of placement options:¹⁰⁸

- 1 A member of the child's family, as determined by reference to Aboriginal or Torres Strait Islander culture.
- 2 A member of the child's community who has a relationship of responsibility for the child, as determined by reference to Aboriginal or Torres Strait Islander traditional practice or custom.
- 3 A member of the child's community, as determined by reference to Aboriginal or Torres Strait Islander traditional practice or custom.

- 4 A person of Aboriginal or Torres Strait Islander background.
- 5 A person who is able to ensure that the child maintains significant contact with the child's family (as determined by reference to Aboriginal or Torres Strait Islander culture), the child's community or communities and the child's culture.

While ATSICPP offers a placement hierarchy for Aboriginal children in care, its significance is broader than this. For example, ATSICPP refers to family and community 'as determined by reference to Aboriginal ... culture' and 'a member of the child's community who has a relationship of responsibility for the child' as determined by 'traditional practice or custom'. These concepts recognise that Aboriginal people have knowledge and experience to make decisions for their children and imply a partnership between government and Aboriginal communities in decision making about children's welfare.¹⁰⁹ Effective implementation of ATSICPP therefore depends on robust, effective consultation with Aboriginal organisations.

ATSICPP is subject to the fundamental principles of the Act, with the additional requirement that 'consideration should be given to the child's cultural needs and identity' in determining a child's best interests.¹¹⁰ Recent amendments to the Children's Protection Act replaced the fundamental principles with a shorter, revised list of objects. The revised objects include to keep children safe from harm and to care for them in a way that allows them to reach their full potential. The phrase 'fundamental principles' presumably now refers to the revised objects. In any event, it is plain that pursuit of ATSICPP should not compromise a child's rights to safety and to reach their full potential.

CHALLENGES TO IMPLEMENTING THE CHILD PLACEMENT PRINCIPLE

There are significant challenges to implementing ATSICPP. There is a critical shortage of suitable Aboriginal carers. Further, a child's cultural background (skin group or moiety) may prevent placement with family members of another group.¹¹¹

Many Aboriginal families already look after for children in care, and they are more likely to offer care than non-Aboriginal families. They are:

*often motivated by a sense of duty or obligation to meet the needs of children within their families and to preserve their families' and the child's identity, and a legacy of shared care giving within families.*¹¹²

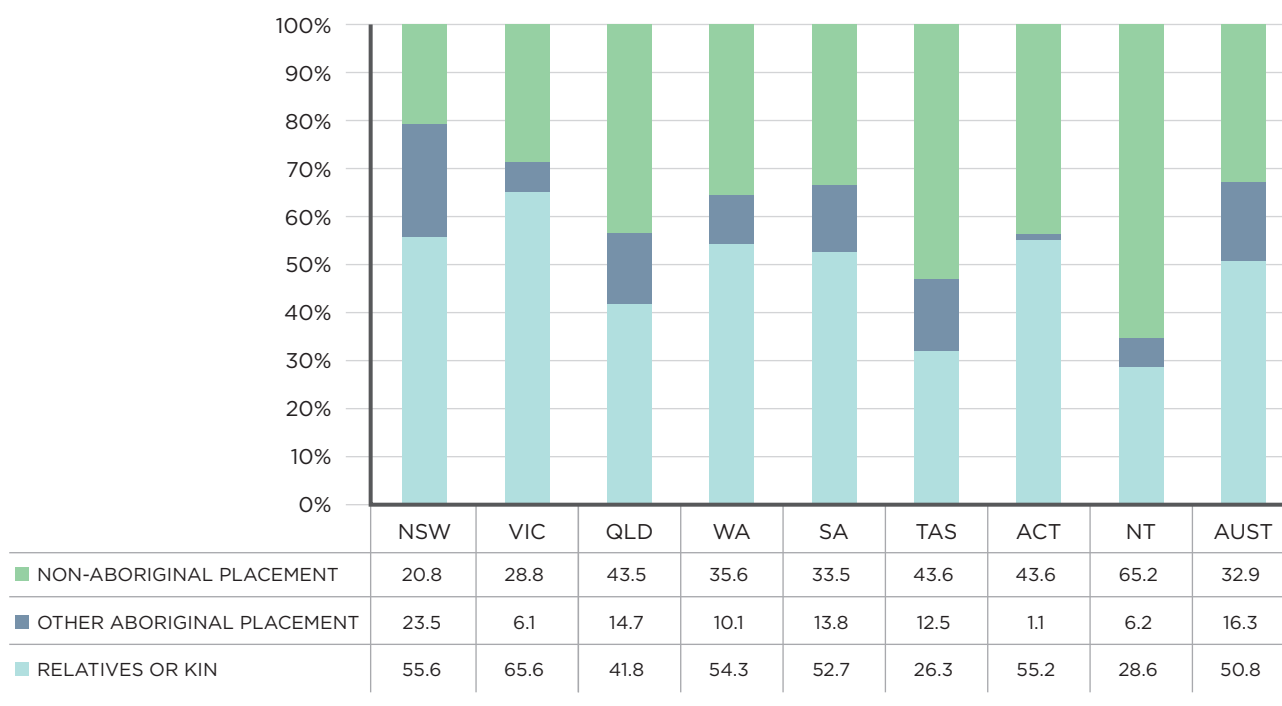


Figure 16.5: Placement of Aboriginal children in out-of-home care, 30 June 2015

Note: Other Aboriginal placement refers to an Aboriginal carer who is not a relative or kin or Aboriginal residential care. Non-Aboriginal placement refers to children placed other than with relative/kin, other Aboriginal carers or Aboriginal residential care.

Source: Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, tables 15A.24, 15.25.

The measures discussed below should improve the recruitment and retention of Aboriginal carers. However, there are limits to the capacity of Aboriginal communities to care for all Aboriginal children in care, and to the number of children for whom a carer can provide safe care. The Chief Executive Officer of AFSS, Sharron Williams, said:

There is not going to be a time when there will be enough community relative family members able to look after the increasing number of children coming into care.¹¹³

While the Agency should strive wherever possible to place Aboriginal children with family and community, an increasing number will require non-Aboriginal carers. Figure 16.5 shows the proportion of Aboriginal children placed with a relative or kin, another Aboriginal placement or a non-Aboriginal placement in each Australian jurisdiction.

Every jurisdiction places a significant proportion of Aboriginal children in non-Aboriginal placements. This represents system failure that contributes to dislocation in Aboriginal families and communities. However, it is

a failure with a long history and no short-term solution. Placing an Aboriginal child in safe non-Aboriginal placements because no safe Aboriginal alternative is available does not equate to system failure for that child. To the contrary, it can offer the child safety, improved health and wellbeing, and the opportunity to develop to their full potential. Further, provided the carers are properly supported in the ways discussed below, it can offer the child the best possible opportunity to maintain their connection to land, language, community and culture.

If this is not acknowledged, then there may a temptation to bridge the gap between supply and demand by allowing Aboriginal children to be placed where they are not safe. Chapter 9 discusses the concerning pattern observed by the Commission of children being reunified with parents who have not addressed serious child protection concerns, only to experience further abuse and neglect. The outcomes for these children are poor and, in the case of Aboriginal children, the results are devastating for the future strength of their families, communities and culture.

The Commission examined selected documents relating to more than 200 ‘care concerns’—reports of children in care being maltreated by their carers—that were referred to the Care Concern Investigation Unit in the Department for Education and Child Development (DECD) between 1 July 2013 and 1 December 2014. Not surprisingly, given the over-representation of Aboriginal children in care, many of these reports related to Aboriginal children. The Commission observed a disturbing pattern of concerns being repeatedly raised about Aboriginal children given poor standards of care by Aboriginal carers, with no indication of the concerns being adequately addressed. Aboriginal children tended to be exposed to more concerns over a longer period of time before an effective response was made than non-Aboriginal children. Examples of concerning cases included¹¹⁴:

- Sean, aged three months, was neglected and emotionally abused by his relative carers, who had an extensive child protection history, including domestic and family violence, alcohol abuse, self-harming and suicidal ideation. This history did not appear to have been recognised or addressed before the carers’ initial registration.
- Susie, aged six years, was sexually abused by her relative carer, who had seven previous care concerns, including at least four relating to sexual abuse.
- Alan, aged 12 years, was physically abused by his relative carer, who had four previous care concerns for physically and emotionally abusing the child. Families SA considered Alan was safe to remain with the carer while it looked for a different placement. The carer remained resistant to a review of her registration or police checks on other adult members of the household.

Aboriginal children are entitled to the same standards of alternative care as other children.¹¹⁵ The Agency should properly screen Aboriginal carers and apply the same standards when responding to all care concerns, irrespective of cultural background.

If a safe Aboriginal placement is not available, the child should be placed with a safe, non-Aboriginal carer. This would not require a reworking of ATSICPP, which already prioritises children’s safety and contemplates the placement of children with non-Aboriginal carers. However, it would require a renewed commitment by the Agency to support non-Aboriginal carers in preserving and strengthening Aboriginal children’s cultural identity.¹¹⁶

It would also require a renewed commitment to consult with Aboriginal communities and organisations. As discussed above, ATSICPP is more than a placement hierarchy: it emphasises the need to draw on the knowledge and experience of Aboriginal communities

and organisations and to work in partnership to promote child welfare. This means that especially in cases where an Aboriginal placement is not available, the Agency should seek the guidance of recognised Aboriginal organisations as to how best to meet Aboriginal children’s ongoing cultural needs.¹¹⁷ Ms Williams of AFSS told the Commission that it wants to be consulted in such cases.

INTERACTION BETWEEN THE CHILD PLACEMENT PRINCIPLE AND CHILDREN’S NEED FOR STABILITY AND PERMANENCE

Chapter 9 recommends changes to the Children’s Protection Act to emphasise children’s need for stability and permanence in care. It sets timeframes for parents to address their problems to allow their child to return to their care and, if those timeframes are not met, for the child to be placed in alternative, long-term care. ATSICPP should be pursued in a way that promotes timely decision making and secures stable, permanent care for Aboriginal children.¹¹⁸

In the case study of Abby, the Commission observed the potential for tension between ATSICPP and a child’s need for stability and permanence. Despite clear advice that there was a short timeframe in which to secure a long-term, stable placement for Abby, Families SA pursued reunification with Abby’s mother for far too long and failed to plan for her long-term care needs. After Abby had resided with stable, non-Aboriginal foster parents for 18 months, Families SA decided to move her to live with interstate relatives who could support her cultural needs, rather than leave her with foster parents who wanted to give her a long-term home, and to whom she had developed important attachments.

The recommendations in Chapter 9 address this tension. The shortened timeframes emphasise the need to identify and pursue very early all potential Aboriginal carers for Aboriginal children. They encourage early decisions informed by ATSICPP as to where children should reside to promote all aspects of their wellbeing, including their cultural identity. Wherever possible, this would mean supporting Aboriginal carers to care safely for Aboriginal children. It would avoid Aboriginal children forming attachments over the long term with non-Aboriginal carers, only to have these connections severed due to the belated application of ATSICPP.

FAMILY SCOPING

The effective implementation of ATSICPP ‘relies upon trustworthy, comprehensive information about family connections and relationships’, commonly referred to as ‘family scoping’.¹¹⁹ Family scoping allows the child protection system to identify all available options for family support, kinship care and respite care.

Family scoping begins with careful information gathering from the first point of contact with a child's family members. It includes consultation with Aboriginal families and communities to identify family connections and relationships of responsibility for the child as determined by Aboriginal culture. This is complex work given the large number of Aboriginal cultural groups in South Australia: there are 52 different clan and kinship groups represented in the northern suburbs of Adelaide alone.¹²⁰

Properly researching a child's lineage is technical, time-consuming work, which is aided by access to genealogical records.¹²¹ Families SA's electronic database, C3MS, has some records of family groups, but these are often incomplete. Institutions such as the state library have extensive genealogical records, but they are not readily accessible to most practitioners.

The Agency should establish a family scoping unit, dedicated to researching family connections for its clients and preparing genograms. The unit should develop strong relationships with Aboriginal communities and organisations, including a strong partnership with Nunkuwarrin Yunti's Link-Up service.¹²²

The family scoping unit's work should be readily accessible to Agency practitioners. The unit should also offer regular training to practitioners about researching genograms, identifying family connections and using its work. It should offer short, rotational placements to Agency practitioners for them to develop skills in this area.¹²³

Within the Aboriginal community there may be people who are aware of family members who are experiencing challenges in parenting, and are aware that the children in the family may, at some point, need an alternative care placement. The family scoping unit could create and maintain a register of such people, with a description of their relationships in the Aboriginal community. This would provide another resource for unit staff to consult when searching for appropriate family to provide care. Registration in this way would not involve any assessment of suitability, or undertakings about decisions that would be made if a child who is related to them needs care. It would provide another source from which to gather information about children and their relationships, and potentially a source for targeted promotion of Aboriginal foster care opportunities more generally. Such a register, if it proved workable, could also have application for non-Aboriginal people. However, it should be trialled in the first instance as part of improved family scoping.

SUPPORTING CULTURAL NEEDS

The Standards of Alternative Care in South Australia emphasise the right of all Aboriginal children in care to know about their cultural and spiritual identity and their community, to have their cultural needs respected and to live in a place where people understand and respect their culture. These standards help Families SA comply with ATSICPP and maintain and strengthen Aboriginal children's cultural identity. In practice, they are routinely contravened. Whereas the standards require all Aboriginal children in care to have a cultural maintenance plan, Families SA policy requires a plan only for those in care longer than six months and those under a Family Care Meeting agreement where the agreement requires a specific placement.¹²⁴

Even this target is rarely met. The Commission required Families SA to produce a selection of 60 cultural maintenance plans prepared for children in care between May 2014 and May 2015; however, the Agency could produce only 11. Plans requested and produced were:

- 20 plans for children in a home-based placement with indigenous carers (three plans produced);
- 20 plans for children in a home-based placement with non-indigenous carers (four plans produced); and
- 20 plans for children in a non-home-based placement (four plans produced).

The plans produced were often incomplete, for example, the checklist for Aboriginal consultation was often not completed. While the plans identified members of the child's family and potential cultural supports, they contained little detail about the child's cultural needs or plans to meet those needs while in care.

The Guardian for Children and Young People attended 80 annual reviews of Aboriginal children in care in 2014/15. Of these, only 33 children (41 per cent) had a cultural maintenance plan. Fifty-one children (64 per cent) had been given information about their cultural heritage, albeit mostly of a general nature rather than specific to their clan group. Thirty-six children (45 per cent) had been given an opportunity to engage in activities to promote their cultural identity, although again this was mostly general.¹²⁵

The 2012 Families SA internal review noted cultural maintenance plans are 'pivotal to achieving therapeutic outcomes with Aboriginal children and families', but are not used consistently:

*due to the complexity of templates and an inconsistent approach to when and how these plans are used, which is influenced by the perception of field staff that these plans are an additional burden to already onerous workloads.*¹²⁶

To bridge this gap, at least two alternative care providers, Life Without Barriers (LWB) and AFSS, prepare their own cultural maintenance plans for Aboriginal children in their care. This is not a role they are funded to perform¹²⁷:

*This was developed by AFSS because we weren't getting cultural plans. And children who are in our system ... need to know their connections ... So this is AFSS's attempt to ensure that children have connection.*¹²⁸

The 2012 review recommended a more user-friendly template be developed to increase its use.¹²⁹ The Agency has since prepared a simplified template, drawing on examples from the Victorian Aboriginal Child Care Agency and Life Without Barriers. This will be trialled in several metropolitan and country locations.¹³⁰

It is very important that cultural planning reflect children's specific cultural background. Many plans are too generic, without sufficient consideration for the child's land, language, community and culture.¹³¹ On occasions, for example, Narungga children are given Kurna information or vice versa. Some children need support to maintain links to multiple cultural groups.¹³²

The Commission heard from non-Aboriginal carers who keenly feel the lack of support for the cultural identity of Aboriginal children in their care. One non-Aboriginal carer tried for three years to find a male mentor for a boy in her care so that he could attend men's business. Families SA's approach seemed to be that any Aboriginal person would do:

*I'm saying, 'I want a Ngarrindjeri man', because to me, having a Kurna man is a bit like saying, 'You're French, you'll have an Italian, it's close enough'.*¹³³

In the case of Abby, no cultural maintenance plan was prepared and her non-Aboriginal carers had no support to maintain her cultural identity. Abby's caseworker maintained that the child was exposed to Aboriginal culture during contact visits with her mother (during which the mother was often affected by drugs) and that it would be 'tokenistic' for her non-Aboriginal carer to support her cultural needs.¹³⁴

As discussed already, some Aboriginal children need to reside with non-Aboriginal carers. Supporting the cultural needs of these children is not tokenistic, but profoundly important.

Families SA should comply with its Standards of Alternative Care. All Aboriginal children in care need cultural maintenance plans that provide for their specific cultural needs. Caseworkers should be trained, supported and supervised to complete these plans, with input

from Aboriginal family practitioners and other Families SA cultural advisors, as well as a recognised Aboriginal organisation.

Training and support should also be offered to non-Aboriginal carers caring for Aboriginal children to help them meet the cultural needs of the children in their care.

Families SA should fund an Aboriginal mentoring service, run by one or more not-for-profit agencies, that links Aboriginal children in care with Aboriginal people from their cultural background.

As discussed in Chapter 10, the Standards of Alternative Care are not actively monitored or reported on. While it would be cumbersome to require the Agency to report performance against all the standards, the Commission considers it necessary that it report to the Minister quarterly on the following service criteria that form part of Standard 3.1.4, 'Each young person's Indigenous, cultural, spiritual and religious heritage is respected, strengthened and maintained'¹³⁵:

- Service criteria 3.1.4.1—Families SA and the service provider support case planning that includes developing cultural maintenance plans with input from local Aboriginal services/groups/forums and gazetted organisations.
- Service criteria 3.1.4.4—Caseworkers and carers support the child/young person's cultural needs with day-to-day support, such as transport to cultural events, respect for religious laws, attendance at funerals, the provision of appropriate food and access to religious celebrations, as agreed in the case plan.
- Service criteria 3.1.4.6—Indigenous children and young people have access to a caseworker/community person/volunteer/relative from the same Indigenous background.

ABORIGINAL CARERS

There are a number of barriers to greater participation of Aboriginal people in providing out-of-home care to Aboriginal children. Aboriginal people are generally more willing than non-Aboriginal people to provide kinship or foster care, motivated by a sense of duty or obligation to meet the needs of children in their community.¹³⁶ Some potential carers need support to overcome material difficulties such as stability of housing and income.¹³⁷ Many Aboriginal families who would otherwise be suitable carers already have households that are at capacity because they are informally caring for children from their family or community. For others, the use of culturally appropriate assessment tools would provide a more holistic and realistic picture of their strengths to care for an Aboriginal child.

In South Australia, AFSS provides a foster care service that places Aboriginal children in culturally appropriate placements. The substantial challenges in recruiting foster parents in the non-Aboriginal community are outlined in Chapter 11. These challenges are magnified for the recruitment of Aboriginal foster parents.

AFSS has had more success in recruiting Aboriginal foster parents in regional areas, where 75–80 per cent of their registrations are from Aboriginal people, than in metropolitan areas, where the organisation supports many non-Aboriginal people to care for Aboriginal children.¹³⁸

'Get foster parents that are Aboriginal so the kids are happy and feel normal'

As services are currently configured, Aboriginal-controlled organisations do not have a role in recruiting or supporting kinship placements for children in care. The reforms recommended in Chapter 11 would enable organisations such as AFSS to expand their operations to assess and support kinship as well as foster care. This would have the advantage of separating assessment and support from the statutory agency, which remains associated with the 'welfare' and has negative connotations of having been responsible for removing children from families. Collocating foster care and kinship care functions is especially appropriate for Aboriginal families, where the division between the two is less stark. For example, some families care for children under both models, depending on the nature of the biological or cultural relationship between them and the children.

Children in care appear to understand the importance of culturally appropriate placements. Participants in the consultation with young people conducted for the Commission identified the significance of these issues¹³⁹:

'Know how to work with Aboriginal [people].'

'Understand and respect beliefs and values.'

'Be, or find, someone who understands Aboriginal culture and is approachable.'

'Get foster parents that are Aboriginal so the kids are happy and feel normal.'

ASSESSMENT OF CARERS

Some Aboriginal families are uncomfortable with the intrusiveness of the current assessment process, fearing scrutiny of what are often minor and dated offences, which nonetheless cause the individual shame and embarrassment.¹⁴⁰ Step by Step, the prescribed assessment tool, is not necessarily appropriate for Aboriginal families, and this can be a barrier to engagement.

AFSS is also acutely aware of the two systems that operate for the registration of kinship or specific child only (SCO) carers (Initial Registration or iREG) and foster parents (Step by Step). There is inconsistency in the requirements for the two categories of carers. The reforms to kinship care assessment proposed in Chapter 11 should go some way to addressing these issues.

Another issue is that the Step by Step tool may not accurately capture the capacity of prospective Aboriginal foster parents. Culturally sensitive tools have been developed in Australia, and the Agency should investigate their potential to be applied to the assessment of prospective Aboriginal foster parents and kinship carers.

A promising model is the Winangay assessment tool, which has been developed specifically for use in Aboriginal communities. It uses a 'yarning' approach to gather information, which is supported by pictorial cards that help to identify areas of strength and concern. The tool is accompanied by training to strengthen practitioners' skills and knowledge of working with Aboriginal people. The tool was endorsed by Queensland's Carmody child protection inquiry¹⁴¹ in 2013 and is now used widely in that state. It has been trialled in New South Wales and is being evaluated by the Australian Centre for Child Protection. Families SA is aware of the tool and has shown some interest in it.¹⁴²

Gillian Bonser and Paula Hayden, who contributed to the development of the tool, were also heavily involved in developing the Step by Step tool. They told the Commission that Winangay was designed to meet the following needs:

*'Often, those foster care tools are a generic tool, they are not culturally appropriate. And we identified a gap ... Pretty early on in that process, we realised the gap was for culturally appropriate strength-based tools that were going to enable Aboriginal kinship carers to participate in the care of the kids.'*¹⁴³

Winangay's approach is enabling rather than assessing. Rather than aiming to identify a family as suitable or not suitable, the tool identifies strengths, concerns and needs to enable families to care for children, focusing on the safety of the child.¹⁴⁴ It identifies areas where a family who is taking on care of child might need particular support.

The movement of kinship assessment and support to the non-government sector would also provide an ideal opportunity to adopt an alternative assessment model. Because the Winangay assessment model focuses on identifying areas in which carers might need support to enable them to safely care for children, it suits an arrangement whereby the organisation that conducts the assessment then goes on to deliver support, in accordance with the specific needs identified.

SERVICE PROVISION IN REMOTE ABORIGINAL COMMUNITIES

This section concerns the provision of services to remote Aboriginal communities in the far north and far west of South Australia: the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, Oak Valley and Yalata. Figures 16.6 and Figure 16.7 show the locations of these communities.

The APY Lands comprise about 102,000 square kilometres. The population varies, but is estimated to be about 2700, of whom almost 90 per cent are Aboriginal people.¹⁴⁵ The median age is 27 years (compared with 37 years for Australia)¹⁴⁶ with about one-third of its population aged 0–19 years (compared with about one-quarter for South Australia).¹⁴⁷

Yalata, which has a population of about 100, is 215 km from the town of Ceduna and Oak Valley, which has a population of about 105, is 517 km from Ceduna.¹⁴⁸

The APY Lands communities share strong family and cultural connections with those in Oak Valley and Yalata, as well as in nearby communities in Western Australia and the Northern Territory. These communities 'share language, historical, cultural and familial connections and concerns for themselves and their families that take precedence over state and territory borders'.¹⁴⁹ These connections 'contribute to high mobility, where families follow a cultural route and connect with kin across the jurisdictional borders'.¹⁵⁰

This means it is a mistake to think of service provision only in state-based terms. For example, Alice Springs in the Northern Territory is the closest municipality to the APY Lands and is much easier for residents to access. In many cases, it makes sense for service provision to the APY Lands to be centred in Alice Springs, rather than Port Augusta or Adelaide.

The communities face the combined challenges of remoteness and high need. The significant gaps between Aboriginal and non-Aboriginal people across a range of measures, outlined above, tend to 'worsen as remoteness increases'.¹⁵¹ At the same time, remoteness makes many aspects of service delivery a challenge (see Chapter 17).

There have been many reviews concerning the APY Lands. The APY Lands Inquiry in 2008 conducted an in-depth examination of the incidence of sexual abuse of children.¹⁵² The serious issues identified in that report caused this Commission to look again at the situation of children in the APY Lands and, by extension, in Yalata and Oak Valley. The communities of Yalata and Oak Valley receive less attention than the APY Lands, but evidence to the Commission suggests that they experience many of the same challenges.

The Commission's task is to examine the child protection system in South Australia. This broad scope means that it could not provide as detailed an analysis of the APY Lands as the APY Lands Inquiry. However, the Commission has been able to identify some key challenges to child wellbeing and service provision and to recommend some obvious areas for improvement. Because the support and involvement of Aboriginal communities are central to the success of child protection initiatives, the Commission's first recommendation is that the government should consult with each community about the implementation of the recommendations that follow.

COMMUNITY PARTICIPATION

Child protection responses are best when they draw on community support and input. This is particularly the case in remote Aboriginal communities, which have a longstanding preference for engagement in, and control of, local services.¹⁵³

There are several examples of collaboration in remote communities that are relevant to this Commission. The elders in one community have worked with partner agencies to help oversee the development and coordination of services and develop a child protection plan for their community.¹⁵⁴ The Pitjantjatjara Yankunytjatjara Education Committee (PYEC), which is made up of representatives from Oak Valley, Yalata and each APY Lands community, oversees strategic direction and policy for education.¹⁵⁵



Figure 16.6: The APY Lands, Oak Valley and Yalata communities in South Australia

Source: Department of State Development, Government of South Australia.

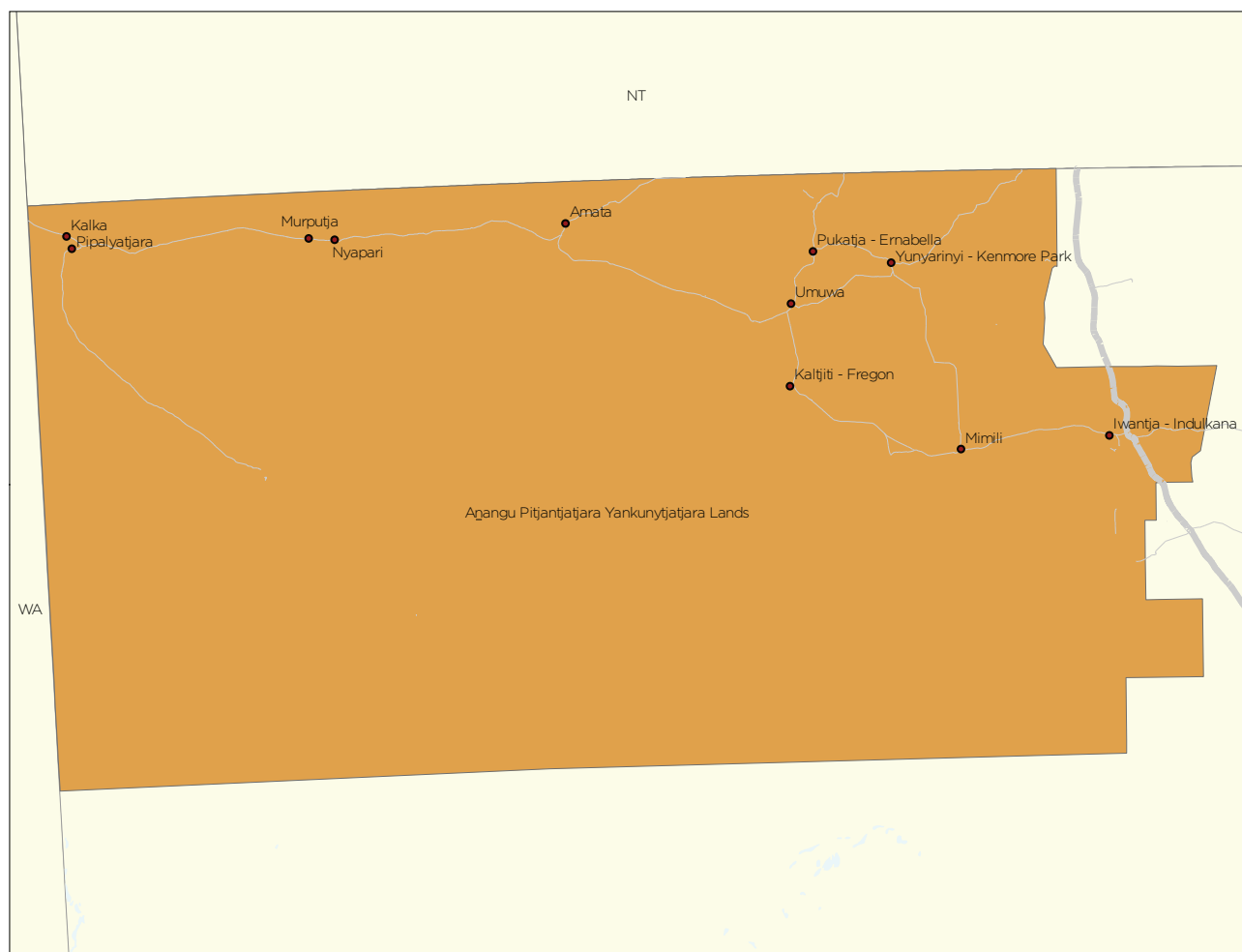


Figure 16.7: The APY Lands

Source: Department of State Development, Government of South Australia.

The NPY Women's Council advocates the use of community safety groups:

Essentially, the model involves remote communities being supported by an external, Aboriginal-controlled agency to develop community safety groups (CSGs), comprising highly respected community members that could act as cultural brokers, interpreters, solution seekers and support workers to assist Families SA workers to develop relationships and carry out their work with families. Further, CSGs could receive wide-ranging child safety education to foster mutual understanding of child safety between professionals and community members and build a local child safety language; the group members could then use their new knowledge and language to educate their respective communities about child safety and develop locally appropriate prevention-focused child safety

*campaigns and programs. Trusted CSG members could support families in liaising with Families SA, by receiving community reports and concerns, and providing advice and guidance to support their interactions with Families SA.*¹⁵⁶

The NPY Women's Council emphasised that were the Agency to employ and interact with a community group, it could 'diminish some of the stigma and complexities for people in working with and alongside "welfare"':

*It can be hard for one Anangu person to work with Families SA. Families might get the wrong idea and think that the person is doing the wrong thing; it's too much pressure. FSA could work with a group of people in each community. Families will understand welfare more if they are working with Anangu, talking together.*¹⁵⁷

Models such as these allow relationships with community members to be 'established as part of an ongoing service system, rather than having to be established in a "crisis mode"',¹⁵⁸

Government should draw on these models to engage remote communities about the strategic direction of services to improve the health, safety and wellbeing of their children. This engagement should aim to help each community to develop a child safety partnership plan in collaboration with key government and not-for-profit agencies. The plan would help to develop a common vision for child safety and wellbeing.¹⁵⁹

THE APY LANDS INQUIRY

The APY Lands Inquiry concluded that child sexual abuse was widespread in APY Lands communities and that it was substantially under-reported. Girls, in particular, had a culture of acceptance that they would be sexually abused and that 'resistance is futile'.¹⁶⁰ This abuse occurred in the context of broader dysfunction and maltreatment:

*Children live in dysfunctional communities where there is considerable violence and fear, drug and alcohol abuse, and a sense of hopelessness. There is considerable unemployment and physical and mental health issues among many Anangu ... it is reasonable to accept that this sense of hopelessness is shared by many [children on the Lands].*¹⁶¹

The inquiry identified an 'urgent need' to implement strategies to prevent sexual abuse.¹⁶²

CHILD WELLBEING AND SAFETY

As in other parts of South Australia, it is difficult to measure with certainty the incidence of child maltreatment in the APY Lands, Yalata and Oak Valley. However, the evidence suggests high levels of child vulnerability and maltreatment.

According to 2012 data, 90 per cent of children aged five years in the APY Lands are vulnerable in one or more domains of human development, including physical (54 per cent), social (44 per cent), emotional (51 per cent), language (56 per cent) and communication (48 per cent). This excludes children with a diagnosed special need or disability.¹⁶³

In a 2012 study, an average of 70 per cent of children across the APY Lands, Oak Valley and Yalata failed a hearing screening.¹⁶⁴ A recent survey of children under five years in one community showed 75 per cent had significant hearing infections, perforations or otitis media.¹⁶⁵

Measures including the introduction of Opal fuel across the APY Lands have reduced the dangerous practice of petrol sniffing to the point where it is rarely seen.¹⁶⁶ However, those who sniffed petrol in the past suffer serious, long-term harm. Many are now having children and struggle to care for themselves, far less raise children safely.¹⁶⁷ Food security and nutrition continue as issues in all APY Lands communities, Yalata and Oak Valley.¹⁶⁸

DECD told the Commission:

*In recent times it has been challenging for families and government to safeguard children living in these communities, including children in care arrangements. While alcohol, cannabis and possession of volatile substances (including petrol) is banned on the Anangu Lands, illicit substance trafficking, resulting in family violence and crime related to substance abuse, continues.*¹⁶⁹

The Commission was told that, while an increased police presence has reduced violence on the APY Lands¹⁷⁰, it remains 'a high-risk place that experiences a lot of violence'.¹⁷¹ A 2009 report commissioned by the NPY Women's Council stated:

*Interpersonal or domestic and family violence is deeply embedded in this region. The level and severity of violence against women who can be repeatedly abused over many years by their husband or partner and subsequent husband or partner is extremely high and it is common for offenders to abuse more than one woman over a period of years. Children directly witness and experience the violence in their homes and communities and learn that it is socially and culturally viewed as acceptable and legitimate for men to use violence against their wives or partners. Anangu men and women perceive that violence is a legitimate action and response for jealousy and in instances where it is alleged that a mother has neglected or abused her child or children.*¹⁷²

Aboriginal women in the cross-border region that includes the APY Lands are more than 60 times more likely to be victims of domestic violence-related homicide than other women.¹⁷³ Children are exposed to, and traumatised by, serious incidents of domestic and community violence, often fuelled by alcohol and other drugs. Episodes of community unrest sometimes involve up to 100 people armed with bats and rocks.¹⁷⁴ The prevalence of alcohol and drugs also deprives children of money for food and other essentials.¹⁷⁵

There is no reason to believe that the incidence of child sexual abuse in the APY Lands has reduced since the APY Lands Inquiry. In 2010, a multiagency task force was established to respond to specific disclosures of sexualised behaviour between children in one APY Lands community. An investigation identified that about two-thirds of the children in the community were either initiators or subjects of sexualised behaviour.¹⁷⁶ As discussed in Chapter 12, persistent sexualised behaviours raise questions of sexual abuse and coercive features raise highly specific concerns. A 2013 evaluation of the response in the same community noted 'widespread agreement [among support agencies] that children are still being abused and are at risk, and [that] maltreatment is endemic'.¹⁷⁷ An experienced health worker expressed alarm to the Commission at the lack of effective response for children in that community.¹⁷⁸

One educator told the Commission, 'There's 50 per cent of boys in a number of [APY Lands] communities who have been sexually abused, who are perpetrating against each other'.¹⁷⁹

CAMHS does not keep records of sexualised behaviour and sexual abuse. However, for a time in 2013/14, it categorised referrals for the presence and seriousness of sexualised behaviour. About 80 per cent of referrals involved either concerning or extreme sexualised behaviour. At that time, CAMHS had about 230 open cases.¹⁸⁰ CAMHS told the Commission:

We are aware of examples where girls aged 11 having been targeted by groups of boys up to the age of 15 years, being anally and vaginally penetrated by more than one adolescent and performing oral sex on others in a single incident and boys from eight years of age having anal sex with each other. Adolescents target younger girls and boys often in group situations while encouraging younger boys to watch, hold others down or masturbate ... Adolescents frequently describe peer relationships where forced sex is the norm: girls saying things like 'at least if you have a partner the others can't have you'.

*Our clinicians are aware of many disclosures made by victims or [their] peers of sexual abuse within family, sexual assault and rape by adults, masturbation in front of children and exposure [to children], [performing] sexual acts for drugs or being forced to participate in such behaviour after being given drugs.*¹⁸¹

Under-reporting remains a problem, with powerful pressures against disclosing abuse or neglect, including shame, fear of social and violent repercussions, and family and community values that tend to normalise child maltreatment.¹⁸² Even when disclosures are made in a therapeutic context, they are rarely confirmed during formal forensic investigations, meaning legal action rarely follows.¹⁸³

It is plain that despite significant changes to service provision since the APY Lands Inquiry, many children remain highly vulnerable and continue to experience all forms of maltreatment.

FAMILIES SA SERVICES

Recruiting and retaining sufficient Agency staff in remote communities is a longstanding problem. For extended periods in recent years, about half of the Agency's available positions in the APY Lands have been vacant.¹⁸⁴ This undermines the ability to offer timely, effective responses to children and families.

FLY-IN FLY-OUT TEAMS

In response to this challenge, in late 2014 Families SA implemented a fly-in fly-out (FIFO) service model for most of its staff on the APY Lands. There are two FIFO teams, each with a team leader and seven practitioners. Each Tuesday, a team boards a chartered aeroplane in Adelaide. The aeroplane usually drops two staff members in Coober Pedy to help service that town and Oodnadatta. The rest continue to Umuwa in the APY Lands. The second team returns to Adelaide. Each team works eight days (from Tuesday to Tuesday, including travel time) and has six days off. The incoming and outgoing team leaders have a short period together to discuss cases and issues.

The model aims to provide consistent staffing and service provision on the APY Lands, including timely responses to notifications. It has significantly reduced travel time.¹⁸⁵

In June 2015, a consultant reviewed the FIFO model and concluded that it provides 'the resources, structure and mode of practice to enable Families SA to meet its statutory and service obligations'.¹⁸⁶ For the first time in years, the teams are fully staffed.¹⁸⁷

APY LANDS-BASED WORKERS

The FIFO model assumes the presence of several Lands-based workers (LBWs), each resident in a community. The APY Lands Inquiry recommended at least six LBWs, one for each major school on the APY Lands. The LBWs were to focus on early prevention strategies and training, but were also to receive and respond to mandatory notifications.¹⁸⁸

In practice, LBWs focus on early prevention strategies, community education and child safety capacity building. They form strong relationships and their knowledge of culture, community and family groups is an invaluable resource for both the Agency's FIFO teams, who respond to child protection notifications, and other organisations.¹⁸⁹ The presence of LBWs allows community

members to seek them out and raise concerns about individual children. However, they deliberately do not perform child protection investigations due to the risk of conflict and cultural 'payback'.¹⁹⁰

LBWs have a challenging role. Recruitment and retention are made harder by the use of temporary employment contracts and the fact that workers must re-apply for retention allowances every three months. Recently, some LBWs were refused the allowance.¹⁹¹ By late 2015, only two remained.¹⁹²

The demise of LBWs risks the viability of the FIFO model. LBWs need stable employment arrangements (after a suitable probationary period) and competitive, ongoing retention allowances.

LBWs were initially employed in the AHP stream, which generally requires a social work degree. More recently they have been employed in the ASO stream, which does not have a minimum qualification. This broadens the range of potential candidates to include those without formal qualifications, but with extensive experience in community development or remote, intercultural work.¹⁹³ Chapter 6 discusses the need for all child protection case managers to hold a tertiary qualification. LBWs have a broader community development focus and do not hold child protection caseloads. It is appropriate to take a more flexible approach to their recruitment, although LBWs without formal qualifications in social work or child protection should receive additional ongoing training to strengthen their practice over time.

The Agency should employ at least six LBWs to support the FIFO service model.

TRAINING AND SUPPORT FOR WORKERS

In view of the challenges, the Agency's workers in remote communities need ongoing training, support and clinical supervision to have the knowledge, skills and techniques to work effectively with Aboriginal children and families in remote communities, including sound knowledge of Aboriginal culture and parenting practices. One promising model is to bring the LBWs and FIFO teams together for training in Coober Pedy about every two months. The Agency should also explore the use of video technology for training.¹⁹⁴

A 2014 review found induction and training was inadequate:

*No written material regarding appropriate practice within Anangu culture is given to new workers to support their orientation and practice. The organisational 'Cultural Awareness' training program is essential to helping workers understand the impact of colonisation on Aboriginal people but is not designed to help workers understand the implications of Anangu culture (including parenting styles and communication styles) for child protection practice.*¹⁹⁵

The review recommended that the Agency engage the NPY Women's Council to deliver orientation training for all new staff, noting that its program is highly regarded. The report also recommended that the Agency establish a learning network for remote area child protection practice, with links to relevant tertiary agencies and Aboriginal organisations, such as the Australian Centre for Child Protection, the Menzies School of Health Research, the NPY Women's Council, the Institute of Child Protection Studies, the Healing Foundation, the Secretariat of National Aboriginal and Islander Child Care and Dr Tracey Westerman of Indigenous Psychology Services. It also recommended that the Agency develop a project plan, linked to the tertiary sector, to produce guidelines and documentation for child protection practice in remote Aboriginal communities.¹⁹⁶

These recommendations would substantially strengthen practice and should be implemented.

Chapter 6 discusses the need to support the Agency's practitioners with access to ongoing support, mentoring and clinical supervision. This is particularly important for workers in remote communities, given the complexity and isolation of their work.¹⁹⁷ The Agency should secure external clinical supervision for LBWs to reflect the fact that it has limited internal experience in community development work.¹⁹⁸

The Agency's workers in remote communities rarely use the services of the two principal Aboriginal consultants (PACs) or the principal social worker. PACs have limited on-the-ground experience in remote communities. They rarely visit them and are not familiar with their family and community structures and geography.¹⁹⁹ It is important that workers in remote communities have access to the strategic guidance that PACs offer to other parts of the Agency. The Agency should either support the existing PACs to develop knowledge, experience and expertise pertinent to these remote communities or recruit an additional PAC to focus on remote Aboriginal service provision.

INTERPRETERS

The APY Lands Inquiry noted the shortage of suitable interpreters for Aboriginal people in the APY Lands and recommended additional training for interpreters be established as a matter of urgency.²⁰⁰ Eight years later, the shortage remains.

Practitioners from the Agency do not generally use formal interpreters as part of their daily business.²⁰¹ The Commission was told that in many cases, APY residents have 'reasonable' English skills²⁰², but if an interpreter is required and requested by the family, practitioners use the interpreter service in Alice Springs or identify a family member to interpret.²⁰³ There is need for caution when using family members as interpreters given the sensitive nature of child protection work and the interconnectedness of many communities.

The South Australian Government would not contemplate sending practitioners to investigate child abuse in a non-English speaking country without reliable access to accredited interpreters. It is unrealistic to expect the Agency's practitioners to operate in remote communities where English is commonly a second or third language without reliable access to interpreters. The difficulty in accessing interpreters encourages these practitioners to proceed without an interpreter in cases where they should not. This inevitably produces sub-optimal results. The Agency's inappropriate use of safety plans with family members who do not understand them is discussed below.

South Australia Police's child abuse team uses interpreters in investigations. The two hospital-based Child Protection Services use interpreters in forensic interviews. The Youth Court Conferencing Unit often uses them in Family Care Meetings.²⁰⁴

The draft Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect (an updated version due to be released in July 2016) emphasises the need for Aboriginal people to have access to accredited interpreter services and cautions against using interpreters who have a close familial or cultural relationship to the child or carers. It notes that this may be challenging in some circumstances, but emphasises that 'the child's right to a fair and just investigation of their current and future safety must not be compromised by the convenient, but inappropriate use of individual interpreters'.²⁰⁵

If the code is to be effective, the government should invest in training to increase the number of accredited interpreters in languages used in remote Aboriginal communities, as recommended by the APY Lands Inquiry. It is also important that the interpreters used have specialist training in phrases and concepts relevant to child protection, to enable them to capture the nuances that need to be communicated in sensitive

matters that will be raised. High school graduates in remote communities should be encouraged to consider interpreting as a career.

While the Commission is conscious of the limited availability of interpreters, practitioners from the Agency should be supported to use interpreters more often and wherever necessary to assist their work and not to overestimate the English language abilities of people they deal with. They should take particular care to ensure that Aboriginal clients understand the content of safety agreements. As a practical measure, all Agency staff operating on the APY Lands should be trained in working effectively with accredited interpreters and complete training in basic language skills (at least the 50 most commonly used words related to child protection discussions).²⁰⁶ The viability of employing an interpreter on a permanent basis to support each of its FIFO teams should also be considered.

EFFECTIVE RESPONSES TO CHILDREN AT RISK

Witnesses told the Commission that the Agency applies higher thresholds of risk and safety in remote Aboriginal communities than elsewhere in the state. They suggested that there is a reluctance to remove children out of a fear of repeating past mistakes:

*They are actually trying really hard to be not charged with stealing children ... we've gone from worrying about the Stolen Generation to generating an abandoned generation.*²⁰⁷

In the course of its Usual Practice review (see Appendix C), the Commission identified 'Josephine', a young girl who lives in an APY Lands community. In 2012 and 2013, Josephine, then aged eight, and her siblings were exposed to ongoing domestic violence. Josephine and some other children in her community were also reportedly having sex with each other. The Agency responded with a safety plan.

The response was plainly ineffective. By mid-2015, Josephine was still exposed to domestic violence, including an incident where her father hit and kicked her mother, who defended herself with knives and broke his arm. The father dragged Josephine across the floor, inflicting large grazes and yelling, 'You are not going anywhere'. Josephine was scared and fled the house. Her parents then left the community, leaving Josephine and her siblings apparently without carers. Josephine continued to be exposed to sexual abuse: in one incident a man in his 30s locked Josephine and her friend in his house and had sex with them. The same man had allegedly exposed himself and assaulted numerous other children in the community.²⁰⁸

Josephine's file depicts a young child exposed to a dangerous, abusive environment over multiple years. Her trauma is recorded, but without an effective response to prevent harm from recurring. It occurs in the context of a broader community crisis, with many children exposed to ongoing abuse and bearing signs of trauma.

SAFETY PLANS

Witnesses expressed concern that Families SA practitioners too often respond to notifications by quickly issuing a safety plan, then closing the case. Practitioners visit with a safety plan already prepared for parents to sign. In many cases, parents cannot read the plan, let alone understand the allegations and what they need to do. When the inevitable re-notification follows, practitioners return to criticise parents for not following the plan, then ask them to re-sign it.²⁰⁹

In one example, the Commission was told of a father with brain damage from earlier petrol sniffing. He was suspected of sexually abusing his sons and had them sleeping in his bed. Families SA had him sign a safety plan that he could neither read nor understand.²¹⁰

Karen Barry, Families SA's APY Lands Manager, accepted past criticism about the misuse of safety plans and the premature closing of files. She said the position had improved now that the FIFO model allowed practitioners to visit families more regularly.²¹¹

Safety plans are a short-term measure to secure a child's immediate safety. They should not be used to address longer-term issues and cannot take the place of formal responses when a formal response is required. Safety plans should be realistic about parents' ability to change and include measures to verify children's ongoing safety. If plans are breached and children remain in harm, then other, more assertive measures will usually be required.

FAMILY CARE MEETINGS

Chapter 9 discusses how Family Care Meetings (FCMs) are supposed to give the child's family an opportunity to develop a plan to care for the child without a court order, but that referrals to FCMs often occur too late, when concerns have escalated and court involvement is inevitable. Families SA practitioners tend to take a different approach in rural and remote Aboriginal communities. They reportedly approach FCMs more as a partnership with the family²¹², and use them to avoid families going through a court process that they often do not understand.²¹³

Witnesses noted that the FCM coordinator uses an interpreter in remote communities and explains the purpose of the meeting and the concerns about the child. The family has time to talk in language, for hours if needed, about arrangements for the child. One

experienced remote worker described the process as 'as close as we can get to culturally appropriate'.²¹⁴ Families tend to remember and support the plan under an FCM agreement more than an arrangement imposed by the Court.²¹⁵

In the past, FCM agreements ran for many years, in some cases until the child turned 18. More recently, agreements in rural and remote areas run for 12 months. If the situation has stabilised after 12 months, no further response is needed. If the concerns persist, Families SA seeks a further 12-month FCM agreement.²¹⁶

The Agency has a different role with children who are under an FCM agreement than for those in care under a court order. Under an FCM agreement, which is voluntary, the family is responsible for decisions about the child. Under a court order, the Minister is ultimately responsible. This responsibility includes obligations, for example, to visit the family and be involved in planning the child's education and health care.²¹⁷

FCMs are held because the Agency has child protection concerns. Experience shows that some FCM agreements are not successful. Good practice requires that children under agreements be monitored for a time to ensure that the plan is resolving the concerns. If concerns persist or there are new notifications, the Agency should consider whether a different response is needed.

ALTERNATIVE CARE OPTIONS IN REMOTE COMMUNITIES

The pool of Aboriginal carers in remote communities is limited. As there are no residential care facilities or foster parents, kinship carers are the only alternative care option if children are to remain in their community.²¹⁸ If a suitable kinship care placement cannot be found, the child is placed away from their community, often in Adelaide.

Practitioners are understandably reluctant to remove children from remote communities:

Staff working on the Lands reported facing a difficult dilemma where a child is at risk and no suitable kinship care option is available. Staff members reported wrestling with the desire to 'do no further harm to the child' in the absence of sound alternative care options. Staff described the trauma for children of being removed from the Lands, particularly where they end up isolated from family, language and culture and are in a city environment, cared for by rotating staff.²¹⁹

This dilemma likely leads practitioners to apply higher thresholds of risk and safety to avoid children being removed from their communities. While practitioners should give due weight to children's connection to culture, they also should be supported to secure children's rights to health, safety and wellbeing. If these rights cannot be protected, then, in accordance with ATSICPP, another placement that preserves their cultural needs should be pursued, even if this means removing the children from their community.

When a child needs to be placed in care, the Agency speaks to family members to help identify a suitable kinship carer.²²⁰ The FCM process is also an opportunity for family members to identify potential caregivers. However, the process of identifying carers is generally ad hoc and often conducted without sufficient understanding of family and community dynamics.

Practitioners need to navigate conflicts between maternal and paternal sides of the family, particularly in cases of domestic violence. For example, children are often placed with the paternal family, which may mean their mother must have potentially dangerous contact with the father to see the children.²²¹

These are complex matters and the Agency's practitioners would benefit from advice from Aboriginal organisations that have knowledge of local families and communities. As noted above, the NPY Women's Council is well placed to perform this role in the APY Lands. Practitioners may also benefit from support from the family scoping team recommended above. Better consultation and improved scoping of family can increase the pool of potential carers and allow better matching between children and carers.

It is likely that some children in remote communities will need to be placed outside those communities. A 2009 report commissioned by the NPY Women's Council opposed a proposal to establish 'safe house' style accommodation for children and carers on the APY Lands in cases of suspected abuse. It noted the lack of privacy and safety for people dealing with serious, sensitive matters such as child abuse on the APY Lands, the active discouraging of children from disclosing abuse and the risk of recrimination. It found that such accommodation would make children and their carers vulnerable and unsafe. It also noted the difficulty in recruiting suitably skilled and experienced carers and specialist staff to remote communities. The report stated that:

*A key feature of safe and therapeutic care for children is secure and safe services geographically distant from the situations and threats of harm and abuse, which can provide a mix of specialised services by well-trained and highly skilled staff.*²²²

The report concluded that these things could not be provided on the APY Lands and that a facility should instead be established in Alice Springs, where users could have the safety and privacy required for them to have trust and confidence in the service.²²³

These same arguments appear to make the establishment of residential care on the APY Lands unviable.²²⁴ They also support the conclusion that some children may not be able to be safely cared for on the APY Lands, because of ongoing threats of harm and abuse.

The impact of moving children away from the APY Lands would be greatly reduced if there were more placement options in locations such as Alice Springs or Coober Pedy. In these locations, children are much more likely to remain connected to land, language, community and culture than if they are removed to Adelaide or Port Augusta.

Many APY Lands residents have family and cultural connections in Alice Springs and travel there frequently. Ms Barry, Families SA's APY Lands Manager, suggested consideration be given to contracting with a foster care agency to recruit carers in Alice Springs for children who cannot stay on the APY Lands.²²⁵ Leanne Haddad, Families SA's Manager of Service and Accountability, confirmed that there are no barriers to such a contractual arrangement and that she would welcome the initiative if it could be funded.²²⁶

Subject to funding, Aboriginal Family Support Services (AFSS) is willing to establish a small residential care facility in Coober Pedy, similar to facilities it operates elsewhere in South Australia.²²⁷

The South Australian Government should partner with not-for-profit agencies to fund additional alternative care options, including a mixture of foster care and residential care, close to the APY Lands, such as in Alice Springs and Coober Pedy.

ASSESSMENT OF CARERS

As discussed in Chapter 11, when children are placed with kinship carers under a court order or FCM agreement, the Agency uses the interim assessment process known as iREG. Because of its brevity, this should be followed by a full assessment within three months. However, full assessments are often delayed, leaving children in potentially dangerous situations for prolonged periods.

These delays are particularly pronounced in remote communities. Local workers complete the iREG and a team in Adelaide is supposed to complete the full assessment. That team no longer attends the APY Lands and about 20 to 30 carers have never been fully

assessed.²²⁸ (In late 2015, there were 33 children in care in the APY Lands, Coober Pedy and Oodnadatta under court orders and another 25 under FCM agreements.)²²⁹

This is a serious risk. In an extreme example, a child was placed with carers under an FCM agreement. The full assessment later revealed that the carers had an extensive child protection history, including serious domestic violence and periods of imprisonment.²³⁰ The Agency should adequately resource the carer assessment process so that full assessments are completed in a timely manner.

The assessment processes are not appropriate for use in remote Aboriginal communities. Carers without a drivers licence or other identification documents struggle to provide the required 100 points of identification.²³¹ Many Aboriginal people in remote communities regard some of the assessment questions as overly intimate, and therefore inappropriate.²³² The assessment shows little understanding of Aboriginal parenting styles. The question-and-answer mode of delivery is also confronting for many Aboriginal people, where a conversational 'yarning' approach would be more appropriate.

Standards of risk and safety should not be compromised. However, wherever possible, assessments should be adapted for use in remote Aboriginal communities to remove unnecessary barriers for potential carers. The Winangay model is especially promising for application in remote communities. The Commission is attracted to its focus on identifying how people in the Aboriginal community can be supported to provide safe care, rather than ruling them in or out on strict criteria.

The Commission supports the trialling of a tool such as Winangay to assess potential carers in remote areas as a matter of urgency.

SUPPORT FOR CARERS

As discussed in Chapter 11, many children in care have complex, challenging needs and carers need support and guidance to meet these needs. Carers in remote Aboriginal communities face additional pressures, such as difficulty in accessing services, threats of 'payback' from family members in the event a child in their care is injured, and community pressure to care for additional children, which can lead to full, chaotic households.²³³

Unlike foster parents, who are supported by not-for-profit agencies, kinship carers are directly supported by the Agency. There are about 40 kinship placements in Ceduna, Oak Valley, Yalata and south to Streaky Bay, and about 25 in the APY Lands, Coober Pedy, Oodnadatta and Tennant Creek. Many placements have multiple children in care.

These placements are supported by two positions in Ceduna and two in Port Augusta. Problems with recruitment and retention mean these positions are frequently vacant. For an extended period, one worker in Port Augusta has been responsible for supporting all these placements, which stretch across about two-thirds of the state. On occasions, the same worker must also support children placed with carers in Western Australia and the Northern Territory.²³⁴

This requires vast amounts of travel. For example, visiting the APY Lands for a week requires at least two days' driving, reducing time spent with carers. Accessing communities in the far west of the APY Lands is particularly time consuming.²³⁵

At most, carers are visited about five times a year, but there can be a gap of several months between visits.²³⁶ This undermines the rapport between carers and the support worker.²³⁷ It also reduces the worker's ability to help carers in times of need. If carers need support, they can telephone the worker in Port Augusta, but he cannot respond immediately. In a crisis, carers seek help from other sources, such as a FIFO worker, Lands-based worker, doctor or school principal, depending on the problem.²³⁸

The Agency should adequately resource support for kinship carers in remote communities. These carers require at least as much support as those elsewhere in the state. Support workers should be based much closer to carers, either in communities, Alice Springs or Coober Pedy or by using a FIFO model. In the case of the APY Lands, the complexity of issues and the number of carers would appear to justify at least one full-time worker.

The Commission recommends, in Chapter 11, that support for kinship carers should shift to the not-for-profit sector. In remote communities, this is contingent on not-for-profit agencies being willing and able to do this work.

RESPONDING TO CARE CONCERNS

Witnesses expressed concern about the risk posed by some carers who are approved to care for children in remote communities:

*Some of the placements we've had kids placed in ... They're dangerous.*²³⁹

This is particularly problematic given the limited support available to these carers.²⁴⁰

As noted above, the Commission reviewed selected documentation from 200 care concerns referred to the Care Concern Investigations Unit (CCIU) between 1 July 2013 and 1 December 2014. These included some children residing with kinship carers in the APY Lands, including the following examples²⁴¹:

- Caden and Ethan are primary school-aged brothers whose carers reportedly drink and gamble excessively, leaving insufficient money for food and clothing. The carers frequently argue and fight and travel to other communities for extended periods, leaving the children without a nominated carer. The boys are always smelly and dirty and rarely attend school. Their medical care has been neglected to the extent that Ethan's long-term health and development are compromised. There have been numerous care concerns with similar issues over a number of years, despite the use of a safety plan.
- Lucas is a preschool-aged boy whose carer reportedly travels to town to 'play the pokies', leaving Lucas to wander the community unsupervised and uncared for. Lucas appears skinny and wears the same clothes for months at a time; he appears to be an 'angry' child. He has not been sighted by the Agency recently. His carer has numerous past care concerns for neglect.
- Jordan, Evan and Noel are three primary school-aged brothers. They repeatedly report being hungry, missing meals and having no food at home, but say that their carer threatens to hit them if they tell anyone. The youngest brother (aged nine) has matted hair and sleeps in a car at night to keep safe from a dog.

None of these cases was assessed to be serious enough to warrant an investigative response by CCIU. Instead, they were referred for management at the local office. In Caden and Ethan's case, CCIU noted the persistent concerns, but decided an independent investigation 'might not be particularly helpful and also inappropriate [sic] given the cultural, distance and timing considerations'.²⁴²

When asked about this case, Philip Adams, the Manager of CCIU, acknowledged that all children at risk need an 'appropriate response', but that 'political and social connotations are considered' for children on the APY Lands.²⁴³ He said that while distance and timing should not weigh against a CCIU investigation, an investigation would pose 'a significant issue ... from a resource perspective'. He said it was difficult for workers to get to the APY Lands and to locate people for interview. 'It could be a significant amount of time would have to be invested in such an investigation'.²⁴⁴ In his 15 months at CCIU, there have been no CCIU investigations on the APY Lands.

Mr Adams stated that the CCIU team did not have experience dealing with the APY Lands and relied on cultural advice from the principal Aboriginal consultants (PACs). As discussed above, PACs have limited experience and knowledge about issues on the APY Lands. CCIU practitioners should be trained in Aboriginal culture, including an understanding of parenting practices.

The care concerns investigation process should be adequately resourced so that children's circumstances, not resources or distance, determine the response to care concerns in remote communities.

CCIU procedures may need to be more flexible when responding to care concerns in remote communities. For example, CCIU may need more support from local practitioners, although it will need to ensure that practitioners with prior involvement in the case do not compromise the investigation's independence.

OTHER SERVICES

There are a number of other service providers on the APY Lands, both government and non-government, that contribute to the child protection system. The key services are outlined below.

EDUCATION

The Department for Education and Child Development (DECD) runs eight schools on the APY Lands: in Ernabella (Pukatja), Amata, Indulkana (Iwanta), Mimili, Fregon (Kaltjiti), Pipalyatjara, Murputja and Kenmore Park (Yunyarinti). It also runs schools in Yalata and Oak Valley. Each school offers classes from Reception to Year 12. The schools range in size from Murputja, which had 21 enrolled students at June 2015, to Ernabella, which had 144.²⁴⁵ Together, the schools have 750–800 enrolled students.²⁴⁶

Each school except Kenmore Park has a preschool for children aged three and four. Each of the preschools has a playgroup for families with children aged from birth to three, except Yalata, which has a crèche instead, and Oak Valley.²⁴⁷

Wiltja school, based in Adelaide, is a residential secondary school for students from the APY Lands. It began in the 1970s when a group of Ernabella women saw the advantages of offering mainstream secondary schooling to APY Lands students. Wiltja was initially based at Ingle Farm High School, then Woodville High School. More recently a senior campus was established at Windsor Gardens Vocational College. Wiltja currently offers schooling and accommodation for up to 100 high school students. It also offers short, one-week visits for students to gain a 'taste' of boarding school.²⁴⁸

Educational outcomes for students in the APY Lands, Yalata and Oak Valley are generally poor. According to DECD, analysis of school data, National Assessment Program – Literacy and Numeracy (NAPLAN) results and the Australian Early Development Index (AEDI) suggests that ‘only a small percentage’ of children aged 14 to 18 in these communities are ‘developing in accordance with expected child development and literacy and numeracy milestones for their age’.²⁴⁹

One reason for this is poor school attendance. In 2013, average school attendance across the communities was 59.6 per cent (compared with statewide Aboriginal attendance of 79.4 per cent and non-Aboriginal attendance of 91.2 per cent).²⁵⁰ Attendance can vary markedly between communities: in 2014, from 45.1 per cent in one community to 89.3 per cent in another.²⁵¹ These figures probably overstate attendance, because the record system assumes children are present unless a teacher advises otherwise²⁵² and records students as present even if they attend for only a short period of the day.²⁵³ DECD is reviewing the system to improve tracking of school attendance.²⁵⁴

Under the National Partnership Agreement on Universal Access to Early Childhood Education, all children should have access to at least 15 hours per week or 600 hours per year of preschool or kindergarten in the year before starting school.²⁵⁵ Children in remote communities can commence preschool at three years of age and attend for two years. A number of the preschools have extended hours to encourage as much attendance as possible. However, average attendance remains only about six hours per week per child.²⁵⁶

Playgroups play a vital role. They help families develop parenting skills in a non-threatening way and set the foundation for preschool and school attendance. Unfortunately, their funding is short term and comes from a range of sources. Workers leave because of this uncertainty and playgroups are closed for months while a replacement is found.²⁵⁷ Existing funding should be pooled and playgroups given secure, long-term funding. Playgroups should be administered by a single agency to ensure consistency.

Many remote Aboriginal people are highly mobile, which contributes to low attendance rates. Students who move between communities are difficult to track. If they attend a different school, their learning records are not readily accessible. This affects learning. Students also potentially repeat or miss blocks of learning as a result of attending multiple schools.²⁵⁸

Some recent initiatives help to address this issue. All schools in these communities now offer a version of the Australian curriculum that is ‘specifically adapted to Anangu communities, culture and language’.²⁵⁹ Schools teach the same units throughout the year and

use a common daily learning pattern. They also have uninterrupted teaching blocks in weeks two to three and six to seven of each term, during which external service providers are not permitted to use the school space. This gives time for students to concentrate, work and develop routines. These measures aim to promote consistency so that students can move between schools without interrupting their learning. They also aim to encourage regular attendance and better learning outcomes by making learning more relevant, engaging and familiar.²⁶⁰

These initiatives would be strengthened by establishing an integrated administration information communication technology (ICT) system. The schools use a data monitoring and tracking tool to store detailed student assessment data and allow teachers to monitor the progress of children over time. However, teachers cannot track attendance and performance from school to school. Nor can they access individual education or behaviour management plans or evidence of a child’s literacy or numeracy. Teachers spend weeks or months reconstructing this information when a child moves school.²⁶¹ Integrated access to this information would arguably benefit schools across South Australia, but is particularly important to address the mobility of students in these remote Aboriginal communities. DECD should invest in a system to provide this functionality.

Persistent non-attendance at school is a child protection issue. Not only does it amount to educational neglect, it may also conceal other forms of maltreatment, a point emphasised by the Coroner’s Court in the inquest into the death of Jarrad Roberts.²⁶² Many children in care in remote communities also do not regularly attend school.²⁶³ This is unacceptable and should be raised with carers as a matter of urgency.

SOUTH AUSTRALIA POLICE

In 2010, new police stations were established in Mimili, Ernabella and Amata, adding to the existing station at Murputja. There are 19 permanent police officers across the four police stations, including an officer in charge, a detective and two child and family violence/crime prevention officers. Another five officers at Marla service Marla, Indulkana and Mintabie. South Australia Police (SAPOL) has temporarily recruited a detective and two investigators to investigate allegations of child sexual abuse.²⁶⁴

SAPOL told the Commission that the increased police presence on the APY Lands ‘has led to a stronger rapport with and acceptance by the communities, an increased visual police presence and timely police responses’.²⁶⁵ The ratio of police to the community on the APY Lands is about 3.5 times higher than anywhere else in South Australia.²⁶⁶

SAPOL facilitates regular community safety committee meetings in several communities. These meetings are attended by community members, including elders, and representatives from other government services. The meetings allow the community to identify issues of concern and work together towards agreed solutions. SAPOL told the Commission:

It has become apparent to police that for any agency to operate successfully on the APY Lands requires a continued presence over time and a desire to work collaboratively with all other agencies ... The establishment of rapport and the building of trust [with community members] are essential.²⁶⁷

SAPOL is also engaged in a range of community-based initiatives to improve community education, support and interaction, such as road safety education, Blue Light Discos, coaching and training of sporting teams, and participation in cultural camps.

DRUG AND ALCOHOL SERVICES SOUTH AUSTRALIA

The abuse of alcohol and other drugs is a long-term social issue with serious adverse consequences for APY Lands residents, particularly women and children. Drug and Alcohol Services South Australia (DASSA) has an outreach team that travels between six communities on the APY Lands. It receives referrals from a range of agencies. One staff member resides on the APY Lands and the rest visit for between two and six weeks at a time. The staff include nurses, social workers and substance misuse workers.

In 2013/14, the service received 81 individual client referrals. Forty-six per cent of referrals in 2013/14 were clients aged 30 years or less at the time of referral and 85 per cent were male.²⁶⁸ In addition to individual therapeutic work, the DASSA team runs community education and development programs, including men's groups, zumba classes and jewellery-making groups for women and education sessions for middle and senior school students.

The most common substances of concern are alcohol and cannabis. Some communities have significantly greater problems than others. Both substances are associated with significant aggression and domestic violence. As there are no detoxification facilities on the APY Lands, the closest options are in Alice Springs or Port Augusta.

With possession or consumption of alcohol prohibited in the APY Lands²⁶⁹, many residents travel to nearby towns to drink excessively or to transport alcohol back to the APY Lands for consumption or sale. In 2012, the Sobering Up Unit in Coober Pedy reported that 81.5 per cent of its clients were transitory clients from the APY Lands.²⁷⁰

In September 2013, the Liquor Licensing Commissioner introduced tighter conditions on the sale of takeaway liquor in Coober Pedy, including²⁷¹:

- A ban on sales to residents of the APY Lands or to those who it is suspected may take liquor back to the APY Lands.
- Purchasers must produce photographic identification.
- Cask wine is banned for takeaway purchase.
- A daily limit of 750 millilitres of wine, port wine, fortified wine or spirits per person.

Measures such as these do not purport to resolve all issues related to problem drinking, but they appear to help. The Liquor Licensing Commissioner is reviewing these changes to assess their impact.

Recommendations made in Chapter 9 will empower the Agency to issue written directions requiring a drug or alcohol assessment where they suspect a child is at risk. This power must also be exercised in remote areas, and its efficacy depends on the availability of services in remote areas to provide such assessments. The Government will need to ensure that DASSA is appropriately resourced to provide the service.

NGANAMPA HEALTH COUNCIL

Nganampa Health Council is an Aboriginal-controlled health organisation and the main provider of primary health care on the APY Lands. Its services for children and families include women's health, sexual health, antenatal care, nutrition education and support, health education, dental programs, hospital liaison and a child health program. Nganampa operates seven clinics in communities across the APY Lands.

The child health program has a strong focus in the areas of immunisation, child health checks, child growth monitoring for children under five years old and trachoma screening for children aged five to seven years. The program is supported by visiting health professionals, including a paediatrician, ophthalmologist, ENT specialist and Australian Hearing.

Nganampa offers annual checks for children aged five, 10 and 13 years in all communities, opportunistic health checks to children outside those age cohorts and a number of screening tests applicable to specific age groups. The program has had significant achievements, including childhood immunisation rates well above the national benchmark. For example, in 2014, 98 per cent of children under the age of seven years in the APY Lands were fully immunised.²⁷²

NPY WOMEN'S COUNCIL

The NPY Women's Council is an Aboriginal-controlled organisation that provides a range of services in the cross-border region in South Australia, the Northern Territory and Western Australia. It employs about 150 staff. Its services cover domestic violence, child nutrition and wellbeing, disability, youth and, through its Walytjapiti program, intensive family support.

NPY Women's Council's youth program employs four full-time youth workers, supported by about 20 part-time Anangu support workers, who operate on an occasional basis. It works with people aged from 10 to 24 years in all APY Lands communities, except Indulkana (where UnitingCare Wesley runs a youth program). The program offers diversionary activities to engage young people who are at risk and improve their wellbeing. It also runs a youth leadership program and offers case management, not only for young people at risk, but to support other young people to achieve their goals.²⁷³

The child nutrition and wellbeing program case manages children whose growth is restricted and offers community education and resource development. It also works with other services such as schools and shops.²⁷⁴ The program has seven workers, as well as several Anangu support workers who help them engage with families and organise community events. Cases often involve other risk factors, such as domestic violence, substance abuse and mental health issues, which affect a carer's ability to ensure their child's nutrition and wellbeing.²⁷⁵

The Walytjapiti program operates in four communities in the APY Lands. It offers intensive support for families who have children experiencing neglect or at high risk of neglect. Although the program is funded by the federal government, families must be referred by the Agency and have an open file at the time of referral. The program offers a range of services, including assistance with practical issues such as access to food and bedding, parenting support, school attendance and referrals to other services.²⁷⁶ A 2014 review endorsed the service, but noted that it was under-resourced: for every vacancy '35 families could be considered for referral'.²⁷⁷

The Agency has agreed to provide overall case management, including advice, problem solving and decision making, for each case referred to this program while their file on the case remains open. It has agreed to consult the program before closing the file and not to close files unless the risk has reduced over a sustained period.²⁷⁸ In practice, the Agency refers to the program and then closes the files.²⁷⁹ Sometimes cases are referred which involve too much risk or where children need therapeutic support, which the program is not designed to offer.²⁸⁰

Apart from the council's child nutrition and wellbeing program—which works with children aged less than five years—there is no early intervention program for vulnerable families on the APY Lands that does not require an open child protection file.²⁸¹

The Agency should provide substantial additional funding to strengthen the Walytjapiti program sufficient to meet demand. It should review its procedures, referral criteria and staff training to ensure that it only refers cases to the program that are appropriate for the service model and to ensure that files are only closed on consultation with the program and after the risk has reduced over a sustained period.

It should also partner with the NPY Women's Council or a similar not-for-profit agency to provide an early intervention service for families whose concerns do not require an open file. The government should consider whether this might involve expanding the council's existing child nutrition and wellbeing program.

SA HEALTH

The Women's and Children's Health Network, which is part of SA Health, provides a range of specialist services to children on the APY Lands, including:

- Child and Family Health Service (CaFHS), which offers nursing responses and support services for children under five years, including developmental health checks, parenting support and education and nutritional advice.
- Child and Adolescent Mental Health Services (CAMHS), which offers family-based therapy, assessments, counselling and a sexualised behaviours program. It has two staff based on the APY Lands, as well as regular visiting teams and a visiting psychiatrist.
- Child Protection Services (CPS), which has visiting psychologists, social workers and medical officers who perform forensic interviews and forensic assessments of young children as requested by the Agency or SAPOL.²⁸²

HOUSING SA

Housing SA offers services to all communities in the APY Lands and emergency maintenance services to many adjacent homelands. Housing SA offers intensive tenancy support services to help tenants care for their properties, manage visitors, pay rent and access other services.

Overcrowding remains a problem, but has improved somewhat with the construction of many new houses, including 304 additional bedrooms since 2010.²⁸³ An audit in 2013/14 found 15 per cent of remote Aboriginal dwellings in South Australia were overcrowded, including 35 per cent of dwellings in Indulkana, 25 per cent in Amata and 21 per cent in Kalka.²⁸⁴

As discussed in Chapter 8, Housing SA's new service model aims to engage the people who receive its services. Housing SA began implementing this model in the APY Lands in mid-2015. Under the model, tenancies must be visited at least once a year and children under five years of age who are registered as residents must be sighted or their whereabouts queried. A risk identification tool and a tenancy practitioner help staff to consider the needs of children.²⁸⁵

IMPROVING COLLABORATION BETWEEN SERVICES

Chapter 21 emphasises the need for collaboration between service providers in the child protection system throughout South Australia. In remote communities, the 'lack of Lands-based service staff, the distance, the level of disadvantage and the complex cultural environment' make collaboration indispensable.²⁸⁶

In practice, relationships between some service providers referred to above in the APY Lands are fractured. A 2014 review stated that 'relationships with some partner organisations were contested and viewpoints entrenched'. It described one inter-agency relationship as 'tense' and another as 'antagonistic and dysfunctional' to the point where it diminished child-focused practice.²⁸⁷

The Commission spoke to key agencies involved in service delivery to children and families in the APY Lands. While there are examples of good working relationships, there are also deep divisions that interfere with the effective delivery of services.

Every practitioner in every agency should commit to repairing and strengthening professional relationships and to working cooperatively to improve outcomes for children and families in these communities. If there are those who, on personal reflection, feel that they cannot put past grievances aside, they should consider employment elsewhere.

Agencies should actively pursue joint training opportunities, not only to maximise finite training resources, but also to promote shared knowledge and skills and to allow staff from different agencies to spend time together. The state government should allocate funding to inter-agency secondments.

Too often, agencies approach their mandate narrowly, which prevents an optimal response to the need in communities. Promoting collaboration and service efficiencies through pooled funding arrangements should be investigated as a strategy to address this. Arrangements should include, if possible, federal funds, especially for programs which address current priorities pursuant to the National Framework for Protecting Australia's Children 2009–2020.

Operational managers from each key agency should meet regularly to identify areas for collaboration and to address issues of concern. They should aim to find areas for strategic cooperation, where agencies can support each other to improve outcomes for children and families.

CHILDREN AND FAMILY SERVICE HUBS

Chapter 8 discusses how Children's Centres and Children and Family Centres act as service hubs, bringing together support services for families and children in a non-threatening environment. Centres commonly include a preschool, playgroups, parenting and personal development programs, and access to health services.

DECD has Children and Family Centres in three APY Lands communities, which offer services from the prenatal phase to five years of age. The Ernabella Centre, for example, is colocated with the school and offers a preschool, a supported playgroup and occasional care, as well as the following services²⁸⁸:

- Families as First Teachers, which is an art education program for mothers and children that focuses on parenting skills and literacy;
- parenting support programs;
- Child and Family Health Services' (CaFHS) early childhood development program for families with young children, which provides developmental evaluations, information sessions, individual support, counselling and advice;
- NPY Women's Council child nutrition and wellbeing program; and
- hearing specialists and a visiting dentist to examine children and talk with parents.

Four communities have Wellbeing Centres, which are funded by a range of sources, including SA Health, the Department for Communities and Social Inclusion and

the federal government. Together with the Children and Family Centres, the Wellbeing Centres are well placed to serve as service hubs, tailored to the needs of each community. They could offer a base for visiting professionals, as well as those permanently based in communities, such as the Lands-based workers. However, having the four Wellbeing Centres run by three different agencies leads to inconsistent, poorly coordinated services with significant gaps and duplication.²⁸⁹

Smaller communities with fewer children may not require a full Children and Family Centre, but they do need adequate facilities to accommodate playgroups, a preschool and other visiting services. The Commission understands that facilities in some communities are below acceptable standards.²⁹⁰

The South Australian Government should conduct an audit in each community to ensure access to adequate facilities to accommodate these services. A single agency should oversee these facilities to provide consistency across all communities. This should also include auditing the facilities that are available in Yalata and Oak Valley.

LOCAL ASSESSMENT OF NEEDS AND SERVICE COORDINATION

The same agency should regularly map the needs of vulnerable families and children in each APY community, with a focus on areas of unmet need and unnecessary or duplicated services. This work should be formalised in an annual Local Assessment of Needs (LAN). The LAN should inform funding decisions to ensure that communities have the services they need.

Although the agency would prepare the LAN, its success would depend on it being an ongoing, collaborative effort with input from the members of each community. The services recommended in the LAN should have the community's support and reflect their needs and aspirations. The agency should aim to build capacity in the community so that, in time, communities might take more control of the direction of their local services.

The agency should also establish processes to coordinate the services offered by different agencies in each community, including implementing stronger referral pathways, consistent referral criteria, better information sharing and integrated, multi-service responses where required. State government agencies should be directed to cooperate with these processes and it should be a condition of government funding for all not-for-profit agencies.

INFORMATION SHARING

Chapter 21 outlines the barriers that impede effective sharing of information relevant to child wellbeing. A complicating factor in the APY Lands is that some agencies do not receive state government funding and are not bound by its Information Sharing Guidelines. Chapter 21 recommends legislative amendments to require all agencies in the child protection system, irrespective of funding source, to share such information.

INTERAGENCY CODE OF PRACTICE AND THE APY CHILD PROTECTION PROTOCOLS

The APY Child Protection Protocols (the APY Protocols) were agreed between key APY Lands agencies in 2010. They were intended to promote consistent responses to allegations of child abuse and neglect, in particular sexual abuse. Among other things, the APY Protocols required that all notifications involving sexualised behaviours be upgraded to at least a Tier 2 intake and be followed by an inter-agency strategy discussion to determine the appropriate response.

Because 'sexualised behaviours' captures a broad range of conduct, the APY Protocols effectively prioritised many relatively minor matters. For example, they required a Tier 2 response to a notification that one boy was laughing and gyrating behind another while lining up with students before class. Without more evidence, this might be classified as a Notifier Only Concern elsewhere in the state. The APY Protocols required a Tier 2 intake followed by a strategy discussion. On a strict interpretation, even the children who observed the boy gyrating might give rise to a Tier 2 intake on the grounds that they were 'exposed' to sexualised behaviour. This distorted the tier rating system and tended to overwhelm practitioners, who were already struggling with high workloads and staffing shortages.

The APY Protocols were reviewed in 2015 and relevant stakeholders agreed to revoke them and be guided instead by the statewide Interagency Code of Practice (ICP). The updated ICP, due to be released in July 2016, deals more comprehensively with all forms of abuse and neglect, not just child sexual abuse. It includes an appendix that contains principles for working with Aboriginal people. It is appropriate that ICP guides inter-agency work in remote Aboriginal communities. While practitioners in these communities should be knowledgeable about Aboriginal culture and parenting practices, they should apply the same standards of risk and safety as apply elsewhere in the state.

WORKING ACROSS JURISDICTIONAL BORDERS

The Cross-Border Justice Scheme was introduced in 2009 to address serious justice challenges, particularly in relation to the abuse of women and children, in the tri-border region in the South Australian, Western Australian and the Northern Territory outback. Complementary legislation in each of the three jurisdictions gives police officers cross-jurisdictional powers to operate throughout this region.²⁹¹ It also allows magistrates, fine enforcement agencies, community corrections officers and prisons of one jurisdiction to deal with offences that occur in another jurisdiction.²⁹² The scheme allows the swift apprehension of perpetrators and has improved safety for women and children in the region.²⁹³

Many of the challenges that led to the introduction of the scheme also apply in child protection. For example²⁹⁴:

- A worker in one jurisdiction may be closest to a child in urgent need of care and protection in a remote community across the border.
- A worker may form a strong relationship with a family that then moves across the border. If the worker continues to support the family it could prevent concerns escalating.
- The most appropriate carer for a child may live across a state border. However, South Australia's carer assessments are not recognised in Western Australia or Northern Territory and vice versa, potentially requiring the process to be repeated.²⁹⁵
- Many mothers from the APY Lands give birth in Alice Springs. The Northern Territory Government must currently seek a child protection order under Northern Territory legislation, if required, even though the child may be placed with carers in South Australia and information for any investigation may be located there. The Northern Territory may then need to transfer the orders to South Australia.

In 2012 and 2013, a cross-border working group, involving representatives from each of the three jurisdictions, discussed these challenges. Western Australia agreed to develop a proposal for legislative reform to permit Northern Territory and South Australian child protection officers to conduct mandated functions under Western Australian law in the state. The other jurisdictions were to be kept informed with a view to possible reciprocal reforms. The working group also explored ways for each jurisdiction to recognise each other's carer assessments and committed to developing minimum standards for kinship care assessments across the three jurisdictions.²⁹⁶

In November 2015, the Agency told the Commission that its Executive has not endorsed these measures, that the working group's outcomes have not been implemented and that the working group has not met since 2013. The

Agency indicated it was keen for the working group to be re-established and to be involved in future cross-border meetings.²⁹⁷

The Cross-Border Justice Scheme shows that challenges to inter-jurisdictional arrangements can be overcome. The South Australian Government should work to re-establish a working group to promote collaborative practice between agencies in the tri-border region. Consideration should be given to expanding the group to include key non-government agencies that also work across this region.

The government should also pursue a cross-border legislative scheme for child protection, similar to the Cross-Border Justice Scheme. It should work to harmonise the carer registration processes used by the three jurisdictions.

YALATA AND OAK VALLEY

The remote, far west communities of Yalata and Oak Valley share strong cultural and family ties with the communities of the APY Lands and also many of the same challenges relating to remoteness and high levels of need. However, they tend to receive significantly less attention than the APY Lands. There were internal reviews of service provision in the APY Lands in 2013, 2014 and 2015²⁹⁸, but no equivalent analyses of Yalata and Oak Valley. The 2014 review specifically noted:

While the focus of this report is on child protection services on the Anangu Pitjantjatjara Yankunytjatjara Lands, the project was informed that many of the issues and recommendations made in this report are relevant to the remote Aboriginal communities of the Maralinga and Tjarutja Lands (Yalata, Oak Valley) in South Australia. Nevertheless, a further full project focused on that area still needs to be undertaken.²⁹⁹

This analysis has not occurred. The Agency continues to struggle to recruit and retain sufficient staff in Yalata, Oak Valley and Ceduna. Persistent vacancies in the Ceduna office also affect Yalata and Oak Valley, which are serviced on a drive-in drive-out basis from Ceduna.

The FIFO service model has substantially addressed staff recruitment and retention in the far north of the state. The Agency should ensure that Ceduna, Yalata and Oak Valley also have a sustainable service model that permits reliable service delivery. The Agency should commission an appropriately credentialed professional to review service provision in Ceduna, Yalata and Oak Valley and, specifically, to consider the viability of introducing a FIFO service model for these three communities. As part of this review, they should consult with the local Aboriginal communities, staff of the Agency and other relevant service providers.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:	
187	Develop an Aboriginal recruitment and retention strategy in the Agency as part of a broader workforce strategy.
188	Review procedures to streamline the sources of internal cultural advice to the Agency.
189	Review practice guidance, funding arrangements and the range of declared agencies to ensure that a recognised Aboriginal agency is consulted on all placement decisions involving Aboriginal and Torres Strait Islander children, in accordance with the provisions of section 5 of the <i>Children's Protection Act 1993</i> .
190	Establish a dedicated family scoping unit.
191	Provide all practitioners in the child protection system with training, support and clinical supervision to give them the knowledge, skills and techniques to work effectively with Aboriginal children and families, including, where appropriate, the specific skills required to work effectively in remote Aboriginal communities.
192	Use the proposed Early Intervention Research Directorate to identify evidence-based service models for early intervention that meet the needs of Aboriginal children and families.
193	Outsource the services currently provided by Kanggarendi to an appropriately qualified and experienced non-government organisation.
194	Commission not-for-profit agencies to develop service models that can respond to higher risk Aboriginal families with multiple, complex needs.
195	Ensure that Local Assessments of Needs (LANs) specifically consider the needs of Aboriginal children and families and consult with local Aboriginal people and service providers.
196	Place local Aboriginal support services within child and family assessment and referral networks to promote service coordination and act as a visible point of entry.
197	Adopt a culturally appropriate assessment tool, such as Winangay, for the assessment of foster parents and kinship carers in the Aboriginal community, initially in remote communities, and more widely if the tool proves promising.
198	Require the Agency to report to the Minister and the Guardian for Children and Young People quarterly on service criteria 3.1.4.1, 3.1.4.4 and 3.1.4.6, which form part of standard 3.1.4 of the Standards of Alternative Care in South Australia.
199	Consult with each remote Aboriginal community about the implementation of the recommendations following this report, as part of ongoing engagement with communities about the strategic direction of services to improve the health, safety and wellbeing of their children.
200	Offer stable employment arrangements with competitive, ongoing retention allowances to attract and recruit six permanent Lands-based workers to support the Agency's fly-in fly-out teams.
201	Actively pursue joint training opportunities for agencies in remote communities and require operational managers from agencies to meet regularly to identify areas for collaboration and to resolve issues of concern.
202	Ensure that at least one principal Aboriginal consultant has experience and expertise in remote Aboriginal communities, including in the APY Lands.
203	Identify opportunities to develop strength in the interpreter service available in remote communities, and ensure that the Agency's practitioners use interpreters where possible. Consider the viability of interpreters accompanying the Agency's fly-in fly-out teams.
204	Ensure that the Agency's practitioners monitor children cared for in accordance with Family Care Meeting agreements to ensure the safety of the child.
205	Commission not-for-profit agencies to provide alternative care in areas close to the APY Lands, such as Alice Springs and Coober Pedy. Alternative care could include a mixture of foster care and residential care.
206	Require that full carer assessments be completed in a timely manner in remote communities.
207	Ensure that approved carers in remote communities receive the same level of support as carers elsewhere in the state, recognising the particular challenges faced by carers in these remote areas.

RECOMMENDATIONS

- 208 Ensure that the unit tasked with investigating care concerns offers a service in remote communities equivalent to that provided elsewhere in the state.

- 209 Provide secure, long-term funding for playgroups in remote Aboriginal communities, administered by a single agency.

- 210 Establish an integrated administration information communication technology (ICT) system to allow access to a complete range of student data to children who move schools in remote Aboriginal communities.

- 211 Provide additional funding to meet demand for the Walytjapiti program, and ensure that the Agency keeps case files open for participants until satisfied about the child's ongoing wellbeing over a sustained period.

- 212 Commission an early intervention service for families in remote communities for whom the Agency has lower level concerns and who could benefit from support to prevent escalation of issues.

- 213 Conduct an audit of services in remote Aboriginal communities to ensure access to adequate facilities to serve as a service hub for playgroups, preschools and other services that visit the community.

- 214 Reform funding and structural arrangements to enable a single agency to oversee the service hub facilities across all communities. This agency should regularly map, in collaboration with the local community, the needs of children and families through an annual Local Assessment of Needs.

- 215 Establish a working group to promote collaborative practice between South Australian, Western Australian and Northern Territory agencies involved in the child protection system in the tri-border region, including working towards a cross-border legislative scheme for child protection across the three jurisdictions.

- 216 Review child protection service provision in Ceduna, Yalata and Oak Valley, including the viability of introducing a fly-in fly-out service.

NOTES

- 1 The term 'Aboriginal' is used as an inclusive term to refer to Aboriginal and Torres Strait Islander peoples.
- 2 Office of the United Nations High Commissioner for Human Rights (OHCHR), Convention on the Rights of the Child, entered into force 2 September 1990, articles 1, 2, 6, 19, 24, 27, 30.
- 3 United Nations (UN), Convention on the Rights of Persons with Disabilities, entered into force 3 May 2008, articles 11–13, 18.
- 4 Australian Human Rights Commission (AHRC), *Social justice and native title report 2015: Aboriginal and Torres Strait Islander Social Justice Commissioner*, 2015, p. 140.
- 5 *ibid.*
- 6 A Jackomos, 'Linking our past with our future: How cultural rights can help shape identity and build resilience in Koori kids', *Indigenous Law Bulletin* 8, no. 17, 2015.
- 7 Productivity Commission, *Overcoming Indigenous disadvantage: Key indicators 2014*, Productivity Commission, Australian Government, 2014; C Holland, *Close the Gap progress and priorities report 2016*, Close the Gap Steering Committee for Indigenous Health Equality, 2016.
- 8 Human Rights and Equal Opportunity Commission (HREOC), *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*, HREOC, Commonwealth of Australia, 1997, p. 22.
- 9 *ibid.*, p. 31.
- 10 *ibid.*, p. 11.
- 11 AHRC, *Social justice and native title report 2015*, p. 162.
- 12 Secretariat of National Aboriginal and Islander Child Care (SNAICC), *Family matters. Kids safe in culture, not in care*, issues paper, South Australia, no date, p. 8.
- 13 SS Yeo, 'Bonding and attachment of Australian Aboriginal children', *Child Abuse Review* 12, 2003, p. 297; SNAICC, *Growing up our way: Aboriginal and Torres Strait Islander child rearing practices matrix*, 2011, pp. 5, 119.
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- 15 S Lohar, et al., 'Strengths of Australian Aboriginal cultural practices', pp. 7, 11.
- 16 S Kruske et al., 'Growing up our way', pp. 777, 783; SS Yeo, 'Bonding and attachment', p. 292; F Ryan, 'Kanyininpa (holding)', no. 2, 2011, pp. 183, 186.
- 17 SS Yeo, 'Bonding and attachment', pp. 292, 299–300.
- 18 F Ryan, 'Kanyininpa (holding)', pp. 183, 189.
- 19 *ibid.*, pp. 183, 188.
- 20 Families SA, 'Child protection manual of practice', internal unpublished document, Government of South Australia, 2010, p. 44.
- 21 G Robinson, 'The state, cultural competence and child development: Perspectives on intervention in the north of Australia', in U Eikelkamp (ed.), *Online proceedings of the symposium 'Young Lives, Changing Times: Perspectives on social reproduction'*, University of Sydney 8–9 June 2011, Sydney, 2012, p. 9, <http://youngliveschangingtimes.wordpress.com/>
- 22 Australian Bureau of Statistics (ABS), *Estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, cat. no. 3238.0, ABS, Canberra, 2014; Australian Institute of Health and Welfare (AIHW), *Child protection Australia 2014–15*, Child Welfare Series no. 63, cat. no. CWS 57, AIHW, Canberra, 2016, Table A47.
- 23 Productivity Commission, 'Child protection services' in *Report on government services 2016*, Australian Government, 2016, tables 15A.6, 15A.7.
- 24 AIHW, *Child protection Australia 2014–15*; Productivity Commission, 'Child protection services'.
- 25 P Delfabbro et al., 'The over-representation of young Aboriginal and Torres Strait Islander people in the South Australian child system: A longitudinal analysis', *Children and Youth Services Review* 32, no. 10, October 2010, p. 1418.
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- 34 Oral evidence: A Groat; B Sanderson.
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- 43 Layton (Chair), *Our best investment*, Recommendation 34;
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OVERVIEW

The Commission received a number of submissions from persons and organisations in regional South Australia, including Families SA (the Agency) staff, non-government organisations and foster parents, highlighting the challenges faced in regional areas. This prompted the Commission to conduct hearings in Mount Gambier and Port Augusta. The Commission also heard evidence in Adelaide from witnesses from other regional areas, including Ceduna, Murray Bridge, Port Pirie and the Riverland.

The capacity of the child protection system to respond to the needs of vulnerable children in regional areas is compromised by limited access to services. Children and practitioners often need to travel significant distances to receive or deliver services. There are few out-of-home care placement options and this can result in children being removed from their immediate community. There is also difficulty in attracting and retaining child protection practitioners in regional areas.

This chapter does not attempt to canvass all the challenges and gaps in service provision for children in regional areas. Rather, it highlights some of the issues that are affecting children in regional areas who come into contact with the child protection system.

This chapter principally relates to the Commission's Terms of Reference 5(a), (b), (c), (d) and (h), in the context of Terms of Reference 1 to 4.

DEFINING REGIONAL

Terms such as 'regional', 'rural' and 'remote' do not have standard definitions. Population size, socioeconomic factors, and distance from goods, services and other communities may lead to differing conclusions as to whether a community is regional, rural or remote.¹

'It is very difficult to identify exactly where the city ends and the country begins'.² Accordingly, this report defines regional areas as those that are serviced by Families SA offices outside metropolitan Adelaide. Those offices, and the government regions in which they are located, are listed in Table 17.1. The regional offices are not part of the Agency's hub structure (discussed in Chapter 5). Unlike metropolitan offices, each regional office performs all functions: assessment and support, protective intervention, and case management of children under long-term guardianship. Regional offices are also expected to provide after-hours services that might, in the metropolitan area, be provided by the Agency's Crisis Care service.

South Australia also has communities in remote areas, such as the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. The needs of children in those communities are discussed in Chapter 16.

Table 17.1: Regional Families SA offices

SOUTH AUSTRALIAN GOVERNMENT REGION ^a	OFFICE
Eyre and Western	Ceduna
	Port Lincoln
	Whyalla
Far North	Coober Pedy
	Port Augusta
Murray and Mallee	Berri (Riverland office)
	Murray Bridge (Murraylands office)
Yorke and Mid North	Kadina ^b
	Port Pirie
Adelaide Hills	Mount Barker
Fleurieu and Kangaroo Island	Victor Harbor ^c
Barossa, Light and Lower North	Gawler
Limestone Coast	Mount Gambier

^a A consistent set of boundaries used by the South Australian Government to define 12 administrative regions in the state.

^b A branch of the Port Pirie office, with limited opening hours.

^c A branch of the Mount Barker office, with limited opening hours.

Sources: Data from South Australian Government regions, www.sa.gov.au/topics/property-and-land/planning-and-land-management/land-supply-and-planning-system/south-australian-government-regions, accessed 6 June 2016, and Families SA offices, www.families.sa.gov.au/department/families-sa-offices, accessed 6 June 2016.

VAST AREAS, LONG DISTANCES

Regional offices are responsible for delivering child protection services across vast areas of the state. For example, the Port Augusta office's footprint covers Tarcoola in the west to Maree in the north to the border of South Australia and New South Wales in the east. For staff, this involves road distances of almost 400 kilometres in each direction.³ The Ceduna office, in the state's far west, covers an area from the border of South Australia and Western Australia (excluding the APY Lands) to townships around Poochera and Mount Cooper (Colley) in the east: a road distance of more than 600 km.

The office in Mount Gambier covers an area from the border of South Australia and Victoria in the south-east to the township of Keith, more than 200 km away.⁴ The Riverland office is responsible for a similar area: from the border of South Australia and Victoria to the township of Truro, about 200 km away by road.⁵

Other regional service providers, both government and non-government, told the Commission about the significant distances they travel to provide services.

CHARACTERISTICS OF REGIONAL POPULATIONS

Children and families in regional areas face different challenges to those living in metropolitan areas. 'A harsh natural climate, higher occupational risks, geographic isolation and the need for long-distance travel are part of life for many rural communities.'⁶ The resilience of individuals and communities can be tested by both economic and environmental challenges, leading to circumstances that may put at risk a child's wellbeing, such as increased family breakdown and social isolation.⁷

In terms of relative socioeconomic disadvantage, regional areas are over-represented. As shown in Table 17.2, among the 35 most disadvantaged local government areas in South Australia, all but four are regional.⁸ Children living in disadvantaged areas may be vulnerable to risk factors including poor educational engagement and unmet health and wellbeing needs.

The Australian Early Development Census (AEDC) provides a measure of early childhood development across a community. The census surveys five key areas of development (or domains) at the time children start school: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge.⁹ AEDC results give an indication of the proportion of children in a community who are developmentally vulnerable.¹⁰ In 2015, across South Australia, 12.2 per cent of children were developmentally vulnerable in two or more domains when starting school. The proportion of children was higher than this state average in 21 regional local government areas.¹¹ Eighteen of these areas are also

listed as most disadvantaged in Table 17.2, reinforcing that developmental vulnerability and socioeconomic disadvantage often go hand in hand.

Poor mental health, psychological distress and drug and alcohol misuse all have a significant effect on parenting practices. While the proportion of people in country areas of South Australia with a diagnosed mental health condition is similar to that in the greater Adelaide region, they are less likely to report psychological distress. Consequently, the rate of diagnosis may not be truly representative of the prevalence of mental health conditions in regional communities.¹²

People in country areas of South Australia are more likely to consume alcohol at a level that poses health risks, both in the short and long term.¹³ People in regional South Australia are also generally more likely to have used illicit drugs in the past 12 months than people in major cities.¹⁴

Some regional areas are experiencing growth in their populations of persons with a culturally and linguistically diverse (CALD) background. Meeting the needs of new populations can stretch limited resources.¹⁵

Population characteristics, such as socioeconomic disadvantage, developmental vulnerability, mental health concerns, substance abuse and cultural diversity, demonstrate that many children in regional areas are particularly vulnerable. Understanding the demographics of a region is essential for service providers. Consideration of risk factors that may be prevalent in a particular region is important when assessing how to respond to the needs of vulnerable children.

Many of the observations in this chapter are of general relevance, but it is important to acknowledge that applying an inflexible, one-size-fits-all approach to improving service delivery in regional areas would ignore the individual strengths and weaknesses of particular regions.

17 CHILDREN IN REGIONAL AREAS

Table 17.2: Relative socioeconomic disadvantage and development vulnerability by local government area

SOCIOECONOMIC DISADVANTAGE RANKING	LOCAL GOVERNMENT AREA	SOUTH AUSTRALIAN GOVERNMENT REGION	DEVELOPMENTAL VULNERABILITY ^a OF CHILDREN ABOVE STATE AVERAGE
1	Anangu Pitjantjatjara Yankunytjatjara Lands	Far North	Yes
2	Maralinga Tjarutja Lands	Eyre and Western	N/a
3	District Council of Peterborough	Yorke and Mid North	Yes
4	District Council of Coober Pedy	Far North	N/a
5	City of Playford	Northern Adelaide	Yes
6	Port Pirie Regional Council	Yorke and Mid North	Yes
7	Rural City of Murray Bridge	Murray and Mallee	No
8	Berri Barmera Council	Murray and Mallee	Yes
9	City of Whyalla	Eyre and Western	Yes
10	Port Augusta City Council	Far North	Yes
11	Renmark Paringa Council	Murray and Mallee	No
12	Unincorporated SA	N/a	Yes
13	City of Mount Gambier	Limestone Coast	Yes
14	District Council of the Copper Coast	Yorke and Mid North	No
15	City of Port Adelaide Enfield	Western Adelaide	Yes
16	District Council of Ceduna	Eyre and Western	Yes
17	Mid Murray Council	Murray and Mallee	Yes
18	City of Salisbury	Northern Adelaide	Yes
19	Wakefield Regional Council	Yorke and Mid North	Yes
20	Regional Council of Goyder	Yorke and Mid North	No
21	Wattle Range Council	Limestone Coast	Yes
22	District Council of Loxton Waikerie	Murray and Mallee	Yes
23	Coorong District Council	Murray and Mallee	No
24	City of Port Lincoln	Eyre and Western	No
25	Yorke Peninsula Council	Yorke and Mid North	Yes
26	District Council of Barunga West	Yorke and Mid North	Yes
27	The Flinders Ranges Council	Far North	No
28	Town of Gawler	Barossa, Light and Lower North	Yes
29	City of Victor Harbor	Fleurieu and Kangaroo Island	No
30	District Council of Yankalilla	Fleurieu and Kangaroo Island	No
31	Kingston District Council	Limestone Coast	Yes
32	District Council of Franklin Harbour	Eyre and Western	Yes
33	City of Charles Sturt	Western Adelaide	No
34	District Council of Tumby Bay	Eyre and Western	No
35	District Council of Mallala	Barossa, Light and Lower North	No

^a Developmentally vulnerable in two or more domains of the Australian Early Development Census when starting school.

Note: Shaded rows signify metropolitan areas.

Sources: Data from Australian Bureau of Statistics, *Socio-economic indexes for areas (SEIFA)*, cat. no. 2033.0.55.001, ABS, Canberra, 2011; Australian Early Development Census, *Public table by local government area (LGA) 2009–2015*, AEDC, Australian Government, 2016.

STAFFING IN REGIONAL AREAS

Contributors to the Commission emphasised that the challenges of attracting, recruiting and retaining child protection staff (discussed in Chapter 6) are of particular concern in regional areas. The capacity of the workforce directly affects the quality of service delivery. A workforce that is under-resourced or given limited professional support will struggle to respond adequately to the needs of vulnerable children.

CONFRONTING CHALLENGES

Working in human services and statutory roles in regional areas presents distinct and confronting challenges, which increase the demands on child protection practitioners. Practitioners may undertake multiple roles in their community that straddle their professional and personal lives. In small communities in particular there is potential for their two lives to collide. Regional practitioners have to guard against undermining confidentiality¹⁶, and must manage potentially volatile relationships between children, birth families and carers, whose paths are more likely to cross in small communities.

Practitioners in regional communities may also be highly visible and lack anonymity. Their practices may be subject to greater scrutiny from other professionals and the community generally.¹⁷ It may be difficult for them to ever be fully off-duty. There may be an expectation that they will fill service gaps, particularly where there is limited assistance available through other services.¹⁸

The demands of covering large geographical areas mean that regional practitioners are able to manage fewer cases than their metropolitan colleagues. Travel commitments may not only limit the time available to properly manage cases, but also lead to fatigue.¹⁹

Organisations should recognise the demands on regional practitioners as they try to work within organisational, ethical and legislative parameters.²⁰

ATTRACTING AND RETAINING STAFF TO IMPROVE SERVICE DELIVERY

High vacancy levels in regional offices and the difficulties of recruiting practitioners to these locations were consistent themes in evidence to the Commission.²¹ The proportion of vacant positions left managers struggling to stretch resources to meet the needs of children across their service areas, let alone develop initiatives to improve service delivery.²²

In 2014/15, one regional office received more than 500 intakes, of which more than 80 per cent had a Tier 1 or Tier 2 response priority.²³ Apart from the supervisors in the office and one senior practitioner (who are generally not expected to carry caseloads), only one

social worker was considered sufficiently experienced to be the primary investigator on intakes. Further, the lack of experienced social workers to work with newer practitioners in this office was an obstacle to the development of their knowledge and skills. The Commission was also told of the 'risk' at one time in this office when it had about six new social workers, but lacked the ability to train them.²⁴

Training usually necessitates travel to Adelaide. This can be a significant expenditure for regional offices. Staff in regional offices told the Commission that insufficient funds were allocated to training, and they expressed frustration that the Agency's Learning and Practice Development Unit rarely travelled to regional areas to deliver training. Professional development and quality of practice should not be compromised because staff work in a regional area. In most circumstances, it would be an efficient use of resources to deliver training locally. The Agency should also make better use of videoconferencing facilities to improve access to training, and support regional staff to engage in external professional development opportunities comparable to those offered to staff in the metropolitan area.²⁵

Workforce sustainability is a key concern. Organisations often overlook the potential of staff attraction and retention initiatives to improve service deficiencies in regional areas.²⁶ To build a sustainable regional workforce, the Agency's attraction and retention strategies could consider employee incentives, such as regional retention allowances. Non-monetary initiatives, including developing better support networks for staff, could also be considered.²⁷

For some practitioners working in a regional area can lead to disconnection and isolation. Professional and personal support networks may be limited or even non-existent. The greater pressures on regional practitioners make it incumbent on employers to ensure that staff are surrounded by robust professional support structures, in particular that they are provided with supportive supervision, that goes beyond simply matters of professional competence.

In Mount Gambier and Whyalla, students can undertake a degree in social work through local campuses of the University of South Australia. Developing positive relationships with the tertiary education sector locally and providing input into the training of students may lead to attracting graduates to the child protection workforce who already have ties to the region.²⁸ The Agency should encourage its regional staff to engage with the universities and promote careers in child protection at a local level.²⁹ Workloads should be managed to allow staff to take these opportunities.

THE EFFECT OF DISTANCE ON SERVICE DELIVERY

Service delivery to children in care is compromised by distance. A child's care team may be geographically dispersed, and have less interaction with the child and each other. The distances caseworkers have to travel to visit children in their placements can lead to fewer visits, fewer opportunities for engagement and relationship building, and irregular oversight and monitoring of placements. Because of travelling time, caseworkers may find it difficult to attend appointments with children, or participate in meetings when children need someone to advocate on their behalf.

Distance can similarly be a challenge for non-government organisations that support foster parents or provide in-home intervention services to families. The Commission was told about non-government workers having to undertake a six-hour round trip to work with a family participating in the Stronger Families Safer Children program. Because of the distance, the workers were able to engage with the family only once a week, for a couple of hours.³⁰

In Chapter 5, the Commission proposes a pilot program for remote access to C3MS in country regions. More innovative use of technology should help to create efficiencies for regional practitioners, and assist in managing their caseloads.

OUT-OF-HOME CARE

Finding appropriate home-based placements for children in care is a significant challenge for the child protection system across the state. However, the issue is even more dire in regional areas.

Families SA regional staff told the Commission that at times they would plan removals of children with 'no idea where they will be cared for'.³¹ When trying to arrange a placement for a child through the Agency's Placement Services Unit, it is common for staff in regional areas to be told there are 'no placements at all'.³² Decision making on the safety of a child should not be based on the availability of an alternative placement. However, with few other options, regional staff can be left asking themselves, 'Are they better where they are than where we're going to put them?'³³

In 2014, the Guardian for Children and Young People (GCYP) reported on the experiences of children in care in regional areas: 'one child from Ceduna placed in Murray Bridge, one family of six children in five different placements in a 100 km radius, and several moved to Adelaide for emergency placement'.³⁴ The evidence before the Commission suggests that these problems persist. Children will be taken from the region in which they have been living and placed in a community that is hours away.³⁵ The local Families SA office has little

control over the location of the placement. If a placement cannot be secured in a *relatively* nearby region, children are placed in Adelaide.³⁶ Some regions have more difficulty finding local placements than others. In some cases it proves impossible.

For the child, being placed in another region can add to the stress of out-of-home care. Relationships in the local community that could have provided much-needed support may be lost, along with the reassurance of familiar surroundings. It can also affect continuity of education.³⁷

'Are children better where they are than where we're going to put them?'

The lack of placements in one region can affect service delivery in other regions. The Mount Barker office covers a vast area across the Adelaide Hills, Fleurieu Peninsula and Kangaroo Island that has proved a fertile recruiting ground for foster parents. Children from the metropolitan area have been placed in this region, as have children from regions further afield, such as Ceduna, Coober Pedy, Mount Gambier, Port Augusta and the Riverland. The movement of children into particular regions can result in some offices trying to case manage the care of more children than their resourcing allows for.³⁸

There are also inconsistent practices as to whether a child will change caseworkers when they move regions. As discussed in Chapter 10, this decision requires flexibility and should be made in the best interests of the child. Finding safe and stable home-based placements for children is of critical importance. However, the Agency must be able to support a child if they are transferred to a different region. The Agency should consider whether the staffing complement and team structures in offices such as Mount Barker that are affected by the movement of children into their region are appropriate to meet the needs of all children in care.

FACILITATING CONTACT

Placing children at a distance from their caseworkers and birth families can lead to logistical difficulties in facilitating contact, including with siblings, and reunification efforts. It can also have a detrimental effect on children in care. Some children are being driven for hours more than once a week to have contact with birth parents and siblings. When arrangements are made to facilitate contact outside school hours, children can be required to travel long distances in the evenings. These difficulties can compromise placement decisions being made in the best interests of the child. For example, a less stable, rotational care placement near to a child's parents may be chosen over a home-based placement that is further away.³⁹

Sometimes reunification is attempted with a child who is residing some distance from their birth parents. Often Families SA staff will transport the child to the parents' location, which may require staff to work on weekends. The Commission was told of occasions when a regional office had put a lot of time and effort into contact but was not able to approve overtime for travel, even though staff spent 'copious amounts' of time on the road.⁴⁰ The Commission also heard of frustration due to simple issues such as staff not having a suitable vehicle in which to transport children.⁴¹ The resources required to facilitate such contact have the potential to sway decision making. The Commission was told:

*there's a fine line ... do you do it too quickly simply because it takes up so much resources, are you reunifying too quickly, but that's an assessment and a judgment you make at the time.*⁴²

In most circumstances, requiring children to travel long distances for contact will not be in their best interests. Placement, and other case management decisions, should not be influenced by a parent's convenience. Normally parents should undertake the travel to have contact with their children. This should be less disruptive for the child and should relieve some of the pressure on the resources of regional offices.

ROTATIONAL CARE

In many regional areas, the limited number of foster care placements is compounded by there being no, or very few, residential care facilities.

Families SA operates two small residential care facilities in regional areas: one in Whyalla and one in Mount Gambier. Each has the capacity to care for three children. Non-government organisations operate another five facilities: in Ceduna, Murray Bridge, Port Augusta, Port Lincoln and Port Pirie. However, the care environment of some of the facilities has been questioned. A Families SA caseworker described one as 'the most depressing, awful, horrible place, and if I was placed there, I would run away ... the children deserve somewhere nice to live'.⁴³

Families SA also has contracts with non-government organisations to provide emergency care in regional areas. The use of this form of care in the Barossa, Light and Lower North region from 2011/12 to 2014/15 (see Figure 17.1) far outweighs its use in other regional areas, with children in these areas spending on average 9457 nights in emergency care each year. This is mostly due to the extensive use of holiday house accommodation in Gawler to house children from many areas of the state.⁴⁴ The numbers of emergency care nights in the region peaked at 11,060 nights in 2014/15, reversing a three-year downward trend. Similarly, Figure 17.2 shows that the use

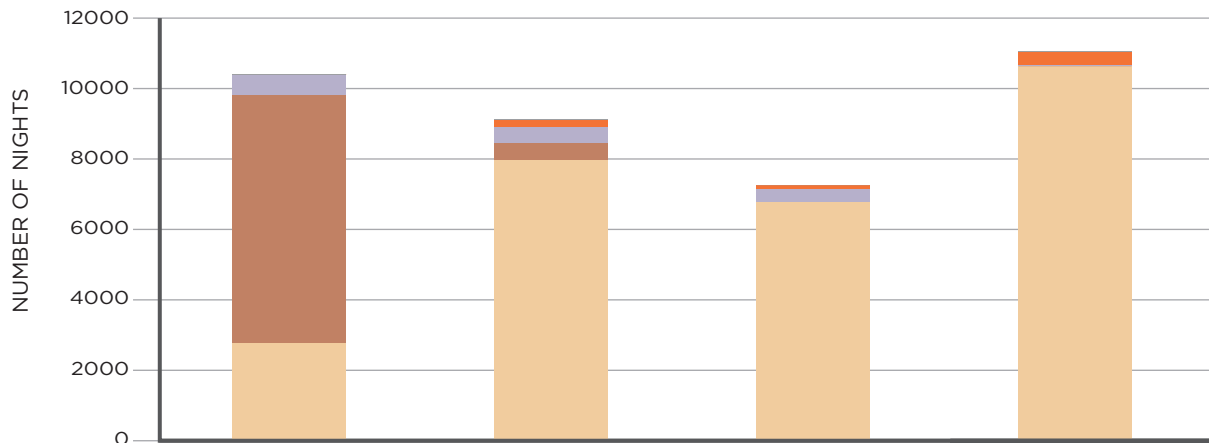
of emergency care was more prevalent in 2014/15 in all regional areas (except the Murray and Mallee) than it was in 2011/12.

Figure 17.2 also shows that some regions rely more on emergency care than others. A number of factors may contribute to this reliance, including more children requiring out-of-home care in a particular region, fewer options for home-based care, and children being moved into regions where emergency care is more readily available.

To accommodate children in emergency care, most regions make use of bed and breakfast style accommodation, apartments and holiday houses or units. In some regions caravan parks have been used. From 2011/12 to 2014/15, children in care in the Yorke and Mid North region spent 2119 emergency care nights of a total of 2138 nights (99 per cent) in caravan parks. In the same period, children in the Far North region spent 744 emergency care nights of a total of 1655 (45 per cent) in caravan parks. Caravan parks are also used to accommodate children in the Eyre and Western region and the Limestone Coast. This is a particularly undesirable form of accommodation for children in care, and demonstrates the need for the Agency to develop strategies to improve the out-of-home options in some regions.

The unpredictability and inappropriateness of the rotational care environment in the regions can be compounded by a paucity of supervision and the need to source carers from the metropolitan area. Such carers may work in the regional location only for a brief time before being replaced by another carer who covers shifts for an equally short period. The service provider supervises the carers from afar. Local Families SA staff try to organise the basic care needs of children, such as medical appointments or after-school activities, through a conduit in Adelaide. This requirement for layers of communication affects relationship building between members of the care team and fragments service delivery.⁴⁵ Direct engagement between local staff and service providers in the community should be encouraged, and not constrained by prescriptive contractual arrangements. These relationships should be collaborative, with practitioners and carers engaging in the best interests of children. They should not be seen as a mechanism for local Agency staff to supervise non-government staff.

17 CHILDREN IN REGIONAL AREAS



	2011/12	2012/13	2013/14	2014/15
MOTEL	0	1	0	3
HOLIDAY UNIT	0	196	107	375
BED AND BREAKFAST	577	453	365	44
APARTMENT	7026	481	4	0
HOLIDAY HOUSE	2796	7981	6780	10,638
TOTAL	10,399	9112	7256	11,060

Figure 17.1: Number of nights children in care have been accommodated in emergency care in the Barossa, Light and Lower North region, 2011/12 to 2014/15

Source: Data from Families SA.

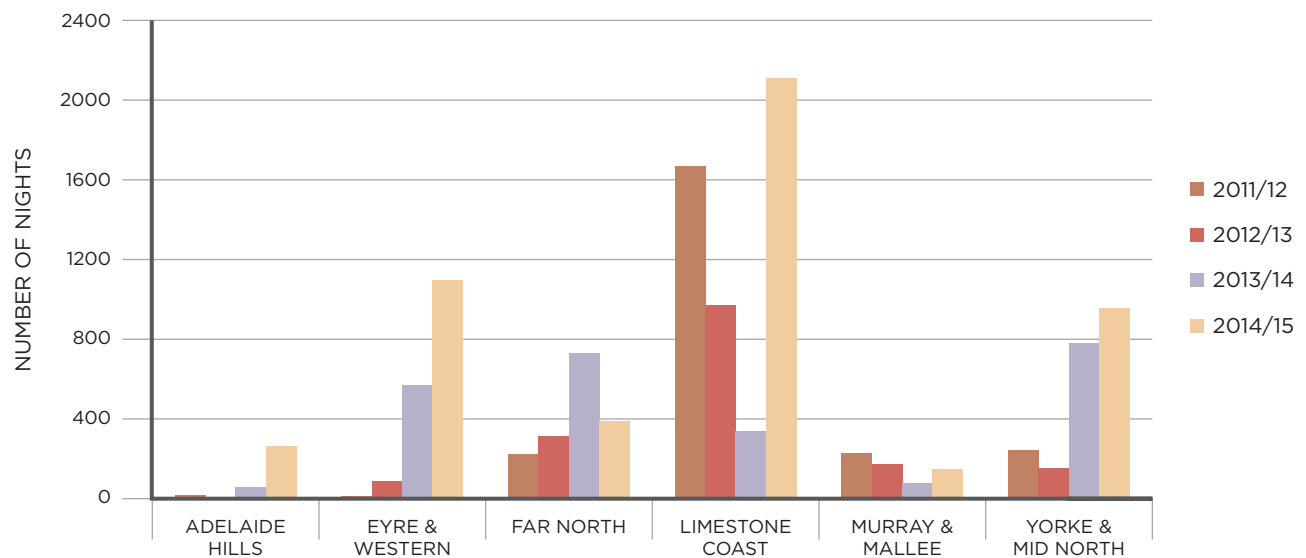


Figure 17.2: Number of nights children in care have been accommodated in emergency care by region, 2011/12 to 2014/15

Source: Data from Families SA.

IMPROVING THE AVAILABILITY OF OUT-OF-HOME CARE

Strategies to increase the number of foster care placements in South Australia are discussed in Chapter 11. This is a particular challenge in regional areas, where there is a narrower pool of potential carers. The Agency should identify the areas of greatest need and collaborate with local service providers to invest in targeted recruitment drives that are tailored to the characteristics of the region.

For some children, small residential facilities will be the most suitable type of care to meet their therapeutic needs. They may also be appropriate for accommodating larger sibling groups together in the same region. The Agency should identify regional areas where there is a particular demand for residential care placements and work towards developing facilities in those areas.

REGIONAL ACCESS TO SERVICES

Difficulty in accessing specialist services, and limited services, in regional areas hampers the ability of the child protection system to respond effectively to children.

THERAPEUTIC AND SUPPORT SERVICES

In some regional areas, risk factors in families, such as domestic violence and mental health issues, were said to be becoming prevalent.⁴⁶ Some regional areas were described as having a 'growing reputation around drug use', yet support services that could contribute to addressing this risk factor had very limited capacity and were not highly visible.⁴⁷

Specialist therapeutic services necessary to respond to children who have experienced abuse and neglect are also limited in most regions.

PSYCHOLOGICAL SERVICES

The lack of access to psychological services for children in care in regional areas was a consistent theme in the evidence before the Commission. Practitioners described long waiting lists, sometimes up to six or 12 months, for a child to engage in therapy. In regions where services are not available, children travel long distances for appointments. The Commission heard an example of an eight-year-old child in care who was self-harming and who would have had to travel about three hours one-way to receive psychological treatment.⁴⁸

The Commission also heard that insufficient resources to transport children were a barrier to children attending appointments for therapeutic services at the metropolitan-based Child Protection Services. In areas that have services based locally, concerns were raised about their quality: for example, some therapeutic mental health services were staffed by youth workers or social workers, rather than clinical psychologists. In regions where private psychological services were a suitable option, obtaining funding to cover the cost was contentious and obstacles were raised even when a foster parent was willing to cover the cost.⁴⁹

'I can do the reassurance, I can do the love, but I'm not a skilled therapist'

One foster parent in a regional area told the Commission that she alerted Families SA that her foster child's trauma-related behaviours were having a significant effect on his life, and were stopping him 'from growing in other ways'. The child was remembering earlier violence he had witnessed, and was having dreams associated with hurting his birth mother. Families SA suggested that a local government mental health service would be the 'best bet'. However, the service did not consider they had sufficiently qualified or experienced staff to provide therapy to particularly traumatised children in care. The foster parent waited for Families SA to respond, but nothing happened. She felt the Agency was not concerned with the child's emotional wellbeing. She said: 'I can do the reassurance, I can do the love, but I'm not a skilled therapist ... I don't think I should be the only person dealing with that'. Finally, the foster parent decided she had no choice but to act, and she contacted a metropolitan-based psychological service. She was willing to pay for the service and provide transport. Her actions caused disquiet in Families SA. The Agency told her she should not have done this without its permission.

Ensuring children in care have access to qualified and experienced psychological services is a critical element of the state's duty of care. The evidence suggests that Families SA's Psychological Services unit has a very limited presence in regional areas, particularly with respect to therapeutic work. Regional staff expressed a need for the Agency's psychologists to be more involved in regional areas, doing more one-on-one work with children and care teams.⁵⁰ The Commission has already noted that the Agency's Psychological Services unit needs a greater focus on therapeutic services. Further to this, the unit needs a greater presence in regional areas, including a dedicated team to deliver services.

OTHER SPECIALIST SERVICES

Access to other specialist health services is also limited in regional areas. For example, the Commission was told of a nine-year-old child in care with physical disabilities, including vision impairment. At the age of seven, due to service limitations, the child was no longer able to access support through a local community health service. There was no local private therapist. To continue therapy the child needed to travel to Adelaide regularly—about five hours return—either with her carers or Families SA staff.⁵¹

The Commission supports improvements to disability and health service provision in regional South Australia, but recognises that resources, including staffing, are barriers. There is the potential for the National Disability Insurance Scheme (discussed in Chapter 18) to expand service provision in South Australia through identifying areas where there is a chronic lack of services and assisting service providers to extend their geographical coverage.⁵² The scheme presents an opportunity for service delivery for children to be improved by attracting providers to regional areas or funding travel to metropolitan areas.

REGIONAL COURT SERVICES

The Commission understands that at present judicial officers of the Youth Court do not personally attend hearings in regional areas. If parties live outside metropolitan Adelaide, the court offers a telephone link to the nearest regional court. However, in recent years, the number of regional courts available for Youth Court matters has reduced but the Court permits landline telephone links to a 'state government office, or other appropriate facility'.⁵³

Telephone link facilities in one regional court were described to the Commission:

We sit around a telephone in a little room ... It cuts in and out, we can't hear all the time what's being said. Parents have no idea who the person is on the end of the phone ... the door on the room doesn't lock, so we have to put a bin against it to make sure it doesn't come open ... the vent between the two rooms for heating and cooling purposes is open and that means we can hear the discussions [next door] and they can hear us.⁵⁴

The Commission's inspection of available facilities in a regional court building confirmed their unsatisfactory nature. Gathered into a small crowded room were Families SA workers, parents, parents' lawyers or support people, and the child's lawyer.⁵⁵ Regional courts use videoconferencing facilities for some criminal proceedings, but not for child protection proceedings.⁵⁶

A sheriff's officer attends hearings in the Adelaide Youth Court to maintain security and organise the parties. Sheriff's officers also attend criminal hearings in regional courts. However, where parties attend a regional court for a telephone link in a child protection matter, a sheriff's officer attends only if notified in advance of a specific risk. If the parties are not well known, the risks posed by them would also be unknown. In the absence of court staff, the child's lawyer is left to organise the parties, including advising who can be present. In the course of the hearing, the child's lawyer is frequently left to explain the procedure and the effect of orders made. At times, this can lead to the lawyer feeling physically unsafe.⁵⁷

This is the standard of facility used at all stages before trial, including status and pre-trial conferences. Negotiating contentious matters is made more difficult because parties are not face to face (the lawyer representing the Agency is in Adelaide).⁵⁸

It would appear that children in regional areas have more barriers to accessing the justice system than those in Adelaide: 'They're being told they're unimportant'

In the past, trials were held at the nearest regional court if the parties resided outside metropolitan Adelaide. Recent practice is that all trials are held in Adelaide and parties must attend throughout. Commonly parents, their lawyers, the child's representative, the Families SA workers and other witnesses are all required to travel. The Legal Services Commission (LSC) pays travel and accommodation expenses for the child's representative, and for the parents' lawyers if they are funded by the LSC. Parents must pay for their own travel and accommodation. There is a concern that some parents consent to orders simply because they do not have the resources to travel.⁵⁹

Leaving aside the experience of parents, it would appear that children in regional areas have more barriers to accessing the justice system than children in Adelaide: 'They're being told they're unimportant'.⁶⁰

Child protection proceedings are important. In some cases they determine a child's care arrangements for many years. Even investigation and assessment proceedings can significantly alter a child's experience of childhood. It is unacceptable that child protection proceedings have less access to court facilities than many summary criminal matters.

Videoconferencing (as opposed to teleconferencing) facilities should be used to connect parties from regional court locations to the Adelaide Youth Court for all hearings of investigation and assessment proceedings and all pre-trial hearings of care and protection proceedings. All care and protection trials should be held at the court location most convenient to the parties. A sheriff's officer should attend all videoconferences at regional courts when a person other than a lawyer or a public servant will be present. It is not appropriate for the lawyer representing the child to be expected to organise parties and to maintain security in proceedings that involve allegations of child abuse or neglect and determine a child's care arrangements.

The Commission appreciates that some of these practices may have developed as a result of resource constraints. However, the Commission trusts that the appropriate court authorities will have regard to the issues discussed in this chapter and endeavour to improve current procedures.

RESPONDING TO THE NEEDS OF A REGION

Restricted access to services is a chronic problem in regional South Australia, for which there is no simple solution. As a start towards improving access, the state government should put in place strategies to better identify and respond to the needs of local communities, and target funding appropriately.

It is important to recognise that Agency staff in regional areas are likely to have more awareness of local needs than metropolitan-based staff, who may be responsible for allocating resources to services.⁶¹ For example, when contract arrangements with service providers are being renewed, the Agency's regional leaders could provide valuable local knowledge, including how service delivery could be improved.⁶²

Local planning, involving close collaboration with local staff and communities, supports the development of local solutions. There is a proposal in Chapter 8 for the establishment of child and family assessment and referral networks, including one each in the state's two largest regional areas (Mount Gambier and either Port Augusta or Whyalla). The networks would be expected to regularly map the needs of vulnerable families and children in their region, and formalise this in an annual Local Assessment of Needs (LAN). A mechanism should be established in the regional areas not serviced by an assessment and referral network for the preparation of a LAN. This could be achieved by engaging an appropriately qualified consultant to collaborate with local service providers to assess current needs, or through contracting with a local service provider who could work in partnership with other services to develop the LAN.

This process should support the development of different modes of service delivery, accounting for differing needs as well as differences of scale and infrastructure in each region.

THE BENEFITS OF LOCAL COLLABORATION

The Commission was encouraged to hear evidence that Families SA was developing strong collaborative practices with other service providers in some regional areas.

Effective links have been established between the Families SA office in Mount Gambier and the local Children's Centre (the role of Children's Centres is discussed in Chapter 8). The Children's Centre developed the Patchwork Program in collaboration with practitioners from Families SA and other stakeholders. It runs the program for parents who are working towards being reunified with their children, and helps participants to learn how to parent safely. The Commission was told that the program could give parents 'really powerful' insight, as they are encouraged to reflect on aspects of their behaviour and lifestyle choices that may affect their children, and create barriers to effective parenting.⁶³

While remaining child-focused, the Patchwork Program also is a source of support for parents and, where necessary, can give them a frank account of their progress. Parents are often more willing to engage with the program's facilitators and listen to their views on progress than they are with practitioners from the statutory agency.⁶⁴

The program has led to regular partnership meetings between local service providers, which in turn have led to collaboration on more initiatives for children at risk. For example, the establishment of a supported playgroup to run alongside the Patchwork Program, which gives parents an opportunity to put what they have learned into practice. The partnership meetings have assisted the Children's Centre to tailor its services to meet the needs of local children and families. The centre has been enthusiastic in its endeavours to work with Families SA and run programs that are going to be of most benefit to children who are coming into contact with the child protection system.⁶⁵

One Families SA practitioner concluded that the Agency would 'be lost without the Children's Centre' in Mount Gambier. Not only was the centre running programs for clients of Families SA, the Agency was able to use its child-focused facilities to meet with families. The practitioner highlighted the importance of this:

if parents have a real issue with our office, and I think about those parents that were under guardianship themselves who now have children in care, just our office is a source of trauma for them ... so we often use the Children's Centre as a place to meet with them.⁶⁶

In Whyalla, the Families SA office has a practical working relationship with the Gabmididi Manoo Children and Family Centre. The centre recognised that Families SA was working in crisis mode and could not prioritise building a collaborative relationship. The centre considered it had an important role to play in alleviating some of the pressures on Families SA by proactively engaging with families who were the subject of child protection notifications. To achieve this, the centre's family services coordinator worked directly with the Agency's local supervisors to identify potential clients. They focused on children in families they considered would benefit from early intervention through engaging with the centre's services. To support these collaborative practices, the family services coordinator worked in the local Families SA office one afternoon a week. While the importance of this relationship was recognised, there was concern that the centre did not have the capacity to keep up with the growing number of referrals from Families SA.⁶⁷

Collaborative practices such as those occurring in Mount Gambier and Whyalla can build capacity in local service providers, and be of significant benefit for at-risk children. They appear to be effective service models in regional areas. There would be merit in replicating them in other regions.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 217 **Develop strategies to improve out-of-home care options in regional areas including:**
 - a **focusing attention on the recruitment of foster parents, particularly in areas of need; and**
 - b **identifying areas where there is a demand for residential care placements and develop facilities in those areas.**
- 218 **Require the Agency to develop a dedicated psychological service to deliver therapeutic services to children in care in regional areas.**
- 219 **Collaborate with the Courts Administration Authority to improve access to justice for children in need of care in regional areas, including providing appropriate technology with respect to hearings in remote locations.**
- 220 **Prepare an annual Local Assessment of Needs for each regional area.**
- 221 **Ensure that the Agency's practitioners in regional areas have access to ongoing professional development, through locally delivered training and videoconferencing.**
- 222 **Require the Agency to develop attraction and retention strategies specific to building workforce sustainability in regional areas, including the use of financial incentives for staff.**

NOTES

- 1 L Roufeil & K Battye, *Effective regional, rural and remote family and relationship service delivery*, Australian Family Relationships Clearinghouse Briefing no. 10, Australian Institute of Family Studies (AIFS), Australian Government, 2008, p. 3; P Munn, 'Rural community context of service coordination', *Rural Society* 13, no. 2, 2003, pp. 49–50; Australian Institute of Health and Welfare (AIHW), *Rural, regional and remote health: A guide to remoteness classifications*, Rural Health Series no. 4, cat. no. PHE 53, AIHW, Canberra, March 2004, pp. 1–12.
- 2 J Baxter, M Gray & A Hayes, 'Families in regional, rural and remote Australia', Fact sheet, AIFS, 2011, p. 2.
- 3 Oral evidence: Name withheld (W73).
- 4 Oral evidence: Name withheld (W23).
- 5 Oral evidence: J Caputo.
- 6 Health Performance Council (HPC), *Mental health in rural and remote South Australian communities*, Government of South Australia, August 2013, p. 9.
- 7 *ibid.*
- 8 Thirty-five local government areas (LGAs) represent about half of all LGAs in South Australia. While there are fewer LGAs in metropolitan Adelaide than in regional areas, for equal representation of advantage there should be about nine metropolitan areas in the 35 most disadvantaged.
- 9 Australian Early Development Census (AEDC), 'FAQs for early childhood educators', website, www.aedc.gov.au/early-childhood/early-childhood-educator-faqs, accessed 6 July 2016.
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- 13 *ibid.*
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- 15 K McDougall & G Tan, *Dynamics of South Australia's population*, Australian Population & Migration Research Centre (APRMRC) Policy Brief 1, no. 9, September 2013; HPC, *Mental health in rural and remote South Australian communities*, p. 10.
- 16 P Jervis-Tracey et al., 'Managing tensions in statutory professional practice: Living and working in rural and remote communities', *Australian and International Journal of Rural Education* 22, no. 2, 2012, pp. 97–100; L Roufeil & K Battye, *Effective regional, rural and remote family and relationship service delivery*, p. 3; P Munn, 'Rural community context of service coordination', pp. 55–56.
- 17 P Munn, 'Rural community context of service coordination', p. 60.
- 18 L Roufeil & K Battye, *Effective regional, rural and remote family and relationship service delivery*, p. 3.
- 19 *ibid.*
- 20 P Jervis-Tracey et al., 'Managing tensions in statutory professional practice', pp. 97–100.
- 21 Oral evidence: J Caputo; name withheld (W23); name withheld (W73). Submission: Centacare Catholic Family Services, Country SA.
- 22 Oral evidence: Name withheld (W73).
- 23 Data from Families SA.
- 24 Oral evidence: Name withheld (W73).
- 25 Oral evidence: Name withheld (W23); name withheld (W58). Submission: Name withheld (S90).
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- 29 Oral evidence: Name withheld (W36).
- 30 Oral evidence: P Munn & E Ward.
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- 62 Submission: J Caputo.

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- 63** Oral evidence: Name withheld (W36); K Williams. Children's Centre for Early Childhood Development and Parenting, *Mount Gambier Children's Centre annual report 2015*, Department for Education and Child Development, Government of South Australia, 2015, p. 1.
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OVERVIEW

Children with disabilities are more vulnerable than their peers. They are at greater risk of harm and neglect. They are at greater risk of the child protection system not recognising, responding to and caring for them.

Disability may not be immediately apparent to the untrained eye. It may not be observably physical or intellectual. It may be developmental or related to a psychiatric condition. The child protection system must account for the fact that for some children their disability is a product of their care environment. In other words, disability may be the product of trauma, stemming from abuse or neglect.

Against that background, this chapter outlines how the child protection system could better protect children with disabilities and improve outcomes for such children who come into the care of the state. It identifies particular risk factors for these children, along with the acute challenges faced by parents who are trying to care for and protect them. Parents caring for a child with disabilities may need intensive and specialist support to reduce the risks to their child. The child protection system must acknowledge and react to this need.

When a child comes into care, a prompt and expert assessment should identify any disability and the extent of any impairment attributable to it. This assessment should provide the information to identify, source and deliver appropriate specialist support for the child.

The recent launch of the Australian Government's National Disability Insurance Scheme (NDIS) provides opportunities for the improved care of children with disabilities, whether that care is by their birth family, a disability service provider or, in the case of children in care, the relevant Minister. This chapter will consider whether opportunities associated with NDIS could be better exploited by South Australia's child protection system, particularly with respect to early intervention. It identifies potential gaps in service delivery created by NDIS, which need to be filled to ensure that children with disabilities are protected.

The observations made in this chapter are not intended to encompass all the challenges faced by children with disabilities or to identify all gaps in service provision. The Commission has simply tried to address the most current issues raised in evidence that come within its Terms of Reference.

The chapter principally relates to the Commission's Terms of Reference 5(a) to 5(d), 5(f) and 5(h), in the context of 1 to 4.

DEFINING DISABILITY

The United Nations Convention on the Rights of Persons with Disabilities recognises that 'disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'.¹ Attempting to define disability brings with it a tension between an objective, impairment-focused 'medical model' and a subjective consideration of barriers to the child's participation in their community created through unequal social relationships arising from negative perceptions of the child's functioning (the 'social model').²

While reflecting on disability from a social perspective is important, the practical question for this Commission is, What is the legal definition of 'disability' that provides the pathway for children with specialist needs to access services and to protect them from harm? That is, for the purpose of responding appropriately to children with disabilities, it is necessary for Families SA (the Agency) and other stakeholders to consider how they will align their services to existing legislation.

The legislative definition of disability is in a state of flux as a result of the staged implementation of NDIS. Children may gain access to NDIS by satisfying either the disability criteria in section 24 of the Commonwealth's *National Disability Insurance Scheme Act 2013* (the NDIS Act) or the early intervention criteria in section 25 of the Act. The eligibility criteria are discussed in this chapter. The state has a similar but less expansive definition in the *Disability Services Act 1993* (SA).³

This chapter considers those children whose impairments are likely to fit within either definition. Services for children with higher therapeutic needs or other impairments that do not meet a legislative definition are considered in Chapter 10.

GREATER RISK, GREATER VULNERABILITY

Whether children with disabilities are in the care of their parents, a disability service provider or under the guardianship of the Minister, they are at greater risk of harm and are more vulnerable than their peers.⁴ Children with physical, intellectual or sensory disabilities experience abuse and neglect at 'rates considerably higher than their peers who do not have disability'.⁵

There are many explanations for this heightened vulnerability. At the earliest stages of an infant's life, parent-infant attachment may be disrupted by a parent's adverse reaction to the birth of a child with a disability. Prolonged stress associated with caring for a child with a disability may lead to frustration which, in turn, increases

the risk of a parent resorting to physical abuse. Children's disabilities may hamper their ability to defend themselves from assault or, even more fundamentally, be aware that they are being abused. Disabilities that manifest in communication impairments may render a child unable to report incidents of maltreatment.⁶ Children coming into care in South Australia commonly have speech delays associated with developmental issues, rendering them more vulnerable because of their limited communication skills.⁷ Even in circumstances in which an injury is observed or reported, there can be difficulty in distinguishing between an accidental injury resulting from a child's impairments and injury inflicted as a result of abuse.⁸

More specifically, a range of factors contributes to children with disabilities being more vulnerable to sexual assault than other children. This includes living in out-of-home care, deficits in communication skills, physical limitations and an impaired understanding of sexuality. In particular, the risk of extra-familial sexual abuse is higher because of their greater exposure to persons outside their family for day-to-day support. Among children with disabilities who are sexually abused, the perpetrator is often someone responsible for 'the most intimate aspects of their daily care'.⁹

Because children with disabilities are more likely to experience abuse and neglect compared to their peers, they are at greater risk of entering the child protection system. As outlined in Chapter 3, abuse and neglect can affect a child's physical, psychological, emotional, behavioural and social development. Prolonged abuse and neglect can result in developmental delays and other disabilities.¹⁰ The child protection system must consistently identify and respond to not only children who have obvious physical or intellectual disabilities, but also children whose disabilities may be more subtle or masked by behavioural complexities.

The greater vulnerability of children with disabilities means that they must receive a higher standard of care than their peers. That higher standard is required from the children's parents, the professionals who support the children and their parents, the people who provide care environments, and the Minister when a child is in the care of the state.

STANDARD OF CARE

The standard of care required of parents who are caring for a child with high needs is inevitably higher than that required in caring for a child with lower care demands. What may be an adequate level of parenting for a child without a disability may amount to neglect of a child with a disability. The critical issue is whether the level of care provided meets the child's needs. Just as a child has greater support needs, so does their family. To prevent children with disabilities coming into care, the child protection system must have the capacity to identify and respond appropriately to families who are caring for children with high needs.¹¹

With appropriate support, parents who are struggling to care for a high-needs child may have the capacity and determination to provide an adequate level of care. Support can take many forms. It may be the provision of equipment or aids to improve the child's experiences. It may be therapeutic, working towards improving the child's functioning or capacity. It may be practical in-home support to assist the child to perform everyday tasks. It may be targeted at addressing challenging behaviours related to developmental disabilities. It may be focused on building a parent's capacity to respond to the needs of their child. It may be providing some respite care.¹²

Because of their high care needs, children with disabilities are also at greater risk of entering the system through being relinquished by their parents into the care of the Minister. Where a child has profound or severe disabilities, or complex and challenging behaviours associated with disabilities, parents may reach a point where they are unable or unwilling to continue to care for their child. If support is too little or too late, even the most determined and capable family may reach the end of their tether.¹³

Until now, the options for state-funded support for children with disabilities and their families have been limited. There was little evidence before the Commission of child protection services, disability services and other stakeholders working in partnership to foster robust early intervention services for such families. However, this is an opportune time 'to improve outcomes for children and families with disability by "breaking down the silos" between child protection and disability services'.¹⁴ NDIS brings with it opportunities to provide better early intervention support for children. Support available through NDIS can assist in building capacity in carers, rather than merely being directed towards improving the child's functioning. Ensuring that children have full access to NDIS has the potential to assist parents to meet the higher standard of care required of them.

THE NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

The structure of disability services in Australia is undergoing significant reform. Before the staged rollout of NDIS, state-funded disability services for children were largely provided by Child and Youth Services (CYS) in the Department for Communities and Social Inclusion (DCSI).¹⁵ The relationship between Families SA and CYS is reflected in a Protocol for Collaboration that covers assessment, planning and service provision for children living with their families, in out-of-home care and transitioning from care.¹⁶ The protocol applies to children aged up to 18 years who are case managed by Families SA and who receive state-funded disability services.¹⁷ Families SA is responsible for the case management of children with disabilities in care, including case planning intended to be based on a comprehensive analysis of individual needs.¹⁸ CYS is responsible for contributing specialist knowledge and expertise to case planning and review processes.¹⁹

HOW NDIS CHANGES SERVICE DELIVERY

The introduction of NDIS has required a restructure of state-funded disability services. The state government will now channel funding for disability services to the federal government, which will fund local registered service providers to deliver services to NDIS participants. A state government agency may be registered as a service provider. At the time of writing, disability service provision in South Australia had not been completely reformed due to the staged rollout of NDIS. Some funding had been transferred to the federal government, while some services were still being funded directly by the state.

The unforeseen number of children in South Australia with autism spectrum disorder and global development delay has slowed the rollout of NDIS. The full scheme is now expected to start on 1 July 2018.²⁰

PARTICIPATION IN THE SCHEME

The federal government's National Disability Insurance Agency (NDIA) has statutory responsibility for delivering NDIS.²¹ NDIS intends to provide sustainable funding and lifelong support to people with a permanent and significant disability.²² The scheme will fund 'reasonable and necessary supports', including early interventions such as therapeutic treatment, mobility or other equipment, home modifications and assistance to take part in activities.²³ A participant's plan will identify and outline the support to be funded.²⁴ It will be developed by NDIA planners in conjunction with participants and, if they choose, their family or carers. An individual funding package is provided in accordance with this plan to support the achievement of their short- and long-term goals. A participant can either manage this funding

package or receive help to manage it through NDIA or another case management service provider. A participant's plan can be reviewed over time.

NDIS is a significant opportunity to improve service delivery to children with disabilities who are at risk of entering the child protection system or who are already in care. Rather than disability services funding being held by a state government agency or another service provider or organisation, NDIS allocates funding to an individual child. The child and their carer can use this funding to decide what services and support will be sought.²⁵

NDIS has a significant focus on early intervention to reduce the cost of disability over a person's lifetime.²⁶ For a child participating in NDIS, funding can be allocated for 'early intervention supports that improve a child's functional capacity, or prevent deterioration of functioning'.²⁷ This support may include speech pathology, physiotherapy, audiology, occupational therapy, podiatry and behavioural services.²⁸

ELIGIBILITY

A child may be eligible to participate in NDIS either through the disability requirements or the early intervention requirements. According to section 24 of the NDIS Act, a child will meet the disability requirements if²⁹:

- the child has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and
- the impairment or impairments:
 - are, or are likely to be, permanent; and
 - result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, communication, social interaction, learning, mobility, self-care or self-management activities; and
 - affect the child's capacity for social and economic participation; and
- the child is likely to require support under NDIS for their lifetime.

A child may meet the early intervention eligibility criteria if they have a developmental delay or an identified impairment across their intellectual, cognitive, neurological, sensory or physical domains or one that is attributable to a psychiatric condition. The identified impairment must be permanent or likely to be permanent. It must be established that early intervention support would be likely to benefit the child. This includes improving, or preventing deterioration of, the child's functional capacity, reducing the level of support the child needs in the future or 'strengthening

the sustainability of informal supports available to [the child], including through building the capacity of [the child's] carer'.³⁰

Developmental delay is defined in the NDIS Act as:

[A] delay in the development of a child under 6 years of age that:

- (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments; and*
- (b) results in substantial reduction in functional capacity in one or more of the following areas of major life activity:*
 - (i) self-care;*
 - (ii) receptive and expressive language;*
 - (iii) cognitive development;*
 - (iv) motor development; and*
- (c) results in the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated.*³¹

It is important to note that a child will not meet the early intervention requirements if it is determined that the support would be more appropriately funded and provided through another service system. For example, this could be the education system adapting programs to meet the needs of a child with a disability, or the health system providing appointments with general practitioners, in-hospital care or pharmaceuticals.³²

NDIS early intervention eligibility requirements are, however, more expansive than those applied by the state. NDIS requires that developmental delay must affect one of the major activity domains. South Australia's eligibility criteria relating to global development delay requires significant delay in three or more domains.³³

EARLY INTERVENTION OPPORTUNITIES

Early intervention is a key to improving outcomes for children in families who need support and reducing pressure on the statutory child protection agency. Early intervention is also critical for parents who are caring for children with disabilities. Access to support services can 'make the difference between a child with a disability being able to remain at home or having to be placed in permanent care'.³⁴

Early intervention funding packages under NDIS can be considerably more generous than those previously provided by the state. Children are able to use their funding to access a 'trans-disciplinary package of services in the early intervention space'³⁵, incorporating a lead therapist and other practitioners such as

occupational therapists, speech pathologists and physiotherapists working in collaboration.³⁶ The funding amount may also be reviewed if service providers discover broader complexities not initially identified. Additional funding may be sought to support the coordination of agencies beyond the registered service provider in areas such as education, child protection and mental health. The packages under NDIS allow for a 'much more intensive level of therapy'.³⁷

Funded early intervention support services may include building the capacity of the parents.³⁸ However, the role of NDIS is not to assertively engage families who are struggling to care for a child who may be eligible for the scheme.³⁹ NDIS assumes that parents will be proactive about investigating eligibility and accessing services on behalf their children. Because this is not always the case, practitioners working across the child protection system, including child and family access and referral network staff (discussed in Chapter 8), should support families to investigate NDIS eligibility where appropriate. To do this, workers need to be aware of what is available and how to access it. Families SA could lead training and education about these opportunities.

Accessing early intervention supports for a child with high needs may contribute to better family functioning, better care for a child and the chance to prevent that child from entering the child protection system.

LINKING CHILDREN IN CARE TO NDIS

For children in care, the Minister bears the parental responsibility to request access to NDIS, develop plans and advocate for support services required by the child.⁴⁰ Where the child is in a home-based placement, the carer should also be part of the decision-making and advocacy process.⁴¹

Families SA caseworkers, on behalf of the Minister, are responsible for linking children with disabilities in care to NDIS. To coordinate this process, Families SA has developed a working arrangement with NDIA.⁴² It is intended that caseworkers will have access to specialist disability support staff in Families SA, to provide advice, consultation and assistance to link children with disabilities in care to NDIS.⁴³

Given the benefits that may flow from accessing NDIS, in particular through the more expansive definition under the early intervention requirements, it is imperative that caseworkers pay close attention to the age criteria attached to the definition of developmental delay. Children seeking access to funds on this path must be aged less than six years. Allowing children in care to drift beyond that limit will result in missed opportunities to access early intervention services.

As discussed in Chapter 3, abuse, neglect or trauma experiences may cause, or aggravate, attachment disorders. Children with attachment disorders may, in some circumstances, be able to access NDIS, particularly under the early intervention requirements. However, the diagnosis alone will be insufficient to establish eligibility. What is important is the effect of the disorder on the child's functioning. If a disorder contributes to a relevant impairment, for example, impaired communication skills resulting from developmental delay, services may be funded.⁴⁴

To access NDIS effectively, knowledge of disability support services is required, along with a high level of planning and advocacy on the part of the child's guardian.⁴⁵

CHILDREN WITH DISABILITIES IN CARE

It was not possible for the Commission to accurately identify how many of the 2838 children in care at 30 June 2015⁴⁶ had a disability. At 1 July 2015, approximately 40 children in care in South Australia were registered with NDIS.⁴⁷ It is not known how many more children in care may be eligible.

Families SA does not track children according to their eligibility for NDIS. The Agency's electronic case management system C3MS requires that children in care be identified if they have a 'disability or health condition'. No distinction is drawn in the applicable recording field between a child who has a health condition such as diabetes, which does not manifest as a disability, and a child with a profound intellectual disability. A child with a health condition may not have a disability, but this difference is not recognised in a systematic way in Families SA's data management.

In June 2015, 250 children in care were accessing, or had accessed, disability services through the state system. This included children who had already registered with NDIS, and had returned with their funding to receive disability services.

Using C3MS, Families SA identified a further 792 children in care as having a disability or health condition.⁴⁸ Families SA analysed this information against the access requirements for NDIS and found that of these children:

- 109 were likely to meet the access requirements for NDIS;
- 190 might be eligible to access NDIS, but would first require further assessment by Families SA;
- 177 did not have enough information recorded to determine whether they would meet NDIS requirements; and
- 316 did not appear to meet NDIS requirements based on the available information.

The Commission is therefore unable to identify how many children in care in South Australia have a disability that could make them eligible for NDIS. It is likely, however, that children with disabilities are over-represented in the South Australian out-of-home care system.⁴⁹ Rather than recording on C3MS the existence of a 'disability or health condition', caseworkers should specifically indicate whether the child potentially meets NDIS eligibility criteria. This requirement would remind workers to request and arrange assessments, applications and planning for what are likely to be beneficial services for children with disabilities in care. Consistent reporting against this measure would also enable Families SA to track trends and develop appropriate system-wide strategies to provide better care for this vulnerable group.

IDENTIFYING ELIGIBLE CHILDREN

Comprehensive health and psychosocial assessments (discussed in Chapter 10) at the point of the child's entry into care, particularly for those children who are suspected of having a disability, are critical to early detection. Early detection provides the best opportunity to ensure children in care will receive the support they need. This is especially important for children with less obvious conditions, including psychological impairments resulting from abuse or neglect, which may, if accurately identified and assessed, be properly described as a disability for NDIS purposes. As noted, the age criteria for early intervention requirements highlight the need for timely and comprehensive assessments when children enter care.

A comprehensive health assessment may not of itself diagnose a disability. However, in appropriate cases it will trigger specific assessments that lead to diagnoses and eligibility for NDIS services.

Caseworkers must ensure an application is made for every child who is potentially eligible to participate in NDIS. For children already in care, this should occur by 31 March 2017.

Caseworkers must become highly engaged in the process of comprehensive health assessments and other more specific assessments to fulfill their role in advocating for services on behalf of a child. In particular, engagement with medical practitioners will arm caseworkers with the required knowledge to negotiate with NDIA and NDIS service providers for the best outcomes for children.⁵⁰

Given the significance of the reform and the opportunities it brings for children, child protection practitioners should be trained in understanding and accessing NDIS. It is critical that those tasked with case managing children in care can navigate the scheme to obtain the best results. Caseworkers must be able to recognise disability and understand what support services should be put in place to improve children's experiences. If children with disabilities who come into

contact with the child protection system have access to the right support services, there is significant potential for NDIS to improve their outcomes.⁵¹

The consequences of a slow response

A young child was taken into care on a short-term order after her birth mother was unable to care for her safely. Before being taken into care, the child was diagnosed with hemiplegia (paralysis of one side of the body), the likely consequence of a stroke before birth. The child was walking with a limp, and early therapeutic intervention was required. When the child entered care, no assessment of the limp was arranged and nothing was done to provide the child with the necessary therapeutic intervention.

A comprehensive medical assessment was arranged about nine months later. By this time the child had developed significant spasticity of her calf and upper limb. This required extensive medical intervention, which could have been avoided had early physiotherapy and splinting been provided.

A closer attention to her disability would have enabled the child's medical condition to be given greater significance in the processes that accompanied her entry into care.

Consistent with international human rights obligations provided in the United Nations Convention on the Rights of the Child, children in care with disabilities must be afforded the right to enjoy a full and decent life. This includes having access to and receiving education, health care, rehabilitation services, preparation for employment and recreation opportunities to support them to achieve the fullest possible social integration and individual development. The state carries a significant burden of providing the best possible care for children with disabilities who are under the guardianship of the Minister.

Attentive case management and planning on the part of Families SA, as discussed in Chapter 10, will contribute to improving service delivery for children with disabilities in care. The Agency must also develop robust systems to ensure children in care who may be eligible for NDIS are identified. As a psychologist from the Women's and Children's Hospital told the Commission, 'If you don't even register with the NDIS then you're going to get nothing and that's my concern'.⁵²

NDIS EARLY INTERVENTION IN PRACTICE

'James' is a young boy who was so severely abused and neglected by his parents that his development was significantly delayed, leaving him with physical and developmental disabilities and in need of high-level care and support (see Volume 2, Case Study 1: James). After James was placed in foster care, he was referred to NDIS for early intervention support services. Accessing these is critical to his long-term development and quality of life. Families SA initiated the referral to NDIS, with necessary information provided by health practitioners who had been working closely with James.

James met the access requirements for early intervention under the NDIS Act on the basis that he required assistance with daily tasks, including communication, social interactions, mobility and skills development. The early intervention services concentrate on these areas, with the intention of reducing the level of support that James will require in later years.

James's initial NDIS package was for more than \$47,000. An NDIS plan was developed to set out how the package could be used effectively to meet James's goals and developmental needs. James's foster parents, his Families SA caseworker, his paediatric social worker (and NDIS lead planner), and an NDIS plan and support coordinator were involved in developing the plan. The involvement of key people in a child's care team is critical to ensuring that the plan reflects the goals and needs of the child, and that appropriate services and supports are identified.

The therapeutic services in James's plan included speech therapy, podiatry therapy, hydrotherapy, physiotherapy, play therapy and assistance to school staff. These services reflect his areas of developmental delay and aim to provide holistic care to improve his quality of life and wellbeing.

James's participation in NDIS is a leading example of the opportunities available through the scheme for children whose traumatic backgrounds have led to disability. It is imperative that children with disabilities who come to Families SA's attention are referred to NDIS at the earliest opportunity to ensure they experience the greatest possible benefit from early intervention.⁵³

SPECIFIC PROGRAMS FUNDED BY FAMILIES SA

It has been Families SA's practice to dedicate financial resources to providing specific support services and programs to assist children with disabilities who are in care and their carers. The Commission understands that in future the funding for these programs will be provided to the federal government for NDIA to administer service provision through registered providers.

ALTERNATIVE CARE THERAPEUTIC TEAM

Families SA currently funds CYS to provide the Alternative Care Therapeutic Team (ACTT) program. Funding for the 2015/16 financial year was \$281,548.⁵⁴ The ACTT program is available to children from birth to school leaving age who are under the guardianship of the Minister, placed in home-based care and registered with a disability agency (an eligibility criteria that predates, and is separate to, NDIS).⁵⁵

The challenges experienced by foster parents and relative carers in meeting the high needs of children with disabilities may be amplified by the development of trauma-related behavioural issues. The ACTT program is primarily delivered by three psychologists who are specialists in disability and trauma. They support and work with children and carers, often conducting home visits, to build capacity in carers and to enhance the safety and wellbeing of children in their placements. For example, given the close relationship between communication and behaviour, the psychologists may focus on establishing a form of communication between the child and the foster parent as a first step to address challenging behaviours. They may then go on to develop a behaviour plan that encompasses specific strategies.⁵⁶

ACTT works with 11 to 20 children a year, remaining involved with a family for about six months.

Families SA has nominated to transfer the ACTT funding to the federal government, which will fund registered NDIS service providers to provide comparable services in South Australia.⁵⁷ If the funding is transferred, Families SA expects that NDIS will meet the need and continue to fund the program for as many children as necessary. Children in care who are receiving support through ACTT must acknowledge this during their NDIS planning process.⁵⁸ The opportunity for ACTT funding to be bolstered through NDIS has the potential to expand the program to serve more children.

ACTT provides an important service to children with developmental delays associated with attachment disorders.⁵⁹ These disorders cause significant stress for carers struggling with children's complex and challenging behaviours.⁶⁰ The specificity of the program is significant, and must be retained.

While it is efficient for all services to be accessible through one scheme, Families SA must ensure the funding channelled to NDIA is not consumed by more generalised early intervention or therapeutic services. The specialist services provided by ACTT should be maintained and expanded, given their focus on supporting challenging care placements. When considered appropriate to meet the therapeutic needs of a child in care, Families SA caseworkers should ensure the child's NDIS plan includes services provided by ACTT.

HOME MODIFICATIONS PROGRAM

The Families SA Home Modifications Program funds modifications, extensions or renovations to the homes of people who care for children with disabilities. It is anticipated that funding for this program will also be transferred to NDIA. The program would then be delivered through registered service providers, with home modifications incorporated in the child's NDIS plan.⁶¹

For children who are eligible for NDIS, consolidation of service provision is beneficial. However, Families SA needs to acknowledge there may be children who are not eligible for NDIS, or who are not yet accessing NDIS, whose placements would be improved through home modifications. Funding outside NDIS must be retained to provide this service to these children.

ONGOING ISSUES POST-NDIS

While NDIS has the potential to assist children who are coming into contact with the child protection system and improve service delivery for many children with disabilities in care, the Commission's inquiries have revealed a number of issues that will persist despite NDIS. The scope of what can be funded through NDIS is restricted by legislation. The legislation requires that consideration be given to whether support services would be more appropriately funded or provided through another service system.⁶² For example, NDIS will not provide out-of-home care for children with disabilities who are under the guardianship of the Minister.⁶³ This leaves Families SA as the agency responsible for locating suitable placements for this group of children, who have high care needs.

FOSTER CARE

South Australia has limited specialist disability foster care placements available. For example, Uniting Communities' Homelink SA for Children program provides specialist foster care for children with disabilities who are aged from five to 17 years.⁶⁴ The target group includes children and young people with complex behaviours and special needs who have a high overall complexity rating on Families SA's complexity assessment tool (see Chapter 10). The program provides five long-term placements and 15 respite placements. Beyond core training, foster parents receive training specific to the needs of the child. All placements are supported by qualified disability coordinators.

Demand for the Homelink SA program is high, but the agency has difficulty in recruiting suitable carers. This led to the funding and size of the program being reduced in 2014. Uniting Communities informed the Commission:

*The amount of skill, knowledge and expertise required for this particular cohort of young people can make it difficult to attract foster carers. Experience has shown us that the amount of reimbursement can act as a barrier as the amount of stress and responsibility are not met fairly with the current monetary reimbursement. This is repeatedly said by potential foster carers as we are attempting to bring them into the program.*⁶⁵

As discussed in Chapter 11, other agencies, in particular Life Without Barriers and Key Assets, also provide a limited number of specialist foster care placements for children with high needs, as indicated by their overall rating on the Complexity Assessment Tool.

The information recorded for children in care who are assessed as eligible for NDIS should be carefully analysed to determine the extent of the need for specialist foster care placements. Further foster care placements should be provided consistent with that analysis.

It is also important to recognise that specialist foster parents may experience the same challenges as birth parents in meeting the everyday needs of a child with a disability. Intensive support services, including regular respite, must be provided to such foster parents to prevent placement breakdown. Placements must be closely monitored and comprehensively supported. The thorough and systematic employment of NDIS for children with disabilities in care could also increase the support services available to foster parents, which could have the benefits of preserving placements and potentially attracting more carers to this very difficult role.

VOLUNTARY OUT-OF-HOME CARE

The Children's Protection Act 1993 (SA) provides for the court to shift guardianship of a child to the Minister, or other suitable persons, when parents do not have the capacity, or are unwilling, to continue to safely care for the child. The court must be satisfied that there is genuinely no parent 'able, willing and available to provide adequate care and protection'.⁶⁶

There will also be circumstances where a parent does not want to abandon or relinquish their child, but support services have failed to alleviate the stresses associated with meeting the child's high care needs. In these cases, an alternative care option becomes necessary in the best interests of the child.

However, there is no legislative basis for the custody or care of children to be transferred to the Minister without the transfer of guardianship, and voluntary custody agreements between parents and the Minister are restricted in their operation to no more than six months.⁶⁷

For parents wanting out-of-home assistance to care for children with very high needs, there is another option: a voluntary out-of-home care (VOOHC) agreement. This option is made without any statutory power or court order and does not involve surrendering guardianship. Parents therefore retain decision-making power on behalf of their child. The service provider is arranged through DCSI and parents are required to make a financial contribution. The parents, in effect, share the care of their child with the service provider and DCSI.⁶⁸

The Commission heard evidence that the NDIS reforms may leave a service gap with respect to VOOHC. While NDIS may fund short-term, temporary out-of-home care for child participants, with some financial contributions from parents, state-funded services remain responsible for long-term or ongoing VOOHC arrangements. It has been suggested that the management of VOOHC is a child protection responsibility and therefore Families SA should provide such placements and care.⁶⁹ The question of who manages VOOHC is important. While the Commission does not have sufficient information to make firm recommendations in this regard, the following observations are relevant.

VOOHC is frequently a cry for help and a last resort for capable and willing parents to access much-needed services. Generally those wanting to access VOOHC are not abandoning their child. They are requesting assistance because they are unable to continue to provide around-the-clock care.⁷⁰ It is in the best interests of these children to remain connected to their parents, both legally and emotionally.

In July 2015 there were 37 children in VOOHC in South Australia.⁷¹ It would not be in the best interests of this group of children to be placed in the care of the Agency. The provision of specialised disability services is not its core business. To suggest otherwise has the potential to undermine the high standard of care that these children need and to divert the Agency's focus and resources from other critical roles it performs for children in care.

18 CHILDREN WITH DISABILITIES

Through access to NDIS, parents who would otherwise need VOOHC arrangements can be better supported. The child protection system, service providers and NDIA planners must ensure that services support capable and willing parents to care for their children, without the need to resort to VOOHC. Where there are genuine child protection concerns for a child with disabilities (including genuine circumstances of relinquishment or abandonment), the statutory agency must respond appropriately.

The Commission recognises that for a small number of children with very complex disabilities, VOOHC is an essential option. If NDIS will not fund VOOHC, the Commission considers that the service should remain the responsibility of disability services in South Australia.

Due to the involvement of federal government agencies, the tensions surrounding the ongoing funding and management of VOOHC cannot be resolved by this Commission. However, it is hoped the relevant federal and state government agencies will facilitate the continuation of VOOHC as a disability service for children with complex disabilities, whose parents are not able to meet their high needs at home.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 223 Ensure that every child in care, or who enters care, and who is potentially eligible, applies to participate in the National Disability Insurance Scheme (NDIS). For children already in care, this must occur by 31 March 2017.
- 224 Develop the function in C3MS to require caseworkers to input information when a child enters care, and for those children already in care, as to their potential eligibility for NDIS. This data should be extractable for analysis.
- 225 Determine and fund demand for specialist disability foster care placements in accordance with the available data about children in care who are eligible for NDIS.
- 226 Employ specialist disability workers to consult across the Agency in matters involving children with disabilities.
- 227 Train Agency caseworkers to recognise and respond to the needs of children with disabilities, particularly in accessing and maximising support services offered by NDIS.
- 228 Ensure Agency caseworkers, when participating in NDIS planning, prioritise the use of the Alternative Care Therapeutic Team program when appropriate to meet the therapeutic needs of a child in care.
- 229 Develop clear guidelines on the role of home-based carers in planning and decision making in NDIS for children in their care.
- 230 Require child and family assessment and referral network members to provide support for families who are caring for children with disabilities, to enable them to engage with NDIS.

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- 14 *ibid.*, p. 271.
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- 16 Government of South Australia, *Protocol for collaboration*, p.4.
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- 18 *ibid.*, p. 12.
- 19 *ibid.*
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19 CHILDREN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

OVERVIEW

The challenges associated with keeping children from culturally and linguistically diverse (CALD) backgrounds safe, and how the child protection system responds to their needs, were not strong themes in the evidence before the Commission. A small number of submissions highlighted the need for system reforms to capture the current and emerging dynamics of our population.¹ Beyond this, changes to improve service delivery and outcomes for children who have CALD backgrounds were seldom proposed.

It is, however, important to recognise the challenges for the system in being culturally responsive, with services delivered by staff who can competently employ culturally informed practices. This is particularly so given South Australia's growing multicultural population.

The Commission's inquiries revealed that the prevalence of childhood abuse and neglect in CALD communities is unknown. Tracking occasions on which CALD children come into contact with the child protection system in this state will be an essential step in building an evidence base for a culturally competent system.

In this chapter the Commission seeks to address, within its Terms of Reference, some aspects of the system that should be improved to better respond to the needs of children from CALD backgrounds. However, this discussion is not intended to examine all challenges faced by this group of children nor address all the areas of service provision that are deficient.

The chapter principally relates to the Commission's Terms of Reference 5(a) to 5(d), 5(f) and 5(h), in the context of Terms of Reference 1 to 4.

DEFINING CULTURAL AND LINGUISTIC DIVERSITY

There are difficulties associated with defining the term CALD and for the purposes of this report it is unnecessary to be categorical in the use of the term. In research and practice CALD is often used to 'distinguish the mainstream community from those in which English is not the main language and/or cultural norms and values differ'.² It may describe whole populations or communities, or subgroups within a population or community. Statistically it may be used to define a person who was born in a country where English is not the main language spoken, or a person who has one parent born in such a country.³

This chapter focuses on those children who have, or whose families have, migrated to Australia. Many Aboriginal and Torres Strait Islander children will also identify as having a CALD background. The needs of,

and system response to, Aboriginal and Torres Strait Islander children are examined in Chapter 16. At a macro level, it is likely there will be parallels between culturally appropriate and informed service delivery for both Aboriginal and CALD children and families.

The Commission focused its inquiries more on refugee arrivals than on children and families who have joined our community through planned migration. This is not to minimise the challenges associated with planned migration. However, the challenges of keeping refugee children safe will often be more acute. The Commission's observations could be applied more broadly to all CALD children and families.

The Commission has not given specific attention to unaccompanied humanitarian minors. However, some observations in this chapter may be relevant to how the system responds to the needs of this vulnerable group of young people.

A POPULATION GROWING IN DIVERSITY

The proportion of Australians who were born overseas is at its highest in more than 120 years. At 30 June 2015, 28.2 per cent of Australia's estimated resident population was born overseas. The percentage of residents who were born overseas has increased every year since 2000.⁴

In South Australia, 24 per cent of the population was born overseas, and 9 per cent of the overseas-born population is aged 0 to 19 years.⁵ Forty-one per cent of South Australia's population has at least one parent who was born overseas.⁶

Australian-born children whose family members are refugees or planned migrants also contribute to the population of CALD children. In the past 10 years, there have been about 127,000 permanent arrivals to South Australia. Over the past decade, children from about 170 countries have arrived in South Australia, with a large proportion from the United Kingdom. Across all ages, arrivals to South Australia from Southern Asia (including Afghanistan, Bangladesh, Bhutan, India, Nepal and Pakistan) increased significantly in the late 2000s and now cumulatively far outweigh arrivals from the United Kingdom. Almost three-quarters of all arrivals have been from Africa, Asia or the Middle East.⁷

Figure 19.1 shows arrivals to South Australia by migration stream. By far the greatest numbers of arrivals are skilled migrants. During the past 10 years, about 11 per cent of arrivals to South Australia (approximately 14,000) have arrived under the humanitarian migration stream, peaking at 1802 in 2011 and falling to less than 1000 in 2015.

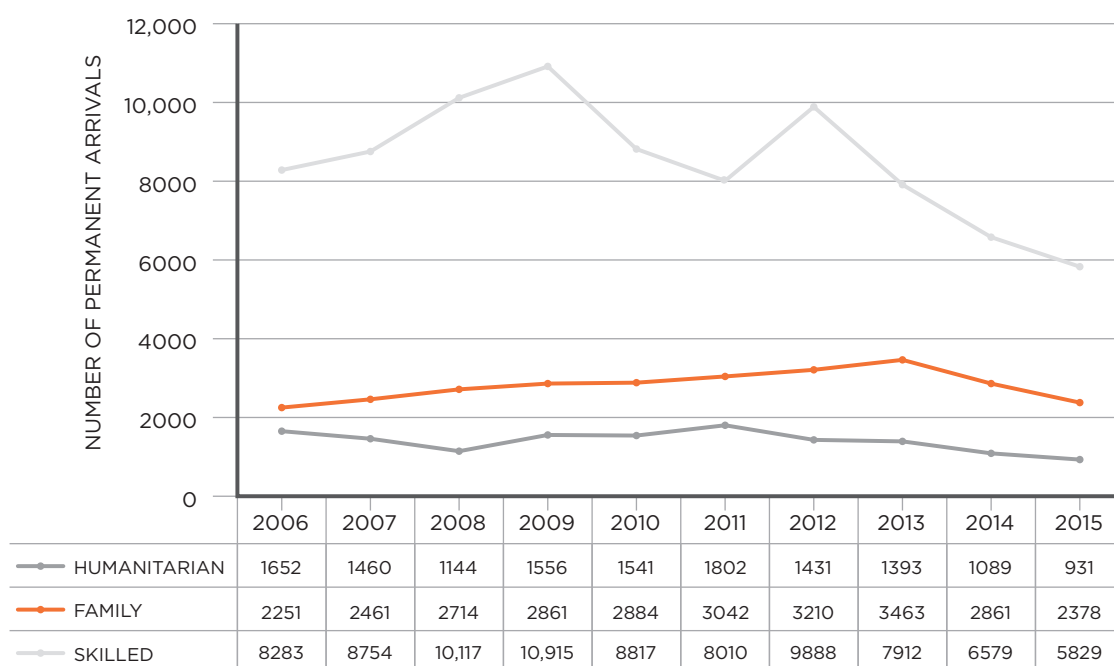


Figure 19.1: Permanent arrivals to South Australia by migration stream, 2006–15

Note: Excludes arrivals whose migration stream is 'Other/Unknown', of which there were less than 20.

Source: Data from *Settlement reporting*, Department of Immigration and Border Protection, Australian Government.

Almost 30 per cent (more than 4000) of the humanitarian arrivals first settled in the City of Salisbury local government area. About 20 per cent settled in the City of Port Adelaide Enfield and a further 14 per cent in the City of Playford.⁸ These local government areas are among the most socioeconomically disadvantaged in the metropolitan region.⁹ Statistical information such as this may be used to guide and focus service provision to improve outcomes for CALD children and families. It is also important for practitioners to be aware of a person's migration stream as this will be relevant to their eligibility for services.¹⁰

The child protection system needs to respond to the changing demographics of South Australia's population. As the cultural diversity of the population grows, so, too, must the system's cultural competency. Having an understanding of the representation of CALD children in the system is of fundamental importance, as is grasping how they interact with the system and how to deliver culturally sensitive services. These issues are as significant for CALD children as they are for Aboriginal children. Given the vulnerabilities of CALD children discussed below, a failure of the system to develop cultural competency has the potential to lead to their over-representation in the system.¹¹ This is clear when it is recognised that the population of children identifying with a CALD background is likely to be greater than the state's population of Aboriginal children.¹²

PRE-MIGRATION EXPERIENCES AND POST-MIGRATION CHALLENGES

The wellbeing and safety of CALD children can be compromised by risk factors common to many families who interact with the child protection system, including socioeconomic disadvantage, social isolation, domestic violence, substance abuse and mental illness. However, their families may face additional challenges and stress as a result of experiences both before and after migration.¹³ Challenges associated with adapting to life in Australia may include¹⁴:

- cultural dislocation or acculturative stress;
- social isolation stemming from limited familial, social and communal support and lack of awareness of, or reluctance to seek, formal support;
- discrimination and marginalisation;
- language deficiencies and communication barriers, limiting the capacity for social and economic integration; and
- financial difficulties and poverty, potentially associated with poor employment opportunities and other socioeconomic factors.

19 CHILDREN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

These challenges may exacerbate pre-migration experiences. For example, mental health problems associated with torture and trauma may intensify for people who do not have support networks of extended family and professionals.

Challenges and stress can exert considerable pressure on children and families, affect a parent's ability to respond to the needs of the child and encourage dysfunctional parenting patterns.¹⁵ The many challenges lead to the conclusion that CALD children should be recognised as a particularly vulnerable group in our community.

Further, post-migration inter-generational tensions can evolve and compromise the safety of CALD children. Children may more readily adapt and become accustomed to Australian culture than their parents, leading them to reject some traditional cultural values. They may see the Australian culture as less conservative and providing greater freedoms. They may break down communication barriers more readily than their parents. They may be caught between the pressures of familial acceptance and abiding by cultural norms, and a desire to be safe from harm when they see aspects of their birth culture as endangering their safety.¹⁶

CULTURAL VARIANCES IN PARENTING PRACTICES

Cultural variances in parenting styles can obscure the identification of abuse and neglect of CALD children. This can make it difficult for practitioners to assess and intervene in CALD families.

The Working with Refugee Families Project completed in 2009 (discussed below) found that the most common types of incidents that resulted in notifications of refugees to the South Australian child protection system were¹⁷:

- physical abuse, a number of which related to physical discipline by parents;
- neglect, primarily arising from children being left without adult supervision and primarily occurring in large, single-mother households; and
- exposure to domestic violence.

Fundamentally, the goals of parenting are consistent regardless of culture. However, culture may influence how a parent goes about achieving those goals. Parenting styles that were customary in a parent's birth country may not be endorsed or even legally acceptable in Australia.¹⁸

Patriarchal family structures may, for example, be the norm in a birth country, but lead to parenting practices that are inappropriate when measured against Australian standards. Authority may be demonstrated through

family violence. Discipline and punishment may be pursued through unacceptable levels of physical violence.¹⁹

In collectivist cultures communal parenting may be the norm, with birth mothers and fathers not being primarily responsible for care giving. Rather, this responsibility is shared across siblings, extended family members and unrelated community members. In circumstances where a community is not available to share responsibility for child rearing, less attentive parenting practices may be a cause for concern. Siblings who are themselves young children may be expected to take on some care-giving responsibilities and children may be left without adult supervision. Practitioners in Australia may view this as supervisory neglect.²⁰

While culture is not an excuse for inappropriate behaviour or the abuse or neglect of children, practitioners must recognise that cultural norms can strongly influence parents' determination as to what is in the best interests of their children.²¹ Practitioners need to be mindful of misinterpreting diverse child-rearing practices, and making uninformed assumptions about their appropriateness or otherwise.²² There is a danger that practitioners, or other responsible adults, will fail to recognise abusive or neglectful parenting practices if cultural norms are given too much weight.²³

Competent and confident practitioners should be supported by assessment frameworks that are sufficiently culturally sensitive to guide them away from misinterpretation and towards evidence-based determinations.

A CULTURALLY COMPETENT SYSTEM

Child protection practitioners must provide CALD children with the same level of safety as other children in the community. Those practitioners who lack an understanding of working with persons from CALD backgrounds may be ill-equipped to look beyond common, readily identifiable risk factors for those that are related to culture or migration. It is important that practitioners take a holistic approach to service delivery for CALD children. Risk factors must not be viewed in isolation.²⁴ Whether a child can remain safely at home or should be cared for by a culturally appropriate alternative caregiver can only be determined by a thorough assessment of the child's needs and the parent's capacity, in the context of their cultural background.²⁵

Further, practitioners need to understand that culture will not be static or tangible. It is 'fluid, flexible and dynamic'.²⁶ Practitioners must be capable of being equally flexible in how they respond to CALD children and their families.

Identifying and responding to the abuse or neglect of CALD children is beset with complexities. A culturally competent workforce would provide a sound foundation for contending with these complexities. Cultural competence requires an awareness of cultural diversity and knowledge of how cultural norms may be relevant to parenting practices and the safety of children. It also requires practitioners to have the skills to confidently apply this awareness and knowledge to practice.²⁷

A culturally competent system is one that:

*acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaption of services to meet culturally unique needs.*²⁸

Building a culturally competent system requires commitment from both individual practitioners and organisation leaders, who can influence approaches to practice and create learning and development opportunities. It requires an acknowledgment that:

*becoming culturally competent is a development process for the individual and for the system. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all.*²⁹

THE PREVALENCE OF ABUSE AND NEGLECT REMAINS UNKNOWN

In 2003 the Layton Review reported that children from CALD backgrounds are generally considered under-represented in some areas of the child protection system. The review suggested that, on one view, this was a result of CALD children being invisible to the system for reasons including³⁰:

- CALD families may be fearful of using services, in particular those offered by the government, or their awareness of services may be limited.
- Service providers may not readily identify safety or wellbeing concerns for CALD children.
- People may be reluctant to report concerns because of uncertainty about how the system will respond or the effect reporting may have on relationships across the wider CALD community.

CALD children may be as invisible now as they were in 2003. The lack of prominence given to this vulnerable group of children in submissions to the Commission is telling. Although the evidence to the Commission

highlighted some CALD-specific services that appear at face value to be purposeful and meaningful, in the main it seems the child protection system is still in the embryonic stages of structuring itself to respond to the protective needs of CALD children.

Empirical research examining the involvement of CALD children and families in child protection systems in Australia is minimal and that which does exist has had difficulty in gathering evidence. For example, a review of 120 child protection case files across six cultural groups (including Indigenous and Anglo-Saxon) in New South Wales noted:

*The findings reported in this study are sparse because the quality of linguistic and culturally relevant data recorded in the case files is not particularly rich or routine. As such there is little empirical evidence that can be ascertained to support the effectiveness or ineffectiveness of any practices or strategies that caseworkers use with their CALD groups.*³¹

Similarly, the Working with Refugee Families Project reported 'difficulties encountered in obtaining relevant case files for the study due to the current practices used by Families SA to identify and record the cultural background of the children who come into contact with the system'. Cultural background was not always recorded and, when it was, the data collection categories limited the practitioner's ability to accurately identify certain cultural groups.³²

While more research is emerging and knowledge is growing about the needs of CALD children and their families, gaps remain.³³

UNRELIABLE DATA

The prevalence of childhood abuse and neglect in CALD communities in South Australia is unknown. C3MS, Families SA's electronic case management system, does include a CALD field for practitioners to complete at intake. However, it is not mandatory and even if a practitioner does complete it, they are not required to record any further information about the culture with which the child identifies, such as the child's or parent's birth country or the language spoken in the home.³⁴

The Commission considered summoning data from Families SA (the Agency) relating to children from CALD backgrounds, in particular the number of notifications and the proportion that were screened in, investigated and substantiated. Families SA informed the Commission that this data was unreliable because it has a very low completion rate. The Commission therefore acceded to the Agency's request not to summons the data.

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The Commission was told that only 0.47 per cent of intakes record whether or not the child is from a CALD background. Families SA was unable to say whether the relevant field on C3MS was incomplete because the child did not have a CALD background, the practitioner had not sought the information or the notifier had not provided it.³⁵

The Commission was told that while the Life Domains area of C3MS includes the ability to record detailed information relating to CALD backgrounds (for example, the language spoken at home, whether an interpreter is required, immigration status and date of arrival in Australia), completing this information is not mandatory. Hence the field is not often populated.³⁶

The Commission also saw examples of contracted service providers reporting to Families SA that their CALD data was unreliable due to data collection issues. Some difficulties capturing statistics relating to CALD referrals were attributed to Families SA practitioners not providing this information as part of the initial referral.³⁷

Because of limitations in the available data and evidence, the Commission is unable to draw any conclusions as to the numbers of, and circumstances surrounding, CALD children coming into contact with the system.

ESTABLISHING AN EVIDENCE BASE

In August 2012 the Second Action Plan of the National Framework for Protecting Australia's Children 2009-2020 was endorsed by the federal, state and territory governments. The plan recognised the need for culturally sensitive strategies and practices, highlighting that a 'one size fits all' approach was insufficient to cater to Australia's diverse communities. It drew attention to the need for an improved and specific evidence base about particular groups of children, including CALD children. It said that collecting child protection data, including on CALD status where possible, was a priority.³⁸

The Third Action Plan, launched in December 2015, again highlighted the 'need to understand the prevalence of abuse and neglect concerning ... families from Culturally and Linguistically Diverse (CALD) backgrounds and new and emerging communities'.³⁹

Despite the issue being on the national agenda for a number of years, and the shortcomings of the state's data collection and recording practices being clearly identified in the Working with Refugee Families Project in 2009, Families SA has not taken steps to address these deficiencies.⁴⁰

At a national level, abuse and neglect data is also not yet disaggregated for children from CALD backgrounds.⁴¹

As a starting point in South Australia, and in line with the national framework's plans, Families SA should purposefully track when CALD children come into contact with the child protection system. Other service providers should support and contribute to this. Reliable data collection is critical to understanding trends and patterns in the interactions of CALD children with the system, in order to better plan and target responses as well as provide a foundation for empirical research.

THE RESPONSE OF FAMILIES SA TO THE WORKING WITH REFUGEE FAMILIES PROJECT

The Working with Refugee Families Project was the first study of its kind in Australia. It was funded by the Department for Families and Communities and completed by the Australian Centre for Child Protection at the University of South Australia in 2009. The project, in part, was designed to identify culturally appropriate strategies and models for intervention with recently arrived families from refugee backgrounds who were at risk of involvement in the child protection system.⁴² The principal finding of the project was 'the critical significance of culturally competent child protection practice when working with refugee families':

*This includes the development of a child protection workforce that is well prepared and confident in addressing the needs of refugee families who come into contact with the child protection system. Equally important, culturally competent child protection practice requires establishing and maintaining high quality relationships with refugee communities based on two-way communication and collaboration.*⁴³

The project made a number of suggestions to build on existing practices and initiatives, including:

- providing information to people from refugee backgrounds about Australian child protection laws and parenting practices;
- developing links with refugee communities, particularly community leaders;
- employing specialist staff within and external to Families SA to act as a liaison between workers and families;
- providing staff with ongoing education, training and information about the diverse refugee communities; and
- enhancing the child protection knowledge of interpreters and translators.

In May 2014, Families SA established the Multicultural Community Engagement Team (MCET). Before this, a Community Development Team linked with Families SA's services for unaccompanied humanitarian minors had undertaken some of the activities now within the mandate of MCET. The information and recommendations from the project informed the service delivery of the Community Development Team.⁴⁴

MCET provides a statewide, community development service to families from CALD backgrounds. The team promotes parenting programs that focus on child protection, child development, strategies for managing children's behaviour and nurturing children's potential. MCET also conducts information sessions on child protection laws and parenting to newly arrived migrants, in conjunction with Families SA's Commonwealth Guardianship Team (a team providing alternative care support services to unaccompanied humanitarian minors).⁴⁵

In 2015 the mandate of MCET expanded to include its staff working together with practitioners in local offices on child protection cases and the case management of children under long-term care and protection orders. MCET provides an early intervention and educational response to some Tier 2 and Tier 3 notifications where it is identified that a culturally appropriate community response would enhance child safety outcomes. MCET also assists with liaison between Families SA staff and CALD communities, particularly through links forged with community elders and leaders.⁴⁶

The Commission was told that MCET staff have led the development of cultural awareness among Families SA staff across the state.⁴⁷

Given the scope of MCET's role in Families SA, the Commission was surprised to learn that the team consists of only three positions: a supervisor employed in the administrative services stream and two social workers.⁴⁸ The mandate of MCET suggests that the Agency understands the need to encourage culturally competent practice. However, it is questionable whether three staff members would have the capacity to adequately provide a statewide service, including working with the Agency's Learning and Practice Development Unit to provide cultural competence training to staff.

The evidence before the Commission does not allow any firm conclusions on whether Families SA's response to the principal findings of the Working with Refugee Families Project has been sufficient and effective. The response seems to be primarily contingent on the ability of MCET to properly engage with staff and CALD communities, whether it be in relation to specific cases or in a more general educative or liaison role.

The capacity of MCET should be reviewed. Because it would take time to gather sufficient empirical evidence to inform the resourcing of the team, in the first instance this review would need to be qualitative, with information sought from front-line staff, other stakeholders, members of CALD communities and the team itself. It would be important to learn whether the practice of those front-line staff working in communities with denser CALD populations is sufficiently culturally informed, or whether Families SA needs to do more to build a culturally competent workforce. The Agency should regularly review the cultural competency of its workforce, identify the areas of greatest need in terms of at-risk children in CALD communities, and deploy resources accordingly. Consideration may be given to collocating MCET staff in offices in these areas.

More specifically, there may be merit in specialist CALD staff working cases together with practitioners in local offices. However, the effectiveness of this approach would need to be evaluated. It would be important to know, particularly from children from CALD backgrounds who are in care, their views on how Families SA and the broader system have responded to their cultural needs. The Commission heard no evidence to indicate that this question was routinely asked of children or, if they were asked, whether it was with the genuine intention to inform and devise a culturally appropriate continuum of care.

CALD CHILDREN IN CARE

Culture is integral to the formation of a child's identity. Supporting a child's cultural heritage and expression, and strengthening cultural identity, should be guiding principles of good practice in the out-of-home care sector.⁴⁹

NO IN-DEPTH GUIDANCE

Families SA's Consents and Decisions Practice Guide for children in home-based care often refers to the need for culturally appropriate decision making, but provides little guidance on how this is to be achieved in practice. It is unclear what expectation is placed on a caseworker with respect to cultural planning and maintenance.⁵⁰

19 CHILDREN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Similarly, Families SA's Residential Care Service Principles refer to a commitment to:

*working with children and young people within the unique context of their cultural and spiritual background and identity. We respect, value and celebrate cultural, religious and linguistic diversity and respond to individual needs with this in mind ... We welcome the opportunity to work with children and young people from new and emerging communities in South Australia and we do all that we can to support them in maintaining their cultural and religious traditions and practices in our care.*⁵¹

The Residential Care Practice Guides, which support the principles, acknowledge the importance of children in care being culturally strong and the need to respect and nurture a child's cultural identity. No meaningful or in-depth guidance is provided on how this might be achieved in practice.⁵²

The practice guides relevant to case planning and caring for CALD children need to be reviewed to better guide staff and carers about how culturally informed practice is best achieved.

CULTURAL MAINTENANCE PLANS

The Commission heard evidence about a number of children in care who identified with CALD backgrounds, yet did not have any plans in place to maintain their cultural identity. The Commission was told Families SA did not show any interest in their culture. One foster parent explained that fortunately she was able to promote a cultural connection for her foster daughter through an opportune personal circumstance. It appears the foster child 'landed in a perfect place' as a result of good fortune, rather than any purposeful cultural assessment or planning.⁵³

It is the responsibility of Families SA to do more than pay lip-service to the cultural maintenance of CALD children in care. Cultural planning should not be left to languish as an afterthought in a care system that is culturally blind or, worse, culturally destructive.⁵⁴ It should be an integral part of the case management of all children who identify with a CALD background. To do otherwise would jeopardise the child's future belonging and connection to culture and confuse their sense of self.

A preliminary step for practitioners in laying the groundwork for cultural planning would be to gather background information and record it in the Life Domains area of C3MS, as a requirement for all CALD children in care. Such information would form the basis for scoping a culturally matched placement for a CALD child who could no longer be safely cared for at home. Further, this data collection would assist Families SA to understand the representation of CALD children in care.⁵⁵

No support to connect a child with his cultural heritage

Taj's birth mother identified with a diverse culture. His foster parent recognised the importance of Taj's cultural heritage, but found it challenging to support Taj to navigate his traditional cultural background as a child in care in Australia. There was a discord between Taj not wanting to be different to other children—for a nine-year-old child this meant 'being as white as possible'—and the foster parent who saw her role as 'helping ... him to be brave enough to identify [with his culture]'. The foster parent took subtle steps through Taj's schooling and sporting activities to encourage connectedness to his culture. Families SA told the foster parent she had to help Taj understand his cultural background, but did not support or assist her to do so and did not provide Taj with a cultural maintenance plan or program.¹

¹ Oral evidence: Name withheld (W112).

This information would also provide the foundation from which a caseworker could develop an understanding of cultural practices and beliefs, and therefore be in a position to offer the opportunity to a CALD child in care to identify with their culture. Consultation with the child's carers, community members and service providers, would assist this process, and it is necessary for a caseworker to develop a meaningful cultural maintenance plan.

The extent to which CALD children engage with their cultural origins, and how they can best be supported to have a safe and enduring identity shaped by this, as well as the Australian culture, should also be informed by the views of the child, together with a child's long-term cultural wellbeing.

Every child in care who identifies with a CALD background should have a comprehensive cultural maintenance plan. The plan should be reviewed regularly, having regard to the child's age and placement circumstances, and informed as necessary through further consultation.

IMPROVING ENGAGEMENT AND SERVICE DELIVERY

The Commission's Intake review (see Appendix C) of 120 notifications made to the Families SA Call Centre (commonly referred to as the Child Abuse Report Line) resulted in some observations about the challenges faced by refugee children and their families, and the adequacy of services for this group.

The Commission saw that refugee children and families who are coming into contact with the child protection system were traumatised by experiences of war and other violence. It is not clear that Families SA has the confidence to assume system leadership for these complex and confronting issues that are often socially and politically fraught.

Families SA does not appear to seek specialist advice from, or refer children and families to, either intensive or more practical support services.

While mindful of the sample size, and acknowledging there may be examples of good practice or meaningful service delivery not evidenced before the Commission, the themes identified by the Intake review are a stark reminder of the vulnerabilities of CALD children and the complexity of developing and maintaining a robust, yet culturally competent child protection system. While Families SA should take a leading role in developing such a system, other stakeholders and service providers should also demonstrate their commitment to establishing cultural competence.

There are examples of service providers reaching out to CALD communities. In November 2015, the Commission visited FamilyZone at the Ingle Farm Primary School and saw firsthand the benefit of colocated services—a TAFE English class was being taught to new arrivals in Australia, while the participants' children were being cared for in an onsite creche (FamilyZone is also discussed in Chapter 8).

The suburb of Ingle Farm is in the City of Salisbury. The student profile of Ingle Farm Primary School reflects a culturally and linguistically diverse society: 72 per cent of students speak English as a second language (with 50 different home languages spoken), 14 per cent of students are humanitarian arrivals and about 70 cultural groups are represented in the school.⁵⁶ The school provides a new arrivals program: an Intensive English Language Centre for students from non-English speaking backgrounds who are in their first 12 months in Australia.⁵⁷

FamilyZone offers culturally specific regular support groups, such as women's groups and playgroups, that provide information and assistance on relevant issues and an opportunity for social connection. Services have been offered to Afghan, African, Chinese and Indian families.⁵⁸ From January to July 2015, 1259 families attended FamilyZone, 45 per cent of whom identified with a CALD background.⁵⁹

FamilyZone can assist CALD families in many ways, such as⁶⁰:

- providing children with the opportunity for bilingual development;
- alleviating depression experienced by parents, through discussing and sharing problems;
- developing social networks and reducing social isolation, including the forming of relationships with other local families and professional staff; and
- providing an ideal stepping stone to services in the wider community.

For CALD families, particularly those who have significant issues with trust and are reluctant to access new services, the collocation of integrated services is of considerable benefit, especially when positioned near a school that embraces diversity.

Soft entry points such as FamilyZone represent opportunities to engage with vulnerable CALD families, develop trusting relationships with them, support their growth in the Australian community and seamlessly connect them with other support services.⁶¹ When developing services for CALD families, the government should look to examples such as FamilyZone as effective service models, providing opportunities for early intervention with vulnerable families.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 231** **Require that the cultural background of children coming into contact with the child protection system be recorded on C3MS, including in the Life Domains area, for all children in care who have a culturally and linguistically diverse background.**
- 232** **Analyse data collected regarding the cultural background of children coming into contact with the child protection system to determine how to best respond to children at risk in culturally and linguistically diverse communities.**
- 233** **Undertake a qualitative review of the capacity of the Agency's Multicultural Community Engagement Team (MCET).**
- 234** **Evaluate the effectiveness of specialist MCET staff working together with front-line practitioners on child protection cases and assess the value of collocating MCET staff in the Agency's offices.**
- 235** **Assist staff and carers who work with children in care who have a culturally and linguistically diverse background to achieve culturally informed best practice through the development of practice guides.**
- 236** **Ensure that every child in care with a culturally and linguistically diverse background has a comprehensive cultural maintenance plan that is regularly reviewed, having regard to the child's age and placement circumstances.**
- 237** **Identify key performance indicators on the cultural competency of the Agency's workforce, and regularly review the effect of these recommendations on that competency.**

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PART VI

SYSTEM-WIDE CHANGES TO IMPROVE SAFETY

20

SCREENING FOR RISK

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OVERVIEW

Screening a person to assess the level of risk they may pose to children in a professional or volunteering environment is one of a range of strategies that organisations should employ to keep children safe. Risk is assessed through sourcing and reviewing certain records relating to a person. However, it is a limited tool and only one part of a broad range of strategies which must be used to create and maintain a child-safe organisation. In South Australia the assessment of the risk is commonly referred to as child-related employment screening.

To understand the effectiveness of the screening scheme in South Australia, and identify deficits and areas for potential improvement, the Commission took a holistic approach, considering both the scheme's ability to screen out unsuitable persons from working or volunteering with children in care, as well as its operation in the broader South Australian community and across jurisdictional borders.

The development and implementation of screening schemes varies across Australian jurisdictions. The federal Royal Commission into Institutional Responses to Child Sexual Abuse (the federal Royal Commission) has recently made a number of recommendations principally concerned with the establishment of consistent national screening standards in its *Working With Children Checks report*.¹ It has therefore been necessary for this Commission to recognise the broader national context when conducting inquiries and framing findings as to screening in South Australia.

In examining the screening system in South Australia, the Commission undertook a review of 150 screening assessment briefings from the 2013/14 financial year in which negative information about an applicant had emerged (see Appendix C). The findings of that review have informed discussion and conclusions mentioned throughout this chapter.

This chapter principally relates to the Commission's Terms of Reference 5(e), in the context of Terms of Reference 1 to 4.

THE PURPOSE AND VALUE OF SCREENING

The aim of child-related employment screening is to help organisations ensure that only appropriate people are permitted to work or volunteer with children. Screening not only eliminates inappropriate individuals but also acts as a deterrent to those who might otherwise try to obtain child-related employment.

The screening is performed by scrutinising records, identifying any risk of harm the person could pose to children, and assessing the extent of that risk.² Screening checks are limited in nature and rely to a significant extent on an applicant's previous history to assess future risk. Generally, an applicant's criminal history will be the most obvious and tangible historical record on which to base this assessment.

Screening is clearly intrusive; it scrutinises in detail personal historical records. A balance needs to be struck between protecting children from risk and not imposing an unfair or unnecessary burden on ordinary parental and community activities or on the workforce.

The screening of people wishing to work or volunteer with children is not intended to constitute a fail-safe measure in its own right. Gaining clearance does not mean that a person has been deemed safe or suitable to work with children—it simply means there is no available history to suggest they pose a threat.

Screening checks will detect only those people who have come to the attention of the authorities in the past, not those with unblemished records. Checks should be implemented in conjunction with other strategies focused on minimising risk to children on an ongoing basis.³ These include 'appropriate leadership, governance and culture; quality recruitment, selection and screening; training; effective child protection policies and procedures; and child-friendly practices'.⁴ The combination of these strategies, together with screening for risk, affords the best protection to children.

WHAT RESEARCH TELLS US

There is very little research evaluating the processes that screen employees and volunteers for risk.⁵ Of what research does exist, some highlights the fallibility, from a risk management perspective, of placing too much reliance on these processes.⁶ An overreliance on screening can come at the expense of other strategies to reduce the dangers of child abuse.⁷

Research conducted in the United Kingdom suggests that highly prescriptive workforce vetting can have the opposite effect to that intended by compromising 'the very bonds which make communities welcoming, safe places for children'.⁸ Due to the threat posed by fines for non-compliance with screening requirements in the UK:

many agencies ... focus solely on carrying out checks at the expense of other measures, such as training and awareness raising, which could be more effective in protecting children from abuse.

It is important not to divert badly needed resources from other services in a child protection system towards a highly prescriptive screening regimen.⁹ Witnesses in evidence raised concerns about the costs associated with screening in South Australia, absorbing resources that could more usefully be applied to early intervention programs and other child welfare services.¹⁰

There is a dearth of empirical research against which the current South Australian screening processes can be scrutinised. However, some research has highlighted the advantages of structured risk assessments over unstructured judgements. The benefits include the following¹¹:

- By basing decisions on standardised points of reference, subjective decision making is minimised.
- The use of structured risk assessment approaches is more reliable and valid than the use of professional judgement alone.
- The assumptions on which the risk assessment models are based can be clearly set out, and may be tested.
- Information can be dealt with transparently, and the person affected can put forward information as well as correct it.
- Public awareness of the use of structured risk assessment models may deter possible offenders.

The question of the sustainability of risk assessment systems which are applied to a broad population in an effort to exclude a small minority of people also cannot be ignored.

Simply implementing more detailed and prescriptive legislation and policies to net more people, and demanding more resource-intensive assessments, is unlikely to be sustainable. This Commission is aware that over time the costs attached to operating and monitoring a reformed screening scheme, as proposed in this chapter, may deter effective implementation of some aspects of the system or that there will be pragmatic 'slippage' as cost-saving measures are pursued.¹² It will be important for the government and policy makers to track the contribution that a reformed and evolving screening scheme makes to the child protection system.

SCREENING ACROSS AUSTRALIA

Since first implemented in New South Wales in 2000, screening schemes have been gradually adopted nationwide, Tasmania being the last to do so in 2014.

The National Framework for Protecting Australia's Children 2009–2020 called for the development of a nationally consistent approach to screening and the implementation of a national framework for the exchange of criminal histories across jurisdictions for

people working with children.¹³ In response, an inter-governmental agreement—Exchange of Criminal History Information for People Working with Children (ECHIPWC)—was developed.¹⁴ This agreement allows government agencies responsible for conducting screening assessments to access more comprehensive interstate criminal history information about a person, such as pending, dismissed or withdrawn charges, convictions, spent convictions and acquittals.¹⁵

A nationally consistent approach to screening has not been achieved. Each state and territory holds individual responsibility for establishing and administering its own screening scheme and there are significant differences across the jurisdictions. These differences relate to who must be screened; who initiates the screening process; what information is assessed; the process to determine if a clearance should be refused; the types of clearances offered; and the duration, portability and ongoing monitoring of clearances.¹⁶

There are three types of screening schemes currently used within Australia. The first—operating in South Australia—is an employer-driven system. This requires employers in relevant fields to review the history of a prospective employee or volunteer. Individuals seeking employment in a child-related role are the subject of a 'point-in-time' screening before being appointed to a position and generally every three years thereafter.¹⁷

The second scheme is a Working with Children Check (WWCC). This operates in Queensland, New South Wales, Victoria, Western Australia and the Northern Territory. Under this scheme individuals have their criminal history and, in most cases, disciplinary information (such as professional disciplinary proceedings) checked to determine their suitability to engage in child-related work for a designated period of time. The individual's continued suitability is assessed on an ongoing basis during the relevant period.¹⁸

The third scheme is a Working with Vulnerable People (WWVP) check, which is used in the ACT and Tasmania and requires individuals to be registered to engage in certain activities or services. Registration involves the assessment of an individual's suitability to work with vulnerable people such as children and disadvantaged adults. It is a hybrid of both the first and second schemes, and three types of screening clearances are offered¹⁹:

- a general registration, which incorporates an initial clearance for a period of three years with ongoing monitoring;
- a role-based registration, which restricts an individual to work with a specific employer; or
- a conditional clearance, which imposes specific conditions on an individual's registration.

The differences between the schemes lead to²⁰:

- varying levels of protection afforded to children across jurisdictions;
- generally, the inability to use screening clearances outside the jurisdiction within which they were issued;
- the need to navigate multiple and/or complex screening laws;
- perpetrators exploiting vulnerabilities and ‘forum shopping’ between jurisdictions; and
- limitations to the effectiveness of information sharing between jurisdictions.

SOUTH AUSTRALIA’S SCREENING SCHEME

In 2003 the Layton Review proposed the development in South Australia of a ‘statutory scheme for screening and monitoring of persons who are working with children, whether as employees or volunteers in education institutions, sports or recreation bodies or religious organisations’.²¹ It was suggested that ‘specific legislation is the first important step in developing a coordinated and consistent approach to screening and monitoring throughout South Australia’.²² The following ingredients were said to be essential for the creation of a coordinated system²³:

- legislation to establish the basic principles, objectives and framework;
- establishment and maintenance of appropriate register(s);
- mechanisms for screening and monitoring;
- processes and responsibilities for notification; and
- appeal processes.

The Layton Review proposed that the function of child-related employment screening would best lie with South Australia Police (SAPOL), given that the police, for their own purposes, maintain records of convicted persons or those under surveillance.²⁴ However, the records currently screened go beyond those held by the police and this should continue to be the case.

When first established in 2011, the Screening Unit was part of the Department for Families and Communities alongside Families SA (the Agency). In 2012, when Families SA merged with the Department for Education and Child Development (the Department), the Screening Unit became part of the new Department for Communities and Social Inclusion (DCSI).

The Screening Unit remains within DCSI and, in addition to child-related employment screening, conducts assessments of persons who work with other vulnerable groups, including disability services and aged care.²⁵

However, the vast majority of all assessments are child-related employment screenings, with about 90,000 applications of this type received in 2015.²⁶

Many government agencies within South Australia rely on the services of the Screening Unit. In addition to DCSI, the key government stakeholders, in terms of information sharing and the functioning of the Screening Unit, are the Department and SAPOL.

South Australia did not develop specific legislation. Instead, the obligation for child-related employment screening was incorporated into the *Children’s Protection Act 1993* (SA). Many of the essential ingredients suggested by the Layton Review have either not been achieved or have been developed in a way that has led to an inadequate or inconsistent screening scheme.

THE LEGISLATIVE INSTRUMENTS

In South Australia, child-related employment screening is governed by the *Children’s Protection Act 1993* (SA) (the Act) and the *Children’s Protection Regulations 2010* (SA) (the Regulations). The provisions setting out the screening scheme are within the division of the Act, entitled ‘Child Safe Environments’.²⁷ The Act and the Regulations are augmented by standards issued by the Chief Executive of the Department.²⁸

In July 2014 the Chief Executive issued Standards for Use of Child Protection Information in the Assessment of an Applicant’s Relevant History in accordance with the Act (the CP Standards). In February 2015 the Chief Executive issued Child Safe Environments: Standards for Dealing with Information about a Person’s Criminal History as part of a Relevant History Assessment (the Criminal Standards). These standards replaced and updated those previously issued in 2012.

Navigating across the Act, the Regulations and standards issued by the Chief Executive is unwieldy, confusing and at times frustrating.

South Australia and the Northern Territory are the only jurisdictions in Australia that do not have stand-alone legislation dedicated to setting the parameters for their screening regimes (see Table 20.1).

In view of the substantial reforms to be made to the screening system in this state in response to the recommendations of this Commission and the federal Royal Commission, it would be appropriate for the South Australian Government to legislate for a new, stand-alone legislative instrument incorporating all relevant reforms.

Table 20.1: Screening legislation by jurisdiction

JURISDICTION	LEGISLATION
Australian Capital Territory	<i>Working with Vulnerable People (Background Checking) Act 2011</i>
New South Wales	<i>Child Protection (Working with Children) Act 2012</i>
Northern Territory	<i>Care and Protection of Children Act 2007</i>
Queensland	<i>Working with Children (Risk Management and Screening) Act 2000</i>
South Australia	<i>Children's Protection Act 1993</i>
Tasmania	<i>Registration to Work with Vulnerable People Act 2013</i>
Victoria	<i>Working with Children Act 2005</i>
Western Australia	<i>Working with Children (Criminal Record Checking) Act 2004</i>

INITIATING A SCREENING ASSESSMENT

In South Australia organisations are responsible for ensuring an assessment is conducted of a person's relevant history before engaging them in a child-related role.²⁹ In all other states and territories (except Queensland), it is the responsibility of the individual to apply for a screening clearance prior to engaging in child-related employment. On receiving such a clearance, that person is able to engage in any child-related employment with any employer without the need for multiple screening checks (unless in the ACT or Tasmania the clearance held is role-based or conditional). In Queensland an employer or volunteer coordinator will apply for a screening clearance on behalf of the individual in question.³⁰

To ascertain which prospective employees must be screened, South Australian organisations have to determine whether they are captured by the Child Safe Environments division of the Act. The division applies to both government and non-government organisations that provide health, welfare, education, sporting or recreational, religious or spiritual, childcare or residential services wholly or partly for children, as well as non-government organisations of a class prescribed by regulation.³¹ Currently, non-government organisations that provide disability services wholly or partly for children and defined passenger transport services are prescribed under the Regulations.³²

If an organisation considers it fits into one of these broad categories, a prospective employee, volunteer, agent, contractor or subcontractor who is to act in a 'prescribed position' or undertake 'prescribed functions' must have their relevant history assessed.³³

The Act defines a 'prescribed position' as³⁴:

- a position that requires or involves the performance of one or more prescribed functions; or
- a position, or a position of a class, in a government organisation designated (by notice in the Gazette) by the organisation's responsible authority³⁵ as a prescribed position for the purposes of this section.

To date, no positions have been prescribed by notice in the Gazette.

'Prescribed functions' are defined as³⁶:

- regular contact with children or working in close proximity to children on a regular basis, unless the contact or work is directly supervised at all times; or
- supervision or management of persons in positions requiring or involving regular contact with children or working in close proximity to children on a regular basis; or
- access to records of a kind prescribed by regulation relating to children;³⁷ or
- functions of a type prescribed by regulation, for example the provision of overnight care which is defined as 'care provided to a child overnight and involving sleeping arrangements (whether such care is provided on a short-term or ongoing basis)'.³⁸

The organisation is obliged to interpret the various legislative provisions and determine which positions and/or functions within its operations are 'prescribed' under the terms of the Act. The answer may not always be clear. For example, the Act does not define 'regular contact' or 'close proximity'. The Criminal Standards state that the terms are to be given their 'ordinary everyday common sense meanings'.³⁹ 'Regular contact' is said to generally imply a pattern that 'recurs at short uniform intervals'. No guidance is provided as to what 'contact' means.⁴⁰ 'Close proximity' is said to imply that the child is 'within sight of the person performing a prescribed function and/or the person has the capacity to engage in dialogue with the child'.⁴¹

Under the Regulations, certain categories of persons are exempt from the requirement that their relevant history is assessed. This includes teachers and police officers, who are subject to distinct screening practices as part of their registration and/or employment arrangements.⁴²

The types of roles that are defined as ‘child-related’ vary across all Australian jurisdictions. While there is consistency with respect to roles that are obviously child-related, where the nature or frequency of contact with children is less clear, there is greater divergence between the jurisdictions.

SCREENING PATHWAYS IN SOUTH AUSTRALIA

The Regulations set out two pathways by which an organisation may fulfil its screening responsibilities for a prospective employee or volunteer. An organisation may choose to⁴³:

- obtain a criminal history report (such as a National Police Certificate) or other prescribed evidence⁴⁴ of the person’s relevant history and undertake its own assessment of that report or evidence, also taking into account any information the person might provide; or
- have an authorised screening unit assess the relevant history of the person.

The first pathway involves an organisation conducting its own assessment of a person’s relevant history. The second involves an organisation arranging for the assessment to be conducted through the South Australian Government’s Screening Unit in DCSI (the Screening Unit). This is the only authorised screening unit in South Australia.

These provisions reflect the unique nature of the South Australian screening scheme.

Disparities and inadequacies in screening pathways constitute weaknesses that unsuitable applicants may be able to exploit.

As a result of the dual pathways, and the apparent lack of clarity with respect to the intrastate portability of clearances (discussed later in this chapter), individuals may be required to undergo multiple assessments or obtain multiple clearances if they wish to engage in more than one child-related role. This leads to frustration and confusion for employers and employees, double handling and unnecessary costs.⁴⁵ One witness told the Commission she was:

*required to have several concurrent checks—one for being a foster parent, one for her current employment, one for volunteering with the CFS, and one for working in the tennis club canteen.*⁴⁶

Permitting two pathways by which a clearance can be obtained produces a system of variable levels of scrutiny. The particular pathway selected will affect what information is assessed, how it is assessed and by whom, and how robustly the risk posed by a person is assessed.

Organisations conducting their own assessments will not have access to the same breadth of information as the Screening Unit. Two organisations engaging the same person could have access to quite different information.

Conducting a screening assessment is a highly complex task and requires significant expertise. Drawing together indicative threads in a person’s history to predict future risk is an unenviable responsibility

Conducting a screening assessment is a highly complex task and requires significant expertise. Drawing together indicative threads in a person’s history to predict future risk is an unenviable responsibility. The scheme provides no clear guidance as to the level of expertise required by those persons conducting risk assessments within an organisation, allowing untrained individuals to make an assessment on potentially inadequate information. There is also limited guidance as to how an applicant’s history is translated into a predictor of risk for children.

There is no clear mechanism for scrutinising assessments conducted by organisations, leaving deficient assessment standards to go unchecked.

By allowing organisations to conduct their own assessments of employees and volunteers, South Australia has created an inconsistent, and flawed, screening scheme. Disparities and inadequacies in screening pathways constitute weaknesses that unsuitable applicants may be able to exploit.

Legislative reform should therefore provide for a single screening pathway in this state, namely the South Australian Government Screening Unit, which should be an employee-driven system.

Table 20.2: Categories of information available to be assessed by the Screening Unit compared to other organisations

CATEGORY OF INFORMATION	SCREENING UNIT	OTHER ORGANISATIONS
1 Findings of guilt for offences committed by the person in South Australia or elsewhere	Yes	Yes
2 Offences alleged to have been committed by the person in South Australia or elsewhere and with which the person has been charged but which have not yet been finally determined	Yes	Yes
3 Information relating to findings of guilt and charges referred to in Categories 1 and 2	Yes	No
4 Information relating to charges for offences alleged to have been committed by the person in South Australia or elsewhere, regardless of the outcome	Yes	No
5 Relevant information lawfully obtained or held for any purpose by the Department, the Department for Communities and Social Inclusion ^a , the Courts Administration Authority and an authorised screening unit	Yes	No
6 Information provided by the person for the purposes of an assessment of their relevant history	Yes	Yes

^a As the administrative unit responsible for the administration of the *Carers Recognition Act 2005 (SA)* and the *Disability Services Act 1993 (SA)*.

Source: *Children's Protection Act 1993*, s 8B(8).

SCOPE OF INFORMATION ASSESSED

The information assessed depends on the pathway chosen by an organisation to fulfil its screening obligations.

Table 20.2 sets out the much broader suite of information the Screening Unit should consider when conducting a screening, compared to the information on which an organisation should base its assessment. The disparity in the range of information highlights the dual standards between the two pathways.

If an organisation conducts its own assessment, it must do so in accordance with the Criminal Standards. These provide guidance on accessing and assessing a person's criminal history, the circumstances in which evidence other than a fresh criminal history record may be accepted, and affording procedural fairness to an applicant in the decision-making process.⁴⁷

As shown by Table 20.2, if an organisation chooses to have the Screening Unit conduct the assessment, in addition to findings of guilt and pending charges (Categories 1 and 2), any information relating to those matters should also be considered. This may include, for example, the circumstances of the criminal act that led to a finding of guilt or the reasons why a particular penalty was imposed by a court. It is not expected that an organisation conducting its own assessment would have access to this additional information. The Screening Unit should also take into account information relating

to charged offences, regardless of their outcome (Table 20.2, Category 4). In other words, the Screening Unit may consider criminal charges that were withdrawn before a finding was made and offences of which a person has been acquitted. An organisation conducting its own assessment will in most cases not have access to this additional information.

The Screening Unit should also consider information held by some government bodies that is relevant to whether a person is suitable for engagement in child-related employment (Table 20.2, Category 5). The most obvious examples of this are a person's child protection history held by Families SA or their care concern history held by the Care Concern Investigations Unit. An organisation will not have access to these potentially valuable sources of information, which may capture occasions, falling short of criminal conduct, when a person has behaved inappropriately towards a child or shown themselves to be a risk to children.

While all states and territories consider the criminal history of applicants and any pending charges, there is significant variation between the jurisdictions as to what information beyond this is assessed. All jurisdictions consider disciplinary or misconduct information of some type. This may include information from professional registration bodies, such as those regulating health practitioners and teachers; information from correctional services; or information on whether the person is subject to a sexual offender prohibition order or a child protection prohibition order.⁴⁸

The circumstances in which jurisdictions consider disciplinary and/or misconduct information also vary. New South Wales and Victoria consider this information as a matter of course, but Western Australia only considers such information if the initial criminal history assessment is adverse.⁴⁹

In view of the lack of general consensus regarding what constitutes best practice in relation to screening, the inconsistency across jurisdictions as to what information is considered is not surprising. It is a likely by-product of the absence of evidence to demonstrate which records are the most reliable indicators of potential risk to children.⁵⁰

OUTCOMES OF A SCREENING ASSESSMENT

If an organisation conducts its own screening of a prospective employee, there is no requirement to provide any type of outcome. The organisation simply conducts an assessment of the relevant history and then makes a decision about employment. However, organisations are expected to keep written evidence of their consideration of an individual's relevant history.⁵¹

Since April 2015, the South Australian legislative scheme has provided for one of two outcomes of an assessment conducted by the Screening Unit: a screening clearance is either granted or the application is refused. When a clearance is granted, a certificate is sent to the individual and the organisation is informed of the outcome via email. When an application is refused, the individual is sent a certificate stating that they pose a risk to the safety of children.⁵² Prior to April 2015, the organisation was informed of a refusal, but no advice was given to the individual.⁵³

The Screening Unit has in the past offered a third outcome—namely, a specific clearance that permitted an applicant to be engaged in a specific role, as opposed to general child-related employment. This appears to be similar to the situation in the ACT and Tasmania.⁵⁴ In all other jurisdictions screening clearances are either granted or refused.

In every jurisdiction except South Australia and New South Wales, persons receiving a clearance are issued with a card authorising them to engage in child-related work for a designated period of time.⁵⁵ In New South Wales the person is issued with an electronic clearance number rather than a card. In December 2015, the Commission was informed that the Screening Unit was working towards issuing individuals with a unique identification number that could be used to check the status and validity of a clearance.⁵⁶

DURATION OF CLEARANCES

Neither the Act nor the Regulations stipulate the duration of screening clearances in South Australia. Instead, the Criminal Standards require the screening of an individual to be undertaken at least once every three years.⁵⁷ Nevertheless, some employers, such as those whose staff work with children in care, require screenings to be conducted every 12 months.⁵⁸ It is likely that this practice has arisen to compensate for the absence of continuous monitoring in South Australia. Some organisations may consider that allowing three years to pass without a fresh assessment of a person's criminal or child protection history is a risk they are not willing to take.

In New South Wales and Victoria, clearances are granted for a period of five years. Clearances in the ACT, Queensland, Tasmania and Western Australia are valid for a period of three years. Clearances granted in the Northern Territory are of the shortest duration, requiring renewal every two years.⁵⁹

OFFENCE PROVISIONS

The South Australian legislation requires organisations, and in some instances natural persons (such as sole traders or volunteers not engaged through an organisation), to undertake an assessment of a person's relevant history in accordance with the legislative scheme. The maximum penalty for failing to do so is \$10,000.⁶⁰ Although the legislation creates an obligation to undertake the process, it is not an offence if a person is engaged in a child-related role despite an adverse screening outcome.⁶¹

In all states and territories except South Australia, it is an offence to engage an individual in a child-related role if they do not hold a valid screening clearance. The ACT includes a strict liability offence; that is, an offence has been committed even if the employer was unaware the individual did not hold a valid clearance.⁶²

It is also an offence in other jurisdictions for an individual to engage in child-related work without a valid screening clearance. In New South Wales, Queensland, Tasmania, Victoria and Western Australia, persons who are refused a clearance are issued a negative notice which excludes them from working in child-related employment for a period of time, and they commit an offence if they do so.⁶³

OPERATIONS OF THE SCREENING UNIT

Generally, the operations of the Screening Unit are structured around two teams: an administration team and an assessment team.

The administration team conducts an initial assessment of applications and can issue a clearance in limited circumstances. Applications that cannot be cleared by the administration team are referred to the assessment team. The assessment team is divided into two screening teams: the child-related employment screening team and the disability, vulnerable persons, aged and general probity screening team. In this chapter, any reference to the assessment team is intended only to encompass the child-related employment screening team.

The assessment team consists of assessment officers employed in the administrative services officer (ASO) stream, across levels five (ASO5) to eight (ASO8)⁶⁴, with duties divided according to the level of complexity associated with each screening application. While assessment officers are not required to hold a qualification, some have tertiary level qualifications in areas including social work, law and psychology. They hail from a variety of professional backgrounds, including law enforcement, the Office of the Director of Public Prosecutions, the Courts Administration Authority, Families SA and Correctional Services.

In January 2015, the size of the assessment team was increased threefold, from 12 assessment officers to 36.⁶⁵

APPLICATIONS

Organisations that choose to use the Screening Unit must make an application through their requesting officer—a person responsible for coordinating screening checks within the organisation. While the application is primarily completed by the potential employee, the requesting officer is required to describe the applicant's proposed role and responsibilities within the organisation.

In July 2015 the Screening Unit began accepting online applications. Previously, applications could only be submitted in hard copy. As at December 2015, approximately 2000 applications had been received through the Screening Unit's online portal.⁶⁶

THE ASSESSMENT PROCESS

Initially a screening assessment involves obtaining the applicant's criminal history from CrimTrac and searching for records relating to the applicant across the Department's C3MS, CIS and Objective databases. (Objective is used by the Care Concern Investigations Unit and discussed in Chapter 15).

CrimTrac is a Commonwealth government agency that provides an information sharing service for Australia's law enforcement agencies. (On 1 July 2016 CrimTrac merged with the Australian Crime Commission to form the Australian Criminal Intelligence Commission.) Through CrimTrac, the Screening Unit obtains comprehensive criminal history information about an individual from across all Australian jurisdictions.⁶⁷

If 'no disclosable court outcomes' are reported by CrimTrac (that is, no criminal history) and there are no database records matching the applicant's name, the administration team can issue a clearance.⁶⁸ If a database reveals a match to the applicant's name or CrimTrac reports a criminal history, the application is referred to the assessment team.

An assessment officer reviews the initial results to ascertain what (if any) further information is needed. The Act allows for information relating to an individual's relevant history to be disclosed to the Screening Unit for the purpose of undertaking an assessment.⁶⁹ In practice, the Screening Unit will request additional information from a variety of sources, including SAPOL, the courts (commonly for sentencing remarks), Families SA (particularly when necessary to view hard-copy historical files), and other agencies, such as hospitals.⁷⁰

The *Spent Convictions Act 2009* (SA) allows for the Screening Unit to also access and assess spent convictions when conducting child-related employment screening.⁷¹

The Screening Unit tries to ascertain whether a person's previous history, when understood in context, indicates that the applicant may pose a risk to the safety of children in an employment or volunteering capacity. An assessment officer relies on a number of policies to guide their assessment, including the standards issued by the Chief Executive of the Department and internal procedures and policies of the Screening Unit.⁷²

Where adverse findings may be drawn or clarification is necessary, the Screening Unit will contact the applicant, usually by letter, requesting information and advising they can respond in writing, over the telephone, or face to face.⁷³

CHILD PROTECTION INFORMATION

If the applicant has a child protection history recorded on the Department's databases, this will be considered as part of the assessment. Assessing a person's child protection history, especially if the allegations have not been substantiated, can be particularly complex. The use of child protection information when conducting assessments was a focus of the Commission's review of screening assessments, and is discussed later in this chapter.

CRIMINAL HISTORY

The assessment officer considers the applicant's criminal history with the aid of an assessment matrix contained within the Screening Unit's procedural documentation. This tells assessment officers how to assess criminal history results and obtain information from the applicant, courts and police if required.⁷⁴

The assessment matrix attributes a level of risk (low, medium or high) to categories of offences. For example, homicide and sexual and indecency offences committed against an adult or a child, and acts intended to cause injury to a child, are categorised as high risk regardless of when they occurred. Other offence categories are allocated differing levels of risk in accordance with how long ago the offence was committed.⁷⁵

In the event that a criminal history reveals a charge that has not been proved, and there is no child protection history revealed through a search of the Department's databases, a clearance is provided without further assessment. However, there are some important exceptions. These include allegations of homicide, or sexual or indecent acts, alleged to have been committed against an adult or a child, and any allegations involving a child.⁷⁶

MEDIUM- AND HIGH-RISK OFFENDING

Assessment officers are authorised to approve clearances for any low- and medium-risk offending. This authority also extends to instances in which an applicant is the subject of unsubstantiated child protection allegations.⁷⁷

Although assessment officers have the authority to approve a clearance for medium-risk offending, they must undertake a more comprehensive assessment of the risk posed by the applicant, considering 'all relevant information obtained during the assessment process, with particular regard to patterns of allegations, courses of conduct and the inherent requirements of the applicant's role'.⁷⁸

In relation to previous offending, the contextual factors an assessment officer should consider include⁷⁹:

- the seriousness of the particular offending, and the seriousness of the applicant's criminal history in its entirety;
- the length of time that has passed since the offending;
- the age and vulnerability of the victim;
- the nature of the relationship, and age difference, between the applicant and the victim;
- the applicant's conduct since the offending;
- the applicant's current age and age at the time of the offending;
- the likelihood of the offending being repeated; and
- the effect on children if the offending were to be repeated.

A similar comprehensive assessment is conducted for offending categorised as high risk. However, regardless of the light the assessment might shine on the past offending, assessment officers do not have authority to approve a clearance when it is determined by the assessment matrix to be high risk.⁸⁰

To conclude the process, an assessment officer prepares a briefing which recommends whether or not the applicant should be cleared to work or volunteer with children. If the officer does not have authority to grant a clearance, they refer the application to a more senior staff member. Depending on the seriousness of the applicant's history, the authority to grant a clearance sits with an assessment supervisor, a senior assessment officer, an assessment manager (previously the principal assessment officer), the manager or the director of the Screening Unit. If the applicant's history includes allegations of a sexual nature, the application must be referred to the Complex Assessment Panel (CAP).⁸¹

The manager and the director of the Screening Unit, as well as CAP, have the authority to refuse a screening clearance.

COMPLEX ASSESSMENT PANEL

CAP (previously the Sexual Assessment Panel) comprises the Chief Executive of DCSI, the Executive Director responsible for the Screening Unit, and the director and manager of the Screening Unit.⁸²

In addition to assessments involving a sexual component, highly complex assessments may also be escalated to CAP. By the time an assessment briefing reaches CAP, it will generally have been reviewed by at least three levels of authority.

As shown by Table 20.3, in the 2013/14 financial year, 739 applications were assessed by senior level staff of the Screening Unit and CAP. The latter assessed 80 applications, and in the vast majority of cases either granted a general clearance or offered the organisation a specific clearance. Of the complex matters escalated to CAP, only about nine per cent of individuals were refused an application. The senior level staff in the Screening Unit refused a similarly low number of applications.

In determining the most complex screening assessments in the state, CAP obviously has a very difficult and unenviable task. CAP may be well served by having a greater mix of expertise and experience, in particular panel members who have forensic expertise in child protection or behavioural indicators of risk.

Table 20.3: Applications assessed by senior levels of the Screening Unit and the Complex Assessment Panel, 2013/14

	SENIOR LEVELS OF THE SCREENING UNIT ^a (PERCENTAGE OF TOTAL)	COMPLEX ASSESSMENT PANEL (PERCENTAGE OF TOTAL)
Total number of applications considered	659	80
General clearances granted	502 (76.2%)	51 (63.8%)
Specific clearances offered	102 (15.5%)	22 (27.5%)
Applications refused	55 (8.3%)	7 (8.8%)

^a Includes Principal Assessment Officer, Manager and Director

Source: Assessment briefings provided by the Screening Unit.

SPECIFIC CLEARANCES

At times, the Screening Unit has offered organisations the option of engaging a person subject to a specific clearance, permitting an applicant to undertake a particular role as opposed to general child-related employment.

Specific clearances have been offered when the Screening Unit considered there was an unacceptable level of risk such that the applicant did not meet the criteria for a general clearance but, having regard to the role to be undertaken, formed the view there was a possibility the organisation would be able to mitigate the risk.⁸³ That is, the level of risk was not sufficiently great to warrant a complete refusal of the application. In those cases, it became a matter for the organisation to decide whether or not to engage the person.

To facilitate the organisation undertaking its own risk assessment, the Screening Unit would provide the organisation's requesting officer with a summarised assessment briefing, generally outlining the applicant's criminal history and other relevant information gathered by the Screening Unit. However, aspects of the applicant's child protection history that had not previously been brought to their attention would not be shared.⁸⁴ The organisation would then conduct its own risk assessment and decide whether it was prepared to carry the level of risk, and if so, engage the person on a clearance specific to the particular role.

Consigning what are likely to be some of the toughest screening decisions to untrained and less skilled persons who may have a commercial or personal interest in engaging the person is potentially detrimental to the safety of children.

An organisation may not appreciate the difference between a 'specific clearance' and a 'general clearance'. This is particularly concerning if the organisation does not itself practise robust child-safe strategies.

Information revealed by the Screening Unit to the requesting officer might not be adequately relayed to staff members working closely with the person and who, in practice, were shouldering the day-to-day responsibility of mitigating the risk posed by that person.

Specific clearances rely on a person remaining in the particular position, and the nature of their role and their level of contact with children not changing throughout the duration of the clearance (generally three years). Without careful monitoring on the part of the organisation, such situational factors could place children at an unacceptable level of risk.

The Commission's review observed that of 55 refusals, 40 resulted from specific clearances being refused by the requesting organisation, but only 15 by the Screening Unit. This suggests that the thresholds applied by the Screening Unit for entry into child-related employment may generally be too low. For example, in one case, the applicant had an extensive criminal history which indicated a clear pattern of violence although it had not resulted in any findings of guilt. The Screening Unit found that a risk of harm had been established but nevertheless provided a specific clearance, leaving it to the employer (another government agency) to make the ultimate decision about his appointment in a role working with Aboriginal youth and their families.

Specific clearances also introduce barriers to portability, both intrastate and between Australian jurisdictions.⁸⁵

The Screening Unit's practice of issuing specific clearances was based on neither legislation nor policy.⁸⁶ However, since April 2015, the Regulations have specifically prescribed this practice:

[a] certificate must not indicate that the person to whom the certificate relates is only suitable or authorised to perform specified prescribed functions (however, a failure to comply with this subregulation will not invalidate a certificate).⁸⁷

Despite the legislative change, the Screening Unit continued to offer specific clearances, issuing 71 between May and November 2015. No specific clearances were offered in December 2015. The Screening Unit proceeded on the basis that, if a person submitted an application prior to the April 2015 legislative change, it was still entitled to determine the application by offering a specific clearance.⁸⁸ It is unfortunate that the legislation was interpreted in this way. The Regulations make it clear that when the Screening Unit completes an assessment the only response available to it is to issue a certificate, and that certificate must not relate only to a specified function. Specific clearances are not and should not be permitted.

THE NUMBER OF SCREENING APPLICATIONS

Table 20.4 shows that the number of child-related employment screening applications made to the Screening Unit has increased significantly from approximately 51,000 in 2011 to more than 90,000 in 2015. Between 2011 and 2013 the annual rate of increase was steady at about 17 per cent a year. However, this trend changed in 2014 with a sharper 24 per cent increase in the number of applications. The timing of the increase coincides with the arrest of Shannon McCooie, which may have prompted organisations to use the more robust assessment pathway through the Screening Unit, rather than undertake their own assessments. Organisations may have also been motivated to seek an up-to-date clearance for current employees or volunteers, or interpreted the legislation more broadly as to who needed to be screened. A legislative change in July 2014 that prescribed an additional class of organisation as being captured by the screening scheme may have also contributed to the increase.

Whatever the reasons, it is clear the workload of the Screening Unit is substantial. Although the rate of increase was only slight between 2014 and 2015

(two per cent), if the number of applications continues to rise, it is questionable how readily the Screening Unit will be able to meet demand for its services. This comes into sharp focus when the implications of the Commission's recommendations to abolish the second screening pathway (organisations screening prospective employees or volunteers themselves) and reform the child-related roles captured by the legislation are considered.

THE PROPORTION OF REFUSALS

Table 20.4 shows that only a small fraction (on average 0.118 per cent) of all screenings undertaken in the last five years resulted in a clearance refusal. To some extent, this may reflect the system working effectively; that is, those people who are aware they are unlikely to obtain a clearance simply do not apply. This is consistent with one purpose of the scheme—deterrence. The exclusion of such a small proportion of applicants from working or volunteering with children also reinforces the basic premise that screening is but one risk management strategy, and limited in its scope.

It raises, however, broader questions as to the effectiveness of the screening process and whether the Screening Unit standards are calibrated and applied correctly. The Commission's review suggested that the Screening Unit's threshold as to what circumstances indicated a risk to children was high. The rate of refusals (percentage of applications not cleared) supports this view. There is no baseline with which to compare the rate of refusals but in light of the negative profiles in most of the reviewed assessments, it seems low.

The rate of refusals has been constant over the past five years. As the number of applications submitted to the Screening Unit has increased, so has the number of refusals. Accordingly, whether or not the standards utilised by the Screening Unit are appropriate, they appear to be consistently applied.

Table 20.4: Applications submitted to the Screening Unit, 2011–15

	2011	2012	2013	2014	2015
Applications submitted	51,281	60,401	70,731	87,883	90,059
Applications not cleared (percentage not cleared)	56 (0.109%)	81 (0.134%)	79 (0.112%)	76 (0.086%)	133 (0.148%)
Applications withdrawn (percentage withdrawn)	159 (0.310%)	261 (0.432%)	324 (0.458%)	121 (0.138%)	886 (0.984%)

Source: Data from the Screening Unit.

20 SCREENING FOR RISK

WITHDRAWN APPLICATIONS

As shown by Table 20.4, the proportion of withdrawn applications increased between 2011 and 2015. The Screening Unit advised the Commission that a backlog of screening applications—eventually processed in 2015—contributed to the spike in withdrawn applications that year. In other words, delays led to many applications being withdrawn as the clearances were no longer needed by the time the application was processed. However, the peak in withdrawn applications in 2015 is evened out by the comparatively low number in 2014, and the average proportion of withdrawn applications across those two years (0.56 per cent), demonstrates an overall trend upwards.

The reasons for withdrawing an application are no doubt many and varied. However, the possibility that a person may seek to withdraw their application to avoid a refusal based on their history should be enough to prohibit the withdrawal of applications.

Once an application is submitted, it should be assessed and a screening outcome determined. All refusals should be systematically recorded. Efforts should be made to develop information sharing practices with interstate screening units so that assessments in this state can benefit from knowing about refusals in other jurisdictions.

CHALLENGES FACED BY THE SCREENING UNIT

In addition to a heavy workload, the Screening Unit faces challenges on several other fronts. These challenges, discussed below, range from applying the appropriate standard of proof, affording applicants procedural fairness and dealing with unsubstantiated allegations, to records management.

THE TIME IT TAKES

The time taken by the Screening Unit to finalise clearances was the focus of many concerns raised with the Commission about the Screening Unit's practices and has been the subject of extensive media attention. However, Figure 20.1 shows that in the 2013/14 financial year, approximately 92 per cent of all applications handled by the administration team were completed within 20 days and less than one per cent of applications took them more than 40 days to complete. Given the limited scope of the administration team's role (basically deciding whether or not the applicant has a criminal history and whether or not they are recorded on the Department's databases) it is expected that the vast majority of this work should be completed within 20 days.

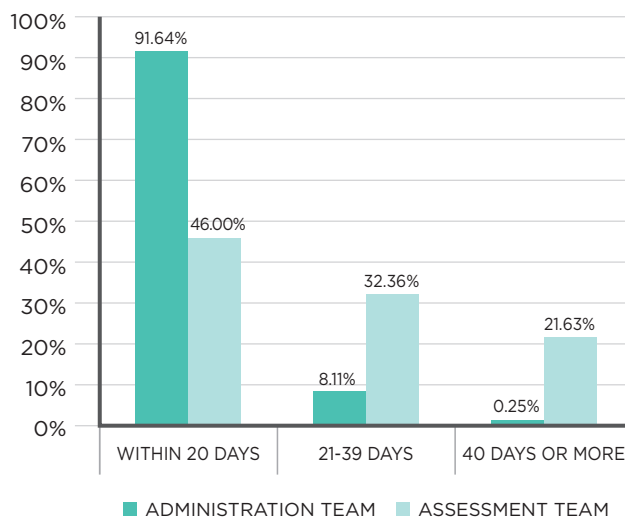


Figure 20.1: Proportion of applications finalised by team and days in 2013/14

Source: Data from the Screening Unit.

Figure 20.1 shows the variation in time taken by the assessment team to finalise applications. This reflects the fact that no two assessments are the same and will involve gathering and reviewing a range of information. However, such variations should not be used to mask avoidable or disproportionate delays.

In the 2013/14 financial year, while the assessment team assessed almost half (46 per cent) of the applications which could not be cleared by the administration team within 20 days, about one-third (32 per cent) of applications still took between 21 and 39 days to process, and about one-fifth took 40 days or more (from the time the application was submitted to the Screening Unit). Such delays inevitably cause frustration for employers, employees and volunteers, and potentially affect the ability of organisations to function efficiently. Those seeking employment are likely to suffer financial strain when obliged to wait for extended periods before being able to commence work. Volunteers whose services might be desperately needed by an organisation may lose interest if the wait for a clearance is too lengthy. Delays also influence the community's perception of the service, as shown by recent media articles reporting, for example, 'dozens of school and preschool support staff' being unable to return to work, and a not-for-profit organisation having about a quarter of its workforce unable to volunteer, due to screening delays.⁸⁹

In February 2015, a Families SA office manager told the Commission the delays were so extensive it was hard for the Department and not-for-profit organisations to respond to fluctuating and unpredictable employment demands. The delays resulted in added stress for existing staff, poor outcomes for clients, and increased risk for the Department and organisations.⁹⁰

Screening delays can hinder the process of registering urgently needed foster parents and kinship carers, causing them to lose patience with the registration process.⁹¹ This is particularly concerning given the clear need for growth in the number of home-based carers in the community (see Chapter 11). The delays also contribute to the challenges associated with finding respite carers at short notice, placing added strain on already overburdened placements.⁹²

The work of the Screening Unit has the potential to influence the operations of most, if not all, aspects of the child protection system. Its service must facilitate and complement the work of organisations, not frustrate it.

IMPROVED PROCESSING TIMES

The influx of staff in January 2015 improved the Screening Unit's processing times. As shown in Table 20.5, the delays have abated significantly in recent times. In the 2014/15 financial year, the Screening Unit took an average of about 24 days to complete an assessment. This decreased to an average of about eight days for the period 1 July 2015 to 31 December 2015. In that period, the administration team was completing applications on average within just four days and the assessment team had achieved a dramatic reduction in its average processing time to 11 days. However, there will remain some occasions when applications take an excessively long time to process. For applications received and finalised in 2015, the longest processing time was 328 days (46 weeks)—the application was received on 9 January 2015 and not finalised until 7 December 2015.⁹³

Table 20.5: Average days taken to complete screening applications, 1 July 2014 to 31 December 2015

	2014/15 (DAYS)	1 JULY 2015–31 DECEMBER 2015 (DAYS)
Administration team	7.18	3.9
Assessment team	41.65	11.1
Screening Unit average	24.29	7.8

Source: Data from the Screening Unit.

Table 20.6 shows that in 2014 the Screening Unit was completing less than one-quarter of all applications within five days. This improved in 2015 and by March 2016 the Screening Unit had achieved a completion rate of almost 60 per cent of applications within five days and almost 90 per cent of applications within 10 days. In 2014 about 20 per cent of applications took more than 31 days to complete; by early 2016, this figure was less than 1 per cent.

Table 20.6: Proportion of applications finalised by days, 2014 to 2016

	2014	2015	2016 ^a
0–5 days	22.13%	35.57%	59.47%
6–10 days	33.25%	25.17%	28.14%
11–15 days	13.43%	14.87%	3.13%
16–20 days	5.74%	8.87%	3.01%
21–25 days	3.13%	4.48%	4.25%
26–30 days	2.24%	3.05%	1.73%
31+ days	20.08%	7.98%	0.28%

^a As at 23 March 2016

Source: Data from the Screening Unit.

This suggests that a properly resourced Screening Unit can assess screening applications in a timely manner, facilitating the efficient operation of those organisations in the child protection system that rely on them to assist in their risk management strategies. The significant reduction in processing times resulting from increased staffing levels also suggests that difficulty obtaining information from other agencies is not a primary contributor to delay. While on occasion particularly complex screening decisions will take longer, this should only occur in exceptional circumstances.

PROCESSING BENCHMARKS

On the basis of the Commission's recommendation to provide a single screening pathway, it will be necessary to review the adequacy of resources to ensure that the Screening Unit is able to continue to meet acceptable benchmarks in light of what is likely to be an increased demand for its service.

In all but the most exceptional circumstances, the administration team should process applications within seven days and the assessment team should process applications within 28 days. However, the public should be made aware that some applications will, of necessity, take longer. For example, the screening agency in Western Australia publicly acknowledges some assessments may take longer than 12 weeks and the NSW screening agency advises the public some risk assessments may take more than six months.⁹⁴

In March 2016, the South Australian Ombudsman published findings following an investigation into the delays in the Screening Unit's practices and the provision of information to applicants during the screening process. The Ombudsman considered 'there should be some mechanism in place to inform an applicant or requesting organisation where an application is in the assessment process'.⁹⁵ It is the Commission's view that if the screening is not able to be completed within 28 days, the Screening Unit should advise the person concerned of the status of their application, but it is not possible to prescribe the extent of the information that the Screening Unit should provide.

APPLYING THE STANDARD OF PROOF

When determining a screening outcome, it is expected that assessment officers will apply the civil standard of proof, that is, they only need to be satisfied *on the balance of probabilities* of future risk. They do not have to be satisfied to the much higher criminal standard of *proof beyond reasonable doubt*.

The Commission's review found very few occasions on which the Screening Unit cited and relied on the lower standard of proof.

The Criminal Standards acknowledge a national view that where an applicant's criminal history suggests a *prima facie* risk of harm to children, it may be appropriate to place the onus on the applicant to prove they do not pose such a risk.⁹⁶ However, this approach was not strongly evidenced in the reviewed assessments revealing a relevant criminal history.

Assessing conduct beyond proven criminal matters may be challenging and at times contentious. However, conduct below the threshold for criminal sanction may, on the balance of probabilities, still indicate potential risk to children.

DEALING WITH UNSUBSTANTIATED ALLEGATIONS

There are three broad categories of unsubstantiated allegations that may be of relevance to a screening assessment:

- criminal charges which do not proceed;

- findings of not guilty of criminal charges; and
- child protection notifications or care concerns not investigated or not substantiated

Criminal charges, particularly those involving allegations of child abuse, may be discontinued for a range of reasons, most of which do not preclude their consideration in a screening assessment. A prosecution may not proceed because the child does not feel able to give evidence in court about highly sensitive experiences involving someone very close to them. In some cases, strict evidentiary rules, together with the criminal standard of proof, will mean there is no longer a reasonable prospect of conviction. Importantly, the discontinuation of criminal charges does not necessarily equate with a complainant recanting their allegations or a determination that the allegations were of no substance.

Further, a verdict of not guilty is a finding that the specific offence alleged has not been *proved beyond reasonable doubt*: it is not a declaration of innocence. In the vast majority of cases it will never be known whether the trier of fact was satisfied on *the balance of probabilities*—that is, more likely than not that the accused person committed the offence. To interpret a not guilty finding as meaning the accused did not partake in the alleged conduct, and therefore does not pose a risk to children, may lead to important indicators or patterns in that person's behaviour being dangerously ignored.

References to charges having been tested in a court of law were rife in the assessment briefings reviewed. This may indicate a misinterpretation of the outcome of a court process, or confusion of the criminal standard of proof with the lower standard applicable to screening assessments. The Screening Unit does not have to operate within the boundaries of criminal law, and allegations not proven to a criminal standard may be relevant to the assessment of risk when making a determination on the balance of probabilities.

As discussed later in this chapter, the large number of child protection notifications that do not get a response or are not investigated also present a significant challenge for the Screening Unit in terms of assessing unsubstantiated allegations. Disregarding such allegations may represent a lost opportunity to identify potentially concerning conduct or patterns of behaviour, particularly for those individuals who have come to the attention of child protection authorities on multiple occasions.

There will therefore be occasions when the Screening Unit should rely on them when undertaking assessments. This is appropriate provided that decisions have a solid evidentiary base, are well reasoned and are in line with the policies and procedures of the Screening Unit.

The Commission identified some isolated screening assessments where, in deciding to refuse a clearance, the Screening Unit had appropriately cited and applied the lower standard of proof with respect to unsubstantiated criminal allegations. In one matter, an applicant who had been the subject of an indecent assault charge which had been dismissed for want of prosecution was refused a clearance. The Screening Unit's assessment included consideration of a child protection notification and information provided by a sporting association with which the applicant was affiliated. This enabled a pattern of predatory and inappropriate behaviour around children to be identified.

Assessing unsubstantiated allegations is clearly a difficult process. On the evidence before the Commission, assessment officers are given only limited guidance on the application of the standard of proof, how this intersects with the outcome of criminal matters and how unsubstantiated allegations might be weighted in a risk assessment. Improved guidance and training in this regard, and the elevation of complex decisions to an appropriate level of seniority, should encourage decision making that demonstrates that the safety of children is paramount. This should also have the added benefit of promoting consistency across decision makers.

PROCEDURAL FAIRNESS AND CHILD PROTECTION NOTIFICATIONS

The Screening Unit has regard to a person's complete child protection history as recorded on C3MS, CIS and Objective, and if necessary, in hard-copy files. Examining a person's child protection history can give an assessment officer significant insight into the risk a person may pose to children. Assessing information to this extent is relatively rare compared to other jurisdictions.⁹⁷ However, assessing a greater level of information brings with it greater challenges.

The Commission's review identified a number of screening outcomes that were concerning. For example, an applicant with a significant child protection history, including notifications involving sexual abuse and a resultant arrest, was granted a clearance on the basis there were no charges laid and no confirmation of abuse. In another case an applicant was granted a clearance allowing her to work with a care agency contracted by Families SA despite her 113 pages of child protection history over a five-year period.

To explore the challenges faced by the Screening Unit when reviewing child protection information, it is necessary to understand that applicants must be afforded procedural fairness throughout the assessment process. A decision of the Screening Unit has the potential to exclude a person from employment, volunteering and roles such as being a foster parent or kinship carer. The outcome of an assessment, if negative, affects a person's substantive rights. 'Procedural fairness demands that there is a rationale for excluding persons from child-related employment. This rationale must be transparent, relevant, evident and objective.'⁹⁸

The importance of affording procedural fairness to applicants should not be understated. However, the Commission's review revealed that at times the Screening Unit appeared preoccupied with maintaining procedural fairness to the applicant to the extent that it compromised child-focused decision making.

This sensitivity to the rights of applicants was particularly evident with respect to cases in which the relevant history revealed unresolved child protection notifications—that is, notifications that had either not been investigated or, if investigated, had not resulted in a formal outcome being recorded. Deficiencies in Families SA assessments and case management processes appeared to influence and compromise child-safe screening outcomes.

The Commission's review suggested that procedural fairness took precedence in circumstances in which the absence of a child protection investigation outcome was due to anomalies or inadequacies in Families SA's intake and investigation processes. Screening assessments commonly reasoned that unresolved child protection notifications did not prevent an applicant from being issued with a clearance. The following statement was ubiquitous throughout the reviewed assessments and was concerning to the Commission:

The standards set out in the Children's Protection Act do not preclude an individual [from a screening clearance] on the basis of unsubstantiated child protection history which resulted in no further investigations by Families SA at the time.

This is troubling—firstly because it suggests a mistaken understanding of the assessment officer's task and secondly because it overlooks the potential significance of a child protection notification to which Families SA has not responded.

While the Children's Protection Act does not preclude the granting of a clearance where an individual has an unsubstantiated child protection history, there are actually no precluding circumstances (either general or specific) in the Act. Even a convicted murderer is not by legislative provision precluded from a screening clearance. Registered child sex offenders are prohibited from engaging in child-related work pursuant to the *Child Sex Offenders Registration Act 2006 (SA)*.⁹⁹ The task of the assessment officer is to assess the applicant's relevant history and determine if they pose a future risk to children; it is not to reason that a clearance can be granted, despite a relevant history, because the Act does not specifically prevent that decision being made.

The Commission is well aware that Families SA's responses to child protection notifications are beyond the control of the Screening Unit. The challenges the Screening Unit faces in this regard illustrate the far-reaching consequences of Families SA attributing incorrect response priorities to notifications and its failure to respond adequately, or at all, to screened-in notifications (see discussion in Chapter 7 and Chapter 9). It is no doubt difficult for the Screening Unit to adopt a muscular approach to an applicant's child protection history when the database on which it relies reflects an inadequate approach to assessment and intervention.

The Screening Unit is not an investigative agency. In having regard to an applicant's child protection history, its purpose is not to investigate or re-investigate the notification or previous outcomes.¹⁰⁰ The Screening Unit will on occasion be left grappling with child protection concerns that indicate, on face value, that the applicant poses a risk to children yet Families SA has not made a determination as to whether or not the concerns are substantiated.

Increasing the Agency's ability to better respond to child protection notifications should gradually improve the robustness of the state's screening processes. The Screening Unit will be able to assess more confidently the appropriate weight to be given to a properly investigated child protection notification for which a clear outcome has been recorded.

Families SA's practices have led to a situation where there will always be historical unresolved child protection notifications on the databases that might be relevant to a screening assessment. Improving the Agency's ability and capacity to respond to notifications will therefore not completely overcome the issue of how to take into account an unresolved notification during a screening assessment. The prevalence of unresolved notifications should however decrease over time.

In attempting to gather contextual information about a child protection notification, the Screening Unit is constrained by section 13(2) of the Act, in that it must not disclose the identity of the notifier to the applicant (or indeed any other person). Affording the applicant procedural fairness by allowing them to comment on such allegations could potentially disclose a notifier's identity.

The Commission's review found there was much less engagement with applicants about relevant child protection notifications which had not been investigated than there was about other types of non-criminal investigations such as care concern investigations. Assessment officers generally assumed that applicants would be unaware of notifications, but made some efforts to enquire obliquely of the applicant with respect to child protection matters that had not been acted on by Families SA. It was evident that some extremely complex child protection histories, which had not resulted in criminal offences, were not elaborated on by the applicant, and assessment decisions were made purely on C3MS and CIS records.

The information that is reported to the Families SA Call Centre (commonly referred to as the Child Abuse Report Line) or otherwise recorded on C3MS is invaluable in understanding a child's experiences and recognising those adults in our community who jeopardise the safety and wellbeing of children. It would be short-sighted for the Screening Unit not to have regard to this valuable information.

STANDARDS FOR THE USE OF CHILD PROTECTION INFORMATION

As it stands, it is questionable whether assessment officers are given sufficient guidance in their use of this information. While the CP Standards require engagement with the applicant in all cases to give them sufficient opportunity to respond to any child protection information, this position appears to be qualified:

*In all cases, the applicant **must** be given an opportunity to provide a submission addressing factors of concern for consideration during the risk assessment ...*

***As appropriate**, in cases where the child protection information has a material bearing on the assessment of risk, the assessor should contact the applicant directly to provide procedural fairness ... The applicant **must** be given sufficient opportunity to respond to any child protection information relevant to the assessment process ...*

*Where child protection information is considered relevant to the assessment process, **and where appropriate**, the applicant must be given notice and information in [sic] (either in writing or verbally) that factors of concern exist and may influence the decision making process ...*

*During the risk assessment, **where practicable** the applicant may be given a reasonable opportunity to submit information relating to their child protection history and for this information to be considered.* [Emphasis added]¹⁰¹

There is no clarity in the CP Standards as to what is an ‘appropriate’ or ‘practicable’ circumstance such that an assessment officer can deviate from the overall position of giving an applicant the opportunity to provide a submission focusing on factors of concern.

Only Standard 4 acknowledges the possibility of inconsistent or unreliable information being uncovered when child protection information is being reviewed. It directs the assessment officer to other sources of information, such as the applicant or SAPOL. However, SAPOL is not commonly involved in child protection notifications, and the applicant often does not have knowledge of them. Assessment officers therefore face an information impasse.

The CP Standards emphasise that child protection information is gathered and recorded for the purpose of assessing risk of harm to children in their *family environment*, and a determination therefore has to be made whether, and to what extent, this indicates the applicant may pose a risk to children in *other settings*.¹⁰² The Commission is not aware of assessment officers being trained in understanding adult behaviour and how their interactions with children might differ depending on the environment. It suggests assessment officers should attempt to understand the nuances of the circumstances leading up to an applicant’s past conduct. This would be the task of a comprehensive psychological assessment, and not one for risk assessments conducted at an administrative level. It also invites assessment officers to have regard to the specific setting in which an applicant will be engaged but this tends against the portability of screening clearances across roles.

When no contextual information can be gathered and the applicant cannot be specifically engaged, it must be extremely challenging for an assessment officer to determine the risk posed to children, particularly if Families SA has not responded to a notification or recorded the outcome of an investigation. The CP Standards recognise that assessments must be made by persons with appropriate backgrounds and skill sets, for example backgrounds in law and law enforcement, child protection, psychology, criminology and/or child development.¹⁰³ The question of the experience and training of assessment officers is discussed later in this chapter. At this point, it is sufficient to recognise that without adequate standards to guide them, even the most qualified or experienced assessment officer may struggle when assessing child protection information.

The CP Standards do not appear to give sufficient clarity to ensure assessment officers are appropriately guided towards child-focused decision making. If child protection information were reviewed by appropriately trained and experienced assessment officers with practical guiding standards, risks posed by an applicant should be identified. Any guiding standards should make clear the circumstances in which an assessment may deviate from a strict adherence to procedural fairness for the applicant. The Commission’s review suggests there will be some child protection histories that are so serious or alarming that to be overly influenced by the inaction of Families SA, and adopt an inflexible ‘innocent until proven otherwise’ stance, risks the safety of children.

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INTERACTION WITH APPLICANTS

The Commission’s review revealed concerning themes with respect to the nature of the Screening Unit’s engagement with applicants in relation to their criminal histories (as well as their child protection histories).

In some circumstances the Screening Unit engaged with applicants by proxy during the screening process, but the grounds on which this was permitted or might be appropriate were not clear to the Commission. For example, in the case of Aboriginal applicants from remote areas, a local community representative commonly translated or spoke on behalf of the applicant. On occasion, a relative communicated with the Screening Unit on behalf of the applicant.

It was difficult for the Commission to draw a conclusion as to how an applicant's responses were weighted in the assessment process and the extent to which issues such as mental health were taken into account. In some instances assessment officers would appropriately weigh an applicant's comments if supported by other evidence, such as judicial sentencing remarks or employer references. At other times, however, the Screening Unit appeared to show extreme sensitivity to the rights of the applicant and an inclination to accept an applicant's uncorroborated responses. There did not appear to be a method for weighting dishonest or inappropriate behaviour by applicants during the screening process. Some applicant behaviours clearly raised questions about professional and personal integrity, yet assessment officers appeared challenged as to how this might affect their decision making.

These themes are highlighted by the following examples:

- An applicant failed to declare a criminal conviction to the Screening Unit for assaulting his own child. Nevertheless he was granted a specific clearance to work in a school.
- An applicant received a clearance despite an allegation that he had sexually assaulted a child in his care, and a failure to disclose his termination from his associated employment with a care agency for misconduct. (The allegation was not investigated by Families SA and did not result in criminal charges.)
- An applicant failed to declare to the Screening Unit a finding of not guilty of robbery with violence because of mental incompetence, yet was granted a clearance for continued employment as a youth worker. The applicant had failed to disclose the matter during a previous assessment which resulted in a specific clearance.

There will be occasions where the decision maker falls into error because they have overlooked a relevant circumstance, or given too much weight to a matter, or taken into account an irrelevant factor. There will also be occasions, as with any discretionary decision-making process, when the circumstances are borderline and others may have reached a different conclusion. This does not necessarily mean the decision was incorrect. However, the Commission is concerned that borderline matters are tending to fall in favour of the applicant, rather than keeping a firm focus on child safety.

The Screening Unit needs to achieve greater consistency with respect to an applicant's responses which inform the assessment process. There needs to be a better understanding across all levels of decision makers in the Screening Unit as to how information from an applicant should be weighted and used in the assessment process. This may be achieved through clearer documented guidance and better training.

The Screening Unit should also be concerned with maintaining the integrity of its processes. It should be made clear to an applicant when lodging an application that a failure to declare a relevant matter to the Screening Unit, or misleading the Screening Unit, may result in a fine, in addition to potentially adversely affecting the outcome of the assessment.

RECORDS MANAGEMENT

The validity of screening assessments depends on the soundness of the databases which underpin them. As discussed, those databases in turn reflect the quality of the assessments and decisions of the relevant authority. The Screening Unit is clearly challenged by the search limitations and poor quality of information on the CIS and C3MS databases. To some extent this is not surprising given these systems were never intended to be used for the Screening Unit's purposes.¹⁰⁴

It was evident from the Commission's review that the Screening Unit often experienced difficulty extracting factual information from child protection databases. The Commission saw examples of the Screening Unit being unable to:

- satisfactorily establish the identity of an applicant in regard to child protection matters;
- determine from the child protection databases whether or not one of the applicant's children was in the care of the state;
- determine from C3MS if a report had been made to SAPOL about the applicant's treatment of foster children; and
- determine from the databases, or Families SA directly, the status of Families SA's earlier directive that the applicant not work with its clients again, or whether this directive had ever been enforced. The applicant had been the subject of a care concern investigation when previously employed by an agency contracted to Families SA. Nevertheless, the applicant was cleared to work for another agency contracted to Families SA.

Gathering information from C3MS and CIS is a resource-intensive process. Assessment officers often spend a large amount of time confirming the identity of individuals, ensuring information has been recorded against the correct person, determining relationships between the applicant and other persons listed on the database, linking children to the applicant and reviewing the histories of those children.¹⁰⁵

A case of mistaken identity?

In an assessment briefing reviewed by the Commission, the Screening Unit was faced with a question as to the applicant's identity. The applicant intended to undertake a volunteer role in a children's dancing program. Records held on child protection databases indicated a possible match to a male with the same date of birth, first name and surname, but a different middle name. A previous address given by the applicant also matched that of the recorded male. The records referred to the male, a number of years earlier, having been imprisoned in New South Wales for 23 years.

More recent records revealed a series of nine child protection notifications in relation to a male with the same first name and surname as the applicant. It was alleged the male had befriended intellectually disabled sisters, aged 15 and 17 years, through the dancing program, whom he then groomed, had inappropriate contact with and sexually abused.

The Screening Unit was unable to obtain information from CrimTrac about the male with the different middle name, as the applicant had not used this name in his application. The Screening Unit therefore had no permission to obtain criminal history information in relation to the different middle name.

The Screening Unit engaged the applicant. He advised he did not have, or use, any other middle names and he had never lived in New South Wales or been to prison there. The assessment officer recommended a general clearance, concluding:

- it is concerning that there is a reference to a male with a different middle name being the subject of a considerable custodial sentence, but this cannot be confirmed and was denied by the applicant;
- it is concerning the applicant appears to be in a relationship with a 17-year-old girl; however, this in itself is not unlawful;
- the other allegations around his inappropriate relationship with the girl's family have been investigated by Families SA and none have been substantiated; and

- the individual is not precluded from a clearance on the basis of unsubstantiated child protection notifications especially considering there is no supporting evidence available to the Screening Unit.

It is worth noting that of the nine child protection notifications, the assessment briefing only referred to Families SA responding to one of them. After the third notification it assessed the children as 'safe and risk assessment moderate'. Its investigation revealed no child protection concerns and it concluded it appeared the situation was motivated by family conflict. After the fourth notification Families SA referred back to its recent investigation and to the fact no disclosures had been made by either child, but noted that the older sister might have been coached in some answers.

Further, although in general terms a sexual relationship with a 17-year-old might not be unlawful, the question of intellectual disability in this case was relevant but it is not clear from the assessment briefing whether that was taken into account.

The matter went through the layers of authority in the Screening Unit and was eventually referred to CAP. At the panel's request the Screening Unit again contacted the applicant. He was asked to detail his address history. Perhaps unsurprisingly there was a period of 23 to 24 years where the detail given by the applicant could at best be described as vague. It is tempting to conclude this imprecision flowed from his incarceration for a significant period of time which he did not want to disclose to the Screening Unit. During this engagement the applicant provided information about his apparently platonic relationship with the sisters.

Following receipt of this information, CAP decided to offer a specific clearance. The panel determined the applicant was not the male with the different middle name who had been incarcerated for 23 years. The only evidence in support of this determination was the applicant's denial. This was accepted despite the matching address and date of birth.

The frustrations experienced by the Screening Unit when accessing the databases of Families SA are not unique. They echo the frustrations of many users of C3MS (see discussion in Chapter 5). The Commission has recommended improvements to the way information is handled on these systems. Such improvements should assist the Screening Unit in its practices and over time lead to less fallible screening outcomes.

KNOWLEDGE AND SKILL OF ASSESSORS

No screening methodology will be perfect or 100 per cent accurate and screening will not pick up those few people with clean records who later commit terrible crimes when working with children.¹⁰⁶ There is no question that the Screening Unit has an extremely difficult task. In a constrained environment, pressured by numbers of applications and complaints about processing times, and in the absence of well-founded formulae for predicting risk, it must attempt to construct an assessment decision from disparate bits of information of variable quality while attending to the rights of the applicant.

The assessment of information beyond proven criminal offending often calls for a highly complex and demanding decision-making process.

The Commission's review demonstrated that, on paper at least, the Screening Unit was operating a procedurally driven and methodical system.

The Creating Safe Environments for Children—Organisations, Employees and Volunteers, National Framework sets out what is required for competent risk assessment and decision making:

*A mix of knowledge, skills and abilities is needed in any environment where risk assessment takes place. Analytical and investigative skills, a capacity for structured questioning and decision making, and understanding of the settings in which child-related employment/volunteering takes place, are all important. Where possible, there is merit in assessments being based upon multidisciplinary knowledge from corrective services, child protection, psychology and the law. Persons responsible for risk assessment may possess this expertise, or it may be gained through consultative arrangements.*¹⁰⁷

In addition to maintaining a team of assessment officers with relevant and diverse qualifications and/or experience, there should be an appropriate suite of tools to encourage consistent decision making in the best interests of the children. Conducting risk assessments will never be an exact science but it is clear that predicting child abuse through a formal risk assessment model is more accurate than leaving it to chance.¹⁰⁸ While the expertise and judgement of assessment officers is

relevant, they cannot be relied on alone. Whatever their qualifications or professional backgrounds, assessment officers need strong case formulation capacities which allow them to integrate multiple threads of factual information with knowledge about relevant predictive data in decision making.

The Commission was told that, in collaboration with DCSI's Registered Training Organisation, the Screening Unit is working towards developing a specific qualification relevant to the role of assessment officers.¹⁰⁹ This development should be pursued with a view to addressing challenges identified throughout this chapter.

OTHER CHALLENGES

EMPLOYER RESPONSIBILITIES IN THE HUMAN SERVICES FIELD

The Commission's review revealed that the screening process on occasion cleared people with troubling personal backgrounds. Of course, an unfortunate personal history does not necessarily result in poor quality work. However, the combination of such matters as low pay, relatively low qualification requirements, low employer expectations, access to vulnerable clients, and work which intersects with personal experience, make the human services particularly attractive for those with personal agendas to pursue or who have few other employment options. It is through a susceptible human services field that some persons with undesirable characteristics will gain access, often unsupervised, to vulnerable and damaged children who require a reliable and expert service.

The Commission reiterates that a screening process is only one part of a whole system to ensure that suitable workers work with vulnerable children and poor or high risk workers do not.¹¹⁰ Screening can never be a substitute 'for proper vigilance by individuals and society'.¹¹¹

Screening can never be a substitute 'for proper vigilance by individuals and society'

Beyond the role of the screening agency, information about applicants disclosed in some reviewed assessments highlighted the need for more rigorous scrutiny in the employee selection process, and any subsequent supervision. The number of persons with negative histories who were already in employment raises concerns about some human service employee selection processes. Post-screening recruitment processes, staff training, staff management and, most importantly of all, staff supervision and monitoring are critical. The Commission is concerned that inappropriate

workers are able to move freely from one job to another in the human services field and vulnerable children suffer the consequences.

PORTABILITY OF SCREENING CLEARANCES

INTRASTATE

In an overview of the South Australian scheme in its *Working With Children Checks report*, the federal Royal Commission commented that 'clearances are not portable; a new criminal history assessment must be undertaken each time a person begins new child-related work'.¹¹² In other words, a person who has a valid clearance may not use it to work or volunteer for different organisations.

However, this Commission was informed by the director of the Screening Unit that clearances are portable within South Australia.¹¹³ Clearance certificates expressly state they 'can be accepted by a number of organisations'. The Criminal Standards also provide that an organisation conducting a relevant history assessment can rely on a certificate issued within the preceding three years by an authorised screening unit.¹¹⁴

However, if an organisation chooses to conduct its own assessment of a potential employee, the employee cannot rely on that assessment with any other organisation.

The intrastate portability of clearances is clearer in other jurisdictions, in part because no other jurisdiction allows organisations to conduct their own assessments and engage a person without a clearance from a screening unit. In New South Wales, Western Australia and the Northern Territory, a Working With Children Check (WWCC) is portable across roles and organisations. Similar arrangements exist in the ACT and Tasmania, with the exception of clearances that are role-based or subject to certain conditions and therefore not transferable. In Queensland and Victoria, WWCCs are portable across roles and employers, but a volunteer's WWCC is not transferable to paid child-related work.

INTERSTATE

The Criminal Standards permit an organisation conducting its own assessment of a person's relevant history to accept a current screening clearance from another Australian jurisdiction.¹¹⁵ Presumably, this is because every jurisdiction at a minimum assesses a person's criminal history and pending charges, and that is all that is required of an organisation.

In all other circumstances, there is no interstate portability of screening clearances. If an individual moves across borders and wants to work or volunteer with children, they will require a new screening clearance.¹¹⁶

THE PROPOSED NATIONAL STANDARDS

A nationally consistent approach to creating child-safe environments has been on the agenda since 2005 when the Community and Disability Services Ministers' Conference established the Creating Safe Environments for Children National Framework. The framework sets out best practice across areas such as risk assessment and decision making when undertaking background checking, excluding people from child-related employment, and cross-jurisdictional information sharing. This was followed in 2009 by the National Framework for Protecting Australia's Children 2009–2020, again encouraging a nationally consistent approach to screening and information sharing of criminal histories.¹¹⁷

Against the background of some progress over the last 10 years, the federal Royal Commission's examination of WWCCs has brought to the fore the inconsistencies and deficiencies of the screening regimes across Australia and has proposed a national model.

The focus of screening must be on the safeguarding of children. Clearly, reform is necessary in South Australia to streamline and strengthen the current scheme. However, the efficacy and necessity of the expected outcomes of a national scheme, such as portability of WWCCs across jurisdictions and assisting organisations and people working across borders to comply with screening requirements, must be considered with the primary focus in mind—will these outcomes improve the safety that can be offered to children?

The federal Royal Commission recommended a national model for WWCCs, highlighting:

*The combined effect of the varied and complex schemes, the lack of portability of WWCCs, the capacity for people to forum shop for a less rigorous scheme, and the lack of infrastructure to support the effective sharing of information across borders weakens the protection that could otherwise be afforded to children by an effective, national WWCC.*¹¹⁸

However, support for a national WWCC scheme does not appear to be unanimous. Although the federal report indicates a general consensus across Australian jurisdictions for a nationally consistent approach to WWCCs, views differed as to the form it should take. There was a large degree of support for establishing a single national scheme from non-government organisations, but state and territory governments were less supportive of this concept. They preferred to implement consistent standards across jurisdictions rather than shift to a single national scheme.¹¹⁹

In response to weaknesses identified in screening schemes across Australia, the federal Royal Commission made a swathe of recommendations aimed at improving the protection afforded to children. For the national model to be achieved, generally state and territory governments need to amend their schemes to include consistent standards across key aspects of the schemes, support information sharing across borders and permit the portability of WWCCs.¹²⁰

While this Commission does not question the fundamental proposition that WWCCs 'deliver unquestionable benefits to the safeguarding of children'¹²¹, it is necessary to consider the value of South Australia supporting and moving towards the national approach proposed by the federal Royal Commission.

As discussed earlier in this chapter, South Australia's scheme is in need of reform and it would be assisted by adopting some of the standards set out in the federal Royal Commission's report.¹²² The following section of this chapter examines the recommendations and standards proposed by the federal scheme by reference to this Commission's inquiry into the South Australian screening system.

WHO SHOULD REQUIRE A CLEARANCE?

The current legislative scheme in South Australia captures a broader range of persons than many other Australian jurisdictions. It includes people who do not have direct contact with children, such as those who access records about children through their work or who manage persons who have contact with children.¹²³ Evidence before this Commission highlighted the prescriptive nature of the scheme in South Australia, particularly with respect to the current requirement that people have to be subjected to screening checks even if contact with children is only incidental to their employment.¹²⁴

In considering legislative reform there should be a simplified definition of who must obtain a clearance to undertake a child-related role, in order to limit subjective interpretation.

Balance should be struck between protecting children through intrusive screening processes and not imposing unnecessarily or unfairly on the workforce, nor on ordinary community or parental activities. Given the Screening Unit operates a fee-for-service model, it is also important that screening is not so far-reaching as to disadvantage potential applicants from low socio-economic areas and deter them from participating in their communities or the workforce.

Employers and caregivers cannot rely on screening to absolve them of responsibility for safeguarding children. There will be some contacts with children that are so incidental to a person's role that strategies other than screening should be employed to ensure the environment is safe. There will also be some instances when children are only put at risk because of irresponsible actions on the part of their caregiving adult. The legislative scheme cannot be so broad as to cover all eventualities of contact, particularly those where it is expected a responsible caregiver would safeguard the child.

Founded on the view that WWCCs should not apply to people who have only incidental contact with children and who do not work with children, the standards proposed by the federal Royal Commission would narrow the scope of persons currently required to be screened in South Australia. For example certain occupations, such as taxi-drivers, school cleaners and people handling children's records, would no longer be subject to a WWCC.¹²⁵ Nevertheless, there is some merit in the proposed standards as to who should require a screening clearance.

DEFINING CHILD-RELATED WORK

The federal Royal Commission has recommended that state and territory governments should amend their WWCC laws to incorporate a consistent and simplified definition of child-related work in line with recommendations contained in its report. This Commission supports that recommendation.

The federal Royal Commission sets out the following categories which can be regarded as child-related work:

- i. *accommodation and residential services for children, including overnight excursions or stays;*
- ii. *activities or services provided by religious leaders, officers or personnel of religious organisations;*
- iii. *childcare or minding services;*
- iv. *child protection services, including out-of-home care;*
- v. *clubs and associations with a significant membership of, or involvement by, children;*
- vi. *coaching or tuition services for children;*
- vii. *commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions;*
- viii. *disability services for children;*
- ix. *educational services for children;*
- x. *health services for children;*

- xi. justice and detention services for children including immigration detention facilities where children are regularly detained;*
- xii. transport services for children including school crossing services; and*
- xiii. other work or roles that involve contact with children that is a usual part of, and more than incidental to, the work or roles.¹²⁶*

However, this definition needs to be read in conjunction with the overarching requirements set out by the federal Royal Commission¹²⁷:

- work must involve contact between an adult and one or more children to qualify as child-related work;
- the phrase 'contact with children' refers to physical contact, face-to-face contact, oral communication, written communication or electronic communication;
- contact with children must be a usual part of, and more than incidental to, the child-related work;
- it is irrelevant whether the contact with children is supervised or unsupervised;
- a person is engaged in child-related work if they are engaged in the work in any capacity and whether or not for reward; and
- work that is undertaken under an arrangement for a personal or domestic purpose is not child-related even if it would otherwise be so considered.

The key issue with respect to these definitions is the interpretation of when contact transcends the incidental to become usual. To lessen the opportunity for subjectivity leading to misinterpretation, it would be helpful for these terms to be further defined and guidance provided as to how often and how regular the contact must be to constitute 'usual'. The purpose of a role and the subject of the service may also be relevant in determining 'incidental' contact. For example, if a person is engaged solely to coach an adult sporting team but in the course of that role has some contact with a children's sporting team at the same club, that contact may or may not be regarded as incidental.

The Commission understands that the application of the above definition of 'child-related work' would mean that some persons in South Australia who currently perform a 'prescribed function' would no longer be screened. Nevertheless, some organisations may still opt for their prospective employees to be screened as a result of some particular feature of their role. For example, a person whose role involves working regularly, with minimal supervision, accessing sensitive health records about children might be the subject of such an optional screening.

It is also useful to refer to section 64(1) of the Child Sex Offenders Registration Act which contains a definition of 'child-related work'. It is in similar terms to the categories set out by the federal Royal Commission. However, the South Australian Act specifically includes work in connection with taxi services and hire car services (whether or not the work involves contact with a child). That is not necessarily captured by the federal Royal Commission definition of transport services for children, unless it is a car service contracted to transport children on a regular basis.

ADULTS RESIDING IN THE HOME OF AN AUTHORISED CARER

The federal Royal Commission proposes a requirement that all adults residing in the home of authorised carers of children should hold a WWCC. While authorised carers should be screened, extending this to other adults residing in the house may not be appropriate. It would, for example, capture the natural son of foster parents who had just turned 18 and who remained living at home. It is not the job of a mandatory screening check to provide a safeguarding measure in ordinary familial circumstances: that responsibility should sit with the authorised carer and the child's caseworker. It may be that a caseworker will seek a screening clearance for another adult residing in the house, but that is a matter to be determined through consideration of the particular circumstances of the residential arrangements.

SCREENING EXEMPTIONS

The federal Commission proposes that defined groups of persons who are engaged in child-related work be exempt from needing a WWCC. Acknowledging that a screening regime is not designed to encompass every person with whom a child comes into contact, generally speaking, the proposed categories are appropriate. If adopted, the most obvious divergence from the current legislative position in South Australia is that registered teachers would no longer be exempt from holding a screening clearance.¹²⁸

TEACHERS

In South Australia, registered teachers are exempt from the application of the screening scheme but are subject to a fit and proper person assessment under the *Teachers Registration and Standards Act 2004* (SA).¹²⁹ In part this involves a criminal history check, obtained by the Teachers Registration Board through CrimTrac.

The exemption of teachers from requiring a screening clearance has been in place since 2010. At that time, the Screening Unit relied on an assessment of an applicant's criminal history similar to the practices of the Board. However, the Screening Unit's assessments have evolved to encompass a much broader suite of information, including child protection records and cross-jurisdictional, expanded criminal history information (ECHIPWC).¹³⁰

From March 2014 the Board has been obtaining access to records held by the Department, most notably child protection information.¹³¹ The Board relies on Families SA personnel to action its requests for information, as opposed to the Screening Unit which has read-only access to the child protection databases.

Teachers have significant relationships and frequent unsupervised interactions with large groups of children.¹³² That relationship may be of even greater import for a vulnerable child who is in care with inconsistent caregivers or who is challenged by their experiences in their home environment.

As at 30 June 2015, there were approximately 36,000 registered teachers in South Australia.¹³³ This Commission acknowledges that the removal of their exemption will result in a substantial increase in the number of assessments which are required to be made by the Screening Unit. However, there is no reason why teachers should be exempt from the most rigorous of screening assessments, which reviews the greatest range of records available. This is consistent with the Commission's recommendation that the Screening Unit should be the only screening pathway for child-related roles in South Australia.

It would appear that the government has already given some consideration to this issue. In June 2013 in the *Report of Independent Education Inquiry*, Commissioner DeBelle referred to an announcement by the Minister for Education of an intention to require teachers and student teachers to undergo a child protection history assessment in addition to a criminal history check. Commissioner DeBelle noted that the screening process would only be effective if the Screening Unit was suitably resourced. He recommended that:

*the complement of staff of the Screening Unit at the Department for Communities and Social Inclusion be appropriately increased to manage the extra volume of work required for the purpose of screening teachers and students intending to be teachers.*¹³⁴

The staffing of the Screening Unit was increased in the 2013/14 financial year. However, teachers remain exempt and have not added to the Screening Unit's volume of work.

This Commission considers that the exemption of teachers from the Regulations should be removed and that teachers be required to be subject to the screening regime which is applicable in this state. The implementation of this recommendation could be staggered with a requirement that teachers obtain a screening clearance at the time of the next review of their three-year registration.

OVERNIGHT CARE

The federal Royal Commission proposes that a person who engages in child-related work for seven days or fewer in a calendar year be exempt, except in respect of overnight excursions or stays.¹³⁵ This reflects a provision in the South Australian Regulations which ties the exemption to a period of not more than 10 consecutive days or not more than one day in any month. However, this exemption does not apply to organisations or persons who provide residential or overnight care for children.¹³⁶

It is not entirely clear whether the federal Royal Commission's reference to 'overnight excursions or stays' is intended to capture emergency care workers who may only work a few shifts with children in care.¹³⁷ However, this Commission considers that, regardless of the number of shifts, no person should be permitted to work in a commercial or residential care environment with children who are in the care of the state without first being screened. Any reformed legislation should leave no room for uncertainty in this regard.

PARENTS OR GUARDIANS WHO VOLUNTEER

Under the South Australian Regulations, a person who volunteers 'to provide a service in his or her capacity as a parent or guardian of a child who is ordinarily provided with the service', is exempt from requiring a screening assessment unless the service involves overnight care or is provided only to children with disabilities.¹³⁸

Similarly, the federal Royal Commission recommended that 'parents or guardians who volunteer for services or activities that are usually provided to their children' should be exempt in respect of that activity, unless it involves¹³⁹:

- overnight excursions or stays; or
- providing services to children with disabilities that involve close, personal contact with those children.

In late January 2016, the Minister for Education and Child Development announced the Department had updated its screening policy, consistent with the federal Royal Commission's recommendations, to make it easier for parents to volunteer their time.¹⁴⁰

The Department's updated screening policy provides that volunteers participating in Departmental services¹⁴¹:

- do not require a screening if they are a parent (or guardian) of the child in direct receipt of the services they are providing;
- do not require a screening if they are a parent (or guardian) coaching a sporting team and their child is in the team. If their child is not in the team a screening is required;

- do require a screening if they are involved in overnight camps, school sleepovers, billets and homestays; and
- do require a screening if they are volunteering with children with disabilities and the services involve close personal contact.

It is not clear what is intended by ‘direct receipt’ of services. Even if a service involves the parent’s own child, for example school outdoor activities or providing transportation for an excursion, other children involved in those activities may find themselves being provided a service directly by the parent volunteer.¹⁴²

The Department’s narrowing of the screening requirement to services that involve ‘close personal contact’ with children with disabilities, while in line with the federal Royal Commission’s recommendations, is inconsistent with the provisions of the South Australian Regulations. Under the Regulations ‘close personal contact’ with children with disabilities is not said to be relevant to whether or not a person is exempt.

Putting to one side the Department’s policy, organisations in the community who engage volunteer parents are left to interpret, and operate within the bounds of, the Regulations.

This Commission is concerned that the position with respect to exemptions for parents who volunteer may be confusing. As a starting point, it is necessary to recognise that ‘by and large, then, extra-familial and mixed-type offenders seek victims close to home—among the children of friends or other children with whom they already have some social relationship’.¹⁴³ The reality is that offenders can also be parents, and many offenders access victims through their own children. However, a balance must be struck between safeguarding children and not intruding disproportionately into ordinary parental activities.

The federal Royal Commission’s recommendation provides some guidance when determining the categories of volunteer parents who should be exempt. However, the state government should consider whether screening of parents or guardians who participate in services that involve close personal contact, such as assistance with toileting or dressing, with any children, not just those with disabilities, is appropriate. Volunteer parents involved in providing overnight services (other than personal or domestic arrangements) should be subject to screening.

A PROHIBITION TO RELYING ON AN EXEMPTION

The federal Commission proposes that persons who have been denied a WWCC should not be able to rely on an exemption to participate in child-related work.¹⁴⁴ This Commission supports this proposal.

WHAT RECORDS SHOULD BE ASSESSED?

This Commission agrees with the proposal by the federal Royal Commission that an applicant’s criminal history should include:

- convictions, whether or not spent;
- findings of guilt that did not result in the recording of a conviction; and
- any charges, regardless of status or outcome.

The proposal requires police services to provide screening agencies with ‘any other available information relating to the circumstances of such offences’.¹⁴⁵ The provision of ‘any other available information’ should be limited to offences in an applicant’s criminal history that the Screening Unit considers warrants further assessment.

In general terms, the proposal of the federal Royal Commission as to the types of criminal matters to be assessed is consistent with the current position in South Australia and the information available through ECHIPWC (the exchange of criminal history agreement). However, the Screening Unit gathers valuable information from a broader range of sources than police services, such as the courts, and there would appear to be no reason to limit this process.

SPENT CONVICTIONS

This Commission agrees with the recommendation of the federal Royal Commission that spent convictions should come within the definition of criminal history and therefore be assessed. However, reform of the screening legislation in South Australia should occur in line with the safeguards in the Spent Convictions Act.

Under the Spent Convictions Act, the Screening Unit may consider spent convictions in its screening process, but only if good reason exists, giving strong weight to the fact that the conviction is spent or relates to circumstances that did not lead to an actual conviction. The Screening Unit must provide reasons if it decides to have regard to spent convictions.¹⁴⁶

INFORMATION BEYOND AN APPLICANT'S CRIMINAL HISTORY

The federal Royal Commission proposes that an applicant's disciplinary and/or misconduct information should be assessed where the conduct was against, or involved, a child, but does not set out the types of records that should be checked. Other jurisdictions include information provided by professional or regulatory organisations associated with teachers, childcare providers, foster carers and health practitioners.¹⁴⁷ The Screening Unit does not routinely undertake checks for professional misconduct. However, it does obtain information from some regulatory bodies, such as the Australian Health Practitioner Regulation Agency and prohibition orders issued by the South Australian Health and Community Services Complaints Commissioner, if there is something in the application or assessment process to trigger that inquiry. As a general rule, the Screening Unit regards searches of publicly accessible sources, such as the Australian Association of Social Workers list of persons ineligible for employment, to be the prospective employer's responsibility.¹⁴⁸

Some disciplinary or misconduct information will not be publicly available, such as that relating to the deregistration of foster carers or formal proceedings of the Teachers Registration Board. Consistent with the proposal of the federal Royal Commission, legislative amendments in South Australia should include a requirement that the Screening Unit assess disciplinary and/or misconduct information, particularly where the information is not publicly available. The legislation should address the way in which this information is brought to the attention of the Screening Unit. There is merit in the federal Royal Commission's proposal to require the bodies responsible for the disciplinary or misconduct information to notify the Screening Unit of relevant information.¹⁴⁹

THE USE OF CHILD PROTECTION RECORDS

The federal Royal Commission does not exclude child protection records from use in WWCCs, but they are not included in the recommended standard on information to be assessed.¹⁵⁰ For the reasons set out in this chapter, this Commission considers that child protection records should always be assessed by the Screening Unit during every child-related employment screening.

Information afforded by child protection notifications and care concerns, which might not be available by simply assessing criminal histories, can be highly informative to screening assessments. The Commission's review found a number of assessments in which a potential risk to children was only revealed through information beyond that associated with the applicant's criminal history, in particular by reference to child protection histories.

In view of the challenges faced by the Screening Unit in assessing child protection records, it is tempting to adopt the federal standards and the practices of many other jurisdictions. This would be the simplest way to overcome issues such as:

- data integrity within the child protection databases accessed by the Screening Unit;
- resource inefficiencies associated with assessment officers wading through cumbersome child protection histories;
- having regard to unresolved child protection notifications in a procedurally fair assessment; and
- deficiencies associated with the investigation of care concerns (see Chapter 15).

These complications are further exacerbated by the fact the CP Standards are silent on data quality or investigation inadequacies and do not provide matrix guidance on risk assessment against the type and number of child protection reports or events.

While there is support for a completely streamlined and integrated national screening system, the Commission does not recommend that the state government adopt a standardised definition of disciplinary and/or misconduct information that would exclude, or narrow, the assessment of child protection information. This would lead to a less rigorous screening scheme and potentially allow children to come into contact with adults who would place their safety and wellbeing at risk. Reviewing child protection information should result in more accurate screening assessments. Research highlights the statistical relevance of prior allegations of child abuse as an indicator of the likelihood of future abuse.¹⁵¹

AUTOMATIC REFUSALS

The federal Royal Commission proposes that the absence of any relevant criminal history and disciplinary or misconduct information should lead to an automatic grant of a WWCC.¹⁵² However, this Commission considers there should not be an automatic grant unless the absence of disciplinary or misconduct information includes an absence of child protection history.

The federal Royal Commission also recommends that any conviction or pending charge for the following categories of offences should lead to an automatic refusal provided the applicant was at least 18 years at the time of the offence:

- murder of a child;
- manslaughter of a child;
- indecent or sexual assault of a child;
- child pornography-related offences;

- incest where the victim was a child;
- abduction or kidnapping of a child; or
- animal-related sexual offences.

The proposal for automatic refusals for these offences is understandable. However, even for the crime of manslaughter, judges often comment on the difficulty of fashioning an appropriate sentence in view of the wide range of circumstances in which that crime can be committed. The same can be said for some sexual offences. For example, an applicant when aged 19 may have had a sexual relationship with a young woman aged 16 who was a willing participant and whose parents were aware of the relationship. Nevertheless, he would still be guilty of a sexual offence. However, 10 years later, with no other criminal or relevant history and married to the young woman concerned, he seeks a screening clearance to volunteer as the coach of a junior boys' basketball team. Under the automatic refusal categories proposed by the federal Royal Commission, the Screening Unit would have no choice but to refuse the clearance.

Although the appeal provisions proposed by the federal Royal Commission would appear to give such an applicant a right of review, it may nevertheless be more appropriate to limit the automatic refusal category to the crime of murder of a child and provide that all other categories mentioned trigger a risk assessment. That would enable the Screening Unit to examine the circumstances of the relevant offence in its historical context.

The federal Royal Commission also proposes categories of offences that should trigger a risk assessment. For some, depending on the time passed since the offending, the Screening Unit currently issues a clearance without further assessment. As part of legislative reform, it would be appropriate to review the offences that trigger an assessment in this state (currently set out in the Screening Unit's assessment procedures and the matrix guiding assessment officers).

It is important to note that a person who is a registered offender according to the Child Sex Offenders Registration Act is prohibited from applying for, or engaging in, child-related work. A person remains a registered offender for life, regardless of whether the period of their reporting obligations has expired. This leaves the Screening Unit with no discretion in respect of registered offenders, even if a significant period of time has passed since their offending, there has been no further offending and they are no longer subject to reporting obligations. Clearly there is a close practical relationship between the screening scheme and this Act. When considering legislative reform, and in particular whether to make any categories of offences the subject of automatic refusals, it will be necessary to ensure there is consistency between the screening scheme and the Child Sex Offenders Registration Act.

CRITERIA FOR RISK ASSESSMENT

The federal Royal Commission proposes that standard criteria for assessing risk be legislated.¹⁵³ These criteria are appropriate and largely consistent with those outlined in the standards currently guiding assessment officers in South Australia.¹⁵⁴ There is merit in the proposal that the legislative scheme expressly provide that, in assessing risk, 'the paramount consideration must always be the best interests of children, having regard to their safety and protection'.¹⁵⁵

CONDITIONAL CLEARANCES

As discussed in this chapter, this Commission considers that screening clearances should never be granted on a conditional basis and should be detached from the organisation or the role the person is intending to undertake. This is consistent with the recommendations of the federal Royal Commission.¹⁵⁶

COMMENCING WORK PENDING A CLEARANCE

The federal Royal Commission proposes that persons should be allowed to commence child-related work while their WWCC application is pending, provided appropriate safeguards are put in place such as a receipt for the pending application being provided to an employer and the employer verifying this with the screening agency. A processing benchmark of five days is proposed, with no longer than 21 days for more complex cases.¹⁵⁷

In South Australia organisations are not permitted to engage a person in child-related work until an assessment of their relevant history has been undertaken. The Commission considers this should remain the position (provided that assessment results in a clearance being granted). In view of recent improvements in processing times the Screening Unit should be able to maintain earlier mentioned benchmarks of seven and 28 days. The Commission believes these times are not unreasonable for a person to wait before engaging in child-related work.

Under the proposed reforms of the legislative scheme, with clearances transferable across roles and valid over a period of potentially five years, it is an unnecessary risk to allow individuals to commence employment before a check is completed. Further, in the proposed system, which is driven by employees rather than employers, individuals who anticipate working in a child-related field could take the initiative and obtain a clearance at any time before being prompted to do so by a particular employment opportunity.

Nevertheless, there will still be a small number of applications that will take longer than 28 days to process. These are likely to be applications that require detailed information gathering or complex decision making. They will relate to those persons who potentially pose a real risk to children, and time is required to make that assessment. To allow such a person to work with children for an extended period of time pending the grant of a valid clearance is not acceptable. This Commission acknowledges this may seem unreasonable for that small proportion of applicants who are not cleared within about one month of their application but the safety of children must always be the paramount consideration.

MONITORING DURING THE LIFE OF A SCREENING CLEARANCE

In addition to determining how often the risk a person poses to children is assessed, the validity period of a WWCC has implications for administrative matters such as application fees and the operational costs of screening schemes. It also determines the currency of information held by screening agencies.¹⁵⁸

The average duration of a WWCC in Australia is three years.¹⁵⁹ Evidence before the federal Royal Commission suggested the principal reason for limiting the duration of a WWCC to within that timeframe was the lack of a national system alerting screening agencies to relevant changes in an individual's criminal history.¹⁶⁰ That is, the validity period is 'linked inextricably to screening agencies' capacity to identify and monitor new relevant records, as they arise'.¹⁶¹

The federal Royal Commission proposes that WWCCs be valid for a period of five years.¹⁶²

Currently, South Australia's screening scheme is a point-in-time assessment of risk that does not involve systematic monitoring during the lifetime of a clearance. Organisations that conduct their own assessment of a person's relevant history cannot effectively facilitate ongoing monitoring.

After granting a clearance, the Screening Unit relies on information coming to light in an opportunistic manner which identifies new risk factors and triggers the need for a reassessment. Such information may come from a variety of different sources, for example chance reports from SAPOL or requesting organisations. The provision of fresh information from the Care Concern Investigations Unit is more structured, with the Screening Unit being routinely advised of serious matters regarding a person who holds a valid clearance.¹⁶³

If additional adverse information is received, the Screening Unit has no legislative mandate to revoke or retrieve a clearance certificate. The Screening Unit has sought to retrieve a certificate following the receipt of additional information on only a few occasions. While the Screening Unit has always notified the requesting organisation, it has not always been successful in retrieving the certificate from the individual.¹⁶⁴

The absence of the ongoing monitoring of screening clearances in South Australia constitutes a significant deficit in pre-employment screening practices. Every other state or territory monitors an individual's criminal history on an ongoing basis. This does not entail reviewing a person's *national* criminal history as is undertaken when a clearance is first issued—it is restricted to the individual's criminal history in the particular jurisdiction.¹⁶⁵ As proposed by the federal Royal Commission, South Australia should work with other jurisdictions towards the continuous monitoring of criminal histories through a national database operated by CrimTrac.

The Screening Unit has announced that in mid-2017 it will move to a real-time monitoring system. Regular updates will be provided to the Screening Unit through linking with SAPOL and other databases. New information that may affect a person's clearance status will be available to the Screening Unit for assessment. A person's clearance status can then be withdrawn if appropriate.¹⁶⁶

If this proves to be a robust system whereby changes that affect a person's complete risk profile are promptly identified and assessed, and organisations are alerted to any consequent changes in a person's clearance status, it would be appropriate to consider extending the duration of all clearances to five years.¹⁶⁷

The implementation of an ongoing monitoring system has the potential to moderate the number of applications submitted to the Screening Unit. Those organisations that currently require annual screenings would be able to rely on continuous monitoring to identify indicators of risk, rather than having to make regular applications to the Screening Unit.

ESTABLISHING A REGISTER

As part of the ongoing monitoring system, a public register should be established and maintained by the Screening Unit of all clearances issued, and their expiration dates. Organisations and individuals should be required to register the use of a clearance with the Screening Unit, to ensure that they are notified if a clearance is cancelled.

Refused clearances should also be registered, but this register should not be available for public viewing.

PORTABILITY ACROSS JURISDICTIONS

At present, individuals seeking to engage in child-related work must hold a WWCC in each jurisdiction in which they wish to be employed. A consistent theme in the federal Royal Commission's report was the need for screening checks to be portable across jurisdictions. This was said to be particularly relevant given the transient nature of the Australian workforce. Although the federal Royal Commission reported that 'more than 300,000 people move across jurisdictional borders each year, and this figure does not include temporary movements to other states or territories'¹⁶⁸, it is unknown what proportion of this group are engaged in child-related positions.

Nevertheless, the federal Royal Commission considers that a national approach and consistent WWCC standards are necessary to support mobility and reduce administrative burdens on organisations providing services across jurisdictions. It proposes that all state and territories should enable WWCCs from other jurisdictions to be recognised and accepted in their jurisdiction.¹⁶⁹

This Commission considers that this state should be cautious in simply accepting a WWCC from another jurisdiction. New jurisdictions should be mindful of the possibility that the applicant may have first applied for a clearance in another jurisdiction safe in the knowledge they did not have any relevant disciplinary or misconduct information in that jurisdiction. Even if the proposed national standards were adopted, there remains the potential for some schemes to be more robust than others. The extent of disciplinary and misconduct information assessed is likely to vary across jurisdictions.

Before a screening clearance from another jurisdiction is accepted, an assessment of all the available information against the legislation and standards that apply in this state should be conducted.

APPEAL PROCESSES

The legislative scheme in South Australia does not provide an appeal mechanism for persons who are refused a clearance.

An applicant wishing to dispute the Screening Unit's decision to refuse a clearance can apply to have it reviewed internally. The applicant must demonstrate a substantive reason exists for the Screening Unit to accept an application for review, such as the availability of new or additional information that might affect the outcome or that irrelevant information was considered as part of the initial assessment.¹⁷⁰

If an application for review is accepted, the matter will be re-assessed by an assessment officer who had no association with the initial screening decision. The same information reviewed in the initial assessment will be assessed afresh, along with any new or additional information provided by the applicant.¹⁷¹

If the applicant is still dissatisfied following an internal review, external avenues of review may be available through government agencies such as the South Australian Ombudsman or the Human Rights Commission. The applicant may also seek a judicial review in the Supreme Court.¹⁷² In all other states and territories a person who is refused a clearance may appeal either to an administrative tribunal or local court.¹⁷³

The federal Royal Commission proposes that any person who is the subject of an adverse WWCC decision should be able to apply by way of appeal to a body independent of the WWCC screening agency, but within the same jurisdiction, for a review of that decision. However they exclude from any such appeal those persons who have been convicted of¹⁷⁴:

- murder of a child;
- indecent or sexual assault of a child;
- child pornography-related offences; or
- incest where the victim is a child.

The person must have also received full-time custodial sentence for the conviction, or by virtue of the conviction be subject to a control order.

The federal Royal Commission had difficulty in identifying all the offences that should exclude a right of appeal due to the differences between states and territories as to the description of relevant offences.¹⁷⁵ However, curiously the proposed categories are less extensive than those for automatic refusals mentioned earlier. Manslaughter, abduction/kidnapping and animal-related offences are not included, but the concept of penalty (that is, imprisonment or a control order) is introduced. A narrow group of offences would therefore be left for which the Screening Unit would be obliged to refuse a clearance, but a right of appeal would be available to the applicant against that automatic refusal.

The Commission agrees with the proposal for an independent review by way of appeal from an adverse screening decision of the Screening Unit. A person convicted of the murder of a child obviously should be excluded from any such appeal. Other than this, a right of appeal should only be excluded from those categories of offences that the South Australian legislature considers appropriately the subject of an automatic refusal.

The ACT, New South Wales, Queensland, Victoria and Western Australia all provide for a right of appeal within their screening legislation to their respective administrative tribunal. On 30 March 2015, the South Australian Civil and Administrative Tribunal (SACAT) commenced. SACAT currently deals with matters such as residential tenancy agreement disputes, the appointment of guardians for persons with a mental incapacity, treatment orders for persons with a mental illness, and the review of some government decisions such as assessment decisions made by Housing SA. SACAT has a broad mandate and a membership with an appropriate range of expertise. Consideration should be given to including a right of appeal to SACAT or some other independent body. It will be important, particularly for the resourcing needs of the Screening Unit, to establish a streamlined appeal pathway that places minimal burden on the Screening Unit. This is possibly best achieved through the review jurisdiction of SACAT that provides for the examination of a decision by way of re-hearing.¹⁷⁶

ENFORCING COMPLIANCE

Amendments to the legislation with respect to the screening scheme in South Australia should include specific offences to encourage compliance with the legislation. Such offences can be guided by those proposed by the federal Royal Commission and also incorporate specific features of the reformed South Australian scheme. For example¹⁷⁷:

- engaging in child-related work without holding a WWCC;
- engaging a person in child-related work without them holding a WWCC;
- providing false or misleading information in connection with a WWCC application;
- as a holder of a WWCC, failing to notify a screening agency of a relevant change in circumstances; and
- unauthorised disclosure of information gathered during the course of a WWCC.

There may be merit in requiring an organisation not only to notify the Screening Unit when they engage (or no longer engage) an individual, but also to report other relevant disciplinary or misconduct information that comes to its attention. This obligation would in some ways be comparable to New South Wales' 'reportable conduct scheme'.¹⁷⁸

Placing an obligation on organisations to report relevant conduct to the screening authority will strengthen the message that a screening clearance does not absolve them of their ongoing responsibility to assess and monitor employees or volunteers. It would be consistent with the requirement that organisations implement a broader suite of strategies aimed at ensuring their organisation is child safe.

The implementation of offence provisions would require a process to monitor and investigate compliance and prosecute non-compliance. The evidence before this Commission does not allow for a conclusion to be drawn as to who would be best placed to perform such functions. The structure would to some extent be dictated by resources. As it stands there is no agency or body in South Australia specifically tasked with monitoring compliance with the screening scheme.¹⁷⁹ It may be that a monitoring and compliance team could be established within the Screening Unit, with statutory powers to monitor compliance with the screening legislation and compel production of information to facilitate this.

TECHNOLOGICAL REQUIREMENTS

Underpinning the utility of a national scheme is the establishment of a centralised database, operated by CrimTrac and accessible by all jurisdictions to record WWCC decisions.¹⁸⁰ While this Commission maintains its position that screening in this state should continue to be of a broader scope than that proposed by the federal Royal Commission, it supports the establishment of a national database. Knowing that an applicant has been previously refused a clearance in one or more other jurisdictions, or is currently the subject of a suspended clearance, would be a significant starting point for an assessment.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

238 Enact a stand-alone legislative instrument to regulate the screening of individuals engaged in child-related work which:

- a declares that the paramount consideration in screening assessment must be the best interests of children, having regard to their safety and protection;
- b invests powers in only one authorised government screening unit which is charged with maintaining a public register of all clearances and their expiration dates;
- c empowers the screening authority to take into account in its assessments criminal offence and child protection history, professional misconduct or disciplinary proceedings, and deregistration as a foster parent or other type of carer under the *Family and Community Services Act 1972*;
- d provides a clear definition of child-related work, including the meaning of incidental or usual contact;
- e declares that the outcome of a screening assessment will be limited to either a clearance or a refusal and that all applications, even if withdrawn, will be assessed;
- f requires individuals to seek and maintain a personal clearance, valid for a period of up to five years, through a card or unique electronic identifier system, which has portability across roles and organisations in the state; and to notify the screening authority of relevant changes in their offence, conduct or child protection circumstances;
- g requires employers to ensure that all relevant personnel in their organisations, at all times, hold current clearances;
- h precludes exemptions from screening requirements for—
 - i registered teachers
 - ii applicants waiting on screening outcome decisions

iii those working or volunteering with children who are in care

iv those who have been refused a WWCC;

- i details offences for individuals and organisations who fail to comply with the provisions of the legislation, including engagement in or for child-related work without a clearance, and dishonesty in the application process; and
- j permits appeals from decisions of the screening authority to the South Australian Civil and Administrative Tribunal or other independent body.

239 Establish a real-time monitoring system which ensures that changes in screened individuals' circumstances are communicated to the screening authority, that clearances are reviewed, and that changes are reflected in the register, and communicated to employers.

240 Charge the screening authority with:

- a ensuring that it has access to forensic expertise in child protection and behavioural indicators of risk;
- b developing a consolidated set of standards, matrices, and weighting guidelines for use in screening assessments, that include substantiated and unsubstantiated criminal, child protection and disciplinary matters, and ensuring that assessors are appropriately trained in their application;
- c developing guidelines for ensuring that applicants are afforded appropriate procedural fairness, including circumstances in which information may be withheld from applicants;
- d developing and promulgating timeline benchmarks for screening outcomes, and procedures for informing applicants whose clearances may fall outside benchmarked times;
- e developing information sharing protocols with interstate screening units.

241 Develop an independent mechanism and evaluation process for reviewing the performance of the screening authority.

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- 31 *Children's Protection Act*, s. 8B(6).
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- 38 *Children's Protection Regulations 2010*, r. 10A(2).
- 39 DECD, *Child safe environments*, p. 12.
- 40 *ibid.*
- 41 *ibid.*
- 42 *Children's Protection Regulations 2010*, r. 14.
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- 70 Witness statement: K Tattersall.
- 71 *Spent Convictions Act 2009* (SA), s. 9A.
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OVERVIEW

It is evident from this report that significant obstacles remain to effective collaboration and information sharing between the many government and non-government agencies that form South Australia's child protection system. This chapter summarises measures discussed elsewhere in this report to improve collaboration and information sharing. It also includes some additional recommendations for recasting the duty to share information within the child protection system and bringing together the leadership of key government and non-government agencies to promote ongoing strategic cooperation.

This chapter principally relates to the Commission's Terms of Reference 1 to 4.

BENEFITS AND CHALLENGES OF INTER-AGENCY COLLABORATION

As discussed in Chapter 8, the potential benefits of coordinating services include¹:

- being able to address complex, interrelated issues simultaneously;
- reducing financial costs by identifying needs and targeting support earlier, and reducing multiple visits to separate support services and duplication of services;
- improving access to services;
- improving information sharing and cooperation between service providers;
- improving service quality, outcomes and satisfaction with service delivery among service users and providers.

At the same time, it is easy to become cynical about initiatives that purport to promote collaboration. Buckley and Nolan have commented on recommendations following reviews and enquiries:

*You can seal [the report] in a brown envelope before you start and know that inter-agency cooperation will come up, probably something to do with adherence to policy and procedure and all these predictable things ... you can bet your bottom dollar that they will come out.*²

In recent years, the Layton Review and the Children in State Care Inquiry emphasised the importance of inter-agency collaboration and recommended measures for improvement in this state. Elsewhere in Australia, the Victorian Vulnerable Children Inquiry³, Carmody Inquiry⁴, Wood Inquiry⁵ and Bath Inquiry⁶ also recommended measures to improve collaboration.

The continuing challenge of inter-agency collaboration was a consistent theme in evidence before the Commission. Services are often fragmented and poorly coordinated, leaving areas of duplication and service gaps (see Chapters 8 and 10). People find it difficult to navigate the system to access the services they need. Information sharing between agencies is often poor and there is a siloed approach to service delivery, as opposed to a coordinated, multi-agency response, which may often be required.

It is easy to criticise agencies for poor collaboration. However, collaboration is difficult. Significant obstacles hinder coordination of the work of the various agencies—including government, for-profit and not-for-profit—that form the wider child protection system. Agencies often have different interests and face competitive pressures that discourage collaboration. Their practitioners come from diverse backgrounds, with differences in training, experience, service approach and ideological views. These barriers need to be overcome by a process that promotes collaborative practice.

MEASURES TO PROMOTE COLLABORATION

The Commission is endorsing and recommending a series of measures to promote service collaboration in South Australia's child protection system. For example, recommendations in Chapter 8 include establishing a cross-departmental Early Intervention Research Directorate to prepare a prevention and early intervention strategy. It would guide the funding of services across the South Australian Government and form the basis of negotiations with federal and local governments. A further recommendation is to establish child and family assessment and referral networks throughout South Australia with a lead not-for-profit agency managing a local entry point for services provided by partner agencies in each region. The network would promote collaborative practice and coordinated, multi-service responses.

The draft Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect (a revision was due to be released in July 2016) (ICP) is the guiding document for inter-agency collaboration in investigating suspected child abuse or neglect in South Australia (see Chapter 9). The revised ICP better addresses all forms of abuse and neglect, not just sexual abuse. It applies to government and non-government agencies that provide relevant services.

Under the ICP, strategy discussions by Families SA (the Agency), South Australia Police (SAPOL) and Child Protection Services are central to coordinating responses to individual Tier 1 and 2 child protection notifications. While the revised ICP encourages Families SA to act as lead agency and to coordinate service provision

throughout the assessment process, this does not always happen. Chapter 9 emphasises the need for the Agency to convene strategy discussions more promptly (and without delay when children present with physical injury), to include all relevant government and non-government participants, and to reconvene discussions throughout the assessment process as required.

Chapter 10 discusses the importance of the Rapid Response policy, which gives priority access to state government services for children in care. It recommends establishing an inter-departmental committee to oversee Rapid Response and review its operation at least biannually.

INFORMATION SHARING

The Information Sharing Guidelines (ISGs) are a 'statewide policy framework for appropriate information-sharing practice'.⁷ They apply to most state government agencies and to non-government organisations contracted by the state government to provide services. The ISGs require agencies to share information where 'a person is at risk of harm (from others or as a result of their own actions) and adverse outcomes can be expected unless appropriate services are provided'.⁸ They guide practitioners step by step in the responsibilities and decisions for information sharing.

A consistent theme in evidence before the Commission was that, in spite of the ISGs, many agencies fail to share information. The Commission was told of a persistent culture that privileges privacy and confidentiality over the need to share information relevant to the health, safety and wellbeing of children.

It may be that the ISGs, as a policy framework, do nothing to ease legislative restrictions on information sharing. The first step for decision making under the ISGs is to follow specific legislative requirements and the guidance of the practitioner's agency.⁹

Most relevantly, section 58(1) of the *Children's Protection Act 1993* (SA) makes it an offence for a person engaged in the administration of the Act to divulge personal information obtained in the course of that administration, relating to a child, a child's guardians or other family members or any person alleged to have abused, neglected or threatened a child. The phrase a 'person engaged in the administration of the Act' is broad enough to include not only the Agency, but also a range of government and non-government agencies that respond to vulnerable and at-risk children and support their families. The personal information caught by section 58(1) is also wide in the context of child protection practice.

Section 58(3) creates exceptions so as not to prevent a person:

- from divulging information if authorised or required to do so by law;
- from divulging statistical or other data that could not reasonably be expected to lead to the identification of any person to whom it relates; or
- engaged in the administration of the Act, from divulging information if authorised or required to do so by his or her employer.

The first two exceptions would not usually help practitioners working with children and families, except when notifying the Agency of suspected child abuse or neglect. The third exception permits very wide divulging of information if authorised by a practitioner's employer, but gives no guidance as to the basis on which such authorisation should be given.

The Department's chief executive has given a general authorisation to Families SA staff to divulge information under section 58(3) when either:

- the information is divulged to a person (government or non-government personnel including carers) with a duty of care for a child or young person; or
- it is necessary to divulge that information to that person in order to protect that child or young person from risk of serious harm.

In each case, staff must proceed to follow the ISG principles and, in the event that personal information is shared without the consent of the person it relates to, first seek approval from a supervisor or another senior officer.¹⁰

This permission offers no assistance to other agencies that must individually decide what information employees are permitted to share. The process is cumbersome and liable to produce inconsistency.

Section 58 effectively assumes personal information is confidential unless an employer provides otherwise. However, legislation in New South Wales strikes a different balance. Section 245A of the *Children and Young Person's (Care and Protection) Act 1998* (NSW) includes the following three principles¹¹:

- agencies with responsibilities for the safety, welfare or wellbeing of children should be able to provide and receive information that promotes the safety, welfare or wellbeing of children;
- those agencies should work collaboratively in a way that respects each other's functions and expertise, and should be able to communicate with each other to facilitate service provision to children and their families; and

- because the safety, welfare and wellbeing of children are paramount, the need to provide services relating to the care and protection of children, and the needs and interests of children and their families in receiving those services, take precedence over the protection of confidentiality or of an individual's privacy.

The NSW legislation expressly permits 'prescribed bodies' to provide information to each other relating to the safety, welfare or wellbeing of a child (or class of children) to help the recipient make a decision, assessment or plan, or initiate or conduct an investigation, or provide a service, relating to the safety, welfare or wellbeing of the child or class of children; or manage risk to the child.¹² Prescribed bodies may also ask each other for information relating to the safety, welfare or wellbeing of a child for the same purposes; generally speaking, they must comply with such requests.¹³ Importantly, the prescribed body must not use or disclose the information for any purpose that is not associated with the safety, welfare or wellbeing of the child (or class of children) to whom the information relates.¹⁴ These provisions take precedence over other laws that might otherwise prohibit or restrict the disclosure of information.¹⁵ Prescribed bodies include NSW Police, a public service agency or public authority, a government or registered non-government school, a TAFE establishment, a public health organisation, a private health facility or any other body prescribed by regulations.¹⁶

These provisions significantly recast the balance in favour of information sharing to promote the best interests of children. The South Australian Children's Protection Act should be amended to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies with responsibilities for the health, safety or wellbeing of children, where it would promote those responsibilities. Amendments should identify the agencies with a common obligation to share information, as providing agencies, receiving agencies, or both. The Agency would need powers to both give and receive information. Such a scheme would require a cultural shift for those agencies accustomed to holding client information closely. The overriding consideration for these proposed arrangements should be the three principles cited above from the NSW Act.

It is important to recognise that even with the proposed amendments, the exceptions provided in section 58(3) will still need to be utilised in some circumstances and must therefore be maintained. For example, information may need to be disclosed to an individual, as opposed to an agency, if their conduct relating to the abuse of a child is being investigated by a person engaged in the administration of the Act.

Multi-Agency Protection Service

The Multi-Agency Protection Service (MAPS) is an initiative led by SAPOL. It brings together in one location staff from SAPOL, Housing SA, Correctional Services, Families SA, Education and Health to share information about incidents of family and domestic violence. It draws upon the United Kingdom example of Multi-Agency Safeguarding Hubs.

After each shift, police officers complete a risk assessment form on any domestic violence incidents. Every morning, MAPS reviews these forms and selects high-risk cases and those otherwise of interest for 'mapping'. In the mapping process, information gatherers from each agency search their respective databases for information relevant to the case. They enter this information into a summary document.

Once all agencies have entered their information, the summary document is forwarded to a tactical team who review the information together and identify actions for each agency. These actions are recorded and the completed document returned to the agencies. Examples of actions include directing the relevant Family Violence Investigation Section of SAPOL to convene a family safety framework meeting, notifying a school so that it is aware of the risk factors or directing a barring order in cases where there is a problem with alcohol. The process helps agencies to make more complete assessments and earlier, better informed responses at the local service level.¹

¹ Oral evidence: J Shanahan; D McLean. Women's and Children's Health Network, 'Women's safety strategy—Multi-Agency Protection Service', internal unpublished document, SA Health, Government of South Australia, no date.

LEADERSHIP TO SUPPORT COLLABORATION

Overcoming the obstacles to inter-agency collaboration requires concerted effort and leadership. To demonstrate this commitment, leaders from agencies with responsibilities for the health, safety and wellbeing of children should meet regularly to identify strategic measures to promote inter-agency collaboration and information sharing. This is a forum at which promising models for collaboration, like the Multi-Agency Protection Service (MAPS), can be pursued.

Attendees should be senior leaders, generally at chief executive or deputy chief executive level or their equivalent, with authority to speak for, and make commitments on behalf of, their respective agencies. They should represent health, education, police, youth justice, disability, housing, mental health, family violence, drug and alcohol services, community services, multicultural services, correctional services and the Screening Unit. The forum should also include representatives from the Child and Family Welfare Association of SA, Aboriginal Family Support Services and other non-government service providers. They should meet at least four times a year.

The NSW legislation expressly requires prescribed bodies to take reasonable steps to coordinate decision making and the delivery of services for children.¹⁷ A similar duty should be included in the South Australian legislation.

As recommended by the Wood Inquiry, chief executives from government agencies that have responsibilities for the health, safety and wellbeing of children should have, as part of their performance agreements, a requirement to ensure inter-agency collaboration in child protection matters and a metric for measuring that performance.¹⁸

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

242 Amend the *Children's Protection Act 1993*:

- a** to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies that have responsibilities for the health, safety or wellbeing of children where it would promote those issues; and
- b** to require prescribed government and non-government agencies to take reasonable steps to coordinate decision making and the delivery of services for children.

243 Require senior leaders from government and non-government agencies that have responsibilities for the health, safety and wellbeing of children to meet at least quarterly to identify strategic measures to promote inter-agency collaboration and information sharing.

244 Review procedures and employment arrangements so that chief executives of government agencies with responsibilities for the health, safety and wellbeing of children have a provision included in their performance agreements that obliges them to ensure inter-agency collaboration in child protection matters, and measure that performance.

NOTES

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- 2 H Buckley & C O'Nolan, 'Child death reviews: Developing CLEAR recommendations', *Child Abuse Review* 23, 2014, pp. 89, 95.
- 3 P Cummins (Chair), D Scott & B Scales, *Report of the Protecting Victoria's Vulnerable Children Inquiry*, State of Victoria, January 2012, pp. 484–485, Recommendation 83.
- 4 T Carmody (Commissioner), *Taking responsibility: A roadmap for Queensland child protection*, Report of the Queensland Child Protection Commission of Inquiry, State of Queensland, 2013, pp. xix, 73–4, 101–2, 157.
- 5 J Wood (Commissioner), *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, NSW Government, November 2008, pp. v–viii, Recommendations 10.4, 10.9, 24.1–24.7.
- 6 M Bamblett, H Bath & R Roseby (Co-chairs), *Growing them strong, together: Promoting the safety and wellbeing of the Northern Territory's children*, Report of the Board of Inquiry into the Child Protection System in the Northern Territory 2010, Northern Territory Government, Darwin, 2010, pp. 9, 31, 34, Chapter 11.
- 7 Ombudsman South Australia, *Information sharing guidelines for promoting safety and wellbeing*, Ombudsman SA, 2014, p. 9.
- 8 *ibid.*, p. 8.
- 9 *ibid.*, p. 13.
- 10 Department of Education and Child Development, *'Information sharing guidelines for promoting safety and wellbeing (ISG)—procedure'*, Government of South Australia, July 2015, pp. 7, 13.
- 11 *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 245A (2).
- 12 *ibid.*, s. 245C.
- 13 *ibid.*, s. 245D.
- 14 *ibid.*, s. 245F.
- 15 *ibid.*, s. 245H.
- 16 *ibid.*, ss. 245B, 248(6).
- 17 *ibid.*, s. 245E.
- 18 J Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, Recommendation 24.2.

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OVERVIEW

The child protection system is frequently at the forefront of public debate and attracts a high level of media interest. When events occur and decisions are made that adversely affect personal relationships and family lives, people can feel aggrieved, excluded and silenced. They can feel powerless to influence decisions which have a substantial impact on them.

Children whose lives are shaped by the way the system operates can be at particular risk of marginalisation if understanding them and taking their point of view into account is not emphasised. Children living in out-of-home care in particular can be constrained in their ability to influence the system and effect changes at a high level.

Both system and individual issues can be independently examined by oversight and review mechanisms, improving transparency and quality of decision making and service provision.

In this chapter, the term ‘oversight’ is used to describe organisations that are tasked with examining matters that come to their attention at a system level. This function might also involve advocacy for particular individuals in the system, but their focus is not on reviewing or investigating individual matters. ‘Review agencies’ are those established to consider individual grievances, and are empowered to report back to agencies on individual matters.

In South Australia, system oversight comes from a group of bodies created and defined in the *Children’s Protection Act 1993* (SA): The Guardian for Children and Young People (GCYP), the Child Death and Serious Injury Review Committee (CDSIRC), and the Council for the Care of Children (the Council). These bodies contribute (among other functions) to the examination and monitoring of children’s wellbeing. The Ombudsman SA and the Health Care and Community Services Complaints Commissioner (HCSCC) provide review functions.

With the exception of the Ombudsman, all current oversight and review bodies were established following the Layton Review of Child Protection in South Australia in 2003, and modified as a result of recommendations from the Children in State Care (CISC) Commission of Inquiry in 2008. Their structure and functions reflect aspects of recommendations from both reports.

The Layton Review also recommended the creation of a Children’s Commissioner, a recommendation not implemented. Instead, the Council for the Care of Children was created. However, agitation has continued for the appointment of the Layton recommended Children’s Commissioner.

At present bipartisan support is strong for the appointment of a Children’s Commissioner but there is some dispute as to the powers and functions of that office. This chapter recommends the appointment of a Children’s Commissioner, and considers the functions that should be included within their remit.

This chapter also considers current structures and proposes a system to create a more complete, cohesive and accessible network for review and oversight.

The chapter principally relates to the Commission’s Terms of Reference 5(a) to 5(h), in the context of Terms of Reference 1 and 2.

CURRENT OVERSIGHT AND REVIEW ARRANGEMENTS

The Layton Review made several recommendations for establishing a framework of services to oversee and promote the interests of children. They were based on comparing services operating in the state against interstate and overseas models for the protection of children’s interests and services. The review recognised an increasing acknowledgement in the community that parents or caregivers might not always be the best advocates for the interests of children, and it was appropriate to empower a specialist body or bodies to represent children’s interests.

The review identified four, then unfulfilled, functions in South Australia: promotion and advocacy for children; an independent complaints and grievance service; screening for child related employment; and a separate representative for children who are in the care of the state.¹

The Layton Review proposed a framework for fulfilling those functions:

- A Children’s Commissioner would promote and advocate for children, and develop screening processes for child-related employment. The model anticipated the appointment of a Deputy Commissioner filled by an Aboriginal² person. The Review did not recommend including a complaints jurisdiction within the role of the Children’s Commissioner, recognising the potential for conflict between complaint and advocacy roles.
- A Children’s Guardian would be an independent statutory body in the Office of the Children’s Commissioner, with functions including a focus on monitoring children in care, and ensuring that the care provided was in accordance with guidelines set out in a charter of rights.
- A complaints and grievance process relating to decisions on administrative actions would include independent review by the Ombudsman. This recommendation would have enhanced the functions

of the Ombudsman, but exclude jurisdiction for those complaints or grievances that fell within the jurisdiction of a proposed Health and Community Services Ombudsman.

- A special unit in the proposed office of the Health and Community Services Ombudsman would investigate complaints and grievances about services concerning children.
- A Child Death and Serious Injury Review Committee would monitor epidemiological factors and develop strategic approaches to protect children from death and serious injury.
- Administrative measures across government were aimed at improving coordination and relationships across all sectors of government, and included as a first step creation of a South Australian Child Protection Board.

The functions of existing oversight and review organisations are outlined below.

GUARDIAN FOR CHILDREN AND YOUNG PEOPLE

GCYP's powers relate solely to children under guardianship or in the custody of the Minister, with a particular focus on children in foster care, kinship care and residential care. The functions of GCYP, set out in sections 52C and 52EB of the Children's Protection Act, include:

- promoting children's best interests;
- individually advocating for children;
- monitoring children's circumstances more broadly;
- advising the Minister about quality of care and whether children's needs are being met;
- investigating and reporting to the Minister on matters referred by the Minister³; and
- developing and monitoring a Charter of Rights for Children and Young People in Care.⁴

GCYP's operations are driven by two imperatives: achieving transparency about the circumstances of children in care, and strengthening the voice of those children.⁵ Former guardian Pam Simmons explained that her focus had been determined by:

*looking at what we are finding from our monitoring, and then whatever the most critical issues are from our monitoring activity, then we make a decision about what we will enquire into, and ... our advocacy flows from that.*⁶

GCYP almost always assists a child who raises a complaint. However, if an adult approaches GCYP with a grievance, GCYP is guided by its capacity and the seriousness of the matter in deciding whether the help can be provided, or if the matter should be referred to a more appropriate source for resolution. The former

guardian considered there was value in exercising both individual advocacy and systemic monitoring functions. In helping with individual complaints, GCYP monitors repetition and identifies ongoing issues for children in care.⁷

For GCYP to conduct a systems inquiry, an identified topic must affect a significant number of children, cause significant disadvantage to them, not be the subject of another inquiry and have some associated urgency. GCYP determines at a quarterly meeting which matters are to be the subject of major inquiry, depending on capacity.⁸

In Chapter 12, the Commission recommends the development of a community visitors scheme for children in emergency care and residential care facilities. This would add to GCYP's oversight responsibilities, especially in relation to monitoring the wellbeing of children in rotational care.

The guardian is independent of the Minister and is empowered to request, and receive, information from government or non-government organisations which provide services to children.⁹ The guardian is obliged to consider children's views and is supported by a youth advisory committee.¹⁰ GCYP reports to the Minister, and its reports must be tabled in Parliament.¹¹

GCYP's office comprises the guardian, assisted by 5.8 full-time employees (FTE)—3 FTE as advocates, 0.8 in communications, 1.0 as office manager and 0.6 as policy officer. Actual spending of GCYP for 2014/15 was approximately \$874,518.¹² The Commission observes that GCYP's legislative remit is currently being satisfied very economically.

COUNCIL FOR THE CARE OF CHILDREN

The functions of the Council for the Care of Children are set out in section 52J of the Children's Protection Act. The Council focuses on advising the government about the rights and interests of children, reporting about the wellbeing of children and considering child-specific legislation. It investigates and reports on matters referred to it by the Minister.¹³ The Council is subject to the direction of the Minister, but has independent authority to make findings or recommendations.¹⁴

In 2014/15, the Council's annual spend was \$268,787.¹⁵ The Council has a staff complement of 1.8 FTE, and its members are offered sitting fees, although some members do not apply for them, preferring that the small budget be preserved for other important work. The modest funding has prevented the Council from fulfilling every aspect of its broad legislative mandate, and it has been unsuccessful in obtaining additional resources to permit it to do so.¹⁶

In 2009, the Council developed a monitoring framework as part of its responsibility to report to government on the wellbeing of children in the state. Guided by a concept of 'child wellbeing', the framework monitors children's outcomes in five domains which measure children's development and participation in life, with the aim of tracking progress over time and identifying areas which require greater focus.¹⁷

The initial report in 2009 set a baseline against which future outcomes could be measured. Two further reports have been published since then, in 2013 and 2015, reviewing and reporting against those key indicators.¹⁸ The development and monitoring of the framework was accomplished through the goodwill of the Council's membership and did not attract any additional funding to support it.

CHILD DEATH AND SERIOUS INJURY REVIEW COMMITTEE

CDSIRC reviews the circumstances surrounding the death or serious injury of children. Its purposes include identifying trends and patterns in cases of child death or serious injury, and reviewing policy, practice and procedures designed to prevent such deaths and injuries. It maintains a database of child deaths and serious injuries, and their circumstances and causes, for performing its roles.¹⁹

CDSIRC reports periodically to the Minister on the performance of its functions and its annual reports are tabled in Parliament. It is subject to the Minister's direction but cannot be directed about its findings or recommendations.²⁰

The committee is restricted from disclosing information about the circumstances of individual cases to relevant agencies or more broadly. Confidentiality provisions apply, except for information on potential criminal offences, information which suggests a child may be at risk of abuse or neglect, or information relevant to a coronial inquiry.²¹

CDSIRC membership comprises experts from across the private and government sector. In the 2014/15 year its 16 members brought together expertise from disciplines including law, social work, psychology and medicine. Private members receive a retention allowance of approximately \$5,600 per year and are paid sitting fees. They are not paid for preparation time for meetings or reviews outside meetings. Government employees are not paid additional allowances as membership is part of their substantive employment. Committee members contribute a great deal of their time for no remuneration.²² The total spend for CDSIRC in the 2014/15 annual year was \$313,870, including salaries for a small secretariat.²³

HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSIONER

HCSCC was created as an independent body with functions relating to health and community services complaints. It fulfils the functions anticipated in the Layton Review for the Health and Community Services Ombudsman. Its overarching purposes are to:

*provide for the making and resolution of complaints against health or community service providers; to make provision in respect of the rights and responsibilities of health and community service users and providers.*²⁴

HCSCC is the primary body tasked with reviewing individual grievances relating to child protection. Its functions include²⁵:

- resolving individual complaints about services, including by conciliation;
- inquiring into and reporting on matters relating to services;
- identifying and reviewing issues arising from complaints, making recommendations about improving services, and advising and reporting to the Minister;
- providing information, advice and reports to registration authorities; and
- developing a Charter of Health and Community Services Rights.

Complaints may be made on grounds that relate to service provision. The most relevant grounds for child protection service complaints are that a service provider²⁶:

- acted unreasonably by not providing a health or community service, or by discontinuing (or proposing to discontinue) a health or community service;
- gave an unnecessary or inappropriate service;
- acted unreasonably in the manner of providing the service;
- failed to exercise due skill;
- failed to treat the user in an appropriate professional manner or failed to respect their privacy or dignity;
- unreasonably disclosed information about the user to a third party; and
- failed to conform with generally accepted standards of service delivery.

HCSCC is not required to act in the interests of children generally or to advocate for them individually or as a group. It is bound by its legislation to encourage and assist complainants to attempt to resolve complaints directly with service providers. It may not act on a

complaint if it forms the view that the complainant has failed to take reasonable steps to resolve the matter with the service provider without good reason.²⁷ However, this is usually inappropriate when a child is the user of the service to which the complaint relates.

THE NATURE AND NUMBER OF COMPLAINTS

A relatively small volume of complaints are received by HCSCC relating to child protection issues. In 2014/15 only 4.6 per cent (102 of a total of 2200) of complaints received related to its child protection jurisdiction. Of these, the vast majority (67.5 per cent) related to service delivery, with the second highest proportion relating to communication or information (24.1 per cent).²⁸ These numbers are consistent with the two preceding financial years.²⁹

The number of complaints received by HCSCC appears out of keeping with the level of dissatisfaction with the child protection system that the Commission has encountered in the course of its inquiry. It is also inconsistent with rates of complaint observed in some other jurisdictions. For example, the rate of complaints was over twice as high in New South Wales, with the Ombudsman's child protection jurisdiction receiving 0.14 complaints per thousand people in the population compared to the 0.06 per thousand people received by HCSCC.³⁰

Three factors may have a bearing on this comparatively low rate: HCSCC does not have a high profile in the community, and service users (particularly children) in contact with the child protection system may be unaware of its service; legislative restrictions on complainants' standing might affect the number of complaints received; and the emphasis is on helping complainants resolve matters directly with the service provider, rather than formally determining complaints.

Following the recommendation of the CISC Inquiry, amendments to the *Health and Community Services Complaints Act 2004* (SA) enabled children who are service users to complain to HCSCC. The CISC Inquiry envisaged that HCSCC would continue the work begun by the CISC Inquiry in hearing complaints about the functioning of the child protection system.³¹ However, the Commission understands that HCSCC has received only two complaints directly from children in the past 10 years.³² The current provisions of the *Health and Community Services Complaints Act* undermine easy access by people with legitimate grievances relating to the child protection system, and reforms are needed.

STANDING TO COMPLAIN

The *Health and Community Services Complaints Act* limits who has standing to make complaints. Primarily, the 'health or community service user' can make a complaint, although the Act provides for options where the service user is a child, or where other circumstances

cause a complaint to be made by someone else.³³ The following options are most relevant to receipt of complaints relating to the child protection system³⁴:

- a person appointed by a child if the child is over 16;
- a parent or guardian of the child if the child is under 16;
- a person approved by the Commissioner to make that complaint on the user's behalf, if the Commissioner is satisfied that it is unreasonable to expect the service user to make a complaint personally; and
- any other person, or anybody who, in the opinion of the Commissioner, should be able to make a complaint in the public interest.

If a child wishes to make a complaint about the actions of the statutory agency, and they are under 16, then their capacity to have an adult act on their behalf may be limited to an adult approved by HCSCC, or an adult who makes a complaint in the public interest. They have the right to have a parent or guardian act on their behalf. However, a birth parent of a child in care is unlikely to be their best advocate in dealings with the complaints body, and as their guardian is likely to be the service they are complaining about, that power is also unlikely to help.

This difficulty is a consequence of the focus of the Act on the quality and efficacy of a service being delivered to a user, and the impact of the delivery (or non-delivery) of that service. The Act does not, on a strict reading, allow a third party who is aggrieved by the service delivery to make a complaint on their own behalf. This can be distinguished from the provisions of the *Ombudsman Act 1972* (SA), which provide that the Ombudsman may entertain a complaint made by any person or body of persons 'directly affected' by an administrative act.³⁵

Many groups may wish to make complaints about services being delivered (or not delivered) to children: relatives, carers and other people aware of a child's circumstances. On a strict interpretation of the legislation they may not make a complaint on a child's behalf. Nor may they make a complaint which focuses on how the nature of the service being delivered to the child impacts on them.

The significance of this issue comes into sharp focus when considering the position of foster parents or other carers aggrieved by a decision made to remove a child under a guardianship order from their care (see Chapter 11). In such a situation, a child may complain about the service delivery by Families SA (the Agency), in removing them from that placement. However, it is unlikely that a child would do so unassisted.

The complexity of the circumstances of a child's removal is likely to make the carer an inappropriate conduit through which a complaint can be made by the child. The focus on the service user excludes the carer from making a complaint about the quality of service delivered to them, because they are not the user of the Agency's service. A carer may be a user of a service being provided by a registered foster care agency supporting the placement of the child, but it is not the actions of that service about which the carer is aggrieved.

Carers may receive some services from Families SA, but they are not the recipient of the care and protection service to which the HCSCC's jurisdiction relates. The service they receive is not aimed at helping them with any disadvantage, rather it is helping them perform such a service for another. The situation of a foster parent or other carer is better aligned to that of a 'service provider', that is, providing a service to the child on behalf of the Agency. Their role is contemplated in the Health and Community Services Complaints Act as that of a volunteer, providing services on behalf of the organisation.³⁶

In another setting, a relative may observe that a young child in the care of their parents is being continuously abused or neglected, notwithstanding the ongoing involvement of the Agency that repeatedly decides not to remove the child from the family's care. Neither the child who is the victim of that abuse and neglect nor the parents who are responsible for it are likely to access the HCSCC to make a complaint. The relative must rely on the Commissioner exercising discretionary powers to receive a complaint on behalf of the child about services being delivered.

The Commission is concerned that the strict interpretation of the Act does not permit many people with legitimate concerns to raise them with the decision-making body that should hear their complaints.

However, the Commission was advised that HCSCC does take an inclusive approach towards the receipt of complaints. Provided a person has a legitimate issue, HCSCC accepts the complaint, even where the complainant does not necessarily fit within the criteria strictly applied. Its basis for receiving the complaint is that it is in the public interest to allow it, or it begins an own-motion inquiry.³⁷ HCSCC receives complaints from birth grandparents, family members, foster parents and other carers, and concerned members of the community.³⁸

HCSCC also considers that foster parents, kinship carers and children are in receipt of community services from Families SA and thus have standing on their own behalf to make complaints to HCSCC.³⁹

The Commission considers that the inclusive position taken by HCSCC, which relies heavily on discretionary powers and a wide interpretation of the jurisdictional provisions, does not reflect the limitations revealed by a strict interpretation of the Health and Community Services Complaints Act. It is only the inclusive attitude taken by the current HCSCC that permits many complaints about child protection to be received and actioned. This flexible approach has allowed the system to function to date, but cannot be considered a long-term solution.

DEFINING A COMMUNITY SERVICE

Child protection services come within the HCSCC's jurisdiction insofar as they are described within the definition of 'community service' in the Health and Community Services Complaints Act. A community service includes both 'a service for the relief of poverty, social disadvantage, social distress or hardship' (section 4(1)(a))⁴⁰ and under section 4(1)(c):

*A service for the care or protection of any child who has been abused or neglected, or allegedly abused or neglected, and includes any service that relates to the notification of any case of child abuse or neglect (or alleged child abuse or neglect), or the investigation of a case where a child may be in need of care or protection, or any subsequent action taken by a service provider arising from any such investigation.*⁴¹

HCSCC receives complaints about child protection services almost exclusively under the definition in section 4(1)(c). If the complaint relates to the Agency, HCSCC assumes that the child concerned is receiving a care or protection service because of abuse or neglect, and accepts that that condition is satisfied.⁴²

The CISC Inquiry recognised that the section 4(1)(c) definition permitted the investigation of complaints regarding many services associated with caring for children who are the subject of abuse, including hospitals, medical services and counsellors.⁴³

However, the Commission observes that the definition, on a strict reading, does not include all children who come into contact with the child protection system. The term 'abuse and neglect' is not defined in the Health and Community Services Complaints Act but is defined in the Children's Protection Act.⁴⁴ Abuse and neglect are not the only bases on which a child may come into the care of the state, or into contact with the system. For example, the relevant test for most intake decisions relates to assessing whether a child is 'at risk'.⁴⁵ This term reflects the potential of abuse or neglect, without any having necessarily occurred, and includes abuse and neglect as one of a number of bases for a finding that a child is at risk.⁴⁶

It is arguable that child protection services might come within the scope of section 4(1)(a). However, the purpose of including section 4(1)(c) then becomes unclear. Yet if section 4(1)(c) is to be interpreted as covering the field of child protection services, it excludes many children who are in contact with child protection systems. The provision should be amended to reflect the broader definition of children at risk in the Children's Protection Act.

POWERS

After receiving a complaint, HCSCC may conduct preliminary inquiries, initiate informal mediation to try and resolve the matter between the service provider and user,⁴⁷ and/or refer the complaint for conciliation, where agreements reached between a complainant and service provider may be made binding.⁴⁸

HCSCC may conduct investigations. It has the power to engage experts, demand information or documents, or require a person to answer questions. It may seek a warrant from a magistrate to enter and search premises for relevant documents.⁴⁹ It must prepare reports following investigation, and may serve a notice of recommended action to a service provider, who may be required to outline what, if any, action has or will be taken about matters in the notice. Copies of notices must be provided to relevant registration bodies, and HCSCC may publish its reports.

HCSCC must produce annual reports to the Minister which are tabled in Parliament. Its reports are then taken to be published as a report of the Parliament.⁵⁰

Following an investigation, HCSCC may refer matters to registration bodies for registered professional groups, or take action where a breach of the code of conduct for unregistered practitioners is identified.⁵¹ With the exception of medical professionals, and some registered allied health professionals including psychologists, these powers would not apply to most practitioners working in child protection services. Social workers, who make up a significant proportion of the professional workforce in child protection, are not registered, so cannot be referred to a registration body. Neither would they come within the definition of a health practitioner for the purposes of the unregistered health practitioners' code of conduct, and consequences that flow from a breach thereof.⁵²

OMBUDSMAN

The Ombudsman's overarching purpose is to 'investigate the exercise of the administrative powers of certain agencies'⁵³, including those of the Department for Education and Child Development (the Department).

The Ombudsman has the capacity to act of its own initiative, on receipt of a complaint or a referral from parliament.⁵⁴ The Ombudsman has the power to conduct

a review of the administrative practices and procedures of an agency where to do so would be in the public interest.⁵⁵

The Ombudsman has flexibility in the categories of persons from whom complaints can be received. Where the administrative act that is the subject of the complaint is 'directly relevant' to the person or body making the complaint, the Ombudsman may receive it. Complaints may also be made on behalf of a person by a member of Parliament or another suitable representative if the person is unable to make a complaint personally, or is deceased.⁵⁶ Complaints made by an employee about an employer's employment-related conduct are specifically excluded.⁵⁷

JURISDICTION

The Ombudsman's jurisdiction is activated by the identification of an administrative act⁵⁸, including those performed by the Agency and by other non-government organisations under a contract with the Agency. It would include the provision of care by for-profit and not-for-profit agencies contracted for that purpose to the Agency.⁵⁹

The Ombudsman's jurisdiction to investigate is set out in section 13 of the Ombudsman Act:

- (1) *Subject to this Act, the Ombudsman may investigate any administrative act.*
- (2) *The Ombudsman may make such an investigation either on receipt of a complaint or on the Ombudsman's own initiative and, where a complaint is made, the Ombudsman may investigate an administrative act notwithstanding that, on the face of it, the complaint may not appear to relate to that administrative act.*
- (3) *The Ombudsman must not investigate any administrative act where—*
 - (a) *the complainant is provided in relation to that administrative act with a right of appeal, reference or review to a court, tribunal, person or body under any enactment or by virtue of Her Majesty's prerogative; or*
 - (b) *the complainant had a remedy by way of legal proceedings, unless the Ombudsman is of the opinion that it is not reasonable, in the circumstances of the case, to expect that the complainant should resort or should have resorted to that appeal, reference, review or remedy.*
- (3a) *The ability to lay a complaint for disciplinary action against a person is to be disregarded for the purposes of subsection (3).*

- (4) *The Ombudsman may investigate any administrative act, notwithstanding any enactment that provides that that administrative act is final or not to be appealed against, challenged, reviewed, quashed or called into question.*

The Ombudsman is the avenue of last resort for complaints resolution and investigation relating to administrative decision making. Where there are rights of appeal or review to any other body, the Ombudsman's jurisdiction is excluded in most circumstances until other avenues are investigated and exhausted.

Because HCSCC holds a specific jurisdictional mandate to consider complaints about community services (including for the care and protection of children), when such complaints are made to the Ombudsman they are referred to HCSCC. The exceptions are complaints unrelated to the HCSCC's jurisdiction, including decisions about registration or de-registration of foster parents and child-related screening decisions. Thus the Ombudsman does not, by and large, conduct investigations into child protection complaints.

POWERS

The Ombudsman's powers of investigation are similar to those of HCSCC. The Ombudsman may conduct investigations arising from complaints or of its own motion, and is subject to a direction to investigate from parliament. The Ombudsman holds an additional power to review administrative practices and procedures of an agency if it is in the public interest to do so.⁶⁰

For the purposes of its investigations, the Ombudsman holds the same powers as a Royal Commission.⁶¹ It can require production of documents under summons, compel a person to attend and give evidence, and inspect, but not search, premises. It may seek a warrant from a court to compel a person to appear and answer questions or produce documentary information.⁶²

The Ombudsman may also issue a notice to an agency to refrain from performing an administrative act for a specified period. Unjustified non-compliance may be reported to the Premier. Further, documents or information obtained, or furnished, by people engaged in service of the Crown or agencies, apart from Cabinet proceedings, may be inspected by the Ombudsman.⁶³

The Ombudsman is empowered to report to the agency investigated if it identifies an error of a defined kind and if it believes that action should be taken⁶⁴, and to make recommendations as it sees fit.⁶⁵ It may subsequently request information about action on those recommendations.

The Ombudsman must provide copies of such reports to the relevant Minister. It may report to the Premier if appropriate steps are not taken to address recommendations, and also report to the Speaker of

the House of Assembly and President of the Legislative Council, requesting that the report to the Premier be placed before each house of parliament. Ultimately the Ombudsman holds the authority to publish information as it sees fit, subject to restrictions in the Ombudsman Act.⁶⁶

OVERLAP OF JURISDICTION

A complaint about a child protection matter may fall into the jurisdiction of both the Ombudsman and HCSCC. A complaint may raise issues relating both to the delivery of a service and an administrative act. If the jurisdiction is shared, section 13(3) of the Ombudsman Act excludes the Ombudsman's jurisdiction. A complaint might also be related to the HCSCC's health services jurisdiction.⁶⁷

The Commission considers that the current jurisdictional arrangements are confusing and unwieldy. At present they are only workable because of the liberal view taken by HCSCC about jurisdiction, and the merits of accessibility. Such an important part of the system should not continue to operate on this basis, and reform is required.

REFORMING COMPLAINTS PROCESSES

THE PROBLEM OF ACCESSIBILITY

The present system of complaints resolution developed in response to the recommendations of previous inquiries, yet the purpose behind the recommendations has arguably not been achieved. The Ombudsman has jurisdiction over administrative acts, but the present application of section 13 prevents the Ombudsman from receiving the majority of child protection complaints. The Ombudsman's office has not developed into a body which effectively and efficiently reviews administrative decisions relating to child protection matters, as was envisaged in the Layton Review.⁶⁸

Similarly, amendments to the Health and Community Services Complaints Act to provide that a child who is a community services user may make complaints have not made HCSCC directly accessible to children with complaints.

Despite the intent of the CISC Inquiry, HCSCC has not developed to continue the work of the CISC Inquiry, investigating complaints of child protection matters and monitoring the effectiveness of child protection reforms.⁶⁹

At present, people with child protection complaints meet barriers to accessing services with the power to investigate their individual case. Legislative provisions surrounding jurisdiction and standing for complaints to HCSCC and the Ombudsman restrict access by people with legitimate complaints.

The Commission has considered whether amendments to the Health and Community Services Complaints Act to broaden standing and jurisdiction would address the problem. The Commission believes it is critical that one agency provide a service that is clearly oriented towards investigating the types of complaints that are agitated, and that the Ombudsman is best placed to provide that service.

THE OMBUDSMAN AS THE PRIMARY AGENCY

HCSCC is strongly oriented towards health services, and focuses on the quality and appropriateness of services provided rather than on administrative acts or decision making. The mandate to inquire into administrative acts, held by the Ombudsman, is more appropriate to the investigation of most complaints relating to child protection services.

Most individual child-protection complaints focus on administrative acts of the Agency. Many complaints do include aspects of service provision, but that is not the main focus.

The most common disputes that have come to the Commission's attention concern:

- decisions to act, or not to act, on a Child Abuse Report Line notification or notifications and in particular failure to intervene after multiple notifications;
- declining to register, or deregistering, a foster, kinship or specific child only carer;
- declining to provide services sought for a child in a foster, kinship or Other Person Guardianship placement;
- delays in basic decision making surrounding children in care, including during the process of considering requests to provide services to children in care;
- decisions to remove a child from a placement;
- delays in the process of investigating care concerns and provision of insufficient information surrounding care concerns; and
- deregistering a foster parent.

Having regard to the nature of the matters described above, the Commission considers that all complaints regarding the child protection system should find principal jurisdiction with the Ombudsman. The Commission recommends that the expertise and resources in the Ombudsman's office be developed to permit it to assume the principal role in the jurisdiction.

The Commission has considered whether a preferable course is to create a fresh body to handle child protection complaints generally. The structure and expertise of the Ombudsman's office, and its profile within the community, are already well established. In these circumstances it is appropriate that the child protection jurisdiction be placed into that service.

Nevertheless, care must be taken to ensure that service-focused complaints which are more appropriately addressed through the HCSCC jurisdiction and focus, or which relate to the provision of health services, still have access to that jurisdiction. The Commission is concerned about continuing to require people with legitimate complaints about child protection to negotiate the overlapping jurisdictions of two agencies.

The Commission recommends that the Ombudsman's Act be amended to empower the Ombudsman also to exercise the jurisdiction of HCSCC in appropriate cases. The Ombudsman and HCSCC should enter into an administrative arrangement to guide which categories of matters remain with the Ombudsman exercising the HCSCC's jurisdiction. The administrative arrangement should identify (at a minimum) exercising dual jurisdictions in child protection complaints, but the Commission does not exclude expansion of this arrangement to other areas in which review processes might be streamlined.

The Health and Community Services Complaints Act should also be amended to remove the ambiguity surrounding the definition of community services as they relate to child protection systems complaints. Specifically, section 4(1)(c) should be amended to more closely reflect the criteria of 'at risk' set out in the Children's Protection Act.

A RIGHT OF APPEAL

A number of contributors argued for reforms which would create an appeal jurisdiction in the South Australian Civil and Administrative Tribunal (SACAT) for some decisions made by the Agency. Foster parents in particular supported the creation of such a mechanism.⁷⁰

An appeal process, it was argued, would expose decision making to greater scrutiny, and potentially shift the entrenched power imbalance between the Agency and the adults and children who are affected by their actions. While this concept has some attraction, and the development of SACAT provides a logical point of review, the Commission is concerned that creating a right of appeal has the potential to divert focus from critical questions of the best interests of the child. Appeals heard in the review jurisdiction of SACAT are conducted according to the *South Australian Civil and Administrative Tribunal Act 2013* (SA). Section 34 of that Act provides for a review to be conducted as a re-hearing, and the Tribunal must 'reach the correct or preferable decision but in doing so must have regard to, and give appropriate weight to, the decision of the original decision maker'.⁷¹ The availability of such a review of selected decisions would, in most cases, exclude the jurisdiction of the Ombudsman, because of the prohibition on the Ombudsman investigating when a remedy is otherwise available through legal processes (unless it is unreasonable to expect those processes to be pursued).⁷²

22 PROMOTING SYSTEM TRANSPARENCY

Table 22.1: Current oversight and review agencies

RELEVANT LEGISLATION	CHILDREN'S PROTECTION ACT			HCSC ACT	OMBUDSMAN ACT
STATUTORY BODY	GUARDIAN FOR CHILDREN AND YOUNG PEOPLE	COUNCIL FOR THE CARE OF CHILDREN	CDSIRC	HCSCC	OMBUDSMAN
PROMOTION OF CHILDREN'S INTERESTS	Promotes best interests of children in care	Promotes safe care of children			
ADVOCACY	Children in care only				
MONITORING	Children in care only		Monitors its own recommendations		
REPORTING	On matters referred by the Minister for investigation Periodic and annual reporting to the Minister on statutory functions. Periodic reports are published by Parliament Children in care only	To government on specific topics Periodic and annual reporting to the Minister on statutory functions	Periodic and annual reporting to the Minister on statutory functions	May publish reports Provides notices of recommended action to service providers after investigation and to a registration authority Provides reports to registration authorities about complaint procedures Periodic and annual reporting to the Minister on statutory functions	May publish reports to: • complainants after investigations • heads of agencies and responsible Minister on its opinions, when error is found • the Premier if agencies do not take appropriate steps to follow a recommendation Annual reporting to government
ADVICE	To the Minister Children in Care only	To government on rights and interests of children To the Minister on specific topics and on matters referred for inquiry by the Minister	Recommendations for the avoidance of preventable child death or serious injury	Recommendations relating to service improvement, rights of service users and dealing with/ reducing complaints Helping service providers resolve complaints To the Minister about relevant services To registration authorities	Recommendations may be made to the head of agencies where error is found
REVIEW		Of the Family and Community Services Act	Cases where children die or are seriously injured. To identify legislative or administrative means to prevent future death/injury	Review and identify causes of complaints, detect trends	May review administrative procedures of an agency if in the public interest
RESEARCH					
INQUIRY	Systemic reform to improve care Children in care only	As referred by the Minister		At own motion or on request of Minister	Administrative audits of practices and procedures of agencies
INDIVIDUAL INVESTIGATION	As referred by the Minister Children in care only			Of individual complaints or issues arising from complaints: • if issues of public interest, safety or importance • if a significant question as to the practice of a service provider arises, or • as directed by Minister	Administrative acts after other avenues exhausted Administrative audits in some circumstances
INDIVIDUAL RESOLUTION				Service complaints Limits on standing to complain Use of mediation May refer to conciliators	Administrative acts Acts only when other avenues of complaint exhausted May use conciliation

The Ombudsman's jurisdiction is one that is accessible, flexible, affordable and informal. It has greater powers to drive its own investigation using coercive powers, and greater capacity to ensure that the child concerned is heard in its deliberations.

In prosecuting a review to SACAT, an adult acting on behalf of a child, or on their own behalf, is unlikely to possess the skills or the knowledge to obtain the amount of information available to the Ombudsman. There is a greater risk of an adversarial process resulting in delay and a deterioration in the relationship between the Agency and the other parties. Appeals of this kind could also see children excluded from proceedings which relate to them. Where a carer appeals a decision about the placement of a child, the relevant parties to that appeal are the carer and the Agency. The child would need to apply to be joined, and obtain representation to ensure their point of view is considered.

SACAT has the power to award costs in certain circumstances, although in the ordinary course each party is expected to bear their own costs.⁷³ The Ombudsman's service is free of charge to the complainant.

The Ombudsman cannot impose an alternative decision upon a government agency. At its highest, a report and recommendation can be made, and escalated to the Premier if not acted upon.⁷⁴ By contrast, a decision on review by SACAT is substituted for the original decision.⁷⁵ However, the Commission considers that a report and recommendation by the Ombudsman will be sufficiently persuasive to achieve a change of approach, despite the absence of power to impose a substituted decision.

For these reasons, the Commission does not believe that the interests of children in the child protection system would be better served overall by allowing parties affected by selected administrative decisions to appeal to SACAT.

SUPPORTING CHILDREN TO COMPLAIN

The Commission recommends that GCYP be explicitly given standing to make complaints to the Ombudsman and HCSCC on behalf of children involved in the child protection system. The Ombudsman and HCSCC presently receive complaints from GCYP, but this is not a right nor without preconditions. For example, the Ombudsman may receive a complaint from GCYP as a person who is a suitable representative of a child, but only if the child is unable to make the complaint.⁷⁶

Complaint pathways should be highly visible and accessible to people who may have grievances with aspects of the child protection system. The low number of complaints received by HCSCC suggests that greater effort should be made to improve the profile of the services.

Information about review bodies should be given to children and carers throughout their involvement with the child protection system. Efforts to raise the profile of services is the responsibility of all child protection service providers, including the Agency. The Ombudsman, HCSCC and the proposed Children's Commissioner should work together on a strategy to increase the knowledge of children about their rights. They should also develop a package of material, including child friendly complaint forms.

REFORMING OVERSIGHT

A significant number of the recommendations made by the Layton Review and CISC Inquiry regarding oversight of child protection have been implemented; however, it cannot yet be said that children's voices are truly heard nor their rights comprehensively protected in South Australia.

The Commission has identified the need for statutory reform to achieve four main aims:

- 1 Raise the profile of recommendations made by the current range of oversight bodies.
- 2 Coordinate the pursuit of common interest of the oversight bodies, and facilitate the sharing of data and research.
- 3 Raise the profile of children's experiences and perspectives in public life.
- 4 Fill gaps in the current oversight regime (shown in Table 22.1).

Clear gaps exist in the following areas:

- There is no body which provides advocacy for children other than those in the care of the state.
- There is no body which monitors children's issues or the condition of children other than those in care.
- Only CDSIRC has capacity to monitor the implementation of recommendations, and then only its own. CDSIRC has limited capacity to perform this function and has no capacity to inquire into the accuracy of information it receives about compliance.
- None of the bodies holds a statutory mandate to conduct research.

A CHILDREN'S COMMISSIONER

The United Nations Convention on the Rights of the Child places obligations on the state to protect the rights of children. Within South Australia there is no unifying body entrusted by the state with this function. A greater focus is needed on promoting children's interests across all aspects of government and public life.

The Commission recommends the appointment of a Children's Commissioner as a visible, high profile figure who acts and speaks on behalf of the state's children about issues that are important for them. A Children's Commissioner must be placed in a position to represent the interests of all children.

People assume that a commissioner is going to fix the child protection system and will prevent tragedies. They won't. They can't.

The Commission heard evidence in support of a broad range of functions for a Children's Commissioner: from an independent complaints resolution service for children in conflict with decision makers, to a body who works with government to draw attention to the practical effects of planning, policies and legislation on children.⁷⁷

The expectations for a Children's Commissioner are high. Former GCYP, Pam Simmons, told the Commission:

*People assume that a commissioner is going to fix the child protection system and will prevent tragedies. They won't. They can't. That's the sad part about it. The best we can do, including myself, is to point to where there are weaknesses and help to address that.*⁷⁸

The GCYP, Amanda Shaw, in a recent publication referring to a Children's Commissioner, observed:

*There is a very real danger in trying to subsume formal child protection functions into the role of a Children's Commissioner. A Children's Commissioner with a very broad brief would find it difficult to sustain the critical expertise and focus on the lives of individual children that is essential to be effective in child protection. And if they could, the high engagement and urgency required in child protection would draw them away from their responsibility to hear from and act for all young South Australians.*⁷⁹

The Commission is mindful that there are limits on what a Children's Commissioner can achieve and its role must be designated with some specificity. It is not a cure-all for the problems that beset the child protection system. Its functions must not be diverted by tasking it with a range of functions that are inconsistent with each other and have the potential to overwhelm it. The Commission has identified important functions which the Children's Commissioner should fulfil in the areas of advocacy, research and inquiry into systems issues.

The Children's Commissioner's activities should be heavily guided by consultations with children. The Commissioner should use the profile of the position to advance children's issues in the wider community, with both industry and government.

The Commission considers some of the current oversight bodies should be aligned to the functions of the Children's Commissioner, providing a mechanism for them to advance issues that reach their attention, but which they are currently unable to advance in the way they see as appropriate. The Children's Commissioner should have the authority to hold government to account when areas of need have been identified, but action has not been taken.

The Commission does not consider it appropriate that a Children's Commissioner be a complaints body, resolving or adjudicating individual disputes. This position is supported by the Council for the Care of Children⁸⁰ and is consistent with the previous recommendations of the Layton Review and CISC Inquiry. A clear separation must be maintained between complaint resolution and advocacy bodies, to avoid potential for conflicts of interest.⁸¹ The Commission considers that the reforms suggested earlier to review agencies provide an adequate check on the actions of staff and organisations involved in child protection matters.

However, the Commission considers it essential that the Children's Commissioner have extensive powers to conduct investigations into systemic issues, including thorough examination of individual circumstances where such an investigation has the capacity to highlight systemic issues. The Commission's own evidence gathering processes have highlighted the worth of conducting individual case studies as a way of reflecting and analysing broader system issues. The identification of appropriate matters must lie entirely within the discretion of the Children's Commissioner.

The restriction of investigative functions to systems issues, and the recommendation against the Children's Commissioner holding a complaints resolution function, reflects an assessment of which functions can bring the most good to children in general. There is greater potential to benefit children as a group if the Commissioner's powers are restricted in this way:

*Population-level improvements in the development, wellbeing and safety of South Australian children and young people are more likely to result from developing systemic understandings of the factors affecting children and young people rather than through investigations and scrutiny of individual cases.*⁸²

Population-level improvements in the development, wellbeing and safety of South Australian children and young people are more likely to result from developing systemic understandings of the factors affecting children and young people rather than through investigations and scrutiny of individual cases

INTERSTATE AND OVERSEAS MODELS

South Australia lags substantially behind other Australian jurisdictions which have enacted legislation creating Children's Commissioners, or substantively similar statutory bodies (see Table 22.2).⁸³

Queensland established the first Children's Commissioner in 1996 with the creation of the Queensland Commission for Children and Young People, a body which has since been dissolved and its functions redistributed. The National Children's Commissioner, Megan Mitchell, was appointed in 2013. In 2015 the Children's e-Safety Commissioner was appointed at a national level, with responsibility for the promotion of online safety.⁸⁴

The role and functions of the bodies differ between jurisdictions. Most provide services to all children and young people; the Northern Territory restricts services to 'vulnerable' children.⁸⁵

There are significant differences in the role of Children's Commissioners as they relate to complaints resolution and investigatory functions. The greater proportion are not individual complaint bodies and have no capacity to investigate individual issues. Their focus is rather on advocacy and promotion of children's rights. Only in the Australian Capital Territory and the Northern Territory do the Children's Commissioners hold the capacity to hear and resolve individual complaints.

In the Northern Territory the Children's Commissioner has no specific advocacy role, although advocacy occurs incidentally through provision of advice to the executive government and its educative function. The NT Children's Commissioner investigates individual complaints regarding the provision of services to vulnerable children. It is also empowered to conduct own-initiative investigations. In the ACT the Children's Commissioner can investigate and determine individual complaints relating to services. The Tasmanian Commissioner for Children investigates circumstances relative to an individual child, but only on request of the Minister.⁸⁶

Table 22.2: Children's representative bodies across Australia

JURISDICTION	STATUTORY BODY	ENABLING ACT
National	The National Children's Commissioner The Office of the Children's e-Safety Commissioner	<i>Australian Human Rights Commission Act 1986</i> <i>Enhancing Online Safety for Children Act 2015</i>
Australian Capital Territory	The Children and Young People Commissioner	<i>Human Rights Commission Act 2005</i>
New South Wales	The Advocate for Children and Young People The Children's Guardian	<i>Advocate for Children and Young People Act 2014</i> <i>Children and Young Persons (Care and Protection) Act 1998</i>
Northern Territory	The Children's Commissioner	<i>Care and Protection of Children Act 2007</i> <i>Children's Commissioner Act 2013</i>
Queensland	The Family and Child Commission, overseen by two Commissioners	<i>Family and Child Commission Act 2014</i>
Tasmania	The Commissioner for Children	<i>Children, Young Persons and Their Families Act 1997</i> <i>Youth Justice Act 1997</i>
Victoria	The Commissioner for Children and Young People	<i>Commission for Children and Young People Act 2012</i>
Western Australia	The Commissioner for Children and Young People	<i>Commissioner for Children and Young People Act 2006</i>

Source: Australian Institute of Family Studies, *Children's commissioners and guardians*, Child Family Community Australia resource sheet, Australian Government, May 2015.

By contrast, the Western Australian Commissioner for Children and Young People may investigate matters affecting the general wellbeing of children if they arise from a matter relating to an individual.⁸⁷

In the United Kingdom, the Welsh model was commended to the Commission in the course of its evidence gathering. The Welsh Children's Commissioner, established since 2001, is an example of a robust Children's Commissioner with broad capacity and functions including:

- providing advice and information regarding children's rights and welfare to children and adults;
- offering advice and support to children and young people;
- assisting children, including financial assistance and representation in legal proceedings, where their rights have not been respected; and
- reviewing effects of policies and the delivery of services to children.

The Welsh Children's Commissioner has the power to conduct examinations into the circumstances of individual children where a question of more general application to the rights and welfare of children arises.⁸⁸

The Welsh Children's Commissioner works with children aged up to 18 who are living in Wales and may act on behalf of people up to age 25 if they have been 'looked after' by (were in the care of) a local authority. It may consider and make representations to the National Assembly about any matter affecting the rights or welfare of children in Wales and was involved in reporting to the United Nations Committee on the Rights of the Child. It has obligations to report at the conclusion of examinations, which must ultimately be published; provides reports on particular subjects; and provides annual reports about its actions, including a version suitable for children.⁸⁹

The differences between mandated functions held by Children's Commissioners in Australia and Wales demonstrate that Children's Commissioners hold different functions dependent upon on the needs of the particular jurisdiction, and the regulatory environment in which the Commissioner sits.

CURRENT PROPOSALS

There is bipartisan political support and broad ranging community support within South Australia for the creation of a Children's Commissioner. The Council for the Care of Children⁹⁰, CDSIRC⁹¹, associations such as the Child and Family Welfare Association⁹² and Uniting Communities⁹³, experts in child protection⁹⁴ and those who work in the field have expressed their support.⁹⁵

Despite this general support, legislation has not yet been passed creating the position. Divergent views about the precise nature of the role appear to be the principal cause of delay, although the Commission acknowledges that more recently progress was halted pending the report of this Inquiry.

The Government's Child Development and Wellbeing Bill 2014 (SA) (the Government Bill) and Opposition's Commissioner for Children and Young People Bill 2014 (SA) (the Opposition Bill) are both before Parliament.

The Government Bill abolishes the Council for the Care of Children⁹⁶ and vests its statutory functions between the Children's Commissioner and a newly formed Child Development Council, which is responsible for the creation and maintenance of an Outcomes Framework for Children and Young People, and for reporting on and promoting the framework.⁹⁷ The existing framework developed by the Council for the Care of Children should inform the development of any future framework, to ensure that continuity of monitoring against the standards already established is not lost.

The Government and Opposition show consensus on most functions. Both have included in their draft legislation the following functions:

- 1 promoting and advocating for the rights and interests of children;
- 2 promoting the participation by children in decision making which affects their lives;
- 3 advising and making recommendations to ministers, state authorities and other bodies (including non-government bodies) on matters related to the rights, development and wellbeing of children at a systemic level;
- 4 assisting in ensuring that the state, as part of the Commonwealth, satisfies its international obligations in respect of children; and
- 5 engaging with children in the performance of other functions (the Government Bill also requires the development of a strategy to ensure this occurs).⁹⁸

The substantive difference between the Bills concerns the extent of the power of inquiry and investigation. The Government Bill includes the function of inquiry and review of matters relating to rights, development and wellbeing of children at a systemic level, but provides very limited powers to enable those functions to be performed.⁹⁹ The sole source of evidence gathering power is the power to issue a notice to a state authority to give information in its possession to the Commissioner, and the Minister may exempt people or bodies from compliance. Consequences for a failure to comply with a written notice extend no further than reporting the failure to relevant ministers and including details in an annual report.¹⁰⁰ Significantly, there is no power to compel the production of documents or testimony or to inspect or search premises.

The limited powers envisaged by the Government Bill can be contrasted to the powers currently available to GCYP, who has a similar mandate to the anticipated Children's Commissioner, but only for children in care. GCYP has the power to issue a notice to 'any government or non-government organisation that is involved in the provision of services to children'.¹⁰¹ The notice may require the production of information in writing or an identified document, or the attendance of a person to answer questions or produce documents. A person who fails to comply with a written notice is at risk of a pecuniary penalty.¹⁰² There is no power for the Minister to exempt any body or person from compliance with a written notice.

The reduced powers in the Government's proposal for the Children's Commissioner, which has a much broader mandate, is curious.

By contrast, the Opposition Bill includes functions of inquiry and investigation in limited circumstances.¹⁰³ It contemplates inquiries into systems issues and investigations into individual matters, where matters of 'particular significance to children and young people' are raised, and it is in the public interest to do so.¹⁰⁴ The Bill contains broad powers which are in the main appropriate to an independent body engaging in inquiries and investigations.

Certain powers contained in the Opposition Bill directed at the investigation and resolution of individual issues and their resolution are not appropriate, namely the power to:

- require state authorities to refrain from taking specified action;
- require state authorities to conduct a joint investigation with the Commissioner; and
- seek an injunction from the Supreme Court to restrain a person from engaging in conduct in relation to an investigation or proposed investigation.¹⁰⁵

The Government Bill includes additional functions, which require the Children's Commissioner to:

- monitor how complaints by children are dealt with;
- monitor the outcomes of complaints; and
- proactively investigate and report on trends in complaints.¹⁰⁶

The Commission does not support inclusion of these monitoring functions. While these are matters which the Commissioner may, in its discretion, choose to inquire into, a requirement to monitor these topics may detract focus from other aspects of the Commissioner's functions. It is a core responsibility of the state to monitor its own performance in dealing with complaints. The role of the Children's Commissioner is,

where appropriate, to inquire into and investigate the effectiveness of those efforts. It should not be part of the Commissioner's ongoing mandate.

The Bills differ in the manner in which they permit the Children's Commissioner to monitor the effectiveness of agencies' responses to recommendations. The Government Bill includes a requirement on the Minister to report back to the Commissioner after receiving a report from the Children's Commissioner about an inquiry. The obligation exists only if the Children's Commissioner has recommended specific action be taken.¹⁰⁷ The Minister must set out what recommendations will and will not be implemented, and the manner of implementation. It is only after this report has been laid before each House of Parliament, and after consultation with the Minister, that the Children's Commissioner may publish its report.¹⁰⁸ The Commission does not support any restriction on the capacity of the Children's Commissioner to publish information relating to its investigations or inquiries in this manner.

The Opposition Bill includes a similar provision, but the obligation on the Minister to respond is not contingent on the recommendation of specific action.¹⁰⁹ The Opposition Bill includes an additional power permitting the Children's Commissioner to monitor the action taken in response to its recommendations.¹¹⁰

Neither of the Bills fully reflects what the Commission considers to be appropriate powers for this state's Children's Commissioner. The powers provided by the Government Bill are insufficient for the Children's Commissioner to carry out its inquiry and investigative functions in a robust manner. The inclusion of a monitoring function risks overwhelming the capacity of the Children's Commissioner to perform other important services.

The Opposition Bill provides greater powers, including some which are more appropriate to a complaints resolution function, a role not appropriate for the Children's Commissioner.

Finally, the Opposition Bill requires the Children's Commissioner to consult (in addition to children and young people, who are the first priority) parents, families and carers of children, and relevant peak bodies and non-government organisations. The Commission considers these obligations to consult more widely as too onerous. It deflects attention from the central focus on children and young people to oblige inclusion of other voices which have other avenues to advance their own interests. While the Children's Commissioner may well choose to consult with such groups in appropriate cases, there should be no obligation imposed in that regard.

ESSENTIAL ELEMENTS

Selection

A robust process to select the Children's Commissioner is critical to establishing the position's credibility and profile. The selection process should attract and secure a candidate who holds the skills needed to perform the wide range of functions envisaged, together with the necessary personal characteristics and child focus.

The Council for the Care of Children has contended that feedback from children should inform the recruitment, selection and work of a Children's Commissioner.¹¹¹

It recommends a detailed recruitment process including the involvement of children in formulating the selection criteria, interviewing applicants and selecting the preferred candidate.¹¹²

The Commission is unable to make any recommendation as to the best course to adopt in this regard but agrees that children be consulted at each of these stages, and recommends that this ought to be considered by reference to the submission from the Council for the Care of Children.

The Government and Opposition Bills do not agree on the method of appointment of a Children's Commissioner. The Government Bill proposes appointment by the Governor on the recommendation of the Minister (following a process calling for expressions of interest), while the Opposition Bill would have the recommendation to the Governor made by a selection panel.¹¹³ The Commission does not express a preference for either model, but notes that the more usual process for appointment to a position of this profile would be by expression of interest rather than an application and formal selection panel. It is important that the process reflects the calibre of appointment that is sought.

Independence

The Children's Commissioner should be independent of any control by the Minister or Parliament. It would be inappropriate for a body which reports on and enquires into conduct of government agencies to be subject to government direction. Independence would also help develop public confidence in its operations. This independence must be specified in legislation.

Provisions for the appointment and dismissal of the Children's Commissioner should be drafted in a manner that protects the body's statutory independence.

What children want in a Children's Commissioner

The Council for the Care of Children consulted extensively with children about their wishes for a Children's Commissioner, and published a report reflecting the results.¹

Children think a Children's Commissioner must:

- be caring;
- like children and young people;
- know, understand and respect children and young people;
- listen to what they have to say and take them seriously; and
- be someone they can trust, who they know will stand up for them and be proactive in effecting positive change.

Children want the Children's Commissioner to focus on:

- providing help and looking after children, including their safety;
- listening and responding to what matters to children and providing feedback;
- educating the community about children's rights, needs and wellbeing;

- sharing children's views and opinions and using children's feedback to make life better for children and young people; and
- educating adults about how to look after children and young people.

A Children's Commissioner should consider vulnerable children and children who live in rural and remote areas.

A Children's Commissioner has a role to play in keeping children safe. Children's views of safety included:

- safety from abuse, neglect and bullying;
- safety in their living environments;
- providing a safe place to go when needed, including to speak with the Children's Commissioner; and
- that the Children's Commissioner was a person who children could trust with personal matters.

Overwhelmingly, children thought that face-to-face contact was the best type of contact with a Children's Commissioner. Written contact, social media and video chat were also mentioned.

¹ The Council for the Care of Children, *Conversations report 2015: Rights and a Commissioner for children and young people*, Government of South Australia 2015.

The Commission observes that the appointment terms of children's commissioners within other Australian jurisdictions range between three and seven years, with a variety of provisions for reappointment. Both the Government and Opposition Bills contemplate five years, with eligibility for re-appointment, although the Opposition Bill places an overall cap of seven years on the appointment of any individual.¹¹⁴ The term of appointment must be sufficient to allow the Children's Commissioner to engage substantively in its functions and achieve a meaningful working relationship with children.

As to the question of dismissal of a Children's Commissioner, the proposed models exhibit some differences. The provisions of the Opposition Bill are modelled on legislation governing the appointment of the Independent Commissioner Against Corruption.¹¹⁵ Given the anticipated profile of the Commissioner, it would be appropriate that a model of this nature, with the attendant scrutiny attaching to any dismissal, apply to a Children's Commissioner.

Cooperation

The enabling Act should include a provision to require government departments and agencies, including organisations acting under contract to those agencies, to cooperate with the Children's Commissioner. Such a provision would demonstrate the government's commitment and provides authority to the Children's Commissioner in the performance of its functions.

Reporting relationships

The Children's Commissioner would need to have a regular reporting relationship to an identified Minister. Section 17 of the Opposition Bill proposes annual reporting responsibilities to the Minister, who must then lay the report before both houses of Parliament.

The Opposition Bill also contemplates reporting to the Minister on inquiries (systems issues) and investigations (individual issues where certain criteria are met).¹¹⁶ There is a discretion about whether a report on an individual issue is provided to the Minister. For both inquiries and investigations the Children's Commission may make recommendations to the state authority concerned.¹¹⁷

It is anticipated that the Children's Commissioner investigate matters which cross portfolios, including health, housing, correctional services, sports and recreation, and child protection. While there must be one Minister identified as primarily responsible for action on matters referred by the Children's Commissioner, it would be necessary to empower the Commissioner to forward copies of reports to the Minister responsible for the portfolio concerned with the specific matters raised in the report.

The Commission therefore recommends that the Children's Commissioner report to a Minister, and hold the power, in appropriate cases, to also report to the Minister with portfolio responsibilities for any of the

matters raised in the report. This would include an annual reporting requirement in the terms set out in the Opposition Bill, and the power to report on all inquiries and investigations.

Recommendations made by the Children's Commissioner should also be reported to state authorities to whom they relate to take action on implementation. The experience of this Commission is that in the past, oversight bodies have repeatedly made recommendations for action to such authorities, with little evidence of action or accompanying practice change. With this in mind, the Commission recommends that the Children's Commissioner have the authority to require a report from a relevant state authority about action taken on recommendations. The authority from whom a report is required must respond in an identified timeframe, setting out the degree of compliance, any proposed action, and any decision not to act on recommendations and the accompanying reasons.

If the Children's Commissioner remains dissatisfied with the response provided, it may forward both the request and the report of the authority to the relevant Minister. That Minister must then report to Parliament setting out the Minister's response to the Children's Commissioner's report and attach the initial request, and the response by the state authority. These documents should be tabled in both Houses of Parliament. The Commissioner should also be empowered to publish all or part of such documents as he or she sees fit.

This regime is an important feature of government accountability for action and non-action on recommendations. The purpose of conducting investigations and making recommendations has the potential to be lost if there is no capacity to track the Government's response. The public is entitled to be kept apprised of recommendations being made and the actions of the Government in response.

The scheme set out above is modelled on section 21 of the Opposition Bill. That Bill contemplates that before requiring a state authority to provide such a response, the Commissioner must identify and specify grounds for his or her dissatisfaction. The Commission considers this requirement to be a potential barrier to robust monitoring. The Commission supports the Children's Commissioner being empowered to make a request for a report without specifying any particular reason for dissatisfaction. This places the responsibility on the Government to report the extent of compliance, rather than requiring the Children's Commissioner to first identify an issue.

The Children's Commissioner has the capacity to raise the profile of important issues within the public sphere. It must be equipped with the best understanding of the dynamics of the situation to allow it to do so effectively. If recommendations are supported, but barriers are in the way of implementation, it is important that this be known.

The Commission recommends that this reporting regime be extended to include recommendations of CDSIRC and GCYP. This proposal will be discussed in the section below, Relationships between oversight bodies.

Recommended functions

A Children's Commissioner should hold the following functions:

- 1 Promote and advocate for the rights and interests of children and young people in South Australia.
- 2 Promote the participation by children and young people in making decisions that affect their lives.
- 3 Advise, and make recommendations to, Ministers, state authorities and other bodies (including non-government bodies) on matters related to the rights, development and wellbeing of children and young people at a systemic level.
- 4 Assist in ensuring that the state, as part of the Commonwealth, satisfies its international obligations to children and young people.
- 5 Inquire into and investigate topics concerning the rights, development or wellbeing of children at a systemic level, including the investigation of individual cases which, in the opinion of the Children's Commissioner, have the capacity to identify systemic issues which are of sufficient importance to warrant inquiry.
- 6 Prepare and publish reports on matters related to the rights, development and wellbeing of children and young people at a systemic level.
- 7 Engage with children in the performance of other functions and the development of a strategy to ensure this occurs.
- 8 Undertake or commission research into topics which relate to children and young people.

The capacity to inquire into systems should not be restricted to formal, government-based systems. It should extend to informal systems that have developed in the community, and which involve areas or issues which have the potential to have great impact on children's lives, or that may affect a large number of children.¹¹⁸

Recommended powers

It is recommended that, in order to carry out its functions, the Commissioner be provided with the following powers:

- 1 Report to Parliament with an unfettered discretion to publish information, including publication in a manner which is accessible to children;

- 2 Perform its function of inquiry and investigation to a level equivalent to the Ombudsman (which has the powers of a Royal Commission in respect to investigations), including:
 - a compelling production of documents and materials, the equivalent of a subpoena or summons, from bodies or individuals, and extending beyond government bodies to the private sector and individuals;
 - b compelling a person to appear to give evidence;
 - c requiring a person to answer questions;
 - d requiring a person or body to respond in writing to questions;
 - e entering and inspecting property; and
 - f appointing investigators in accordance with the provisions of the Opposition Bill.¹¹⁹
- 3 Refer a complaint or information raising a concern about an individual issue to an appropriate complaints or investigatory body (including the Ombudsman, HCSCC, relevant professional registration bodies, South Australia Police), and to provide information obtained by the Commissioner to those bodies.
- 4 Make recommendations related to investigations or in response to other observed issues.

Pecuniary penalties should accompany non-compliance with the Commissioner's powers of inquiry, as should the power to apply to the Court for a warrant for failure to comply with a summons. It is not sufficient that non-compliance be followed only by a report to a Minister or the Premier.

To allow the Children's Commissioner to obtain information, the enabling legislation should provide an exemption from other laws which would restrict disclosure of relevant information. An example of such a provision is contained in section 43(1) of the Opposition Bill. Both Bills contain provisions which prevent people engaged in the business of the Children's Commissioner from inappropriately disclosing information which they have obtained in the course of their duties, which the Commission also views as appropriate.¹²⁰ Furthermore, it is appropriate that the legislation include protections for whistleblowers, to prevent them being victimised because of making a complaint or otherwise assisting the Children's Commissioner.¹²¹

The powers recommended are necessary for the Children's Commissioner to effectively perform its functions. Restriction of these powers risks frustrating the Commissioner's capacity and undermining public confidence in the office's overall capacity.

Consultation and engagement

A key role of the Children's Commissioner would be consultation with children and young people. This Commission supports the inclusion of legislative provisions which mandate this function. It would be appropriate to articulate the obligation to consult, but decisions about its precise manner should be left to the Commissioner, in consultation with children and young people. The Commission does not support the inclusion of an obligation to publish a strategy about how engagement will occur.

It is appropriate that the Children's Commissioner engage with the community in the performance of its functions, but the Commission does not support provisions requiring the Children's Commissioner to develop and publish a community engagement plan, as contemplated by the Opposition Bill.¹²² Excessive prescription about the manner in which relevant parties will be engaged has the potential to divert the Commissioner's focus.

The Children's Commissioner should consult with individuals and community representatives on an as-needs basis on topics affecting their interests. In particular, it is recommended that the Commissioner consult with Aboriginal and Torres Strait Islander community groups, culturally and linguistically diverse groups, children with a disability and children who reside in regional areas. A requirement to maintain an ongoing consultative committee is not supported. In evidence to the Commission, the former guardian reported that this is not always the best way to conduct consultations, particularly with children, a position which is supported by the Commission.¹²³

Resourcing

The effectiveness of the Children's Commissioner would depend not only on providing appropriate powers and functions: the office should be resourced at a level commensurate with the broad range of expected functions. Resources should be not only financial and staff, they should include the ability to access expertise and knowledge.

The Commission has observed that the statutory bodies currently holding a child focus in South Australia are constrained by insufficient resources. Both the Council and CDSIRC rely on professionals who provide their time and expertise to the state for minimal or no remuneration because of their commitment to the important work.¹²⁴ GCYC receives the greatest allocation of resources—\$874,518 in the 2014/15 financial year—but nevertheless is restricted in capacity to achieve its broad statutory mandate and must be selective in its work.¹²⁵

Although functions vary, a comparison with interstate bodies provides a perspective on the adequacy of funding. Table 22.3 shows the level of funding of some other child oversight bodies.

Table 22.3: Data from annual reports setting out expenditure for 2014/15

WA (Commissioner for Children and Young People)	\$3,114,424
VIC (Commission for Children and Young People)	\$6,428,000
QLD (Family and Child Commission)	\$9,636,000
ACT (Children and Young People Commissioner)	\$3,521,000
NSW (Children's Guardian)	\$27,558,000

Sources: Commissioner for Children and Young People, *Annual report 2014-15*, Government of Western Australia, 2015, pp. 48-52; Commission for Children and Young People, *CCYP Annual report 2014-15*, Victorian Government, 2015, pp. 81-84; Family and Child Commission, *Annual report 2014-15*, Queensland Government, 2015, p. 52; Australian Human Rights Commission, *Annual report 2014-15*, Australian Government, 2015, p. 70; Office of the Children's Guardian, *Annual report 2014-15*, Government of New South Wales, 2015, pp. 72-77.

Despite the level of funding, the Chair of CDSIRC, Dymphna Eszenyi, who observes the operation of Children's Commissioners interstate, told the Commission that 'often the role of a Children's Commissioner is a thankless and under-resourced one'.¹²⁶ She observed:

It would be sad to see South Australia appoint a Children's Commissioner that does not have real teeth. I don't mean real teeth to pursue individual cases, because I think that the Coroner and the Department itself should have those teeth, but real teeth to interact with the bureaucracies to say, 'This has to happen'.¹²⁷

The Commission does not believe the appointment of assistant commissioners¹²⁸ is required. However, the Children's Commissioner should have the capacity to engage experts and commission research as necessary, and funding should be provided for this purpose. The ability to employ staff should not be restricted to seconding existing public service employees. There is a potential for a conflict of interest if the Commissioner was required to engage employees seconded from business units which may become the subject of scrutiny. The Commission supports the inclusion of provisions such as those contained in sections 18 and 19 of the Opposition Bill, which permit the Commissioner to engage employees on terms and conditions determined by the Children's Commissioner, and which allow the Commissioner to make use of staff of a public service business unit by agreement with the responsible Minister. These terms mirror the powers in the *Independent Commissioner Against Corruption Act 2012* (SA).¹²⁹

The Children's Commissioner should be provided with discretionary funds to help children whose rights have not been respected. The funds may be used in flexible ways. One potential use would be to fund legal representation for or on behalf of children in proceedings where it appears that children's rights have not been respected. The Victims of Crime Commissioner in this state has authorised similar undertakings as part of his broad mandate.

THE RELATIONSHIP BETWEEN OVERSIGHT BODIES

CDSIRC and GCYP each hold an existing statutory authority for aspects of child-focused oversight. The Commission supports the maintenance of their independence from the Children's Commissioner.

GCYP has an important role focusing exclusively on children in care, a marginalised and vulnerable group who have particular needs which require a specialist focus. The Children's Commissioner must be able to focus more broadly, on the needs of all children.

CDSIRC holds a specific public health focus. It has no advocacy role. CDSIRC should maintain its independence in the performance of its review functions.

As noted above, the Government Bill proposes consolidation of the functions of the Council for the Care of Children between the functions of the Commissioner and a newly formed Child Wellbeing Committee. The Commission supports the reform of those functions contemplated in the Government Bill.

COORDINATING FUNCTIONS

Notwithstanding the importance of their continued independence, there is capacity for GCYP, CDSIRC and the Children's Commissioner to collaborate and coordinate in performing their respective functions. At an administrative level, there is scope for collocation and sharing of resources to achieve efficiencies, and to make it easier, when appropriate, for children and young people to access the Children's Commissioner and GCYP.

There is also capacity for GCYP and CDSIRC to ask the Children's Commissioner to use its statutory powers to monitor their own recommendations in appropriate circumstances. Both bodies expressed frustration to the Commission about the number of recommendations that had been accepted in principle, but not then implemented.¹³⁰ The fact that some of these recommendations are made repeatedly has contributed to this frustration.

As part of its monitoring functions CDSIRC will enquire of agencies about the implementation of its recommendations. Over time it has lost faith in assurances by agencies that policy change and staff education are achieving the outcomes anticipated by the

recommendations. When CDSIRC does become aware of a failure to properly implement recommendations, its only recourse is to refer to this in its annual report. It has no power to require agencies to demonstrate the extent to which they have implemented recommendations and there are no associated sanctions.¹³¹

The Commission considers a mechanism should be established by which GCYP and CDSIRC could escalate selected matters to the Children's Commissioner. The Children's Commissioner should be empowered to advance those matters (where he or she regards it as appropriate) through the exercise of all of its statutory powers and functions, including employing the regime to monitor government responses to recommendations, and escalate the matter to the Minister and Parliament where necessary.

Legislation should permit GCYP and CDSIRC to refer recommendations or topics of concern to the Children's Commissioner. On receipt of such references the Children's Commissioner may:

- conduct an inquiry or investigation;
- use its power to require a state authority or the Minister to report on the implementation of recommendations, and to report to Parliament if the explanation is unsatisfactory;
- conduct research; and
- engage in advocacy.

As it is proposed that the Children's Commissioner has the power to publish reports and findings, consideration has been given to whether this power should include matters referred by CDSIRC and GCYP.

GCYP already has the power to publish, and make publicly available a range of important reports and recommendations. However, GCYP is mindful of respecting the particular interests of children in care and determines whether or not to publish according to the best interests of that group. The discretion about publication should therefore remain exclusively with GCYP. Where GCYP refers matters to the Children's Commissioner, the latter should not make the material received from GCYP publicly available unless consent is first given by GCYP.

CDSIRC focuses its analysis on system issues and makes recommendations about avoiding death and serious injury in the future.¹³² It is not concerned with identifying individual liability, and does not hear oral evidence from witnesses. It is therefore unlikely to be appropriate for the details of reports and recommendations to be made publicly available. The Commission recommends that where matters are referred by CDSIRC, the Children's Commissioner should not publish information obtained from CDSIRC in the public arena.

These restrictions should not apply to any information which is subsequently obtained by the Children's Commissioner in the exercise of its own functions where matters have been referred by the GCYP or CDSIRC.

CDSIRC, GCYP and the Children's Commissioner are each likely to have powerful data and research available on issues of common concern. Legislative reform should permit, but not require, each body to share de-identified data with one another for the purpose of advancing their individual mandates. The Child Development Council is not included within this arrangement, on the basis that the Commission assumes that monitoring data against the outcomes framework would be made publicly available.

The current legislative regime concerning these bodies is fragmented. As the reforms suggested would require legislative amendment, the opportunity should be taken to consolidate the powers for the Children's Commissioner, CDSIRC and GCYP into a single Act.

The proposed oversight agencies and their reporting relationships are described in Figure 22.1.

REFORMS TO THE CHILD DEATH AND SERIOUS INJURY REVIEW COMMITTEE

In the course of reviews conducted by CDSIRC, information was received about the conduct of practitioners which it considered should be referred to the Australian Health Practitioner Regulation Agency (AHPRA) for investigation. Confidentiality provisions currently prevent CDSIRC from releasing the information, meaning that potentially adverse information about the conduct of registered professionals may never come to AHPRA's attention.¹³³

The Commission recommends a legislative amendment to permit CDSIRC to refer information obtained to AHPRA or any other professional regulatory body if it is of the opinion that the information may raise disciplinary issues. An example of such a reporting obligation in another context is the obligation on the Law Society to report certain information to the Legal Profession Conduct Commission.¹³⁴

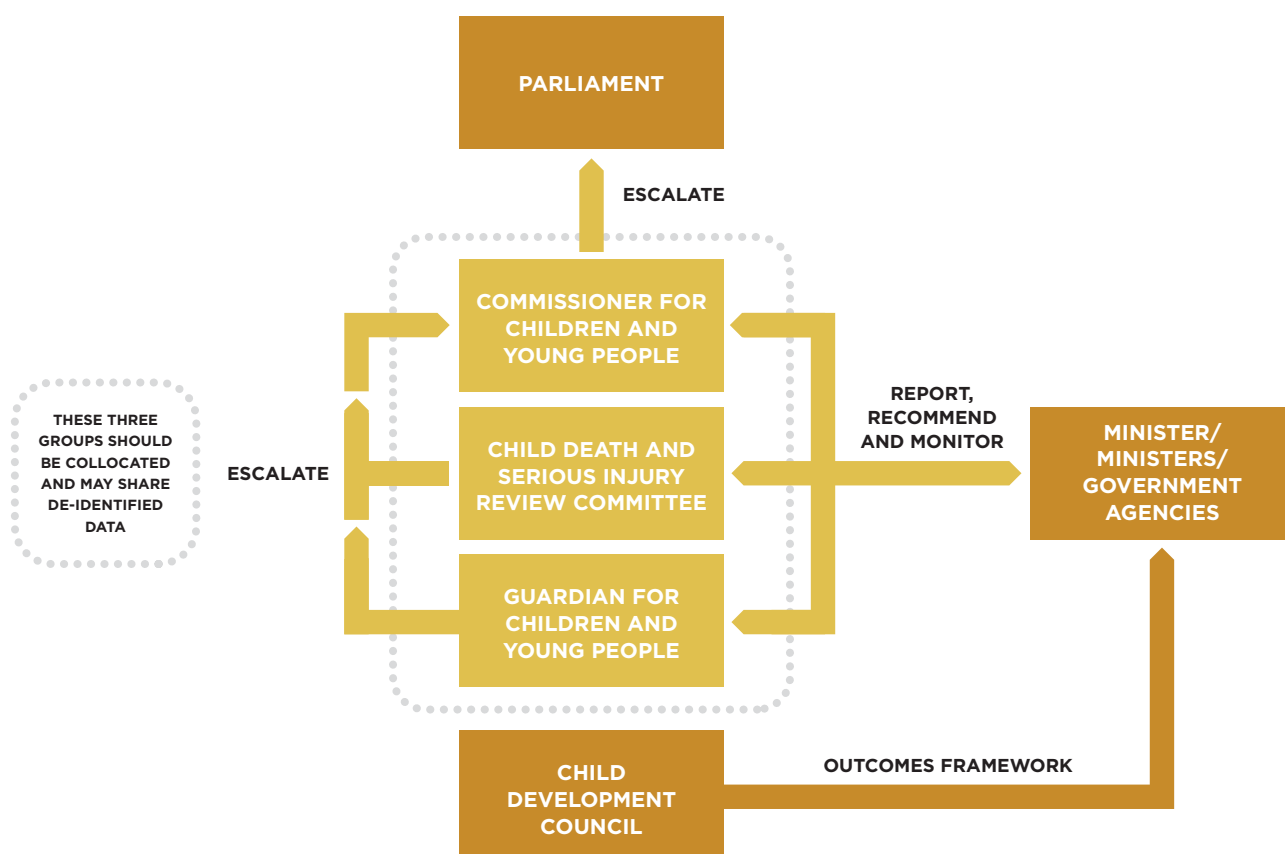


Figure 22.1: Proposed oversight agencies and their reporting relationships

22 PROMOTING SYSTEM TRANSPARENCY

Confidentiality requirements currently restrict CDSIRC from sharing detail of children's stories and experiences as part of its reporting function. The CDSIRC's submissions to the Commission sought a greater capacity to share such details with relevant agencies, while protecting individual children's identity. Sharing these stories would give the CDSIRC's recommendations important context, and greater 'moral imperative' for change.¹³⁵ The Commission recommends that section 52X of the Children's Protection Act be amended to enable disclosure of information about individual cases to the agencies to whom recommendations and reports are directed.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:		253	Amend the <i>Ombudsman Act 1972</i> to permit the Ombudsman to exercise the jurisdiction of Health Care and Community Services Complaints Commissioner (HCSCC) in appropriate cases.
245	Establish the statutory office of the Commissioner for Children and Young People and provide the Commissioner with the functions and powers referred to in this report.	254	Develop an administrative arrangement between the Ombudsman and HCSCC to determine matters in which the Ombudsman would exercise dual jurisdictions, including, but not limited to, child protection complaints.
246	Consolidate the legislation for the Children's Commissioner, the Guardian for Children and Young People (GCYP), the Child Death and Serious Injury Review Committee (CDSIRC) and the Child Development Council in a single Act of Parliament.	255	Develop the capacity of the Ombudsman's Office to respond specifically to child protection complaints.
247	Empower GCYP and CDSIRC to refer matters to the Children's Commissioner, where they are of the view that escalation through processes available to the Children's Commissioner is appropriate.	256	Develop a package of information regarding making complaints about child protection matters, including information and complaint forms which are suitable for children and young people.
248	Empower the Children's Commissioner to exercise its statutory powers and functions in relation to such matters, including employing the regime to monitor government responses to recommendations, and escalate the matter to the Minister and Parliament where necessary, at his or her sole discretion.		
249	Collocate the Children's Commissioner, GCYP, CDSIRC and the Child Development Committee, and make arrangements for the sharing of some administrative functions.		
250	Amend legislation to permit, but not require, GCYP, CDSIRC and the Children's Commissioner to share de-identified data.		
251	Amend legislation to empower the Children's Commissioner or GCYP to make complaints to the Ombudsman and HCSCC on behalf of a child.		
252	Amend the <i>Ombudsman Act 1972</i> (SA) to ensure that complaints about the actions of government agencies, and other agencies acting under contract to the government, concerning child protection services, find principal jurisdiction with the Ombudsman, and not the Health and Community Services Complaints Commissioner, where the complaint is about an administrative act.		

NOTES

- 1 RA Layton (Chair), *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, Department of Human Services, Government of South Australia, Adelaide, 2003, pp. 5.9–5.13.
- 2 The term 'Aboriginal' is used as an inclusive term to refer to Aboriginal and Torres Strait Islander peoples.
- 3 *Children's Protection Act 1993* (SA), s. 52C(1).
- 4 *ibid.*, s. 52EB.
- 5 Oral evidence: P Simmons.
- 6 *ibid.*
- 7 *ibid.*
- 8 *ibid.*
- 9 Children's Protection Act, ss. 52AB, 52CA.
- 10 *ibid.*, s. 52C(2), 52EA.
- 11 *ibid.*, ss. 52D, 52DA.
- 12 The Office of the Guardian for Children and Young People (GCYP), *Annual Report 2014–15*, Government of South Australia, 2015, p. 32.
- 13 Children's Protection Act, s. 52J.
- 14 *ibid.*, s. 52F(6).
- 15 The Council for the Care of Children, *Annual report 2014–15*, Government of South Australia, 2015, p. 43.
- 16 Submission: The Council for the Care of Children.
- 17 Oral evidence: F Arney. Submission: The Council for the Care of Children.
- 18 The Council for the Care of Children, *A snapshot of young South Australians*, 3rd edn, Government of South Australia, 2015.
- 19 Children's Protection Act, ss. 52S(6), 52T.
- 20 *ibid.*, ss. 52N(2), 52S(1), 52W.
- 21 *ibid.*, s. 52X.
- 22 Oral evidence: D Eszenyi.
- 23 Department for Education and Child Development, email to the Child Protection Systems Royal Commission, 14 July 2016.
- 24 *Health and Community Services Complaints Act 2004* (SA).
- 25 *ibid.*, ss. 4, 9, Parts 5, 6.
- 26 *ibid.*, s. 25(1).
- 27 *ibid.*, ss. 9(f), 29(5).
- 28 Health and Community Services Complaints Commissioner South Australia (HCSCC), *Annual Report 2014–2015*, pp. 16, 19.
- 29 HCSCC, *Annual report 2013–2014*, pp. 36, 39; HCSCC *Annual report 2012–2013*, pp. 34, 37.
- 30 Figures obtained by comparing data produced in the HCSCC *Annual report 2014–15*, p. 16, and the Ombudsman New South Wales *2014–2015 Annual report*, p. 79, against population data from the Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, Sep. 2015, September Key Figures.
- 31 EP Mullighan, *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct*, Children in State Care Commission of Inquiry, Adelaide, South Australia, 2008, pp. 425–427, Recommendation 31.
- 32 S Tully, correspondence with the Child Protection Systems Royal Commission, 21 June 2016. Noting also that amendments to the Health and Community Services Complaints Act which enabled children under 16 to make complaints took effect at the end of 2009.
- 33 Health and Community Services Complaints Act, s. 24.
- 34 *ibid.*, s. 24(b), (g), (l).
- 35 *Ombudsman Act 1972* (SA), s. 15.
- 36 Definitions for these terms are contained in the Health and Community Services Complaints Act, s. 4.
- 37 Health and Community Services Complaints Act, ss. 9(h), 24(l); S Tully, correspondence with the Child Protection Systems Royal Commission, 21 June 2016.
- 38 Submission: Name Withheld (S127).
- 39 S Tully, correspondence with the Child Protection Systems Royal Commission, 21 June 2016.
- 40 Health and Community Services Complaints Act, s. 4(1)(a).
- 41 *ibid.*, s. 4(1)(c).
- 42 S Tully, correspondence with the Child Protection Systems Royal Commission, 21 June 2016.
- 43 EP Mullighan, *Children in State Care Commission of Inquiry*, p. 424.
- 44 See s. 6(1) and in relation to notifications s. 10 of the Children's Protection Act.
- 45 Children's Protection Act, ss. 19(1), 20(1), 27(1), 37(1).
- 46 *ibid.*, s. 6(2).
- 47 Health and Community Services Complaints Act, s. 30.
- 48 *ibid.*, s. 42.
- 49 *ibid.*, Part 6, Division 2.
- 50 *ibid.*, ss. 16, 17.
- 51 *ibid.*, ss. 56A–56F.
- 52 *ibid.*, ss. 4; Health and Community Services Complaints Regulations 2005, Schedule 2.
- 53 Ombudsman Act.
- 54 *ibid.*, ss. 13, 14.
- 55 *ibid.*, s. 14A.
- 56 *ibid.*, s. 15.
- 57 *ibid.*, s. 17(1).
- 58 *ibid.*, s. 13.
- 59 *ibid.*, s. 3.
- 60 Ombudsman Act, ss. 13, 14A.
- 61 *ibid.*, s. 19.
- 62 *ibid.*, s. 19; *Royal Commissions Act 1917* (SA), ss. 5, 10, 11, 11A.
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- 64 *ibid.*, s. 25.
- 65 *ibid.*
- 66 *ibid.*; Royal Commissions Act, s. 5.
- 67 Health and Community Service Complaints Act, s. 25(1)(f).
- 68 RA Layton (Chair), *Our best investment*, p. 5.10.
- 69 EP Mullighan, *Children in State Care Commission of Inquiry*, pp. 426–427.
- 70 Oral evidence: K Ryan. Submission: Connecting Foster Carers SA Inc.

- 71 *South Australian Civil and Administrative Tribunal Act 2013*, s. 34. However, the Act which confers jurisdiction on SACAT may modify the operation of the Act insofar as it sets out the test on rehearing.
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- 73 *South Australian Civil and Administrative Tribunal Act*, s. 57.
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- 83 Namely the National Children's Commissioner, the ACT Children and Young People Commissioner, the NSW Advocate for Children and Young People, the Queensland Family and Child Commission, the Tasmanian Commissioner for Children, the Victorian Commission for Children and Young People, and the WA Commissioner for Children and Young People.
- 84 The Australian Institute of Family Studies, *Children's commissioners and guardians*, Child Family Community Australia resource sheet, Australian Government, May 2015.
- 85 *Children's Commissioner Act 2016* (NT), s. 10.
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- 87 *Commissioner for Children and Young People Act 2006* (WA), s. 23.
- 88 Children's Commissioner for Wales Act 2001 (United Kingdom); Children's Commissioner for Wales Regulations 2001, r. 6.
- 89 Children's Commissioner for Wales, Children's rights in Wales, website, <http://childrensrightswales.org.uk/children-commissioner.aspx>, accessed on 25 March 2015; Children's Commissioner for Wales Act; Care Standards Act 2000 (United Kingdom).
- 90 Submission: The Council for the Care of Children.
- 91 Submission: Child Death and Serious Injury Review Committee. January 2015.
- 92 Submission: Child and Family Welfare Association.
- 93 Oral evidence: S Schrapel.
- 94 Oral evidence: F Arney.
- 95 Oral evidence: Name withheld (W112).
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- 98 *ibid.*, s 16; Commissioner for Children and Young People Bill 2014 (SA) ss. 15(3), 15(4).
- 99 Child Development and Wellbeing Bill, s. 16(d).
- 100 *ibid.*, ss. 3, 19.
- 101 Children's Protection Act, s. 52CA(1).
- 102 *ibid.*, s. 52CA(5).
- 103 Commissioner for Children and Young People Bill, ss. 20 and 23.
- 104 *ibid.*, s. 23.
- 105 *ibid.*, ss. 30, 31.
- 106 Child Development and Wellbeing Bill, ss. 16(1)(f), 16(1)(g).
- 107 *ibid.*, ss. 20
- 108 *ibid.*, s. 20.
- 109 Commissioner for Children and Young People Bill, ss. 22, 34.
- 110 *ibid.*, s. 21.
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- 113 Commissioner for Children and Young People Bill, s. 11; Child Development and Wellbeing Bill, s. 14.
- 114 *ibid.*
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- 116 Commissioner for Children and Young People Bill, ss. 22, 34.
- 117 *ibid.*, ss. 21, 32.
- 118 Oral evidence: F Arney.
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- 120 *ibid.*, s. 43; Child Development and Wellbeing Bill 2014 (SA), s. 35.
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- 122 Commissioner for Children and Young People Bill, s. 15(3)(e).
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- 124 Oral evidence: D Eszenyi.
- 125 Oral evidence: P Simmons.
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- 127 *ibid.*
- 128 See the Commissioner for Children and Young People Bill, s. 14.
- 129 Independent Commissioner Against Corruption Act, ss. 12, 13.
- 130 Oral evidence: D Eszenyi; P Simmons.
- 131 Oral evidence: D Eszenyi. Submission: CDSIRC.
- 132 Children's Protection Act, s. 52S.
- 133 Oral evidence: D Eszenyi.
- 134 *Legal Practitioners Act 1981* (SA), s. 14AB.
- 135 Submission: CDSIRC, September 2015.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

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THE GOVERNMENT'S RESPONSE: IMPLEMENTATION, MONITORING AND OVERSIGHT

Throughout this report, the Commission has endeavoured to recommend improvements to establish the best system possible to protect the vulnerable children in our society and enable them to achieve their full potential. However, the work of the Commission will be to no avail unless there is a committed and positive response from the state government as to the implementation and ongoing monitoring of the recommendations. It will not be enough for the government to accept recommendations but then simply rely on the child protection agency to implement them without providing endorsement, support, funding and prompt decision making, together with appropriate independent oversight and a process of monitoring to ensure accountability.

The implementation of recommendations should be continuous. It will also require a multi-agency collaborative commitment that is transparent, independently assessed and robust.

The importance of establishing a framework to monitor the implementation of recommendations is demonstrated by referring to past reviews. For example, the government was not mandated by legislation to respond to, or report progress against, the Layton Review when it was released in 2003.¹ The government produced a report in 2004 that outlined actions taken in 2003/04 as a result of the Layton Review and intended future actions, but there was no publicly available follow-up. Prior to the delivery of the reports of the Children in State Care Commission of Inquiry² and the APY Lands Commission of Inquiry³, legislation was enacted to require ongoing reporting on the recommendations contained in those reports.

Section 11A of the *Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004* provides that the Minister was required to respond to those reports as follows:

- (a) *within 3 months after receipt of the report by the Governor, the Minister must make a preliminary response indicating which (if any) of the recommendations of the Commissioner it is intended be carried out; and*
- (b) *within 6 months after receipt of the report by the Governor, the Minister must make a full response stating—*
 - (i) *the recommendations of the Commissioner that will be carried out and the manner in which they will be carried out; and*

- (ii) *the recommendations of the Commissioner that will not be carried out and the reasons for not carrying them out; and*

- (c) *for each year for 5 years following the making of the full response, the Minister must, within 3 months after the end of the year, make a further response stating—*

- (i) *the recommendations of the Commissioner that have been wholly or partly carried out in the relevant year and the manner in which they have been carried out; and*
- (ii) *if, during the relevant year, a decision has been made not to carry out a recommendation of the Commissioner that was to be carried out, the reasons for not carrying it out; and*
- (iii) *if, during the relevant year, a decision has been made to carry out a recommendation of the Commissioner that was not to be carried out, the reasons for the decision and the manner in which the recommendation will be carried out; and*

- (d) *a copy of each response must be laid before each House of Parliament within 3 sitting days after it is made.*

In May 2015 the federal Royal Commission into Institutional Responses to Child Sexual Abuse commissioned the Parenting Research Centre to review the status of implementation and recommendations arising from previous inquiries of relevance to that Commission. The review assessed 288 recommendations and found that 48 per cent were implemented in full, 16 per cent were partially implemented, 21 per cent were not implemented and 14 per cent could not be determined.⁴

The review referred to the importance of the development of an accountability framework to monitor implementation to:

- *maintain the momentum of reform and prevent 'slippage' in compliance and standards over time*
- *allow for an assessment of whether implementers have done what they said they would and, if not, determine nonetheless whether what they are doing is good enough*
- *anticipate hurdles and barriers and take action to avoid or address them as they arise*
- *justify resourcing or, where outcomes clearly do not justify resourcing, modify the approach, (that is, financial accountability)*
- *extend the knowledge base about what particular approaches work, and why other approaches don't, providing an opportunity to modify the strategies.*⁵

The review identified that the period immediately following the handing down of recommendations, but before implementation begins, is a critical point at which the impetus for reform can start to wane. Recommendations for the early establishment of monitoring mechanisms were seen as prudent.

This Commission asked the University of South Australia's Australian Centre for Child Protection (ACCP) to conduct a similar review of the implementation of recommendations by independent child protection inquiries in this state.⁶ The ACCP review looked at 349 recommendations arising out of four South Australian inquiries: the Layton Review (206 recommendations), the Children in State Care Inquiry (54 recommendations), the APY Lands Inquiry (46 recommendations) and the DeBelle Royal Commission⁷ (43 recommendations).

As discussed in Chapter 2 of this report, the ACCP review concluded that the intent of the CISC and DeBelle inquiries had been generally met. It found that it was not possible to verify the implementation of a large proportion of the Layton Review recommendations, although a number of key initiatives had been introduced. Regarding the APY Lands Inquiry, the review commented that despite most of the recommendations being reported as accepted in the state government's annual implementation reports, a number of the responses appeared not to have addressed the recommendation's intent or resolved the issue. The ACCP analysis concluded that 'Recommendations are more likely to be implemented where some form of accountability framework and monitoring process is in place'.

IMPLEMENTATION AND MONITORING FRAMEWORK

STAGED AND STRATEGIC APPROACH TO IMPLEMENTATION

The period immediately following the release of this report will involve great change, including the establishment of a new child protection department and the appointment of a new Chief Executive. Although some matters set out in this report can and should be addressed urgently, others require time.

This report has discussed problems posed by Families SA's earlier Redesign reform agenda, including its attempt to implement multiple, complex changes in a short timeframe without sufficient staff support or consultation. The Commission's own recommendations, taken as a whole, represent significantly wider reforms to all parts of the child protection system. A staged and strategic approach is vital to their effective implementation.

In addition to considering what recommendations will be accepted, the government should make a realistic assessment as to what can be done in the short, medium and long terms. These are decisions for Cabinet with specific input from the Child Protection Reform Cabinet Committee.

RESPONSE AND IMPLEMENTATION TEAM

The government should establish a response and implementation team consisting of staff with expertise in child protection, policy, data analysis, stakeholder engagement and legislative development. This team would be responsible for implementing on a day-to-day basis recommendations accepted by the government in accordance with the timeframes determined by the government.

As discussed elsewhere in this report, the effective support of vulnerable children requires coordinated action from a range of government and non-government agencies. An important aspect of the response and implementation team's work is therefore to consult with affected agencies and stakeholders to ensure a coordinated approach.

STEERING COMMITTEE

The government should also establish an across-government steering committee to oversee the response and implementation team and to ensure a coordinated, whole-of-government approach. Committee members should include representatives from key government agencies, including:

- Attorney-General's Department
- Crown Solicitor's Office
- Department for Communities and Social Inclusion
- Department for Education and Child Development
- Department of Health and Ageing
- Department of the Premier and Cabinet
- Department of Treasury and Finance
- South Australia Police.

It should also include other government agencies as and when specific issues relevant to their particular agency arise, such as Aboriginal Affairs and Reconciliation.

The members of the steering committee must have sufficient authority to speak for, and make commitments on behalf of, their respective agencies so as to address any obstacles to implementation that may emerge over time. The steering committee should report to the Minister for Child Protection Reform as Chair of the Child Protection Reform Cabinet Committee.

The steering committee should draw upon expertise external to government where necessary to inform its work, including from the many not-for-profit agencies that form part of the broader child protection system.

In addition, at least one of the steering committee's permanent members should have relevant child protection expertise and be external to the South Australian Government. This member can offer perspective and advice independent to government and assist the committee to assess whether agencies have indeed implemented specific recommendations to improve child health, safety and wellbeing.

SUPPORT FOR THE NEW CHILD PROTECTION DEPARTMENT

The Commission's recommendations require significant change for the newly formed child protection department when compared with the current Agency. The steering committee and the response and implementation team must work to ensure that change within the newly formed department is adequately managed. This will include identifying high-level change agents within the department to build the skills, knowledge and expertise of child protection staff to respond more effectively to the complex needs of vulnerable children and families.

REPORTING

Transparent reporting on reform items is crucial to allow the public to judge the degree to which the government has implemented the Commission's recommendations. Because implementation may take a number of years, it is important that reporting extend for a commensurate period. The government should prepare an initial report on or before 31 December 2016, setting out:

- the recommendations of the Commission that have been implemented either partly or in full;
- the recommendations of the Commission that have been accepted but have not yet been fully implemented, the manner in which they will be fully implemented and the intended timeframe for that implementation; and
- the recommendations of the Commission that will not be implemented and the reason for not implementing them.

The government should prepare subsequent reports by 30 June 2017 and then annually for at least the following five years. These reports should address the first two items listed above. In the event that the government decides to implement a recommendation that it previously indicated was not to be implemented,

the reports should also state the reasons for that decision and the manner in which the recommendation will be implemented.

Reports should be readily available to members of the public, including being published online.

RECOMMENDATIONS

The Commission recommends that the South Australian Government:

- 257 Establish an across-government steering committee to monitor and oversee the implementation of recommendations. Membership of the committee should include representation by senior executives from relevant government agencies and include at least one independent member external to the South Australian Government. The Committee should report directly to the Minister for Child Protection Reform as Chair of the Child Protection Reform Cabinet Committee.
- 258 Establish a response and implementation team consisting of staff with expertise in child protection, policy, data analysis, stakeholder engagement and legislative development.
- 259 Ensure the implementation of recommendations within the newly formed child protection department is adequately managed with high-level change agents and appropriately qualified and skilled child protection staff.
- 260 Respond to the recommendations in this report as follows:
 - a on or before 31 December 2016, provide a report setting out—
 - i the recommendations of the Commission that have been implemented either partly or in full
 - ii the recommendations of the Commission that have been accepted, but have not yet been fully implemented, the manner in which they will be fully implemented and the intended timeframe for that implementation
 - iii the recommendations of the Commission that will not be implemented and the reason for not implementing them;
 - b on or before 30 June 2017, provide a further report as to—
 - i the recommendations that have been wholly or partly implemented and the manner in which they have been implemented

- ii if a decision has been made not to implement a recommendation that was to be implemented, the reason for not implementing that recommendation
- iii if a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for that decision and the manner in which the recommendation will be implemented;
- c for a period of not less than five years after the provision of the report referred to in paragraph 4(b) hereof, provide an annual report setting out—
 - i the recommendations that have been wholly or partly implemented in the relevant year and the manner in which they have been implemented
 - ii if, during the relevant year, a decision has been made not to implement a recommendation that previously was to be implemented, the reason for not implementing that recommendation
 - iii if, during the relevant year, a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for the decision and the manner in which the recommendation will be implemented;
- d make reports publicly accessible, including being published online.

NOTES

- 1 RA Layton (Chair), *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia, Department of Human Services, Government of South Australia, Adelaide, 2003.
- 2 EP Mullighan, *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct*, Children in State Care Commission of Inquiry, Adelaide, 2008.
- 3 EP Mullighan, *Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A report into sexual abuse*, Children on APY Lands Commission of Inquiry, Adelaide, 2008.
- 4 Figures do not total 100 per cent due to rounding. Parenting Research Centre, *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse: Final report*, Royal Commission into Institutional Responses to Child Sexual Abuse, May 2015, p. xiv.
- 5 *ibid.*, pp. 142–143.
- 6 S McDougall et al., *The implementation of recommendations made by independent child protection inquiries in South Australia: A report to the Child Protection Systems Royal Commission*, Australian Centre for Child Protection, Adelaide, April 2016, www.agd.sa.gov.au/child-protection-systems-royal-commission
- 7 BM Debelle, *Royal Commission 2012–2013: Report of Independent Education Inquiry*, Independent Education Inquiry, Adelaide, 2013.

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APPENDIX A— RELEVANT LEGISLATION

APPENDIX A RELEVANT LEGISLATION

AUSTRALIAN

SOUTH AUSTRALIA

Adoption Act 1988
Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981
Child Development and Wellbeing Bill 2014
Children's Protection Act Amendment Act (No. 49 of 1969)
Children's Protection Act 1993
Children's Protection (Miscellaneous) Amendment Act 2005
Children's Protection Regulations 2010
Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004
Commissioner for Children and Young People Bill 2014
Child Sex Offenders Registration Act 2006
Controlled Substances Act 1984
Disability Services Act 1993
Evidence Act 1929
Family and Community Services Act 1972
Health and Community Services Complaints Act 2004
Independent Commissioner Against Corruption Act 2012
Legal Practitioners Act 1981
Mental Health Act 2009
Ombudsman Act 1972
Public Sector Act 2009
Royal Commissions Act 1917
South Australian Civil and Administrative Tribunal Act 2013
Spent Convictions Act 2009
Summary Offences Act 1953
Summary Procedure Act 1921
Teachers Registration and Standards Act 2004
Young Offenders Act 1993
Youth Court Act 1993

ACT

Human Rights Commission Act 2005
Working With Vulnerable People (Background Checking) Act 2011

COMMONWEALTH

Family Law Act 1975

NEW SOUTH WALES

Children and Young Persons (Care and Protection) Act 1998

Child Protection (Working With Children) Act 2012

Ombudsman Act 1974

NORTHERN TERRITORY

Care and Protection of Children Act 2007

Children's Commissioner Act 2013

QUEENSLAND

Commission for Children and Young People Act 2000

Public Guardian Act 2014

Working With Children (Risk Management and Screening) Act 2000

TASMANIA

Children, Young Persons and Their Families Act 1997

Registration to Work with Vulnerable People Act 2013

VICTORIA

Children, Youth and Families Act 2005

Working With Children Act 2005

WESTERN AUSTRALIA

Children and Community Services Act 2004

Children and Community Services Amendment (Reporting Sexual Abuse of Children) Act 2008

Commissioner for Children and Young People Act 2006

Working With Children (Criminal Record Checking) Act 2004

INTERNATIONAL

NEW ZEALAND

Children, Young Persons, and Their Families Act 1989

UNITED KINGDOM

Care Standards Act 2000

Children Act 1989

Children's Commissioner for Wales Act 2001

Children's Commissioner for Wales Regulations 2001

APPENDIX B— THE COMMISSION

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APPENDIX B—THE COMMISSION

APPROACH AND CONDUCT OF THE COMMISSION

ESTABLISHMENT

On 15 August 2014, the Commission and the relevant Terms of Reference were formally published in the Government Gazette. Staff appointed to the Commission immediately began making the practical arrangements necessary to begin operations.

The Commission occupied premises located at Level 9, 50 Grenfell Street, Adelaide from October 2015, and set up a free call 1800 number (1800 826 866), GPO mail box, generic email address and website. The website contained information on the work of the Commission, including practice directions, frequently asked questions, a fact sheet for government employees, and information sheets on procedure at hearings. Later, some submissions received on a non-confidential basis were published on the website for the benefit of the public.

CALL FOR SUBMISSIONS

On 21 October 2014 a media release advised the public that the Inquiry had begun and that in due course, submissions would be sought from any person or organisation with information relevant to the Terms of Reference. It advised that the schedule of work for the Commission would include hearings where evidence would be taken. It was anticipated that, initially, hearings would be in private, but there was power to hold public hearings in certain circumstances. The release pointed out that individual cases would not be investigated as part of the Commission work, except where they highlighted systemic problems relevant to the Terms of Reference. It also advised that any criminal matters identified during the investigation process would be referred to the appropriate authorities.

On 1 November 2014, a Public Notice published in the *Advertiser* newspaper invited submissions through the website or by post. The notice was also published in other selected metropolitan and country newspapers during November. At the same time, letters were written to relevant stakeholders, individuals and organisations inviting them to make submissions.

RESPONSE TO CALL FOR SUBMISSIONS

The response to the initial media release and newspaper advertisements was disappointing. The Commissioner undertook a number of media engagements and also wrote to people/organisations identified as key stakeholders inviting them to make submissions. Initially, this request also had a limited response. The modest early response to the call for submissions was concerning and was attributed to a number of causes. The establishment of this Commission coincided with hearings by the federal Royal Commission into Institutional Responses to Child Sexual Abuse.

In addition, a State Parliamentary Select Committee on Child Protection had begun an inquiry on child protection issues on 21 May 2014 and had also called for submissions. There was a degree of confusion in the community about the organisation to which submissions should be directed. A number of individuals/organisations indicated an erroneous impression that a submission made to the Parliamentary Select Committee would automatically be made available to this Commission. Of particular concern was the lack of response from workers currently employed by Families SA who the Commission believed would be able to provide first-hand information as to relevant system issues. The reticence on the part of current workers to contact the Commission was in part attributed to a concern that to do so might constitute a breach of the Code of Conduct under the *Public Sector Act 2009*. That difficulty was, to some extent, resolved by the Deputy Chief Executive for Child Protection issuing an advice to all Families SA employees that the Commission would be visiting offices to discuss its work and to talk directly with staff about their work. He encouraged staff to attend those meetings and, if they wished, to participate in the Commission inquiry process.

The situation appeared to have been further exacerbated by the Coronial Inquiry into the death of Chloe Valentine, which began on 14 August 2014 and continued over a number of months. The Coroner's findings and recommendations were delivered on 9 April 2015. That inquiry was the subject of intense media attention; certain employees of Families SA were identified by name and had their photographs appear on television and in the newspapers. Several staff were pilloried in the press as a result of perceived inefficiencies in their work practices. It became clear that there was an apprehension among Families SA workers generally that anyone electing to give evidence before the Commission would be similarly identified and subjected to adverse comment and publicity.

In order to dispel such concerns, members of the Commission visited metropolitan and country offices of Families SA. Workers were reminded of the advice from the Deputy Chief Executive and were informed about the nature of this inquiry and the procedures that would be followed to gather evidence. They were reassured about the ability to give evidence and/or make submissions on a confidential basis. In performing this service, lawyers from the Commission were assisted by Di Gursansky, a member of the Expert Advisory Panel.

Eventually, the Commission received a total of 374 submissions, either online or in writing, many on a confidential basis. The Commission also invited 72 individuals and organisations to make submissions. Of that group, 30 responded to the invitation.

CONSULTATIONS, SITE VISITS AND WITNESSES

As part of the Inquiry the Commission engaged in a number of consultations and informal meetings with relevant stakeholders and other interested parties. None of these people gave evidence on oath nor were required to make an affirmation. The information obtained in the course of such meetings and consultations was not therefore treated as evidence before the Commission but was used to inform the Commission about relevant matters and to assist further enquiries. However, most of those consulted subsequently became witnesses and gave evidence on oath or affirmation. The Commission also visited some sites to better understand some of the evidence given in the course of hearings.

On 2 July 2015, Counsel Assisting, together with a senior solicitor made a presentation about the work of the Royal Commission to legal staff of the Criminal Law Section at the Legal Services Commission. The Commissioner and Counsel Assisting also presented to Judges of the Supreme, District and Magistrates Courts at the Judicial Development Day held in November 2015. Judges from the Federal Circuit Court were also in attendance.

In the course of this Inquiry the Commission took evidence from a total of 381 people, including evidence taken in private hearings and the five case studies. Some witnesses were obliged to give evidence more than once because of overlapping issues particularly with the case studies. For statistical purposes, they have been counted only once in calculating the above figure. Witnesses who gave evidence in the course of the case studies numbered 76 for McCoolle and 66 for the other four. The remaining witnesses gave evidence in private hearings.

HEARING PROCEDURE

The first formal hearing of the Commission was held on 5 November 2014. This included an opening statement by Counsel Assisting as to the future work of the Commission. This was followed by some formal evidence from Shirley Smith, the Redesign Program Manager for Families SA, whose evidence was primarily concerned with the organisational structure of the Office for Child Protection and Families SA, its operational arm. The transcript of the opening by Counsel Assisting was subsequently published on the Commission website. Thereafter, hearings were adjourned until submissions closed at the end of January 2015.

Hearings commenced at the beginning of February 2015 and continued through to March 2016. With the exception of the formal case studies and some more formal hearings, all metropolitan hearings took place in the hearing room at the Commission premises, 50 Grenfell Street, Adelaide.

During the week beginning 1 June 2015 the Commission travelled to Mount Gambier and conducted hearings at Mount Gambier Courthouse. In the week beginning 13 July 2015, the Commission conducted hearings at Port Augusta Courthouse. The Commission considered travelling to the APY Lands for hearings but decided to take evidence from relevant witnesses using audio-visual links. This technology was also used to take evidence from witnesses in the Northern Territory and New South Wales.

Most witnesses were served with a summons before giving their evidence and witnesses either gave evidence on oath or made an affirmation to tell the truth.

In accordance with the Commission's Practice Directions, all of these hearings were held in private. From time to time a list of witnesses and the dates and times on which they were due to give evidence was published on the Commission's website. No applications were received to have any of these hearings declared open to the public.

CASE STUDIES

The evidence at each of the case study hearings was not confidential but those hearings were also held in private to protect the identities of the young people who were the subject of the relevant case study. However, the Commission took the view that the high level of public interest in McCoolle's activities required a different approach. Nevertheless, the evidence in McCoolle referred extensively to the names of children in care, their residential locations and in some cases details of their abuse. In those circumstances, it was not considered appropriate that the hearing be open to the public at large. The balance between the public interest in these proceedings, and the need to protect the privacy of the children concerned, was resolved by permitting accredited media to be present during hearings and to report as to evidence, subject to undertakings and/or orders as to non-publication of sensitive details.

In the course of the hearings, non-publication orders were made on the names of some witnesses who established in evidence that they would suffer hardship by reason of publication of their name and/or image, as well as some items of evidence of a sensitive nature.

APPENDIX B—THE COMMISSION

STAFF

A total of 29 staff were employed at the Commission; not all staff worked for the whole term of the Inquiry.

LEGAL STAFF

Emily Telfer was appointed as Counsel Assisting the Commissioner. Ms Telfer has been employed by the Office of the Director of Public Prosecutions (ODPP) for many years and as a Senior Prosecutor has had extensive experience managing a team of trial prosecutors working on complex trials. This included trials involving the abuse of children and solicitor's work in country areas including the APY Lands. In earlier employment with the Legal Services Commission, Ms Telfer had experience in criminal defence work acting for children and young people charged with criminal offences. Ms Telfer undertook counsel work in hearings, as well as supervision and management of legal and research staff.

Counsel assisting support was provided by Melissa Wilkinson, who also has extensive experience as a prosecutor in the ODPP. They were ably supported by a legal team of:

Kate Hodder (Senior Solicitor)
Lisa Duong (Senior Solicitor)
Samuel Whitten (Senior Solicitor)
Julia Beauchamp (Solicitor)
Scarlett Schumacher (Solicitor)
Ruxandra Voinov (Solicitor)
Natalie Wade (Solicitor)
Rebecca Millwood (Legal Research)
Melissa Keys (Legal Research)
Edward Barson (Legal Research)
Sarah Draper (Legal Research)
Jordan Phoustanis (Legal Research)
Melanie Ellis (Special Investigator)
Julie Bertossa (Witness Assistance Officer)

ADMINISTRATION STAFF

Angel Williams was appointed Director of the Commission office; she oversaw strategic direction and managed financial, administrative and human resource matters, including being the key conduit to government. The Commission was ably assisted by the following team of experienced business, administration, information and records management and communications personnel:

Christina Papapavlou (Senior Communications Officer)
Snezana Savic (Business and Information Manager)
Aleksandra Wragg (Business and Information Manager)
Jane Caperna (Senior Administration Officer)
Jackie O'Brien (Executive Assistant to the Commissioner)
Amelia Greer (Administration Officer/Legal Support)
Nora Willis (Administration Officer/Legal Support)
Linda Knights (Administration Officer/Legal Support)
Karen McDiarmid (Administration Officer/Legal Support)
Margaret Hough (Administration Officer/Legal Support)
Sophia Karakousis (Administration Officer/Legal Support)

Rowena Austin undertook the enormous editing task of the Commission report, assisted by consultant editors Karen Disney and Kathie Stove.

EXPERT ASSISTANCE

EXPERT ADVISORY PANEL

DR DIANA HETZEL

Dr Diana Hetzel brings an important perspective to the Commission, with her public health background, medical experience, research skills and specialist knowledge in population health. Dr Hetzel has a long history as an advocate for children and families, and has strongly supported early intervention and interdisciplinary strategies in child protection. She has a clinical medical background in child health; and over 30 years' experience in the health and welfare sectors, including public health research; service planning and program evaluation; and policy development. Her current research interests are in the areas of health inequalities; the socioeconomic determinants of population health; and the impact of disadvantage and violence on the health and wellbeing of infants, children and young people. She has chaired the SA Council for the Care of Children, and been a member of the SA Children's Interests Bureau, SA Child Health Council, and the SA Child Death and Serious Injury Review Committee. She has also served as a non-executive member on a number of boards of organisations, which provide health and education-related services to children and young people.

MS ROSEMARY KENNEDY

Rosemary Kennedy is a registered psychologist also admitted as a practitioner of the Supreme Court of South Australia. Ms Kennedy worked for several years as a psychologist in mental health and disability institutions, and in the management of secure and community based residential care services for children at risk and young offenders. Ms Kennedy worked for many more years as a Senior Lecturer at the University of South Australia teaching social workers, a wide range of human service workers, and psychologists. In this role she also consulted and researched in the areas of human service law and ethics, human service training, employment and regulation, human service practice, and service delivery arrangements including case management. She has published several books on case management, law and human services and human service failures. She has undertaken adverse events and integrity allegations reviews for a range of organisations. Ms Kennedy now works part-time in her own psychology consultancy and part-time for the Australian Health Practitioner Regulation Agency. Ms Kennedy maintains an interest in human service research, and has been a member of several organisational research ethics committees including that of the Department for Communities and Social Inclusion.

MS DI GURSANSKY

Di Gursansky is a social worker who has been actively involved in professional practice with government and non-government agencies, social work and human service education and both state and national leadership of the Australian Association of Social Workers. Ms Gursansky has had a long-standing interest in issues relating to children, particularly those identified as 'at risk' or children in the care of the Minister.

She has held ministerial appointments previously to the Children's Interests Advisory Committee and is currently appointed to the SA Child Death and Serious Injury Review Committee. Over the period of ten years on this latter committee Ms Gursansky has undertaken many in-depth reviews where there has been neglect, abuse and/or complex medical and disability issues. Ms Gursansky has a strong interest in practice research, evaluation and has written texts on case management. Ms Gursansky has conducted organisation and program reviews in relation to children's services in South Australia and interstate. She has extensive experience of administrative law settings in particular through her previous role with the Social Security Appeals Tribunal and currently with her appointment to the South Australian Civil and Administrative Tribunal.

OTHER EXPERT ASSISTANCE

In addition to support from the expert advisory panel, the Commission relied on research support provided by the Australian Centre for Child Protection (ACCP), based at the University of South Australia. It is the only national centre dedicated to child protection research, policy and practice development. The relationship with the ACCP provided the Commission access to leading researchers in the area of child protection, and provided valuable guidance in contemporary best practice. Professor Fiona Arney, ACCP Director, Dr Sara McLean and Dr Kerry Lewig, provided particular assistance.

The following research papers prepared by ACCP for the Commission are available online at www.agd.sa.gov.au/child-protection-systems-royal-commission

- The implementation of recommendations made by independent child protection inquiries in South Australia;
- The effectiveness of child protection income management in Australia;
- Report of therapeutic residential care; and
- Report on secure care models for young people at risk of harm.

The federal Royal Commission into Institutional Responses to Child Sexual Abuse is responsible for commissioning and managing a formidable body of research in the area of child abuse prevention and response. The Commission has benefitted from the cooperation and assistance of the federal Royal Commission's Policy and Research Branch, in particular providing access to results of research, including research in progress and research not yet publicly available.

Other researchers assisted the Royal Commission from time to time. Professor Paul Delfabbro, based at the University of Adelaide's School of Psychology provided access to his vast research portfolio concerning child protection and out of home care. Dr Philip Gillingham, from the School of Social Work and Human Services at the University of Queensland similarly assisted by enabling the Commission to access his research about the use of information and communication technology in social work.

Luke Broomhall, a clinical psychologist working in private practice at Broomhall Young Psychology gave expert assistance to the Commission by evaluating psychometric tools employed in the selection of staff to positions in the child protection system.

APPENDIX B—THE COMMISSION

INFORMATION GATHERED BY THE COMMISSION

SUBMISSIONS, NON-CONFIDENTIAL

ORGANISATIONS

Aboriginal Family Support Services
AnglicareSA
Anglicare Tasmania
Anglicare Youth 180 Program
Australian Association of Infant Mental Health (AAIMHI)
Australian Association of Social Workers (AASW)
The Australian Centre for Social Innovation (TACSI)
Australian National University, Regulatory Institutions Network
Baptist Care (SA) Inc
Barnardos Australia
BoysTown
Bravehearts Inc
Centacare Catholic Family Services Adelaide
Centacare Catholic Family Services Country SA
Child and Family Welfare Association of South Australia (CAFWA)
Child Death and Serious Injury Review Committee
Child Focussed Practice Operational Group, Domestic Violence and Homelessness Sector
Connecting Foster Carers SA Inc.
Council for the Care of Children
Courts Administration Authority (CAA), Family Conferencing Unit
CREATE Foundation Ltd
Fairness in Religions in School (FIRIS), SA
Fighters Against Child Abuse Australia (F.A.C.A.A.)
Flinders Medical Centre, Child Protection Service
Foster Care Family Advocacy Inc
Government of South Australia
Gowrie South Australia
Guardian for Children and Young People, Office of the
Health and Community Services Complaints Commissioner (HCSCC), South Australia
Junction Australia
Law Society of South Australia
Legal Services Commission of South Australia
Life Without Barriers
Lutheran Community Care (South Australia and Northern Territory)

Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY)
Women's Council, Aboriginal Corporation (NPYWC)
People Against Intentional Neglect (P.A.I.N.)
Psychologists Association SA Branch
Public Service Association of SA Inc.
Royal District Nursing Service (RDNS), SA
Relationships Australia South Australia Ltd, Post Care Services
Salvation Army—Australian Southern Territory
South Australian Aboriginal Advisory Council (SAAAC)
South Australian Council of Social Service (SACOSS)
Southern Area Local Health Network (SALHN), Flinders Medical Centre Emergency Department
Southern Domestic Violence Service
Time for Kids
Uniting Care Wesley, Country SA
Uniting Communities
Winangay Resources Inc
Women's & Children's Hospital, Department of General Medicine
Women's & Children's Hospital, Department of Paediatric Emergency

INDIVIDUALS

Abokamil, Hala
Abraham, Karen
Aitchison, Gillian
Andary, Angela
Anson, Ron and Sally
Arnold, Gillian
Arnold-Moore, Dr Timothy
Atchison, Nicola
Balek, Peter
Barton, Judith
Bastian, Carmela
Bean OAM, John
Beltman, Marc
Bennett, Nicola
Berginetti, Nadia
Bicknell, Peter
Biggs, John
Bishop, Lewis
Bobridge, Jennifer and Sonia
Boemia, Kymberli

Bolton, John
 Bowden, Graeme and Jacqueline
 Briggs AO, Emeritus Professor Freda (deceased)
 Brock, Peter
 Brooks, Christine
 Burley, Lindsay
 Cappel AO, Monsignor David
 Caputo, Jacquelyn
 Chisari, Alex
 Cobb, Victoria
 Collings, Caroline
 Collins, Carl
 Connell, Daniella
 Cooper, Professor Lesley
 Coppin, Dr Brian
 Coralive, Christin
 Coulston, Liam
 Cowie, Danielle
 Davis, Angela
 Denley, Louise (Lou)
 Denton, Michelle
 Dunne, Gareth and Kate
 Dunne, Margaret
 Dunstan, Sandra
 Dyer, June
 Edwards, Dr Jane
 Ehrke, Sean
 Ejderos, Hanna (group submission with 13 contributors)
 Ekert, Kath
 Ellis, Marjorie (Marj)
 Flesher, Alison
 Flynn, Samantha
 Ford, Darlene
 Forde, Karen
 Foster-Holland, Shona
 Franks MLC, Hon. Tammy
 Gilbertson, Bradley (Brad)
 Goodall, Dr Kenneth
 Gorman, Melanie
 Gorman, Melanie (group submission with 7 contributors)
 Goss, Steven
 Gribble, Dr Karleen

Gunter, Troy and Budgen, Sarah
 Hale, Avril (group submission with 8 contributors)
 Hale, Emily (group submission with 6 contributors)
 Hall, Rosemary
 Hawthorne-Jackson, Dawn
 Hewson, Janet (Jan)
 Hoffmann, Shae
 Holland, Benjamin
 Holler, Bianca
 Holmes, Sharon
 Hood, Dr Mary and Tomlian, Kim
 Horgan, Claire
 How, Christopher
 Ibis, Hakan
 Jackson, Allen and Sandra
 Jackson, David
 Jacobs, Julie-Anne
 Jaspers, Susan
 Jezeph, Toni
 Johnston, Alan (Bruce)
 Jones, Jillian
 Jones, Kenneth (Brian)
 Jukes, Christine
 Justice, Ingrid
 Kaipara, Sue
 Kakoschke, Gregor (Greg)
 Kay, Matt
 King, Elizabeth (Libby)
 King, Sue
 Knox, Amanda
 Kyriacou-Balopitos, Elsa
 Kyrkou, Dr Margaret
 Latella, Michelle
 Leeder, Tim
 Lindblom, Fiona
 Liston, Tara
 Little, Dannielle
 Lloyd, Rosalyn
 Luethen, Paula
 Lunn, Dawn
 Madden, Paul
 Maddigan, Simone

APPENDIX B—THE COMMISSION

Maragkos, Anna	Roberts, Lynda
Marshall, Julie	Rootsey, Raymond (Ray)
Martin, Sandra	Ryan, Louise
McCarron, Declan	Saunders, Pamela
McDermott, Telisha	Schneider, Heidi
McGregor OAM, Margaret	Schofield, Mark
McInness AM, Dr Elspeth	Scott OAM, Emeritus Professor Dorothy
Mechielsen, Pieter	Scroop, Beryl and Trevor
Melvin, Kate	Sephton, Lynda (Lyn) (group submission with undisclosed contributor number)
Michael, Sally	Shephard, Helen
Miers AM, Sue and Miers, Tony	Silvestri, Leo
Mignonne, Margot	Stanway, Rebecca
Miller, Phillip	Starke, Serena
Mortier, Nicole (Nikki)	Stevens, Julie
Munday, Melissa	Stewart, Leanne
Munyard, Steve	Stewart, Dr Nigel
Murdey, Adam	Stuckey, Thelma
Myers, Nigel	Summers, Terri and Scott, Kevin
Nesci, Nick	Sutton, Gayl
Neville, Alicia	Symons, Victor (Vic)
Nicholls, Susan (group submission with 2 contributors)	Taplin, Anne-marie
O'Loughlin, Joe	Teo, Kean and Fox, Greg
O'Neill AM, Dr Marie	Ternezis, John
Osborn, Rachel (group submission with 5 contributors)	Thelning, Stuart
Page, Gail	Thomas, Narelle and Robert
Page, Steven	Thomas, Owen
Palachicky, Ruth	Thomson, Jillinda
Papageorgiou, Andrew	Thorpe, Emeritus Professor Rosamund
Paton, Allison	Thorsen, Shiree
Paxton, Philippa	Titley, Rachel
Pearce, Hazel	Truskewycz, Eleonora
Pirgousis, Jacqueline	Vince, Carrie
Quinn, Steve	Wade, Janet
Raikiwasa, Sera	Walker, John
Rainford, Irma	Wallace, John
Ramsell, Geraldine (Gerry)	Walters, Karen
Rayment, Patricia	Ward, Martin (group submission with 6 contributors)
Rayment, Patrica and Simmons, Claire	Warren, Christine
Rhodes, Sally	Weber, Micheal
Richards, Jodie	Weber, Peter
Richter, Pia	Wendt, Rebecca
Riggs, Dr Damien	

White, David
 Whitfield, Professor Dexter
 Whittaker, Ann
 Wiederkehr, Angelika
 Williams, Alan
 Williams, Joseph
 Williams, Pauline
 Wills, Racheal
 Willson, Rachel
 Wood, Catherine
 Wood, David

122 individual names withheld

1 organisation name withheld

CONSULTATIONS

ACADEMIA

Australian Centre for Child Protection:

Arney, Professor Fiona
 Bromfield, Leah

School of Social Work and Social Policy, Trinity College, Dublin, Ireland:

Buckley, Associate Professor Helen

Flinders University:

Hallahan, Associate Professor Lorna (Head of Social Work, and Chair of Social and Behavioural Research Ethics Committee)

JUSTICE SECTOR

Youth Court of South Australia

Broderick SM, Mr Philip
 McEwen, His Honour Senior Judge

Family Drug Treatment Court, Victoria

Buggy, Elisa, Program Manager
 McPherson, Kay, Magistrate

Family Court of Australia

Dawe, The Honourable Justice, Senior Judge

Courts Administration Authority

Doherty, Carolyn, Family Care Meetings

Judicial Education Committee

McIntyre, Her Honour Judge, Chair

NON-GOVERNMENT ORGANISATIONS

Berry Street Childhood Institute

Brunzell, Tom, Senior Advisor, Teacher & Learning,
 McCluskey, Trish, Director, Gippsland

Life Without Barriers/ Northern Country Region

Fielder, Anya, Manager

Connecting Foster Carers

Jarvis, Josephine

Aboriginal Family Support Services, Ceduna

Micka, Katharine, Manager

CREATE Foundation

Scalzi, Claudine, SA State Coordinator

SA GOVERNMENT ORGANISATIONS

Child, Death and Serious Injury Review Committee

Eszenyi, Dymphna (Deej), Chair
 Watts, Sharyn, Executive Officer

Department for Communities and Social Inclusion (DCSI)

Tattersall, Kelly, Director, Screening Procurement and Stanton Institute

Department of Education and Child Development (DECD)

Kummerow, Dr Liz, Manager/ Families SA, Psychological Services

Lovegrove, Trevor, Director, Office for Resources Operations and Assurance

Richards, Dr Jane, Project Director HR Reform, Human Resources and Workforce Development

Riedstra, Julieann, Formerly Deputy Chief Executive (Resources) Office for Child Safety

Scheepers, Etienne, Deputy Chief Executive, Office for Child Safety

Simmons, Claire, Principal Clinical Psychologist, Families SA, Executive Services

Stasiak, Nicole, Director, Families SA, Residential Care

Health and Community Services Complaints Commissioner

Tully, Steve, Commissioner

APPENDIX B—THE COMMISSION

Office of the Guardian for Children and Young People

Shaw, Amanda, Guardian

Simmons, Pamela (Pam), Former Guardian

Ombudsman SA

Hall, Peter, Manager Administration Improvement (Education)

Mayhew, Donna, Principal Advisor Information Sharing

Norton, Sharon, Legal Officer

Philpot, Megan, Acting SA Ombudsman

South Australia Police (SAPOL)

Dickson, Assistant Commissioner Paul, and members of the Special Crimes Investigation Branch

Shanahan, Detective Superintendent Joanne, and McLean, Detective Inspector Deborah: Multi-Agency Protection Service (MAPS)

Women's and Children's Hospital

Donald, Dr Terry, Former Specialist Paediatrician, WCH (now in private practice)

SITE VISITS

GOVERNMENT AND NON-GOVERNMENT ORGANISATIONS

DCSI Screening Unit

Child Abuse Response Line (CARL)

Lochiel Park Residential Care Unit (decommissioned)

Families SA large residential care facilities (three facilities; locations suppressed)

Mount Gambier Children's Centre

Anglican Community Care, Mount Gambier

Helen Mayo House, Glenside

FamilyZone Community Centre, Ingle Farm

Ruby's Reunification Program, Therapeutic Youth Services, Thebarton

Wiltja Residential Program (Secondary Schooling Boarding), Northgate

Multi-Agency Protection Service, SAPOL

Ethical and Professional Standards Branch, SAPOL

FAMILIES SA—METROPOLITAN

Southern Assessment and Support

Southern Protective Intervention

Southern Guardianship

Central Assessment and Support

Central Guardianship

Northern Assessment and Support

Northern Protective Intervention

Northern Guardianship

FAMILIES SA—COUNTRY

Mount Gambier

Berri

Mount Barker

Port Augusta

Port Pirie

Kadina

Ceduna

WITNESSES, NON-CONFIDENTIAL EVIDENCE

ORGANISATIONS

Academia

The University of Adelaide

De Crespigny, Professor Charlotte

Delfabbro, Professor Paul

Malvaso, Catia

University of South Australia

Arney, Professor Fiona, Australian Centre for Child Protection

Segal, Professor Leonie

Expert

Gursansky, Dianne (Di)

Hetzel, Dr Diana

Kennedy, Rosemary

Solution Based Casework, Social Services Associates, LLC, Santa Fe, New Mexico, USA

Christensen, Dr Dana

Non-government organisations

Aboriginal Family Support Services

Guppy, Warren

Williams, Sharron

Anglicare SA

Press, Joanne

Sandeman, Reverend Peter

The Australian Centre for Social Innovation (TACSI)

Curtis, Carolyn

Shen, Dana

Baptist Care (SA) Inc.

Brown, Jeremy

Gassner, Lee-Anne

Santillo, Teresa

Centacare Catholic Family Services Adelaide

Drew, Kirsty

Centacare Catholic Family Services Country SA

Munn, Dr Peter

Ward, Elizabeth

Child and Family Welfare Association of South Australia

Barelds, Albert

Connecting Foster Carers SA Inc.

Jarvis, Josephine

Ryan, Kelly

CREATE Foundation Ltd

Evans, Pam

Scalzi, Claudine

Junction Australia

Briggs, Dawn

O'Rafferty, David

Phillips, Sue

Key Assets

Davies, Gareth

Life Without Barriers

Jeffreys, Dr Helen

Longbottom, Jane

Mayfield, Dr Belinda

Lutheran Community Care (South Australia and Northern Territory)

Lane, Susan

Lockwood, Helen

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC)

Balmer, Liza

Kean, Melissa

Nganampa Health Council Inc.

Busuttil, David

Kelly, Dr Martin

Psychologists Association South Australia Branch

Tustin, Dr Richard (Don)

Relationships Australia South Australia Ltd

Cross, Judith

Ray, Mergho

Salvation Army, Australian Southern Territory

Brettig, Karl

Elvin, Andrew

Uniting Communities

Hillier, Cheryl

Schrapel, Simon

Uniting Care Wesley, Country SA

Pavy, Anthea

Winangay Resources Inc.

Blacklock AM, Aunty Sue

Bonser, Gillian

Hayden, Paula

SA Government organisations

Child Death and Serious Injury Review Committee

Eszenyi, Dymphna (Deej)

Courts Administration Authority, Youth Court of SA

Doherty, Carolyn

Radhakrishnan, Manoj

SA Health

APY—Women's and Children's Health Network

Sawyer, Bobbi-Jo

Drug and Alcohol Services South Australia (DASSA)

Ali, Professor Robert

APPENDIX B—THE COMMISSION

Child Protection Service, Flinders Medical Centre

Beall, Dr Jacqueline

Molden, Kerri

Thorpe, Kiaran

Department of Psychological Medicine, Women's and Children's Health Network

O'Rourke, Patricia

McEvoy, Dr Prudence

Helen Mayo House, Women's and Children's Health Network

Hollamby, Sharron

Swift, Dr Georgina

Lyell McEwin Hospital

Nozza, Dr Josephine

Yarrow Place Rape & Sexual Assault Service, Women's & Children's Health Network

Dee, Katrina

Kolarz, Vanessa

Women's and Children's Hospital

Jenkins, Alan (Mary Street, Adolescent Sexual Abuse Prevention Program (ASAPP))

John, Melissa

Ketteridge, Dr David

Rosser, Dr Jane

Department for Communities and Social Inclusion (DCSI)

Child and Youth Services, Disability Services

McAuley, Karen

Exceptional Needs Unit, Disability SA

Gillissen, Monique

O'Loughlin, Richard

Tregenza, Bronwyn

NDIS Reform, Disability SA

Nowak, Zofia

Northern Connections

O'Brien, Dr Beverley

Davidson-Tear, Jeremy

Department for Education and Child Development (DECD)

Barry, Karen

Bennett, Anthony

Brooks, Tamara (Tammy)

Guerin, Lyn

Haddad, Leanne

Kelly, Clare

Kelly, Laura

Keogh, Caroline

Kranz, Jacqueline

Macdonald, Sue

Marquard, Ann

Matschoss, Garry

Newman, Paul

Niehuus, Sally

O'Leary, Susan

O'Loughlin, Phillip

Pamminger, Melina

Richards, Dr Jane

Rudd, Mark

Sanderson, Benjamin

Scheepers, Etienne

Skilbeck, Robyn

Smith, Shirley

Starrs, Rebecca

Stasiak, Nicole

Whitten, Rosemary

Williams, Kelly

Legal Services Commission of SA

Chester, Lana

Croser, Robert

English, Andrew

Ombudsman SA

Hall, Peter

Norton, Sharon

Philpot, Megan

Guardian for Children and Young People, Office of the Simmons, Pamela (Pam)

South Australia Police (SAPOL)

McLean, Deborah (Multi-Agency Protection Service (MAPS))

Shanahan, Joanne (MAPS)

Individuals

Abokamil, Hala
Adams, Philip
Bastian, Carmela
Beltman, Marc
Birchmore, Kristina
Brooks, Christine
Caputo, Jacquelyn
Champion, Marion
Clark, Michelle
Cranney, Julia
De Kievit, Jenni
Edwards, Dr Jane
Ellis, Marjorie (Marj)
Flesher, Alison
Fluin, Kathryn (Kate)
Gaffney, Philippa (Pip)
Goss, Steven
Gunter, Troy and Budgen, Sarah
Hood, Dr Mary
Hutson, Tania
Jackson, David
Johnston, Alan (Bruce)
Kakoschke, Gregor (Greg)
Kay, Helen
Kemp, Anthony (Tony)
Kyrkou, Dr Margaret
Lindblom, Fiona
Madden, Paul
Miers AM, Sue and Miers, Tony
Miller, Phillip
Nicholls, Susan
Palachicky, Ruth
Paxton, Philippa
Pearce, Colby
Robertson, Judi
Ryan, Louise
Squires, Rodney (Rod)
Stewart, Dr Nigel
Summers, Terri
Thompson, Helen
Tomlian, Kim

Turvey, Simon
Valentine, Belinda
Walker, John
Ward, Heather
Weber, Peter
Wiederkehr, Angelika
Williams, Alan
Williams, Pauline
Worsman, Christine (Chris) and Paul

***81 names withheld*

WITNESSES, CASE STUDIES

Witness names are not included here if they are listed elsewhere or a non-publication order was made over their name.

Abela, Ann (Marie)
Andrews, Keiron
Bament, Danielle
Bateson, Holli
Beames, Vanessa
Birchmore, Megan
Borgas, Mignon
Braham, Catherine
Calvert, Darren
Cole, Tanya
Cookes, Samantha
Crawford, Kate
Creek, Julie
Cross, Peter
Curyer, Graham
Dale, Wendy
Davis, Angela
Decoster, Katherine
Dennis, Wendy
Dimond, Josie
Donald, Dr Terry
Elliott, Amber
Emmerton, Peter
Evans, Jodie
Feeney, Keryn
Fisher, Natalie
Franklin, Nadine

APPENDIX B—THE COMMISSION

Frick, Daniel
Gray, Robert
Gregg, Andrew
Gregory, Janet
Griffin, Robert
Grigg, Megan
Groat, Annette
Hall, Margaret
Hammond, Simone
Hams, Corinne
Harman, Catherine
Harmston, Wendy
Hawke, Kate
Heinrich, Dorle
Hodges, Jacqueline
Hoffmann, Shae
Holmes, Noel
Hurley, Linda
Jeffs, Debra
Jezeph, Toni
Johnston, Jayne
Kevesevic, Danijel
Knight, Daniel
Kuehn, Kristin
Lamont, Julia
Lane, Margaret
Lawson Hall, Julie
Lawson, Katie
Mackie, Carmel
Manderson, Christina
Mares, Dr Sarah
Martin, Bernadette
McCoole, Shannon
McCulloch, Maree
McKenna, Danielle
McLean, Noel
McLeish, Patricia (Kelly)
Mitchell, Diane
Nelson, Lisa
Nicholson, Shelby
Nicolaou, Anne
Norman, Lee

O'Hare, Dorothy
Ogloff, Professor James
Osborn, Rachel
Packer, Roslyn
Pinos, Jessica
Player, Jan
Plush, Leila
Purton, Louise
Rawlinson, Kirsty
Reedman, Narelle
Reilly, Adam
Rhodes, Sally
Riedstra, Julie-Ann
Ritchie, Kalari
Roberts, Karen
Rogers, Lincoln
Rowley, Melissa
Ruddell, Aleesha
Shard, Carol
Short, Jewell
Simmons, Claire
Sorensen, Tanya
Steffensen-Smith, Helen
Sterzl, Shane
Strachan, Patricia (Trish)
Taheny, Katrina
Thompson-Francis, Alice
Turner, Jayne
Vajdic, Srdjan
Vidovic, Mirjana
Wallis, Wendy
Waterford, William (David)
Whitehorn, Grant
Williams, Don
Willsmore, Russell
Willson, Rachel
Wood, Catherine
Worth, Trudy
Ziegeler, Anne

OTHER STATISTICAL INFORMATION

SUMMONSES

The Commission issued 680 summonses in the course of this Inquiry, 280 to produce documents and 400 to witnesses to appear at hearings. Summonses to produce documents brought more than 11,000 records before the Commission.

EXHIBITS

The total number of exhibits received by the Commission, for all hearings, was 1028, including 78 exhibits for the McCoolle case study and 149 for the other four case studies.

WEBSITE

The Commission website went live soon after the commission was established. It housed information including the Terms of Reference, practice directions, hearing schedules and instructions on how to make a submission online. At the time of writing, the website had received 12,034 visits over the course of the Inquiry.

APPENDIX C— EXPERT ADVISORY PANEL PROJECT METHODOLOGY

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THE PROJECTS

To increase the Commission's understanding of practice quality, members of the Expert Advisory Panel (see Appendix B) reviewed selected files across four areas of interest:

- How the Screening Unit in the Department of Communities and Social Inclusion (DCSI) completed assessments as part of child-related employment screening.
- How Families SA responded to child protection notifications, including assessments and case planning, as recorded in C3MS files—the Usual Practice review.
- How Families SA responded to the possibility of children suffering cumulative harm—the Cumulative Harm review.
- How Families SA Call Centre practitioners screened notifications (whether they were assessed as requiring a response and, if so, what form of response)—the Intake review.

The results of the reviews have been referred to throughout this report. A summary of the methodology applied in the reviews follows.

REVIEW OF SCREENING ASSESSMENTS

This project involved a qualitative review of 150 screening assessment briefings from 2013/14 that contained negative information about the applicant for child-related employment. Samples of assessment outcomes from each decision-making level in the Screening Unit, including those of the Complex Assessment Panel, were selected and reviewed. Thematic analyses of the outcomes within and across samples focused on the following broad issues:

- compliance with standards;
- management of discontinued criminal charges;
- management of child protection notifications, including those not investigated or substantiated;
- engagement of the applicant and weight given to their responses;
- elicitation and use of information from additional sources;
- weighting of information in decision making;
- cancellation of clearances;
- expertise of assessors;
- appropriateness of 'rules'; and
- appropriateness of specific clearances.

'Rules' refers to the material used by the Screening Unit to guide its screening assessments. The rules were taken to consist of the following:

- *Children's Protection Act 1993* (SA), Division 3
- Children's Protection Regulations 2010 (SA)
- DCSI, Assessment Procedure for Dealing with Criminal History Information: Child Related Employment, including Matrix for Assessing Criminal History Information, 1 October 2014 (internal unpublished document)
- DCSI, Approvals Authorisation: Child-related Assessment, including Approval Authority Matrix, 11 September 2014 (internal unpublished document)
- Department for Education and Child Development (DECD), Standards for Use of Child Protection Information in the Assessment of an Applicant's Relevant History Pursuant to the *Children's Protection Act 1993*, issued 1 July 2014 (internal unpublished document)
- DECD, Standards for Dealing with Information Obtained about the Criminal History of Employees and Volunteers who Work with Children, issued July 2012.

USUAL PRACTICE REVIEW

This project involved a review of 60 Families SA child protection C3MS files from 2013/14, picked at random. The reviewers used a checklist containing a set of broad indicators of good practice derived from the literature and practice experience to review each child's file. The reviewers sought evidence in each file of the child's point of view, the influence of theoretical underpinnings and practice approaches to decision making, supervision and professional judgements. They reviewed the screening of the notification, assessment, case planning, intervention, monitoring and case closure practice as presented in the files. They also looked at the use and contribution of C3MS to case management and decision making.

CUMULATIVE HARM REVIEW

This review examined a selection of cases to consider how Families SA assessed and responded to the risk of cumulative harm to children. The Commission provided 19 cases to two members of the Expert Advisory Panel, who examined each case in the context of a number of research articles, their practice and professional knowledge, and consideration of the long-term effects of cumulative abuse and neglect on children's wellbeing.

INTAKE REVIEW

This review examined 120 notifications taken by the Families SA Call Centre over five months, from 1 July to 1 December 2014. Of the notifications, 20 were classified as Tier 1, 20 as Tier 2, 20 as Tier 3, 20 as Notifier Only Concern, 20 as No Grounds for Intervention and 20 as Adolescent at Risk. The 20 notifications of each type were provided by the Agency and therefore their selection was not necessarily random.

For each notification, the Commission staff extracted from C3MS and tabulated the following information:

- the child's date of birth;
- the child's Aboriginal or non-Aboriginal status;
- the method of notification—Child Abuse Report Line (CARL) or eCARL;
- the date of allegation;
- any previous child protection concerns relating to the child;
- the identity of the notifier for eCARL notifications;
- the designation/profession of the notifier;
- the weight given to the notifier's status;
- the provision or otherwise of diversionary options in response to the allegation;
- the rationale for the decision made; and
- any other noteworthy observations.

These areas were decided by Commission staff in consultation with two members of the Expert Advisory Panel, who then reviewed the material and provided commentary on each case. The commentary was structured on the following issues, which were decided by Commission staff in consultation with the experts:

- the quality of information;
- the diversionary responses that appear to have been warranted;
- the appropriateness or otherwise of the notification; and
- the appropriateness of the chosen tier rating.

The experts then drew general conclusions about intake processes evidenced by the project sample.

SHORTENED FORMS

AAR	Adolescent at Risk
AASW	Australian Association of Social Workers
ACCP	Australian Centre for Child Protection
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principal
ACTT	Alternative Care Therapeutic Team
ADHD	Attention deficit hyperactivity disorder
AEDC	Australian Early Development Census
AFP	Aboriginal family practitioner
AFSS	Aboriginal Family Support Services
AHP	allied health professional
AHP+PDRP	Allied Health Professionals plus Professional Development Reimbursement Program
AHPRA	Australian Health Practitioner Regulation Agency
AIFP	Australian Institute of Forensic Psychology
AIFS	Australian Institute of Family Studies
ALRC	Australian Law Reform Commission
ALSR	Adolescent Late Stage Reunification
APY	Anangu Pitjantjatjara Yankunytjatjara
ARACY	Australian Research Alliance for Children and Youth
ASD	autism spectrum disorder
ASO	administrative services officer
ATSI	Aboriginal and Torres Strait Islander
AYTC	Adelaide Youth Training Centre
C3MS	Connected Client and Case Management System
CaFHS	Child and Family Health Service
CAFWA	Child and Family Welfare Association
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service
CARL	Child Abuse Report Line
CARU	Carer Assessment and Registration Unit
CAT	Complexity Assessment Tool
CCIU	Care Concern Investigations Unit
CCR	care concern referral

CDSIRC	Child Death and Serious Injury Review Committee
CfC	Communities for Children
CFC	Connecting Foster Carers
CIS	Client Information System
CISC	Children in State Care
CNA	Closed No Action
CNCI	Could Not Complete Investigation
CNL	Closed Not Located
COAG	Council of Australian Governments
CPD	continuing professional development
CPS	Child Protection Services
CRIS	Client Relationship Information System
CRP	Case Review Panel
CRU	Crisis Response Unit
CSO	Crown Solicitor's Office
CWA	child wellbeing assistant
CWC	child wellbeing consultant
CWP	child wellbeing practitioner
CYFS	Children, Youth and Family Services
CYS	Child and Youth Services
DALY	disability adjusted life year
DART	Diversion Assessment Response Team
DASSA	Drug and Alcohol Services South Australia
DCSI	Department for Communities and Social Inclusion
DECD	Department for Education and Child Development
DNA	Divert Notifier Action
DPC	Department of the Premier and Cabinet
DR	differential response
eCARL	electronic Child Abuse Report Line
ECHIPWC	Exchange of Criminal History Information for People Working with Children
EIRD	Early Intervention Research Directorate
EXF	Extra-familial

SHORTENED FORMS

FACS	Department for Family and Community Services
FAYS	Family and Youth Services
FCM	Family Care Meeting
FGC	family group conference [New Zealand]
FMC	Flinders Medical Centre
FNR	Full Investigation Not Required
FTE	full-time equivalent
GCYP	Office of the Guardian for Children and Young People
HCSCC	Health and Community Services Complaints Commissioner
HR	human resources
ICL	Independent Children's Lawyer
ICP	The Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect
IFSS	Integrated Family Support Service
IMD	Incident Management Division
iREG	Initial registration [Specific Child Only and kinship carers]
ISGs	Information Sharing Guidelines for Promoting Safety and Wellbeing
ITRS	Infant Therapeutic Reunification Service
ITS	Intensive Tenancy Support
LAN	Local Assessment of Needs
LAPDU	Learning and Practice Development Unit
LF	Linking Families
LMH	Lyell McEwin Hospital
LSC	Legal Services Commission
LWB	Life Without Barriers
MAPS	Multi-Agency Protection Service
MAS	Manager—administrative services
MCET	Multicultural Community Engagement Team
NAPLAN	National Assessment Program—Literacy and Numeracy
NCA	National Crime Agency [United Kingdom]
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGI	No Grounds for Intervention

NGO	non-government organisation
NOC	Notifier Only Concern
NPY	Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara
NRAS	National Registration and Accreditation Scheme
NVCI	non-violent crisis intervention
OOHC	out-of-home care
OP	Other Person [guardian]
OPG	Other Person Guardianship
OPS	operational services
PAC	principal Aboriginal consultant
PI	Protective Intervention
PO	professional officer
PRC	Parenting Research Centre
PSU	Placement Services Unit
PSW	principal social worker
PYEC	Pitjantatjara Yankunytjatjara Education Committee
RIT	Risk Identification Tool
ROA	Refer Other Agency
ROU	Report on Unborn
RPI	Resources Prevent Investigation
RTO	registered training organisation
SACAT	South Australian Civil and Administrative Tribunal
SAPOL	South Australia Police
SATS	Stabilisation and Transition Service
SBC	Solution Based Casework™
SCO	Specific Child Only [care]
SDM	Structured Decision Making®
SEIFA	socio-economic indexes for areas
SILS	Supported Independent Living Service
SIU	Special Investigations Unit
SMART	Strategies for Managing Abuse Related Trauma
SNAICC	Secretariat of National Aboriginal and Islander Child Care
SOC	supporters of carers

SHORTENED FORMS

SSO	school services officer
TACSI	The Australian Centre for Social Innovation
TILA	transition to independent living allowance
TIS	Targeted Intervention Service
UNCRC	United Nations Convention on the Rights of the Child
VCA	Voluntary Custody Agreement
VOOHC	voluntary out-of-home care
WCH	Women's and Children's Hospital
WCHN	Women's and Children's Health Network
WWCC	Working with Children Check
WWVP	Working with Vulnerable People [check]

GLOSSARY

This glossary defines key terms used in this report.

Aboriginal An inclusive term to refer to Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander Child Placement Principle A principle implemented in all Australian states and territories which prioritises the placement of Aboriginal children in care within the child's family, community and culture.

Aboriginal family practitioner (AFP) A flexible employment classification in the allied health professional stream for Aboriginal employees in Families SA. AFP duties include undertaking casework with Aboriginal families and helping non-Aboriginal staff engage Aboriginal families more effectively.

Adelaide Youth Training Centre (AYTC) A secure government care facility for children and young people who are sentenced to detention or remanded in custody under the *Young Offenders Act 1993* (SA).

Adolescent at Risk A screening category assigned by Families SA's Call Centre to an adolescent believed to be at risk of harm from circumstances that may include family conflict, homelessness, drug or alcohol problems, self-harm or suicidal tendencies.

adoption A legal process by which an adopted child becomes, in contemplation of law, the child of the adoptive parents, and ceases to be the child of any previous birth or adoptive parents.

Agency, the See *Families SA*. Also refers to the administrative unit that will perform statutory child protection functions in the future.

Allied health professional (AHP) Employment classification defined in the *South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2014*. Refers to employees in a range of professions who are undergraduate degree qualified and perform roles that enable them to obtain state or territory registration, be licensed or accredited to practice, or be eligible to join the relevant professional association. Some Aboriginal employees with the appropriate background and skills but without a formal qualification are employed in this stream.

Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Aboriginal-owned lands in the far north of South Australia, covering approximately 102,000 km².

APY Lands Inquiry Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry.

assessment and support Also intake and assessment. The receipt, prioritisation and investigation of intakes received by the statutory agency. Includes delivering some short-term family support where appropriate.

Assessment and Support Hub The Families SA offices tasked with delivering assessment and support functions.

Australian Early Development Census (AEDC) A census that provides a measure of early childhood development across a community in five key areas of development at the time children start school: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge.

best interests representation A model of child representation where the representative forms an independent view based on the evidence of the child's best interests and acts accordingly.

burden of disease A measure of less tangible costs of disease such as fear, mental anguish, physical pain and disability.

C3MS Connected Client and Case Management System: the computer system used by Families SA since 2009 as a complete case management system and the primary source of information about a child.

Call Centre A Families SA office that operates 24 hours a day with telephone lines and an internet-based service for receiving notifications of suspected abuse or neglect.

Care and Protection Order An order under Part 5, Division 2, of the *Children's Protection Act 1993* (SA), commonly to place a child under the guardianship of the Minister for either 12 months or until the child turns 18 years of age.

Care and Protection Worker A role in Families SA within the operational services (OPS) classification stream with similar duties, caseload and work complexities as qualified social workers. May also be used as a generic term to describe certain employees of the Agency.

care concern referral A report of suspected abuse or neglect of a child in care.

Care Concern Investigations Unit The Families SA unit responsible for assessing and responding to suspected abuse or neglect of children in care.

care leaver A young person previously in the care of the state whose Care and Protection Order has expired (usually when they turn 18).

carer Term used to refer to foster parents, kinship or relative carers, or persons employed to care for children either by Families SA or commercial agencies.

GLOSSARY

case reading A quality assurance process that involves reviewing a small and random sample of the work of each practitioner against a set of specific criteria.

caseworker Staff member within the Agency with primary responsibility for the management of a case.

Charter for the Rights of Children and Young People in Care A charter developed by the Guardian for Children and Young People pursuant to section 52EB of the Children's Protection Act which establishes a range of rights for children and young people under the guardianship, or in the custody of, the Minister.

child abuse and neglect Non-accidental behaviour by parents, carers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child. The terms *child abuse and neglect* and *child maltreatment* are used interchangeably.

Child Abuse Report Line (CARL) The collective name for the telephone lines used for reporting notifications to the Call Centre.

Child and Adolescent Mental Health Service Mental health service provided through SA Health's Women's and Children's Health Network, which provides mental health services to infants, children, adolescents and perinatal women and families.

child in (state) care Child in the care of the Minister pursuant to a guardianship order, a custody order or a voluntary custody agreement.

child maltreatment Non-accidental behaviour by parents, carers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child. The terms *child abuse and neglect* and *child maltreatment* are used interchangeably.

child protection assessment A broader evaluation (compared with investigation) of a child's needs, safety and risk, the family situation and environmental context.

child protection investigation A determination of whether an incident of child abuse or neglect has occurred, and the circumstances of its occurrence.

child protection notification A report to the Agency (usually via the Call Centre) concerning suspected child abuse or neglect.

child protection order An Investigation and Assessment Order or a Care and Protection Order made under the Children's Protection Act.

Child Protection Services Two hospital-based health units (Women's and Children's Hospital and Flinders Medical Centre) that perform forensic child medical assessments and forensic child interviews, as well as provide therapeutic services for children who have been abused or neglected.

child protection substantiation A professional judgement as to whether abuse or neglect has occurred.

child removal The removal of a child from their parents' care pursuant to the Children's Protection Act.

Child Safe Environments training Training that educates mandatory notifiers and other people working in the child protection system to recognise and respond to child abuse and neglect. This training is not a legal requirement for mandatory notifiers under the Children's Protection Act. It is also referred to as Responding to Abuse and Neglect (RAN) training.

child-related employment screening The process of assessing identified categories of information about a person to assess the level of risk they may pose to children in a professional or volunteering environment.

Children and Family Centre A centre that delivers similar colocated services as a Children's Centre, initially established by the Australian Government, and which has a stronger focus on services for Aboriginal families.

Children's Centre An early childhood service that brings together support services for families in a 'one-stop shop'. Services vary, but commonly include preschool, occasional care, parenting and personal development programs, targeted playgroups and health services.

CIS Client Information System: the computer system used by Families SA, in conjunction with paper files, until 2009.

Closed No Action A closure code used by Families SA when there are insufficient resources to respond to the notification, and the relative case risk has been weighed against other incoming child protection work.

Closed, Abuse Not Substantiated A closure code used by Families SA where an investigation did not substantiate alleged abuse or neglect.

College for Learning and Development A registered training organisation that delivered in-house training to Families SA workers until government changes in 2011/12 when Families SA joined the Department for Education and Child Development.

commercial care Care that is provided to children in care by staff who are engaged through private agencies on commercial terms. This care is provided on a rotational basis in locations such as short-term rentals, motels, caravan parks and Families SA owned properties.

commercial carer A carer who is employed by a private agency, to care for children on a rotational basis. Commercial carers may also work in Families SA's residential care facilities.

Common Approach An assessment tool developed for use by practitioners who have regular contact with children and families, but who may not have experience in making formal assessments.

Communities for Children Program (Australian Government) A model where a not-for-profit facilitating partner consults local stakeholders and prepares a whole-of-community plan and then funds not-for-profit partner agencies to provide services in accordance with the plan. The model aims to improve service collaboration to benefit local children and families.

community residential care Care that is provided in a large residential unit, typically housing 12 children or young people who are cared for by paid staff working on a rotational basis.

comorbidity The existence of co-existing problems, for example, substance abuse, mental illness and/or domestic violence.

complex trauma The range of cognitive, affective and behavioural outcomes that arise from trauma. May include a disturbed ability to relate to others and form healthy relationships, difficulties with emotional regulation and an impaired sense of self or wellbeing.

Complexity Assessment Tool (CAT) A tool used by the Agency to measure the complexity of a child's needs by considering behavioural factors such as substance use, sexualised behaviour, offending behaviour, school behaviour and general behaviour. It also considers special needs such as physical health and development, intellectual ability, mental health and physical disability. The overall complexity rating is determined from all these scores and informs the child's placement and service options. The CAT rating ranges from 1 (minor or no problems) to 4 (extreme problems).

concurrent planning The term is most often used to describe efforts to reunite a child with their family, while at the same time developing an alternate plan for permanent care. Concurrent planning is designed to reduce case drift and to give children stability as early as possible. It also refers to case planning to support a child staying in a placement that is at risk, while concurrently planning for another suitable placement if one is needed.

congregate care Another term for community residential care.

contact (also access) Contact between a child in care and their family of origin.

Convention on the Rights of the Child An international human rights instrument which sets out civil, political, economic, social, health and cultural rights of children.

CrimTrac National information-sharing service provider for Australia's police, wider law enforcement and national security agencies. On 1 July 2016 CrimTrac merged with the Australian Crime Commission to form the Australian Criminal Intelligence Commission.

Crisis Care Service provided at the Families SA Call Centre between 4pm and 9am on weekdays, and 24 hours on weekends and public holidays, staffed by Agency practitioners who respond to child protection notifications and issues.

Crisis Response Unit Former name for Families SA's Call Centre.

Critical Incident Report A report which is completed after a major incident occurs in residential care. Incidents include, but are not limited to, a child being restrained, a situation requiring police attendance, or a child or staff member being seriously injured.

Cross-Border Justice Scheme Complementary legislative scheme introduced in the Northern Territory, Western Australia and South Australia in 2009 which gives police officers cross-jurisdictional powers to operate throughout the tri-border region and allows magistrates, fine enforcement agencies, community corrections officers and prisons of one jurisdiction to deal with offences that occur in another jurisdiction.

Cultural Consultation Report A report prepared by an organisation declared as a recognised Aboriginal or Torres Strait Islander organisation for the purposes of section 5 of the Children's Protection Act.

cultural maintenance plans A written plan for Aboriginal children in care that details measures to strengthen and maintain the child's connection to land, language, community and culture.

cumulative harm Chronic incidents of maltreatment over a prolonged period that affect a child's safety, stability and wellbeing.

custody order An order made according to section 38 of the Children's Protection Act granting custody, but not guardianship, to a person other than the child's parents.

GLOSSARY

Department for Communities and Social

Inclusion Government department whose functions include Housing SA, Disability SA, Disability and Domiciliary Care Services and Youth Justice. This department is responsible for the Screening Unit.

Department for Families and Communities

Government department responsible for statutory child protection functions between 2006 and 2011.

differential response A reform model adopted in different forms in many jurisdictions around the world which allows notifications to be filtered, and the appropriate response determined according to the level of risk.

differential response (tool) Case management delivered according to the intensity required by the child. Differential response is also used as a workload management tool.

direct representation A model of child representation where the representative must follow the child's instructions as far as it is practicable to do so.

Diversion Assessment Response Team A former Call Centre team dedicated to receiving notifications from the education sector. It had a 'diversionary' focus, helping notifiers to respond directly to concerns without the need for Families SA's direct intervention. The team has now changed focus and is known as *Linking Families*.

Divert Notifier Action A rationale used by the Call Centre to screen out a notification because the concerns meet the definitional threshold, but the notifier has agreed to intervene with the family to address the protective issues.

domestic violence Violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes that family member to be fearful, including physical violence, sexual assault and other sexually abusive behaviour, economic abuse, emotional or psychological abuse, stalking, kidnapping or deprivation of liberty, damage to property, causing injury or death to an animal, and behaviour by the person using the violence that causes a child to be exposed to the effects of that behaviour. Also referred to as *family violence*.

Early intervention Interventions directed at individuals, families or communities displaying the early signs, symptoms or predispositions that may lead to child abuse or neglect.

eCARL notification A notification using the Call Centre's electronic, internet-based service.

emergency care Short-term care arrangements that are created and disbanded in response to immediate need and staffed by carers engaged casually by a private agency. This care is provided on a rotational basis in locations such as short-term rentals, motels, caravan parks and Families SA owned properties. See also *commercial care*.

emergency carer A carer who is employed by a private agency, and is deployed to care for children on a rotational basis in emergency care placements.

emotional abuse A form of abuse involving a parent or carer's inappropriate verbal or symbolic acts toward a child, and/or a pattern of failure over time to provide a child with adequate non-physical nurturing and emotional support.

enhanced foster care model Model of care where foster parents are provided with additional training and reimbursement in order to provide a specialist care service, including therapeutic care or care with the intent of reunifying the child with their parents.

extra-familial A rationale used by the Call Centre to screen out a notification because the alleged perpetrator is not the child's parent or carer. These notifications are referred to SA Police for investigation.

Families SA The service delivery arm of the Office for Child Protection. The term Families SA has also been used to refer to the statutory agency in South Australia more generally. Commonly, the Office for Child Protection and Families SA are used interchangeably.

Families SA Psychological Services A unit within Families SA that employs psychologists and maintains a panel of private psychologists and psychiatrists to perform assessment and therapy. The unit delivers both assessment and therapy services.

Families SA Service and Accountability Unit A unit within Families SA that is responsible for the registration and deregistration of foster parents, the licensing of foster care agencies and residential care facilities managed by non-government organisations, and the management of service contracts for the delivery of foster care, support, residential care and advocacy.

Family Care Meeting A meeting convened by the Youth Court Conferencing Unit under Part 5, Division 1, of the Children's Protection Act designed to allow the child's family to prepare a plan to address child protection concerns.

family preservation services Services offered to families whose children are at risk of being removed, to overcome concerns and reduce the risk of future harm while children remain in their parents' care.

family reunification services Services offered to families whose children have been removed, seeking to address the concerns so their children can return when it is safe to do so.

family scoping The process of identifying a child's extended family members, commonly recorded in a genogram.

Family Support Services Programs Programs delivered by not-for-profit service providers pursuant to a service agreement with Families SA. Three types of program are delivered: targeted intervention, family preservation and reunification.

family violence See *domestic violence*.

foetal alcohol syndrome A condition that can occur in a child whose mother consumed alcohol during pregnancy.

forensic interview An interview of a child conducted in relation to suspected abuse or neglect, for the purpose of legal proceedings.

forensic medical assessment Medical assessment of a child conducted in relation to suspected abuse or neglect, for the purpose of legal proceedings.

foster care The system of placing children in the care of foster parents in South Australia.

foster care agency An agency registered to carry on the business of placing children with foster parents pursuant to section 48 of the *Family and Community Services Act 1972* (SA).

foster parent A person who is not a relative or guardian of the child who maintains and cares for a child on a residential basis. Foster parents must be approved according to sections 41 and 42 of the *Family and Community Services Act*. Once approved they are registered by Families SA.

grooming Behaviour that is designed to prepare or accustom a child or young person to sexual contact, to reduce the likelihood they will resist or disclose the abuse. Grooming may also be directed at adults in the child's environment to make it less likely that they will raise concern about observed behaviours.

Guardian for Children and Young People An independent statutory office holder established by Part 7A, Division 1, of the *Children's Protection Act* whose duties include promoting the best interests of children in care. Also referred to as the guardian, and the Office of the Guardian for Children and Young People.

guardianship hub The Families SA offices tasked with case managing children on long-term guardianship orders.

guardianship order An order made according to section 38 of the *Children's Protection Act* placing a child under the guardianship of the Minister. A short-term order lasts up to 12 months, and a long-term order lasts until the child attains the age of 18.

home-based care Care provided to a child in a family or home-based setting. Includes foster care and kinship or relative care. Also described as family-based care.

Incident Management Division (IMD) A division of the Department for Education and Child Development established following the Independent Education Inquiry (the DeBelle Inquiry). Is responsible for investigating complaints against employees and providing disciplinary and misconduct advice.

income management An intervention under which an agency quarantines a portion of a person's income for specific purposes. There are voluntary and compulsory forms of the intervention.

independent living Arrangements where children in care or after they leave care are helped to live without onsite carers.

intake The record of the assessment by the Call Centre concerning a screened-in notification.

Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect (ICP) The guiding document for inter-agency collaboration in the investigation of suspected child abuse or neglect in South Australia. An updated version was due to be released in July 2016. This version will deal more comprehensively with all forms of child abuse and neglect. It will also apply more broadly, in particular to non-government agencies that provide relevant services.

Investigation and Assessment Order An order under Part 4, Division 4, of the *Children's Protection Act* authorising investigations or assessments of the child where there is reasonable suspicion that a child is at risk, commonly accompanied by an order granting custody of the child to the Minister for 42 days.

IREG The interim carer process used by Families SA to register kinship and specific child only carers.

Kanggarendi teams Two early intervention teams operated by Families SA and serving southern and north-western metropolitan Adelaide. They respond to notifications relating to Aboriginal children and families where a non-investigative, community-based response is appropriate.

GLOSSARY

Kaurna A group of Aboriginal people whose traditional lands include the area around the Adelaide Plains.

kinship care The system of family-based care in South Australia involving care by members of a child's extended family. See also *relative care*.

Lands-based worker Families SA employees based full time on the APY Lands who focus on providing early intervention and prevention, community education and child safety capacity building.

Learning and Practice Development Unit A unit within Families SA tasked with providing training and development opportunities for Families SA staff.

Layton Review *Our best investment: A state plan to protect and advance the interests of children*, Report of the Review of Child Protection in South Australia.

Linking Families A phone-based service located at the Call Centre which aims to refer families about whom lower level notifications have been made (Tier 2 and 3) to support services.

Link-Up A family tracing service run by Nunkuwarrin Yunti for Aboriginal people separated under past policies and practices in Australia as well as Aboriginal people over the age of 18 years who have been adopted, fostered or raised in institutions.

long-term care An order made pursuant to section 38 of the Children's Protection Act placing a child under the guardianship of the Minister until the age of 18. Also described as long-term guardianship.

maltreatment Non-accidental behaviour by parents, carers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child.

mandated notifier A person who is required by section 11 of the Children's Protection Act to notify the Department for Education and Child Development about suspected child abuse or neglect.

Mandatory reporting/notification The system that requires mandatory notifiers to notify the Department for Education and Child Development about suspected child abuse and neglect.

Maralinga Tjarutja Aboriginal-owned lands in the far west of South Australia.

Medical neglect A form of neglect characterised by a carer's failure to provide appropriate medical care. This could occur through a failure to acknowledge the seriousness of an illness or condition, or the deliberate withholding of appropriate care.

Men's business (indigenous culture) Ceremonial activities for Aboriginal men and boys.

Multi Agency Protection Service (MAPS) A service led by South Australia Police that brings together staff from police, Housing SA, Correctional Services, Families SA, Education and Health in one location to share information about incidents of family and domestic violence. It aims to promote more complete assessments and better informed responses.

Multi-generational abuse Where children who have suffered abuse and neglect within their family go on to abuse or neglect their own children, creating an inter-generational cycle.

Narungga A group of Aboriginal people whose traditional lands are located on Yorke Peninsula.

National Framework for Protecting Australia's Children 2009-2020 A framework agreed by the Council of Australian Governments in 2009 as a long-term approach to ensuring the safety and wellbeing of children and effecting a substantial and sustained reduction in child abuse and neglect over time.

National Partnership Agreement on Universal Access to Early Childhood Education Agreement An agreement signed by the Council of Australian Governments in 2008 to work together to ensure that all children have access to quality early childhood education.

National Standards of Out-of-Home care A set of standards developed as a priority project of the National Framework for Protecting Australia's Children which set consistent standards for children living in out-of-home care.

Neglect The failure of a parent or carer to provide a child with the conditions that are culturally accepted in a society as being essential for their physical and emotional development and wellbeing.

Ngarrindjeri A group of Aboriginal people whose traditional lands include the lower Murray River, western Fleurieu Peninsula and the Coorong in South Australia.

No Action A response category assigned to care concern notifications where they are assessed as not requiring any action.

No Grounds for Intervention A closure category used by the Call Centre to screen out a notification that technically meets the threshold for a response from Families SA but does not warrant one because the child is safe, the event is historical, another agency is addressing the matter, or the perpetrator no longer has contact with the child and the carer is protective.

no wrong door An approach that aims to provide service users with the most appropriate service irrespective of the service provider they first contact.

non-government organisation Any organisation involved in the delivery of services which is not part of the government. Includes not-for profit and for-profit organisations.

non-violent crisis intervention (NVCi) A behaviour management program that focuses on preventing disruptive behaviour. The program includes a model of physical intervention, which is used only as a last resort.

notifier A person who notifies Families SA of suspected abuse or neglect.

Notifier Only Concern A closure code used by the Call Centre to screen out a notification that is insufficient or vague, or the notifier lacks credibility or the notification does not meet the definitions of abuse or neglect.

Nunkuwarrin Yunti An Aboriginal organisation that offers a range of allied health and specialist services for Aboriginal children and families.

Objective A database used by the Department for Education and Child Development's Care Concern Investigations Unit.

observation log A document used by staff in residential and emergency care to record observations about children and young people living in the facility.

Office for Child Protection The name of the unit within the Department for Education and Child Development that is responsible for the functions of Families SA. Families SA is commonly used to describe the same unit. Formerly Office for Child Safety.

Operational services officers (OPS) Operational Services: an employment classification stream in the South Australian public sector. Operational services officers employed in the Agency to work in areas such as residential care and in front-line roles are not required to hold a formal qualification.

Other Person Guardianship A legal arrangement where guardianship orders over a child are made in favour of parties other than the Minister in child protection proceedings.

Outcomes Framework for Children and Young People Scheme proposed in the Child Development and Wellbeing Bill 2014 to track the development and wellbeing of children and young people in the state against performance indicators.

out-of-home care System of caring for a child who is removed from their family of origin. Includes (but is not limited to) home-based care, emergency care and residential care.

parenting order Order made in the Family Court of Australia relating to parenting arrangements of a child.

permanency planning Arrangements that provide for stable, safe, long-term care arrangements for a child which will meet their developmental needs.

physical abuse The non-accidental use of physical force against a child that results in harm to the child.

primary (universal) services or interventions An intervention program that targets whole communities, building public resources to prevent child maltreatment.

primary system The system of universal services offered to the population as a whole.

professional notifier A person who notifies Families SA of suspected abuse or neglect, but who has special knowledge or skill to assess the child's situation by virtue of their professional training or experience.

proportionate universalism A conceptual model of service provision that offers some support to all of a population through primary interventions, with increasing levels of service proportionate to need.

protective intervention Services provided by Families SA and other agencies to address the issues that cause children to be at risk, to enable them either to remain in their parents' care or to return there safely.

protective intervention hub The Families SA offices tasked with delivering protective intervention services.

psychometric testing Testing designed to measure mental ability or personality traits.

public health model A conceptual model for the child protection system which proposes multiple, integrated levels of intervention, including primary/universal interventions for whole communities, secondary

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interventions for vulnerable families and tertiary intervention for families in which maltreatment has occurred.

Rapid Response A plan developed and applied across a number of government departments from 2005, focusing on providing a coordinated approach to physical health, psychological and emotional health, developmental progress, disability needs, education, housing, and post-guardianship services for children.

Redesign A reform model pursued by Families SA from 2013 onwards. Redesign included adoption of a universal practice approach called Solution Based Casework™, and the restructure of local offices into specialist hubs.

relative care The system of family-based care in South Australia involving care by members of a child's extended family. See also *kinship care*.

Report on Unborn A screening category used by the Call Centre where there is high risk to an unborn child.

residential care A care model where children are cared for in facilities either run by the Agency or by not-for-profit organisations which are licensed under the Family and Community Services Act. Care is provided by staff on rotating shifts. Includes community residential care units.

residential care directorate The unit of the Agency tasked with the administration of internally established and managed residential care facilities.

respite care A short-term care arrangement for a child in care in which the child and the child's usual carer spend a short period apart.

reunification The process of returning a child in care to the care of their parents.

Reunification Assessment Tool An evidence based Structured Decision Making tool which helps practitioners make decisions about reunifying children in care to the care of their parents.

rotational care A care arrangement where a child is cared for by paid staff who work on rotating shifts across a 24-hour day. Rotational care is delivered in both residential care and emergency care.

rule of optimism The tendency of practitioners to reduce, minimise or ignore concerns for a child's welfare or safety by applying overly positive interpretations to the cases they assess. This tendency can result in children being left in situations of significant danger and experiencing prolonged trauma.

Safeselect® Psychometric Testing System A group of tests marketed as a testing package to assess the suitability of applicants for public safety roles.

safety assessment Assessment by Families SA staff to determine a child's present safety and any immediate interventions to protect the child.

safety plan A short-term agreement between Families SA and a child's parents that details measures to manage threats to a child's safety.

screened (in or out) A term used by the Call Centre to indicate whether the situation described by the caller (notifier) is of sufficient concern to warrant intervention by Families SA. Those that meet the threshold are screened in; those that do not are screened out. See also *Divert Notifier Action, extra-familial, No Grounds for Intervention*.

screened-in notification A notification assessed by the Call Centre as meeting the threshold for intervention and therefore requiring a response by Families SA. Can be classified as Tier 1, Tier 2 or Tier 3.

secondary intervention/service According to the public health model of child protection, interventions targeted at vulnerable children and families.

Select Committee on Statutory Child Protection and Care A select committee established by the South Australian Legislative Council in 2014.

sexual abuse The involvement of a person in sexual activity that they do not fully comprehend, are unable to give informed consent to or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power.

sexualised behaviours Sexual activity by or between children of any age that involves coercion, bribery, aggression, clandestine behaviour and/or violence; behaviour that is abnormal for age or developmental capability; compulsive, excessive and/or degrading behaviour; or where there is a substantial difference in age or developmental ability between participants. Also described as problem sexualised behaviours.

short-term guardianship Also short-term care. An order under section 38(1)(c) of the Children's Protection Act placing the child under the guardianship of the Minister for up to 12 months.

social worker A practitioner who holds qualifications and/or experience that make them eligible for membership of the Australian Association of Social Workers.

Solution Based Casework™ A child protection practice model adopted by Families SA.

South Australian Public Sector Wages Parity Enterprise Agreement: Salaried 2014 The agreement governing the classifications, conditions, and pay rates for South Australian public sector employees. Also known as the Enterprise Agreement.

Standards of Alternative Care in South Australia Agreed standards that set benchmarks for service delivery across the alternative care sector, including the Agency and government and non-government organisations who deliver services.

Special Investigations Unit Unit within the Department for Education and Child Development generally responsible for the investigation of employee misconduct.

specialist hub One of eight metropolitan Families SA offices, each of which specialises in one of three child protection functions: assessment and support, protective intervention, or guardianship.

Specific Child Only carer An arrangement whereby approval of a foster parent is restricted to the care of a specific child, being a person with whom the child has an existing relationship although that person might not be a relative.

statutory agency In South Australia, Families SA. In other jurisdictions, the agency vested with statutory authority to investigate suspected abuse and neglect and to protect children at risk.

statutory threshold The threshold of risk and safety concerns for a child that justifies a response by the statutory agency, Families SA.

Step by Step The carer assessment tool used to assess foster parents in South Australia.

Stolen Generation The generations of Aboriginal children who were forcibly removed under past policies from their parents' care as reported by the *Bringing them Home* report.

strategy discussion An interagency meeting usually involving Families SA, SA Police and Child Protection Services that helps coordinate responsibilities during the response to Tier 1 and Tier 2 cases.

Structured Decision Making® (SDM) Evidence- and research-based tools that help practitioners make decisions about specific issues in practice.

supervision order An order under section 38(1)(a) of the Children's Protection Act placing a child under the supervision of the Chief Executive or some other person for the duration of a written agreement undertaken by the child's parents, guardian or other person who has the care of the child to do, or to refrain from doing, any specified thing.

supervisory neglect A form of neglect characterised by absence or inattention that can lead to physical harm or injury, sexual abuse or, in an older child, criminal behaviour.

tertiary interventions Interventions that target families in which child maltreatment has occurred, focused on reducing the long-term consequences of maltreatment and prevention of further recurrence or escalation. They include statutory child protection services. Also known as tertiary services.

The Department Department for Education and Child Development.

transition planning Planning by key agencies, stakeholders and children in care to prepare children to transition into adulthood in a way that supports their independence.

Voluntary Custody Agreement An agreement under section 9 of the Children's Protection Act whereby a child's parents agree to transfer custody of the child to the Minister for up to three months, with a possible extension to no more than six months.

Winangay A carer assessment tool developed specifically for use in Aboriginal communities.

written directive A direction given by the Chief Executive of the Department pursuant to section 52AAB of the Children's Protection Act to an adult to prevent them from behaving in a specified way towards a child in care. Behaviour prohibited may include communicating or attempting to communicate with the child, or harbouring or concealing the child.

Yaitya Tirramangkotti The former dedicated unit in the Call Centre for assessing notifications about Aboriginal children and families, moved to the Central Assessment and Support Hub in 2014.

Yarning (Aboriginal culture) An informal, culturally friendly conversation style used in many Aboriginal communities to establish rapport and to exchange information.

Youth Court A specialist South Australian court which deals with young offenders, child protection, adoption and surrogacy.

GLOSSARY

Youth Court Conferencing Unit A division of the Youth Court that convenes family conferences under the Young Offenders Act and Family Care Meetings under the Children's Protection Act.

youth worker Worker employed in the operational services (OPS) stream, engaged most often caring for children and young people in residential care.



Child Protection Systems Royal Commission Report

Volume 2: Case Studies

August 2016

The life they
deserve

The life they deserve

CHILD PROTECTION SYSTEMS ROYAL COMMISSION REPORT VOLUME 2: CASE STUDIES

**The Hon Margaret Nyland AM
Commissioner**

August 2016

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PROTECTING THE PRIVACY OF CASE STUDY PARTICIPANTS

In the course of this inquiry, the Commission considered the circumstances of a number of children and young people whose lives have been affected by the child protection system. Their experiences were examined by considering documents and hearing oral evidence.

Four case studies which considered the individual circumstances of young people currently or recently in care were conducted. The Commission did not take formal evidence from the children concerned, although some informal communication occurred in one case.

The fifth case study considered the circumstances in which Shannon McCool offended against a number of children in care.

All the children referred to in the case studies have been given pseudonyms to protect their privacy. Any details that could identify the children have also been changed, but only where the Commission considers that it would not affect the reporting of their experiences. For the same reason, some adults related to the children have also been given pseudonyms.

Evidence given during the case studies was not confidential; however, some witnesses applied for non-publication orders pursuant to section 16A of the *Royal Commissions Act 1917* (SA). Where an application was granted, the witness has not been identified.

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CASE STUDY 1 JAMES—VULNERABLE CHILDREN, BIRTH TO SCHOOL AGE

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CASE STUDY 1 JAMES—VULNERABLE CHILDREN, BIRTH TO SCHOOL AGE

OVERVIEW

On 15 October 2013 South Australia Police (SAPOL) officers were called to a domestic dispute at a house in the northern suburbs of Adelaide. Officers who attended found the house in a state of utter squalor and there was an overwhelming rotten smell coming from the house. Two adults were present, Ms F and Mr G. Both were under the influence of alcohol and/or drugs. One officer, alarmed by the state of the house, asked Ms F if there were any children living inside. Ms F said that their son was inside sleeping. What confronted the police officer when she entered the house was shocking:

I walked towards the rear of the house and to my left was the kitchen. There was an overpowering smell of rubbish and rotting food. I observed every surface to be covered in rubbish, including the floors, bench tops and sink. I turned right down a corridor and continued to step on and over piles of rubbish. Several times I almost fell due to the depth of the rubbish.

The light in the corridor did not work so I used my torch to be able to see to the end where I observed a door to the left and a door to the right of the corridor facing each other. I further observed several shoelaces and cords tied together from each of the doorknobs holding them firmly shut. I attempted to untie the knots to be able to gain entry into the room on the left where I had been told ... that the child was sleeping ... I had to push on the door ... as it was being blocked by something on the other side.

I saw that the bedroom light was on and it was very bright. I looked around behind the door and saw a small clearing on the floor where there was a small, extremely skinny child, who I know to be James, sitting on the floor holding up a blue plate. I observed the child to be male, very pale, with blonde hair and blue eyes, wearing no clothing or a nappy.

He was sitting on a bare floor with his legs tucked into his side. His bones were visible and he was dishevelled and shaking and shivering. The room was filled with items and the only uncovered floor was where the child was sitting. There were several blue plates on either side of the door.

I also observed ... a brown liquid dried on the floor which I assumed to be faeces ... I advised my partner to look into the room as I took off my jacket and wrapped the child in it, picking him up. The child was cold to touch and was dirty. His eyes were sunken and he was unable to move without trembling.¹

‘James’, the little boy inside that room, was four years old. His parents were Ms F and Mr G. James weighed little more than a toddler and was suffering developmental delay and serious malnutrition. In his four years of life

he had been the subject of a number of notifications to Families SA (the Agency). That the family was very vulnerable and likely to experience challenges was known to authorities even before James was born.

Neither of James’s parents had enjoyed the advantages of warm consistent parenting in their own childhoods. Ms F had experienced abuse and neglect as a child and had been let down repeatedly by the child protection system in this state. James’s father, Mr G, had also been deprived of stable and consistent care in his childhood. They were both young and socially isolated. While none of these circumstances excuses Ms F’s and Mr G’s behaviour, they help to explain how the young family came to be living in such dire circumstances, and what barriers existed to greater service involvement to support the young family to care for James safely.

The parents’ horrendous treatment of their son was ultimately the subject of criminal charges, which resulted in each of them being imprisoned. The community’s response to the story was understandable outrage about their conduct, the state in which James had been forced to live, and the failure of the system to intervene. This case study investigates why the system had not intervened earlier, and what changes to the system are necessary to promote the visibility of vulnerable children in the birth to school-age period.

This case study also examines the system’s response to James after he was rescued and placed under the guardianship of the Minister.

EVIDENCE

MS F’S AND MR G’S BACKGROUND

Ms F was the second of three children, the eldest of whom was taken into care at an early age and raised by relatives. Ms F’s mother had suffered longstanding mental health and drug issues. In 1993, before Ms F was three years old, a notification was made to Families SA about the conditions of her care. Less than a year later a second notification was received, with Ms F’s parents unable to care for her because they were detoxifying from drugs. In 1997, when Ms F was seven, Families SA received a report that her father had doused her and her mother with petrol, then attempted suicide by carbon monoxide poisoning. His suicide attempt failed, but he was left with brain damage. The notification was not investigated and Ms F remained in the care of her mother.²

Towards the end of the same year, Ms F’s mother left that relationship, but took up with another man who was also violent and abusive towards her, sometimes in the presence of Ms F. In 2001 an ambulance was called to Ms F’s mother. She was semiconscious due to ingestion of

drugs and alcohol. She was reported to have been in that state for about 12 hours. Ms F and her sister, then aged 11 and 3 respectively, were outside playing. Families SA took no action on this notification. In April 2002 Families SA became aware that Ms F had been present when her mother attempted suicide. Families SA confirmed abuse, but the children were not removed. Instead, a safety plan was created to keep the children safe when Ms F's mother felt unable to cope. In 2002 three separate reports were made to Families SA notifying that Ms F and her sister were being neglected because of domestic violence, alcohol, or a combination of both.³

In May 2003, after witnessing some frightening events at their mother's home, Ms F and her sister refused to return home. Ms F's mother entered a voluntary custody agreement with Families SA, enabling an alternative placement for the children to be secured. Thereafter both children went back and forth between their mother's care and alternative care. By February 2004 Ms F was living with Mr and Mrs B, the parents of a school friend. By January 2006, at the age of 15, Ms F had left that placement and was staying with another family.⁴

In 2008 Ms F's younger sister discovered her mother's body after she committed suicide at home. Ms F's sister had recently been reunified to her mother's care with the support of Families SA. Ms F's sister had been prepared for the suicide, her mother having given her a telephone number to call if ever she could not wake her up.⁵

At the time of her mother's death, Ms F was living in Victoria, having moved there to live with her older sister. That arrangement proved unsatisfactory. Ms F then moved in with Mr G, soon after meeting him. She was still a teenager and he was 20 years old.⁶

Like Ms F, Mr G experienced challenges during his childhood. Concerns about his mother's ability to care for him were raised with the Victorian authorities. Mr G's mother was consistently subjected to domestic violence and repeatedly left and returned to a violent partner. Violence was inflicted against her in the presence of Mr G and at times violence was inflicted upon him. His mother also used alcohol and prescription medication in a way that affected her ability to care for her child.⁷

In 2008 Ms F returned to South Australia with Mr G to attend her mother's funeral. While in South Australia the couple discovered that Ms F was pregnant. They decided to remain in South Australia and moved into Ms F's mother's Housing SA rental property in the northern suburbs. The house was full of boxes and property belonging to her late mother. A blood stain on the carpet marked the location of her mother's suicide.⁸

SUPPORT FOR NEW PARENTS

Ms F was 18 years of age when James was born. James was her first child. Neither Ms F nor Mr G had any family support in South Australia.

Unbeknown to South Australian authorities, James's father, Mr G, had previously had an infant removed from his care in Victoria. The removal was sparked by concerns about Mr G and his then partner's capacity to provide safe care. The infant was reported to have received no stimulation, been deprived of affection, and given regular doses of Panadol to keep her asleep. She was kept in a dark house in front of a heater and not taken outdoors. After the infant was removed to alternative care, Mr G had no further contact with her.⁹ Jurisdictional boundaries meant that none of this information reached the attention of child protection authorities in South Australia until after James was taken into care.

James was brought to the attention of Families SA before his birth. In November 2008 Ms F's circumstances were discussed at a high-risk infant meeting held at the Lyell McEwin Hospital. Ms F's youth, lack of family support and her difficult background were identified as making her especially vulnerable. The meeting noted that Mr G received a disability support pension, although the nature of the disability was not clear. By the time of the meeting, Ms F had already declined a referral for social work support and a referral to a young mothers' support group.¹⁰

On 23 March 2009 a notification was received at the Child Abuse Report Line (CARL). Ms F was 34 weeks pregnant and had attended for limited antenatal care. Attempts to contact her for follow-up had not been successful. The notifier was concerned that Ms F had no family support and had not attended for social work support. The notification also contained information extracted from the Families SA database that identified Ms F's history of abuse and neglect, and her mother's recent suicide. The information was recorded as a Report on Unborn, and attracted no response from Families SA.¹¹

James was born at the Women's and Children's Hospital after Ms F attended in an ambulance. Ms F and Mr G were both observed by hospital staff to have 'dirt stained skin', poor hygiene, and an unpleasant odour about them. James was born by emergency caesarean section, the result of a breech presentation which was undiagnosed due to Ms F's lack of antenatal care.¹²

CASE STUDY 1 JAMES—VULNERABLE CHILDREN, BIRTH TO SCHOOL AGE

While Ms F was in hospital a social worker attempted to refer her for support on discharge. The social worker recommended that visiting midwifery staff check the state of the house, particularly in light of the physical presentation of the parents. Ms F was also referred to the Child and Family Health Service (CaFHS). The referral was accompanied by a consent signed by Ms F for the Universal Contact Visiting Service (a service for every child born in South Australia), together with some additional information which recorded the history of suicide in the family, Ms F's difficult childhood history and her lack of family support. The referral strongly recommended that Ms F be provided with the Family Home Visiting Service, a two-year, more intensive, home visiting program also provided by CaFHS.¹³

Ms F discharged herself from hospital earlier than recommended, and against medical advice. She told nursing staff that she could not wait because a friend was giving her a lift home.¹⁴ As planned, midwifery staff from the Women's and Children's Hospital Domiciliary Care visited Ms F's home on three separate occasions; however, they were unable to gain access to check on Ms F, James, or the conditions inside the home.¹⁵

A few days after discharge, Ms F returned to the hospital accompanied by Mr B, the man who had provided foster care to her when she was a teenager and who had continued to provide some limited support. Mr B had been asked to transport Ms F to hospital because neither she nor Mr G could drive.¹⁶ James was weighed and had lost 180 grams from his birth weight. Ms F's caesarean wound was infected. Mr B told midwives he thought Ms F might have avoided the domiciliary care visits because she was embarrassed about the state of the house. Ms F was readmitted to hospital.¹⁷

Midwifery staff noted that Ms F needed intensive assistance to understand how to make up formula for feeding. One note recorded that Ms F would 'need very sound teaching in basic skills like keeping a room tidy, hanging out clothes etc., proper use of a bin!'¹⁸

Before Ms F's discharge from hospital on the second occasion a social worker again spoke with her. Ms F identified Mr B as being a support to her. The social worker discussed a referral to a support service called Kids N You.¹⁹ No referral was ultimately made to the Kids N You program because the service was not available in the area in which Ms F was living.

Families SA received a further notification about James. The information provided built on what was already known from the Report on Unborn notification and stated that Ms F had (probably) avoided the home visits by Domiciliary Care, and that James had lost weight after his discharge from hospital.²⁰

This notification was assessed as a Tier 2 priority because notifications involving infants at risk could not be rated at the lower level of Tier 3. Families SA policies gave weight to the particular vulnerability of infants and prevented them from being relegated to a Tier 3.²¹ The infants at risk policy required workers to make a visit to hospital to sight the infant, as well as a second visit to the family home to assess the infant in its usual environment. The policy suggested this visit might be made in conjunction with the first Universal Contact Visit.²²

Both these policies are sensible and workable but neither was applied in this case. The Tier 2 was allocated to a social worker, Kate Crawford, who worked under the supervision of Katrina Taheny. On 12 May 2009, in response to an enquiry, a social worker from the Women's and Children's Hospital told Ms Crawford that Ms F had consented to the following service referrals:

- Domiciliary Care (the service Ms F had previously not engaged with when discharged on the first occasion);
- Kids N You (the parenting program which turned out to be unavailable in Ms F's area); and
- Universal Contact Visit.

Mr B, Ms F's former foster parent, was identified by her as an ongoing support.²³

On the basis of these actions, Families SA closed the notification using the code FNR – Full Investigation Not Required.

Ms Taheny, the supervisor who authorised the closure of the intake without a full investigation, said that she was obliged to make an assessment about what was the most urgent need at the time.²⁴ It was impossible to respond to all notifications, and an assessment of the most urgent cases had to be made. It is impossible now to determine whether the decision to close this matter was correctly made without considering the competing priorities for that day. The point is that a functioning child protection system should not place workers in a position where a properly assessed Tier 2 notification about a newborn infant cannot be responded to in the way its own policies require.

Ms Taheny was asked about the possibility that Families SA might stay involved long enough to assertively engage Ms F in a voluntary program such as the Universal Contact Visiting scheme. It was suggested that a joint home visit might emphasise to Ms F the importance of engaging with that program. Ms Taheny explained that the FNR code can be used only when some work is done on an intake, but without any contact with the family; that is, a worker can carry out investigations short of making contact in order to satisfy themselves that either no further action is needed or a full investigation is

required. Policy, and good professional practice, do not permit Families SA to perform a partial investigation that involves making contact with a family.

Ms Taheny said there was a danger associated with Families SA workers becoming involved only for a limited purpose. She was concerned that²⁵:

- any dangers to the child might not be identified by a narrow or restricted assessment;
- an approach could introduce an organisational risk because the Agency had purported to do something (that is, an assessment) according to its statutory mandate that had in fact not been done in a holistic or complete manner; and
- the risk to the child might increase from the partial involvement of a statutory agency.

A partial assessment in a family that is socially isolated and fearful of engaging with services might also serve to escalate their fear and exacerbate their isolation.

However, Families SA's strategy not to launch a full investigation on the basis of service referrals having been made was inappropriate. There were no feedback mechanisms that would have enabled Families SA to monitor engagement and assess whether the identified risk to the infant had reduced. Families SA did not check that the referrals were actioned, or that Ms F engaged with the services in a way that addressed the existing risks to James. A verbal assurance that referrals would be made did nothing to change the nature of the risk, a risk that Families SA policies required be given a high priority and a high degree of observation and assessment. Nor did anyone make it clear to Mr B that reliance was being placed on his involvement with the family to secure the safety of the infant.

Ms F received the Universal Contact Visit service available to all new parents. Ms F told the visiting nurse that she had family support on Mr G's side. The genogram prepared by the visiting nurse recorded the existence of Mr G's older child, noting that she was in foster care in Victoria.²⁶ The visiting nurse who recorded that information failed to consider whether those circumstances might raise a concern about Mr G's capacity to safely care for an infant.

At the first home visit, sleeping and feeding issues were discussed. Ms F cancelled the next two scheduled home visits. At the following visit Ms F declined a referral to a CaFHS day service to assist with settling and sleeping routines. She had previously declined a referral to Torrens House, a residential service to assist with the same issues. However, Ms F expressed an interest in a young mothers' group, and flyers for local services were provided.²⁷

The visiting nurse continued to follow up Ms F, but without success. A final letter was sent noting that the service had not been able to make contact, and inviting Ms F to make contact.²⁸ The extended Family Home Visiting Service had been offered to Ms F but she had declined a referral, saying she did not think it was necessary.²⁹ CaFHS closed its file while Ms F was still residing at her mother's former premises. James was six months old.

During James's first year of life Ms F took him to her local GP on four occasions. He received his two, four, six and 12 month vaccinations. James was weighed and measured at each visit and his growth throughout that period was within normal limits.³⁰

SUPPORT TO MOVE HOUSE

James next came to the attention of services when he was two years and four months old. Ms F was still living at her mother's premises in the outer northern suburbs. Housing SA had received numerous complaints from neighbours about the condition of the property's exterior, and a concern about Ms F's poor health.³¹

A housing officer completed a home inspection and identified areas in the house which posed a high risk to the property and the people residing within it. The risks included the presence of excessive clutter, such as boxes and rubbish bags. The garage was full of furniture and access to the back door was blocked by flammable materials.³²

Housing SA was trialling a social work initiative and a referral was made for Ms F to access assistance and support from social worker Grant Whitehorn.³³ Mr Whitehorn conducted a home visit and formed the view that the property was simply unsuitable for Ms F and James. He observed that a large quantity of Ms F's mother's goods still occupied space in the house, and the boxes piled high upon one another could be hazardous for James. Mr Whitehorn became aware that Ms F was socially isolated and had no family support with raising James. They discussed local playgroups and a toy library situated nearby. Mr Whitehorn agreed to investigate whether the Wyatt Trust might be able to provide assistance to buy a new washing machine. A number of machines were at the house, but none was in working condition.³⁴

Ms F, with the support of Mr Whitehorn, completed an application to transfer to a larger, more suitable home.³⁵ A referral to the Anglicare Intensive Tenancy Support service was also completed.³⁶ This service is delivered by Anglicare to people who are homeless or at risk of homelessness because of tenancy issues.³⁷ The issues identified for Ms F were not only the condition of the property, but also her isolation, and the need for her to develop social linkages to support optimal parenting.

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Dorle Heinrich was assigned as Ms F's support worker.³⁸ Ms Heinrich's first visit was planned as a joint visit with Mr Whitehorn. Ms F cancelled arrangements for the visit on both 31 August and 9 September 2011.³⁹ Mr Whitehorn and Ms Heinrich then attended as arranged at the property on 16 September 2011. No-one appeared to be home.⁴⁰ The joint visit finally occurred on 25 October 2011. Ms Heinrich spoke to Ms F about the advantages of permitting Families SA to become involved to enable her to access services.⁴¹ Ms F agreed to accept a referral to the Families SA financial counselling team. It was anticipated that this referral would enable Families SA to cover some costs associated with the move to more suitable housing.⁴² During this visit Ms Heinrich discovered that there had not been any hot water at the house for some time due to an unpaid gas bill, which had resulted in the gas supply being cut off. The bathroom smelled. Ms F said that she could not use the bathtub because there were faeces in it.⁴³ She had previously been using the bathtub for washing clothes, doing dishes and washing James.

Mr Whitehorn made a notification to CARL about the state of the house. He did so because he was concerned about the condition of the property, the physical risk to James associated with the clutter, and the family's social isolation. The CARL worker who received the notification recorded these concerns, along with Ms F's child protection history and previous notifications received about James's safety.⁴⁴ However, Mr Whitehorn's notification was assessed as not meeting Families SA's criteria of risk and was recorded as a Notifier Only Concern (NOC). This classification required no action on the part of Families SA. Mr Whitehorn was aware that it would be difficult for Families SA to become involved, but hoped that his notification might spark a move to make other services available. He took the view that Ms F needed support with her parenting, but things were not at a stage where James needed to be removed.⁴⁵

Mr Whitehorn ultimately managed to secure the involvement of Families SA through a professional relationship at the local level with Megan Birchmore, a Families SA social worker in the Community Partnerships team. The relationship had developed from attending meetings with key workers from other government agencies working in the same region.⁴⁶ Ms Birchmore agreed to open a file to establish eligibility for Ms F to access Families SA's financial counselling.⁴⁷ As the Community Partnerships team focused on the child, the case was opened in C3MS (Families SA's electronic case management system) in James's name.

A referral for financial counselling was then made. The file created in C3MS for financial counselling was held in Ms F's name, those services having an adult focus.⁴⁸ The financial counselling team, among other functions,

provided a limited financial assistance service where clients were clearly unable to pay certain accounts themselves.⁴⁹

Lisa Nelson, a financial counsellor from Families SA, was allocated Ms F's case. At the time that Ms Nelson received the referral, financial counselling services had been expanded to include broader support than previously, under the concept of 'integrated practice'.⁵⁰ Ms Nelson's involvement now extended to conducting home visits and general support.

On 4 November 2011, Ms F accepted an offer made by Housing SA for more suitable housing.⁵¹ The various agencies that were involved then began to focus on assisting Ms F to clean and pack up her mother's property and financially supporting her to move.

Ms F did not engage well with the Anglicare Intensive Tenancy Support service. Of the eight home visits scheduled, three were cancelled, and one was missed without explanation.⁵² Of the four which occurred, Ms Heinrich sighted James on only two occasions.⁵³ Ms F frequently declined offers of assistance from Ms Heinrich and was defensive about Ms Heinrich coming inside the house.⁵⁴

Notwithstanding the relatively few opportunities she had to observe James, Ms Heinrich made important observations about his physical development. She observed that James was carried most of the time by Ms F. On the few occasions he was not being carried she noticed that he walked on his tiptoes, and did not appear to be able to place his heels to the ground. Ms Heinrich did not mention her concerns to Ms F, fearing that she did not have the kind of relationship that would make that conversation possible. In particular Ms Heinrich observed that Ms F was defensive and worried excessively about anyone questioning her care of James.⁵⁵

Ms Heinrich mentioned her concerns about James to Ms Nelson, the financial counsellor. Ms Heinrich recalled that Ms Nelson shared her concern that Ms F's parenting was over-protective and deprived James of the space in which to grow and develop.⁵⁶ However Ms Nelson stated in evidence that at no time did she have concerns about Ms F's capacity to parent James. She agreed that she had noticed him tiptoe walking, but as she had no particular training in child development, she did not appreciate that it might be developmentally significant.⁵⁷

Throughout the course of her involvement Ms Heinrich introduced Ms F to the idea of a referral to Anglicare's Family Support Program. This program had a different focus to the Intensive Tenancy Support service in the sense that it focused on the family, that is, the needs of the parents and children, rather than immediate housing needs.⁵⁸ Ms F agreed to accept a referral. By January 2012, Ms Heinrich's involvement ceased.

Ms Nelson, the financial counsellor, remained involved. Ms F told Ms Nelson that she did not like seeing doctors or counsellors because they would tell her that she had mental health problems, and she feared this made her similar to her mother. The tenor of the conversation was that she did not like counselling not because she did not need it, but because she feared what counsellors would tell her.⁵⁹

On 14 November 2011, during her sixth visit, Ms Nelson finally appreciated the significance of the rubbish accumulated at Ms F's mother's property. Ms Nelson encouraged and supported Ms F to clean the house and discard some of the property in readiness for a move to her new home. Ms Nelson observed rubbish throughout the house, including soiled nappies and food scraps. She thought the house looked as if the occupants did not use a bin at all.⁶⁰ She tried to raise the topic with Ms F, but feared she would offend Ms F or appear judgemental. Ms Nelson accepted that she was inexperienced in dealing with this kind of issue.⁶¹

In evidence to the Commission Ms Nelson was asked:

Q: Do you think there was a possibility at this stage that if the state of the new house deteriorated then Ms F wouldn't engage because of the embarrassment she felt?

A: Certainly.

Q: Did you also think that it was important that Ms F knew that the state of the house at [her mother's old Housing SA rental] was unacceptable?

A: Yes, I did. I felt, at the end, that the final clean-up probably did not happen. I never really knew. I felt that I'd gotten a really large skip and that it wasn't going to be used. I had the impression in the end that Housing SA weren't going to push for her to physically pick that rubbish up and put it in the skip, and I guess I had concern about that because it's a bit like my children, if you don't pick up after yourself then you're going to keep making a mess and I just felt that if it was cleaned up ...

Q: Did you think the state of the house was unacceptable for James to be in?

A: I didn't feel it was unsafe.

Q: Did you feel it was unhygienic?

A: Yes.

Q: Did you ever tell Ms F that it was unhygienic to have a child in that environment?

A: I don't recall.

Ms Nelson sensed that Ms F began to disengage when she challenged her about the kind of food that James was being fed. After Ms Nelson raised this topic Ms F cancelled the next scheduled home visit.

By the time Ms F had moved into the new house that Housing SA had sourced for her, Ms Nelson was aware of a number of worrying circumstances for James. She knew of Ms F's history with, and distrust of, Families SA. She held concerns about Ms F's ongoing capacity to keep her house in a hygienic state. She was aware that Ms F was vulnerable to disengaging with services that she might need because she was embarrassed and felt judged. Ms Nelson knew that Ms F had lived at her previous house with James for almost a year with no hot water because of an unpaid gas bill. She had observed the interactions between Ms F and James and their social isolation. Ms Nelson agreed that the aggregation of those factors might give rise to concerns about which she could have spoken to a social worker. She maintained, however, that a social worker could not act on concerns at that level, as there was no evidence of the child being in immediate danger.⁶² She said that perhaps her lack of experience at the time hampered her capacity to bring those concerning factors together.⁶³

On 17 February 2012 Ms Nelson spoke with Ms F about gathering James's immunisation records so that he could go to child care. Ms F told Ms Nelson that she was managing well and did not need any assistance. The Families SA financial counselling file was closed on 19 April 2012.⁶⁴ By this time Ms F had moved house, and Families SA had provided her with the necessary financial assistance to make that move successful.

In December 2011, the referral for Anglicare's Family Support Program had been actioned and Jan Player, a family support worker, was allocated.⁶⁵ The referral for the program clearly set out that emotional health, parent-child interaction and social isolation were relevant issues.⁶⁶ Ms Player was aware that Ms F's care history raised a risk that she might struggle with parenting, Ms F not having had a healthy parenting experience herself.⁶⁷

Ms Player was involved with Ms F from 21 December 2011 to 28 March 2012. Over this three-month period Ms Player scheduled 11 home visits. Ms F kept only four of those appointments. On only two of those four occasions did Ms Player sight James. On 25 January 2012, Ms Player visited the home for the first time. In the course of taking preliminary information, Ms F told Ms Player she had been diagnosed with borderline personality disorder and schizophrenia.⁶⁸

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Ms Player's assistance over the next four appointments did not extend beyond establishing rapport. Although the Family Support Program was a home visiting program, Ms Player never entered any part of the house beyond the lounge room. She did not ask to be shown any other area of the house, notwithstanding that she completed a safety assessment with Ms F's permission, recording that there were no safety hazards in the house.⁶⁹ Ms Player maintained that it was not her place to look at the house to get a full view of Ms F's needs. Nor did she regard it appropriate to ask to see the house, on the basis that at this early stage she was focused on relationship-building with the client.⁷⁰ At no time did Ms Player challenge Ms F about the pattern of cancelled appointments. Ms Player took the view that the need to establish a relationship precluded her from having difficult conversations that might have revealed issues that bore on James's safety and welfare.

On 28 March 2012, following two missed appointments, Ms Player attended Ms F's home. She became concerned that a note that she had left at the time of the last missed visit was still in the letterbox, and the home's air conditioning was running. She became worried about the safety of Ms F and James and contacted the police to conduct a safety check.⁷¹

Police officers knocked on the front door and received no response. They then knocked on doors and windows declaring themselves, but there was still no response. In order to gain entry to the backyard, one officer had to push a pile of boxes and general rubbish aside.⁷² Police then entered the house via an unlocked back door.

The kitchen benches were completely covered with various types of rubbish, including a large number of empty energy-drink cans. There was no clean bench space for food preparation and debris flowed onto the kitchen floor.⁷³ There was also a strong smell of rotting food.⁷⁴ One officer headed towards a bedroom which had a closed door. As the officer approached, the door opened and Ms F and Mr G emerged. James was inside the room.⁷⁵ Ms F expressed a high level of concern about the possibility that the state of the house would be reported to Families SA and she repeatedly asked police not to do so.⁷⁶

Notwithstanding the state of the house, James appeared happy and healthy. Ms F was told that police would be making a CARL notification, as police regarded the house as unhygienic and unsafe for James.⁷⁷

Police who made these observations spoke to Ms Player, who was waiting outside. They told her that the house interior was 'like the house of horrors', a statement Ms Player interpreted as referring to another house in horrendous condition in the northern suburbs where a

large number of children had been removed due to child protection concerns. Police told Ms Player they did not know how a child could be living there.⁷⁸

As Ms Player had never ventured beyond the lounge room she had no idea about the state of the kitchen/dining area of the house.⁷⁹

Ms F followed police out of the house. She was upset and challenged Ms Player about why she had contacted the police. Ms Player did not attempt a long explanation. She saw no profit in speaking to Ms F while she was agitated and upset. Ms F was shaking and told Ms Player, 'Now they're going to blame my mental illness'. Ms F told Ms Player that she was not welcome back at the house. Apart from trying unsuccessfully to make telephone contact later, Ms Player made no other attempts to speak with Ms F after the incident, or to re-engage at a time when Ms F might be calmer.⁸⁰

THE MARCH 2012 NOTIFICATION

Families SA received a notification from the police about the incident at Ms F's house, which included details about the conditions in which James was living.

The notification was taken by CARL worker Samantha Cookes.⁸¹ Ms Cookes screened in the information as she was satisfied that there was an existing risk to James which met the classification of 'Inadequate basic care—Shelter'. This category requires the worker to consider whether any of the following conditions (or similar) are present:

Shelter: The child's living conditions are hazardous for the child. Certain household conditions are present AND are hazardous for the child. Consider the child's age in relation to the extent and location of the hazards. Examples include, but are not limited to the following:

- human or animal excrement in the living areas
- excessive rubbish or decaying food that threatens health
- broken windows or stairs
- exposed electrical wiring
- insect or rodent infestations
- accessible weapons, drugs or chemicals etc.⁸²

Once information has been screened in, the worker uses a response priority assessment tool to determine a tier priority.⁸³ In this situation, the neglect decision tree was used. In general terms, a Tier 1 response is dictated only in circumstances where the information establishes that the living situation is immediately dangerous; the child appears seriously ill, injured or in need of immediate medical or mental health attention; or the child is currently unsupervised.⁸⁴

A Tier 2 rating might be achieved if the child is school aged, as the next question focuses on whether the circumstances satisfy inter-agency processes for high-risk children who are chronic school non-attenders. As James was under school age, his vulnerability was not captured by this question. The decision tree then asks whether the child has a chronic illness or condition or a significant injury requiring medical, dental or mental health attention that is not being given. As James was, at that time, apparently healthy, the answer to this question was 'no'.

The next question requires a high level of interpretation and the exercise of professional judgement. The question asks whether there is a severe condition or pattern of caregiver behaviour that presents a significant risk of serious neglect. If the answer to this question is 'yes', the information is rated a Tier 2; if 'no', it is rated a Tier 3.

Ms Cookes did not consider that she had sufficient information to be satisfied that a pattern or severe condition existed. She emphasised that the severe condition or pattern of behaviour related to the caregiver, not the condition of the home. Ms Cookes took the view that the previous notification (made by Mr Whitehorn) was insufficiently proximate to establish a pattern.⁸⁵

Ms Cookes was asked about the potential significance of James's social isolation, and the significance of his mother's untreated mental illness. She said she would need more information to determine their significance, and would need to be satisfied that social isolation was having an observable impact on the child's development.

The notification was rated a Tier 3 on the basis that there was insufficient evidence of a severe condition or pattern of behaviour. The notification was referred to the Modbury office. At that time the office had no capacity to provide any family support or investigatory response to Tier 3 notifications. When student social workers were available, they would send out letters framed in standard terms to families notified in Tier 3 matters.⁸⁶

Aleesha Ruddell, a student social worker completing one of her professional placements in the Modbury office, was asked to send a letter to Ms F and Mr G. Ms Ruddell contacted the Anglicare worker, Ms Player, to 'get a bigger picture of what was going on'. According to a C3MS note recorded by Ms Ruddell, and her recollection of the conversation, Ms Player did not offer any information about Ms F's poor engagement. Ms Ruddell did not think to enquire.⁸⁷ The note taken by Ms Ruddell recorded that Ms Player:

Spoke positively about her relationship with Ms F saying that their rapport was 'good' and Ms F was a lovely girl, considering what she has been through in her life. [Ms Player] said there had never been any problems with Ms F. A concern that [Ms Player] spoke

*about was when she used to visit ... she never saw James or even heard any noise from him and as [Ms Player] stated this is a concern because James is 2 years old and this is unusual for a toddler not to make any noise. [Ms Player] seems to think that Ms F stays up late with James and then they sleep all day.*⁸⁸

Given the reality that Ms F had engaged very poorly with the Anglicare support program this was a dangerous and misleading statement, particularly in light of the risk that someone might later refer to that note.

The letter sent by Ms Ruddell invited Ms F and Mr G to make contact with a duty social worker to access services to assist with parenting or manage a difficult situation. There was, unsurprisingly, no response to this letter. Ms Ruddell understood that people generally do not respond to such letters.⁸⁹ Ms F was especially unlikely to respond in view of the events that had given rise to the notification in the first place.

It is impossible to determine how the adults in James's household responded to the letter. The mere sending of the letter may of itself have caused a heightened risk to James. It may have confirmed Ms F's fears that allowing services into her home increased the risk that her child would be removed.

James was now approaching his third birthday. The following notifications had been made to CARL during his short life:

- 23 March 2009, Report on Unborn—no action;
- 6 May 2009 with further information added on 8 May 2009, Tier 2 Infant at Risk—full investigation not required;
- 15 August 2011, Notifier Only Concern—no action; and
- 28 March 2012, Tier 3—letter sent.

To enable James's circumstances to be comprehensively assessed, Families SA needed to know that Ms F had not engaged with the CaFHS Universal Contact Visit program and had declined referrals to other appropriate services, had not engaged with Anglicare's Intensive Tenancy Support service delivered by Ms Heinrich, and had not engaged well with Anglicare's Family Support Program delivered by Ms Player. While none of these failures of itself would provide a basis for statutory intervention, when combined with the information about the state of the house, and James's potential developmental issues, an inquiring and analytical mind might have better understood and assessed the risk to James. The paradox in the response priority tool, which relied on information being available, was that Ms F was able, through isolating James, to forestall a child protection response because simply not enough was known about his developmental delay or challenges to justify a higher tier rating.

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The use of assessment tools also discourages the analysis of information behind the immediate safety concern identified and categorised. In order for James's circumstances to attract a protective response, the actual household conditions that were identified as a risk to his safety must be the focus of the priority assessment. There is no scope for a practitioner to look beyond the symptom (the state of the house) and ask why Ms F and Mr G were unable to keep the house in a habitable condition and what that underlying cause might mean for their ability to care for James. The system did not equip or prompt anyone to ask, 'If this family cannot keep the house in a hygienic condition, why do we think they are capable of safely parenting a small child?' or 'What is the cause of the family living like this, and what impact might that cause or condition also be having on the child?'.⁹⁰

The manner in which information available to Families SA at the end of March 2012 was dealt with was unhelpful. Families SA was left with an impression from Ms Player that the Family Support Program had come to an end after six months of accessing the support service and that there had been no issues. Ms Player was silent about the missed appointments, the lack of achievement of goals and the fact that the program was ending at Ms F's insistence. Although she did share her concerns that she had sighted James infrequently, this had to be viewed against the background of the rest of the picture that was being painted.

These observations are not to suggest that different information would necessarily have led to a different outcome. Evidence heard by the Commission suggests that in March 2012 Families SA was ill-equipped to provide any response to children where notifications were rated a Tier 3 priority. A gathering of all the available information, and a high-level analysis and assessment of it, might not have revealed circumstances that would have justified an investigative response that took priority over other more urgent matters. The nature of neglect, which accumulates in its pervasive impact on child development, is such that at each point in time there will be an acute problem in each Families SA office that will take priority over addressing chronic and growing risk.

REFERRAL TO OTHER AGENCIES AND INTER-AGENCY COORDINATION

Ms F's social isolation originated in her difficult childhood and her psychological dysfunction. It was exacerbated by a fear that if she allowed others to examine her living conditions James would be removed from her care. She appeared to have a fear that she would be labelled as mentally ill, and that such a diagnosis might have consequences for her continued ability to parent James.⁹⁰ The complexity of the circumstances surrounding the family required a commensurate level of skill in service delivery to be effectual.

The Anglicare Family Support Program was ill-equipped to deliver this level of assertive and skilled engagement. Ms F engaged for as long as was convenient and useful to her. She minimised the challenges that faced her and overstated the level of support informally available to her. The high point of her engagement with services was at the time of her move to more suitable housing, when Anglicare, Families SA and Housing SA provided a large investment of time and money in supporting her to clean the house and accomplish the move. Ms F demonstrated a pattern of service disengagement when practical aspects of the support, including financial support, were exhausted.

Ms Player's involvement with Ms F failed to move beyond initial engagement. Activities during home visits were dictated and shaped entirely by Ms F's needs, with little focus on James. Ms Player made no assertive attempt to follow up Ms F and have difficult conversations that were necessary after the attendance of the police at the house.⁹¹

Anglicare was not required as a condition of its funding arrangements to report back to Families SA or any other body about the performance of a client on a program. Even if Families SA had been able to access the records kept by Ms Player, the notes were restricted in their scope to factual observations with no accompanying analysis of the level of engagement or commitment of the client. This approach was in line with an Anglicare policy that case notes recorded factual observations only and that clients be given a copy of all notes.⁹² These restrictions inhibit the proper recording and analysis of client progress. They limit the insight available at a later time and the access by other workers who have a legitimate interest to professional records of a program.

By March 2012, when Anglicare withdrew its support, Ms F had been the recipient of services from Housing SA, Anglicare's Intensive Tenancy Support, Families SA's financial counselling and Anglicare's Family Support Program. The fragmentation, lack of coordination and lack of sustainability of the services meant that no single worker had the full picture of what life was like for James. No single worker had the accumulated picture of Ms F's service avoidance.

At the time that any of these workers was involved, there is no evidence to suggest that the circumstances for James had begun to approach the dire condition in which he was found 18 months later. The lack of information about the circumstances of the family at the time of the final attendance by police makes it impossible to determine whether the statutory hurdles to compulsory assessment and investigation had been cleared. However, what must have been clear was that Ms F was a young mother who was isolated and experiencing difficulties parenting James in a way that would permit him to reach his full potential. Coupled with her personal history and

the history of other concerns from various sources, it should have been obvious to anyone in possession of the collective knowledge of the workers who had been involved with her that a more assertive approach was needed.

Fragmentation of service provision resulted in fragmentation of the information available and the dissipation of responsibility for service delivery across a number of agencies. It is also possible that the involvement of so many different workers became simply a source of irritation to Ms F.

EVENTS LEADING TO REMOVAL

Ms F, Mr G and James went unnoticed for another 18 months following the notification and the letter sent by Families SA. There was no follow-up letter, no report sought from Anglicare about the progress of the family and no check on James's level of social engagement. James slipped under the radar because he was too young for school and was not engaged in any activity outside the home that would bring his plight to the attention of attentive and concerned adults.

During this period of time James was so hidden, so invisible, that Ms F's neighbours were not even aware that a child was living at the house.⁹³ One neighbour made a number of calls to Housing SA about the state of the house and the blight of a rat infestation, but she was not in a position to see that a child was suffering inside.⁹⁴

In the early hours of 15 October 2013 James was discovered malnourished and close to death inside his bedroom. The house was in a state of utter squalor. James had been locked in his room for up to 12 days, being fed plates with yoghurt and custard slipped under the gap between the door and the floor.⁹⁵

James's plight was not discovered through any investigation or monitoring by Families SA, but by the attendance of police officers at the house in response to a call from Ms F complaining that she had been assaulted by Mr G. It was the questioning by those officers about the presence of children that led to James's situation being brought to light. It is not overstating the situation to observe that, but for the intervention of the police, James might well have died as a result of neglect.

James was removed from the house and taken by ambulance to the Women's and Children's Hospital where he was admitted in the early hours of 15 October 2013. He was discharged a month later.⁹⁶ He was developmentally delayed, had very little speech, and was malnourished. Criminal charges were laid against both Mr G and Ms F. Those charges ultimately resulted in each of them being sentenced to imprisonment.

Dr Terry Donald, the consultant paediatrician who oversaw James's care during his admission to hospital, attended at the women's prison and spoke to Ms F about James's developmental history and challenges. Dr Donald concluded that James's developmental delays were likely to be primary rather than secondary to his malnutrition. Dr Donald observed in a later report that⁹⁷:

It is not clear how much of James's developmental delay was secondary to his isolation and the lack of meeting of his emotional and developmental needs. The undersigned believes that there were manifestations of developmental problems at a time when the level of neglect was much lower than it became before he was admitted to hospital.

In fact, the undersigned considers that it is possible that many of the challenges with James that Ms F found difficult to manage and did not seek help in managing, were a consequence of his emerging developmental problems. However, the crucial issue in this regard is her lack of apparent attempts to seek advice, when she clearly had a level of understanding of his developmental delays. It is clear that the level of psychosocial adversity within the family, and Ms F's own poor parenting templates, meant that rather than seeking assistance for the parenting challenges that faced her, Ms F isolated herself from help that may have improved James's long-term outcomes.

In a report tendered to assist in sentencing Ms F in the District Court, a forensic psychologist noted that:

Ms F had opportunities to seek assistance for James, but had limited psychological resources with which to seize those opportunities. Her personality functioning was such that she feared abandonment and the loss of the only relationship that had offered her any form of love, safety and stability. She had limited emotional and practical coping and decision-making skills, and she was dependent and passive in the relationship. Further, she experienced considerable depressive symptoms including feelings of hopelessness, helplessness and poor motivation and energy.⁹⁸

THE SERVICE RESPONSE FOLLOWING REMOVAL

The inter-agency response following James's removal and admission to hospital was a model of action and cooperation. It is to be commended as an example of best practice for all children who are removed from the care of their parents. All parties involved praised the level of cooperation and information sharing that was accomplished at the first strategy discussion, held via telephone on 15 October 2013.⁹⁹

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Families SA had the benefit of a thorough police investigation which identified the relevant facts and provided a comprehensive forensic examination of the premises and detailed and skilled interviews of both Ms F and Mr G.¹⁰⁰ This case study therefore did not require an assessment of the quality and skill of the investigative or assessment process.

Patricia Strachan headed an internal inter-agency review of the circumstances leading to James's removal. She gave evidence about the nature of the police investigation, and said (responding to a question about the need for service providers to engage more assertively and not be afraid to have direct and difficult conversations):

One of the things that really stood out for me at that first meeting, that first inter-agency meeting, was the intelligence that SAPOL brought to the conversation. I mean, hindsight was wonderful, but, in fact, it was their line of questioning, and ... I would like to see that skill replicated in other service providers. Sometimes it is very intimidating to go into a home where there are really difficult circumstances, where partners are really aggressive, and for a young health professional or Families SA worker to feel confident enough to actually ask quite a direct question.

Much of the activity following James's removal on 15 October 2013 was directed to securing an appropriate long-term foster care placement for him. A therapeutic placement was secured without James being required to endure the rotational care arrangements usually associated with transitional accommodation or emergency care. By 13 November 2013, foster parents Mr and Mrs C, who were trained in delivering therapeutic care to a child with high needs, had been selected.

A great deal of time and energy was invested in providing detailed information about James to management and the Minister. In the early days these updates were daily and later became weekly. The case attracted a degree of attention from the departmental hierarchy and the Minister that was unprecedented, at least for the witnesses involved.¹⁰¹

The intense scrutiny ensured that James was provided with a high level of service. A great deal of attention was focused on realising a good outcome for him. It is commendable that the Department was able to achieve an appropriate and timely result for a child with high level needs. However, the questions posed by the evidence are how this high level of scrutiny was able to produce a result that is denied to a large group of children who have also been the victims of trauma, abuse and neglect¹⁰², and how that level of service can be reproduced as a benchmark for all children.

The severity of James's medical condition meant that he benefited from a lengthy in-patient stay and a comprehensive medical assessment at an early stage in his care journey. His medical and developmental needs were well identified at the time of his discharge and a series of appropriate referrals were made to community health services in the area local to his foster parents. Shelby Nicholson, the social worker primarily responsible for identifying a suitable placement for James, said that she was not encouraged to pursue kinship care options once appropriate foster parents had been found.¹⁰³ It was obvious to the professionals involved in James's care that his best option was a placement with skilled foster parents willing and able to provide a long-term home. Those involved in his care agreed that James would need stability and what was being put in place was a long-term care arrangement.¹⁰⁴

It is easy to see why a skilled long-term placement was the best option for James. Families SA was able to focus on what was best for James and acknowledge that family relationships were best accommodated in ways other than a kinship placement. The decision to select Mr and Mrs C as foster parents was accompanied by a high level of communication to ensure that the family understood James's high ongoing needs, and that they were equipped to meet those demands.

Once appointed, the transition of James to the care of his foster parents was facilitated through frequent hospital visits and by meetings attended by everyone in the care team. The foster parents were gently introduced to James in hospital and they gradually took over from nursing staff attending to his basic care needs.¹⁰⁵ Information was freely and directly shared by medical staff who had been caring for James with the family who would care for him on his discharge from hospital. The foster parents received information, particularly about his history of abuse, which was greater than that usually provided to new foster parents. Ms Nicholson told the Commission that it was her practice to freely share information, including a child's trauma history, with foster parents. However, she would not necessarily share information which related to the parents' backgrounds and childhoods. Dr Donald regarded it as critical that he be given the opportunity to communicate medical information directly to the foster parents. He thought Families SA had not always been able to convey accurately the level and type of concern that medical staff had for James. His past experience was that it had not been possible to have that level of direct contact with foster parents.¹⁰⁶

The best practice that was evident from the placement of James with Mr and Mrs C, and the levels of communication that accompanied it, appears to have been accomplished because James was given a high priority within the organisation. The Placement Services Unit and social workers knew much more about the

foster parents who were proposed, and this enabled them to foresee and plan in a more structured way. Life Without Barriers, the foster care support agency, was able to anticipate and plan for the challenges that the foster family might face, and funded therapeutic support on an ongoing basis, as well as putting in place from the outset respite services that were regular and consistent.¹⁰⁷

INTERSTATE LIAISON

The most important piece of information that would undoubtedly have made a difference to James's circumstances at an early stage was Mr G's conduct towards the infant who had been removed from his care in Victoria.¹⁰⁸ The circumstances, once known, had a chilling resonance in the experience of four-year-old James: it was suspected that the infant received no stimulation, was deprived of affection, was kept in a rocker in front of the heater and given regular doses of Panadol to make her sleep.

A CARL practitioner involved in the assessment of one of the early notifications about James told the Commission that had this information been available to her she might well have concluded that James was at imminent risk, and a child protection response was more likely to have been activated.¹⁰⁹

At the time that the first notification was received about James (after his birth) Families SA was told that Ms F and Mr G had recently moved back to Adelaide from Ballarat. The practitioner who received that notification did not regard that as sufficient, in the circumstances, to justify seeking a request for information from interstate.¹¹⁰

Deciding whether or not interstate information should be sought in relation to a notified family will always be problematic. It is not possible in advance to dictate what would amount to sufficient information for the requisite enquiries to be made. Given the difficulties in making requests for interstate information, it is impractical to suggest that interstate checks should be done for every notification. However, state borders are becoming less significant and populations more mobile. Families with child protection histories wanting to avoid attention in the future may well be motivated to move jurisdictions for a 'fresh start'. Significant risk factors are likely to be missed if interstate connections are ignored.

OBSERVATIONS

Parents who are reluctant to engage with services, especially parents whose reluctance stems from a fear of having their children removed (because of their own guardianship history)¹¹¹, will generally engage with medical services around the time of birth. The period just before, and just after, birth is a critical window of opportunity within which to engage vulnerable parents in programs or services that will be beneficial to them and enable them to develop their parenting skills.

CaFHS SERVICES

At the time James was born, CaFHS offered a limited range of services. A comprehensive service to families with complex issues was not available. Although Ms F's circumstances meant that she was eligible for the Family Home Visiting service, that program required her consent to participate beyond the Universal Contact Visit. There is no evidence of any assertive attempt to obtain her consent.

However, since James's birth there have been changes to the way the Universal Contact Visiting program operates. The changes came about with a project called Care Plan Modelling and involve the use of a new contact consent form and priority information form. The priority information form contains more information than was previously available from the birthing hospital and identifies a parent's particular vulnerabilities.

In training and program scope, the need to assertively engage families with respect to child protection issues now has greater emphasis.¹¹² The new priority information form includes space for a hospital social worker, if one has been involved, to provide contact details for further follow-up.¹¹³ The program allocates staff on the basis of the complexity and type of issues identified in the forms. It is no longer a matter of allocating the next available member of staff, but rather a clinical process matching resources according to need. The intake and assessment nurse responsible for allocating the new cases may also contact the referring hospital for more information when necessary.¹¹⁴

When Ms F disengaged from the Universal Contact Visiting program, there was no assertive follow-up to the standard terms letter she had been sent.¹¹⁵ CaFHS has now developed a path of escalation where child protection concerns exist within a family who disengages. Those pathways are set out in the CaFHS Decision Making and Escalation Framework.¹¹⁶ The framework sets out two processes, one to be followed when there are no child protection concerns and the other where such concerns exist. The escalation options include making a CARL notification when appropriate.

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These changes, and the increasing focus on postnatal mental health, mean that the visiting service becomes privy to much more information about the family than previously.¹¹⁷ This requires clinicians to act upon more complex information and make more use of other referral pathways and services for families, including general practitioners or private mental health services.¹¹⁸ The changes to the service promote comprehensive assessments and provide opportunities for multidisciplinary work with families with more complex needs.

CaFHS also delivers a program called Strong Start, which uses a model named Parents Under Pressure that allocates a combination of nursing, allied health and family support workers in accordance with the needs of the particular family.¹¹⁹ Referrals to the program are made during the antenatal period, both to provide support during the pregnancy and to build relationships before the baby is born. Referrals to the service are made by the major public birthing hospitals in each region. Referrals, however, depend on a mother attending antenatal services and being referred to the service at that time.

The current range of CaFHS-run programs is under review. CaFHS aims to develop a more seamless response in preference to a number of discrete services. That is, it will not be necessary to identify (to the family at least) the precise program to which a family is allocated, and there will be flexibility in the level of service delivery depending on the family's need at any particular stage.¹²⁰ The Commission commends the move in this direction.

HOUSING SA SERVICES

Housing SA has demonstrated a growing focus on the needs of children of the families that live in their properties. It mandates for all workers an increased focus on sighting children during housing inspections.¹²¹ All Housing SA staff are being trained in working with children and families in crisis. There is an emphasis on staff being willing to have a conversation with tenants about their children, their whereabouts and their living conditions.¹²²

The change in focus and skill level for Housing SA staff envisages an agency frequently being inside the houses of vulnerable families and having conversations about their particular challenges. These conversations will focus on the part that the residents of the house play more widely in the community, and their responsibility to one another, as well as to the specific premises and the neighbourhood.

The value of Housing SA having these conversations is that it occupies a special position as an agency that provides a benefit to the client. The conversation will occur in the context of the practical and visible

advantage of affordable housing, rather than in the context of stigmatising and confronting questions about the adequacy of their care for children.

Staff working in Housing SA are being trained to use a risk identification tool in their everyday practice in assisting clients with their housing needs. Risk factors are categorised as:

- priority risk factors;
- secondary risk factors;
- protective factors; and
- additional factors.

If a priority risk factor is identified a referral is made to a tenancy practitioner, or the Regional Response Team. The staff working in those teams have various skills, but they are led by social workers and have a focus on human and social issues as well as the security of the asset.¹²³ Priority risk factors include the following issues with a specific child protection focus¹²⁴:

- a member of the household is involved in the family safety framework;
- an intervention order has been issued against or to protect the client;
- a child protection order is in place and the child is under five, Families SA is involved and the child is under five, or there is a child protection issue and the child is under five;
- the condition of the premises presents an immediate risk to the residents, neighbours or visitors; or
- a Youth Court order exists.

If a secondary risk factor is identified then a referral is made to the Regional Response Team. Secondary risk factors that have a specific child protection focus include the following:

- a child protection order is in place and the child is over five, Families SA is involved and the child is over five, or there is a child protection issue and the child is over five;
- domestic violence or Aboriginal family violence has been identified; or
- the condition of the premises presents a risk of harm to the health of residents, neighbours or visitors.

The staff in the Regional Response Team have a case management role. They may take on the role of the lead agency in inter-agency work, or they may work with another agency as the lead. The role is an ongoing one for the life of the management of the risk.¹²⁵

Tenancy practitioners working with vulnerable families will use a tool known as the Outcomes Star.¹²⁶ That tool provides a simple way to identify issues and qualitatively assess progress on those issues.

The Regional Response Team members are using a more complex tool designed to assess and monitor more complex issues. This tool is the Client Assessment and Plan.¹²⁷ This tool enables a practitioner to identify and assess risks to children including (but not limited to):

- domestic and family violence;
- social isolation;
- mental health issues;
- substance misuse issues; and
- child protection concerns broadly.

The use of these tools encourages workers to keep the protection of children within the household front of mind.

Changes to Housing SA, and the growth in the quality of information about families that is available to child protection agencies, depend on Housing SA officers passing the right information on, and Families SA both listening to that information and asking the right questions.

CONCLUSION

The study of the service response to James in the first four years of his life highlighted a number of themes which have informed discussions and recommendations throughout this report, but in particular chapters 7, 8 and 10.

Several themes were evident which the Commission regarded as especially important. These are summarised as:

- A regular failure to ‘close the circle’. That is, there was a pervasive practice of referring on, moving on, and failing to follow up or check on progress. This approach meant that follow-up would be undertaken only if there were a re-notification of the child, meaning that the risks had persisted and or the child had suffered harm.
- A prioritisation of relationship-building with the parent as the client over the need to keep the child at the centre of decision making and service provision, and a corresponding reluctance to pursue a conversation that raised difficult issues for fear of the impact such a conversation would have on the adult client’s ‘engagement’.
- An assessment and triage system within Families SA that did not prioritise the risk of cumulative harm, nor attempt any analysis of family circumstances beyond immediate safety concerns.

- The absence of any intensive support program that had the capacity to actively engage Ms F and/or Mr G, and which had strong links back to Families SA for follow-up if required.
- A lack of acknowledgement that persistent failure to engage with services might be a risk factor in itself for a child, especially a child who is under school age.
- Fragmentation of information about a family across different government departments, which undermined the ability to build a comprehensive picture of risk to a child.
- Fragmentation of information about a family across state jurisdictional boundaries that was dangerous, particularly where parents had child protection histories that did not follow them across state boundaries.

Families SA showed itself capable of high quality, child-focused work in the aftermath of James’s removal from his parents’ care. There is reason to believe that the manner in which James’s high needs were accommodated could, with sufficient goodwill and attention, be replicated for other children with a lower profile in the organisation.

It is clear that services delivered by Housing SA and CaFHS have been substantially reformed since those agencies delivered services to James. The evidence suggests that both agencies have moved in a direction that is likely to improve the safety of children engaged with their services.

CASE STUDY 1 JAMES—VULNERABLE CHILDREN, BIRTH TO SCHOOL AGE

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2

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CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

OVERVIEW

'Abby' entered care as a two month old baby. Her mother, Ms B, had a history of child protection concerns, including drug use and exposure to domestic violence. Families SA was warned from the outset that Abby's need for stability and permanence permitted only a short timeframe in which to pursue reunification with her mother. It was warned to 'concurrently plan' for Abby's return to her mother or for placement with a suitable carer, preferably with identified relatives or other suitable carers in Western Australia.

Abby is an Aboriginal child. Families SA practitioners were obliged to consider how to maintain and strengthen her connection to land, language, community and culture. They were under the specific obligation to consult with a recognised Aboriginal organisation before making decisions about where or with whom she would reside and to observe the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).

This case study examines how Families SA balanced three considerations in practice:

- supporting Ms B to address her problems to resume the care of Abby;
- meeting Abby's need for an attachment relationship with a consistent care giver; and
- securing Abby's right to develop a cultural identity.

The case study identifies the improvements required to ensure that practitioners facing similar practice challenges in the future do not lose sight of the interests of the child in care.

EVIDENCE

EVENTS LEADING TO ABBY'S REMOVAL

Ms B gave birth to her first child, a son, in Western Australia when she was 17 years old. Her son's father was violent towards her and he was incarcerated soon after the child's birth. Concerns existed about Ms B's drug use and her ability to parent her son. She agreed to a shared care arrangement with her son's paternal grandmother.¹

Approximately five years later, in November 2011, Ms B, pregnant with Abby, attended a hospital in Western Australia. She had extensive bruising as a result of domestic violence perpetrated by Abby's father, Mr J. Mr J was about 13 years older than Ms B, and had a history of domestic violence and illicit drug use. Ms B had been sleeping in a tent on a beach and carrying her belongings around with her. She had no means of contacting family members. She declined help to find refuge accommodation.²

A report was made to the Western Australian Department for Child Protection (DCP). DCP opened a file due to concerns for the unborn child, but was unable to engage meaningfully with Ms B. In late December 2011, Ms B told a DCP caseworker that she had separated from Mr J and had relocated to Adelaide to live with her mother, Ms D. She said she was open to working with support services in South Australia. The DCP closed its case and made an Interstate Child Protection Report to Families SA.³

Ms D was Ms B's only known family member in South Australia. She was said to suffer from bipolar disorder and had a history of criminal behaviour including illicit drug use. She had been gaoled when Ms B was a young child. Ms B had then been placed under a long-term guardianship order in Western Australia and cared for by a relative.⁴

In March 2012, Ms B, aged 22, gave birth to Abby at the Flinders Medical Centre. Families SA social worker Carmel Mackie visited Ms B while she was in hospital. Ms B presented well and interacted appropriately with Abby. Ms B said she planned to live with her mother Ms D and that Mr J was returning to Western Australia. Ms B agreed to work with support services and to participate in further assessment once she was discharged. Ms B was in the company of Mr J when she was discharged from hospital. They were reported to be arguing as they left.⁵

A week later, during an altercation, Mr J damaged a car and cut up Ms B's clothes. South Australia Police (SAPOL) were contacted and Mr J was charged with an offence. He entered into a bail agreement, with conditions not to contact Ms B, Ms D or Abby.⁶

The following day, Ms Mackie completed a safety plan with Ms B. The main concerns were domestic violence and Ms B's engagement with services. Her drug use was not identified as a current concern. At subsequent home visits, Ms B presented as cooperative and willing to work with services.⁷

On Friday 13 April 2012, Ms B left her mother's house with Abby, having earlier left Abby in her mother's care while using drugs. In consultation with the principal social worker and principal Aboriginal consultant, Abby's removal from Ms B was approved.⁸

Over the weekend, and before she had been located or the removal effected, Ms B contacted the Crisis Response Unit (now known as Families SA Call Centre) requesting financial assistance to pay for a motel room. The Crisis Response Unit practitioners attended the motel and found Ms B lucid and not under the influence of drugs. Abby appeared well cared for. A supervisor decided that Abby would not be removed.⁹

Ms B returned to stay with her mother on Monday 16 April 2012. However, Families SA was concerned about the relationship between Ms B and her mother, and they offered Ms B supported accommodation at L House, a staffed residence for young mothers.¹⁰

On 24 April 2012, Ms B left Abby with her mother for about 48 hours, during which time Ms B was said to be using drugs and was with an older man. He was known to Families SA as a perpetrator of domestic violence. Two days later Families SA moved Ms B and Abby into L House. Ms B agreed to regular drug screens, and to work with services, attend appointments and have no contact with Mr J.¹¹

The following day Ms B's drug screen was positive for methylamphetamine and cannabis. On 8 May 2012 she did not attend a prearranged drug screen.¹²

On 11 May 2012, her drug screen did not detect any drugs, but she had no formula left for Abby and reported that her wallet was missing. Later that evening, she was observed leaving L House with Abby, telling staff she was taking empty suitcases to her mother's house. She had, in fact, removed all her belongings from her unit. With SAPOL's assistance, Ms B was located and Abby removed from her care. The following day, Ms B returned to Western Australia where she remained for approximately two weeks.¹³

THE ASSESSMENT PROCESS

On 21 May 2012, the Minister obtained a custody order for Abby for a period of six weeks to allow for investigation and assessment to inform the future direction of her care.¹⁴ This order was later extended for four weeks. Ms B agreed to work with a reunification program so that she could be reunified with Abby and return to Western Australia. Families SA planned that if they could not be reunified, Abby would be cared for by Aboriginal relatives in Western Australia, Ms G and/or Ms H, who would be assessed as suitable carers by DCP.

As part of the assessment process, Families SA psychologist Megan Grigg assessed Ms B's parenting capacity. She reported that Ms B showed limited insight into the impact of drug use, exposure to domestic violence and transience on her children. Ms B did not believe that she needed to make any changes to regain custody of her children.

While Ms B appeared motivated at the time of the assessment and had made recent improvements, Ms Grigg doubted she could sustain these changes. She questioned Ms B's ability to regain care of Abby, and to

maintain her care in the future without intensive, ongoing support.¹⁵ Significantly, Ms Grigg concluded:

Given Abby's age (in that she will be entering active attachment in approximately five months), it is imperative that a stable caregiving environment be established for her as soon as possible to ensure she is provided with an opportunity to develop attachment relationships with safe, stable and nurturing caregivers ... Ms B will need to improve her parenting capacity and achieve and maintain meaningful change within a six month timeframe if successful reunification is to be achieved. Alternatively, in the event that Ms B does not demonstrate meaningful change within the specified timeframe ... it is crucial that Abby's long term care is immediately secured to allow for her 'transfer' to Western Australia. It is strongly recommended that Families SA concurrently plan for Abby's return to her mother's care and the possibility that Abby will require a suitable long-term placement (preferably with her family or a suitable foster parent in Western Australia). This will require Families SA to immediately attempt to identify suitable kinship placements in Western Australia ... returning Abby to Western Australia either in her mother's care or by transferring her care to Western Australian authorities will allow her to develop and maintain her cultural and familial connections.¹⁶

Ms Grigg said that Ms B needed to demonstrate improvements to her parenting capacity, by engaging meaningfully with a reunification service and therapist, obtaining stable accommodation and abstaining from illicit drugs and contact with Mr J. Ms Grigg recommended she be included in planning processes for Abby's possible reunification with her mother.¹⁷

On 3 August 2012, Abby was placed under a 12-month guardianship order.¹⁸

A VARIETY OF PLACEMENTS

After her removal from her mother, Abby was initially placed with Anglicare foster parents for one night and with an Aboriginal Family Support Services (AFSS) foster parent for two nights.¹⁹

AFSS proposed a placement for Abby in a north-eastern suburb of Adelaide. Ms Mackie declined this placement on the basis that the court would expect Families SA to provide daily contact with her mother, and this was too difficult with Ms B residing in the southern suburbs.

Instead, on 14 May 2012, Abby was placed with an AFSS foster parent in the southern suburbs. The foster parent already had a high number of children in her care and placing Abby with her exceeded the number of children permitted in the placement.²⁰ AFSS advised that the foster parent could only provide emergency care for Abby for seven days. She remained there until the placement broke down on 6 July 2012.

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AFSS was unable to offer another placement and Abby returned to the care of the Anglicare foster parents who had initially cared for her, until that placement broke down in early December 2012.²¹ On 14 December 2012, aged eight months, Abby entered a placement which was staffed by rotational carers.

In January and April 2013, AFSS offered potential home-based placements for Abby in the north-eastern suburbs. On each occasion, Abby's new social worker Shae Hoffmann declined the placement because its location would require Abby, a young baby, to travel long distances four times per week for contact. Ms Hoffmann accepted in evidence that perhaps Ms B could have done the travelling, but there was generally a resistance to asking struggling parents to travel to contact. She also described difficulties with asking other offices to provide space for, and to supervise, contact.²²

Abby remained in residential care for more than five months. In May 2013, aged about 14 months, Abby was placed with non-Aboriginal Anglicare foster parents, Mr and Mrs K, in the southern suburbs.²³ Abby remained in their care for the next 18 months.

ENQUIRIES WITH WESTERN AUSTRALIA

In May 2012, Ms B identified a relative in Western Australia, Ms G, as a possible carer for Abby. Ms Mackie contacted Ms G, who explained she could only offer short-term care, because of her age, but that her daughter, Ms H, could care for Abby on a long-term basis, if required.²⁴

Ms Mackie considered transferring Abby's case to Western Australia. However, after telephoning someone in the DCP to 'sound them out' and consulting with the Crown Solicitor's Office, Ms Mackie formed the view that it was too difficult to transfer orders and that Western Australia was reluctant to accept them.²⁵

Ms Mackie emailed Mignon Borgas, Families SA's acting interstate liaison officer, with a generalised enquiry about aspects of the Western Australian court process.²⁶ The email was not a formal request to transfer the case. The first 12-month guardianship order had not been made at the time of this enquiry, so the response from Western Australia's interstate liaison officer was that there was not yet an order capable of being transferred to Western Australia.

Ms Mackie misunderstood that email response. She concluded that Western Australia had refused to accept the transfer of an order in relation to Abby.²⁷ This error was recorded on the case plan and persisted throughout Families SA's management of the matter. Apparently on this basis, no-one reconsidered the question even after the 12-month guardianship had been made.²⁸

Ms Mackie declined to escalate this issue to higher levels of management. She did not think it was her role to do so and her supervisor had told her that she did not think it would get them anywhere.²⁹ Ms Mackie also regarded it as significant that Ms B had decided to remain in South Australia.

Ms Mackie also believed that services for Ms B would be better in South Australia. This was based not on any conversation with Western Australian service providers or the DCP, but rather on a conversation with Ms G.³⁰ There would be an obvious benefit to Abby long term if better services could secure the necessary changes to enable Ms B to parent Abby safely. However, there is no evidence of any real analysis of the risks and rewards of not pursuing an interstate transfer.

On 5 June 2012, Ms Mackie consulted with principal Aboriginal consultant Annette Groat. The case note states that Ms Mackie would request the DCP to assess Ms G as a carer. Despite this, Ms Mackie said she did not see it as her role (as an assessment and support worker) to request a carer assessment. It was included in the case plan as a task for the reunification worker, Ms Hoffmann, to whom Abby's case was transferred in September 2012. Neither Ms Mackie nor Ms Hoffmann initiated any assessment of relatives in Western Australia.³¹

THE PLAN FOR REUNIFICATION

Families SA's case plan was for Abby to be reunified to Ms B's care and for them to return to Western Australia to live with or near their relatives, particularly Ms G. Abby's move to Western Australia would be planned in consultation with the family and the DCP.³² No consideration was given to what would happen if reunification was not possible.

From May to August 2012, Ms B underwent 11 drug screens: eight were clean, two were positive for cannabis and one was positive for methadone. In the same period, she had about 34 scheduled contact visits. She missed one and was late to three or four; on two occasions Abby was very distressed after contact. The remaining contact visits were uneventful and Ms B demonstrated she was able to interact appropriately with Abby.³³

A clean drug test in September 2012 and an assertion by Ms B that she no longer took 'dope or speed' led to a decision to increase contact from three to four times per week. Ms B also indicated she was willing to engage with a reunification service and financial counselling.³⁴ However, because of a practice not to engage an outside service provider until workers were confident that reunification could be achieved, they did not make a referral to the AFSS reunification service until 4 February 2013.³⁵ This was at the end of the six month window contemplated in the psychological report by Ms Grigg.

In late 2012, Ms B was not abstinent from drugs. In October, she tested positive to amphetamines and, later, benzodiazepines. She missed two drug test appointments. In November, she admitted to having had a relapse. In December, she reportedly attended for contact with her son in Perth under the influence of drugs. In this period, Ms B missed three of about 17 scheduled contact visits with Abby.³⁶

In January 2013, Ms B's behaviour meant that her supported accommodation was at risk. In early March 2013, she was evicted. Thereafter she stayed with friends, on the streets or in a caravan.³⁷

Ms B delivered clean drug screening tests on 12 November 2012 and 13 May 2013. Between those dates no screens were done. However, her presentation and behaviour were observed as consistent with her being under the influence of drugs. While Ms B spoke to a Families SA drug and alcohol worker about having relapsed, she was evasive about what drugs she was using. For the most part, she did not attend appointments with the drug and alcohol worker.³⁸

Between January and April 2013, Ms B did not attend about eight of 30 scheduled contact visits. When she did attend she was observed to be incoherent, erratic, aggressive towards workers, and spent a lot of time talking on the telephone and texting. Eventually a contact visit had to be stopped because of Ms B's anger. At a subsequent contact, Ms B shouted at Abby.³⁹ This behaviour led to contact being reduced.⁴⁰

In February 2013, the drug and alcohol worker suggested Ms B enter a residential rehabilitation program.⁴¹ Over the following months, Ms B vacillated between acknowledging this was her only option to regain care of Abby and contending that she was capable of abstaining from drugs on her own.⁴²

FIRST ULTIMATUM

On 13 May 2013, Ms Hoffmann told Ms B that she needed to show commitment to her reunification goals (attendance at contact, abstaining from drugs and engaging with her AFSS support worker and drug and alcohol worker) or an application would be made for long-term orders. On 15 May 2013, Ms B travelled to Western Australia. She was due to return to Adelaide by 21 May to have contact with Abby on 22 May and attend an interview at a residential rehabilitation facility on 23 May. On 21 May 2013, Ms Hoffmann telephoned Ms B. Ms B was still in Perth; her speech was slurred and she was difficult to understand, although she denied taking drugs.⁴³

On the same day, Ms Hoffmann sent an email to her supervisor Catherine Wood recommending that the reunification assessment tool's recommendation be overridden. The tool clearly identified that reunification efforts should cease. Instead, Ms Hoffmann proposed to work intensively with Ms B over four to six weeks to decide whether to persist with reunification or to seek a long-term order. She noted that if long-term orders were sought, 'it would be in Abby's best interest to source a kinship placement in Western Australia'.⁴⁴ In support of overriding the tool, Ms Hoffmann noted that Ms B had demonstrated some positive parenting skills and established a close bond with Abby, including positive interactions during contact. She said that Ms B had demonstrated she could be abstinent from illicit drugs, although this was only recent and she had yet to 'demonstrate sustained change'.⁴⁵ She did not refer to the difficulties encountered during contact or her suspicion that during her telephone conversation that day Ms B had been under the influence of drugs.

Ms B did not return from Western Australia in time for contact, nor for her interview with the rehabilitation program. On 27 May 2013, Ms Hoffmann met with Ms B and explained that her actions showed she was not committed to having Abby back in her care. She gave Ms B four weeks to demonstrate her commitment and to avoid a long-term order. Ms B agreed over this period to attend every contact, engage twice weekly with her AFSS support worker, meet with the drug and alcohol worker weekly, remain drug free and attend an appointment at the residential rehabilitation facility.⁴⁶

Ms B attended one appointment at the rehabilitation facility, but did not otherwise comply with her commitments. Specifically, she continued to use drugs, including cannabis and amphetamines, failed to attend three scheduled contacts and presented drug affected to two others, missed two appointments with her drug and alcohol worker, and engaged so inconsistently with her AFSS support worker that the service questioned the utility of their involvement. She still did not have stable accommodation.⁴⁷

Ms B missed contact on 11 July 2013 and then presented at the office under the influence of methylamphetamines. The next day Ms Hoffmann told Ms B that Families SA planned to seek a further short-term guardianship order, based primarily on Ms B's expressed willingness to enter rehabilitation.⁴⁸ However, on 24 July 2013, Ms Hoffmann became aware that Ms B had been removed from the rehabilitation facility's waiting list as she had failed to telephone them twice weekly as required. Ms B said she was still willing to attend the facility and do what it took to get off the drugs.⁴⁹ Families SA did not amend its decision to seek a second 12-month order.

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On 25 July 2013 Ms Hoffmann affirmed an affidavit for the court in support of the 12 month order, annexing a report dated 24 July 2013. The report stated that Families SA expected Ms B to enter the facility in August 2013.⁵⁰ Ms Hoffmann could not recall whether she had had a chance to amend the report in light of the new information that Ms B was no longer on the waiting list. She conceded that this was perhaps why court reports should not be left to the last minute.⁵¹

A second 12-month guardianship order was made on 2 August 2013.⁵² Ms B never entered a residential rehabilitation program. There is no evidence that the report to the court dated 24 July 2013 was ever corrected.

ABBY'S CULTURAL NEEDS

At the time of applying for the second 12-month guardianship order, Families SA consulted with AFSS. Leila Plush, a cultural consultant employed by AFSS, provided a report which made a number of recommendations including⁵³:

- prepare a genogram to source an appropriate placement as per ATSICPP;
- encourage and educate Abby's carers to support the development of her cultural identity;
- develop a detailed cultural maintenance plan to meet Abby's cultural needs; and
- develop a detailed contact plan to ensure significant contact with family and extended family to develop 'strong positive relationships that are beneficial for her emotional and psychological wellbeing'.

Contrary to this advice, Ms Hoffmann took the view that supporting Abby's foster carer, Mrs K, to teach Abby about her culture would be 'tokenistic'. She considered that Abby was receiving cultural input from her mother at contact visits and that preparing a cultural maintenance plan to address the issue more formally also ran the risk of being 'tokenistic'.⁵⁴ In fact, there appears to have been no effort to address any of Ms Plush's recommendations. Instead, attention continued to be focused on Ms B's needs, with little regard to planning for Abby's long-term care and wellbeing. No contact plan of any kind was put into place which would have given Abby the chance to become familiar with her wider family circle, in case she were to transfer ultimately into their care.

SECOND ULTIMATUM

In August 2013, Families SA told Ms B that she was 'running out of time' and had three months to demonstrate that she could abstain from drugs and show stability in parenting, or a long-term order would be considered.⁵⁵ Over the following three months, Ms B tested positive for cannabis on three occasions, missed seven scheduled contact visits and attended one contact

visit under the influence of drugs. On 1 November 2013, Ms B arrived 20 minutes late for contact and was again warned that Abby could no longer wait for her to get her life in order.⁵⁶ The reunification assessment tool completed in September and October recommended that Families SA cease reunification and pursue an alternative long-term, stable living arrangement for Abby.⁵⁷ These recommendations were consistently overridden.

On 8 November 2013, Ms Hoffmann told Mr and Mrs K's support worker that Families SA would look to apply for a long-term order and that she expected this would take up to three months.⁵⁸ In November, Ms B did not attend any contact visits with Abby and tested positive for methamphetamines and cannabis.⁵⁹ No application for long-term orders was made.

In December 2013, as a result of Redesign (which rearranged work management from Families SA local offices to specialist hubs), Abby's case was transferred to the Families SA Aberfoyle Park office.⁶⁰ Jemma Andrew took over from Ms Hoffmann, but only for a short time, before she also moved to a different office. Ilona Merckenslager was then the caseworker for a few months, followed by Wendy Wallis, the team's senior practitioner.⁶¹

FIRST REUNIFICATION ATTEMPT

Abby had settled into her placement with Mr and Mrs K and formed an attachment with Mrs K. The Ks were keen to be considered as long-term carers if reunification was unsuccessful. Ms Hoffmann had encouraged them by suggesting that Ms B might agree to Abby staying with them long term.⁶²

On 10 December 2013, Ms B moved into supported accommodation at O Lodge and remained there until late June 2014. However, she spent a third of her nights away from O Lodge and for extended periods did not participate in her case plan, engage in financial counselling or pay her rent. She was aggressive at times while Abby was in her care (though not at Abby) and was suspected on numerous occasions of using drugs.⁶³

By late January 2014, Abby was being transported to O Lodge once a week for three hours of contact with Ms B. They also had frequent contact at the Families SA office. Ms B missed contact on four occasions from January to March.⁶⁴

In April 2014, Mr and Mrs K advised Families SA that they wanted to travel interstate for two weeks and were willing to take Abby with them. Families SA were concerned that this would disrupt the reunification plan. A decision was made, in consultation with Tammy Brooks, a principal Aboriginal consultant who assisted while Ms Groat was unavailable, to bring forward

reunification with a view to transferring Abby back to Ms B full time when her foster family went on holidays. The plan was to start two overnight contact visits per week for two weeks, followed by full reunification.⁶⁵ No consideration appeared to be given to the fact that if reunification failed, Abby's foster family would be away on holidays and not available to her.

The reunification attempt failed. After an uneventful first night, Ms B's new partner, Mr S, attended O Lodge. An altercation occurred, SAPOL attended and Ms B left Abby with O Lodge staff while she argued with Mr S. The following morning, staff found drug paraphernalia belonging to Mr S. Ms B displayed anger, and was careless, towards Abby. Abby cried inconsolably on the journey back to her foster parents and did not stop until she was with Mrs K.⁶⁶ Abby's behaviour was volatile for a couple of days, alternating between physical aggression and wanting to be constantly held.⁶⁷

Families SA persisted with a further overnight contact. On 7 April 2014, Ms Merckenschlager delivered Abby to O Lodge at about 4.00pm. Ms B was asleep and had to be woken. She was unable to respond appropriately to Abby's needs and appeared groggy and erratic even after she had time to get dressed. O Lodge staff encouraged Ms Merckenschlager to follow up drug testing Ms B as a priority. Despite this, Ms Merckenschlager left Abby in Ms B's care and contacted O Lodge staff after about an hour to obtain an update. Ms B was reportedly 'okay' and making Abby dinner. The next day, Ms B tested positive for cannabis and methylamphetamine.⁶⁸

THIRD ULTIMATUM

On 10 April 2014, Ms Wallis and Ms Wood met with Ms B and Mr S. They discussed the positive drug test and the relationship between the two of them. Families SA decided to stop any attempt at reunification including overnight contact. Ms B was told she needed to demonstrate change in the coming month as Families SA would be making a decision about applying for long-term orders. The following day, Ms Wallis transported Abby to O Lodge for further contact. Again, Ms B had to be woken. Ms B failed to clean or change Abby's clothes during contact, despite Abby having vomited on them during the trip.⁶⁹

In early May 2014, Families SA asked DCP in Western Australia for help to scope possible relative carers for Abby. The DCP could not assist, but suggested Families SA seek assistance from a non-government organisation.⁷⁰

Ms B's drug use and failure to attend appointments continued. Her engagement with a counsellor was short lived, ending in mid-May. She tested positive for cannabis twice in the second half of April and did not attend drug

tests in May and June. She missed two contact visits in May 2014 and was not present at O Lodge once when Abby arrived for contact. On another occasion, Ms B requested Abby be collected half an hour early as she had a sore back. When the worker arrived, at the original time not early as requested, Ms B yelled at her to pick up the 'fucking child'.⁷¹

On 21 May 2014, Mrs K provided detailed feedback to Ms Wallis and Ms Merckenschlager on Abby's response to contact, including that her behaviour after contact was the worst she had observed: within ten minutes of returning, Abby began to scream, throw tantrums and scratch those around her. At times, she remained unsettled for long periods. For a number of weeks, she had become concerned about falling when lying on the change table and was saying that she wanted to stay with Mrs K in the lead up to contact.⁷² This information did not alter the contact regime.

In late June 2014, after residing at O Lodge for about six months, Ms B was told she had to leave.

SECOND REUNIFICATION ATTEMPT

None of this curbed Families SA's enthusiasm for reunification. On 1 July 2014, Ms B returned to L House and signed an agreement to not allow Mr S into the premises. As Ms B's housing issues appeared to have resolved, Families SA decided that full reunification could proceed over the next six months. However, her relatives in Western Australia would also need to be assessed, either to support Ms B and Abby when they returned to Western Australia, or to care for Abby should the need arise. Ms Wallis completed a referral for a Family Care Meeting on the basis that Families SA would seek a further six month guardianship order.⁷³

Two days later, on 3 July 2014, staff at L House advised Ms Wallis that they were going to ask Ms B to leave. In breach of her agreement, Ms B had allowed Mr S into the premises and he stayed overnight. Ms Wallis advocated for her to remain, indicating if her accommodation broke down, it would end any reunification attempt. When reminded of her decision several months earlier to end her relationship with Mr S, Ms B said she had tried, but could not do so. Staff at L House agreed to allow Ms B to continue to reside there. Contact and reunification attempts continued.⁷⁴

On Friday 4 July 2014, Ms B had supervised contact with Abby. Later that evening, she left L House, failing to return until late Sunday night, when she appeared to be under the influence of drugs. Ms B admitted she had relapsed over the weekend, and she tested positive for cannabis and methylamphetamine. Ms B could no longer reside at L House, and Families SA finally decided to cease reunification.⁷⁵

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After consulting with principal Aboriginal consultant, Ms Groat, Ms Wallis decided that Abby needed a strong relationship with a family carer in Western Australia as soon as possible. She sought an assessment by a Families SA psychologist (not Ms Grigg), which was not done because the psychologist could not complete it in time for the court hearing for the long-term order.⁷⁶

DECISION TO SEEK A LONG-TERM ORDER

On 9 July 2014, Ms Wallis told Ms B that reunification would cease and Families SA would seek a long-term order. Ms B identified Ms G as a possible, though not her preferred, carer for Abby. Ms G confirmed she was still willing to care for Abby with the support of her daughter, Ms H. She agreed to come to Adelaide with Ms H to attend the Family Care Meeting on 30 July 2014.⁷⁷

Mrs K brought Abby to meet Ms G and Ms H at a playground while they were in Adelaide. No-one had told Mrs K that they were potential long-term carers. She realised that was the case from a comment made during the meeting. The meeting lasted no more than 45 minutes. The following day, Ms G and Ms H spent about 50 minutes with Abby during her contact with Ms B.⁷⁸

CULTURAL CONSULTATION

The application for a long-term order was first heard on 1 August 2014. Ms B did not attend and the matter was adjourned. On 7 August 2014, Mr and Mrs K emailed Ms Wallis and her supervisor Ms Wood setting out their wish to be considered as long-term carers for Abby, noting Abby's attachment to their family and their willingness to do whatever was required to maintain Abby's connection to culture. They wanted Ms B to know their commitment before she decided on her daughter's future.⁷⁹

In an email to the Ks on 8 August 2014, Ms Wallis commented:

*As you realise long term placement principles and practices for children, especially Aboriginal children, are set out in clear agreed documents which we all have to follow along with PAC and AFSS consultations.*⁸⁰ [Emphasis added]

On 8 August 2014, AFSS Cultural Consultant, Ms Plush, prepared a Cultural Consultation Report, as required by section 5(1) of the *Children's Protection Act 1993* (SA). She discussed the report with AFSS Manager, Anne Nicolaou. While Ms Plush supported the long-term order, she did not support the plan to move Abby from her placement, because it was contrary to Abby's best interests to disturb her attachment relationship with Mrs K. She recommended that Abby remain with the Ks, with her connection to family and culture strengthened with other strategies.⁸¹

Surprised at this view, Ms Wallis spoke with Ms Nicolaou. Ms Nicolaou supported Ms Plush's position and gave no undertaking that AFSS would review its position. Despite this, the Cultural Consultation Report was filed in Court on 11 August 2014, with an addendum report from Ms Wood stating that AFSS had agreed to review its position on the placement and case plan for the child by about 13 August 2014.⁸²

Ms Wood told the Commission that she included this information in the addendum report on the basis of advice given to her by Ms Wallis. Ms Wallis did not recall any undertaking being made by Ms Nicolaou or Ms Plush to review the report.⁸³

On 11 August 2014, Ms B consented to a long-term order, on the understanding that Abby would be placed with Ms G. On this basis a long-term guardianship order was made. AFSS did not review its position (subsequent to the order being made) and had never intended to do so.

THE TRANSITION PROCESS

After the long-term order was made, Abby had less frequent contact with Ms B. On 25 September 2014, persistent concerns with Abby's distress at separating from Mrs K at the start of contact came to a head. Abby's distress led to Ms B becoming upset and Ms B wanted Abby to return home with Mrs K. Ms Wallis and her supervisor, Ms Wood, decided Mrs K would no longer transport Abby to contact or be involved in the plan to transition to Ms G and Ms H, other than a 'meet and greet' visit. Ms Wallis considered that Mrs K should not be involved in any direct transfers of Abby to her new carers, on the basis that Mrs K had previously shown reluctance and over-involvement when transferring Abby to Ms B, causing Abby to become upset.⁸⁴

Relationships within Abby's care team became strained. On 26 September, foster care supporter of carers, Amber Elliott, recommended to Ms Wallis that Abby should be psychologically assessed. Ms Wallis refused, allowing only the possibility of a psychologist working with Abby during the transition, if required. Ms Wallis refused to accept Ms Elliott's suggestion that Anglicare's Aboriginal consultant could help ensure Abby's cultural needs were being met in her current placement. Ms Wallis explained that if Ms G and Ms H were approved as carers, Families SA would seek to transition Abby to reside in Western Australia. The process was dependent on Abby's response, but Ms Wallis thought at that time it would occur over a minimum of two weeks.⁸⁵

On 23 and 24 October 2014, Ms Wallis travelled to Perth to assess Ms G and her husband. The assessment form recorded no significant concerns. With respect to Abby's views and needs, the form noted that while Abby did not know Ms G, their relationship would be established during a transition period and Ms G was aware it might

be helpful to maintain contact with Mrs K to support Abby during the transition and afterwards. Ms Wallis recommended that Ms G and her husband be approved as ongoing carers for Abby.⁸⁶

On 30 October 2014, there was a case consultation between Ms Wood, Ms Wallis, psychologist Rachelle Smith and principal social worker Brenton Carr. Ms Wood supported the plan to transition Abby from her current placement to her Aboriginal family in Western Australia. Ms Wood and Ms Wallis expressed concern that Abby had 'an attachment disorder (possibly insecure)'—a conclusion not based on any psychological opinion or assessment—and that 'Abby's behaviour has never been a concern in contact with the mother but has been an ongoing concern for Mrs K'.⁸⁷

Following the case consultation, Ms Wallis met with psychologist Ms Smith to discuss a transition plan for Abby. They agreed that the transition should happen as soon as possible, given Abby's age and that it should be preceded by⁸⁸:

- an exchange of photographs of people, the home and pets;
- video calls between the Abby and her new carers; and
- Abby being told she would go to live with her new carers and given time to digest this information.

On the same day as the case consultation, Ms Wallis told Mrs K that Abby's relatives had been approved as her long-term carers and proposed a transition in November. Mrs K agreed to share information on Abby's daily routines, and her challenging behaviours and strategies for dealing with them. Ms Wallis again refused Mrs K permission to transport Abby during the transition on the basis that it would not be good for Abby. Mrs K asked for a longer transition period than one week and Ms Wallis advised that the length of transition would be determined with the psychologist on the basis of how Abby was coping. Ms Wallis agreed to Mrs K's request for photographs of Abby's new carers so that Abby would know what to expect. They also discussed Abby maintaining contact with Mrs K after she left her care, along with her need for attachment therapy in Western Australia.⁸⁹

On 9 November 2014, Ms Wallis sought approval for Abby to travel to Western Australia to live with her relatives long-term. She reported that initial stages of the transition plan had been implemented, including an exchange of photographs, telephone calls and Abby being told she would live with her birth family. In fact, none of these steps had yet occurred. The application was approved with a handwritten endorsement on the memorandum 'Excellent Outcome!'⁹⁰

On 10 November 2014, psychologist Ms Smith emphasised to Ms Wallis:

*Abby needs someone she knows well at visits with her, preferably her attachment figure/s, because her new carers are still largely unfamiliar people to her. She also needs us to work from her pace and build up gradually. Ideally, current and new carers should work together in a highly cooperative way that enables Abby to form familiarity and a growing bond with her new carers while she can still hold onto the relationships that have held her (her current carers). Abby should receive the message that her current carers and significant people in her life trust her new carers to meet her needs and are safe people to be around.*⁹¹

She also identified the need to track Abby through the transition process through observations and by asking those involved in the transition how Abby was responding, and to reassess and alter the plan, if required.⁹²

On 12 November 2014, Ms Wallis attended at Mr and Mrs K's home to show Abby a book of photographs of her relatives from Western Australia, along with photographs of their home and their pet dogs. Ms Wallis noted that Abby initially 'whimpered' on seeing her and 'went to Mrs K for a cuddle'. Ms Elliott, who was also present, assessed Abby as somewhat more distressed than that. Abby only partly recognised her family in the photographs. After showing Abby the book and talking about who and what was shown in the photographs, Ms Wallis assessed that Abby was not ready to be told that she was moving and asked Mrs K to go through the book with Abby 'each day in a fun way'. Mrs K agreed to do so and to receive telephone calls from Ms G afterwards.⁹³

Mrs K asked for the transition to be 'long'. Ms Wallis responded that the new carer had responsibilities to care for other children, but would stay 'as long as she can'.⁹⁴ On 13 November 2014, Ms Wallis telephoned Ms G to recommend that she start telephone calls with Abby and to say that Abby did not know yet that she was coming to live with them as she needed time to get to know her first.⁹⁵

On 18 November 2014, Ms Wallis contacted Ms G who confirmed that she could fly to South Australia with Ms H on Tuesday 25 November. However, Ms H had to return to Western Australia on Monday 1 December and Ms G could not say whether she would need to return at the same time or whether she could stay longer. This depended on her husband getting leave from work. Ms G had not yet telephoned Abby, but would try to do so later that day. When Ms Wallis telephoned Ms G the following day, Ms G explained that she had been sick and had not yet called Abby, but would try to that day.⁹⁶

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On 20 November 2014, Ms Smith and Ms Wallis telephoned Mrs K to discuss the transition plan. Mrs K wanted to prioritise Abby's needs during the transition by being part of the visits and transports. It was agreed that Mrs K would participate, as requested. Mrs K expressed the view that the transition was very short but that, while she did not agree with the plan, she would work with it. She agreed to tell Abby that she needed to live with her relatives after Abby met them and to reassure her that she supported the plan and would not lose contact with her.⁹⁷

Ms G and Ms H arrived in Adelaide on 25 November 2014 and the transition began the next day. Six days later, on 1 December 2014, Ms G and Ms H returned with Abby to Western Australia. The transition proceeded as follows.

On 26 November 2014, Ms Wallis took Ms G and Ms H to spend about an hour and a half with Abby at Mr and Mrs K's home. Ms Wallis did not remain during the whole period. However, she noted that Mrs K and Ms G were 'talking happily about maintaining contact' and that Abby was happy in Ms G and Ms H's company. That evening, Mr and Mrs K told Abby that she would be leaving them to live with Ms G and Ms H. Mrs K was not sure that Abby understood.⁹⁸

On 27 November 2014, Ms G and Ms H observed contact between Abby and Ms B before spending time with Abby having lunch, at the beach and a playground, without Ms B present, but observed by a support worker. They interacted positively.⁹⁹

On 28 November 2014, Mrs K transported Abby to spend time with Ms G and Ms H. Ms G and Ms H returned to Mr and Mrs K's house with Abby and had dinner with them. The events of this day were not observed by Families SA. Ms Wallis telephoned Ms G who reported that the day had been good, with Abby separating from Mrs K that morning without any problem and not asking for her. Ms Wallis recorded that Ms G was sounding happier and more confident as she built her relationship with Abby. Ms G later reported concern that Abby's mood changed when the Ks arrived, appearing angry towards the K family and acting out. Ms Wallis and Ms G reflected that Abby could be 'showing them her displeasure about the planned move'. However, this was not noted in the case file until 1 December, the day Abby returned to Western Australia.¹⁰⁰

The events on Saturday 29 November and Sunday 30 November also were not observed by Families SA. On Monday 1 December 2014, Ms G reported that Mrs K was three hours late transporting Abby and her belongings to them on the Saturday. Mrs K and her sister remained with Abby for about half an hour. Abby settled herself and presented as 'OK and not distressed' when Mrs K left.

Abby asked if she was going home to sleep and was told that she would be sleeping with Ms G and Ms H. She then slept through the night.

On the Sunday, the K family met with Ms G, Ms H and Abby to say goodbye. Ms G reported that Abby was fine in the morning, but changed after the Ks arrived and appeared a different child: angry, lashing out at the Ks and quite difficult to manage. Abby settled after the Ks left and slept well on Sunday night.¹⁰¹

When Ms Wallis arrived on 1 December 2014 to collect Ms G, Ms H and Abby to transport them to the airport, Ms B was present. Ms G said Ms B knew they were staying in Glenelg and had been 'scouring' the area to spot them. Ms B left after the car was packed and then met them at the airport. Ms Wallis remained with Ms G, Ms H and Abby at the airport until they checked in for their flight. At 1pm on Monday 1 December 2014, about 18 months after entering the Ks' care, Abby left South Australia with Ms G and Ms H. Ms B returned to Western Australia on the same flight. That evening Ms G sent a message to Ms Wallis to advise that the flight went really well and that Abby was settling in very well.¹⁰²

On the evening of 27 November 2014, Mrs K emailed Ms Wallis to express concern about Abby's reaction to the transition process:

I broached the topic of going to live with Nan and Auntie Ms H and she immediately responded with 'No, I stay Mummy K!' and began to cry at which I dropped the subject and comforted her. When I asked her about [contact], what she did and how it was, the first thing she said was, 'I hit Auntie Ms H', and looked quite sheepish.

After some reflection on your observations of Abby at [contact] today running up and hugging Ms B and then Ms H, I find it concerning more than heartening that she reacted to Ms H the way she did. What two year old child runs up and hugs a person she only effectively met the day before, a stranger? It is somewhat comforting to see they are making a connection, but Ms H flies out to work on Tuesday, the very day after Abby arrives at her new home, and will also be coming and going for work.

...

I must express to you my concern that this transition plan is appalling in expectation and length and in my opinion is not child-centred. I know you have been in consultation with professionals and I have heard all the reasoning but that doesn't mean that I, as the person that knows Abby best, think the Department is doing what is best for her within this plan.¹⁰³

On 2 December 2014, Mrs K spoke with Abby on the telephone. Abby asked Mrs K when she was coming to pick her up. It appeared that she was very upset during and after the telephone call. Ms Wallis later advised Ms G that she could decide whether to accept further telephone contact. Initially, Ms G did not want further telephone contact for one month and Ms Wallis duly suspended telephone contact for one month. After the month, Ms G still did not accept any further telephone calls from Mrs K.¹⁰⁴

About a week after Abby left South Australia, Ms Wallis went on leave before retiring.¹⁰⁵

OBSERVATIONS

A SHORT TIMEFRAME

Psychologist Megan Grigg specifically warned at the outset that Abby's attachment needs would need to be prioritised from about the age of nine months, leaving a window of only six months for reunification. She 'strongly recommended' that concurrent planning begin to identify a suitable kinship or foster placement in Western Australia.¹⁰⁶

Families SA's policies also emphasise the importance of prioritising attachment needs, particularly in young children:

Research and practice evidence clearly shows that continuity of attachment ties is essential to the overall healthy development of a child, and that when children and young people are separated from their birth families stable foundations must be re-established as soon as possible with their birth family or, where this is not possible, with an alternative long-term family. When children who have been abused subsequently experience disrupted or unstable care arrangements and the associated attachment and grief difficulties, harm can be compounded and their life potential can become significantly limited.

...

Timely decision making is particularly important for young children, as the very early years of a child's life have been identified as the most critical period for both brain development and the development of attachment relationships. After the preschool years, attachment patterns are much more stable and difficult to change.

*Expert opinion is that for younger children in particular, a decision about reunification should not take longer than six to twelve months.*¹⁰⁷

This urgency is reinforced by Families SA's evidence-based reunification assessment tool that reunification workers are expected to complete every six weeks. The tool recommends for infants who enter care before their first birthday that if the risk remains high after six months in care (or six of the last nine months in care), reunification efforts should cease.¹⁰⁸ This reflects the developmental dangers of prolonged short-term arrangements for an infant.

POOR CASE PLANNING

This guidance did not translate into Abby's case plan or her ongoing case management. In August 2012, Ms Mackie prepared Abby's case plan in accordance with a pro forma that is no longer used by Families SA. It was a convoluted, repetitive document that did not grasp the critical timing issues with any clarity. The overall plan was for 'Ms B to be reunified with Abby and then for them both to go and live with or near relatives (Ms G in particular) in Perth, Western Australia for support'.¹⁰⁹ The plan noted that 'Abby is a vulnerable infant who needs a secure primary attachment figure, and stability and consistency in her contact with family'.¹¹⁰ However, it did not set out clearly that this secure primary attachment figure needed to be involved in her life for the long term.

The plan did not grapple with the urgency of Ms Grigg's warning that Abby could wait only six months for long-term arrangements to be made, nor did it reflect her recommendation that concurrent planning occur. While the case plan recorded the need 'to prioritise Abby's attachment need when making decisions regarding her family contact and placement' and 'to consult with the Families SA psychologist in regard to Abby's attachment needs',¹¹¹ there is no evidence that these things happened.

In September 2012, after the case transferred to the reunification team, Families SA prepared a Family and Safety-Centred Assessment and Planning Framework, which also did not record the urgency of Abby's attachment timeframes and the ongoing need for concurrent planning.¹¹² Rather, it appears to have been assumed that Abby's wellbeing was secured as soon as she was removed from the unsafe situation and placed in alternative care, with no consideration of the ongoing impact on Abby of being in a temporary placement.

The reunification assessment tool helps practitioners weigh the child's need for permanence and stability against the promise of reunification. A principal social worker must authorise the overriding of the tool's recommendation.¹¹³ In Abby's case, the tool was repeatedly overridden.

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Ms Wood told the Commission that she could not recall an occasion when it had been possible to achieve reunification within six months.¹¹⁴ This suggests that overriding the tool is common Families SA practice, which ignores the emphasis it gives to the infant's stability and attachment needs. No serious consideration appears to have been given in Abby's case to the impact overriding the tool would have on her.

The Families SA Care Planning Policy required that:

*Case planning needs to be characterised by open and respectful communication and a process that involves the child or young person (as appropriate), the birth family, carer, professionals and other relevant parties in all elements. The process must clearly articulate the risks to be addressed, the expectations of parents and the changes required before the children can be returned to their care.*¹¹⁵

The documents in the case file did not clearly identify the changes that would be necessary for Abby to be safely returned to Ms B. The lack of clearly identified goals at the outset meant that, as the matter proceeded, decision making was reactive and crisis driven. Management of the case lacked focus, and the consequences of a failure to make identified and measurable changes were not set out.

EXCESSIVE OPTIMISM

Assessments by Families SA in this case were betrayed by excessive optimism about Ms B's potential to overcome multiple, entrenched, complex problems. The case was allowed to drift without timely decision making to give Abby the stability and permanence she needed.

Families SA practitioners gave Ms B a succession of ultimatums, each giving way to the next without apparent consequence. Threats of long-term orders if Ms B did not change proved hollow time and time again.

Ms Grigg recommended in her report that she be involved in consultations on possible reunification.¹¹⁶ Abby's case plan stated the Families SA psychologist would be consulted on her attachment needs.¹¹⁷ There is no evidence that this occurred. Ms Grigg told the Commission that, if she had been asked, she would most likely have advised against a second 12-month order. Given the prolonged uncertainty and the trauma of separating Abby from a foster parent who would become her psychological parent, Ms Grigg would have wanted 'really good signs that mum was almost ... there' to consider a second 12-month order.¹¹⁸ On any view, Ms B was not 'almost there'.

There was nothing to prevent Families SA returning to court before the second 12-month order expired to seek a long-term order. Perhaps with this in mind, Families SA gave Ms B a further ultimatum in August 2013 to demonstrate commitment over three months to avoid a long-term order. Ms B continued to take drugs; she missed contact or attended contact under the influence. The reunification assessment tool continued to recommend stopping reunification. In November 2013, Families SA told Mr and Mrs K's support worker that it would seek a long-term order,¹¹⁹ but no application followed, perhaps due to a loss of focus when the case transferred offices as part of the Redesign process.

The rushed attempt at reunification, in April 2014, was based not on a thorough assessment of Ms B's readiness for the next step, but on convenience and the needs of the adults in the situation. The summary given to the principal Aboriginal consultant included¹²⁰:

- the 2012 psychological assessment recommended reunification;
- Ms B had clear drug screens since December 2013; and
- Ms B was engaged with a Nunkunwarrin Yunti counsellor and seeking assessment for mental health.

Each point was misleading. The psychological assessment had recommended reunification be pursued for six months only. Ms B had not had positive drug screens since November 2013, but she missed scheduled drug screens in February which Families SA would usually treat as positive results.¹²¹ Between August 2013 and March 2014, Ms B attended only two sessions with Nunkunwarrin Yunti. She had agreed to meet a new counsellor in April 2014; she had not yet done so. Nunkunwarrin Yunti reported in July 2014: 'with only three sessions and many missed appointments, I feel it is early days yet to achieve any of Ms B's goals'.¹²²

As events turned out, Ms B was not abstaining from drugs and could not control her behaviour sufficiently to safely care for Abby. The reunification attempt was aborted, and the process appeared to cause Abby additional distress. A professional and dispassionate view of the situation would have shown that Ms B was nowhere near ready for Abby to return to her care.

Ms Wallis was asked why it was appropriate to consult with a principal Aboriginal consultant (who is not required to, but might, have social work qualifications) rather than a principal social worker on whether to bring forward reunification. Ms Wallis appeared to treat the principal Aboriginal consultant as the equivalent of a principal social worker, where the child concerned was Aboriginal, whatever the nature of the issue.¹²³ It is not possible to determine whether this was a perspective unique to Ms Wallis, or something more pervasive

than that. If the latter, it is of concern, as it allocates to Aboriginal children a different standard of clinical input to decision making than for non-Aboriginal children.

Families SA pursued reunification throughout mid-2014, despite Ms B continuing to take drugs, to miss contact and, on at least one occasion, to display aggression in Abby's presence. Signs of distress displayed by Abby before and after contact, including stating that she wanted to stay with Mrs K, were ignored. It is difficult to understand why reunification was pursued.

As late as July 2014, Ms Wallis completed a referral for a Family Care Meeting on the basis that Families SA would seek a further six month short-term order.¹²⁴ Twenty-six months after the psychological report recommended reunification attempts be pursued for no longer than six, a further extension was contemplated. This alone underlines the skewed view that workers concerned with the matter had developed.

Time and again, challenges were issued for Ms B to make changes but they were ignored. The practitioners appeared determined to pursue reunification at any cost, without considering the impact on Abby. Only when Ms B was evicted from her second stay at L House, did Families SA finally decide to seek long-term orders.

DEFICIENCIES IN CULTURAL CONSULTATION

Section 5(1) of the Children's Protection Act requires that a recognised Aboriginal organisation be consulted before any decision or order is made under the Act as to where or with whom an Aboriginal child will reside (see Volume 1, Chapter 16). In Abby's case, Families SA consulted AFSS only on court applications. It did not consult on other decisions about where Abby should live. Ms Wood maintained such consultation was not necessary.¹²⁵

This interpretation is too narrow. The Act requires consultation for any decision or order made under it as to where and with whom an Aboriginal child may reside. The Act gives the Minister power to make arrangements for the placement of children (whether with a guardian, a member of the child's family, an approved foster parent, or a facility suitable for that purpose).¹²⁶ Placement decisions for Aboriginal children in care are therefore made under the Act and trigger the consultation requirements. AFSS also considers that it should be consulted on placement decisions.¹²⁷

When applying for the second 12-month order, Families SA consulted with AFSS. Ms Plush made a series of recommendations to help maintain and strengthen Abby's cultural identity, but it does not appear that any effort was made to follow them. In particular, Ms Hoffmann rejected AFSS's advice to support Mr and Mrs K on Abby's cultural identity, taking the idiosyncratic

view that to do so would be 'tokenistic'. Many Aboriginal children need to reside with non-Aboriginal foster parents and supporting their cultural needs in that situation is profoundly important.

Ms Hoffmann also ignored advice to prepare a cultural maintenance plan on the basis that this also 'ran the risk' of being tokenistic. However, the South Australian Standards for Alternative Care require cultural maintenance plans for all Aboriginal children on entry to care, with input from local Aboriginal services/groups/forums and recognised organisations.¹²⁸

At the time of seeking the long-term order, Families SA again consulted with AFSS. Ms Plush's report supported the long-term order, but opposed the plan to move Abby from her foster parents. Ms Wood forwarded Ms Plush's report to the court, together with an addendum report stating that AFSS had agreed to review its position.¹²⁹ This statement was wrong. At no time did Ms Nicolaou give such an undertaking. Ms Wallis, the allocated caseworker, never claimed there was such an undertaking. Ms Wood said that she received the information second-hand, but did not take the time to confirm with Ms Nicolaou that what she was presenting to the court was accurate.¹³⁰

It is not necessary to determine how Ms Wood came to incorrectly represent Ms Nicolaou's position. What is important is that the court was given a misleading note which undermined the impact of a consultation report that the Act mandates be submitted to the court. It was inappropriate for Ms Wood to prepare that note without taking time to confirm its accuracy. There is no evidence that the error communicated to the court was ever corrected.

Ms Wood took the view that she did not need to further consider AFSS's perspective that Abby should remain with the K family, because ATSICPP 'talks about placing the child within their kinship as a priority'.¹³¹ She believed that the legislation in its reference to ATSICPP supported the plan to return the child to Western Australia. Ms Wallis told Mrs K that the decision was made on the basis of 'culturally advised practice and procedure that we needed to follow'.¹³² This is a simplistic understanding of the legislation which, as discussed below, requires that overriding consideration be given to a child's best interests.

The failure to follow up an addendum consultation report or to make any effort to properly understand the basis for the difference of views smacks of a determination to proceed with a fixed plan and an unwillingness to listen to alternative points of view. It demonstrates a lack of regard for the views of others, in particular the views of the recognised organisation. A consultation which is given weight only if it supports a pre-determined decision is no consultation at all.

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In her statement to the Commission, Ms Plush said:

It's really difficult to know whether anything I put down is actually followed ... The difficulty is the way it is written is that the Department should consult on where and with whom a child is to live, but they use the principal Aboriginal consultants within Families SA for that role, as opposed to my role. They tick a box by requesting my report, but whether it's genuinely followed or given any sort of consideration, or whether they just go ahead with what they intended to do anyway, I don't know.¹³³

The consideration given by Families SA to Ms Plush's consultation reports in both 2013 and 2014 suggests that, in this case at least, the recommendations were entirely disregarded.

THE APPROACH TO PLACEMENT

The requirement in section 5(a1) of the Children's Protection Act to place a child in accordance with ATSICPP establishes the basis for keeping children within their families and communities to maintain their links with family, community and culture (see Volume 1, Chapter 16). Its significance is broader than a mere placement hierarchy. It implies a partnership between government and Aboriginal communities in decision making about children's welfare. It requires robust, effective consultation with Aboriginal organisations.

At the same time, ATSICPP is subject to the overarching objects of the Act, including the need to keep children safe from harm and to care for them in a way that allows them to reach their full potential. It is plain that pursuit of ATSICPP must not compromise a child's rights to safety and the opportunity to reach their full potential.

Because Aboriginal children have the same need for stability and permanence as other children, ATSICPP should be applied early and potential carers identified at the outset. Wherever possible, this means helping Aboriginal carers to care safely for Aboriginal children; it also means not setting up long-term connections of Aboriginal children with non-Aboriginal carers only to sever them by the belated application of ATSICPP.

In Abby's case, Families SA practitioners were strongly motivated by a desire to comply with ATSICPP and, more generally, to maintain and strengthen Abby's connection to land, language, community and culture. One obstacle was the limited range of suitable Aboriginal carers that AFSS could offer Abby, and she resided with a number of non-Aboriginal carers, including Mr and Mrs K.

At the same time, Families SA repeatedly turned down potential Aboriginal foster parents because they lived too far from the mother and would have required too much travel for contact. Considerable weight was given

to Ms B's convenience, without countenancing Ms B, not Abby, travelling to contact. In May 2012, Abby was thus placed in a short-term emergency foster placement with more than the maximum number of children for whom the foster parent had been approved. As at early 2013, Abby had remained in residential care with rotational carers for five months, an arrangement which offered her no chance to develop a secure attachment relationship.

Ms Hoffmann, Abby's caseworker was 'horrified' by the idea of an infant being cared for in rotational care.¹³⁴ Ms Grigg, the psychologist, described rotational care for infants as 'highly detrimental'.¹³⁵ Rotational care, quite simply, prevents infants from forming the secure attachment relationships they need for their brain development.

The pattern of decision making in this case failed to prioritise Abby's attachment needs. Nor did it comply with ATSICPP.

INTERSTATE TRANSFER

Abby had relatives in Western Australia who were apparently willing to care for her long term, and could meet both her attachment and cultural needs. Where a child's community of origin is located outside the jurisdiction, ATSICPP permits consideration of placement outside the jurisdiction. Jurisdictional difficulties should not get in the way of making decisions that prioritise a child's best interests.

Interstate transfers of child protection orders (as defined in section 54) may be transferred by administrative arrangement between respective departmental chief executives, or by application to court.¹³⁶ The Act also contemplates the transfer of proceedings, defined as any proceedings brought in a court for the making of a finding that a child is in need of care and protection.¹³⁷ The *Children and Community Services Act 2004* (WA) provides for the registration of orders transferred under an interstate law in the Western Australian court and for the resolution of transferred child protection proceedings in Western Australia.¹³⁸

In each scenario, the relevant departmental chief executive must consent to the transfer. A protocol governs the relationships between states for the transfer of care and protection orders.¹³⁹ The protocol provides that the receiving state *must* accept a transfer unless it is contrary to the child's interests, or is an exceptional case where it is clearly impractical to accept the transfer or is not legally possible.

A receiving state declining to accept a transfer must provide a written statement outlining the reasons for their decision. A sending state may request that the decision to decline be reviewed by a senior officer. The protocol provides that decisions about accepting

transfers must be made within three months, as long as the request is accompanied by all the necessary information.¹⁴⁰

In this case a transfer either of the proceedings (the application for a 12-month guardianship order) or the order, once it was made, was legally possible. The relevant legislation contemplated the transfer and a protocol was in place which could be considered if resistance to the transfer was encountered.

An early transfer of the case to Western Australia was clearly the best option for Abby. It offered her a potential placement that would serve her immediate needs while reunification with Ms B was pursued, or a long-term, alternative placement should the need arise. Consistent with ATSICPP, this option allowed her to remain connected to family, culture and community.

It is inexplicable that Families SA (believing erroneously that DCP had refused the transfer) did not regard the case worthy of escalation to executive level. Abby was an Aboriginal infant entering her active attachment phase and the case notes suggested it was likely that a suitable kinship placement would be available in WA. The gravity of the situation warranted a formal letter of request, and if that did not succeed, escalation of the issue in accordance with the protocol.

The approach displayed a lack of understanding of the protocol governing the transfer of orders and proceedings. Ms Mackie appeared not to know, nor to have made any attempt to understand, the process by which a transfer might be accomplished. She appeared to rely on an experiential understanding of what was possible and practicable.

These actions reflect an organisation that failed to analyse the issues from the child's point of view. Throughout, Families SA adopted the path of least resistance rather than advocating a solution which gave the child the best outcome.

DELAYS IN CONCURRENT PLANNING

Ms Grigg 'strongly recommended' that Families SA plan concurrently for both Abby's return to her mother and a suitable long-term placement, in case it was needed, preferably with relatives or a foster parent in Western Australia.¹⁴¹ Ms G and Ms H were identified as potential carers and Families SA planned that they would be assessed by DCP. The case plan prepared by Ms Mackie, before transfer to Ms Hoffmann, also noted Ms G's contact details were recorded on C3MS.¹⁴²

In evidence, Ms Hoffmann appeared confused about what concurrent planning for a long-term placement in Western Australia might have involved. Case notes revealed that Ms Hoffmann made telephone contact with

Ms C, Ms B's great aunt in May 2013, about three months before the first 12 month guardianship order expired. The call related in part to an enquiry about the whereabouts of Ms B, but concluded with discussion about Ms C's capacity to provide long-term care. Ms C said that her health prevented this and she did not know of anyone else on her side of the family who would be suitable.¹⁴³

There is no evidence that Ms Hoffmann contacted Ms G or Ms H, despite the fact that they were clearly identified on the file as relatives willing to be considered as long-term carers. This is supported by Ms G's statement to Ms Wallis when eventually contacted about providing long-term care that 'she had been asked to care for Abby about two years ago and she had spoken to her husband about this and they had agreed to do this, but this had not happened.'¹⁴⁴

Ms Hoffmann said about concurrent planning, that she:

*asked mum if there were people that she would recommend, out of respect, and spoke to the auntie about if she knew of anyone else. But apart from that, no.*¹⁴⁵

This overlooked the important work already done to identify suitable carers. When asked if there were barriers to assessing kinship carers and having them get to know Abby a little, Ms Hoffmann said there would simply not be enough time in a social worker's case load to do a formal assessment.

Ms Hoffmann's supervisor, Ms Wood, referred to the contact Ms Hoffmann had with Ms C, but maintained in evidence: 'from my understanding Ms B was very reluctant to give Ms G and Ms H's names to us and they came very late onto the scene'.¹⁴⁶ In late 2013, Ms Hoffmann prepared a further case plan stating under the heading 'concurrent planning' that Families SA would liaise with Western Australian relatives about an appropriate long-term placement.¹⁴⁷ This was the same recommendation that Ms Grigg made in July 2012 which had not yet been actioned.¹⁴⁸

No concurrent planning was ever done. Ms G and Ms H were assessed as carers and encouraged to build their relationship with Abby only after July 2014 when reunification had clearly ceased.

CONTACT ARRANGEMENTS

Ms Wood said in her written statement to the Commission that Ms B's contact visits were supervised, and that contact would not proceed if she presented under the influence of drugs. Ms Wood also said, 'Ms B always tried to put Abby's needs first when she came, and her contact visits were really lovely, they had a good connection the two of them'.¹⁴⁹

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The observation records suggest that Ms B was not regular in her attendance at contact. The records also show that there were occasions when she could not prioritise Abby's needs above her own and became angry and behaved in a way that upset Abby. Ms B was observed to be under the influence of drugs at contact, but it was permitted to continue nonetheless.¹⁵⁰ When Abby displayed signs of distress before and after contact and asked not to go, these signs were ignored.

Contact which is pursued incorrectly or for the wrong reasons can undermine a child's development. Children have a right to safety from harmful contact experiences with their family. They need to know that the caring adults around them see and hear their distress and will protect them.

A FORESEEABLE OUTCOME

The haste with which the decision to transition Abby to kinship carers in Western Australia was eventually made highlights that ATSICPP was applied in a mechanistic way, without weight to the other legislative requirements such as stability and the best interests of the child. A proper consideration of those issues might well have come to the same decision, but it was a decision that warranted much closer consideration than appears to have been given.

By July 2014, Abby was two years and four months old. She had spent five of those 28 months in rotational care and 14 of them in the care of Mr and Mrs K and their family.

Families SA became faced with two unpalatable options for Abby: deny her the only family she had come to know and with whom she had developed an attachment, or deprive her of everyday contact with her biological family and the cultural immersion that would offer. The dilemma is aptly described in the AFSS Cultural Consultancy Report:

Unfortunately AFSS was not consulted earlier in relation to Abby's situation, and this late presentation of the plan to move Abby to a new placement with interstate relatives who she does not know, leaves the Cultural Consultant with a significant dilemma: whether it is best for this young Aboriginal child to remain in the care of her non-Aboriginal carers, to whom she is attached, and who have given her stable and loving care, or move her to a new placement, with family members who have recently indicated that they are willing and able to provide a culturally appropriate place for her?

It would have been far preferable had proper planning and consultation occurred early in the piece to avoid such compromised outcomes.¹⁵¹

Ms Wood, who made the decision that Abby would return to Western Australia, told the Commission that remaining with the foster parents was not a possibility that she had ever considered. Although returning to Western Australia in the care of Ms B or kinship carers was an option identified at an early stage as being in Abby's best interests, it was made on the basis that reunification work would proceed for no more than six months and a prompt decision would be made about a long-term placement. The scenario that faced Ms Wallis and Ms Wood by July 2014 was quite different.

The decision was a difficult one and not *necessarily* wrong. However, the Families SA workers did not appear to appreciate the complexities that poor case management had introduced into the situation. A lack of planning throughout became a situation of urgency which played out in the months of August to November 2014.

The case notes suggested that a psychological assessment was thought appropriate but was left too late to be completed in time for the Youth Court hearing. Mrs K had been keen for a psychological assessment and Ms Wallis had been aware of that for some time before the hearing. The request was repeated by Mrs K with the support of Ms Elliott at the meeting on 26 September 2014. Ms Wallis thought an assessment with such a young child had limitations, and there was no point having psychological input to help Mrs K to manage Abby's behaviours.¹⁵² Her earlier case note however suggested she believed an assessment would be a worthwhile exercise.

Ms Wallis told the Commission that there was a dual purpose in seeking the psychological report—to help both the Youth Court and transitional planning. Ms Wallis conceded that Abby's transition from the K family to her kinship carers was a complex event for Abby. She said that once it was clear the report would not be available for the Youth Court, she did not pursue it. She said that she had no idea how long she would have to wait to obtain it and there were strict parameters around the circumstances in which such a report could be provided.¹⁵³

Ms Grigg confirmed that from a psychological point of view transition planning must be approached with great care. She explained that:

I think there would have to be a high level of information and planning and discussion around the needs of that specific child, and that would really need to involve both the current carer and the new carer. They would both need to be very involved in the process. So a lot of information sharing about what the child's needs are, what their routines are, what their favourite things are—really detailed planning so that everyone is on the same page about that child.

*You would certainly need to build up familiarity with that new carer, and you would also need to do that with the support of the current carer where possible. So hopefully having joint visits together, the current carer talking about the new carer, photos, discussions, story books, all those kind of things to help the child familiarise themselves with that person if that person is not already familiar.*¹⁵⁴

Ms Grigg highlighted that transitioning a child who already had some attachment difficulties would be more, rather than less, complex. She told the Commission she would be concerned about a five-day transition period for a child of Abby's age to carers with whom she had no previous relationship. She noted that the process of transition for a child who had spent as long with a foster parent as Abby had with Mrs K would be traumatic for the child 'no matter what'. This was so, whether or not the child was exhibiting external signs of internal distress. Indeed, it would set off 'alarm bells' if a child in these circumstances did not show signs of distress.¹⁵⁵

Ms Nicolaou, an experienced social worker, said that a child of Abby's age had a high level of vulnerability in a transition process. Children at that age, she observed, were less resilient than older children who would have a stronger sense of their place in the world, a more defined sense of identity.¹⁵⁶ In her opinion, a child of Abby's age would require a period of weeks or months to transition to new carers with whom she had no previous relationship.

Ms Nicolaou was realistic about the practicalities of such demands. She recognised that such a timeframe would not always be possible. However, she maintained that the needs of the child would always be the starting place, and you would then work back from there.

The transition plan created for Abby lacked the required level of planning. It did not start from a point of Abby's best interests, but from a timeframe acceptable to the new caregivers. No effort was made to question the limitations placed on the timeframe by the new caregivers. No effort was made to think more about the transition timeframe or to approach the movement of the child from one caregiver to another with any creativity.¹⁵⁷

At the time of the five-day transition in November 2014, Abby was aged two years and eight months, and had lived with the K family for 18 months. She had spent only an hour or so in the presence of her new carers four months previously.

Ms Wallis told the Commission that the transition plan was flexible, and could have been changed depending on how Abby was coping. Ms Wallis felt that she would have observed it if the child was not coping. She could not recall whether the psychologist gave any advice

about the caution that ought to be exercised around a child of Abby's age not displaying any distress about the circumstances of the transition.¹⁵⁸

Ms Wood had a different recollection. She believed that they were alive to the possibility that behaviours displaying distress might not show until after the transition was finished and Abby was in WA.¹⁵⁹ However, it was unclear how this impacted on their ability to slow or change the transition plan if necessary.

Ms Wallis was asked why no consideration had been given to possibly transitioning Abby in the school holidays when the new caregivers might have been able to stay for a longer period of time. Ms Wallis said:

*We're talking about the timeframe on attachment running out at three years. We're talking about trying to do this from July onwards. We're talking—so you're talking about did we consider extending it for another two or three months? No we didn't.*¹⁶⁰

The reunification process had extended for far too long without any concurrent planning to help the new carers or to enable them to develop their relationship with Abby. However, there was now a rush to move Abby to a permanent placement before her primary attachment window closed—and Abby's needs were sidelined.

No-one involved in managing this case could satisfactorily explain the lack of concurrent planning. All their efforts were put into reunification, with scant consideration of building the basis for a good transition to permanent alternative care. Ms Hoffmann and Ms Wallis both seemed to be unaware that Ms G had been approached earlier and at least appeared to be suitable to provide long-term care.

Ms Wallis described Abby getting onto the aeroplane with her new carers as a 'very calm little girl'.¹⁶¹ This description brings to mind the evidence of Ms Grigg, that a child involved in a quick transition showing no apparent signs of distress should set off alarm bells. Similarly, Ms Wallis was taken to information from Mrs K that Abby was distressed and aggressive in her care during the transition. She dismissed the observation as being consistent with ongoing problems, and associated with tiredness, rather than reactive to the particular transition circumstances.¹⁶²

Ms Wood was more realistic about the impact of the transition on Abby, noting that it was unlikely that they would see problematic behaviours until after the move had been made.¹⁶³ Taking into account the evidence of Ms Grigg about the dangers of relying on an absence of distress as evidence of lack of trauma or lack of coping, the idea that the transition would be slowed if Abby showed signs of distress was meaningless.

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A BROADER VIEW OF THE ROLE OF FOSTER PARENTS

Mrs K was distressed about Abby's move from her care. She hoped that she and her husband would be considered as long-term carers. Ms Hoffmann's statements encouraged her to believe that might be possible. As Abby's full-time carer for 18 months, Mrs K had much to contribute to any discussion about support for Abby during any transition. However, little heed appears to have been given to her information and advocacy on behalf of Abby.

Ms Wallis took the view that Mrs K found it emotionally very difficult to let go of the child. Ms Wallis had a clear view of the limits of the role of a foster parent, particularly the foster parent of a child on a short-term order. Ms Wallis recounted an incident where Mrs K, having handed Abby over to her mother at a contact visit, then turned around to kiss Abby. Ms Wallis described that action as 'crossing boundaries when you're trying to establish a good relationship with the mother. You expect the foster parent to help support the child to come across'.¹⁶⁴ Rather than discuss the issue and negotiate with Mrs K, Ms Wallis simply decided that Mrs K should no longer transport Abby to contact visits. Ms Wallis speculated in a case note taken during a particularly difficult contact that Mrs K may have told Abby that it was the social worker who said she had to go to contact.¹⁶⁵

Ms Wallis displayed a narrow view of the role of foster parents in the care system. On occasion she appeared to show a lack of respect for Mrs K's role in Abby's life. For example, when Mrs K was asked to bring Abby to meet the prospective relative carers visiting Adelaide, she did not tell the Ks the visitors were being considered as long-term carers.¹⁶⁶

Ms Wallis took the view that foster parents cannot be invited to Family Care Meetings because they are 'not part of the family'.¹⁶⁷ She noted that some foster parents would be obstructive to the aims of the family court process.¹⁶⁸

However, section 30(1)(d) of the Children's Protection Act provides for invitations to be forwarded to 'any other person who has had a close association with the child and who should, in the opinion of the Co-ordinator, attend the meeting'. In appropriate cases, this could include a foster parent. Permitting Mrs K to attend the meeting and to be a part of the discussion about Abby's long-term care may also have reassured Mrs K that everyone had Abby's best interests at heart. It would have allowed her to be a part of planning for transition. The last-minute nature of the planning and decision making and a lack of understanding about the potential scope of the meetings made that approach impossible.

Ms Wallis's attitude towards Mrs K and her view of the limited role she had to play in making decisions for Abby was obvious during the evidence. A more inclusive and collaborative approach, which assured Mrs K that she was being heard and which placed weight and value on her advocacy for Abby might have lessened Mrs K's dissatisfaction with the process. If Abby had been assessed by a psychologist and been able to speak to that psychologist, Mrs K may well have found it easier to accept that everyone had Abby's best interests at the front of their minds.

CONCLUSION

The observations in this case study identified issues and themes that have informed discussions and conclusions principally in Volume 1, Chapters 9 and 16 of this report.

Practitioners require additional training, support and clinical supervision to help parents deal with multiple, complex problems, and make realistic assessments of the viability of reunification. The recommendations in Chapter 9 to promote permanency and stability should help prevent cases from drifting as Abby's did, without due regard to the impact of prolonged uncertainty and instability. The recommendations in Chapter 16 should encourage practitioners to consult meaningfully with Aboriginal organisations and to apply ATSICPP in a way that supports children's connection to culture and community while not compromising their broader wellbeing.

NOTES

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- 2 Families SA, Report in support of an application for an investigation and assessment order—Abby; DCP, 'Safety and wellbeing assessment: Approved outcome report'—Abby.
- 3 DCP, 'Safety and wellbeing assessment: Approved outcome report'—Abby, 23 November 2011; DCP, 'Request for interstate notification'—Abby, internal unpublished document, no date.
- 4 DCP, 'Request for interstate notification'—Abby; DCP, 'Safety and wellbeing assessment: Approved outcome report'—Ms B; Families SA, 'Report in support of an application for an investigation and assessment order—Abby'.
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- 6 Families SA, Report in support of an application for an investigation and assessment order—Abby.
- 7 Oral evidence: C Mackie. Families SA, Report in support of an application for an investigation and assessment order—Abby; Families SA, 'Safety plan'—Abby, internal unpublished document, 4 April 2012.
- 8 Families SA, Report in support of an application for an investigation and assessment order—Abby.
- 9 *ibid.*
- 10 Oral evidence: C Mackie. Families SA, Report in support of an application for an investigation and assessment order—Abby.
- 11 *ibid.*
- 12 *ibid.*; Families SA, Report in support of an application for an investigation and assessment order—Abby; Families SA, C3MS records—Abby, internal unpublished documents, 27 April – 8 May 2012.
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- 16 M Grigg & J Elford, 'Psychological assessment'—Abby, p. 12.
- 17 M Grigg & J Elford, 'Psychological assessment'—Abby.
- 18 Youth Court of South Australia, Care and protection order—Abby, internal unpublished document, 3 August 2012.
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- 20 Aboriginal Family Support Services (AFSS), Contact records—Abby, internal unpublished document, May 2012; Families SA, C3MS records—Abby, 14 May 2012.
- 21 Oral evidence: A Elliott. Angicare, Case notes—Mr & Mrs T, internal unpublished document, July–December 2012.
- 22 Oral evidence: S Hoffmann.
- 23 Oral evidence: A Elliott. Families SA, C3MS records—Abby, December 2012.
- 24 Oral evidence: C Mackie.
- 25 *ibid.*
- 26 *ibid.* C Mackie, email to M Borgas, 1 June 2012.
- 27 Oral evidence: C Mackie. L St John (Department of Child Protection), email to M Borgas & C Mackie, 1 June 2012.
- 28 Oral evidence: W Wallis; S Hoffmann. Families SA, 'Case plan'—Abby, internal unpublished document, 14 August 2012.
- 29 Oral evidence: C Mackie.
- 30 *ibid.*
- 31 Oral evidence: C Mackie; S Hoffmann. Families SA, 'Case plan'—Abby; Families SA, C3MS records—Abby, 5 June 2012.
- 32 Families SA, 'Case plan'—Abby, 14 August 2012.
- 33 Families SA, C3MS records—Abby, May–August 2012; Healthscope Pathology, Drug screening results—Ms B, internal unpublished documents, 11 May – 2 August 2012.
- 34 Families SA, C3MS records—Abby, 21 & 24 September 2012.
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- 41 *ibid.*, 18 February 2013.
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- 49 AFSS, Contact records—Abby, 24 July 2013.
- 50 Families SA, Report in support of an application for a care and protection order—Abby, 24 July 2013.
- 51 Oral evidence: S Hoffmann.

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CASE STUDY 3 HANNAH—LEAVING CARE

OVERVIEW

'Hannah' was in the care of the state between the ages of nine and 18. During those nine years she experienced multiple placements in both foster care and residential care. At the age of 16 Hannah was disengaged from any education or training, and was cared for in a series of short-term foster placements. Hannah's treatment in her early developmental years and the subsequent instability that dominated her journey in care rendered her highly vulnerable to exploitation by adults in the community, and made supporting her path to independence challenging. This case study examines the difficulties Hannah faced as she approached the age of 18, in the knowledge that the support of Families SA was about to cease and she would be required to live independently, making her own decisions and supporting herself.

Hannah's experience of negotiating these challenges between the ages of 16 and 18 may shock many families who would not consider asking the same of their own children at that stage in their lives. Young people transitioning from care to independent living often face greater challenges in establishing themselves, against a background of considerable vulnerability, and are expected to do so at a much younger age than their peers.

This case study examines how Families SA and other service providers supported Hannah to negotiate these challenges, and what improvements are needed to better support children leaving care for adulthood.

EVIDENCE

HANNAH'S EARLY YEARS

Hannah was born in South East Asia in 1996. Her mother suffered from ongoing mental health issues and Hannah was her eighth child. While still an infant Hannah was abandoned at a hospital when the relationship between her parents broke down. She was then cared for in an overseas orphanage until the age of three-and-a-half. Hannah was then transferred to a family-based placement to prepare her for adoption. An Australian couple adopted Hannah when she was four years old.

Hannah's early childhood experiences left her with emotional and psychological challenges, with which her Australian family struggled. They sought professional assistance from many organisations, including Child and Adolescent Mental Health Services. Hannah had just turned nine when her adoptive parents relinquished her to the care of the Minister. Although contact with them initially continued for a few hours a week, this soon ended at Hannah's request. Hannah had no contact with her adoptive family thereafter.

On her entry into care Hannah was placed in short-term emergency foster care before being moved into a large residential care unit. The unit housed boys and girls and was staffed by carers who worked rotating shifts. She was nine years old when she entered this placement. At the age of 11, Hannah was placed in specialist foster care in a country town with Ms T. This placement lasted three-and-a-half years and ended due to Hannah's mental health and behavioural issues. Afterwards, however, Hannah remained close to her foster mother, Ms T, who continued to be a source of support to her throughout her later teenage years.

By the age of 10, Hannah had been diagnosed with an attachment disorder, conduct disorder, dysthymic disorder and separation anxiety, all of which originated in her early childhood experiences. They had not been ameliorated by her care once she was placed under the guardianship of the Minister.

THE BACKGROUND TO INDEPENDENT LIVING

In December 2011, at the age of 15, Hannah was living in a residential care facility run by a non-government organisation. She struggled to cope emotionally in that environment. Her distress culminated in an attempt to commit suicide and a subsequent admission to the Women's and Children's Hospital. Following her discharge, Hannah was placed in short-term emergency foster care. She had become disengaged from education, and the fact that no long-term care could be found made it difficult for her to settle sufficiently to re-enrol in any education or training program.

The short-term arrangement drifted into the longer term, notwithstanding that the agency supporting the foster placement held concerns that the carer did not have good parenting skills, and was unwilling to accept support and guidance. Particular concerns existed that the carer would use physical restraint, and was unwilling to recognise the inappropriateness of this approach. Ultimately the carer terminated the placement, indicating she had no idea how to handle Hannah's behaviour.¹ Hannah was moved on to yet another short-term foster placement.

When Hannah was still 15, Families SA became aware that she was associating with an adult by the name of Mr B, who was known to harbour children under the guardianship of the Minister when they went missing. Families SA feared that Mr B was exploiting Hannah for sexual purposes.

The concerns held by Families SA about this relationship came to a head in June 2012. Fifteen year old Hannah went missing for an extended period and Families SA staff were unable to locate her, although it was strongly suspected that she was staying with Mr B.²

A case conference was convened, attended by Hannah's caseworker, Nadine Franklin, and the supervisor, Keiron Andrews, along with other social workers who might be able to help. The case conference identified a number of strategies to find Hannah and bring her home safely.

One of the strategies was to 'follow up with legal measures (written directives etc.)'.³ A cautionary letter was to be sent to Mr B, warning him of 'potential legal action' if he did not cooperate with Families SA.⁴ Mr Andrews told the Commission that the legal action being contemplated was the criminal offence of harbouring a child who is under the guardianship of the Minister and who is absent from a placement.⁵ There was no evidence that the proposed cautionary letter was sent. No such letter was uploaded to the C3MS system, although Mr Andrews and Ms Franklin both thought that they had seen a draft at some point.⁶

Another option available to Families SA, and discussed at the case conference, was to issue a written direction to Mr B pursuant to section 52AAB of the *Children's Protection Act 1993*.⁷ This would require Mr B to refrain from communicating or attempting to communicate with Hannah, placing the obligation on Mr B to cease the relationship. Disobedience to a written direction is a criminal offence.

A short time later, however, Hannah was located at a suburban shopping centre and returned to her foster care placement. No written direction was issued to Mr B by Families SA. Ms Franklin continued to manage this issue by emphasising in discussions with Hannah that the relationship with Mr B was unhealthy and not in her best interests.

JULY 2012 EVENTS

Hannah again went missing on 2 July 2012.⁸ Families SA filed a missing person report which recorded a suspicion that she had returned to the home of Mr B. On Friday 6 July 2012 Ms Franklin spoke with Hannah and Mr B. Hannah would not disclose where she was but confirmed that she was safe. Ms Franklin explained that Mr B was breaking the law if he continued to harbour Hannah. During the telephone call Ms Franklin arranged for Hannah and Mr B to meet with workers to develop a plan to stop Hannah running away from her placement.⁹ Ms Franklin told Hannah to 'keep safe' and that she would call her on the Monday.¹⁰ Although Hannah had been contacted, the missing person report filed with the police was not deactivated by Families SA.

Ms Franklin accepted in evidence that her statement to Hannah that she should 'keep safe' and she would call her after the weekend might have given Hannah the impression that Families SA was content for her to remain with Mr B for the moment.¹¹ She told the Commission

that she had emphasised to Hannah that Families SA did not support her relationship with Mr B, but she did not necessarily repeat that during the telephone call.¹²

At this time Hannah's placement was in short-term foster care supported by Life Without Barriers (LWB), a registered foster care agency. LWB sought clarity from Families SA about how Hannah was going to be managed over the weekend of 7–8 July 2012. On ascertaining that Families SA had determined not to make any assertive effort to locate her, and as she was not at her foster care placement, LWB took the view that they were not prepared to manage her wellbeing over that weekend.¹³

LWB staff sought an assurance that Families SA would 'risk manage' the placement over the weekend.¹⁴ The request for confirmation was met with the following email authored by Mr Andrews and addressed to Hannah's caseworker¹⁵:

As we discussed earlier today, we don't actually know where Hannah is. We believe she will be with Mr B, we believe there's a more than reasonable chance that she's staying there, but you'd have to think that she'd be expecting us to turn up. As you can recall from our phone call with Hannah earlier today, neither party is feeling obliged to tell us where they are.

Under these circumstances, Families SA's hands are tied. We could go to Mr B's home again, bang on the door and not have them answer it. We could even ask the police to open the door for us, not that they would. We could force or goad Hannah into going to another carer and she will be gone before we close the front door. I am inclined instead to leave it for the next 2 days, we have a commitment from Hannah that she will talk with yourself and Ann about how they can make their relationship work while remaining in a stable placement. I believe that pushing any further at this moment without being sat in front of her will only drive Hannah deeper underground.

It isn't a matter of Families SA choosing for Hannah to stay with Mr B; it's a matter of Families SA choosing not to pursue the matter for the next 2 days in the hope that we can talk some sense into her on Monday.

Feel free to share this email with ... Ann from LWB

On Saturday 7 July 2012, Hannah was located by police who were acting on the missing person report. The police intended to return Hannah to her foster care placement and contacted LWB on its after-hours telephone number to make the arrangements.¹⁶ On the strength of the email and the other conversations that had occurred, LWB told police that Families SA was content for Hannah to remain with Mr B over the weekend.¹⁷ Hannah therefore remained at Mr B's home with the apparent agreement of Families SA.

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Mr Andrews accepted in evidence that in hindsight, the message that ‘Families SA [was] choosing not to pursue the matter’ could have been misinterpreted. In context, aspects of the email authored by Mr Andrews were capable of being interpreted as an acceptance, in the short term, of the status quo.

The possibility of legal orders to prevent Mr B from having contact with Hannah was raised again with Mr Andrews in an email sent on 25 July 2012 by a staff member from LWB.¹⁸ Mr Andrews responded to the email, asserting that he was ‘fully aware of the existence and use of intervention orders in many contexts including this one and the recommendations of the Mullighan Inquiry’.¹⁹ He explained that Hannah was ‘not willing to be a party to the application’ and therefore he did not think that such an order would change her behaviour. He told LWB that the police already had the option of charging Mr B with a criminal offence in relation to the sexual relationship if they were so inclined.

Mr Andrews was asked in evidence whether he saw a role for the use of written directions in securing the safety of young people. His view of their application was very limited:

I think, if Hannah was absconding to a well-meaning adult member of society’s home who was convinced that Families SA just wasn’t caring for her, and we were having trouble having that reasonable adult help us provide a safe place, then yes, there is a role for them.²⁰

Mr Andrews was asked about the circumstances in which he might revisit the question of a written direction to keep Hannah safe. He said that:

I’m not sure that we were able to plan that long term with Hannah, at the time, to be honest. It was more like whenever we had an opportunity to reach her and talk to her, we would try and cram as much guidance and common sense into those little windows as we could.²¹

Mr Andrews held the firm view that issuing a written direction would have no impact on Mr B’s behaviour. He told the Commission that given that Mr B was prepared to risk the legal consequences of having a sexual relationship with 15 year old Hannah, he saw no reason to think that a written direction would dissuade him. Neither did he think that the written direction would curb Hannah’s determination to run away to stay with him.²² Mr Andrews believed, on the basis of a telephone conversation he had with Mr B, together with reports of interactions that Ms Franklin had with him, that Mr B had contempt for the law. He took the view that Mr B was unrepentant about his conduct towards Hannah and appeared ‘disinterested about the degree of trouble he may be finding himself in’.²³

Mr Andrews also feared that the issuing of a written direction might drive Hannah towards Mr B, because in Hannah’s mind, if she was prevented from doing something she would pursue it with even greater vigour.²⁴

Mr Andrews’ various responses suggest that he was not as aware of the reasoning of Commissioner Mullighan QC as he claimed. Written directions were specifically designed to overcome the barriers involved in proving offences that required the cooperation of the young person at risk of exploitation. They were designed to be easy to obtain and enforce without requiring a court application. Mr Andrews failed to appreciate that the critical difference between police action on a written direction and police action in relation to an alleged sexual offence is that the former did not rely in any way on cooperation in the process from Hannah.

COMMERCIAL CARE PLACEMENT

In September 2012, Hannah’s final foster care placement ended. There were no other suitable foster care options that she could be offered²⁵, and commercial care became the only remaining option. Although Hannah had not lived with her previous foster mother Ms T for some years, she retained a close supportive relationship with her. Hannah’s preference was to live in a location that permitted her to have frequent visits with Ms T and her family.

The Placement Services Unit was unable to identify a site for commercial care close to Ms T and a placement with commercial carers provided through HenderCare was established at Gawler.²⁶

Hannah appeared to enjoy the commercial care placement. She did what she pleased. As the carers attended to her every need, she did not seem to be learning any skills about self-sufficiency or independence. Hannah’s caseworker, Ms Franklin, attempted to have carers work with Hannah on cooking and cleaning skills but her requests appeared to have little effect.²⁷

In a memorandum to David Waterford, the then Executive Director of Families SA, dated 25 October 2012, approval was sought to continue commercial care arrangements until the end of December 2012. The total estimated cost for the placement over the entire period was \$112,640.²⁸ The memorandum noted that Hannah was ‘currently incapable of independent living’, and that short-term commercial care was necessary to provide for Hannah’s social and emotional wellbeing.²⁹

Although Hannah was now 16 years old, nothing had been done to develop her independent living skills. The focus of her case management had been to diffuse the relationship between her and Mr B and keep her living in one place where she was safe. This is

notwithstanding the National Standards requirement that transition planning begin at 15, together with the high likelihood that Hannah would seek independence at an early age.³⁰

At the end of November 2012 the commercial care placement at Gawler ended. Carers made an environmental report to SA Health about the state of the premises and as a consequence the placement could not be sustained.³¹ Despite the fact that only a month earlier Hannah had been assessed as incapable of living independently, a decision was made to refer her to the Muggy's program, an independent living program (funded by Families SA and operated by the Salvation Army) that provides case management and supported accommodation for young people leaving care. Hannah's placement with Muggy's was preceded by some time at a residential care facility managed by UnitingCare Wesley. It was proposed that Muggy's staff would begin to work with Hannah at that residential care facility while she waited for a property to become available.³² Hannah was enthusiastic about the Muggy's program, having identified her ultimate goal as independent living³³, and being 'out of the system'.³⁴

2012 ANNUAL REVIEW

On 11 December 2012, an annual review panel was convened in accordance with section 52 of the Children's Protection Act, which requires that the circumstances of a child under a guardianship order until the age of 18 be reviewed annually by a panel appointed by the Minister. The panel is required to 'keep under constant consideration whether the existing arrangements for the care and protection of the child continue to be in the best interests of the child'.³⁵

The panel consisted of three staff members from Families SA. Its conclusions were brief and uninspiring; the following extract was recorded as its recommendations:

Worker to follow up on Muggies [sic] referral with [Placement Services Unit].

Continue to work towards preparedness for independent living.

Follow up on dental check-up.

GP-mental health plan-private psych.

Life story book to commence.

*... financial counselling.*³⁶

Hannah's contribution to her annual review is captured in a one-page document which was posted to her to complete. There is no evidence that she was invited to attend. This approach does not meet the Families SA Standards of Alternative Care in South Australia, which

require that children and young people be actively encouraged and supported to participate in their annual review process.³⁷

The conclusions of the panel do not refer to Hannah's future hopes or goals. There is nothing recorded about educational, training or employment planning. Neither do the interventions recorded have an aspirational quality. Despite the panel discussing the influence of Mr B, it developed no plan to manage the relationship. In addition, although the panel noted that work towards independent living was to continue, it gave no clear picture of what independent living for Hannah might look like. There was no acknowledgement that 'independent living' is a multidimensional concept, and that working towards it requires more than just securing a house and an income and developing the skills to manage each of those things. There was nothing recorded to identify what phase of transition planning was being engaged in, and to what ultimate goal.

ACCEPTANCE INTO THE MUGGY'S PROGRAM

On 13 December 2012, Hannah attended a meeting with staff from the Muggy's program and agreed to be involved. The Families SA financial counselling program was approached for financial help to set up her new home—an independent living unit in a small regional town within driving distance of Adelaide.

The Muggy's program offers a young person the chance to live in independent accommodation and receive support to ultimately transition into independent living. A young person can be referred to the program from the age of 15, but usually will not be allocated a property until they are at least 16 years old. At that age a young person (subject to certain requirements) will be eligible for a youth allowance payable through Centrelink. The young person agrees to pay for rent and food from that allowance, although the costs of utilities are met by the Muggy's program. Rent of \$85 per week is payable no matter what the size or type of property allocated.³⁸

Prior to being allocated a property a young person who has been accepted into the program will be offered regular appointments with key workers, which usually take place at the local Muggy's office. These appointments are aimed at building relationships but also begin to build the skills that the young person will need for independent living.

In the early stages of her involvement with the Muggy's program, Hannah was encouraged to engage with the local TAFE: enrolment in education or training was one of the conditions for obtaining the youth allowance that Hannah would need to pay for her rent and food. She was given help to apply for a learner's driving permit, and appointments were scheduled to assist her with budgeting and cooking skills.

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All young people preparing to leave care are eligible for brokerage money, a payment that helps them move into independent living. Muggy's provides unfurnished accommodation but assists program participants to spend their brokerage money on furnishings in a financially responsible way. Brokerage is usually paid to a maximum of \$5000.

Hannah was accepted into the Muggy's program starting January 2013³⁹, and offered a property from March 2013. At the time that she moved into the property she was 16 years of age. Just prior to moving in, Hannah was supported by Muggy's workers to buy furniture and other items for her home.

MANAGING RELATIONSHIP ISSUES IN INDEPENDENT LIVING

Soon after joining the Muggy's program Hannah mentioned to workers that she was planning to visit 'Adam' in Adelaide. By January 2013, Families SA was well aware that 'Adam' was Mr B, the adult with whom Hannah was suspected of being in a sexual relationship. However, Families SA had not shared that information with Muggy's as part of the referral to the program, thus placing Muggy's staff who were supporting and supervising Hannah at a significant disadvantage. They had no understanding at this stage of the inappropriateness of Hannah making the trip, and no basis on which to counsel her against it.

VIOLENCE AGAINST HANNAH

Later, in March 2013, Hannah disclosed to Muggy's staff that Mr B had travelled to see her at her Muggy's unit and in the course of an argument had punched Hannah in the face; she claimed, however, that it had been 'accidental'. Hannah told worker Dianne Mitchell that she did not want to involve the police because she did not want to exacerbate Mr B's trouble with the police. Muggy's staff made a notification to the Child Abuse Report Line (CARL).⁴⁰ The report was forwarded to Hannah's caseworker, but was not actioned for three weeks.⁴¹ Notwithstanding that since June 2012 the possibility of issuing a written direction had been discussed several times, this strategy was not revisited despite information that Mr B's dangerous behaviour towards Hannah had escalated.

Three months later, Muggy's staff became aware that Mr B had again assaulted Hannah. On 1 July 2013, Holli Bateson from Muggy's collected Hannah from the bus stop after she returned from a trip to Adelaide. She was in a dishevelled state and complained she had been assaulted by Mr B. Ms Bateson encouraged Hannah to report the matter to the police and discussed strategies to keep her safe.⁴² Hannah was given help making a report to the police about the assault.

Six days later, Hannah contacted Muggy's staff and advised them that she was in Adelaide seeing some old friends. Staff suspected that Hannah was not with friends, but had returned to Mr B. Two days later, Hannah again contacted Muggy's. She was in a distressed state and disclosed that she had been with Mr B and that she had again been assaulted by him. Muggy's contacted the police on Hannah's behalf; the police located Hannah and took her to the Women's and Children's Hospital for assessment.⁴³

When Hannah was released from the hospital, Families SA supervisor Mr Andrews was asked to organise her return home. He arranged for Hannah to take a taxi from the hospital to the bus depot, and to travel home by public bus. Muggy's staff collected her from the bus station. Hannah was, at this time, just shy of her seventeenth birthday. It is difficult to imagine a parent requiring their 16 year old child, who had been admitted to hospital following an assault, to make their way home alone on public transport. An arrangement of that kind would hardly have given Hannah a sense that she was cared for or that her welfare was anyone's priority.

When asked about this arrangement, Mr Andrews told the Commission that it was difficult in hindsight to indicate what other options might have been available, and it was possible that he was attempting to put something in place quickly to prevent her from 'voting with her feet'. He said that transport in that scenario was ultimately a question of finding out what was available and what was the best fit at the time.⁴⁴

Following this incident, Mr B was charged with harbouring a child under the guardianship of the Minister, an offence against section 52AAC of the Children's Protection Act. Despite Muggy's support, Hannah later determined that she did not want criminal charges to proceed, a decision she formalised in September 2013.⁴⁵ Hannah said she had ended the relationship with Mr B and wanted to move forward.

A NEW RELATIONSHIP

Hannah's determination to end the relationship with Mr B at this time appeared to be galvanised to some extent by the arrival of Mr F in her life. Mr F, an adult who lived in the local area, was observed spending time at Hannah's unit. Hannah was now 17 years old and Mr F was not committing a criminal offence if he was engaging in a sexual relationship with her. His presence and influence, however, began to have a destabilising influence as Hannah tried to build her skills towards transitioning to independence.

By this time Hannah's case management file had been transferred to a Families SA office closer to her Muggy's placement. This transfer brought a change of caseworker and supervisor guiding her case. Her new caseworker was Rachel Osborn and the supervisor was Russell Willsmore.

As 2013 progressed, it became increasingly clear that the relationship between Hannah and Mr F was placing her tenancy and her participation in the Muggy's program at risk.⁴⁶ Mr Willsmore described the dilemma that confronted him, recognising that Hannah was now 17 but was still highly vulnerable to exploitation:

You're caught between a rock and a hard place. She's under the guardianship of the Minister, and yet she's over the age of consent. So if she chooses to engage in sexual intercourse with an individual ... we might not approve of that, or support that, but it is her choice, as damaging as it might be. But until we got to the point that she said 'no, he's actually raping me', and we're looking at a criminal act, that's when we've sort of got a bit of ground to push the written directive.⁴⁷

By October 2013, Hannah was no longer attending TAFE and had been cut off from her Centrelink payments. She fell behind in her rent and Muggy's staff began to notice alcohol bottles in her unit. They reported to CARL that they suspected Mr F was supplying Hannah with alcohol.⁴⁸ Hannah's commitment to attending appointments with her key workers also fell away and workers observed that Mr F was frequently staying overnight at Hannah's unit, in breach of house rules that restricted the frequency with which she could have friends stay.

In December 2013, Muggy's staff advised Hannah that Mr F's influence upon her was creating a situation where her accommodation was at risk. Hannah complained to Muggy's staff that Mr F was supplying her with cannabis and alcohol, and in exchange he expected sex several times a day.⁴⁹ This information was reported to CARL. At this point, as long as the information was believed to be credible, there was sufficient evidence of a Part 5 *Controlled Substances Act 1984* offence to justify the giving of a written direction to require Mr F to not communicate with Hannah.

At the time a fact sheet concerning written directions had been created by Families SA and was available to staff. The fact sheet is inaccurate in its terms and describes the circumstances in which a written direction can be given in much narrower terms than is provided by the legislation.⁵⁰ Any staff member who had regard to the fact sheet without returning to a close reading of the legislation would be left with an inaccurate understanding of the scope of written directions (see Vol. 1, Chapter 10).

Mr Willsmore was asked in evidence about his understanding of the scope of a written direction to prevent exposure to illicit drugs. His answer revealed a restricted view consistent with the inaccurate information which was at the time contained within the Families SA fact sheet.⁵¹ He said⁵²:

I suppose my understanding of written directives at the time—well, I don't think that's really changed over time, but it's more about the contact—the contact they're having with an individual, and the implications of that contact with the individual, in terms of if they're putting their own safety and welfare at significant risk. So, for us, you might not support a person having contact, but unless you've got the grounds to suggest that they're in harm's way by having that contact, you wouldn't necessarily seek a written directive ... and with an evidence base such as a disclosure that, 'this is what's occurring for me when I'm with this person'.

This evidence would explain why the information that had been reported to CARL about Mr F supplying drugs to Hannah was not viewed as being sufficient to form an evidentiary basis for issuing a written direction against Mr F.

It is noteworthy that several witnesses gave evidence that there was a lack of training and consistent understanding across Families SA about how written directions operate and in what circumstances they could be employed.⁵³

In the same month Muggy's staff told Families SA that Hannah was unlikely to have her lease renewed because of the choices she had been making.⁵⁴ Hannah was given an ultimatum about engaging in the program and attending appointments, or making a choice to move out of the property.⁵⁵

On 31 December 2013, Ms Osborn and another Families SA worker met with Hannah. Their purpose was to discuss the danger of her losing her Muggy's tenancy if she continued to breach the rules of the program. Ms Osborn told Hannah that she was at risk of homelessness if this happened.⁵⁶ Mr Willsmore told the Commission that the reality was that as a child in care she would not be homeless, but that it was important that Hannah understood that her options were limited. They wanted her to think carefully before she made decisions that would lead to her losing her accommodation.⁵⁷

Hannah decided that she would move out of her accommodation, and told Muggy's staff that she would move in with Mr F. She planned to save some money and move to Adelaide. Hannah said she thought that Muggy's and Families SA had been preventing her from pursuing her goals.⁵⁸

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Once it became clear that Hannah was at risk of homelessness if her lease with Muggy's was not renewed, Hannah's caseworker Ms Osborn was directed by her supervisor to lodge a referral with the Placement Services Unit to ensure that an alternative was identified. However, there was no evidence that such a referral was made, or that any alternative placement was ever offered to Hannah.

THE TENANCY ENDS

On 20 January 2014 Families SA learned that Hannah intended to leave her Muggy's accommodation and move in with Mr F from 23 January 2014.⁵⁹ In evidence Mr Willsmore was asked why, when Families SA had been aware for at least a month of the possibility that Hannah would lose her Muggy's house, there was no referral made to source an alternative placement. Mr Willsmore was practical about the available options. He was pragmatic about the fact that the only option for Hannah was an emergency commercial care placement. Such a placement would not be approved two weeks out from a placement breakdown, and a referral for an alternative placement was pointless, would involve a lot of paperwork, and would lead to the inevitable conclusion that there were no suitable options.⁶⁰

Hannah's situation highlights a difficulty for young adolescents making the transition to independent living. The Muggy's program attempted to replicate real life by allowing Hannah to experience the natural consequences of her decision making. But Hannah had few other options available to her. For a young person with a disrupted placement history who was almost 18, a home-based placement was not appropriate. For most young people who have been living independently, a residential care placement will not be sustainable either.

On 28 January 2014 Families SA staff made contact with Hannah to discuss her accommodation. Ms Osborn, her caseworker, reiterated to Hannah that Families SA did not support her living at Mr F's house. Hannah told Families SA that it was 'better than the streets'.⁶¹ In discussions with Families SA Hannah agreed to remain involved with the Muggy's caseworkers although she no longer wanted to live in their housing.⁶² Hannah moved into Mr F's house with him. It is impossible to determine what influence, if any, Families SA's statement that she risked homelessness without her Muggy's tenancy played in that decision, and whether she thought she had any other realistic options.

Hannah remained connected to the Muggy's program and on 7 February 2014 she dropped into their office. She disclosed to workers that Mr F had been sexually assaulting her, and that she felt obliged to put up with his behaviour because otherwise she would be homeless.⁶³ This information was reported to CARL and to Ms Osborn.

On 12 February 2014 the notification was acted upon. Families SA attended Mr F's house in company with the police who were in possession of a general search warrant. Police acting on the authority of the warrant conducted a search for illicit drugs on the premises.⁶⁴ On becoming aware of the presence of Families SA and the police, Hannah became distressed and upset. She eventually agreed to leave Mr F's house with Families SA staff and return to the local office.

Although Families SA planned the attendance at Mr F's house with the police, and knew Hannah was still connected to the Muggy's program, it did not involve Muggy's in discussions about how Hannah could be supported if she agreed to leave Mr F's house. Once she became distressed, Muggy's support workers were contacted to assist her. This was the first time those staff had been informed of Families SA's actions.

Muggy's key worker, Ms Bateson, collected Hannah from Families SA and took her to the Muggy's office. Arrangements were made for a commercial care placement to be established for Hannah at a local caravan park.

The cabin that was sourced for the placement only had one bedroom. This is despite the fact that carers would be present there with Hannah 24 hours a day. The cabins at the caravan park were described as 'old ... in disrepair. Run down. A bit grotty'.⁶⁵ There were concerns about the unsavoury character of some long-term residents of the park.⁶⁶ Families SA intended to stabilise Hannah in commercial care arrangements, with a view to encouraging her to re-engage with Muggy's and transition into a new supported living unit.⁶⁷

During a conversation between Ms Osborn and Hannah on 13 February 2014, Hannah expressed the view that even if she could not reside with Mr F, no one could stop her from seeing him if that is what she chose to do. Ms Osborn agreed with Hannah's observation.⁶⁸ At that time, Hannah's observation correctly reflected the state of affairs, because no written direction had yet been obtained to prevent Mr F from having contact with Hannah, despite the fact that the issue had first been raised in respect to Mr B over 12 months earlier.

It was clear to Families SA that Hannah intended to continue the relationship with Mr F, despite the various disclosures she had made about how he had treated her.

By the evening of 14 February 2014, Hannah was again missing from her commercial care placement. She had not been seen for one night and a day. Families SA decided to terminate the commercial care placement (release the workers and terminate the lease on the property) and to place the onus on Hannah to contact the Crisis Response Unit over the weekend if she needed a place to stay.⁶⁹ Mr Willsmore, the supervisor responsible for that decision, believed that if Hannah contacted the Crisis Response Unit over the weekend the commercial placement could quickly be reinstated.⁷⁰ This decision meant that Families SA had chosen to provide no placement for 17 year old Hannah, who was, by law, the responsibility of the Minister.

On 15 February 2014, Hannah told Muggy's staff that she was back staying with Mr F. She told them that she had returned there because when she went home to her placement at the caravan park, no one was there.⁷¹ With the uncertainty associated with where she would be sent if she called the Crisis Response Unit, Hannah preferred to stay with Mr F.

Kelly McLeish, a senior practitioner involved in Hannah's case, told the Commission that she did not agree with the decision to shut down the placement. She said while Hannah was clearly 'voting with her feet' by returning to Mr F, a better approach would have been to leave the placement open, in case she changed her mind. Ms McLeish agreed with the proposition that the only option open to Hannah once the commercial placement was terminated was to return to Mr F.⁷² Ms Osborn, the caseworker, agreed with that observation.⁷³

By this time, Hannah was subject to a bail agreement following her arrest relating to illegal use of a motor vehicle. Hannah had no other history of involvement in the criminal justice system, and the allegations were isolated. The incident had occurred when she was in the company of another young person. They had both driven the vehicle at high speed and Hannah had been involved in a collision. The conditions of the bail agreement required her to live at the caravan park as arranged by Families SA.

To reflect the fact that she was now living with Mr F, Hannah attended the Youth Court and made an application to change the residential conditions of her bail. The conditions of bail were varied to require Hannah to live at Mr F's house. Families SA staff were aware of the possibility that the application would be made but were not notified that it was listed for hearing, nor were their views sought about the suitability of that placement.⁷⁴ Had they been notified, they would not have supported Hannah's bail conditions being changed, although they were well aware that she was living with Mr F because they had terminated arrangements for the only other place in which she had to live.

THE WRITTEN DIRECTION

A decision to use a written direction against Mr F was finally made on 28 February 2014. Arrangements were made to prepare the documentation and on 12 March 2014 the written direction was served on Mr F. The commercial care placement at the caravan park was reinstated to give Hannah somewhere to live.

After the direction was served, the inconsistency between Hannah's conditions of bail and the written direction became apparent: the direction prevented Mr F from communicating with Hannah, but Hannah's bail conditions required her to live at his address. Families SA attempted to have Hannah return to court to have her bail address changed. She refused to do so. Hannah's non-attendance at court resulted in a warrant being issued for her arrest.

At 11:05am on Friday 14 March 2014 the placement at the caravan park was shut down. Families SA noted that the carers would need to vacate the cabin by noon to avoid an additional night's charges, so the decision was made early in the day to avoid those fees.⁷⁵

That evening, during a phone call with Muggy's staff, Hannah was informed that there was a warrant for her arrest.⁷⁶ Arrangements were made for Hannah to attend the police station and she surrendered herself on the warrant.⁷⁷

At 9:48pm police contacted Families SA's Crisis Response Unit and advised that Hannah would be granted bail if there were a suitable address. The placement at the caravan park had been cancelled and it was not possible for Families SA to obtain commercial care workers at short notice.⁷⁸ Hannah was refused bail and was taken to the Adelaide Youth Training Centre ('Cavan') for the weekend. At this time she had very little exposure to the youth justice system. There is little doubt that Hannah would have been bailed had a suitable placement been organised by Families SA.

A RETURN TO COMMERCIAL CARE

Hannah was bailed on 17 March 2014, with conditions that she reside at the caravan park with a curfew from 9pm to 7am. An additional bail condition was later added preventing her from having contact with Mr F.⁷⁹

Following Hannah's experience of custody, her stability improved. Hannah's caseworker was convinced that her resolve to be at her placement at least nightly was brought about by a combination of the curfew conditions and an overwhelming fear of being returned to Cavan.⁸⁰

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Hannah's transition to independent living was completed in a one-bedroom cabin, being cared for around the clock by commercial carers. Families SA and Muggy's became concerned about the effect that environment was having on Hannah's independent living skills. Ms McLeish observed that all the skills Muggy's had worked so hard to instil in Hannah were unravelling as the carers attended to her every need. The living conditions in commercial care were inconsistent with preparing a young person for independence. Ms McLeish observed of the commercial care providers that:

they were in cramped accommodation, they didn't have anything else to do ... Because Hannah could be quite challenging, so I think they probably did a lot of things to keep her happy and to make the work go past quicker. But it wasn't helping support the work that we were doing ... with Hannah to try and encourage her into her own accommodation by the time she turned 18.⁸¹

Hannah remained at the caravan park until she was offered a direct lease rental through Housing SA.⁸² She moved into that property one month before her 18th birthday, but vacated it only six months into the lease.⁸³

Hannah turned 18 in late 2014. By that time her court matters were resolved and the written direction preventing Mr F from contacting her had lapsed. Hannah's caseworker took her out for lunch and gave her a bicycle that had been purchased for her as a birthday present. Hannah's Families SA file was formally closed shortly after her 18th birthday.⁸⁴

OBSERVATIONS

Hannah was a young woman whose frequent placement changes and instability meant she risked a disrupted transition out of care, and subsequent unemployment and homelessness. She did not have the benefit of a stable early life, and trauma in the critical developmental period affected her capacity to form healthy social relationships as an adult. Hannah lacked a network of close friends and family to proactively help her to negotiate challenges as she approached adulthood and independence. When Hannah made poor decisions, she felt their full impact. No worried parent waited for Hannah when she was taken to hospital after being assaulted by her boyfriend. No family or friend raced to the Women's and Children's Hospital to drive her home and comfort her. When Hannah was taken into police custody, no one got out of bed in the middle of the night to bail her out. The advantages of a flexible and tolerant approach to a young person's growing independence and exploration of the world are simply not available for some young people in care. Programs and services cannot

replace a family, but they must attempt, as far as is possible, to replicate the flexible support that is available in many families as teenagers grow to adulthood.

Hannah's entry to the Muggy's independent living program came not as the culmination of a carefully planned transition but as a result of a reactive case management regime which ran out of other options to care for her. She did not enter independent living on terms that suited her—it was all that was available at the time.

Hannah's progress was impeded by the distractions of unhealthy relationships that promised to fulfil her need for attention. These relationships competed with what the Muggy's program could provide for her—a wraparound service that coordinated her engagement with education and taught her skills she would need to live independently. While there were tools available to proactively intervene in such relationships, Families SA did not use those tools assertively, and ultimately applied them too late to make a difference in Hannah's engagement with the Muggy's program.

TRANSITION PLANNING AND THE NATIONAL STANDARDS

The National Standards require that transition planning (preparation) begin when a young person is 15 years of age.⁸⁵ When Hannah was 15, however, her case management was dominated by her absconding behaviour. There was little attention paid to long-term goals and to the support required to achieve the stability she would need to work towards those goals.

Ms Franklin, Hannah's caseworker at the time she was 15, told the Commission that the question of transition planning for Hannah had arisen during supervision, but it was thought that she was too young and naïve to manage it successfully. Transitioning her to independent living at 15, she thought, would be setting her up to fail.⁸⁶

The National Standards contemplate *planning* from the age of 15, including a focus on the stability of care arrangements. From the age of 14 it was not possible to secure for Hannah a long-term and stable family-based placement. With the majority of case management efforts focused on tracking where Hannah was and what placement options were available to her, there was little space to consider long-term planning. There was no evidence of any planning for Hannah that involved obtaining an understanding of what Hannah's goals were for the future and the support she would need to achieve them.

The evidence supports the conclusion that the referral to Muggy's was what Hannah wanted, the timing being by coincidence rather than by design. The Muggy's program gave Hannah the independence that she sought coupled with the continuity and intensity of support offered by Muggy's staff. Independent living, with the support that she would need on an around-the-clock basis, offered Hannah her best chance of stability.

Notwithstanding the barriers along the way to Hannah's engagement with Muggy's, Hannah developed her skills and knowledge while part of the program. Ms Bateson told the Commission that Hannah was 'amazing at cooking' and her literacy skills improved through her engagement at TAFE. Hannah grew in confidence, learned to say 'no' and to stand up for herself.⁸⁷

The barriers to Hannah's successful transition lay not in an inability to develop the skills and knowledge to negotiate adulthood, but in the relationship distractions which presented themselves along the way. Ms Franklin told the Commission that she thought Hannah's vulnerability lay in her attachment disorder. She said:

*Hannah ... wanted to be accepted. She wanted to be loved. They were her words to me, many times. 'I just want to belong, I just want to be loved'. And when somebody showed her any type of kindness, or you know, just a general, being nice, she held on to that, and would do anything for them, to hold on to that person. So I think it's about trying to be accepted, and to be loved, and to feel like she belonged somewhere.*⁸⁸

EFFECTIVE USE OF AVAILABLE TOOLS

Controlling teenage relationships is notoriously difficult even in a traditional family structure with the benefits of psychologically stable attachments. The challenge of controlling teenage relationships lacking those structures and attachments should not be underestimated. Families SA, in acknowledgement of the particular vulnerabilities of some children in their care, has available a set of unique tools to manage young people who choose relationships that are not in their best interests.

One tool that is not available in traditional family structures is the power to give written directions to adults in certain circumstances. The power enables Families SA to use the law to intervene between young people under the custody or guardianship of the Minister and unsuitable adults who seek to exploit them. Section 52AAB of the Children's Protection Act gives the Department's Chief Executive the power to issue written directions to persons requiring them not to communicate, or attempt to communicate, with a specific child during a specified period.

Exercise of the power requires the Chief Executive to be satisfied that the issue of a notice is reasonably necessary:

- (a) to avert a risk that the child specified in the notice will—
 - (i) be abused or neglected, or be exposed to the abuse or neglect of another child; or
 - (ii) engage in, or be exposed to, conduct that is an offence against Part 5 of the Controlled Substances Act 1984; or
- (b) to otherwise prevent harm to the child.⁸⁹

Failure to comply with a written direction is an offence that carries a maximum penalty of \$4000 or imprisonment for one year.⁹⁰

Evidence revealed that Families SA staff lacked knowledge about written directions and were reluctant to use them proactively to make adults responsible for staying away from young people. This is surprising given that the power to issue written directions has been available since June 2010.⁹¹

The topic of the issuing of a written direction was raised on multiple occasions with supervisor Mr Andrews. Notwithstanding the dangerous position in which Hannah was placing herself, no written direction was issued to Mr B to effectively intervene in her relationship with him in 2012 and leading up to her placement in the Muggy's program in 2013.

Mr Andrews' evidence revealed an inflexibility of thinking about the potential of a written direction. Although he told the Commission that a written direction always remained on the table, his evidence suggested a reluctance to attempt such an approach.

Not only was there a reluctance to utilise the available tools, there was a lack of planning about the circumstances in which the matter would be escalated from merely talking to the parties in an effort to persuade them to comply, to the more direct assertive approach of a written direction. Although Mr Andrews spoke to Mr B about the consequences of his behaviour, nothing was done to place the police or Families SA in the best position to use the law against him to secure Hannah's safety. Reactive case management, coupled with a series of crisis-driven decisions, resulted in the use of a written direction being overlooked.

By 22 June 2012, Families SA had information that Mr B had been using drugs (cannabis and amphetamines) in Hannah's presence and that she was engaged in a sexual relationship with him.⁹² There is no doubt that the evidentiary standard required for deployment of a written direction had been achieved at that early stage.

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There was a danger, of course, that a written direction employed against Mr B could drive the relationship underground and further endanger Hannah. This appeared to be the ongoing reason for preferring a cooperative approach. But there was no evidence at any time that the cooperative approach was working or that Mr B was amenable to cooperating with Families SA to ensure Hannah's safety. In those circumstances, Families SA should have given greater consideration in a planned and structured way to issuing a written direction.

At no time did any Families SA staff member discuss with Hannah the possibility that her relationship with Mr B or subsequently with Mr F, coupled with her consistent absconding, might lead to a written direction which would prevent either of them from associating with her. Hannah was left with the impression that her consent was required for any action against Mr B. A case note taken by a Muggy's worker when a written direction was later served on Mr F records:

Hannah said that it all doesn't make sense and doesn't know how Rachel did what she did [getting a written direction] ... without consent from Hannah. Staff said that Rachel can do this as she is Hannah's guardian. Hannah said that when she wanted a restraining order against Mr B Nadine ... said she couldn't do it without Hannah signing forms.⁹³

Standard 4.1 of the Standards of Alternative Care requires that a young person will be an active participant in all decision making which relates to them.⁹⁴ This became particularly important once Hannah was asked to take a heavy responsibility for herself by living independently. She should have been treated as an active member of the care team and her views sought about the management of her relationships. Had Hannah been engaged actively and honestly in consultation about the range of legal options that were available to control her unhelpful and damaging relationships, it is possible that a different outcome might have been achieved.

It is also possible that a different outcome might have been achieved if Families SA staff had a better understanding of the scope of written directions, and the circumstances in which they might usefully be deployed.

COLLABORATION BETWEEN AGENCIES

The capacity for Families SA and other programs to work collaboratively will often be determined by the extent to which the Agency is prepared to share the information it has about a young person in its care.

Hannah was effectively left in the care of Mr B over the weekend of 7–8 July 2012 as a result of poor communication between Families SA and the registered foster care agency. The case approach preferred by Families SA did not place weight on the views of the registered agency charged with managing the placement, nor was the strategy of allowing the status quo to continue well thought out. The incident highlights the value of having a clear case direction which is shared with everyone who is involved in a child's care, and against which all decisions are made. The management of Hannah's absconding behaviour continued to be incident-based and reactive, and the lack of a clear, shared case direction between LWB and Families SA contributed to significant misunderstanding. The incident highlights the value of identifying contingencies and a joint approach to such contingencies so there is clarity for all parties managing what was potentially a dangerous situation for a vulnerable young person.

Families SA's communication and information sharing with the Muggy's program was also deficient. Katie Lawson, the Regional Operations manager for Muggy's, gave evidence that the information accompanying referrals varied significantly in the level of detail. She emphasised that the more information Muggy's received about a young person's needs, the better the service they could offer.⁹⁵

Notwithstanding the need for this cooperative approach, and the fact that Muggy's staff would be involved in supervising Hannah's day-to-day welfare, they were given no information about her relationship with Mr B and the challenges it might present for Hannah's transition. At the time the referral was made to Muggy's there was a lengthy history of concern about Hannah absconding to Mr B, and yet Ms Bateson, Hannah's key worker, knew no more about him than that he was Hannah's boyfriend and he lived in Adelaide.⁹⁶

In circumstances where the key workers were attempting to build relationships with Hannah and mentor her and guide her about healthy relationships, this was critical information. It was especially so when Families SA had chosen to rely on a consistent message to Hannah that the relationship was not healthy, rather than issue a written direction. A cooperative approach would have permitted that message to have been delivered consistently by all agencies with a role in caring for Hannah.

In 2013, when Families SA finally took a more assertive approach to the management of Hannah's relationships and removed her from the home of Mr F, it failed to involve Muggy's in either the planning of this action or its execution.⁹⁷ This is despite the fact that Muggy's staff continued to be an ongoing support to Hannah, and much of the important information that Families SA was receiving about her welfare was coming through them.

One staff member explained the difficulties that Muggy's staff faced when dealing with a crisis situation of which they had no warning:

Part of the way we want to work with our young people is about being honest ... because if you're honest, it can show caring, concern ... and going behind their back is not always ... the best thing. So because it was our information that a lot of this was based on, I would probably have preferred to have been able to have this conversation with her about why we've reported things ... or even to have sat down with Families SA first and look at what the plan would then be.⁹⁸

It is clear that there were people in Hannah's life whose views she trusted. A consistent theme was that the relationship with her former foster parent, Ms T, was very important, and she would listen to what Ms T had to say about issues relating to her safety and best interests. That Hannah was prepared to place trust in and listen to the advice of people with whom she had secure and continuous relationships is an important observation. It highlights the power of young people having continuity of relationships, particularly during adolescence, when the pull of other relationships might divert them from a healthy transition to adulthood.

AVOIDING CUSTODIAL PLACEMENTS

Hannah's stay in a youth detention facility over the weekend of 14–16 March 2014 was unnecessary. Her detention was not required to protect either her or the public, nor was it necessary as punishment, as she had not yet been convicted of any offence. Hannah was incarcerated because the Agency tasked with providing her care was concerned with the costs of keeping her placement open if it was not needed.

Hannah was not someone whose criminal history would otherwise have justified her being remanded in custody. She was let down by a system that could not keep a placement open for a vulnerable young person. When Hannah made a series of poor decisions, she did not have a safe place to land. Instead, she ended up in the youth justice system because the care system could not respond to her outside business hours. Youth custody should never be used as a placement option for young people under guardianship orders when their incarceration is not otherwise properly justified.

Young people should, at all times, have somewhere to call home, even if that home is a commercial care placement in a cabin at a caravan park. If the Agency stands in the shoes of a good parent, it must ensure that its services reflect what would reasonably be expected of a good parent in such circumstances.

HANNAH'S POINT OF VIEW

The Commission had a discussion with Hannah after the hearing of this case study. Hannah is an intelligent, resourceful and resilient young woman who now lives independently. She regrets not finishing her schooling, and wishes that she had had greater stability in her teenage years to enable her to do that. She is being supported by Ms T, her former foster parent. In 2015 Hannah made a freedom of information application to Families SA to obtain her proof of Australian citizenship, tax file number and Medicare information. Twelve months later she had not yet been provided with those documents.

Hannah was aware of the existence of post-care services but found the idea of calling a service with which she was unfamiliar and speaking to someone that she did not know confronting. Hannah emphasised the need for continuity in the relationships of care around her, and felt that changes in staff and placements had been disruptive for her.

She is actively job seeking, but finds it difficult to list her achievements in applications to prospective employers because many of them disclose that she grew up in care, a matter that she still regards as having some stigma associated with it. Although she felt worried about the challenge of independence as she approached 18, she felt elated that she was out of the system, and able to make her own way in the world, making her own friends and becoming her own person rather than constrained by the system.

CONCLUSION

The observations in this case study identified issues and themes that have informed discussions and conclusions principally in Chapters 10 and 14 of this report.

It is clear that significant reform is needed to the support that is available to young people transitioning out of care. Planning for this phase is a critical part of casework and must be done in a flexible, sensitive and child-focused way. Hannah's journey was dominated by reactive decision making and crisis management which did not always serve her best interests and did not always keep her safe. The high standard of care required by young people in the care of the state is not always consistently delivered, and reforms are necessary to improve the journey of these important young people.

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NOTES

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- 38 Oral evidence: K Lawson.
- 39 L Fewster (UnitingCare Wesley), email to N Hosking & K Reed, 22 January 2013.
- 40 The Salvation Army, Case notes—Hannah, internal unpublished document, 31 March 2013; Families SA, C3MS records—Hannah, internal unpublished document, 31 March 2013.
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CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

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CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

OVERVIEW

Children who come into the care of the state might demonstrate complex behavioural and psychological conditions which have developed as a result of their inadequate or abusive backgrounds. To the untrained or ill-informed observer, these children are identified as behaviourally dysfunctional. It is thought their condition results from a lack of effective discipline that can be remedied by firm boundaries and clear expectations.

A closer examination of the circumstances and a deeper understanding of the psychological development of children reveal a cohort of high-needs children whose development has been disrupted by pathological parenting practices. They have not been given the fundamental relationship building blocks taken for granted in functional families. These children with 'high or complex needs' share very similar characteristics, and can be reliably and efficiently identified at an early stage in care.¹

Child protection systems can be poor at recognising and responding to this group. However, resources can be concentrated to support these young people before they experience the series of multiple placement disruptions that appear to characterise their journey in care.

This case study tracks the journey in care of Nathan, a child who falls into the category of having 'high or complex needs'. It explores:

- his earliest accommodation in foster care placements and emergency care;
- his accommodation in a large congregate care facility (the unit);
- his progress through the education system; and
- Families SA's planning and decision making on placement choices.

The case study reveals that neither the child protection nor education system responded adequately to Nathan's condition. Faced with the undeniable complexities of caring for a child such as Nathan, each service was constrained by practices and resources inadequate for the task and, at times, the absence of informed and consistent on-the-ground practices. Nathan is a case of frustrated plans and lost opportunities.

The inability of each system to tailor responses to Nathan's needs resulted in a pattern of inappropriate placements and methods of education. The inadequacy of each service affected Nathan's capacity to succeed in the other. As Nathan's behaviours escalated in seriousness, he appeared to 'fail his way' out of education and placements, and into the criminal justice system.

This case study questions the capacity of these systems, in their present form, to provide services to children who require intensive support as a result of their complex behaviours and psychological conditions.

EVIDENCE

NATHAN'S BACKGROUND

Nathan was removed from the care of his mother when he was about 18 months of age. Before his removal, Nathan had experienced serious and sustained abuse at the hands of his mother and her partner. It is likely that only a small portion of Nathan's total abuse and trauma was ever known to Families SA (the Agency).

The first of two 12-month guardianship orders was made when Nathan was two. He was initially placed in the care of his grandmother and attempts were made to reunify him with his mother. These attempts were abandoned during a second 12-month order after Nathan's mother was physically and emotionally abusive towards him during contact visits.

Soon after reunification attempts were abandoned, concerns were also raised about the capacity of Nathan's grandmother to care for him full time, and the appropriateness of the placement was reviewed. A long-term order placing Nathan under the guardianship of the Minister until the age of 18 was made when Nathan was four. Between Nathan's removal from the care of his mother and the making of the long-term guardianship order, he did not experience stable or secure care arrangements.

REACTIVE ATTACHMENT DISORDER

Nathan was subject to two short-term orders (12 months each) during critical developmental phases when stability was needed to establish healthy attachment relationships. Nathan's capacity to develop the strong and stable attachment relationships necessary for healthy psychological development was undermined by lengthy uncertainty and subconscious concern about safety during contact visits and repeated moves between the care of his mother and grandmother.²

Nathan was diagnosed with reactive attachment disorder (see Chapter 10) even before starting school. When Nathan was four years old a private psychologist became involved in his care.

The success of therapy for children with reactive attachment disorder depends on a consistent approach to care being maintained within and between the child's home and educational environments. Yet consistency of responses is frequently unsustainable. In the face of sustained poor behaviour, caregivers might quickly

conclude that the unfamiliar suggested strategies are not working and move through different strategies to try and find something that works. This trying and testing re-enacts 'the inconsistency and unpredictability that was a feature of the children's care environment before they came into care'.³

A strict disciplinary approach does not achieve the behavioural changes that parents of children with secure attachments would expect. The approach fails to understand that children with reactive attachment disorder are unable to self-regulate. Practices such as 'time out' are entirely ineffective. Disciplinary strategies depend on a relationship existing between child and caregiver in which the child seeks approval from the carer. This relationship does not exist for children with reactive attachment disorder. Such children are motivated by fear of the carer, not a desire to please, and could be actively interested in pushing the person away. In such cases, disapproval can act to reinforce the poor behaviour.⁴

EARLY PLACEMENT HISTORY

A FOSTER CARE PLACEMENT

Following a decision that placement with his grandmother was not appropriate, Nathan was placed with foster parents, Mr and Mrs H.

Nathan's psychologist considered that effective therapy for Nathan should take the form of a combination of psychotherapy (Theraplay) and advice to Nathan's foster parents and school environment about the care and management of an attachment disordered child.

Mr and Mrs H found management of Nathan's behaviour difficult and Families SA staff became increasingly concerned that they would lapse into an inappropriate disciplinary approach when Nathan's behaviour became particularly challenging. This approach was contrary to advice from Nathan's psychologist. In his opinion the inconsistency of approach was likely to have a 'profoundly deleterious impact on Nathan's longer-term development, emotional wellbeing and adjustment in view of his likely perception that those whom he began to trust became mean and uncaring again'.⁵

The psychologist recommended to Families SA that a final effort be made to support Mr and Mrs H to adopt a more helpful approach, but otherwise to consider transitioning Nathan to a different foster care placement where carers were less likely to cycle through appropriate and inappropriate care and management practices.

That year Nathan completed kindergarten and began his schooling. He had already demonstrated challenging behaviours and an inability to relate to others. During his first year of school concerns surfaced about his conduct

towards other students. At the age of five, Nathan was suspended from primary school after he was violent towards two other students. Nathan was not permitted to return to school until a student development plan had been finalised. This was the first of many suspensions.

Mr and Mrs H were becoming increasingly concerned about the sustainability of Nathan's placement in their family. When Nathan was six, on the advice of his psychologist, a decision was made to end the placement.

A PERIOD IN COMMERCIAL CARE

Nathan was placed in rotational care—out-of-home care staffed by rotating commercial carers—where he remained for almost two years until he was eight years old. The problems associated with this form of care are discussed in Chapter 12.

The seriousness of Nathan's conduct escalated in this form of care, and Nathan's caseworker, the supervisor and his psychologist all agreed that commercial care arrangements were 'inadequate for the remediation of his attachment disorder' and a home-based placement was urgently needed.⁶ The psychologist recorded that 'psychotherapy is unlikely to make any significant headway in the absence of there being a stable caregiver who can consistently implement a parenting plan that promotes Nathan's security'.⁷

At least twice, the staff paid to care for Nathan exhibited inappropriate conduct towards him. One carer cut the heads off Nathan's teddy bears as a punishment for poor behaviour, and another carer permitted Nathan to spend the night at his house after some confusion about where Nathan would spend Easter.

Following Nathan languishing in commercial care for 18 months, the Emergency Accommodation Review Panel of Families SA recommended funding approval for a \$180,000 specialist package of care, which would be available to source a specialist therapeutic foster care placement. Approval was given by David Waterford, then Executive Director of Families SA.

Four months later, a suitable placement had not yet been located. Nathan's psychologist reported to Families SA that he had become increasingly emotionally detached from others, despite efforts to maintain a connection with his former foster parents and to establish a regular care team. This response was functional as it permitted Nathan to come to terms with feelings of being unloved and uncared for. However, it was accompanied by extreme behaviour and affective displays with no regard for the effect on others or on relationships. Nathan viewed his actions as justified.⁸ While the change to commercial care had initially settled Nathan's behaviour, the long-term detrimental effect of the rotational care placement was now clearly observable.

CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

NATHAN'S EDUCATION

By the time Nathan was six his educational engagement was breaking down. He was excluded from school and attended a learning centre (designed for students who require intervention beyond the capacity of a mainstream classroom). From that time Nathan's education was interrupted by a series of suspensions, reduced hours and being sent home from school early.

THERAPEUTIC FOSTER CARE

Just after Nathan turned eight, a therapeutic foster placement was found for Nathan with Mr and Mrs P, an older couple with adult children. Nathan's transition to this home-based placement was associated with some particularly poor behaviour at school.

NATHAN'S ROTATION THROUGH SCHOOLS

Less than one month into the placement with Mr and Mrs P, Nathan was suspended indefinitely from his second primary school. He then rotated through a series of schools, all of which struggled to manage his challenging behaviours.

By the time Nathan was 11, he had attended seven separate schools, including two private schools. His attendance could not be stabilised at any of them. One transition between schools was planned, in an attempt to place him in an environment that would improve his learning outcomes. However, in all other instances he was suspended indefinitely or excluded, or the school asked that another school be located as it was not resourced to meet his needs. Nathan was also excluded from the learning centre.

In each instance the suspensions and exclusions resulted from an inability to manage Nathan's behaviour, culminating in instances of violence against people and property, including the assault of teachers and students.

In a therapy report Nathan's psychologist observed that he:

continues to have difficulty forming a close and loving dependency relationship with adult females in a caregiver (and/or teacher) role. He remains susceptible to bouts of extreme emotional and behavioural dysregulation that places others, particularly children, at high risk of serious physical and emotional harm. This is almost exclusively an aspect of his presentation in educational environments, where Nathan's psychological characteristics are not fully understood or adequately managed. As a result, there are ongoing, significant difficulties with regard to Nathan's placement in the mainstream education system.⁹

The one period when Nathan's schooling stabilised was accompanied by 'wrap around' services. He attended school for three days per week and was at all times

supported by a student services officer (SSO), who was equipped with the understanding and capacity to use appropriate interventions. The behavioural incidents that did continue were managed not with external suspension but with send-homes and in-school suspension. This was the only school from which Nathan transitioned in voluntary circumstances.

Nathan's schooling difficulties were exacerbated by extended periods between enrolments. It was difficult to locate a school that was able and willing to accommodate his needs. In one instance, it took five to six weeks of negotiations before a school could be located and conditions of enrolment agreed; in another it took three months. Sometimes negotiations between Education and Families SA as to who would pay for additional services, such as SSO support, contributed to the delay. The reluctance of one public school to take Nathan was such that, despite his enrolment, the arrangements required for him to attend were never put in place.

At times Nathan was not permitted to attend because agreements could not be reached between Families SA and the school about the conditions of attendance, including the nature of support services to be provided. For example, Nathan was not permitted to return to one private school as Mr Waterford would not permit the SSO to restrain Nathan, a condition required by the school. On another occasion, 16 prerequisites accompanied an offer to enrol Nathan at a public primary school. Taken together, they would have had the impact of precluding Nathan from any real participation in the school community.

Mr and Mrs P were strong advocates for Nathan's enrolment and engagement at school. When Nathan was 10, Mrs P calculated that in the six schooling terms since coming into their care, Nathan had attended 95.5 out of a possible 294 days, with 15 send-home early days. Mrs P pointed out how disadvantaged Nathan was becoming educationally and socially. She helped Nathan make a complaint to the Commissioner for Equal Opportunity.

THE EFFECT OF SUSPENSION ON THE PLACEMENT

Nathan's continued suspension and exclusion from school placed undue pressure on the placement with Mr and Mrs P. During periods when he was not attending school his behaviour would deteriorate.

Mr and Mrs P warned Families SA that the placement was at risk because of delays in finding Nathan appropriate schooling and the consequent pressure on them of having him at home 24 hours a day, without respite.

In a therapy report Nathan's psychologist said that, despite making great progress with Mr and Mrs P, Nathan remained prone in certain conditions to extreme arousal dysregulation and associated gross acts of violence and destructiveness towards persons and property.

An advocate from the Office of the Guardian for Children and Young People (GCYP) intervened on Nathan's behalf with Families SA. She advised Nathan's caseworker that there was a danger that the placement with Mr and Mrs P was not sustainable. In particular, she said that the lack of respite was becoming problematic, and the circumstances required parallel planning in case the placement broke down.¹⁰ However, no alternative placement was planned.

The disintegration of Nathan's behaviour came to a head when he was 11. Nathan was attending the Families SA office for tutoring (with a private tutor as an alternative to mainstream schooling) when a dispute arose. Nathan had to be physically restrained by Mr P in the Families SA waiting room for more than 50 minutes, and the police were called as a result.

A case conference followed, and Families SA, with Mr and Mrs P in attendance, made the decision to end the placement. Mr and Mrs P emphasised the hurdles to engaging Nathan in education as leading to the placement stress and subsequent breakdown.

Following that decision, a request was lodged with the Placement Services Unit seeking emergency care.¹¹ An internal memorandum noted that Nathan would pose a 'significant risk to other young people' if he were placed in a congregate care environment. Neither congregate care nor home-based placement was recommended.¹²

PLACEMENT AT THE UNIT

A placement was identified for Nathan at a large unit in the northern suburbs of Adelaide. In an email, the acting supervisor at the congregate care unit raised a number of concerns about Nathan joining the unit, in particular about him being admitted just before the weekend, as had been planned. Staffing arrangements were not suited to manage the complexities of a new young person joining the unit over the weekend; and the unit was experiencing high levels of violence and drug use from other particularly complex young people. It was recommended that Nathan's admission be delayed until the following Monday.¹³

The recommendation was not heeded. Nathan was admitted on a Friday, as originally planned, and he was not informed of the move until the day it occurred.

On the day of his admission, Nathan disappeared from the unit and a missing person report was made. It was the first in a long series of such reports. That night he

was twice arrested, first for property damage and then for assault. He was remanded to the Adelaide Youth Training Centre, for the first of many stays.

A missing person's baseline risk assessment records the risks for a young person if they go missing from residential care. This assessment was completed for Nathan soon after his arrival at the unit. It recorded a low risk rating for offending behaviour, self-harming behaviour, substance misuse and sexualised behaviours.¹⁴ This reflects the reality at that time. Although he had a long history of complex behaviours that were often difficult to manage, Nathan had not yet come into conflict with the youth justice system. He had not been using drugs or alcohol, he had not been missing from his placement, nor was he associating with unsavoury adults in the community.

A TEMPORARY PLACEMENT

Nathan was placed at the unit against expert advice. Despite their concerns about the suitability of the move, Nathan's caseworkers supported the placement on the basis that advocacy for a therapeutic placement would continue. GCYP was advised by Nathan's caseworker that Nathan was 'on the waiting list' for a therapeutic placement. This was confirmed by the manager of the Families SA office.

Nathan was placed in the unit at a critical time in his development. A case conference on 8 July 2013 was attended by nine professionals, including members of the Placement Services Unit. Psychiatrist Dr Prue McEvoy cautioned, '[i]f Nathan were to stay in community residential care, he will continue on an anti-social path'.¹⁵ Angela Davis, a clinical psychologist, described this as a 'pretty predictable path' for children with attachment disorders who enter large congregate care units.¹⁶

Claire Simmons, principal clinical psychologist, observed:

the ones I really worry about going into the units are the kids who haven't picked up the absconding or the sexualised stuff or the drugs or alcohol. I always feel devastated, I think it is not overstating it, when we have to place a child in that environment who hasn't got those behaviours yet, because it really does feel like the system's just helpfully adding ... another problem for these kids.¹⁷

The case conference recommended a placement in a transitional accommodation house, with one other child, and Nathan never being alone in a placement, as his best option. It was also recommended that Families SA consider an intensive therapeutic care (ITC) placement when one became available.¹⁸

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Nathan's placement at the unit was intended to be temporary, until a more appropriate option could be sourced. At best, the unit was better than commercial care, but still not suitable for Nathan's needs.

NATHAN'S EXPERIENCE AT THE UNIT

Nathan's experience in the unit followed the 'predictable path'. It was characterised by conflict and the uptake of risk-taking behaviours he had not previously demonstrated. By mid-August 2013 Nathan was extremely unsettled. He had to be restrained physically almost every day due to his behaviour.

During the first six months at this placement Nathan was reported missing on 40 separate occasions—20 of those times overnight and once for four nights in a row.

While off site, Nathan was often assaulted, including by other residents from the unit. One poorly matched group of boys who resided together at the unit had caused a great deal of property damage: 20 critical incident reports had been made over the previous month. While on a missing person report the boys stayed with an adult male, where they obtained and used illicit substances; Nathan reported he did so to 'numb the pain'.¹⁹ Investigation of other placement options were recommended for the boys, but none could be located.

Nathan continued to cause property damage at the unit. He also began self-harming behaviours, and inhaling aerosol deodorant.

NATHAN'S VULNERABILITY

While he was still 11 Nathan was assaulted and suffered a serious injury.²⁰ Nathan told staff that he had been assaulted by Tim, a fellow resident of the unit. As a consequence of this assault, Tim was moved.

The unit supervisor reported that Nathan did much better in the period following Tim's removal. Nathan did not go missing and was more engaged. The unit supervisor thought this was due to Nathan's fear of seeing Tim following the assault, rather than a long-term improvement.

However, Tim and Nathan subsequently reconciled. Tim was said to have 'forgiven' Nathan for reporting the assault, and Nathan reverted to his previous pattern of going missing and associating with Tim outside the unit.²¹ More dangerous and anti-social behaviour followed.

From mid-2014 to early 2015 Nathan was admitted to hospital:

- twice because of abuse of over-the-counter medication;
- once after spending the evening intoxicated and with a male who he said had been abusive towards him;
- once after a bicycle accident while severely intoxicated by alcohol and cannabis; and
- once after an incident while he was seriously intoxicated and showing responses indicative of amphetamine use. Nathan was examined and detained under the Mental Health Act 2009. He was 12 years old.

NATHAN'S CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

In the first six months of Nathan's admission to the unit, he committed a total of 22 criminal offences over 16 occasions. Mostly, they were violence against property and people, dishonesty offences and offences involving minor disorderly conduct. During this period he was incarcerated in youth detention on five occasions.

By February 2014, Nathan's caseworker recorded in a case note that Nathan's behaviour was escalating, with more assaults on other residents and staff at the unit.

Following one assault alleged to have been committed by him, Nathan was bailed to reside at the unit despite residents being 'petrified' of his return. Nathan advised a Youth Court Magistrate that he continued to breach his bail because he hated his placement and did not want to be there. He said he would rather be in custody.

EDUCATION WHILE IN THE UNIT

Nathan's engagement in education remained poor, except for the periods when he was in custody.

Nathan was referred to the Families SA Mentoring Program to occupy him with some activities during protracted negotiations over his school enrolment. Even though a mentor was not allocated, a mentoring program should not be used as a substitute for educational engagement.²²

A meeting to consider Nathan's transition to high school noted that he had engaged very little in education during the past 12 months. On starting high school, Nathan was enrolled on a 'flexible learning options' basis. It was hoped that he would engage in some programs through Re-Engage, a youth services program.²³

RECORDING NATHAN'S EXPERIENCE

Nathan was subjected to almost daily restraints while at the unit.²⁴ The unit supervisor reported that during one period Nathan's conduct was explosive, 'almost like a wild animal being caged and he did not know what to do'.²⁵ As the current workers did not have a relationship with Nathan and were not able to recognise the signs leading to such behaviour, Nathan would very quickly end up being restrained. The supervisor observed:

Sometimes that would look ugly, in the sense that there's this tiny little boy and there's three of us trying to control this young person, and you can imagine what that causes to staff and to him. I mean, I shake every single time after 10 years, if I have to do the restraint, partly because of the natural reaction, adrenalin kicks in, partly because it is traumatic.²⁶

Seventy-six critical incident reports on Nathan were produced to the Commission for the period from his admission to the unit in June 2013 until mid-February 2015.

Regulation 14 of the Family and Community Services Regulations 2009 requires an account from the child be recorded in instances where force, including restraint, is used against the child. The vast majority of critical incident reports indicated that no account from Nathan had been taken. Not every critical incident report would require an account to be taken, as force was not used against Nathan in all instances. However, the majority of reports involved some use of force and the records produced displayed a systemic failure to comply with the recording obligations of Regulation 14.

The failure to record Nathan's version of events ignored an important safeguard for him provided by the Regulations. The monitoring of use of force is intended as protection against the improper or arbitrary use of force. For further discussion of the legislative requirements for recording the child's account in critical incident reports see Chapter 12.

PLANNING FOR A PERMANENT PLACEMENT

When Nathan was initially placed at the unit aged 11 it was intended as a short-term option. Accordingly, planning decisions that saw Nathan continue to reside at the unit require consideration.

ADVOCACY FOR A NEW PLACEMENT

On several occasions Pam Simmons, who was at that time the Guardian for Children and Young People (the guardian), raised concerns at an Executive level in the Agency about Nathan's ongoing placement at the unit. Faced with this advocacy and the strong advice from Dr McEvoy that intervention was urgently required,

Families SA could not have been in any doubt that urgent attention was required to source an alternative placement for Nathan.

A CHANGE IN POSITION

During the early stages of Nathan's placement the guardian had received the following information from Families SA:

- Julia Lamont of Families SA's residential care directorate advised there was no plan to move Nathan from the unit, and that his needs were best managed there, with staff and support from the unit available to manage his anger, in consultation with a psychologist. Ms Lamont expressed the opinion that ITC was not appropriate for his care, as it was designed for children who were incapable of regulating their behaviour. This was not the case for Nathan.²⁷
- Four days later, Mr Waterford advised by letter that there were no other suitable placements available at the time, although Families SA supported a move to a placement with fewer children if one became available.²⁸
- In a subsequent meeting this position was confirmed and the guardian was advised that Adam Reilly, the soon to be appointed manager of the Families SA office in charge of Nathan's case would be asked to look for a short-term placement in a smaller residence with extra staff.²⁹

These communications demonstrate a marked change from the initial position that the placement would be short term and that ITC would be considered as an alternative. It is worthy of observation that Nathan had been seriously assaulted by another resident at the unit, just a week before Ms Lamont said that Nathan's needs were best met in the unit.

The position taken by Families SA towards locating a placement for Nathan can be characterised as passive.

Sonia Daniel, a supervisor from the local Families SA office in charge of Nathan's case, expressed the view that 'should an opportunity present itself for Nathan to move placements where there are less children, the ... office would be supportive of exploring this option further'.³⁰ The letter sent by Mr Waterford to the guardian on 25 October 2013 also took the same approach.

No longer than three months after Nathan entered the placement on the basis of it being temporary, the Agency stopped looking for something more suitable. No active steps were being taken at an organisation level to locate an alternative for Nathan.

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THE SATELLITE PLACEMENT PROPOSAL

Faced with an 11-year-old boy spiralling out of control, Nathan's caseworker, Zoe Dalton, began to formulate a proposal for an alternative placement. This came to be known as the 'satellite placement'.

This model allowed for Nathan to be housed in a small residence on his own which was situated sufficiently geographically close to the unit to be considered a 'satellite'. The proposal permitted consistent care as workers based at the unit, with whom Nathan had established functional relationships, would staff the residence. It was hoped that separating Nathan from the influences of the larger unit would help meet his therapeutic needs. However, the proposal was expensive and would require significant residential care staff resources.

Despite support for the proposal from Dr McEvoy, who performed a consultative role in Nathan's case, and warnings against continued delay³¹, the satellite placement plan was never put in place. The relevance of the satellite proposal to this case study lies not in the merit of the ultimate decision, but in the process by which it was reached. The process demonstrates deficiencies in the manner in which Families SA makes planning decisions for children in care.

The written proposal contemplated that five people along the chain of command would record their agreement or otherwise with the proposal before it reached Rosemary Whitten, the Executive Director ultimately responsible for such decisions.³² The proposal did not progress beyond the first two steps of the chain of command and was never formally approved, or disapproved, by any of the managers who saw it.

The concept of the satellite placement was first raised at a meeting of a large number of professionals interested in Nathan's welfare on 21 February 2014. At that time, Nathan was frequently being restrained, staff were having difficulties building relationships with him and other residents were frightened of him. In the opinion of Srdjan Vajdic, a Families SA psychologist, the gravity of the situation was seriously underestimated.

In March 2014 the proposal first went to Mr Reilly, Manager of the local Families SA office. Mr Reilly wanted to fully exhaust the current placement options by testing a variety of strategies to manage Nathan's behaviour before significantly changing his placement.³³ He advised the guardian that other strategies should include emphasis on rewards and recognition. He thought that placing gym equipment in the backyard might encourage Nathan not to run away.

In an email on 2 April 2014, Mr Reilly sent the proposal to his line manager, Caroline Keogh. He indicated his understanding that Ms Whitten was awaiting the

proposal. He did not recommend the proposal to Ms Keogh. His view was that some options had not been fully explored and he indicated that he had taken a more active role in case direction.³⁴

One role of a manager of a local office was to:

*provide leadership and direction of critical, complex, and highly political case management issues including children with high and complex needs who are at risk of death or serious injury.*³⁵

This requirement is consistent with Mr Reilly taking a more active case direction role in Nathan's highly complex case.

However, local office managers do not need clinical experience or expertise to be appointed to the role, and there are no essential minimum qualifications. They are appointed at MAS3 level in the discipline 'administrative'. Mr Reilly, for example, progressed to his position through the public service management stream. He had no clinical or child protection expertise.³⁶

Mr Reilly's position required him to become involved in highly complex case management issues and provide leadership on them, yet he was appointed to the role without experience in this area. The role of the office manager, where the position is held by an individual without clinical practice expertise, is one which requires careful consideration.

Mr Reilly took a pragmatic view that the satellite placement proposal was unlikely to attract support at an executive level unless it was possible to demonstrate that other options at a more modest cost had been tried but were ineffective. The more modest 'creative' ideas that Mr Reilly believed needed to be attempted did not have the support of the care team who had known Nathan for some time.³⁷

At a case conference on 16 April 2014, to which caseworker Ms Dalton and her supervisor Bronwyn Warren were not invited, the satellite proposal was briefly discussed. The Commission heard that it was not unusual for caseworkers to be left out of case conferences. A freer flow of information from management levels to caseworker level on case work decisions may have resolved some of the subsequent lack of focus surrounding the proposal. The presence of caseworkers at important meetings would help information flow.

Ms Keogh advised Ms Whitten that the proposal and other alternatives would be considered at the meeting, following which the proposal and alternatives would be sent to Ms Whitten.³⁸ However, the meeting did not produce any further clarity about the viability of the

satellite proposal. Conflicting accounts demonstrate that the meeting participants had different understandings of the outcome of the meeting.

Ms Keogh and Mr Reilly in particular appeared to have conflicting views about whether the satellite placement proposal had been dismissed. Ms Keogh reported to Ms Whitten following the meeting that, before the case conference, a decision that Nathan would remain at the unit had already been made, reportedly at a regular residential care placement meeting.³⁹ In contrast, Mr Reilly advised the guardian that the proposed placement was not ruled out in the long run.⁴⁰

It appears that two outcomes were determined from the meeting. The first was that matching an older youth to live with Nathan in a smaller placement was to be investigated. A placement of this nature was consistent with the advice of Dr McEvoy as to the appropriate form of placement for Nathan. The second was that, Families SA would also try other behaviour management options, as proposed by Mr Reilly, despite them not being supported by unit supervisor Danijel Kevesevic or principal clinical psychologist Ms Simmons.⁴¹

Mr Reilly took the view that the key to moving Nathan to a smaller placement was finding another well-matched child or young person who could live with Nathan. Mr Reilly passed these views to the caseworker Ms Dalton. Ms Dalton was left with the belief that her satellite proposal was 'sitting with executive'.⁴² Ms Dalton contacted Janine Searle at the Placement Services Unit to request that efforts be made to identify another young person who would be suitable to live with Nathan in the satellite placement.

Ultimately, no action was taken on the request to source a placement match. Ms Searle held a mistaken belief that Nathan was to remain at the unit. She expressed this view to Mr Reilly, who, in effect, confirmed her mistaken belief. He told Ms Searle the care team wanted Nathan out of the unit, but he was not currently supporting the satellite placement. Ms Searle took the view this clarified the situation and the placement match was not pursued.⁴³

Ms Whitten advised Amanda Shaw, the acting guardian, that she took responsibility for not approving the satellite proposal. However, she took that responsibility as the most senior executive involved, not because she had made the decision.⁴⁴ She told Ms Shaw that there was 'potential for a house' but no staff yet.⁴⁵ Any potential for Nathan being moved to a smaller house was contingent on there being an active referral for him with the Placement Services Unit.⁴⁶ The evidence supports the conclusion that no such active referral had been made.

The Commission is unable to determine who, if anyone, ultimately determined to reject the satellite proposal. With multiple parts of the Agency involved in decision making, and with decisions made in the absence of key personnel, the lines of communication became fatally confused. Failure to follow the chain of authority of decision making, and to document decisions made, added to the confusion.

With the satellite proposal having 'drifted into obscurity'⁴⁷, and no effort being made to find a child to reside with Nathan, or an appropriate house, all efforts to secure a more appropriate placement for Nathan stalled. The short-term initiatives implemented did Nathan no harm, but they were no solution to his more fundamental underlying relationship issues. As time passed without remediation, these issues were severely impairing Nathan's functioning.

THE QUARANTINED WING

A multi-agency meeting was held on 18 June 2014, under the auspices of the Community Protection Panel, to discuss placement options for Nathan. Of all of Nathan's challenging issues, his placement was regarded as the most pressing. Families SA reported it was exploring a short-term 'hybrid' option which came to be known as the 'quarantined wing'.

The proposal was based on an understanding that Nathan would react negatively, and most likely violently, if forced to have close relationships with one to two people, as would be the case in any placement on his own. The quarantined wing would encourage Nathan to develop such relationships by placing him in a wing of the unit by himself with 'a consistent team of carers, who could push his capacity to form and maintain relationships, but not to the point where he would become overwhelmed'.⁴⁸

The plan depended on three other residents in Nathan's wing being relocated. Families SA would incur the cost of three out of four beds in a wing being unoccupied.

It was hoped that Nathan could later transition to a more intense arrangement such as a specialist therapeutic residential care program or foster placement. It was emphasised at the multi-agency meeting, and subsequently by Dr McEvoy, that Nathan's ability to cope with any changes in care arrangements would need to be carefully assessed. Dr McEvoy reported that 'overwhelming Nathan with new relationships is potentially harmful and will undermine the plan agreed to at this meeting'.⁴⁹

The plan was approved, Nathan agreed to the change and an action plan was put in place. By the end of July workers had been identified to work alone with Nathan in his wing. Then progress stopped.

CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

On 1 September 2014 the guardian Ms Simmons wrote to the Minister for Education and Child Development about Nathan. She said she did so as a 'last resort'. She told the Minister that 'his self-harming and high risk behaviour has escalated in the past two months. I fear that he may unintentionally die.'⁵⁰

Taking into account his time in emergency care and his time at the unit, Nathan had spent almost a third of his childhood in care arrangements that were universally agreed to be inappropriate for his care. A third of his life had been spent waiting for something more suitable.

It was not until June 2015 that the quarantined wing came into operation.⁵¹ The other occupant, a 17-year-old violent male, had refused to leave the unit until he turned 18.

The success of the quarantined wing was in part dependent on the availability of a small group of skilled workers who had been able to build a relationship of trust with Nathan. However, by the time the wing was available, staff originally identified as appropriate had changed.⁵² Despite recommendations against changes to the plans, and despite advocacy from GCYP against the move, the unit supervisor Mr Kevesevic, one of Nathan's key workers, moved away from the unit shortly after.

By July 2015 no long-term plans had been made for Nathan's case direction or placement transition from what had been intended to be an interim measure. GCYP continued to advocate for planning and a transition to more appropriate care.

In September 2015, Nathan was still residing in the quarantined wing at the unit, but his care team included only one of the original group identified to work closely with him. That worker was to move to a different position soon after.⁵³

OBSERVATIONS

The case study highlights system deficits in four key areas:

- the effect that emergency rotational care can have on the psychological health and development of children, perhaps particularly, children with pre-existing trauma and neglect histories;
- the extent to which educational systems understand and are capable of providing services to trauma-disturbed children, and the effect of educational disengagement on the stability of care placements;
- the lack of appropriate residential care options for young people with complex needs; and

- the quality of case planning and the manner in which complex, expensive and high profile case management decisions are made in the Agency.

Each of these areas is considered in this section.

THE EFFECT OF EMERGENCY CARE

The operation of Nathan's reactive attachment disorder undermined his ability to settle into his foster placement with Mr and Mrs P, which would otherwise have given him his best chance of stable and sustained long-term care.

From age six to age eight Nathan was placed in emergency rotational care. All the experts who gave evidence regarded the period in emergency care as contributing to Nathan's high level of dysfunction.⁵⁴ In 2010 Nathan's psychologist reported to Families SA:

Nathan's behaviour is no longer regulated by a concern for maintaining close emotional ties with significant people in his life. He is not being properly socialised. He is prone to extreme behaviour and affective displays in association with longstanding difficulties with affect regulation and clinically elevated autonomic (brain) arousal. There are no restraints on him committing such acts. In the absence of him being afforded the opportunity to form and maintain close emotional ties with a consistent carer or caregivers, he is almost certain to experience poor outcomes in most if not all aspects of his life. He is also a significant risk to the welfare and wellbeing of others. He is eight years old.⁵⁵

The experts agreed that the rotational care environment was not helping to give consistency between the care environment, educational environment and messages being delivered through therapeutic engagement. Any progress in remediating Nathan's psychological dysfunction, and developing the relationship capacity necessary for healthy future functioning, was not possible while Nathan was being cared for by a series of rotational carers with no training in the complex needs of a trauma-damaged child.

SUPPORTS PROVIDED BY EDUCATION SYSTEMS

Nathan's behavioural and psychological issues presented the public education system with a challenge it appeared ill-equipped to meet.⁵⁶ Repeated attempts were made to safely engage Nathan in education, yet they all failed. Nathan's educators attempted the same strategies over and over again expecting to achieve different results. Each school approached Nathan with the expectation that special measures would enable him to fit into the existing system, rather than having the flexibility to change the system to meet his needs.

The failure of these repeated efforts shows that the education system was not equipped to offer a different approach to Nathan's challenging condition. At the core of these failures a rigid system failed to understand that traditional methods of behavioural management were ineffective for Nathan's reactive attachment disorder. This approach had troubling consequences for Nathan.⁵⁷

A public education system must be able to accommodate young people with behavioural challenges stemming from trauma-related backgrounds. It is the task of Education to accommodate every student: 'there's no-one else'.⁵⁸ The system should demonstrate an understanding of what is required to support high-needs students to participate in education.

The case study identified failings in five key areas in education services for Nathan:

- transition between schools;
- adherence to departmental policies;
- understanding how to support a child with reactive attachment disorder;
- working with Families SA; and
- missed opportunities.

TRANSITION BETWEEN SCHOOLS

When it is necessary to remove a particular child from a particular school, their start at a new school should not be unduly delayed.

Some planning was needed to ensure Nathan's new school environments were suitable. However, the delays exceeded any necessary planning period. Nathan spent lengthy periods not attending school while members of his care team negotiated and advocated for his enrolment, even after a particular school site was directed to enrol him. These periods saw his growing disengagement from education and an exacerbation of behavioural symptoms.⁵⁹

School principals must provide a safe learning environment for school, staff and every child. Risk planning, special conditions of enrolment and additional support might be needed to secure the enrolment of students who have high needs.⁶⁰ However, those conditions cannot be so onerous that they have the effect of precluding high needs students from participating in public education. For Nathan, the conditions sought by one school were prohibitive, and based on a flawed understanding of reactive attachment disorder's effects. Imposing such restrictive conditions effectively excluded Nathan from attending that school.

NON-ADHERENCE TO POLICY

Strict policies operate for the use of part-time schooling for students who are challenged by full-time attendance (see Chapter 10). Specific exemptions, with authorisation at different levels, are required, depending on the duration of the part-time school attendance.⁶¹

Despite Nathan's school attendance being based on reduced hours for a number of years, Education held only two exemptions for Nathan attending less than full time. This suggests a failure to comply with the strict processes governing reduced school engagement for students of compulsory school age. Nathan's behaviour presented particular challenges that might have justified part-time school on occasions, but inconsistent compliance with the necessary safeguards undermined oversight of his educational needs.⁶²

UNDERSTANDING HOW TO SUPPORT A CHILD WITH REACTIVE ATTACHMENT DISORDER

Continued efforts were made by Education to put in place supports that would help manage Nathan's behaviours. However, the same or slightly varied measures were repeatedly adopted by the different schools, despite previous failure. This demonstrates a global inability to communicate and learn from past experience.

At the individual care level, the Commission observed gaps in understanding and responses to the effects of Nathan's reactive attachment disorder on his behaviour. The support of an SSO was an important feature of the measures adopted to allow Nathan to safely engage in schooling. The evidence raises the possibility that some SSOs engaged to work with Nathan lacked the necessary understanding of his psychological challenges. There was no evidence that any had completed any specialised training to equip them to support Nathan.

A frequent response to Nathan's more extreme behaviours was the use of suspension. As has been observed, the use of traditional punitive methods is not effective in managing the behaviour of children affected by reactive attachment disorder. The continued use of such methods reinforced Nathan's negative behaviours and undermined the effect of therapeutic approaches adopted by Nathan's carers. Nathan's educators appeared to be unwilling to acknowledge that traditional punitive and exclusionary approaches would not bring about sustainable behavioural change.⁶³

Moreover, continued suspension had a damaging effect on the stability of Nathan's placement. His behaviour worsened, and Mr and Mrs P failed to receive the respite that school attendance would have given them.

CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

Employees at learning centres receive training in managing abuse-related trauma. The Commission observed that learning centre staff did not demonstrate the level of understanding and acceptance of trauma-related behaviour that would be expected for staff working with the demographic of children who attend learning centres. Instead, instances of staff demonstrating poor understanding and response to Nathan's behaviour were observed (see Chapter 10).⁶⁴

During exclusions a student should be referred to a learning centre. The child should be helped to manage their behaviours and seriously work on re-engagement.⁶⁵ A learning centre could also be used as a stepping stone to a student attending a new mainstream school.⁶⁶ The time Nathan spent at learning centres did not lead to his re-engagement in mainstream education.

WORKING WITH FAMILIES SA

There was little evidence that public education systems were prepared to work collaboratively with Families SA and Nathan to ensure his education was not threatened by long periods of disengagement.

The inability of Families SA and Education to reach agreement about funding school supports is noteworthy. It was not clear where ultimate responsibility rested for financing specific supports. Nathan's case management was punctuated with discussions about payment for education supports and attempts to shift those costs.

The more significant issue is why Families SA were expected to make a financial contribution to the public education system for supports for Nathan. In the usual course of events, parents or caregivers are not expected to fund one-to-one support for a high needs child where it is considered necessary. Jayne Johnston, the Department's Chief Education Officer, was unable to explain why Families SA would be expected to contribute to this funding, other than to suggest it had been the practice in the past.⁶⁷ In the absence of clear policies, children in care are disadvantaged by futile bureaucratic squabbles about funding.

MISSED OPPORTUNITIES

Nathan's difficulty in engaging in mainstream education was apparent almost from the outset. Mr and Mrs P were keen for Nathan to attend mainstream school, but it is unclear why opportunities were not taken earlier to enrol him in available intervention programs,⁶⁸ which included⁶⁹:

- behaviour centres—early intervention programs for children becoming disengaged from school to help them develop their education and social skills outside a mainstream classroom; and

- the Flexible Learning Options program—which provides a case manager funded by Education and alternative programs that focus on engaging Nathan and his carers in his learning.

Patricia Strachan, the former Executive Director of the Office for Children and Young People in the Department, acknowledged that case management would have been an important part of supporting Nathan to re-engage with schooling.⁷⁰ Ms Johnston pointed out that the Flexible Learning Options program 'is designed exactly for students like Nathan ... if there'd been a case to be more flexible in the primary years ... Nathan's is the case. We really should have taken it.'⁷¹

THE EFFECT OF SYSTEM FAILURE

Nathan's lack of engagement in schooling placed strain on Mr and Mrs P. The eventual placement breakdown should have been foreseen by members of the care team working closely with them.

In addition to the benefits participation in education has for children and young people, there are key benefits for their caregivers. Respite is but one element. Participation in a positive education setting can improve a young person's social skills, relationship capabilities and self-regulation of behaviour.

School suspensions or exclusions can generate hopeless circularity for children and young people with complex needs. The burden on caregivers can contribute to placement breakdowns which create instability across all aspects of a child's life. Instability affects a child's capacity to participate in education, and the cycle repeats.⁷²

Given the consistency with which Nathan was suspended and excluded from mainstream schooling, it is not surprising that he was almost completely educationally disengaged even before he began secondary schooling. Nathan's poor academic outcomes raise the possibility that he will not experience the feeling of accomplishment that comes from making a valuable contribution to the workforce or participating in post-secondary education or training.⁷³

THE NEED FOR TRAUMA-FRIENDLY EDUCATION SERVICES

The public education system exhibits a rigidity that does not easily allow or encourage diversion from the norm. It was unable or unwilling to give Nathan the flexible and positive learning environment necessary to support and manage his trauma-related behaviours. '[S]chools need to be able to provide inclusive education to meet the needs of their students irrespective of the profile of disabilities, challenging behaviours, children who have been traumatised.'⁷⁴

A culture of preparedness to engage with vulnerable students must be developed. To do so, professional development and practical supports are necessary for teachers to improve the level of understanding of students with significant trauma backgrounds. Specifically trained SSOs could be one aspect of the necessary supports.⁷⁵

INSUFFICIENT CARE OPTIONS FOR CHILDREN WITH COMPLEX NEEDS

Nathan's high needs were apparent from an early age. With the exception of his placement with Mr and Mrs P, his care history does not demonstrate placements that appropriately supported his condition.

The placement of this child with reactive attachment disorder in emergency care staffed by commercial carers contributed to the worsening of Nathan's condition. The absence of home-based care options or a more appropriate residential placement equipped to care for Nathan, whose needs were already highly complex at age six, reflects the general absence of specialised residential care services for children with complex needs.

While home-based placements are commonly viewed as the best option for children in care, sometimes children's needs are better served in other environments. That point for Nathan came on the disintegration of the therapeutic foster placement. Nathan needed a placement that reflected his care needs, which were specifically informed by his reactive attachment disorder.

After the placement with Mr and Mrs P had broken down, was there a realistic prospect of improving Nathan's condition if he had been placed in different care environments?

A REALISTIC ASSESSMENT OF NATHAN'S PROSPECTS

At the point that Nathan left his placement with Mr and Mrs P, principal clinical psychologist Claire Simmons felt that Nathan's best chance of a different trajectory was a therapeutic environment that could contain him, available from the time he left his foster placement. She agreed in evidence that the best option for him was a smaller house, although safety issues would need to be worked through because of the lower staff levels.⁷⁶ If an intensive therapeutic placement had been available she would have liked Nathan to be given that chance. However, she opined that in all likelihood Nathan would find such an arrangement too intense and would run from it.⁷⁷

Ms Simmons said the extent of Nathan's trauma, coupled with his anger, his rage and his physical strength set his circumstances apart as a child with especially high and complex care needs.

Ms Simmons was realistic about the prospect of Nathan achieving a different trajectory even if a more appropriate placement was found. Even if Nathan had been placed in a smaller house, with a lower risk of exposure to anti-social and criminal behaviour, his circumstances were nevertheless likely to lead him down that path. She explained:

so my concerns around residential care are that they come into contact with people, pick up new at-risk behaviour from other children or young people, so absconding obviously, or drug use or alcohol use, or becoming involved in high risk sexualised behaviour—all of these things. You get a sense of cross contamination ... but kids basically show each other all their other problem behaviours and they pick those up ... [C]hildren like Nathan, they run and they find each other.⁷⁸

With such prognosis, it was all the more necessary that, at this critical point, care was provided at a standard and in a form that gave Nathan's condition the best chance to improve.

THE UNIT

At the time that Nathan was placed in the unit, no-one there was capable of managing the complex trauma behaviours of an 11-year-old boy without resorting to police intervention.

The placement offered a greater capacity than commercial care to control the quality of care for complex children,⁷⁹ but otherwise remained an inappropriate choice for Nathan, a conclusion supported by all the experts.

This option was the least-worst option available at the time. It was not a good choice, but it was not as bad as the alternative, that is, emergency care.

The lack of available placement options for children with high needs, such as Nathan, not only leaves them in a holding pattern, it has the effect of contributing to their disadvantage. The effects of poor placement decisions also flow on to other children in the placement. As observed in Nathan's case, ill-advised combinations of children in placements can contribute to instability and exposure to damaging behaviours such as drug use, absconding and offending.

CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

Placement choices for Nathan's care were made in the context of limited available placement options. Families SA was compelled to act against considered advice from its own experts, who correctly plotted the trajectory of Nathan's disintegration within the care environment. This does not meet the commitment given by Families SA in 2011 in its policy statement Directions for Alternative Care in South Australia 2011–2015 to:

deliver a service which provides a range of care placements that are:

- *flexible within and across the whole of the alternative care sector*
- *responsive to the individual needs of children in care.*⁸⁰

The problem of limited placement options can be observed not only in the decision to place Nathan at the unit but also in his continued residence for almost two years before arrangements tailored to his needs could be put in place.

OTHER VIABLE OPTIONS

When Nathan was placed at the unit it was on an understanding that it would be an interim measure.

The question arises: were there other options available for Nathan's care?

ITC was an option under consideration. During the period that Nathan was at the unit, other young people were being accommodated in customised intensive placements. Nathan's advocate from GCYP, and Ms Davis, a clinical psychologist, were aware of small numbers of children with issues of a similar complexity to Nathan who had been offered placements where they were cared for individually, with two workers available at any one time. Nathan's advocate from GCYP knew of four such instances in the two years preceding Nathan's entry to residential care.

However, the path to access ITC is unclear. None of the Commission witnesses intimately involved in the field of residential care and the support of children within that environment, were able to identify the precise pathway by which a child might obtain an ITC placement.

In addition, there was confusion about the availability of any placement for Nathan. Some within Families SA clearly thought that Nathan was on a waiting list, or that he would be eligible for such care if a placement became available. This had been conveyed to GCYP.⁸¹ However, this conflicts with other information. In October 2013, Ms Daniel, supervisor at the local Families SA office, reported to Mr Waterford that the Placement Services

Unit had indicated from the start that no other placement options were available for Nathan.⁸² Even two weeks after Nathan's admission to the unit, a case note recorded:

*At this time the best option for Nathan is to remain in [community residential care] with Families SA staff to work with him on establishing clear boundaries and support him in developing appropriate skills and coping mechanisms. As he settles and becomes ready to explore alternative care arrangements, a new placement request will be undertaken.*⁸³

As late as December 2013 there remained a degree of confusion, at an organisational level at least, as to whether Nathan was in fact on a waiting list for a therapeutic placement.

It is not possible to determine on the available evidence whether ITC was ever a viable alternative for Nathan. Certainly the evidence supports a conclusion that within weeks of his placement at the unit it was removed as an option.

Other placement options subsequently considered for Nathan included the satellite proposal, the placement in a house with an appropriately matched other child and, ultimately, the quarantined wing. Each required additional commitment by way of staff and infrastructure, combined with these resources becoming available. It took two years for the circumstances to arise in which care could be provided to Nathan in an environment mimicking, but not matching, that initially contemplated when he entered the unit.

CARE PLANNING

It is clear that Nathan's placement at the unit was a decision borne out of what was available rather than what was appropriate. A number of factors contributed to the decision to place Nathan in a large congregate care facility and the case drift that saw him remain there:

- no concurrent planning at an early stage when it was clear that the foster care placement was at risk, which made it necessary to take the first available placement versus planning for the best placement fit for Nathan;
- confusion about the existence of an intensive therapeutic care placement and, if it existed, in what circumstances it would be authorised;
- a lack of attention to the urgency of placing Nathan in an appropriate home environment that considered his developmental timeframe and risk-taking behaviours;
- a disconnect between case planning work at caseworker level and decisions made at the Executive level;
- a lack of clarity about the decision-making authority and responsibility;

- poor communication with the caseworker about what was and was not possible;
- expansion of the care team beyond a core group which dispersed decision making and undermined clarity of purpose;
- the lack of strength in the residential care workforce which hampered the flexible deployment of staff in accordance with the best interests of the child; and
- the large residential care facility which, by design, was unsuitable for accommodating complex young people in a congregate care setting.

By the time Nathan was 10 years old, it was clear to Families SA staff managing him that his foster care placement was in peril and, if it could not be saved, then thought and planning would need to be invested in determining the best alternative. However, rather than proactive case planning at an early stage, the foster placement was permitted to drift towards a crisis which then necessitated reactive decision making.

Early decision making was contaminated by the view that Nathan could be moved into something more appropriate quickly. As observed, some staff believed the waiting list for therapeutic placements existed and Nathan was on it.

The evidence in this case study supports the conclusion that by the time the placement with Mr and Mrs P broke down, the most sophisticated proactive case planning may not have changed Nathan's outcome. Attributing blame to case planning assumes that what Nathan needed was in existence or could be arranged at the time. The evidence supports the conclusion that the state of the residential care workforce was such that any flexible arrangements for high needs young people were very difficult to staff without resorting to commercial care providers. It also supports the conclusion that by this time Nathan's needs had become exceedingly complex.

Acceptance of the unsatisfactory placement at the unit as a temporary measure saw Nathan's priority for placement decrease. Ms Simmons observed that once children are placed in units, they become victims to a process of triage. Their needs are seen as less than those of many other children in other inappropriate arrangements. This process of triage is driven by the highest need on the day.⁸⁴ It can be envisaged that children with complex needs, for whom significant planning is required to achieve an appropriate placement, are at a disadvantage in this process.

When this triage process was added to the observed lack of proactive planning by Families SA during the early part of Nathan's placement, the available options for Nathan narrowed further.

There came a point in Nathan's care journey when, despite the inappropriateness of the physical environment, the relationships that he had built with staff at the unit had assumed an importance to him that could not be disregarded in his therapeutic plan. Ms Whitten observed in evidence (in a different context) that 'young people aren't packages to be picked up and moved elsewhere because adults make decisions about them'.⁸⁵ Nevertheless, Nathan's placement in what everyone agreed was an unsuitable environment from the start, carried with it the very real risk that it would drift along and become a permanent, unsuitable, home.

When Ms Dalton finalised her proposal for a satellite placement, there were significant barriers to implementation. As observed, there was no clarity about the status of the proposal. Decisions were made within the residential care directorate about where Nathan would remain without any significant input from his caseworkers or other professionals advising on his care.

The Commission observed a clear disconnect between managers and executives having input into Nathan's care and the workers that were managing him day to day. High level decision making and identification of issues did not appear to filter down in a systematic way. What was and was not possible was not clear and case direction floundered. Mr Reilly observed that the separation of decision making across residential care, case management and executive level managers led to silos of information and decision making. He favoured a much more transparent approach of making all the information clear and feeding back down to case manager level the known constraints and barriers.⁸⁶

It is difficult to precisely identify the source of this disrupted information flow. Mr Reilly observed that in contrast to other government agencies in which he had worked, the culture of Families SA tended to emphasise hierarchy and chain of command, with significance on people's level and responsibility. This, he thought, made it difficult for a worker to have direct conversations with managers who were having direct input into case management on individual children.

It is inappropriate to blame individual workers for the events which saw Nathan's circumstances deteriorate. Entrenched deficiencies in the flexibility of alternative care restricted the options that could realistically be offered, even with the most proactive and creative case management.

CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

CONCLUSION

This case study reveals that changes are required at a fundamental level in the alternative care sector to provide supportive placements for children with complex needs.

The ability of Families SA to provide such placements depends on the availability of staff and facilities for placements appropriate to the needs of the individual child. This includes staff who understand and can react appropriately to the complicated behaviours demonstrated by children who have experienced trauma. The case study demonstrates that Families SA is not adequately equipped to provide such services to children for whom it cares.

Inappropriate placement choices do more than place children's needs on hold. They actively foster disadvantage for children. For very young children, at crucial stages in the development of attachment relationships, placement in environments such as rotational care does not help them to form normal attachments. For older children, their placement in congregate care environments, such as units, exposes them to drug use, violence and other risky behaviours. For children with complicated psychological or psychiatric conditions, placements might be staffed by carers who are not sufficiently trained to respond to their needs. Nathan's placements exposed him to each of these disadvantages during his care journey. Each acted to contribute to the development of reactive attachment disorder and its effect on him.

Attention should be given to a child's placement throughout the child's period in care. The need for placement change should be recognised and considered attention should be given to planning for change. In addition, the warning signs of disintegration in an otherwise appropriate placement need to be heeded and steps taken to avert placement breakdown.

For Nathan, targeted intervention at an earlier stage in his placement was the best chance he had to divert from the negative trajectory he took on entering the commercial care placement and, subsequently, the unit. The inability of Families SA to grasp these opportunities can be attributed to the absence of placement planning at an earlier stage, deficits in decision-making processes and communication within the Families SA hierarchy. They also failed to source more appropriate placements when he entered these unsuitable care environments. Possibly the greatest cause was the absence of accessible and available placements for children with complicated care needs.

The manner in which the public education system responded to Nathan's complex behavioural and psychological needs exhibited similar deficiencies. Lack of understanding of Nathan's condition, combined with a rigid system which expected him to conform to its standards, prevented him from actively participating in education. Squabbles between agencies and unrealistic conditions placed on enrolment saw Nathan too frequently absent from schooling.

Nathan's experience demonstrates the importance of schooling on a child's wellbeing and on the stability of placements for children in care. Education and child protection systems are intrinsically entwined in a child's experience. For children in care, systems need to work together to support care and schooling placements as a means of supporting and maintaining the wellbeing of the child and helping them develop to their full potential.

NOTES

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5

CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

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CASE STUDY 5 SHANNON MCCOOLE— KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

OVERVIEW

On 10 June 2014 police attended the home of Shannon McCoolle. They had been alerted to McCoolle by law enforcement authorities interstate and overseas who were investigating a child abuse website. Images on the website appeared to have been produced to share with others. Evidence pointed to McCoolle as the creator of images on the website.

McCoolle's computer equipment was seized by the police. They discovered a vast number of images, which included images of McCoolle sexually abusing seven different young children. Six of those children, but not the seventh, were identified as being in the care of the state. McCoolle had been entrusted with looking after them in the course of his employment, primarily in the southern region of Adelaide. He was charged with offences of sexual abuse with respect to those children and, in addition, offences relating to the production and dissemination of child pornography. The latter offences included his activities in creating the images and acting as the administrator of a website which disseminated child pornography, as well as discussing the sexual exploitation of children.

This case study is concerned with the deficits in the child protection system that enabled McCoolle to gain access to his victims and to escape detection for an extended period of time.

On 7 August 2015, Judge Rice in the District Court sentenced McCoolle to 35 years imprisonment and fixed a non-parole period of 28 years. In the course of his sentencing remarks, the judge described McCoolle's conduct as evil and depraved—conduct which evoked feelings of rage and revulsion in right-thinking people. He observed that McCoolle's conduct impacted not only the infants and children who were the victims of his offending:

Families SA is another victim because your actions have unfairly and unreasonably clouded its vital functions. Confidence and trust here have been called into question. Individuals in undertaking their important roles feel as though they need to be watchful and even suspicious of those with whom they work. In a sense, no-one is above suspicion.¹

Although McCoolle's offending conduct was unprecedented in its frequency and severity, the risk of abuse to vulnerable children in institutional environments has been well known for some years, both within Families SA and in the community more generally. Currently, it is the subject of the Royal Commission into Institutional Responses to Child Sexual Abuse.

This case study highlights a tolerance of acknowledged risks that developed within Families SA through poor workforce planning and budgetary pressures, which led to a dearth of alternative care options for the increasing number of children entering residential care.

Children removed from their birth families suffer developmental disadvantages which can manifest in challenging behaviours. These disadvantages are amplified when such children are cared for in rotational environments, including emergency and residential care. Knowledge about a child's behaviour, health, psychological and emotional wellbeing is scattered throughout Families SA. Without a high level of organisation and commitment, it is impossible to obtain the full picture of a child's experience, as would be possible in a caring environment with no more than one or two consistent carers.

The case study examines McCoolle's employment at an out-of-school-hours care (OSHC) service which helped him obtain a position at nannySA, an agency which supplies staff to residential care facilities. It examines the processes of recruitment and management of workers by nannySA and Families SA to determine the extent to which they protect children from adults who might be inclined to abuse or neglect them. It reviews workplace policies, practices and culture, and examines the conduct of a care concern investigation into McCoolle's behaviour.

Deficiencies were observed in each of these areas, which permitted McCoolle to offend undetected for such a long period of time.

The evidence against McCoolle was not gained from any of the victims of his abuse, nor from his work colleagues advancing their concerns to the point that they were heard, but rather from his own recordings of his crimes.

EVIDENCE

In 2011, Families SA engaged paid staff to look after children in care in a variety of settings. One residential care program, known as transitional accommodation, provided care to children in small homes staffed by rotating shifts of carers. Most of those staff were employed by Families SA, and were subject to their direct supervision and oversight. A second program began in 2011; it placed children in housing obtained through the Australian Government's Nation Building Stimulus Package (Nation Building houses). Delays in the recruitment of staff to this program (see Chapter 12) meant most of the staff in these houses were employed through a commercial agency. They were not supervised nor managed with the same rigour as Families SA residential staff.

CASE STUDY PARTICIPANTS

PSEUDONYM	POSITION (AT THE RELEVANT TIME)	ORGANISATION
Ms A	Director	OSHC
Ms B	Youth worker	Residential Care Directorate, Families SA
Ms C	Youth worker	Residential Care Directorate, Families SA
Ms E	Assistant director	OSHC
Mr F	Recruitment coordinator (selection panel for McCoole)	Residential Care Directorate, Families SA
Mr G	Senior youth worker	Residential Care Directorate, Families SA
Ms H	Carer, subsequently youth worker	nannySA, subsequently Residential Care Directorate, Families SA
Ms K	Carer	nannySA
Ms L	Carer	nannySA
Ms M	Youth worker (selection panel for McCoole)	Residential Care Directorate, Families SA
Ms N	Manager	Special Investigations Unit, DECD
Ms O	Youth worker	Residential Care Directorate, Families SA
Mr P	Youth worker	Residential Care Directorate, Families SA
Mr Q	Youth worker (selection panel for McCoole)	Residential Care Directorate, Families SA
Ms R	Human resources consultant	Human Resources Misconduct and Incapacity Unit, DECD
Ms T	Rostering consultant	nannySA
Ms U	Trainee youth worker	Residential Care Directorate, Families SA
Ms V	Carer	nannySA
Mr and Mrs W	Foster parents for Chelsea	
Ms X	Placement support worker for Chelsea	Lutheran Community Care
NAME	POSITION (AT THE RELEVANT TIME)	ORGANISATION
Ann Marie Abela	Recruitment coordinator/human resources officer	nannySA
Marc Beltman	Caseworker for Chelsea	Families SA
Cate Braham	Chief Clinical Services Coordinator	Child Protection Service, Flinders Medical Centre
Dr Ken Byrne	Managing Director	Australian Institute of Forensic Psychology (Safeselect testing system)
Darren Calvert	Senior youth worker	Residential Care Directorate, Families SA
Tanya Cole	Managing Director	Hessel Pty Ltd (nannySA is part of Hessel Pty Ltd)
Peter Cross	Rostering consultant	nannySA
Graham Curyer	Youth worker	Residential Care Directorate, Families SA
Katherine Decoster	Supervisor, Transitional Accommodation program	Residential Care Directorate, Families SA
Wendy Dennis	Carer	nannySA
Josie Dimond	Carer, subsequently youth worker	nannySA, subsequently Residential Care Directorate, Families SA
Brett Dixon	Principal Investigator	Special Investigations Unit, Families SA
Peter Emmerton	Chief Executive Officer	nannySA
Janet Gregory	Carer	nannySA

DECD: Department for Education and Child Development OSHC: out of school hours care

CASE STUDY 5 SHANNON McCOOLE— KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

NAME	POSITION (AT THE RELEVANT TIME)	ORGANISATION
Robert Griffin	Senior youth worker	Residential Care Directorate, Families SA
Simone Hammond	Carer	nannySA
Corinne Hams	Youth worker (also acting senior youth worker)	Residential Care Directorate, Families SA
Catherine Harman	Manager	Care Concern Investigations Unit, DECD
Wendy Harmston	Youth worker	Residential Care Directorate, Families SA
Linda Hurley	Manager	Aberfoyle Park Office, Families SA
Toni Jezeph	Caseworker allocated to Mikayla and Levi	Aberfoyle Park Office, Families SA
Daniel Knight	Senior youth worker	Residential Care Directorate, Families SA
Kristin Kuehn	Principal consultant	Human Resources, DECD
Julia Lamont	Manager	Southern and Country Housing, Families SA
Julie Lawson Hall	Manager	Human Resources Misconduct and Incapacity Unit, DECD
Sue Macdonald	Director	Child Protection Service, Flinders Medical Centre
Christina Manderson	Youth worker (also acting senior youth worker)	Residential Care Directorate, Families SA
Dr Sarah Mares	Consultant infant, child and family psychiatrist	Expert witness
Bernadette Martin	Detective Sergeant	SAPOL South Coast Family Violence Section
Maree McCulloch	Operations manager	Bubble 'n' Squeak (child care facilities owned by Hessel Pty Ltd)
Danielle (Dani) McKenna	Business manager	nannySA
Noel McLean	Detective Senior Sergeant	SAPOL Special Crimes Investigation Branch
Lee Norman	Senior youth worker (supervision of McCoole)	Residential Care Directorate, Families SA
Professor James Ogloff	Clinical and forensic psychologist	Expert witness
Roslyn Packer	Customer care and administration manager	nannySA
Jessica Pinos	Youth worker	Residential Care Directorate, Families SA
Louise Purton	Acting senior youth worker	Residential Care Directorate, Families SA
Narelle Reedman	Carer	nannySA
Dr Jane Richards	Clinical psychologist, project director (implementation of recommendations from Hyde Review)	DECD
Karen Roberts	Youth worker	Residential Care Directorate, Families SA
Lincoln Rogers	Senior youth worker	Families SA
Melissa Rowley	Supervisor of Toni Jezeph	Aberfoyle Park Office, Families SA
Dana Shen	Director	Residential Care Directorate, Families SA
Nicole Stasiak	Director (current)	Residential Care Directorate, Families SA
Shane Sterzl	Supervisor, Nation Building scheme	Residential Care Directorate, Families SA
Mirjana Vidovic	Case manager for William	Families SA
David Waterford	Deputy Chief Executive	Office for Child Safety, DECD (Families SA)
Pamela Watson	Caseworker for Chelsea	Families SA
Don Williams	Supervisor with oversight of care concerns	Residential Care Directorate, Families SA

DECD: Department for Education and Child Development OSHC: out of school hours care

Families SA also provided emergency care for children yet to be placed in longer-term environments. Emergency care used places such as motels, hotels and suburban homes, and was also staffed by workers employed through commercial agencies. They, too, received limited supervision by Families SA.

At the start of 2011, McCoolle was employed through the commercial care agency nannySA, his first employment to look after children in state care. He worked shifts in all three forms of care through that agency. In May 2012, McCoolle was offered a contract as a child and youth support worker in Families SA. He worked shifts in that capacity until just before his arrest on 10 June 2014. During the time he was employed by Families SA, McCoolle continued to work shifts through nannySA, sometimes two shifts in sequence, one employed by Families SA and the next employed by nannySA.

EMPLOYMENT AT OSHC

Before he worked with children in care, McCoolle had had experience working with children in OSHC. Such experience is usually viewed favourably by Families SA and commercial care agencies supplying staff to residential care facilities. McCoolle's experience at an OSHC, at a suburban government primary school², was a stepping stone to his employment with nannySA.

From January 2010, McCoolle worked casual shifts at OSHC³, in his first remunerated position in Australia caring for children.⁴ These shifts continued alongside work for nannySA and Families SA until January 2014.

In about 2006, McCoolle had become friends with Ms A, whom he had met socially. She was the Director of OSHC for most of the time that McCoolle was employed there⁵ and responsible for the daily administration of OSHC.⁶ The only other full-time employee, Ms E, focused on supervision of the children.⁷ OSHC was otherwise staffed from a casual pool. A high staff turnover created pressure to frequently recruit casual staff.⁸

In late 2009, Ms A suggested to McCoolle that he might be able to obtain work at OSHC. McCoolle told her that he was enrolling in a teaching qualification at university.⁹ Ms A, assisted by Ms E, selected casual staff. The usual process of employment was submission of a curriculum vitae (CV), and a brief meeting with Ms A and Ms E where the applicant's experience was discussed, followed by a tour of the service. Suitable applicants were then offered trial shifts when the applicant could see how the service operated. Ms A did not conduct referee checks unless more information was required than was available in the CV.¹⁰

No formal qualifications were required for the position, although experience working with children was desirable. OSHC employment is often an entry point for people who are interested in working with children. It provides an opportunity to develop the skills which might be required for other positions.¹¹

The Commission has been unable to determine the specific process by which McCoolle was employed at OSHC. Ms A was not able to recall whether the usual process was followed, but maintained that she did not believe she would have diverted from her usual practice. She was aware that McCoolle's only prior experience working with children was in the United States of America at a summer camp. She did not contact referees from his last place of employment in South Australia, where he had worked as a communications technician, because she considered the work not relevant. She felt that her knowledge of McCoolle, obtained in a social setting, enabled her to adequately assess his character.¹² Ms E did not participate in the process of appointing McCoolle to OSHC; she was not present at any interview, nor was she asked her opinion of him.¹³

The selection process used contrasts with OSHC policies: staff selection processes must be merit based¹⁴, including the advertising of vacant positions, interviews conducted by a three-person selection panel which recorded processes and decisions, and confirmation or termination of the appointment of casual staff by the governing council after a probationary period.¹⁵ This process was not applied to *any* staff member appointed to OSHC.

McCoolle undertook his first shift with OSHC on Monday 18 January 2010. It is not clear from the evidence whether this was a trial shift. However, it was rare for applicants who were offered trial shifts not to be engaged.¹⁶ The high demand and turnover of staff meant some applicants were not scrutinised to an appropriate degree before they were hired.¹⁷

McCoolle's recruitment process might seem to have been more casual and ad hoc than the norm but it appears to be usual practice for friends or family. On occasions, when such people were engaged for casual work, it was without a formal consideration of their merits.¹⁸ McCoolle did not provide his national police clearance certificate until 26 February 2010, almost a month after his first shift. McCoolle completed Responding to Abuse and Neglect (RAN) training, the equivalent of Child Safe Environments training, in August 2010, about seven months after he began his shifts.¹⁹ At the time OSHC did not require employees to complete RAN training until after they had started employment.

CASE STUDY 5 SHANNON MCCOOLE— KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

Ms A maintained in evidence that the process by which McCoolle was appointed was 'merit based'. She saw no potential conflict in assuming the whole responsibility for hiring a friend.²⁰ This view demonstrates a lack of understanding of the concepts informing basic human resource processes.

MCCOOLE'S CONDUCT AT THE SERVICE

On 7 December 2010, Ms A provided a telephone reference for McCoolle to Ms T, who was considering an application by McCoolle for casual employment at nannySA. According to notes taken by Ms T, Ms A rated McCoolle's flexibility, maturity and punctuality highly.²¹ Ms A did not mention any concerns about his interpersonal skills or the way in which he approached the care of the children.²² She did not identify any areas needing improvement beyond 'perhaps more involvement in food prep'.²³ This appeared to accurately reflect Ms A's opinion of McCoolle's work at that time.²⁴

During McCoolle's employment at OSHC he exhibited behaviours which caused a number of his colleagues concern, although there is no evidence to suggest that Ms A was aware of that conduct before providing the reference to nannySA. McCoolle's conduct included attempting to discuss details of children in care with a colleague and showing photographs of such children to others. The latter was brought to Ms A's attention and she understood it was not appropriate. However, she did not do anything to raise the topic with Families SA or nannySA.²⁵

McCoolle was observed behaving inappropriately with children at OSHC. He was seen holding hands with children and on one occasion he commented to a colleague that a particular child needed to wear a bra. He exhibited a preference for a small group of children and engaged in play that was rough, and tickling beyond what was appropriate.²⁶ Ms A was made aware of some if not all of these behaviours and a number of them were raised with McCoolle as being inappropriate.

McCoolle was also seen behaving inappropriately with children while seated on the floor at OSHC. On one such occasion a female child was seated between his legs and was moving her hands on his legs. Ms A spoke to both the child and McCoolle, telling them to get up off the floor. McCoolle simply laughed the matter off and no further action was taken.²⁷

Ms E became unhappy about McCoolle working at OSHC. On more than one occasion she told Ms A that she thought there was something not right about him. In 2013 Ms E told Ms A, 'if you don't get rid of him or say something it's going to come back and bite you on the bum'. Ms E reported McCoolle's conduct and attitude concerning children to Ms A, and identified specific incidents of inappropriate behaviour towards children.²⁸

Ms A denied that she was told of Ms E's concerns about McCoolle's conduct but she was aware of Ms E's concerns about his personality, arrogance and boisterousness.²⁹ On this topic, the Commission prefers the account of Ms E.

MCCOOLE'S SUSPENSION

In mid-2013, McCoolle was suspended from Families SA (the Agency) while a care concern (discussed below) was investigated. There was no mechanism in the Agency to advise Ms A about this suspension; Ms A was told about it by McCoolle. He told Ms A that there was an allegation of inappropriate behaviour involving a child's bottom. Ms A did not believe McCoolle to be capable of the kind of behaviour alleged. She believed the complaint must be false.³⁰

Ms A did not seek advice from anyone in the Agency about dealing with a staff member who was suspended from Families SA. Ms A knew she could seek advice from the Agency's OSHC unit but did not see the need to do so. She made no attempt to ascertain the precise nature of the allegations to assess whether they might impact on McCoolle's suitability for continued employment at OSHC. As events transpired, McCoolle did not work any shifts at OSHC while he was suspended from Families SA. However, this was not the result of a specific decision not to roster him while suspended, but rather a fortuitous state of affairs as all shifts were filled by other staff.³¹

The Commission considers Ms A should have placed greater emphasis on the supervision and performance management of McCoolle, particularly after she was made aware of incidents of inappropriate conduct and the concerns of other workers.

THE CHAT LOGS

In the course of this case study, the Commission obtained access to a record of online chat logs which set out McCoolle's conversations with other like-minded people about his sexual attraction to children and how to get access to them. Statements made by him in these logs indicate that he was actively contemplating how to gain access to children within the OSHC environment. It is also clear from the chat logs that McCoolle had formed an intention to offend against children before he began work with nannySA and Families SA.³²

The chat logs include discussions about offending against children in care. McCoolle consistently turned his mind to how he could to gain access to children through his employment and discussed numerous strategies which could be used to avoid detection for sexual offending.³³

EMPLOYMENT BY NANNYSA

In late 2010 McCoolle applied for casual work with nannySA, part of Hessel Group Pty Ltd, a private company contracted to supply emergency care workers to Families SA. McCoolle began shifts with nannySA in January 2011 from its casual pool, which was maintained to fulfil contractual obligations with Families SA. At the time, nannySA consultants recruited and managed staff. They had no expertise in human resources or recruitment and no formal training or guidance as to the skills and capabilities required in an emergency care worker.³⁴

Applicants began the process by submitting their CV to nannySA for consideration. Suitable candidates were then invited to attend an interview at which they completed a registration form that included questions about their state of health. In his form, McCoolle claimed a clean bill of health. That conflicts with earlier statements to OSHC staff, and his subsequent application to Families SA, which noted a diagnosis of depression and the use of medication to treat anxiety.³⁵

Consultants interviewed candidates using pro-forma questions. After the interview the consultant would make a recommendation about the applicant's suitability for inclusion in the casual pool. McCoolle was interviewed by Ms T. Her notes of the interview and the ratings given to some of McCoolle's answers suggest that no more than a cursory understanding of the requirements of the role was sufficient for appointment to the casual pool.

Ms T's recommendation on McCoolle read (in full):

*Seems very level headed
ticked all the boxes re questions
had done his homework about nsa
very happy with his answers presentation and articulation.*³⁶

Ms T did not make the final decision about the appointment of McCoolle. She passed on her recommendation and references to a colleague in a different area of the organisation.

Applicants for emergency care work were not required to hold any minimum formal qualifications. Experience caring for children was desirable rather than mandatory. By way of contrast, applicants for positions in child care centres operated by Hessel were obliged to hold a Certificate III in Children's Services.³⁷

By 2010 some consultants were concerned they were unable to properly perform their recruitment role, that they had insufficient time to perform the function and felt pressure to hire enough carers to fulfil the agency's contractual obligations.³⁸ At times, this pressure left Ms T dissatisfied with the standard of staff appointed.³⁹

nannySA had a requirement that workers who had not undertaken shifts with them for a period of time needed to reapply through a fresh application process, although there was no fixed rule as to the circumstances in which a new application would be required. In 2012 and again in 2013 McCoolle was required to reapply for inclusion in the casual pool.

By 2013 nannySA had consolidated recruitment functions under the management of human resources and recruitment consultant, Ann Marie Abela. Ms Abela told the Commission that re-registration was subject to the same degree of scrutiny as the initial application and was dependent on the merits of each applicant. However, this was not the situation for McCoolle's re-registration in 2013. Ms Abela understood McCoolle had been approached to return to nannySA and said her task was limited to completing the necessary paperwork.⁴⁰ Ms Abela interviewed McCoolle as part of the re-registration process but she agreed that no genuine merit-based selection was applied.⁴¹

TRAINING

nannySA had to provide training and development to emergency care workers according to the conditions of its contractual agreements with Families SA.

nannySA depended heavily on Families SA for this training, although the training failed to deal with the complexities of providing care to children in emergency and residential care environments. Some deficits in the experience of casual workers were addressed by training delivered by nannySA. For example, McCoolle had no experience in caring for young children but nannySA gave him training in infant care and child nutrition—which took only about four and a half hours. It was intended to equip a person with no previous experience caring for young children with the skills required to care for between one and three children at a time, potentially on a single-handed shift. It focused on some of the practical aspects of caring for an infant but child development and milestones were not covered in any detail.⁴²

In 2010, Families SA delivered orientation training to nannySA workers who were going to undertake shifts in Families SA facilities. It was four months after McCoolle's first shift with Families SA before he undertook this training.⁴³ Specialised training outside of the basic induction was provided on the job by Families SA workers, and then only if a nannySA worker was tasked with caring for a child with particular needs.⁴⁴

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Some workers engaged through nannySA felt ill-equipped to work in Families SA facilities. They had little if any training about the kinds of behaviours they would see in children with a history of abuse and trauma.⁴⁵ From time to time the Managing Director of Hessel, Tanya Cole, received feedback to this effect from new workers. She attributed this to a lack of information from Families SA about the particular needs of the children in the placement, rather than inadequacies in the induction or training process.⁴⁶

When McCoole began his orientation, the training was delivered by a Families SA trainer. Over time this training program has changed. Presently, nannySA trainers deliver the orientation training in accordance with a package developed by Families SA. The package provides more information about dealing with children with trauma-related behaviours than was provided in the past. However, the training is not delivered by experts in the field of caring for children with complex needs. One of the trainers is Ms Abela, whose training and experience is in human resources.⁴⁷

The only training by nannySA on child sexual abuse was a generic course in child safe environments. This did not focus on the challenges of residential or emergency care environments. The only ongoing training was in the form of emailed practice guides dealing with specific issues.⁴⁸

SUPERVISION

When McCoole started his shifts looking after children in care, the Nation Building houses had begun operation. They were staffed exclusively by nannySA workers, under the supervision of Families SA operational services staff at senior and supervisor levels (OPS4 and OPS5).

From the start of this arrangement there was a lack of clarity about lines of responsibility for supervision and performance management of agency staff. Shane Sterzl was the first supervisor OPS5 appointed by Families SA to oversee Nation Building houses. He thought that Families SA senior staff were obliged to report concerns only to nannySA.⁴⁹ Ms Cole thought Families SA was responsible for performance management. These conflicting views left gaps in the supervision and performance management of workers.

In addition, lead carers or shift leaders were not identified. At times, this resulted in conflict. Work performance complaints made by nannySA staff were often dismissed as vindictive attempts to gain more shifts for themselves. One rostering consultant consequently adopted a practice of moving staff between houses to find a 'better fit'⁵⁰, an approach also evident in Families SA. This practice is perceived by other workers as moving problem performers rather than dealing with their issues.

Peter Cross, the nannySA rostering consultant responsible for supervision of McCoole, was aware of complaints that McCoole was too bossy and would tell supervisory staff 'what they wanted to hear'. However, other workers liked working alongside him because he was prepared to take a leadership role and got things done. Mr Cross thought that sometimes workers with such characteristics 'got shot down'.

THE ANONYMOUS CALL TO NANNYSA

On 16 March 2011, about two months after McCoole's first shift with nannySA, Roslyn Packer, the nannySA customer care and administration manager, received a telephone call from a person who remained anonymous. The caller wanted to provide information about a worker he identified as 'Shannon'. Ms Packer determined that 'Shannon' was McCoole.⁵¹

The caller said he was a friend of McCoole's. He said McCoole had been discussing looking after three young children, changing nappies, the children wanting kisses and cuddles at bedtime and places he takes the children.⁵² The caller also referred to McCoole posting derogatory comments about his employer on Facebook.

Ms Packer took the view that the information provided by the caller raised a concern about a breach of confidentiality on McCoole's part, rather than an allegation of anything more sinister. The information was passed on to Mr Cross as the relevant rostering consultant.⁵³

Mr Cross spoke with McCoole about this report and raised the concern about breach of confidentiality. McCoole claimed that someone was 'trying to make trouble for him'. He denied taking children anywhere except to collect them from school. He suggested the only comments he might have made about his employer would have related to difficulties with a former employer.⁵⁴

Given the limited information, and lack of context, nannySA took no further action. The information was not passed on to Families SA nor was there any contractual obligation to do so.

ACCESS TO INFORMATION AND RECORDS SYSTEMS

The capacity of commercial carers to access information about the children in their care was very limited. nannySA workers were not able to access the computer-based C3MS case management system and thus could not access or upload information on children in care. They recorded information about children manually, with the expectation it would be uploaded by Families SA senior staff. They also could not access the Families SA email system. Information that needed to be disseminated consistently to all workers in the residential care directorate (the directorate) could be communicated only personally by senior Families SA staff.

nannySA workers expressed concern to the Commission about the level of information they were given about children in their care. Julia Lamont, manager of the southern region and country area within the directorate, was aware of this concern. She understood the practice resulted from a concern about giving access to the system to workers who were not part of the ongoing workforce. Ms Lamont acknowledged this caused difficulties, particularly for nannySA staff who worked on a regular and continuous basis with a group of children, as was the case in the Nation Building houses.

Day-to-day events in residential facilities were recorded manually by workers in hard copy observation logbooks. Significant observations from these logs would then be extracted by a Families SA senior worker and entered into C3MS for the attention of a child's caseworker.

Critical incident reports are completed to record events that are too serious to be captured in the day-to-day records. Reports can be completed online by Families SA staff and directed to the attention of the relevant senior or supervisor. Agency staff in the Nation Building houses had to manually write reports and leave them to be collected by Families SA staff.⁵⁵

There was an inconsistent understanding about whether important observations of a child could be communicated directly by an agency worker to a child's caseworker. Some workers thought the practice was frowned upon, a view shared by some Families SA workers.⁵⁶ Mr Sterzl accepted the practice was contentious, but he had no issue with direct communication. However, lack of email access meant that contacting a caseworker could be a challenge for commercial carers, especially when hours of work did not align.

THE ORGANISATIONAL CONTEXT 2010-14

When McCoole began work with nannySA in early 2011, approximately 120 children were being cared for in 'emergency accommodation'. Other children were living in houses owned or managed by Families SA and staffed by commercial carers.⁵⁷

In October 2011 Nation Building houses in the southern area became available to Families SA. The properties were ready to house children, but the project to put them into operation stalled awaiting Cabinet approval for an increase to the full-time equivalent (FTE) cap that was required to staff them. In the interim, the houses were staffed with commercial carers. Formal approval to increase Families SA staff numbers was not given until June 2013, and from late 2011 until then recruitment in Families SA was limited to short-term contracts. It was during this period that McCoole initially applied for and received employment under a contract with Families SA.

CONTRACTUAL ARRANGEMENTS FOR THE USE OF NANNYSA WORKERS

Over time, nannySA held a series of service agreements for the supply of staff as emergency care workers. It was not until 26 September 2013 that a service agreement was in place which specifically provided for agency staff to work in Nation Building and transitional accommodation houses—both offered more long-term care for children than was contemplated by the service agreements for emergency care workers. In the interim, agency staff were either engaged in environments outside the description of emergency care, or without any agreement in place at all. Between 30 September 2012 and 25 September 2013, no documented agreement covered the use of nannySA workers in Families SA properties; a service agreement entered into on 26 September 2013 was expected to have retrospective operation.⁵⁸

The agreements in place contemplated workers providing temporary short-term care to children in crisis, where no other care options were available.⁵⁹ Staff were not obliged to have a high level of knowledge about child development and their training was not rigorous. The service agreements specified a worker to child ratio of 1:1. In practice, ratios of one commercial care worker to three children were commonplace.

In addition, the agreements did not reflect the presence of Families SA supervisors at Nation Building houses, and lacked any written instruction on how the new relationship between nannySA workers and Families SA staff would work. They contained no provisions which referred to oversight of the agreement's operation.

Residential care grew without the necessary service agreements covering staffing keeping pace. Houses were staffed with disregard for the existing contractual terms, and crucial aspects of service provision and systems oversight developed unchecked. The effect of this is highlighted in the different understanding of nannySA and Families SA as to who bore responsibility for worker supervision and performance management. Training was kept at the basic level, barely sufficient for providing emergency care, for staff deployed to care for children on a long-term basis.

EMPLOYMENT BY FAMILIES SA

By February 2012, McCoole had worked for nannySA for just over a year. His offending against children in care had started shortly after he worked his first shift through nannySA. It was well entrenched by the time he applied for work with Families SA.

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RECRUITMENT

In 2012, recruitment to Families SA's residential care directorate was managed by a recruitment coordinator. In late January or early February 2012, Mr F was appointed to this role, and the selection process involving McCoole, the first that he oversaw. Mr F had extensive experience working in residential care, but his exposure to recruitment practices in the directorate was limited to having acted as a peer representative on previous interview panels and from a handover period soon after he began the role.⁶⁰

Dana Shen was the Head of the Residential Care Directorate at this time and she bore the ultimate responsibility for recruitment decisions. Ms Shen had taken up this role in about October 2011.⁶¹ General human resources support was available to the directorate, but Mr F did not consider it extended to specific support for recruitment processes. He sought limited assistance from human resource consultants on some decisions.⁶²

Mr F's employment as recruitment coordinator coincided with the push to recruit large numbers of staff. He understood that Families SA wanted to be able to replace nannySA staff in Nation Building houses (although they could only do so by employing staff on short-term contracts). Mr F felt under pressure to increase staff numbers and his decisions were influenced by this pressure.

At the time of McCoole's application, OPS3 youth workers were not required to hold any formal qualifications. Successful applicants were required to 'undertake training to acquire certification relevant to the role'.⁶³

These conditions must be seen in the context of the responsibilities of the role such as:

- providing day-to-day care and support to infants and children;
- developing and implementing programs to assist and teach children;
- sensitively ascertaining information from children about their situations;
- supporting and counselling them and assisting in the development of a case plan; and
- assisting in training other workers.⁶⁴

Youth workers were expected to have '[d]emonstrated experience in working with vulnerable young people, and use of communication skills, behavioural intervention techniques and the physical capability to manage young people in crisis' and demonstrated knowledge of relevant child-related legislation.⁶⁵

MCCOOLE'S APPLICATION

On 16 February 2012 Families SA received McCoole's application. In addition to background information McCoole provided responses to four behavioural questions which were aligned to the role description.⁶⁶

In the CV attached to the application, McCoole said he was currently studying for a Bachelor of Education (Primary/Middle) at the University of South Australia. There was a reference to his experience with nannySA and OSHC, at a summer camp in the USA, as a rental technician supervisor at a ski store for children in Canada and in a YWCA Connect 4 Program. The referees named in the CV included staff from nannySA and Ms A from the OSHC program.⁶⁷

Mr F was joined on the selection panel by two youth workers, Ms M, an experienced senior youth worker, and Mr Q. Neither had previous experience in recruitment, nor had they received any training in recruitment or merit-based selection. Ms M and Mr Q continued to work shifts around their recruitment duties. The process placed significant demands on their time.⁶⁸

Each application was assessed by a panel member to determine whether it should progress to the next stage, considering the applicant's previous experience and responses to the behavioural questions.⁶⁹

McCoole's CV and written application demonstrated relevant prior experience working with children and young people. His responses to the behavioural questions were reasonable and he satisfied the criteria to advance. It is not surprising that he was advanced to the next stage along with 60 of the original 104 applicants.⁷⁰

On 28 February 2012 McCoole sat a suite of written tests compiled by the Australian Institute of Forensic Psychology (AIFP).⁷¹

The suite had three components: the Ability Test of a reading, numerical and writing component; the Shipley-2 of a vocabulary component and block pattern component; and five separate psychological tests.⁷²

The AIFP Test Event Summary report divided applicants into three categories:

- Recommend Further Evaluation with Comprehensive Report and Structured Interview;
- Recommend Caution—High Risk; and
- Recommend Review Application or Conduct Brief Initial Telephone Interview.⁷³

The advice provided on Recommend Caution—High Risk was:

*These applicants have either obtained an Overall Potential of Suitability (OPOS) Rating of Very Unsuitable or Unsuitable, or a COPS (Test 4) Prediction Ranking of Very Poor or Poor, or have tried so hard to 'fake out' the test that the results are unreliable. This happens with a Fake good score of 13 or higher. Applicants who have failed to answer a large number of items, or have a very low IQ score, or have answered extremely carelessly, will also be on this list. A Ranking of Very Poor or Poor is obtained by endorsing a **LARGE NUMBER** of items which reflect psychological disturbance, poor work attitudes, or personality traits that are incompatible with the role.*

*Extreme caution should be used in advancing a High Risk candidate's application. A thorough evaluation using the Comprehensive Report and Structured Interview is required.*⁷⁴ [Emphasis in original]

The Test Event Summary report revealed McCoole was among 14 applicants categorised as Recommend Caution—High Risk. His Prediction (Test 4) Ranking was very poor and his OPOS Rating was very unsuitable.⁷⁵

The reports provided two other measures. The Prediction Ranking was an estimate of job success, and a measure of potential psychological disturbance, negative work attitudes and potential for personality problems. The OPOS was a prediction of the applicant's potential for success in the particular role applied for. McCoole received the worst possible rating on both of these measures.⁷⁶

A comprehensive report about McCoole, described as a psychological report, was obtained. The report revealed McCoole held a number of attitudes potentially associated with immaturity. He would probably be less sophisticated in evaluating interpersonal situations and would be less willing to accept direction from supervisors. He was somewhat above average in both aggression and impulsivity, signifying some potential for abuse of authority. Possible concerns associated with drug and alcohol use, and gender and racial bias were identified.⁷⁷

The report identified a number of issues that warranted further enquiry⁷⁸—previous depression, isolation, the use of prescription medication for a nervous, psychiatric or emotional problem, and recent poor state of personal relationships.⁷⁹

It is not clear how the panel used the AIFP test results to determine whether or not an applicant would progress through the recruitment process, including on what basis the panel might exclude an applicant.⁸⁰ What was clear was that a Caution—High Risk recommendation

(coupled with advice that extreme caution should be used in advancing such an applicant), was not regarded as sufficient to exclude an applicant from advancing to the interview stage.

Ms M and Mr Q both concluded that McCoole should not be advanced to interview. They expressed their view but were overruled by Mr F, as the most experienced panel member and recruitment coordinator. Both were willing to defer to his views and did not challenge his decision to progress McCoole notwithstanding his test results.⁸¹

Mr F thought the high risk assessment was most likely attributable to past emotional concerns of McCoole. He did not consider that any aspects of the results were particularly concerning.⁸²

McCoole was one of 23 applicants advanced to the next stage of the selection process. He was not the only applicant with a Caution—High Risk recommendation who progressed.⁸³

On 9 March 2012 Families SA was advised by the Department for Communities and Social Inclusion Screening Unit that a National Criminal History Record Check and Screening Assessment had been completed and McCoole had been cleared.⁸⁴ This was a prerequisite for employment.

In late March 2012, McCoole undertook two observation shifts in different residential care houses, during which he shadowed a youth worker, who prepared a report for the selection panel. Following both shifts McCoole received positive reports.⁸⁵

The interview process

On 2 April 2012 McCoole was interviewed by the panel.⁸⁶ Although the Caution—High Risk recommendation advised an evaluation using the Comprehensive Report and structured interview, this process was not adopted. Mr F did not believe he was in a position to conduct such an evaluation. Instead, Mr F asked McCoole one or two questions about topics of concern identified in the report. Mr F found it difficult to determine which questions to ask. Some questions could elicit very emotional responses from applicants, and others related to sensitive topics, such as suicidal ideation, which Mr F did not consider could be appropriately explored in a panel setting.⁸⁷

McCoole's responses to the questions asked by Mr F assured Mr F that there were no problems that would prevent McCoole being appointed to the role.⁸⁸ During the interview McCoole was asked five standard questions aimed at assessing his abilities and suitability to work with children in residential care. The panellists recorded their own notes and scored each answer out of 5 for a maximum score of 25.⁸⁹

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Each panellist recorded some adverse comments about McCoolle's responses. Mr F noted some of McCoolle's responses were non-specific. He had to be prompted in relation to one question, he showed '[t]oo much allegiance to staff, not enough benefit of the doubt to [young person]' and demonstrated 'NGO Syndrome', an overconfidence in applicants who were already working in residential care facilities through an agency.⁹⁰ Ms M recorded that McCoolle answered one question 'with lots of hesitation to believe the child'.⁹¹ Mr Q noted that McCoolle required prompting and was autocratic. He observed a lack of child focus.⁹² Ms M and Mr Q both recorded comments relating to McCoolle's anxiety diagnosis.

McCoolle achieved scores of 15 from Mr F, 17 from Ms M and 16 from Mr Q.

On 3 April 2012 McCoolle underwent a medical examination. The report commented on two main issues: McCoolle had a very high body mass index, increasing the risk of manual handling injury, and a history of psychological difficulties, including the past use of anti-anxiety medication.⁹³ This result did not disqualify McCoolle from employment. Unlike his approach to AIFP results, Mr F would refer concerning aspects of medical assessments to a manager senior to him who would determine whether to progress the applicant.⁹⁴

Although referee checks were said to be conducted for external applicants, there is no evidence of such checks during McCoolle's recruitment process.⁹⁵

The panel report

A panel report to Ms Shen bearing a date of 11 April 2012 was prepared from a pro forma.⁹⁶

Only limited reference was made in the report to the AIFP results. The report included the following information:

Of the 61 applicants invited to the AIFP Suitability Assessment:

24 applicants recorded a 'do not advance' and were exited out.

...

23 applicants should be 'Advanced' to the next step of the selection process.⁹⁷

There was no reference to the fact that applicants who had identified as Caution—High Risk had nonetheless been advanced through the process. Ms Shen was not aware of this practice and assumed, from the wording of the report, that applicants who had received a poor AIFP report were not advanced.⁹⁸

The evidence suggests that the practice of advancing such candidates was in place long before Mr F or Ms Shen took up their positions. Despite asking applicants to undertake the test the directorate continued to use the results inappropriately. Moreover, Ms Shen was asked to approve recruitment decisions acting under a mistaken assumption of some assurance from the proper use of a psychometric test.⁹⁹

McCoolle, like other successful applicants, was recommended for a casual contract. The selection committee report noted he would benefit from training and experience with Families SA leadership but did not include any of the adverse impressions of the panel members from interview nor any reference to his history of anxiety.¹⁰⁰

McCoolle's performance at interview was allocated a rating of 64 per cent. The range for all interviewed applicants was 43 per cent to 88 per cent. In determining the percentage ratings only the interview scores were considered; and no regard was had to AIFP testing nor observation shifts.¹⁰¹ Of 19 applicants interviewed, 12, including McCoolle, were recommended for casual OPS3 contracts. Three applicants were recommended for casual OPS2 contracts.¹⁰²

The offer of employment

All new child and youth support workers were required to undertake a six-week induction and training course. This included learning both on the job and in a class-based setting,¹⁰³ and included topics such as non-violent crisis intervention, safe care of children and responding to challenging behaviour.¹⁰⁴ During his training McCoolle was employed on a full-time temporary contract from 1 May 2012 to 8 June 2012.¹⁰⁵ Following this induction, McCoolle was offered a casual contract to 31 August 2012.¹⁰⁶

TRAINING IN THE USE AND INTERPRETATION OF THE AIFP RESULTS

Mr F received no formal training in the use of the AIFP testing system. He had no broader training in psychology, and other panellists were in a similar position.¹⁰⁷

Mr F felt unqualified to understand and interpret the test results. Consequently, he considered it unfair to screen applicants out before interview on the basis of those test results. Mr F had no training or expertise in how to elicit information on those topics during an interview, nor in how to use any relevant information that was elicited. The end result was that test results were not considered appropriately.¹⁰⁸

Mr F said he told Ms Shen he did not feel equipped to properly assess the AIFP test results. He raised the same concerns with senior staff and managers in the directorate. Mr F said that Ms Shen told him in early 2012 the recruitment process had been reviewed by David Waterford, the Deputy Chief Executive, Office for Child

Safety, and he was happy with it. At the time Ms Shen was not concerned about a non-psychologically trained person being responsible for the testing as she assumed unsuitable applicants were not being progressed.¹⁰⁹

Mr F did not believe that the AIFP test was an overly credible, appropriate or fair test for residential care workers. He believed the statistical data underpinning the testing originated from studying public safety officials in the USA.¹¹⁰ Mr F thought the reports were an exercise in rubber-stamping reassurance regarding an applicant's risk of being overly aggressive.

Mr F said Dr Ken Byrne offered him training in the interpretation of the AIFP test. The cost of the training was approximately \$7000 for a group of 10. Dr Byrne also raised the topic of training with Ms Shen. Mr F said he was advised by Ms Shen that the Executive had declined to provide this training as it was considered too expensive.¹¹¹

THE JULY 2012 APPLICATION

In July 2012, McCoolle applied for another casual OPS3 youth worker position. This was commonplace when youth workers wanted to transition from an OPS2 to OPS3 position or from casual to full-time employment.¹¹²

McCoolle was one of 34 internal applicants. Mr F was the recruitment coordinator, assisted by two different panel members. A similar selection process to the original process was adopted, but there were variations for internal applicants.¹¹³

As part of this application, McCoolle included in his CV that he was studying for a Bachelor of Education at Charles Darwin University. Confirmation of this enrolment was never sought as part of the recruitment process.¹¹⁴ If it had been, the panel would have learnt that McCoolle was not in fact enrolled at Charles Darwin University and never had been.¹¹⁵

Internal applicants were not required to re-sit the AIFP psychometric testing. Consistent with practice, McCoolle's earlier test results were not considered by the subsequent panel. The second and third panel members therefore had no knowledge of McCoolle's unfavourable AIFP test results.¹¹⁶

As a current employee, McCoolle was not asked to perform an observation shift. Rather, a work report was sought from Lee Norman, a senior youth worker responsible for his supervision. The work report rated his performance in most areas as excellent. Mr Norman commended McCoolle's '[a]bility to relate positively to young people' and '[a]bility to manage young people in crisis', and rated McCoolle's communication abilities as 'excellent in all areas'. He concluded, 'Shannon is a well-rounded, confident, strong team player and is task oriented. A great addition to any team!'¹¹⁷

McCoolle was one of 13 applicants recommended for a full-time temporary contract.¹¹⁸

SIMULTANEOUS EMPLOYMENT WITH FAMILIES SA AND NANNYSA

Over some periods, McCoolle worked shifts through nannySA while employed as a Families SA casual.¹¹⁹ Many of the directorate's senior staff were aware of this practice. The reasons put forward for this practice varied:

- The shifts a Families SA casual worker received could fluctuate and were limited to 10 shifts per fortnight. They may therefore choose to be registered with nannySA to get more work and shore up their income.¹²⁰
- If the shift to be filled was in a strictly nannySA house, it would be offered first to a nannySA worker.¹²¹
- The directorate operated two pools of money: one budget for residential care, the other for agency use. At times supervisors were told they were not allowed to use Families SA casual employees because of budgetary issues. Instead they had to use agency staff.¹²²

The reasoning behind the notion of strictly nannySA houses, in which Families SA casual staff would not be used, was unclear and might have been that:

- they did not want to place staff together who had different training and approaches to youth work;
- Families SA had no direct supervision over the houses, or it was a remnant from a time when that was the situation; or
- because of industrial issues they wanted to ensure Families SA casual staff were available as needed to place in houses that were staffed by other Families SA workers.¹²³

A number of senior staff appreciated the practice could lead to some loss of oversight of the hours worked by individuals. For example, when engaged by both Families SA and nannySA, McCoolle was able to work two shifts in a row without it being considered overtime. None of the personnel management systems used by Families SA or agencies had capacity to police which shifts individuals were working.¹²⁴

Employing a worker through a commercial agency who was available on Families SA's casual list meant that the same service was obtained at a premium cost.

The processes used by senior staff in houses staffed by Families SA workers to fill isolated or more regular shifts were also inconsistent. Shifts were generally first offered to a Families SA casual staff member, but practices varied as to what steps should be taken before an agency worker could be sought.¹²⁵

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MCCOOLE'S CONTACT WITH CHILDREN

McCoole worked across a number of different residential care houses, bringing him into contact with many children. Some of them had difficult emotional and psychological problems and many expressed these issues behaviourally. Chapter 12 discusses the behavioural indicators of abuse, in particular sexual abuse. It emphasises the importance of monitoring behavioural signs within the residential care setting, both as a means to address the therapeutic needs of children, and to deter and detect potential sexual offenders in these environments.

Some of the children with whom McCoole worked exhibited behaviour that should have raised concerns about their relationship with McCoole. Others exhibited high levels of psychological distress that, while not clearly attributable to any particular source, should have been investigated and addressed.

RICKY JONES

From 29 January 2011 to 18 May 2011 McCoole was employed to work at an emergency care facility at Old Reynella where Ricky Jones and his older siblings resided. Ricky was aged between two and three years, and suffered from a developmental disability which affected his ability to communicate.

McCoole was charged with offences related to Ricky in that period. He pleaded guilty to two counts of indecent assault and one count of committing an act of gross indecency. The charged offences were evidenced by recorded images located on McCoole's computer.

No criminal charges were laid against McCoole with respect to Ricky's older sister, Amy. However, contemporaneous statements made by McCoole in the chat logs raise the possibility that he also offended against her and that his offending began as early as his first shift with these children.

TOBY AND JACINTA MASON

Between 26 May and 12 October 2012 McCoole looked after Toby, Jacinta and Cain Mason. The children were initially placed at a property at 11 G Crescent, and subsequently moved to 10 L Street.

The 11 G Crescent property was staffed entirely by nannySA workers with little oversight from Families SA senior staff. nannySA worker Narelle Reedman said that in the time she worked there she never saw a Families SA supervisor in attendance. The Nation Building house at 10 L Street was also staffed by nannySA workers. A higher level of oversight was offered at these premises, with a greater presence of Families SA senior staff.¹²⁶

Although the staffing structure at 10 L Street included periods when two staff were rostered on shifts, there were many occasions when McCoole was alone with the two younger children, Toby and Jacinta. A single worker worked the night shift.

McCoole pleaded guilty to persistent sexual exploitation of both Toby and Jacinta. The offences were committed between 15 June 2011 and 11 February 2012, when Toby was aged two and Jacinta three. This offending was also evidenced by images produced by McCoole that were discovered by police.

The Commission heard that staff who worked with the Mason children had a general dislike for McCoole and were relieved when he was moved on to work at other premises.¹²⁷ Some noticed unusual behaviours from the children towards McCoole. Ms Reedman noticed that Jacinta would avoid contact with McCoole, particularly when dressing, and that her relationship with McCoole was different from that which she had with other male workers. However, McCoole assured Ms Reedman that Jacinta interacted freely with him on occasions when Ms Reedman was not present.¹²⁸

Ms Reedman described an incident which involved two year old Toby. McCoole was seated on a couch. Toby approached him and touched his crotch. Ms Reedman noticed that McCoole made no effort to remove Toby's hand or move himself away until about 15 to 20 seconds later when McCoole became aware that Ms Reedman was watching him. Ms Reedman said she did not record this observation in the logbook because of the risk that McCoole would see it and complain. She considered confidentially informing senior workers but was deterred from doing so in the belief that the seniors were friends with McCoole and a fear that her concerns would not be taken seriously.¹²⁹

PAIGE THOMSON

Between 6 and 18 March 2012 McCoole worked a small number of shifts at 6 S Street caring for six Thomson siblings, who ranged in age from three to nine years old. On 10 May 2013 McCoole worked another shift with the Thomsons at another property.

Seven year old Paige Thomson was a bed-wetter. Although workers thought her behaviour originated in emotional problems, they were not made aware of any therapy to offer her or told of ways they could support her.¹³⁰ Paige began to experience night terrors. Jessica Pinos, a Families SA worker, observed that Paige became distressed in her sleep. She heard Paige say, 'get it out of my face'. Another worker told Ms Pinos that she had also heard Paige make a similar comment while asleep. Ms Pinos did not notify Families SA's Child Abuse Report Line (CARL) because she assumed Paige's comments were referable to trauma from previous sexual abuse.¹³¹

nannySA worker Ms V worked night shifts caring for the Thomson children. She observed changes in the behaviour of two of Paige's siblings. This included regression in four year old Kendall's toilet training. She started to defecate in the corner of rooms. Bradley, the eldest sibling, told Ms V that none of the children wanted to travel in the car with McCoolle. However, Ms V did not record Bradley's comments in the logbook.¹³²

ROSE HARRIS

Over a period of approximately one month in 2012, McCoolle worked four shifts with Rose Harris, who was 18 months old. Another 18 month old child was also cared for in the same placement and two workers were rostered per shift. However, there were occasions when individual workers were left alone with one or both children.

McCoolle pleaded guilty to two counts of unlawful sexual intercourse against Rose. Both offences were committed on 7 April 2012 and were evidenced by recordings made by McCoolle. He committed these two offences three minutes apart.¹³³

nannySA worker Janet Gregory regularly cared for Rose. At one nappy change, she noticed that Rose's genital area was red and her vaginal opening appeared abnormal. Ms Gregory drew the matters to the attention of her colleague, Simone Hammond.¹³⁴

Neither Ms Gregory nor Ms Hammond countenanced the notion that a carer might have sexually abused Rose. Ms Gregory wondered if Rose had been sexually abused by a relative. However, both carers ultimately favoured the conclusion that it was nappy rash, or that it was due to teething.¹³⁵ Neither recorded their observations in the logbook, although another worker recorded that Rose's genitals appeared red, or red and sore, on five separate occasions between March and May 2012.¹³⁶

The Commission's examination of the logbooks kept at Rose's placement revealed a gap in time between the end of a logbook which was completed at 12.50pm on 7 April 2012 and the next book which began at 10.00pm that night.¹³⁷ This is particularly noteworthy as McCoolle was working a shift which coincided with the time at which the new logbook should have begun.¹³⁸ The gap included the time following McCoolle's offending against Rose.

Logbooks are intended to give a continuous record of the events in the house, including how the children are being cared for and important observations about their wellbeing. However, it appears that no-one reviewed the logbook sufficiently closely to identify this gap of more than nine hours—another lost opportunity for the Agency to require an explanation from McCoolle about his work practices.

ANNA, CAITLIN, CLAIRE AND GEORGIE PHAM

After McCoolle completed his training as a Families SA youth worker in May 2012, he worked regular shifts at 14 R Road.¹³⁹ This was a Nation Building house under the supervision of Mr Sterzl. At the time the Pham siblings, Anna (aged nine), Caitlin (aged eight), Claire (aged seven) and Georgie (aged five), resided in the house.

McCoolle has not been convicted of any offence which identifies any of these children as a victim. However McCoolle was convicted of an offence of indecent assault committed on 14 July 2012 against an unidentified victim. McCoolle maintained he could not recall this particular incident, but the timing of the offence coincides with a shift McCoolle worked with the Pham sisters, during which time he was alone with them.¹⁴⁰ It can therefore be inferred from the evidence that one of the Pham sisters was the victim of that offence.

Families SA was aware of allegations that before coming into care the sisters had been sexually abused by their older brother.¹⁴¹ Nevertheless, their brother was permitted to stay overnight at the house as part of reunification efforts. On these occasions two workers were rostered to work the overnight shift, undertaking their duties so that they maintained constant supervision of the girls' bedrooms.¹⁴²

While in care, the Pham sisters exhibited high levels of sexualised behaviours. Workers tasked with caring for them were not well equipped to investigate or manage this behaviour. Wendy Harmston, a Families SA youth worker, understood that discussing these behaviours or comments with the girls was not encouraged. Workers were told to simply ignore the behaviour or divert the girls to something else.¹⁴³

There were instances where the children's conduct had the potential to raise concern about McCoolle's behaviour towards them, or general concerns about the levels of distress they were experiencing. For example, Ms Harmston observed Caitlin's behaviour would escalate when McCoolle came on shift including temper tantrums and yelling and screaming.¹⁴⁴ Ms Harmston considered that recording these observations in a logbook would be inappropriate because it was available for all staff members to inspect.¹⁴⁵

Two particular instances should have resulted in action by staff.

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Night shifts at 14 R Road were staffed exclusively by nannySA workers. Ms V regularly worked these shifts alone. She recalled a night shift when Anna woke up and asked her who was working in the morning. On being told that it was 'Shannon', Anna responded that she did not like Shannon 'because he is a paedophile'. Ms V was confident that Anna understood the meaning of the word paedophile, and she replied to Anna saying 'that's not very nice'. Anna replied 'well he is'.¹⁴⁶

The following morning Ms V spoke to the Families SA worker on the morning shift. She was assured that workers were aware that Anna called McCoolle a paedophile and that the statement had been recorded in the logbook and reported to senior staff. On that basis, Ms V herself did not make a logbook entry.¹⁴⁷ Her reluctance to do so was due, at least in part, to the power imbalance between agency and Families SA workers, and a consequent reluctance to report matters that reflected poorly on Families SA staff. She appreciated her obligation to notify CARL about Anna's statement, but did not do so because she had been assured by the Families SA worker that they were aware of the matter.¹⁴⁸

Families SA worker Graham Curyer had observed Anna to regularly use the word 'paedophile' as a term of general abuse, in circumstances when she was in an agitated state. However, Ms V said that had not been her experience and Anna had not been in an agitated state when she had made the allegation.¹⁴⁹

nannySA worker Ms K was also engaged at 14 R Road predominantly on night shifts. On one occasion, after McCoolle finished a shift, Ms K overheard Caitlin and Claire talking to each other in the bedroom they shared. Claire said 'everyone sounds scared. I can't sleep, what if he comes back in here', to which Caitlin responded 'if he puts his dick in my mouth again I'll bite it off'. Ms K entered the room and assured the girls she was there and everyone was safe. She did not specifically raise the comments with the children, believing that if such matters needed to be discussed that should occur at Child Protection Services (CPS), which offered a specialist service.¹⁵⁰

Ms K believed she recorded the incident in a logbook and prepared a separate incident report. However, no such documents were located in records produced to the Commission, although an incident report may not have come within the terms of the summons issued by the Commission if it had not been uploaded to the C3MS database.¹⁵¹

Ms K thought the comments she overheard referred to the abuse allegations that had been made about the Pham's older brother. She did not receive any feedback about what she recorded in the logbook or the incident report. She did not follow up the matter as she had previously experienced a resistance from Families SA

staff to her asking questions. Under questioning, Ms K accepted that what she had heard obliged her to have made a report to CARL.¹⁵²

CHELSEA FLOROS

Chelsea Floros was removed from her mother's care following her admission to hospital with injuries consistent with a serious assault. She required special attention. She was underweight and developmentally delayed.

Her first placement was in commercial care at 11 L Street, a placement staffed by nannySA workers and overseen by Families SA seniors and supervisors. Siblings, unrelated to Chelsea, aged two and three years were also placed at the house.

In approximately February 2013, two year old Chelsea was moved to 57 C Street, a transitional accommodation house staffed by Families SA workers, with two teenagers. The teenagers had irregular school habits, were often hyperactive and used inappropriate language. None of the five Families SA staff at 57 C Street had experience working with very young children; only one had the experience of caring for her own children.¹⁵³ They received a small amount of training but remained, in one worker's opinion at least, ill-equipped for the task. The house had no bathtub and Chelsea was bathed in a tub on the shower floor.¹⁵⁴

Managing the needs of the teenagers, as well as Chelsea's high needs, became increasingly difficult, but over time staff numbers were reduced from double-handed shifts to a single worker rostered to care for the three children.¹⁵⁵

McCoolle worked at least one shift with Chelsea in September 2012 at 11 L Street. He may have worked another shift in August 2012, but Families SA records are in conflict in this regard. McCoolle worked regular shifts with Chelsea at 57 C Street.¹⁵⁶ McCoolle subsequently pleaded guilty to the persistent sexual exploitation of Chelsea. He offended against her at both premises.¹⁵⁷

On many occasions during her time in care, and after her placement in foster care, Chelsea demonstrated behaviours which were indicative of trauma.

On one occasion at 11 L Street Chelsea became distressed during a nappy change, thrashing around and screaming 'no', while covering her genital area with both hands. Ms K observed this behaviour and said she called for her colleague Ms L to come into the room. Ms K recalled preparing an incident report and discussing the behaviour with a senior. However, the relevant logbooks have no record of the incident and no incident report was produced to the Commission. If the report was not

uploaded onto C3MS by a Families SA staff member it may not have been identified by the terms of the summons.¹⁵⁸

Two relevant observations were recorded in the logbook. On 5 September 2012 a worker noted Chelsea was excessively interested in her genitals and appeared to be trying to masturbate.¹⁵⁹ On 7 September 2012 Ms K observed that when Chelsea was lying down waiting to be dressed after her bath, she appeared distressed and behaved in an unusual manner, crying ‘don’t daddy, don’t daddy’. These observations were both recorded in the observation log as late entries on 9 October 2012.¹⁶⁰

These entries were sent by OPS4 senior youth worker Lincoln Rogers to Chelsea’s caseworker Pamela Watson.¹⁶¹ Ms Watson assumed the behaviours originated in the trauma of physical abuse suffered by Chelsea before she entered care. It did not occur to Ms Watson that Chelsea was at risk of sexual abuse in care nor was she concerned about the adequacy of her care. No action was taken to investigate or address the behaviours or distress being exhibited.¹⁶²

Chelsea’s unusual behaviours continued after her move to 57 C Street. She was observed playing violently with her doll, sometimes touching its genitals in an apparently sexualised way. On one occasion a carer noticed Chelsea’s genitals were very red, which she thought was unusual because Chelsea was no longer in nappies.¹⁶³

Ms O, a Families SA youth worker, was aware from regular discussions at staff meetings that Chelsea had been playing aggressively with her doll. On 22 April 2013 during a day shift Ms O came across Chelsea with her pants down poking the feet of her doll either close to or into her vagina. Ms O was concerned about the incident and recorded her observations in the logbook.¹⁶⁴

A second Families SA worker observed similar behaviour from Chelsea. That worker had received no training in how to deal with sexualised behaviours in a child as young as Chelsea. He spoke with Ms O. She told him she had seen something similar and had ‘handed it on’, indicating that she had made senior staff aware of it.¹⁶⁵

Weekly summary updates were prepared as a mechanism by which significant information was passed to a child’s caseworker. Ms O’s observations of Chelsea’s play were included in a weekly update. However her observations were reported as Chelsea poking the dolls feet *towards* rather than into her vagina.¹⁶⁶

Ms O was concerned about the significance of what she had seen and wanted Chelsea reviewed by a psychologist. She was concerned about the origin of the behaviour, as she was not aware of any history of Chelsea being sexually abused. She spoke about her concerns directly with Marc Beltman, Chelsea’s new caseworker.¹⁶⁷

In due course Mr Beltman told Ms O that he had spoken with a psychologist about the behaviours she had observed. Mr Beltman told Ms O that the psychologist considered them not inappropriate for a child of Chelsea’s age.¹⁶⁸

In May 2013, a foster care placement was secured for Chelsea with Mr and Mrs W. They were new foster parents, originally interested in providing a child with long-term care. They agreed to foster Chelsea on the basis that it was possible she might need long-term care if reunification efforts with her mother were unsuccessful. Mr and Mrs W cared for Chelsea between May and December 2013. She was then transitioned to the long-term care of a family member interstate.

Mr and Mrs W were not given any information about Chelsea’s history of sexualised behaviours¹⁶⁹ but almost immediately they were challenged by this conduct. On coming into Mr and Mrs W’s care Chelsea’s toilet training regressed slightly, and she returned to wearing nappies for a period of time. Chelsea would become upset during nappy changes, often repeating the words ‘Shannon do pat pat’ accompanied by moving her hands to her genital area before Mrs W applied nappy cream. On occasion Chelsea became quite insistent when Mrs W did not apply the cream. Sometimes Chelsea mentioned ‘Charlie’ in this context. Mrs W said she redirected the behaviour and after a few weeks it subsided.¹⁷⁰

Mrs W told Mr Beltman about this behaviour early in the placement, including reporting Chelsea’s reference to the names ‘Shannon’ and ‘Charlie’. Mr Beltman told Ms W that it was likely the names were associated with someone Chelsea knew from being in care or from other experiences in her past. Mrs W felt her concerns had not been taken seriously. She said she also told Mr Beltman that Chelsea frequently experienced night terrors during which she also mentioned the name Shannon.¹⁷¹

Mr and Mrs W were helped by a foster care support worker Ms X, who consistently advised Mr and Mrs W to report the behaviours they observed to Mr Beltman.¹⁷² Chelsea continued to talk about ‘Shannon’. On one occasion Mrs W told her support worker that Chelsea had been mentioning ‘Shannon’ at odd times. One morning while Chelsea was watching morning television with Mrs W she said ‘[w]ho put your pee-pee on Shannon’s pee-pee?’ followed by ‘Shannon’s pee-pee right there!’¹⁷³ Although Mrs W believed she would have reported this incident to Mr Beltman, he had neither recollection nor a note of it.

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As the placement progressed, Mr and Mrs W and their support worker Ms X continued to ask for psychological input to support their care of Chelsea.¹⁷⁴ Mr Beltman was not receptive to this suggestion, on the basis that Chelsea was too young to benefit from psychological therapy. Ms X disagreed and believed there were psychologists capable of helping the family to better support Chelsea.¹⁷⁵

The lack of attention given to Chelsea's behaviours

Mr Beltman told the Commission that while Chelsea was in residential care no issues had come to his attention that caused him to be concerned that she had been sexually abused.¹⁷⁶ Although a young child masturbating to soothe themselves could suggest sexual abuse, Mr Beltman concluded that this behaviour was also consistent with physical abuse, which was evident in Chelsea's history, and he did not investigate the matter further.

Mr Beltman said he was unaware that the previous caseworker, Ms Watson, had been told about Chelsea's distress during nappy changes while in residential care. He had failed to read the relevant C3MS records when familiarising himself with Chelsea's history.¹⁷⁷

Ms O told the Commission that she reported her observations of Chelsea's sexualised behaviours directly to Mr Beltman. Mr Beltman accepted that she may have done so, but he had no memory of it. He remained of the view that her behaviours could be attributed to sexual or physical abuse. This is contrary to the evidence of Dr Sarah Mares, an experienced specialist infant, child and family psychiatrist, who expressed the opinion that a child of Chelsea's age inserting objects into her vagina amounted to a 'specific indication of probable sexual abuse and should raise a high level of concern'.¹⁷⁸

Mr Beltman claimed that he consulted a number of experienced practitioners, including his supervisor, a principal social worker and Child Protection Services, to obtain advice about Chelsea's behaviour generally. He said notes of these consultations should be recorded on C3MS, but they were not located by the Commission. A failure to record such details makes it impossible for subsequent caseworkers to fully understand a child's complete history. It is not possible for the Commission to determine whether the consultations ever occurred.

Mr Beltman acknowledged receiving advice from Mr and Mrs W about their concerns but he could not recall the specific detail. Although he asserted that he recorded such information when he could, no such records were located on C3MS.¹⁷⁹

Mr Beltman followed up Chelsea's reference to the name 'Shannon' by contacting the house where she had previously resided. He was told that 'Shannon' was the name of a worker who had been previously employed

there. Mr Beltman did not give the reason for his enquiry as he was concerned about confidentiality. He finally assumed that Chelsea's use of the name 'Shannon' was associated with a good memory and that she had enjoyed a level of trust with that person.

No therapeutic support was provided to assist Mr and Mrs W to manage Chelsea's behaviours. Mr Beltman considered that these issues did not need to be addressed until Chelsea was in a long-term placement. He agreed that this attitude effectively placed Chelsea's needs on hold.¹⁸⁰

NICKY SCHULTZ

In September 2013, McCoole undertook some shifts at 14 R Road, after his return to work from suspension for the investigation of a care concern (discussed later). A group of five siblings by the name of Schultz, aged between two and 15 years, resided in the house.¹⁸¹

McCoole was not charged with any offences relating to these children. In the course of the investigation that followed McCoole's arrest, Nicky Schultz, aged seven, disclosed that McCoole had touched her indecently but her disclosure lacked specific detail.¹⁸²

Louise Purton, an acting senior youth worker who supervised the house at 14 R Road, noticed that Nicky showed a clear dislike for McCoole. On one occasion Ms Purton observed Nicky screaming, crying, and kicking in anticipation of McCoole putting her to bed. Her behaviours were so heightened that Ms Purton intervened and asked another worker to put Nicky to bed.¹⁸³

JAYDEN CONTI

In January 2014 McCoole began working regular shifts at 10 S Street with Jayden, who was seven years old. For some time, Jayden was the only child in the placement, partly due to his difficult behaviours.¹⁸⁴

A chart on the wall had photographs of the staff on it, so Jayden would know who was caring for him on the various shifts. More than once, Jayden removed the photograph of McCoole from the chart. He said he did so because McCoole did not smile properly. The only photographs that Jayden ever removed from the chart were those of McCoole.¹⁸⁵

In the early stages of the placement, Jayden exhibited protective sleeping and bathing habits. He preferred to sleep under rather than on top of his bed, and would often bathe with his clothes on. Advice from a clinical psychologist supported workers permitting Jayden to sleep and bathe as he pleased as long as he was safe. Most workers were happy with this approach.¹⁸⁶

However, McCoole had his own ideas. He believed that children's behaviours should be as normal as possible. Whenever he oversaw Jayden's bedtime routine he insisted that Jayden sleep on top of his bed rather than underneath. On occasion, this caused Jayden's behaviours to escalate.¹⁸⁷

Jayden's difficult behaviours extended to a habit of drawing pictures of penises around the house, on paper, on walls and on furniture. Jayden was unable to explain why he did this.

On one occasion Families SA worker Ms B found an image of two penises that Jayden had drawn on the wall of his bedroom. She said these appeared different from his other drawings. One penis was larger than the other. It had an angry face and appeared to be ejaculating. The other had a sad face. Ms B asked Jayden what was coming out of the angry faced penis and he said it was 'just piss'. Ms B logged this observation for it to be passed on to Jayden's psychologist.¹⁸⁸ She also photographed the images and spoke with Jayden's caseworker about them.¹⁸⁹

However, Ms B was advised not to ask Jayden about these behaviours because she was not a psychologist.¹⁹⁰ This behaviour eventually stopped by about late April 2014. At that stage, McCoole had moved to another house.

BROOKE ANDERSON

Between March and June 2014 McCoole worked at 6 S Street where he cared for 13 year old Brooke Anderson. In the same street was a second Families SA residential care house. That made it convenient for workers at both premises to help each other when the need arose.

On 12 April 2014, Ms C was working at the other S Street house when she received a telephone call from McCoole. He was upset and told Ms C that Brooke had called him a paedophile. McCoole asked Ms C to come to the house to support him. When Ms C arrived, McCoole told her that that he had had an altercation with Brooke. Brooke had gone to the bathroom and he became worried that she was intending to self-harm. He said he jangled his keys to warn Brooke that he was going to enter the bathroom, and when he went in he found Brooke sitting on the toilet with her underpants down.¹⁹¹

Ms C then spoke to Brooke about the matter. Brooke told Ms C that contrary to McCoole's version of events, he had entered the bathroom without warning. Brooke again called McCoole a paedophile.¹⁹² Brooke appeared calm, but when Ms C indicated that she was going to leave, her behaviour escalated again. Brooke attempted to assault McCoole and she was physically restrained. Robert Griffin, a senior youth worker, then arrived at the house. McCoole told Mr Griffin that he had knocked on the bathroom door and called out to warn Brooke before

entering. This was different to the version he had given Ms C. Mr Griffin also spoke with Brooke. She insisted that McCoole entered unannounced and she was naked from the waist down.¹⁹³

Mr Griffin accepted McCoole's version of events. He did so on the basis that McCoole was the adult and he believed that youth workers recruited to Families SA underwent a rigorous selection process and were bound by a code of ethics. He was aware that Brooke had a history of self-harming and dishonesty and that led him to doubt her account.¹⁹⁴

Because Brooke had been physically restrained, McCoole was obliged to complete a critical incident report.¹⁹⁵ This report presented a version of events which was inconsistent with Ms C's own observations as well as McCoole's account to Ms C. It was also inconsistent with the version of events relayed by Brooke, as given to Ms C. Brooke's version was not recorded in any way in the report, contrary to the requirements of regulation 14(3) of the Family and Community Services Regulations 2009.

Notwithstanding serious deficits in the report Katherine Decoster, the supervisor tasked with reviewing and approving the report, endorsed it, noting that the incident was well managed.¹⁹⁶ At the time Ms Decoster was unaware of the requirement set out in the regulations to record the child's account of events. In addition, no process existed for McCoole's report of the incident to be shown to Ms C, as a witness to events, nor to allow her to record any disagreement she had with the version given by McCoole.

SUPERVISION OF MCCOOLE

Throughout McCoole's employment with OSHC, nannySA and Families SA, aspects of his conduct and behaviour indicated an employee whose performance was substandard. Specific incidents should have raised serious questions about McCoole's suitability to work with children in care and, in particular, whether children were at risk of harm in his care.

A series of events occurred while McCoole was working in Families SA houses, the most serious of which is the care concern relating to Mikayla Bates, discussed later in this case study.

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The evidence before the Commission showed that McCoole was an unpopular worker. Very few other workers wanted to work with him and he was not well liked. Some workers thought that his bed and bath time routines took too long. They noticed that he preferred to do those things alone, and he usually refused help. He was described as arrogant, dominant and overconfident. He was not considered a team player and many colleagues questioned the appropriateness of his approach to youth work. On some occasions, McCoole's conduct was considered positively offensive to people who worked with him.

THE R-RATED MOVIE

In late 2012, McCoole was working at 14 R Road caring for the Pham sisters. On occasion, carers would bring in movies from home for the girls to watch. There was a particular occasion when McCoole brought a computer hard drive to the house, which he said contained some movies suitable for the girls. He advised others in the house that they were also welcome to use it. It is not clear from the evidence how long the hard drive was at the house, but it appeared that it had been there previously and the children could have accessed it.¹⁹⁷

When some carers went to access the movies on this hard drive, they discovered that in addition to children's movies, there was a folder which contained movies which were not G-rated. Among these movies was one entitled *Young people fucking*, which was R-rated. The carers were especially alarmed by the title as 'young people' is a term commonly used to refer to children in care.

Mr Norman was the supervisor of the house at this time. He was told about the movie on the hard drive and he asked Mr Rogers, the senior on shift, to go to the house to investigate.¹⁹⁸ Mr Rogers then retrieved the hard drive. He said there were a number of children's movies on the hard drive¹⁹⁹, but in a subfolder labelled 'personal files' he located the movie, *Young people fucking*. He watched the first few minutes of the movie. That portion did not depict any sexual acts. The movie was rated R (restricted to viewers over the age of 18), but Mr Rogers did not consider it was pornography. He concluded that it had been recorded from mainstream television as he identified an SBS watermark in the corner of the screen. He thought the movie was subtitled and assumed that it was not in English.²⁰⁰ However, Mr Rogers considered that what was contained on the device was 'absolutely inappropriate' and that McCoole required supervision, including possibly being placed on a performance management plan.²⁰¹ He confiscated the hard drive and left it on Mr Norman's desk at the administration building. He detailed what he knew about the nature of the movie in a document addressed to Mr Norman.²⁰²

Mr Rogers' assessment of the movie should be considered in the context of features of the movie overall²⁰³:

- it depicted five separate couples performing various sexual acts with one another;
- some sexual acts involved the use of sexual aids;
- a third person was depicted observing some of the sexual acts; and
- it was in English and would not require subtitles if broadcast on Australian television.

Mr Rogers told the Commission that he advised Mr Norman that he had only looked at the first couple of minutes of the movie.²⁰⁴ Mr Norman said he was not sure whether Mr Rogers had watched the whole movie but he said that he had checked an internet database and that suggested to him that the movie was a comedy, similar in style to the film *American pie*. Mr Norman assumed the movie might contain some sexually explicit content but relied on Mr Rogers' assurance it was 'not of any nefarious nature'. It did not occur to Mr Norman there might be something concerning about a person bringing a movie with that particular title into a house in which care was being provided for young children.²⁰⁵

The topic was raised in a supervision session on 8 January 2013 with McCoole. The Commission is unable to determine which of the senior staff made the decision to address the matter in this way. Mr Norman and Darren Calvert (acting in the Nation Building supervisor role at the time) both denied responsibility. Mr Norman thought that this response was adequate and in line with protocol. Mr Calvert knew of no policy, protocol or procedure which would guide a response to such events. Mr Calvert could provide no insight into why a discussion in supervision was an adequate response.²⁰⁶

Mr Calvert and Mr Rogers conducted the supervision session and the resulting notes record:

The title was an MA-rated movie, not pornography. Lincoln viewed the movie and confirmed this to be true. Darren discussed that either way, any movies of that subject matter should not be accessible by [young people]

*Shannon stated that this was an oversight and that it shouldn't have happened, and will not again*²⁰⁷

The note incorrectly records the movie as MA-rated.²⁰⁸

Mr Calvert's main concern was that personal material had been brought into a residential care house. He went so far as to assert in evidence that the content of the movie was irrelevant because there was no evidence that any of the children had watched the movie. This misses the point in two respects: first, McCoole spent periods of

time alone with the children and there is no suggestion that anyone asked the children if they had seen the movie; and secondly, it fails to consider that bringing such a movie into the house might be indicative of an intention to use the sexualised images in the process of grooming a child or young person.

McCoole's assertion that the incident was an oversight was not questioned, and he was not asked to elaborate on the circumstances. Mr Calvert accepted McCoole's claim without conducting any probing or critical examination.²⁰⁹

Mr Norman responded to the incident by sending an email to all southern area Nation Building staff advising that no personal hard drives were to be brought into the houses.²¹⁰

GEORGIE PHAM

McCoole worked with the Pham sisters when Georgie, the youngest, was between five and six years old. McCoole appeared to have a better relationship with Georgie than with her sisters. His approach to her was softer and gentler than with the others, and Georgie responded by cuddling McCoole and sitting on his lap.²¹¹

Every Friday night the sisters were permitted to watch a movie with the workers on shift. On two or three occasions during such movie nights, Corinne Hams, a Families SA worker, observed Georgie sitting on McCoole's lap for extended periods of time. Ms Hams considered this inappropriate, particularly as there was information that the girls had been sexually abused before coming into care. Ms Hams was also concerned because Georgie did not behave the same way towards other male workers. Ms Hams told both McCoole and Georgie that Georgie should sit beside McCoole and not on his lap. Nevertheless, the behaviour recurred the following week, and Ms Hams reported her concerns to Mr Norman.²¹²

Ms Hams was not told whether McCoole was spoken to about this behaviour. A meeting was held with all six staff members which included a general conversation about the children's behaviours. The outcome of the meeting was that Mr Norman introduced a 'no touch policy' that applied to all workers working with the Pham children.²¹³

Ms Hams was aware through other staff that Anna Pham had referred to McCoole as 'Mr Paedophile'. Ms Hams understood Mr Norman's decision to stop all physical contact was made both because McCoole was allowing Georgie to sit on his lap and because McCoole was referred to as Mr Paedophile.²¹⁴

Mr Norman disputed that the policy had been introduced as a result of the conduct of McCoole. Initially, he said that he put the no touch policy in place because workers, in particular males, would often worry about allegations

being made against them and they would prefer not to physically touch the children. To avoid children having a preference for certain workers on account of differences in their care approach, Mr Norman said he decided to enforce a policy under which no worker would be allowed to physically touch the children.²¹⁵

Mr Norman recalled that Ms Hams reported her concern that Georgie would consistently sit on McCoole's lap. However, he understood that those concerns related to Georgie's affection towards males generally, including himself, which made him feel uncomfortable.²¹⁶ He did not understand that Ms Hams thought that McCoole was treating Georgie's affection inappropriately.²¹⁷ The Commission prefers Ms Hams' version of events and is satisfied that McCoole's specific behaviour was drawn to Mr Norman's attention by Ms Hams.

ANNA PHAM

Families SA youth workers are trained in non-violent crisis intervention (NVCI). This training includes teaching workers how to restrain a child if it is necessary as a last resort. Any restraint should be performed calmly and should not harm the child or cause pain.

On 17 February 2013 McCoole, Ms Harmston and trainee Ms U took the Pham sisters shopping. The girls had some pocket money and wanted to look around to find something to buy. Nine year old Anna selected something that cost more than the money she had. She had more money in a savings account, but required permission from a senior worker to access this, and they were not contactable while the girls were at the shops. Anna became upset about not being able to buy anything and her behaviour escalated as the group returned to the vehicle. Ms Harmston placed Anna in the vehicle but was not able to secure her seatbelt.

McCoole intervened. He took hold of Anna and restrained her outside the vehicle. Anna was tiny, slight and had 'no body weight'.²¹⁸ Ms U could hear Anna screaming. She felt the incident was going on for too long so she exited the car.²¹⁹ McCoole was speaking loudly and gruffly to Anna, telling her he would not let her go until she calmed down. He was kneeling behind her, with her back against his stomach and her legs spread out on the ground. The hold was not consistent with NVCI practices. Each time McCoole spoke, Anna's behaviour got worse.²²⁰

Ms U considered that McCoole's response was unnecessary. He could easily have escorted her to the van. She thought the restraint of Anna was an exercise in aggression and power.²²¹ McCoole subsequently completed the requisite critical incident report. Once again, aspects of McCoole's report were inconsistent with the observations of other workers present, and it painted McCoole's behaviour in a less serious light.²²² The report again failed to record any account from the child.

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However, Mr Sterzl considered and approved the report, commenting ‘this situation was handled well by the staff team involved’.²²³

JAYDEN CONTI

Jayden Conti (whose circumstances have been discussed earlier) sometimes threatened to harm himself and the staff working with him. Jayden was a small child. When necessary he would allow workers to restrain him using an NVCi hold. He generally responded to restraint by sitting and verbally abusing staff, and it was not necessary to hold him very firmly. Often while being held, Jayden would ask to go to the toilet. Sometimes this appeared to be his way of asking to be let go. Usually at that point workers would end the restraint and Jayden would go calmly.²²⁴

Other workers observed occasions when McCoolle would restrain Jayden quite forcefully. On 12 February 2014 Jayden had been sent to his bedroom after becoming agitated in the course of a conversation. He was throwing things at Ms B, one of his workers. Ms B stood in the doorway to his room and was speaking to him to calm him down. McCoolle pushed Ms B out the way and placed Jayden into a restraint.²²⁵ Jayden yelled a couple of times that he was going to ‘piss himself’ and he complained that McCoolle was hurting him. McCoolle continued to hold Jayden until Ms B intervened and said ‘[t]hat’s enough’. She said she thought it had reached the point at which it had gone on for too long and it was inappropriate. McCoolle initially ignored Ms B but he ended the restraint not long after.²²⁶

McCoolle completed a critical incident report. He recorded:

*Staff put Jayden in the NVCPi position to keep him safe from hitting his head again. Staff (Ms B) enters the room as support and to observe. Jayden begins crying and telling staff he is going to wet himself but is still elevated. Jayden tells staff (Shannon) they are hurting him. Staff tell Jayden they are barely holding his arms, **this is observed by the second staff member.**²²⁷ [Emphasis added]*

McCoolle’s assertion that he was ‘barely holding Jayden’s arms’ is inconsistent with Ms B’s observations. Ms B was not asked to endorse the contents of the report. She believed that she could not read such a report until after it was approved by management. Jayden’s view or account of the incident was not obtained.²²⁸

Neither the logbook entry nor the critical incident report records Ms B’s request to McCoolle to stop the restraint. Ms B explained that senior staff had issued an instruction not to log conversations or concerns which related to other staff members.²²⁹ The logs and reports are thus

not necessarily a complete or accurate record of a child’s experiences, and incomplete accounts could protect staff members whose actions require examination.

Ms B recalled that she spoke to a supervisor or a senior, possibly Daniel Knight, about the incident. She explained that the hold went wrong and she did not agree with it.²³⁰ Mr Knight could not recall this specifically, but he did recall Ms B telling him about a restraint that involved McCoolle moving or shoving her out of the way. Mr Knight did not recall speaking to McCoolle about the matter. Ms Decoster subsequently approved the report prepared by McCoolle, commenting ‘[s]taff managed the incident well ... Staff also made sure Jayden understood the reasons as to why they need to hold him and keep him safe’.²³¹

Ms Decoster said she would have investigated the incident further if she had been aware that Ms B had a different version of events from McCoolle, in particular that Ms B did not agree that McCoolle was barely holding Jayden’s arms or that she had felt the restraint went on too long.²³²

The report included a reference by Jayden to a complaint that staff were hurting him during the restraint. Nevertheless, Ms Decoster’s approval of the report indicated her belief that the incident had been managed well. She did not investigate the matter further or try to ascertain why Jayden complained that he had been hurt. She resolved the inconsistency between McCoolle’s assertion that he was ‘barely holding his arms’ and Jayden’s complaint by accepting unquestioningly that McCoolle was telling the truth.²³³

MOLLY COLLINS, WILLIAM AND JENNA MOORE

From late August 2012 to February 2013, McCoolle, as a Families SA employee, undertook shifts at 9 T Avenue. In October 2012, 11 year old Molly Collins was placed in the house, joining William (aged seven) and Jenna (aged nine) Moore.²³⁴

On New Year’s Day 2013, nannySA worker Wendy Dennis and McCoolle took the three children to the beach.²³⁵ Twice during the excursion Ms Dennis observed McCoolle interacting with Jenna and Molly in what she considered to be an inappropriate manner. On one occasion he held the girls inappropriately while lifting them up and throwing them in the water. Later he swam into deeper water with both girls hanging onto him around his neck. Ms Dennis did not feel comfortable with what she observed but did not report her concerns to anyone.²³⁶

NICKY SCHULTZ

Friday, 13 September 2013, was McCoolle’s second shift back from suspension after the Mikayla Bates care concern. nannySA worker, Ms Hammond, and McCoolle took some of the Schultz siblings to a play café.²³⁷ Ms Hammond observed that McCoolle was taking photographs on his personal mobile phone of seven year

old Nicky, wearing a skirt, when she was coming down a slippery dip. He was possibly also taking photos of two year old Lachlan. When Ms Hammond approached McCoolle he put his mobile phone away, saying, 'I will upload those later'.

Photographing children in care on a personal mobile telephone was, and is, prohibited. House cameras were available for staff to record the experiences of children. At times staff did use their own devices, but some, at least, believed that prior permission from a supervisor was needed for that to occur.²³⁸

The visit to the café was recorded in the logbook, but not the taking of photographs.²³⁹ Ms Hammond was aware of the Mikayla Bates care concern and did not want to alert McCoolle to her concerns about him. A day or two later, Ms Hammond telephoned Mr Sterzl and reported her concerns. She asked Mr Sterzl to check the house computer for the photographs.²⁴⁰

She subsequently saw Mr Sterzl using the computer, but did not know if he checked for the photographs. Ms Hammond was never advised whether Mr Sterzl located the photographs nor of the outcome of her report.²⁴¹

During a regular senior staff meeting, Ms Purton, a senior youth worker, became aware that a concern had been raised about McCoolle taking photographs on his personal mobile telephone. In response to this issue, a formal email was sent to all staff to remind them that such a practice was prohibited.²⁴²

Manager Ms Lamont told the Commission she thought that at some stage she had been made aware that McCoolle had taken photos of children in care on his personal device. She said the play café occasion sounded familiar, although she was unable to recall with precision when that had occurred or when she had been told about it. Ms Lamont assumed the supervisor would have met with McCoolle to discuss the issue²⁴³ but there is no evidence that any such meeting ever took place.

DEGRADING COMMENTS ABOUT CHILDREN

A number of workers heard McCoolle make inappropriate or degrading comments about the children in his care. Nine year old Anna Pham often had difficulties with bedwetting. Ms U researched the issue. She ascertained that bedwetting by an older child might be associated with psychological difficulties and it could also be a protective mechanism if a child was being abused. Ms U shared this information with McCoolle. McCoolle responded that Anna was 'just fucking lazy'. A verbal altercation followed. McCoolle suggested they deal with the bedwetting issue by leaving Anna to lie in it, adding 'oh, that's right, she does that anyway'.²⁴⁴

During shift handovers at 14 R Road Ms K heard McCoolle describe the Pham girls as 'nothing but fucking cunts'. Ms K asked McCoolle not to use such language.²⁴⁵ On other occasions McCoolle was heard to refer to children as 'little shits', 'bitches' and an 'idiot'.²⁴⁶

He referred to a 12 year old child with autism as a 'real der'.²⁴⁷ At one mealtime he was disparaging and critical of the same child, aggressively telling the child to '[s] top being a pig. Stop eating like that'. When Mr Curyer, another worker in the house, challenged his approach, McCoolle said the child 'deserved it. The kid's a pig. No-one's going to show him. He needs to be shown. He can't keep doing that.' McCoolle ignored advice that his approach to the child was demeaning and unhelpful.²⁴⁸

APPROACHES TO YOUTH WORK

Children in residential care are faced with workers who care for children in a variety of ways. Their care ranges from a therapeutic nurturing and supportive approach to a highly rule-focused strict and consequence-oriented one.²⁴⁹ As a result, workers' personal views at times prevail over the appropriate evidence-based approach for children with trauma-related backgrounds.

MCCOOLE'S MILITANT APPROACH

McCoolle's approach towards discipline was at the more extreme end of the rule-based approach. He demonstrated little flexibility or preparedness to back down, and unwillingness to negotiate with children or alter his rules.²⁵⁰

McCoolle's approach was variously described as strict, militant, regimented, authoritative, dictatorial, dominant and controlling.²⁵¹ Some children were fearful of McCoolle and complied with his directions because of this. Some children would respond when McCoolle pointed at them, without him needing to speak.²⁵² He:

- used his loud voice, size and physicality to get his point across and intimidate children;
- he was willing to shout at children from different rooms of the house²⁵³;
- was prepared to regain control over children by physically moving them²⁵⁴; and
- had children do household chores in his place.²⁵⁵

In the circumstances it is understandable that some workers were surprised that McCoolle was working with children.²⁵⁶

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PERSONALITY ISSUES

Although some of McCoolle's peers thought his work practices could not be faulted²⁵⁷, most considered aspects of his behaviour so disagreeable or offensive that they struggled to work with him. McCoolle created disharmony.²⁵⁸ Some staff actively avoided him and would leave shift handovers early to avoid interacting with him.²⁵⁹

Comments by McCoolle's colleagues included:

- he was arrogant, bombastic, opinionated, obnoxious and dominating;²⁶⁰
- he spoke about being better than other staff members²⁶¹;
- he told colleagues he was getting looked after by management and management had sent him to fix teams or houses²⁶²;
- he critiqued staff members in a negative way to other workers and highlighted the faults of other workers to senior staff²⁶³;
- he took credit for other people's work and presented issues that had been addressed by a team as his personal achievements or efforts²⁶⁴;
- he talked up the tasks he had undertaken to management²⁶⁵; and
- he was willing to argue his point in team meetings.²⁶⁶

However, this was in stark contrast to McCoolle's behaviour towards senior staff. He was known to 'suck up' to seniors.²⁶⁷ Ms Hams suggested McCoolle's approach to her was not as confronting as with other workers because he knew she had occupied leadership roles.²⁶⁸ Mr Rogers was aware from the time McCoolle was a nannySA employee that he was eager to please and would 'brown nose' senior staff.²⁶⁹ McCoolle would go out of his way to impress males and get on the side of the men working in residential care.²⁷⁰

GENDER AND RACIAL BIAS

Many female workers found McCoolle challenging. He was described as chauvinistic, demeaning and was said to often put women down. He held strong ideas about male and female roles and what were appropriate tasks for male or female workers. On occasion, McCoolle shared his views about gender roles in front of children.²⁷¹

Ms B worked with McCoolle in the care of Jayden Conti. Because Jayden had some challenging behaviours, one staff member would always sit in the rear of the car with him when it was necessary to transport him anywhere. McCoolle insisted that he should always be the one to drive the vehicle and Ms B was always relegated to the back with Jayden. McCoolle repeatedly commented to Ms B that they looked like a Muslim family. When she was away from the children, Ms B told McCoolle his comments were not appropriate.²⁷²

However, McCoolle persisted with inappropriate remarks. Ms B expressed her frustration to senior youth worker, Mr Knight. Mr Knight thought that McCoolle should not make Ms B feel uncomfortable in the workplace, and he sent an email to his supervisor, Ms Decoster, explaining the issue. He took no further action.²⁷³

According to Ms B, the following day Ms Decoster rang her to enquire if she was all right. Ms Decoster assured Ms B that McCoolle's conduct was unacceptable. Ms Decoster asked Ms B if she wanted to make a formal complaint or if she wanted the matter taken to human resources. Ms B said she told Ms Decoster she simply wanted her complaint noted in case the conduct continued in the future.²⁷⁴ However there is no record of this complaint in McCoolle's supervision file.

Ms Decoster denied in evidence that she had been made aware of Ms B's concerns about McCoolle and she could not recall a conversation with Ms B where she enquired about her welfare.²⁷⁵ However, the evidence of Ms B and Mr Knight is to be preferred on this topic. The Commission is satisfied that Ms Decoster was made aware of McCoolle's gender and racially offensive conduct but did nothing about it.

A PROBLEM PERFORMER

The Nation Building senior youth workers and supervisor were aware of the discontent and instability McCoolle was causing within months of him becoming a Families SA employee. Mr Norman spoke to colleagues in the workplace of McCoolle as a problem worker who was loud, opinionated and 'rustling feathers'. Mr Norman was dismissive of a suggestion by Mr G, a senior youth worker, that Mr Norman would have to 'pull [McCoolle] up'.²⁷⁶

Mr Rogers was aware that McCoolle was not well-liked and that the consequent disharmony was affecting the functioning of teams. McCoolle was moved between houses frequently.²⁷⁷ It is likely that his workplace performance and inability to work effectively as a part of a team were responsible, at least in part, for some of his moves.

Senior staff went so far as to enquire of some youth workers whether they would be prepared to work with McCoolle. Christina Manderson was asked by Mr Sterzl whether she would work with McCoolle at 14 R Road. She said she regarded McCoolle as bombastic and arrogant but she told Mr Sterzl that as a professional she would work with him. Ms Manderson had worked in residential care for at least four years and had not ever been given this choice about any other worker.²⁷⁸ Ms Hams also agreed to be partnered with McCoolle as everyone else had refused to work with him.²⁷⁹

Mr Sterzl described McCoolle as having a loud, robust personality which could ‘rub people the wrong way’. Mr Sterzl knew other workers had raised issues about McCoolle’s interpersonal skills. Consistent with Mr Rogers’ evidence, Mr Sterzl described moving McCoolle from location to location to try to ‘find a match’ of staff members who could work together, although he later confined this comment to the period when McCoolle returned to work from suspension.²⁸⁰

LACK OF RESPONSE TO COMPLAINTS

Although a number of workers raised both formal and informal complaints about McCoolle, little effort was made to deal with them.²⁸¹ Over time, dislike for McCoolle grew in the workforce, peaking just before his arrest.²⁸²

In March 2014, four separate complaints were made by female staff members to senior youth worker Mr Knight and supervisor Ms Decoster. The complaint by Ms B about McCoolle’s persistent inappropriate remarks was one of the four complaints.

On 3 March 2014 youth worker Karen Roberts sent an email to seniors Mr Knight, Mr Griffin and Linda McLaren, and to Ms Decoster, raising concerns about an impending move of McCoolle to the house at 6 S Street.²⁸³ Ms Roberts raised a number of concerns which included the need for consistency of staff and her knowledge of McCoolle, which suggested he would be a poor fit for the children in the house. She said that one child had already expressed a fear about McCoolle coming to work in the house.²⁸⁴ The events which followed this complaint are discussed later in this case study.

On 8 May 2013, another worker, Ms C, emailed Mr Knight, setting out a series of concerns about McCoolle’s conduct. She told Mr Knight that this was the first time that she had ever made such a complaint and it was out of character for her to do so. Ms C could not recall ever receiving a response to that complaint.²⁸⁵

Youth worker Sharyn Ball also complained about McCoolle’s conduct towards her. She felt that he belittled her both in the house and in public. Mr Knight became aware of Ms Ball’s feelings through one of her colleagues, because Ms Ball did not want to make a formal report. Mr Knight viewed it as unprofessional to make a complaint and then not follow it up officially. He considered that a complaint had to be reduced to writing to make it official.²⁸⁶

Mr Knight responded to these concerns by having an informal conversation with McCoolle in which he advised him there were some issues with the way he was speaking to people.²⁸⁷

On 10 April 2014 Ms Decoster called a supervision meeting with McCoolle, attended also by Mr Knight. None of the concerns raised by the female workers were addressed at this meeting.²⁸⁸ Although Mr Knight thought the concerns required attention he deferred to Ms Decoster’s approach to the meeting.²⁸⁹ This meeting is discussed further below.

Following this meeting, Mr Knight did not make any enquiry with any of the workers as to whether the issues with McCoolle persisted.²⁹⁰ Against this background, it is understandable that some staff viewed McCoolle as ‘bulletproof’.²⁹¹ Despite the constant challenges and difficulties McCoolle caused in team environments, senior staff consistently failed to address his workplace conduct.²⁹²

SUPERVISION

On 8 January 2013, Mr Calvert conducted a supervision session with McCoolle. This concerned three incidents that reflected poorly on McCoolle. One was the discovery of the *Young people fucking* movie discussed earlier. The second related to events which had led to William Moore being badly sunburnt on a trip to the beach on New Year’s Day 2013 and the third was an occasion when McCoolle attended a residential care house outside of work hours without permission.²⁹³

As to this last incident, Mr Rogers had given permission for McCoolle to visit 10 L Street to say goodbye to the Mason siblings who were leaving residential care to move to home-based care. However, McCoolle did not attend the house on the agreed day while he was on shift. Rather, he attended on another day without warning when he was not working. The clear rule was that staff were not permitted to attend houses when not on shift.²⁹⁴

The supervision notes include the following topics of discussion:

- The negative effect of McCoolle’s visit on the children, which drew attention to the transition. A team decision had been made not to mention the transition, to avoid the children stewing on it.
- That McCoolle had failed to ask for permission to attend on the day he did and had he sought such permission it would not have been granted.

McCoolle acknowledged his decision had been poor, and agreed that he would go through the proper channels in the future. In relation to accumulated concerns, McCoolle claimed that he had been ‘off his game’ recently and suggested supervision ‘was the motivation he needed to kick back into gear’.²⁹⁵

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The supervision notes also recorded that ‘the need for staff to reduce the amount of gossip and rumour in the workplace, as it promotes disharmony amongst teams’ was also raised with McCoolle. Mr Calvert said it was necessary to raise these matters with McCoolle to ‘achieve harmony, trust and compliance within teams’²⁹⁶ and because McCoolle had the ‘emotional IQ of a peanut ... he just didn’t get the message ... he wasn’t the most endearing person’. Mr Calvert did not regard these emotional deficiencies as unique. Mr Calvert asserted there was very little effort put into achieving harmonious teams, and they:

*constantly get sent people that have not fitted in somewhere else or not suitable to the teams or the workplaces. There was very little effort put into harmonious teams in the business.*²⁹⁷

Approximately five months into his employment with Families SA, it was obvious McCoolle’s performance as a residential care worker was unsatisfactory.²⁹⁸ McCoolle was placed on fortnightly half-hour supervision sessions to be conducted by Mr Norman for an indefinite period. Mr Norman said this was to get McCoolle ‘back on track’, not to keep a closer eye on him.²⁹⁹

Two supervision sessions, approximately three weeks apart, were conducted by Mr Norman in January and February 2013.³⁰⁰

Goals identified for McCoolle during the session on 30 January 2013 were:

To improve on appropriate use of voice control

*Attempt to try a few different methods of getting an idea heard and accepted by team mates, in the least offensive way as possible.*³⁰¹

Mr Sterzl explained that these were performance issues identified for McCoolle. McCoolle had an inability to appreciate the impact of his potentially intimidating voice in a residential care environment, and senior staff were addressing the issue by trying to get him to use a softer voice.³⁰²

This issue persisted at the 20 February 2013 supervision session although some improvement was noted.³⁰³ Mr Norman suggested that from his observations of McCoolle from outside the formal supervisions, McCoolle’s work habits appeared to be improving.³⁰⁴

The next supervision session was scheduled for 4 March 2013.³⁰⁵ However, on 25 February 2013 McCoolle was moved from Nation Building to the transitional accommodation program.³⁰⁶ These programs were separately managed. Ms Decoster became McCoolle’s supervisor but she did not consult written supervision records which were available to her.³⁰⁷

The fortnightly supervision sessions ended. Some 13 months later, on 10 April 2014, McCoolle had his first and only supervision session with Ms Decoster and Mr Knight. This is the supervision referred to earlier which followed the four complaints raised by female workers about McCoolle.³⁰⁸

Ms Decoster initially said in evidence that the complaints she had received from Ms C and Ms Ball about McCoolle’s communication skills were not discussed at the meeting. She stated that it was not her intention to do this and the issues were not discussed. She gave this evidence after referring to notes that were taken at the time.³⁰⁹

However, Ms Decoster changed her story when she was referred to a statement which she had given to police in November 2014. She asserted, consistent with that statement, that these complaints had been discussed at the meeting and she could not explain why that conversation was not reflected in any way in the supervision session notes. She remained adamant that performance issues in the context of the complaints had been discussed.³¹⁰

Mr Knight was also in attendance at this supervision session and he in fact took the notes. Consistent with the notes and Ms Decoster’s original evidence, Mr Knight said that concerns raised by the staff members had not been addressed with McCoolle. He was certain that all the feedback given to McCoolle during the supervision was positive.³¹¹

A number of workers described a mistrust of Ms Decoster as a supervisor, regarding her as having misrepresented the truth on occasions.³¹² Workers complained that Ms Decoster would deny saying things that she had said and would claim to not know about issues that had clearly been brought to her attention. On occasions, when confronted by workers about these issues, Ms Decoster would claim not to remember, or that she was unwell.

Ms Decoster was an unsatisfactory witness in the case study. At times her evidence was contradictory and difficult to follow. Under close questioning about failures of her management of McCoolle she claimed to be unwell but when given the opportunity to explain her problem, said that she was exhausted and the questioning was difficult emotionally. The Commission rejects Ms Decoster’s evidence about speaking to McCoolle about his performance and finds that no such conversation ever occurred.

The supervision of McCoolle by senior staff in Nation Building and transitional accommodation was as inconsistent as it was ineffectual. It was characterised by a constant lack of response to legitimate workplace concerns. In that environment it is not surprising that the most blatant red flag to McCoolle’s activities failed to provoke the response that was so desperately needed.

THE MIKAYLA BATES CARE CONCERN

In June 2013, nannySA worker, Ms H, lodged a care concern about McCoolle's conduct towards six year old Mikayla Bates. This event occurred in the period during which McCoolle was offending against children in care. Appropriate action on this care concern would not have prevented most of McCoolle's offending, but it gave Families SA the best opportunity to enquire into his conduct and potentially remove him from the workforce.

The investigation of this care concern brings together important issues about the capacity of the organisation to protect children against child sexual offending. It demonstrates the importance of:

- maintaining a high level of knowledge in the workforce of child sexual abuse and behavioural indicators of abuse;
- clear policies, procedures and practices which must be enforced in practice; and
- maintaining and critically examining comprehensive records of both employee and child behaviour to properly address the needs of children in rotational care environments.

It also highlights the negative effect of poor organisational culture and the influence individual staff can have on the efficacy of processes such as investigating care concerns.

On 23 May 2013 McCoolle started a series of shifts through nannySA at 10 L Street, a Nation Building house. Mikayla Bates, her seven year old brother Levi and an older, unrelated child, had recently been placed at the house.³¹³

Ms H had not worked with McCoolle before this placement. An afternoon shift on 3 June 2013 was only the fourth occasion they had worked together. That evening McCoolle initiated bath time with Mikayla and Levi. While bathing the children McCoolle twice approached Ms H as she prepared dinner. He commented that he found it funny that the children would freely expose themselves while bathing and become shy when they got out of the bath. The second comment related directly to Mikayla. He said '[i]t's funny how Mikayla lays in the bath exposing herself to me but when she gets out she'll cover herself with a towel and say "Ooh don't look at me"'. Ms H said she felt uneasy about these comments by McCoolle with respect to Mikayla's behaviour.³¹⁴

THE EVENING OF 5 JUNE 2013

On 5 June 2013 Ms H worked an afternoon shift with McCoolle. McCoolle initiated bath time and Ms H prepared dinner. McCoolle made similar comments to those he made two nights earlier.³¹⁵

After dinner, they were watching television. McCoolle began tickling Mikayla around her stomach and ribs. Mikayla appeared to happily engage with McCoolle. McCoolle then withdrew his attention. He said to Mikayla 'get off me' and told her not to touch him with dirty hands, which appeared to make Mikayla feel shame and confusion. McCoolle restarted tickling Mikayla in a pattern of alternating lavishing and then withdrawing his attention. Ms H recognised this conduct as potentially indicative of grooming.³¹⁶

At bedtime, Ms H went with Levi to his bedroom and started reading a story to him while McCoolle did the same with Mikayla. Mikayla's bedroom was close to Levi's. While reading, Ms H heard a noise which sounded like a heavy object or body lying on Mikayla's bed. McCoolle called out to Ms H that the beds were not big enough. McCoolle's voice then lowered to a whisper and Ms H heard the word 'tickle'. Mikayla sounded as if she was trying to laugh, but was uncomfortable. Ms H heard Mikayla say '[s]top, don't, don't tickle me there'. Ms H did not hear a response from McCoolle.³¹⁷

Ms H felt something was not right and moved to quietly enter Mikayla's bedroom. However, as she left Levi's room, Levi yelled out loudly, 'hey, what about a hug?' By the time Ms H reached Mikayla's room, McCoolle was on his way out. He pushed past her, walking down the hallway towards the office.³¹⁸

Ms H entered the bedroom and saw Mikayla on all-fours on her bed, positioned on top of the bedding. She was staring wide eyed at the doorway and appeared to be in shock. No lights were on. Ms H told Mikayla it was time to get under the blankets and tried to pull the blankets from under Mikayla, but she did not move. Mikayla then said, 'my bottom hurts'. Ms H asked her why and Mikayla only repeated the words.³¹⁹

Ms H then heard McCoolle coming back towards Mikayla's room. Mikayla moved under the blanket and pulled it up to her nose. As Mikayla lay down, Ms H again asked why her bottom hurt.³²⁰

McCoolle entered the bedroom. He pushed past Ms H and stood between her and Mikayla.³²¹ McCoolle placed a bracelet on Mikayla's tallboy, saying 'I've got this for you Mikayla'.³²² McCoolle shepherded Ms H from the room, remaining close to her as she returned to Levi's room to give him a hug goodnight. He remained immediately behind her as she walked down the hallway. When Ms H paused at the entrance to Mikayla's room, McCoolle pushed her until she moved towards the office.³²³

Ms H did not record her observations of McCoolle's behaviour in the logbook. She described being in shock and not knowing how to record what she had observed.³²⁴

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Ms H believed McCoolle was not rostered to work the following day.³²⁵

MIKAYLA'S BEHAVIOUR THE FOLLOWING NIGHT

On the afternoon shift the following day, 6 June 2013, Josie Dimond worked with McCoolle at 10 L Street. McCoolle spent time alone with Levi and Mikayla during the shift.³²⁶

As Ms Dimond was putting Mikayla to bed, Mikayla reached out and tickled Ms Dimond under her arm, asking '[d]oes this tickle?' She repeated the tickling on Ms Dimond's neck. She then reached her hand out towards Ms Dimond's crotch and attempted to tickle her, asking '[h]ow about there?' Ms Dimond told Mikayla to stop and spoke to her about appropriate behaviour.³²⁷ Ms Dimond concluded that Mikayla was simply being inquisitive. In those circumstances she did not believe it was necessary to record her observations in the logbook.³²⁸

On the following two evenings Mikayla demonstrated aggravated or upset behaviour at bedtime.³²⁹

MIKAYLA'S DENIAL

On 7 June Ms H worked the morning shift with McCoolle.³³⁰ While in the car with Mikayla on the way to school, Ms H asked Mikayla if her bottom still hurt. Mikayla scowled, put her head down and responded 'I never said that' in a growl. Ms H repeated the question and Mikayla repeated her denial.³³¹

The same day, Ms H returned to the house to work an afternoon shift with Ms Dimond. Ms Dimond told Ms H about Mikayla trying to tickle her crotch the previous night. Ms H then shared some of her observations of McCoolle's behaviour on the evening of 5 June. Ms H asked Ms Dimond to log Mikayla's tickling behaviour. Ms Dimond made a late logbook entry.³³²

FIRST ATTEMPT TO NOTIFY THE CHILD ABUSE REPORT LINE

Ms H said she had spent 6 June gathering her thoughts. She felt she had interrupted McCoolle raping Mikayla and was processing her observations. She found the concept of a person who worked in child protection being a paedophile inherently shocking.³³³

Ms H refrained from discussing her observations with anyone as she feared she would not be believed. She had not found the seniors approachable when it came to less serious concerns, let alone a situation of this apparent magnitude. She was also aware of the experiences of a colleague who had reported observations about a Families SA senior and was subsequently falsely accused of misconduct. All of these matters contributed to Ms H not reporting her observations immediately.³³⁴

On 8 June Ms H was unwell and did not work. However, she felt she had a duty to decide what to do and she contacted a friend who was studying law for advice. Following that advice, Ms H made notes of her observations. Ms H had also been giving thought to her obligations as a mandated notifier. By 8 June 2013 she had fixed in her mind the significance of her observations and decided to report her concerns to CARL. She first attempted to contact CARL on the evening of 8 June 2013 but abandoned the call after being left 45 minutes on hold.³³⁵

LEE NORMAN'S RESPONSE

On 9 June 2013 Ms H spoke with senior youth worker, Mr Norman. The following matters were raised with him³³⁶:

- McCoolle had made comments about Mikayla exposing herself to him in the bath. Mr Norman told Ms H she probably did not need to come to him with these concerns. He said they sounded 'like Shannonsisms' and she could have taken this up with McCoolle.
- Ms H described her observations of McCoolle's behaviour in Mikayla's bedroom. When she reported that she thought McCoolle had lain on the bed, Mr Norman said he often did this himself with the children.
- She described her observations within Mikayla's bedroom, including Mikayla's position and that she had complained her bottom hurt.

Mr Norman told Ms H he would email Mr Sterzl as he (Mr Norman) was going on leave. He appeared to be drafting an email.

Mr Norman told Ms H that nannySA staff often made accusations about other workers and did not want them to know. Ms H indicated she had no issue with McCoolle knowing she made the report.

Mr Norman said he would talk to McCoolle about it. He told Ms H he had often talked to McCoolle in the past about pulling his head in and McCoolle was often targeted because of his weight and loud voice. He told Ms H not to worry about reporting the matter to nannySA as he would take care of it.

Ms H made notes of this conversation. She felt her concerns were downplayed and dismissed by Mr Norman.

On 10 June Ms H again spoke with Mr Norman. She told Mr Norman she was going to report the incident to nannySA, as it was her obligation to do so as a nannySA staff member. During this conversation, Mr Norman denied having previously told Ms H he would report the concern to nannySA.³³⁷

In evidence Mr Norman gave an account of this conversation that differed substantially from that given by Ms H. In particular, he denied being informed that Ms H had found Mikayla on her hand and knees and that Mikayla had complained that her bottom hurt. Mr Norman said that Ms H told him no more than that she had read a logbook entry for the day recording that Mikayla had a sore or red bottom, that she had seen McCooles leave Mikayla's bedroom to get a drink of water and had felt intimidated by McCooles. Mr Norman reported Ms H as saying that she had 'joined the dots together and I know something happened in that bedroom ... I just know something happened. Call it women's intuition.'

There is no evidence in the logbooks of Mikayla complaining of a sore bottom during the relevant time period.³³⁸ Ms H made contemporaneous notes of the conversation with Mr Norman. She understood that it was significant and would have repercussions. The totality of the evidence supports the conclusion that Mr Norman did not consider the matter especially serious, and placed little weight on the account given by Ms H. The Commission accepts Ms H's account of the events and her subsequent conversation with Mr Norman in their entirety.

INITIAL ACTIONS

On 11 June, Ms H contacted Ms McKenna at nannySA to report her observations. On advice from Ms McKenna, Ms H immediately made a notification to CARL.³³⁹

Ms McKenna contacted supervisor Mr Sterzl about Ms H's report. It appeared to Ms McKenna she was giving Mr Sterzl information he had not heard before. Mr Sterzl gave Ms McKenna advice about contacting McCooles, who was on leave. He mentioned the possibility of McCooles attending a meeting with them both on his return from leave.

The Commission finds that Mr Sterzl learnt of the allegations from Ms McKenna. His immediate response was to plan to meet with McCooles to discuss the allegations, even though he had not received any information about the reported conduct. This is denied by Mr Sterzl, who asserted that he only intended the discussion to be a general conversation, that he was already aware of the care concern, and believed a CARL notification had already been made. Mr Sterzl's account is in conflict with his subsequent conduct and the evidence of other witnesses.

At about midday on 11 June Ms H received a telephone call from Mr Sterzl. Ms H provided an account of the events she had witnessed. She told Mr Sterzl that she had already made a CARL notification. He responded with a deep sigh, leading Ms H to feel that she had acted incorrectly. During this conversation Mr Sterzl advised Ms H that she could take back the allegations. Ms H reiterated that she stood by everything she had said.³⁴⁰

Mr Sterzl maintained in evidence that he would not have suggested that Ms H could take a CARL report back. However, in all the circumstances, his account on this topic is rejected. The Commission accepts Ms H's account of the conversation.

On about 12 or 13 June 2013 Ms McKenna telephoned McCooles and advised him he was stood down. She scheduled a meeting with him for 19 June 2013. She advised Mr Norman and Mr Sterzl of the meeting by email, although this meeting did not eventuate as a result of the ongoing investigation.³⁴¹

THE CARE CONCERN

Ms H's CARL notification was referred to the Care Concern Investigations Unit (CCIU—which investigated complaints related to children in care) for a category determination. On 12 June 2013, Catherine Harman, then manager of CCIU, allocated the care concern to Ms Lamont, and Don Williams. Mr Williams was a supervisor in the directorate whose work included responding to care concerns. Ms Harman was responsible for allocating a category to the care concern but had not yet made the decision.³⁴²

The interagency code of practice: Investigation of Suspected Child Abuse or Neglect defines three categories of care concern and the responses expected from agencies for each: minor, moderate and serious. Minor care concerns 'are minor breaches of accepted care standards that pose a minor risk to the safety and wellbeing of the child/young person'. They are managed jointly by the contracting agency/alternative care service provider and Families SA in a general practice case management process.³⁴³ Serious care concerns are 'serious breaches of accepted care standards where the child is expected to be in immediate danger or has already suffered serious harm or is at significant risk of serious harm as a result of the carer, staff member or volunteer's actions'. An investigatory response by a CCIU investigator is required and a strategy discussion, attended by various agencies involved with the child and person under investigation, must be held.³⁴⁴

On 13 June 2013, Ms Harman determined the care concern as minor. She made the determination despite Mr Williams raising concerns in an email about the allegations, which he felt indicated grooming and required a proper investigation.³⁴⁵

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Ms Lamont informed Ms Harman by email that she intended to meet with McCoolle and make a decision as to whether he would receive further shifts with Families SA. The email said this appeared unlikely.³⁴⁶ As McCoolle was a casual employee, Ms Lamont was contemplating whether there was an option not to provide him with further shifts. In response to this email, Ms Harman indicated she would need to report the matter to SAPOL, although she doubted anything would occur. She told Ms Lamont she might assess the care concern as minor as Ms Lamont was 'well on to it' and could liaise with nannySA. The classification could be reconsidered if SAPOL took action. Ms Harman could not assist the Commission with what she meant by this comment.³⁴⁷

Ms Harman understood the allegations reported by Ms H related to a potential sexual assault. She agreed that, generally speaking, it would not be appropriate to deal with an allegation of sexual assault against a child in the manner contemplated for minor care concerns.³⁴⁸

The consequence of this determination was the assignment of responsibility for the response to the local office, the directorate and nannySA. In explaining why she determined the care concern was minor, given sexual allegations were involved and the minor determination would divert responsibility away from CCIU, Ms Harman said that she had confidence in the ability of the local office to respond to allegations involving sexual offending.

On 14 June an email was sent notifying representatives of the directorate, Aberfoyle Park local office, nannySA and SAPOL of the 'minor' designation. It attached a copy of the care concern referral (Ms H's CARL notification).³⁴⁹

Detective Sergeant Bernadette Martin of SAPOL South Coast Family Violence Section considered the matter in consultation with Detective Senior Sergeant Noel McLean of the SAPOL Sexual Crimes Investigation Branch. They received the care concern referral and Ms H's typed notes. Det Sgt Martin determined there was insufficient information to justify a criminal investigation at that stage. Det Sgt Martin accepted that it was possible to draw an inference that a criminal offence had occurred, but she maintained that there was insufficient evidence to support a prosecution. Both officers agreed that if further information was identified, the matter could be referred back to SAPOL.³⁵⁰

On 19 June Det S/Sgt McLean advised Brett Dixon from the Department's Special Investigations Unit (SIU—which investigated serious misconduct alleged against departmental employees) by email that SAPOL would not investigate the matter, that inappropriate behaviour only was indicated, and that the matter could be reviewed if further information arose.³⁵¹

SHANE STERZL'S INFLUENCE

Linda Hurley, manager of Aberfoyle Park office, allocated responsibility for the care concern to Melissa Rowley. Ms Rowley was the supervisor of Toni Jezeph, who was the allocated social worker for Mikayla and Levi. Ms Jezeph was on leave when the local office received the care concern referral.³⁵²

On 14 June 2013, before the receipt of the care concern referral, Mr Sterzl and Ms Rowley had a telephone conversation about the care concern. Mr Sterzl requested a social worker attend 10 L Street to interview Mikayla.³⁵³ Mr Sterzl told the Commission he was unaware that Ms Lamont was asking SAPOL to consider the care concern. He agreed it was probably not his role to ask Ms Rowley to arrange for Mikayla to be interviewed, particularly in circumstances where the referral had not even been received. Mr Sterzl pointed to a lack of understanding of the process and a desire to ensure everything was followed up as his reason for making this request. Mr Sterzl said it did not cross his mind that having Mikayla interviewed at this stage might interfere with a police investigation.

Although Ms Lamont could not recall if she asked Mr Sterzl to organise for Mikayla to be interviewed she felt it was too soon for that to occur, particularly if SAPOL were to become involved. She regarded that task, in any event, as the responsibility of the case manager (social worker).³⁵⁴

Ms Rowley considered that during their conversation Mr Sterzl was attempting to influence how seriously she viewed the care concern by minimising its seriousness and shaping her perception of McCoolle and Ms H.³⁵⁵ She said Mr Sterzl told her³⁵⁶:

- he hoped the social worker and Mikayla could have their conversation before McCoolle returned to work on 19 June (Ms Rowley understood Mr Sterzl intended to return McCoolle to shifts at that point);
- no concerns had previously been raised about McCoolle;
- he had spoken with Ms H and she explained she needed time to think about whether she was right about what she had observed, accounting for the week delay in her report; and
- neither Mikayla nor Levi had said anything and there had been no change in Mikayla's behaviour or indicators which suggested she had been abused.

Mr Sterzl did not recall whether he made a number of these comments. He denied saying no previous concerns had been raised about McCoolle. His evidence as to when he became aware of the earlier complaints about McCoolle was unclear, but he ultimately asserted that he may not have been aware of the issues at the time of the care concern. He said that the length of

time McCooole was off the floor was not his concern. He denied minimising the seriousness of the care concern in conversation with Ms Rowley.

The Commission accepts Ms Rowley's account of the conversation. Mr Sterzl made a series of comments that he either knew to be inaccurate or failed to check the accuracy of, including:

- how long Ms H had delayed her report;
- any uncertainty of Ms H about her observations;
- there had been no relevant changes in Mikayla's behaviour; and
- no concerns had previously been raised about McCooole.

As a result of this conversation with Mr Sterzl, Ms Rowley did not view the care concern as being overly serious.³⁵⁷ The Commission considers that the comments were made by Mr Sterzl with the intention of minimising the seriousness of the allegations. He succeeded in doing so, at least until Ms Rowley was provided with the written care concern document.

Mr Sterzl's conversation with Ms Rowley is the start of a pattern of conduct by him directed at undermining Ms H. Mr Sterzl's conduct, as described by a number of witnesses, demonstrated an attitude of questioning the veracity of Ms H's account. Mr Sterzl maintained his improper attitude towards Ms H even after the care concern had been resolved.

TONI JEZEPH'S INTERVIEW WITH MIKAYLA

After Ms Rowley read the care concern referral she believed that an unhealthy interest in Mikayla had been identified, which required investigation.³⁵⁸ Ms Rowley assumed SAPOL and Child Protection Services (CPS) had already declined to interview Mikayla because the matter had been allocated a minor determination.³⁵⁹ She did not believe any of the social workers in her team had the expertise to conduct an inquiry into a potential sexual assault.³⁶⁰

Ms Hurley decided to send Ms Jezeph to interview Mikayla. Ms Rowley did not initially support this approach, but she ultimately agreed.³⁶¹

When Ms Jezeph returned from leave on 17 June 2013, she was asked by Ms Rowley to go to 10 L Street and speak with Mikayla.³⁶² Ms Rowley said she advised Ms Jezeph to speak to Mikayla in a formal way and in a private setting.³⁶³ Ms Jezeph did not follow up arrangements which had been made for her to be accompanied by Ms Wallis, a more experienced social worker.³⁶⁴ Ms Jezeph said that this was because she viewed Ms Wallis as more of a hindrance than a support.

Ms Jezeph had no experience conducting forensic interviews with children to investigate allegations of abuse. She had limited experience in responding to care concerns. She was not aware of the principles guiding interviewing in the Interagency Code of Practice.³⁶⁵

Ms Rowley said she gave Ms Jezeph the care concern referral and made her aware the interview was part of a care concern investigation.³⁶⁶ Ms Jezeph said that she was not advised the notification was a care concern but her evidence is rejected on this point. Her own notes demonstrate that she was aware of this fact.³⁶⁷ The Commission also accepts the evidence of Ms Rowley in preference to that of Ms Jezeph on the point that she provided Ms Jezeph with some limited advice as to how to conduct the interview with Mikayla.

Before speaking with Mikayla, Ms Jezeph had received information that led her to believe the care concern was not being taken seriously. Ms Rowley advised her that workers at the house had said there was nothing in the care concern. Ms Jezeph was also told the notifier had delayed reporting her observations for a week. However, Ms Jezeph could not recall whether she received this information from Ms Rowley or Mr Sterzl.³⁶⁸

Ms Jezeph advised Mr Sterzl that she would be attending to interview Mikayla. She said Mr Sterzl told her he did not think there was much in the care concern. He said it resulted from a personality clash and by reference to Ms H said, 'basically she's a fucking bitch anyway, she wanted the job and Shannon got it'.³⁶⁹ He also told her McCooole was pretty loud, that some people did not know how to take him and 'there is no way he would do that'.³⁷⁰

Mr Sterzl recalled a telephone call with Ms Jezeph, but could not recall the exact conversation. He doubted that he referred to the personality clash in those terms. He denied referring to Ms H as a fucking bitch or that he asserted McCooole would not act in the way alleged.³⁷¹

Ms Jezeph's account of this conversation is preferred to that of Mr Sterzl. Ms Jezeph advised Ms Rowley of Mr Sterzl's comments. Ms Rowley told Ms Jezeph that, if anyone knew McCooole, they would.³⁷²

Ms Jezeph was frank about the impact this conversation had on her own views.³⁷³ Although she thought the circumstances described by Ms H indicated a possible sexual assault, she was confused because the suggestion of concoction had been raised.³⁷⁴ A professional investigation would not have had placed weight on comments of this type.

CASE STUDY 5 SHANNON McCOOLE— KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

On 18 June 2013 at 3.45pm Ms Jezeph attended 10 L Street and spoke with Mikayla.³⁷⁵ The circumstances of the discussion and method of questioning were not conducive to providing Mikayla with the best opportunity to disclose any concerns she may have had. The discussion took place in an open living area with multiple distractions. Mikayla's brother and workers were close by and one of the workers participated in the conversation. Mikayla had a telephone conversation with her father, and she was also playing a computer game.³⁷⁶ It was inappropriate for Mikayla to be interviewed where carers were present. Mikayla may also have anticipated the return of McCoolle at any time.

The method adopted to interview Mikayla was a significant departure from best practice. The questions posed were so broad that they failed to focus Mikayla's attention on what had occurred at bedtime on 5 June. They did not give her sufficient guidance as to what Ms Jezeph wanted to discuss with her.

During the interview, Mikayla mentioned McCoolle by name in response to a question about whether any of the carers at the house made her feel uncomfortable. Mikayla said that McCoolle had told her she could have dessert at any time, but then she couldn't. Ms Jezeph, unaware of the potential significance of this statement responded with 'oh well, these things happen', and did not pursue the matter.³⁷⁷

Ms Jezeph's response may well have indicated to Mikayla that Ms Jezeph was not interested in anything she might have had to say about McCoolle. Ms Jezeph was unconcerned about McCoolle in this context. She did not think that Mikayla might have been throwing out McCoolle's name to her to test her reaction and to possibly follow it up. She failed to record in her notes that McCoolle was the person to whom Mikayla referred.³⁷⁸ Ms Jezeph said she had been told not to record the name in her notes. This decision meant that those who later assessed this discussion were unaware of the potential relevance of the reference to McCoolle.

Following the interview, Ms Jezeph spoke to some of the carers in the office. Their evidence establishes that Ms Jezeph conveyed that she did not think Mikayla had said anything of note during the interview. Their evidence also establishes that they were told that Ms H was the notifier who raised the allegations and were advised of their content. Ms Jezeph asked whether it was normal for Ms H to have interpersonal issues and whether she had a vendetta against McCoolle. Ms Dimond mentioned to Ms Jezeph her own recent experience when she had withheld dessert after Mikayla had behaved badly at dinner time, which Mikayla had not mentioned in the same context.³⁷⁹ This information should have brought the importance of Mikayla's reference to McCoolle in this context into greater prominence.

It is not possible to determine whether it was Ms Jezeph who shared information about the allegations and Mr H's identity. It may have been Mr Rogers who did so. Whoever it was, those matters should not have been discussed in that environment.

RESPONSE TO THE INTERVIEW

Ms Jezeph was not aware of the incident in which Mikayla tickled Ms Dimond on 6 June or Mikayla's subsequent distressed behaviour at bedtimes. Ms Jezeph relied on C3MS weekly updates to inform her of Mikayla's behaviours, rather than checking the logbooks. The relevant weekly update of these matters was not uploaded until after Ms Jezeph had made her assessment that the allegations were not proven.³⁸⁰ Ms Jezeph's conclusion was accepted by the local office without question, despite concerns being held about Ms Jezeph's capacity to interview Mikayla. Following the uploading of the care concern, the local office's position was that Nation Building staff were responsible for deciding what action to take.³⁸¹

Ms Jezeph spoke to Mr Norman about the allegations. He told her that Ms H was 'a bitch' and sang McCoolle's praises. He suggested that Ms H had a motive to lie, and that there was 'no way that McCoolle would do that [sexually assault a child]'. Mr Norman denied making those statements, but the Commission rejects those denials.³⁸²

Mikayla's father was not advised of the care concern by Families SA as Ms Rowley believed that 'natural justice' principles did not allow it.³⁸³

Ms Lamont met with Ms H on 20 June 2013 to discuss the allegations. Ms Lamont found Ms H to be credible.³⁸⁴ After the meeting, Ms H contacted Ms Lamont and advised her of Ms Dimond's late logbook entry which recorded the tickling incident.

Ms Lamont had initially been of the view that the matter required investigation rather than case management and she continued to advocate with Ms Harman for this to occur. Ms Harman agreed to call a strategy meeting to discuss how the care concern would progress after Ms Lamont drew her attention to the late logbook entry.³⁸⁵

In the meantime, Mr Williams emailed Mr Dixon of SIU asking whether they would conduct an investigation.³⁸⁶

THE 2 JULY 2013 STRATEGY MEETING

On 2 July 2013 a strategy meeting was held, attended by Ms Harman, Ms Lamont, Ms Hurley, Ms McKenna and Ms R of the Department's Human Resources Misconduct and Incapacity Unit (HR-MIU).³⁸⁷ The interface between SIU, CCIU and the HR-MIU was poorly defined. HR-MIU provided a human resources advice function to managers and a liaison point for employees where performance

issues arose, which were not sufficiently serious to require an investigative response from CCIU or SIU. Any action by HR-MIU would await the resolution of investigations being conducted by CCIU or SIU.

Ms Harman indicated that she was not prepared to change the category of the care concern. She considered that, without a disclosure from Mikayla, there was insufficient evidence to proceed to an investigation.³⁸⁸

The meeting resolved that further action should be taken to determine if any further evidence could be obtained. The steps to be taken were to³⁸⁹:

- make an attempt to have Mikayla formally interviewed;
- provide the late logbook entry to SAPOL with a request that they review their decision not to investigate; and
- have Ms R of the HR-MIU speak with the manager of SIU about a skilled investigator interviewing McCoolle (SIU had not decided whether it would investigate at that time).

Both Ms Lamont and Ms McKenna were advised by Ms R to refrain from interviewing McCoolle while these actions were being completed.³⁹⁰ Some of the attendees, including Ms Harman, viewed a response that focused on the delivery of training to McCoolle as appropriate, rather than any more serious action.³⁹¹ Ms McKenna was pushing for speedy action to be taken to resolve the care concern. She viewed her role as including acting as an advocate for McCoolle.³⁹²

Following the meeting there was confusion as to which documents would be sent to SAPOL and by whom.³⁹³

On 3 July 2013 Ms Harman forwarded Ms H's typed notes to Det S/Sgt McLean. However, SAPOL had already received this material and advised that it did not change their decision.³⁹⁴

SAPOL did not ever receive the logbook entry.³⁹⁵ It is unnecessary to determine why, but it is clear that the intention at the meeting was that it should be sent. SAPOL was thus not given information that both SAPOL officers agreed was relevant, and which Det S/Sgt McLean felt would have led him to the view that an investigation should proceed.

REFERRAL TO CHILD PROTECTION SERVICES

On 5 July 2013 Ms Jezeph made a request to CPS for a forensic interview with Mikayla.³⁹⁶ CPS was given information on the progress of the investigation and told that SAPOL would not investigate. CPS also received a copy of the logbook entry.³⁹⁷

A properly conducted forensic interview gives a child the best opportunity to disclose.³⁹⁸ Forensic interviews are conducted by a CPS interviewer with a SAPOL officer and senior CPS employee present in a separate room. It is unusual for CPS to conduct an interview without SAPOL involvement.³⁹⁹ A prosecution resulting from an interview undertaken in the absence of a police officer to verify any transcript produced for court purposes, may face evidentiary difficulties.⁴⁰⁰ CPS would not conduct a forensic interview without SAPOL present. However, if CPS disagreed with SAPOL's position not to investigate, it remained open to CPS to call for a strategy meeting and advocate for their position.⁴⁰¹

Cate Braham considered the referral to CPS. She said that a decision not to interview Mikayla was made by Sue Macdonald, the CPS Director, on the basis that the available information did not merit a forensic interview.⁴⁰² Ms Braham advised the local office, Ms Lamont and Ms Hurley by email that a forensic interview would not be conducted. She cautioned against other staff interviewing Mikayla, a prospect that had been contemplated.⁴⁰³

In evidence, Ms Macdonald accepted she had made that decision although she had no memory of it and she was quite frank in indicating that she now held a contrary view. She explained that the decision would have been made in the context of a particularly chaotic environment at CPS at that time. Ms Macdonald's willingness to accept responsibility for the decision reflects a principled and conscientious approach. However, it is unnecessary to attribute this decision to any particular individual. If the matter unfolded in the way described by Ms Braham, Ms Macdonald's decision does not show a deficit in her skill or judgement, rather it was a decision made in particular circumstances, on the day in question.

Ms Macdonald expressed the opinion in evidence that the content of the notification was concerning and would justify the conduct of a forensic interview or, at least as a first step, an interview with the child's care giver. It is not a precondition to a forensic interview that a child has made a disclosure. In some instances, a series of observed circumstances might be sufficient to justify a forensic assessment or interview.

REFERRAL TO SPECIAL INVESTIGATION UNIT AND HR MISCONDUCT AND INCAPACITY UNIT

SIU was responsible for the conduct of investigations into serious misconduct alleged against departmental employees. SIU and CCIU operated concurrently, with CCIU investigating only complaints that related to children in care. Despite CCIU declining to investigate this care concern, it remained open for SIU to conduct an investigation into any alleged worker misconduct.⁴⁰⁴

CASE STUDY 5 SHANNON McCOOLE— KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

SIU, like CCIU, operated a system of categories which dictated the response to allegations of misconduct. Again, the allegations in this case were allocated the lowest category, category C—matters such as minor breaches of duty of care, being absent without proper cause or failing to comply with management directions.

This decision was made in the face of the allegations potentially sitting within the contemplation of categories relating to serious misconduct. Category A* includes any complaint of a potential criminal offence of sexual contact or behaviour or the sexual abuse of a child. Category A includes other potential criminal offences and other serious or significant breaches of duty of care.⁴⁰⁵

The category decision was made at a meeting attended by Ms R, the HR-MIU employee allocated to the matter, and Ms R's manager Julie Lawson Hall on 19 July 2013. Ms R and Ms N, SIU manager, held different views about the appropriate categorisation. It is unclear precisely what occurred at the meeting or the role of Ms Lawson Hall in the decision. However, it is likely that the category decision was made, if not solely, then principally by Ms N.⁴⁰⁶

It is significant that Ms N in evidence remained of the view that the category determination was correct. She believed that the responsibility to investigate concerns about a child in care lay with CCIU. As SAPOL and CCIU had declined to investigate, she concluded that SIU was unable to deal with any suspicion of sexual assault within the allegations. As such, the threshold test to conduct a category A or A* inquiry was not met.⁴⁰⁷

The category decision had a significant impact on disposition of the matter. SIU did not conduct investigations into Category C matters. Such matters were referred to the HR-MIU.⁴⁰⁸ With CCIU and now SIU declining to investigate, it fell to the directorate, in conjunction with nannySA, to conduct any necessary inquiry. It was Ms R's role, as the allocated HR-MIU case manager, to help and advise the directorate and fulfil the HR functions.⁴⁰⁹

Ms R intended to write a letter to McCoolle setting out the allegations and requesting a response from him. Using a similar rationale to Ms N, she took the view that only disciplinary issues could now be addressed in the Department's response. Allegations which supported sexual assault could not be considered.⁴¹⁰

NANNYSA

Ms McKenna had refrained from meeting with McCoolle because of the initial advice from Families SA that any nannySA interview with McCoolle had to await their action.

While Ms McKenna was on leave, Mr Sterzl maintained contact with Peter Emmerton, chief executive officer of nannySA. Following a continuing pattern, Mr Sterzl made comments to Mr Emmerton which demonstrated his view that the allegations probably had little substance.⁴¹¹

McCoolle maintained regular contact with Ms McKenna during his suspension. Over time he became increasingly angry and threatened legal action against nannySA. This contributed to Ms McKenna's anxiety about the care concern. She felt under increasing pressure, to the extent that she asked Mr Emmerton to take over conduct of the care concern.

On 22 July 2013 Ms R informed Ms McKenna that SIU would not conduct an investigation. The Commission accepts Ms McKenna's evidence that Ms R also informed her that nannySA could now conduct an interview with McCoolle.⁴¹²

On 23 July 2013 Ms McKenna and Maree McCulloch, operations manager of Bubble 'n' Squeak (another business arm of Hessel), interviewed McCoolle.

The purpose of the interview, as perceived by Ms McKenna, was for McCoolle to have an opportunity to answer the allegations. She did not view it as an investigation into a sexual assault. Ms McKenna considered it would enable her to assess whether nannySA was content to put McCoolle back to work and whether he needed direction or retraining.⁴¹³

Ms McKenna viewed the allegations surrounding McCoolle's conduct in the bedroom as the area of concern. She agreed it could be inferred that McCoolle had tickled Mikayla where she was not comfortable and it was possible something had happened in relation to Mikayla's bottom. However, Ms McKenna felt there may have been innocent explanations for what had been observed. For example, she thought the comment by Mikayla that her bottom was sore could have been attributable to a medical condition such as worms or constipation.⁴¹⁴

Ms McKenna was not concerned about McCoolle's comments about children exposing themselves in the bath, as they were not made repeatedly. She interpreted the allegations of lavishing and withdrawing attention in the tickling game as akin to a brother treating a sister unkindly and not indicative of grooming.⁴¹⁵

Ms McKenna approached the interview by reading the allegations to McCoolle and allowing him to respond. Any questioning of McCoolle was limited to one or two questions.⁴¹⁶

McCoole gave the following responses⁴¹⁷:

- He made general denials of the comments about the children bathing and saying ‘oh, don’t look at me’.
- He denied tickling Mikayla and said it was ‘gentle poking’ while watching TV. He asserted the behaviour may have given the impression of lavishing and withdrawing attention because he only did this during ‘ad’ breaks. Ms McKenna thought this was a possible explanation, but agreed she could have checked its accuracy with Ms H.
- Ms McKenna thought McCoole made a general denial that he had been whispering in the bedroom.
- McCoole gave no explanation why Mikayla was on her hands and knees or why she said her bottom hurt. Ms McKenna did not recall if she specifically put this to him. At the time Ms McKenna did not think it significant that McCoole failed to address these topics.

Ms McCulloch’s sole involvement in the interview was acting as scribe.⁴¹⁸

Immediately on completion of the interview, Ms McKenna advised McCoole she was satisfied with his responses and the allegations appeared to be unfounded. She regarded McCoole’s responses as credible and thought that Ms H’s concerns had resulted from a misunderstanding. In hindsight, Ms McKenna accepted the interview process was inadequate as she did not probe into the areas where McCoole failed to provide an explanation, and she did not investigate further the possibility of a ‘misunderstanding’ with Ms H.⁴¹⁹

On 24 July 2013, Ms McKenna emailed Ms Lamont advising her that she was ‘fully satisfied’ with the explanations given by McCoole at interview. By this, Ms McKenna meant that she was satisfied the care concern was not substantiated in view of the principle that a person is innocent until proven guilty, although she did not include that qualification in her communication with Ms Lamont.⁴²⁰

Ms McKenna completed the interview with McCoole shortly before her last day of work with nannySA. She wanted to finalise nannySA’s position on the care concern so someone else would not be left with a ‘mess’ to deal with. She denied that this influenced the way she dealt with the matter, and that accepting McCoole’s account was the tidest outcome. She also asserted she had ‘not really’ resolved the matter in this way to avoid legal action. Rather, she tried to follow due process after an already long delay.⁴²¹

CARE CONCERN CLOSURE RECOMMENDATION

On 9 August 2013, Mr Williams uploaded a case closure recommendation onto C3MS. The recommendation noted that⁴²²:

- the acting supervisor of 10 L Street had reported that neither Bates sibling had said anything and that there had been no change in Mikayla’s behaviour;
- the interview conducted by Ms Jezeph did not elicit any observed concerning behaviour nor concerning comments;
- SAPOL had assessed ‘all available information’ and decided not to investigate;
- the agreement at the 2 July meeting was that the focus of the care concern needed to be inappropriate behaviour in the residential care environment;
- CPS had declined to conduct a forensic interview;
- SIU would conduct its own investigation from ‘HR’s point of interest’; and
- ‘case management responses regarding this event have been finalised’.

In making this recommendation Mr Williams intended to advise the local office that the directorate had completed its actions and to prompt a response from, or review by, that office. Whether the office would have done so is questionable given Ms Rowley’s belief that the local office’s involvement in the care concern had ended following completion of the interview with Mikayla.⁴²³

Mr Williams relied on information he received from Ms Lamont and C3MS to prepare the recommendation.⁴²⁴ Mr Williams’ summary was inaccurate in a number of respects and omitted relevant information which was available on C3MS. In particular, the summary failed to reflect a C3MS entry of Ms Harman relating to the 2 July meeting which referred to the logbook entry.⁴²⁵ Mr Williams assumed, incorrectly, that SIU would investigate as Mr Dixon had not responded to the contrary to Mr Williams’ email of 24 June.⁴²⁶ Furthermore, the recommendation was made before the directorate completed its inquiry; McCoole had not been interviewed by the directorate, as Ms Lamont intended.

The care concern was closed by Ms Hurley on 13 August 2013.⁴²⁷

ACCEPTANCE OF NANNYSA INTERVIEW BY FAMILIES SA

McCoole was never sent a letter by HR-MIU. Ms R did not send it herself. She said she asked Kristin Kuehn, who assumed conduct of the matter when she went on leave in August, to do so. Ms Kuehn did not send it. Ms Kuehn in evidence did not recall being asked to send the letter, but other evidence supports Ms R’s account that she was asked to do so.⁴²⁸ The Commission accepts that she was asked to send the letter.

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Ms Lamont had deferred her interview of McCoolle until the letter had been sent. Ms R informing Ms McKenna that McCoolle could be interviewed by nannySA, combined with the failure to send the letter, meant that the directorate had not conducted its own inquiry before the nannySA interview.

Ms Kuehn received notes of nannySA's interview with McCoolle. On 20 August she recommended to Ms Lamont that she should accept the opinion of nannySA, that the concerns were unsubstantiated. She wrote:

it may be best to progress this matter by acknowledging the content and outcomes of the interview and confirming performance expectations with Mr McCoolle. This may need include a refresher in standard operating procedures.

This rationale is internally inconsistent; if it was accepted that the allegations were unfounded, it is difficult to see why retraining was required.

Ms Kuehn attributed her recommendation that Families SA accept nannySA's interview and judgement to an erroneous belief that McCoolle was solely a nannySA employee. She was unable to explain why she suggested the outcome of the interview should be accepted when McCoolle had not been required to provide an explanation for some of the alleged conduct.

Ms Lamont remained concerned about the qualifications of the interviewer and felt that the interview did not contain enough information from McCoolle about the events to form a basis for her assessment. However, faced with an absence of support for ongoing action, and with nannySA indicating its satisfaction that the allegations were unsubstantiated, 'it just died'.⁴²⁹

Ms Lamont met with McCoolle and Mr Sterzl on 22 August 2013. The purpose of the meeting was a performance management discussion with McCoolle. They discussed additional training, the need for McCoolle to develop a better understanding of the dynamics of abuse and that he needed to stop tickling children. In the meeting McCoolle denied the allegations and that he had any gaps in his understanding about sexual offending.⁴³⁰

THE DIRECTORATE'S RESPONSE

Ms Lamont held lingering concerns about placing McCoolle back to work with vulnerable children on single-handed shifts. She wanted McCoolle monitored for the safety of the children with whom he worked. McCoolle's return to work was on the proviso he only work on double-handed shifts for one to two months. Ms Lamont was reassured by her understanding that double-handed shifts would ensure McCoolle would always be monitored by the presence of a second staff member. Ms Lamont's decision to return McCoolle to work was also influenced by staff shortages in the directorate. A staff freeze

was placing pressure on the workforce: it had reached a stage where filling shifts required day-to-day crisis management.⁴³¹

McCoolle's casual employment contract with Families SA expired on 23 August 2013, the day following the performance management discussion. Ms Lamont thought that she was obliged to renew the contract as all staff on short-term contracts had been informed their contracts would be renewed. She spoke with the directorate's business manager and understood there were no grounds to refuse to extend McCoolle's contract.⁴³²

In contrast, Ms R thought that Families SA was not obliged to give McCoolle work. He was employed on a casual basis, so she thought there was no impediment to Families SA not giving him shifts and, at the end of his casual employment contract, no obligation to offer him a further contract. Ms R said she advised Ms Lamont of her view.⁴³³

It is not possible to resolve the inconsistency between the two witnesses on this issue.

At 10 L Street, a new policy was put in place prohibiting all carers from sitting on children's beds while reading stories. A sign to this effect was displayed and the policy was discussed at a staff meeting.⁴³⁴

CONVERSATIONS WITH MS H

On 17 August 2013, Ms H had a conversation with Mr Norman in which she sought an update on the status of the investigation. Mr Norman advised Ms H that McCoolle would be cleared and he would go back to work with their full support. Ms H felt Mr Norman was justifying the behaviour of McCoolle and dismissing her concerns. When she said that she had no reason to falsify anything, Mr Norman responded 'yeah, but we don't know you'. He said she could be trying to set McCoolle up and was in any event just 'putting dot points together anyway'. He questioned her observations and belittled her opinions. Part of the conversation was overheard by another nannySA worker.⁴³⁵

Mr Norman's account of the conversation contrasts greatly with that of Ms H. He paints her as aggressive and unprofessional, pushing for more to be done in the investigation as she had heard McCoolle was returning to work. He shared this account of the conversation in an email sent on 20 August to Mr Sterzl, Mr Calvert and Mr Rogers. He concluded the email saying:

*Ms H's willingness to condemn a fellow worker simply based on her feelings and the connecting of imaginary dots is quite dangerous and professionally intolerable. I made this very clear throughout her conversation.*⁴³⁶

Notwithstanding the content of the email sent by Mr Norman, Ms H's account of the conversation is accepted, and Mr Norman's rejected.

Soon after this email was sent, Ms H became aware that McCoolle was returning to work when Mr Norman made a phone call in her presence, asking McCoolle to pick up some shifts. Although Mr Norman denied in evidence that this call was deliberately staged to emphasise to Ms H his loyalty to McCoolle, the Commission is satisfied on the weight of the evidence that the call was placed with that intention.

MCCOOLE'S RETURN TO WORK

McCoolle returned to regular shifts with Families SA on 13 September 2013.⁴³⁷ In addition to restrictions requiring him to work double-handed shifts, McCoolle was not permitted to work at 10 L Street.

The restrictions in place on McCoolle's work were not explained consistently to Nation Building seniors, nor were operational staff made aware of any restrictions on his conduct. The perception that McCoolle had been 'cleared' of the allegations arose, and was the position put to seniors.⁴³⁸ The miscommunication extended to Ms Purton, who was asked to monitor his first shift back to work. She was told that McCoolle was allowed to be alone with children, in direct conflict with Ms Lamont's intent.⁴³⁹

The manager had stipulated a double-handed shift requirement for a period of one to two months. The restriction should have been enforced with such rigour that no member of the senior staff group could have had any doubt as to the required working arrangements or the outcome of the care concern.

McCoolle was then placed on shift with Mr Curyer at 9 T Avenue. Soon after, Mr Curyer ceased work for a period of time and McCoolle took over his position. As there were insufficient Families SA employees, McCoolle worked single-handed shifts. It is unclear precisely when this occurred, but it was likely before the end of the one to two month period specified by Ms Lamont. Even during the period that McCoolle was working double-handed shifts he would have been alone with children from time to time.⁴⁴⁰

The response of the workforce to McCoolle's return to work was not positive. Some workers objected to him moving to houses at which they worked.⁴⁴¹

Mr Curyer and other workers were consulted about their willingness to work with McCoolle, a circumstance so rare as to be notable.⁴⁴² Ms Lamont was advised of a complaint by one worker, but otherwise was not informed at that time of other complaints, such as the report of McCoolle photographing Nicky Schultz on his mobile telephone, during the period he was supposed to be supervised.⁴⁴³

MCCOOLE'S PROMOTION

Between 18 and 26 January 2014, McCoolle was appointed to the position of acting senior for six shifts on the recommendation of Mr Norman, who at the time was acting in Mr Sterzl's position.⁴⁴⁴ Mr Norman said McCoolle had demonstrated an interest in an acting position, and that he decided to give him the opportunity. Mr Norman explained he was attempting to replace a male senior with another male. He wanted to keep the gender balance to promote consistency for the children. He took this position despite the fact all the other seniors in the section were male.

Mr G, another senior youth worker, said he had a conversation with Mr Norman in which Mr Norman warned him about Ms H. In this conversation Mr Norman said he placed McCoolle in the acting position in response to Ms H and her friends calling McCoolle a 'pedo'.⁴⁴⁵ Mr Norman denied making this comment but his denial is rejected.

Mr Norman's explanation for his decision to promote McCoolle also cannot be accepted. Consistent with Mr Norman's comments to Mr G, the Commission is satisfied that Mr Norman did not base his decision solely on a consideration of merits. He was motivated, at least in part, by a desire to demonstrate his loyalty and show the women he thought had acted improperly towards McCoolle, that McCoolle's professional standing would not be affected by their actions.

SHANE STERZL AND LEE NORMAN'S BEHAVIOUR

Mr Sterzl and Mr Norman continued to publicly express their poor opinions of Ms H following the resolution of the care concern. The conduct extended to attempting to influence the views of other employees towards her.

Towards the end of 2013 Ms H applied for and was offered a position with Families SA working in residential care houses. She was to be deployed in a group of houses managed separately to Nation Building and transitional accommodation. Mr Sterzl on two occasions made derogatory comments about Ms H's work capacity and intellect. The first was in Ms H's presence. On learning that she had been accepted to a position with Families SA he said 'how did someone like you get through?'. He did not appear to be joking. He subsequently reiterated his point to Ms Hammond, saying 'she's got rocks in her head, that one'. On the second occasion Mr Norman belittled Ms H's intelligence in the presence of Ms Hammond and Mr Rogers.⁴⁴⁶

Mr Sterzl denied making any of the comments.⁴⁴⁷ The Commission is satisfied that the comments were made.

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Ms Hammond was given the impression that Ms H was a laughing stock among the seniors. She did not appear to receive any support from nannySA, nor from Families SA seniors or supervisors during the care concern process. Ms Hammond observed that Ms H appeared distressed and affected physically by the stress of the process.⁴⁴⁸

When Ms H began work with Families SA she was allocated to a group of houses which were managed separately to Nation Building and transitional accommodation. Mr G, Paula Elliott and Mr P were seniors in that area. While they were discussing Ms H joining their section, Mr Norman approached them and advised them to watch out for Ms H as 'she's trouble' and was 'going around accusing good workers of being pedos'. Mr P concluded that Mr Norman's view of Ms H was quite negative.⁴⁴⁹ Mr Norman denied having ever spoken with Mr P about this topic and did not recall this discussion. Mr G recalls that at a later time, after McCoolle's arrest, Mr Norman referred to Ms H and those supportive of her as 'a bunch of scorned old women'.⁴⁵⁰

Later in 2014, Mr Norman told Ms D, an acting supervisor in the Seaford area, that he did not really want Ms H to return to Nation Building houses as she was a troublemaker and could not be trusted.⁴⁵¹

Ms S, another worker, overheard a telephone call between Mr Sterzl and a person she believed to be Mr Norman in which Mr Sterzl described Ms H as a troublemaker.⁴⁵²

After McCoolle's arrest was made public, a meeting of the 10 L Street team was called. Mr Norman conducted the meeting. When asked by Ms Dimond what staff should do if they had information they felt may add to the case, Mr Norman cautioned them against assuming who had been arrested, as that may risk the investigation. He asserted they should not ring a police hotline to give information because there was a suppression order. This comment made no sense to Ms Dimond. Mr Norman also said that information Ms Dimond had would probably not be evidential. He twice subsequently indicated to Ms Dimond that passing information on to Ms Harman would be sufficient and reiterated that she need not call the police hotline.⁴⁵³

In evidence, Mr Norman said he did not recall this specific team meeting. He said he was psychologically injured by the discovery of what had occurred and his memory of the days and weeks thereafter was scant. Ms Dimond's evidence is accepted on these matters.

Mr G recalled receiving a text message from Mr Norman after McCoolle's arrest. The message contained a link to an Advertiser article which referred to McCoolle being promoted. Mr G said Mr Norman wanted him to 'suss out' whether Ms H had leaked the information.⁴⁵⁴ Mr Norman does not recall sending such a text message and

expressed a view that Ms H and Mr G may have colluded to concoct evidence against him. The Commission rejects Mr Norman's evidence on this topic.

Mr Sterzl and Mr Norman were both unsatisfactory witnesses whose evidence on most issues was not credible. There is a substantial body of credible evidence that they continuously undermined Ms H, both during and after the Mikayla Bates care concern.

ORGANISATIONAL CULTURE

The events discussed in the context of the Mikayla Bates care concern should be viewed in the wider background of the organisational culture in Families SA southern residential care area. Throughout McCoolle's employment, red flags were ignored and discounted. The ineptness of the response by senior staff to McCoolle's workplace performance, and the apparent condoning of his conduct, can be properly understood only as part of the prevailing culture.

The organisational culture provided an arena where the interests of employees and agendas of individuals overshadowed the need to act in the best interests of the children in care.

Nicole Stasiak, current Director of Residential Care, reflected on what she had come to understand about the cultural issues following the arrest of McCoolle. She reported hearing about senior staff trying to shut down staff members debriefing. Ms Stasiak described pockets of close-knit groups within which incidents or issues would remain confined. Staff were told the only option available to them to report concerns was to the next ranking person. The culture was dysfunctional and not healthy or supportive.

Ms Stasiak had become aware of some staff being promoted through being 'tapped', without training in leadership or support to develop the necessary skills. In her opinion, knowledge of legislation, and of departmental policies and processes, was limited, and understanding of the differing roles of youth workers and social workers was lacking.⁴⁵⁵

The reflections of Ms Stasiak echo many of the experiences of the organisation's culture described in evidence to the Commission.

THE STATUS OF COMMERCIAL CARERS

Commercial carers employed by agencies such as nannySA are permitted to care for vulnerable children who are in care. They often do this on shifts alone with multiple children and without supervision or oversight. This is an immense responsibility and places unparalleled trust in commercial carers. Yet, in many respects, Families SA staff treated them as inferior.

Commercial carers are given unconstrained access to children in care, but are limited in their access to information about those children. In a sense, information about the children was, at times, guarded more closely than the children themselves. The training offered to commercial carers is scant compared to that expected of Families SA employees.

Indifferent attitudes to nannySA workers permeated the senior staff level. Ms K described the approach to nannySA workers under senior Mr Calvert as '[w]e were on a need-to-know basis and we didn't need to know'.⁴⁵⁶ Mr Calvert would not respond to matters escalated to him by nannySA workers. Ms Hammond described Mr Calvert's attitude towards her as being one of disregard.⁴⁵⁷

For Mr Calvert's part he told the Commission he had no views about the quality of commercial carers. While at one time he was keen to support them, his approach changed because of the complexities of supervising staff not employed by the government. Mr Calvert considered it was not possible to have the same expectations of commercial carers as Families SA staff. Despite these views, he maintained he did not see agency staff as having a different role or status to Families SA workers. He disputed the comments made about his conduct towards commercial carers.

The view commercial carers had of their status in the workplace was relevant to how they responded to their observations of McCooles' conduct. For example, nannySA worker Ms V did not log Anna Pham calling McCooles a paedophile in part because Families SA workers made her feel as though they were 'higher up', even though they did the same work.⁴⁵⁸

Supervisors, in consultation with seniors, have the power to determine which agency staff are given shifts. Remaining in favour with the senior staff is therefore important. Ms Hammond said this dependence on Families SA to receive shifts meant many nannySA workers were reluctant to log or report incidents. Ms Hammond was not alone in her perception.⁴⁵⁹

In the absence of collaborative and respectful working relationships, it is difficult to see how the care given to children can be the best possible standard. Unbalanced and unsupportive relationships challenge the organisation's ability to focus on the wellbeing and protection of children in its care.

THE SOCIAL WORKER-YOUTH WORKER DIVIDE

On 1 January 2013, while cared for by McCooles and Ms Dennis on an excursion to the beach, William Moore was badly sunburnt. Ms Gregory, who cared for William that night, described the sunburn as 'bad enough for the child to be screaming all night'.⁴⁶⁰

William's social worker Mirjana Vidovic was advised of the incident. She sought more information and, in consultation with her acting supervisor and manager, gave the matter close consideration to ensure that it met written criteria before raising the matter as a care concern on 9 January.⁴⁶¹

Ms Vidovic was allocated to manage the relevant response. On 23 January, Ms Vidovic and her acting supervisor met with a senior youth worker and acting supervisor Mr Calvert to discuss the care concern. The relevance of this meeting is unrelated to the response to the care concern; Mr Calvert had taken steps to address the care concern which Ms Vidovic considered adequately dealt with the issues. The relevance is in Mr Calvert telling Ms Vidovic in the meeting that the care concern should not have been raised. He expressed the view that the more care concerns that are raised about a particular youth worker, the more unfavourable it looks.⁴⁶²

Ms Vidovic was clear the relevant policy supported the incident being raised as a care concern, and explained that to Mr Calvert.⁴⁶³ Mr Calvert did not consider the youth workers had failed to meet the necessary standard of care as the sunburn did not require hospital treatment. In his view, the social workers were 'setting a standard that most parents could not meet'.⁴⁶⁴ He thought if such a line was taken, staff would decide not to take children to such activities, which was more negligent than the occasional incident that arose. Ms Vidovic understood Mr Calvert's position was that if workers adhered to all practices, children would not be able to do anything at all.

The response to this care concern is indicative of tensions between those Families SA staff delegated to be the legal guardians of children in care and those youth workers tasked with providing day-to-day care to the children. Delegated legal responsibility for a child in care sits with social work practitioners in local offices, not the directorate.⁴⁶⁵ If the social worker ultimately responsible for the child considers there has been a failure to meet a sufficient standard of care, questioning that view gives the appearance of the worker's interests being prioritised over the child's interests.

THE CONDUCT OF DARREN CALVERT AND HIS EVIDENCE BEFORE THE COMMISSION

Mr Calvert asserted that Ms Vidovic was 'playing it safe', and 'made a judgement from an office that was based around her career as opposed to the outcomes for the kids'.⁴⁶⁶ Mr Calvert suggested rules provided staff with guidance only and that their application was discretionary.

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The Commission's ability to foresee the significant criticisms Mr Calvert would level against Ms Vidovic in evidence was limited because he did not provide a statement before giving evidence. Mr Calvert was given that opportunity but declined it when told that the Commission would not inform him in advance of exactly what the Commission wanted to know.⁴⁶⁷

Consequently, Ms Vidovic did not have an opportunity to respond to the allegations which emerged for the first time during Mr Calvert's evidence.

However, the Commission does not accept Mr Calvert's assertions in relation to Ms Vidovic's reasons for raising the care concern.

It is appropriate at this point to comment on Mr Calvert's evidence in general. His responses in evidence were dominated by an assertion that he did not recall events and circumstances. These purported memory gaps were not the result of medical impairment or psychological issues. Importantly, giving Mr Calvert the opportunity to refer to documents during his evidence did little to assist his memory.⁴⁶⁸

Mr Calvert and Mr Norman worked together for 10 years and were close friends.⁴⁶⁹ Following Mr Norman's evidence, but before Mr Calvert gave evidence, the two of them discussed Mr Norman's evidence. Mr Norman told Mr Calvert the questions he had been asked in evidence. Remarkably, when giving evidence less than 24 hours later, Mr Calvert claimed he could not recall any of the questions discussed.⁴⁷⁰

Despite understanding that he was summonsed to give evidence in relation to McCoolle, and that McCoolle was the focus of this inquiry, Mr Calvert made no effort to gather his thoughts about his involvement with McCoolle. His casual attitude bordered on contemptuous. He implied that the Commission was to blame for his faulty memory because the Commission had not advised him in advance of the questions he would be asked.⁴⁷¹

Mr Calvert did not try to assist the Commission, nor answer any questions to the best of his memory and ability, despite his extensive involvement in significant aspects of McCoolle's employment with Families SA.

LOGGING A COLLEAGUE'S NAME

Evidence surrounding the recording and logging practices of workers calls into question the robustness of information-gathering processes in residential care environments. Practices did not appear to be entirely consistent, but the prevailing view was that observations that reflected negatively on another worker should not be recorded in logbooks.⁴⁷²

Families SA worker Ms C said she received a clear instruction through training that when recording observations about another worker in a negative light the other worker should not be named.⁴⁷³

nannySA worker Ms Hammond logged a disclosure, including the name 'Darren', made to her by one of the Schultz children regarding Mr Calvert's conduct.⁴⁷⁴ Within days the logbook containing the entry was removed from 14 R Road and a directive was issued by Mr Sterzl that the names of other workers were not to be mentioned in logbooks. Rather they were to be generically described as 'youth worker' or 'yw'.⁴⁷⁵ Mr Sterzl's evidence did not help the Commission understand the reason for this practice.

Various reasons were given for the recording practices. Most related to concerns about access to the recorded information by the worker concerned or a wider audience, including by non-government organisations. Clear instructions were given that notes must be factual, and may not contain matters of opinion. The view that the logbook was a legal document was also put forward.⁴⁷⁶

Some staff indicated that rather than recording negative observations they would either report the matter to a senior staff member or get advice about what to record. This view was supported by manager Ms Lamont. This practice gives workers a process to follow but does not necessarily clarify recording practices. In the absence of clear guidance, or an alternative mechanism for recording negative observations, it is possible that concerning matters may never be documented.⁴⁷⁷

The line between factual observations and opinions is not always easy to draw. Staff may be left uncertain as to whether they should record a significant event because they do not understand the distinction. Further, it is unclear why a staff member considered capable of caring for vulnerable children should be discouraged from recording a relevant opinion. For example, recording that a restraint continued for three minutes and was unnecessarily protracted (facts and opinion), is much more informative and child focused than merely recording the restraint lasted three minutes (factual).

THE BARRIERS TO COMPLAINING

A significant enabler of McCoolle's workplace conduct, both criminal and performance related, was the unwillingness of staff to raise concerns or complaints. The reasons are numerous and varied, and include:

- concerns about job security;
- the perception of an impenetrable alliance of senior staff members;

- senior staff confusing debriefing with gossiping, having the effect of stamping out the reporting of, or response to, genuine concerns;
- well-founded beliefs that complaints would not be addressed appropriately, leading to a sense of futility;
- the puzzling fixation of senior staff on employing a mediation process; and
- senior staff misidentifying workplace conduct issues as personality issues not deserving of their consideration.

Job security

McCoole's conduct took place in a climate where Families SA workers were being employed on short-term contracts, sometimes as brief as one month. Fear that their contracts would not be renewed affected the workers' preparedness to raise issues and concerns with senior staff.⁴⁷⁸

Lack of job security not only plagued workers at the OPS3 youth worker level. As an OPS4, Mr Rogers was regarded as being sympathetic to the concerns and challenges faced by staff. However, he was also on contract for a period of time. He told youth worker Ms Pinos he 'felt as though his hands were tied' and he would be able to 'speak his mind' once he was made ongoing. Mr Rogers did not accept being on a contract made it difficult for him to deal with complaints, but acknowledged he was 'not going to rock the boat too much' while trying to establish himself in the role.⁴⁷⁹

Social connections

'The boys club' became a shorthand term used by many workers to refer to a block of relationships between senior male staff that diminished workers' willingness to raise concerns. Manager Ms Harman knew staff spoke of 'the alleged' boys club. Other senior staff members were aware at least of very tight relationships, if not the perception of the club.⁴⁸⁰

Ms Lamont was aware Mr Sterzl had a very tight team with his seniors, in particular Mr Norman, Mr Calvert and Mr Rogers. She said she was not aware of the extent of any social relationships between them. Ms Lamont did agree that it is not good for staff to think they cannot penetrate a group of senior staff if they have a complaint to make.⁴⁸¹

While Mr Calvert was aware some youth workers referred to some senior staff as being in a boys club, he did not know if he was included in the group. Other seniors, including Mr Norman, Mr Knight, Scott Reed and David Hehir raised the topic with him on several occasions. He dismissed it as uninteresting, commenting 'I've got nothing to say on it'.⁴⁸² Mr Calvert was clearly not concerned with the perceptions of the workers he was overseeing. Similarly, Mr Norman's concern was centred

on his view that workers were making sexist remarks by referring to the boys club. He pointed out there was not a club; they were males put together by management.

Mr Norman, Mr Calvert and Mr Knight were all considered central figures in the boys club.⁴⁸³ The precise 'membership' of the club beyond this is unclear, as is the nature of the relationships between its members. It is unnecessary to make any determination about this matter. What is significant is the perception of a tight circle of relationships between a number of senior male staff members, which was too hard to penetrate and which was a barrier to raising complaints. A perception of relationships between senior staff members being 'incestuous' is not a sign of a healthy organisation.⁴⁸⁴

Debriefing vs gossiping

From the perspective of OPS3 staff members, discussing matters with colleagues is considered an important support mechanism to cope with the challenging and complex environment in which they work:

*staff are very close and we talk a lot and often, if you have a bad shift, you need to debrief with somebody, so a fellow staff member, either one that works in your house or works in another house, we confide in each other.*⁴⁸⁵

However, many senior staff in the southern residential care area expressed concern that workers gossiping with their peers was prevalent and detrimental.

Ms H considered she was entitled to debrief with selected colleagues about her experiences, at the time of the care concern relating to Mikayla Bates. However, Mr Norman took the view 'this gossip will inevitably garner snowballing weight against [McCoole's] name and professional working relationships will be damaged'.⁴⁸⁶

Mr Norman made the point in evidence to the Commission that 'gossip is very dangerous in our field'.⁴⁸⁷ However, his objectivity on this topic must be considered in the context of his belief that he, too, had been unfairly targeted by gossip and was, at the time of giving evidence, suspended from Families SA in relation to allegations of criminal conduct. Subsequent to Mr Norman giving evidence, he pleaded guilty to two offences committed in the course of his employment. The behaviour concerned theft of prescription medication from a child in care.

In Mr Norman's view:

*the unfortunate part about our business is gossip and once one person says something about another person it spreads like cancer which is something that we tried really really hard to stop from happening ... there started to be gossip about Shannon.*⁴⁸⁸

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Mr Norman described gossip as including informal chats between people. If a staff member was to debrief with another colleague about their difficult experiences with McCoolle, in Mr Norman's view this would be considered gossip and could be perceived as a breach of the public sector code of ethics:

*because basically you're passing on personal opinion to a colleague on the same level as you that's very negative in nature and if everybody did that about everybody then no-one in the work environment would essentially get along.*⁴⁸⁹

Mr Norman was clear: ethically, the only option a person had was to debrief with a senior staff member and this position applied across the public sector. He explained the code of ethics allowed a staff member to debrief with their senior or supervisor as that is the 'conflict resolution chain'.⁴⁹⁰

While Mr Norman disagreed he had spoken to Mr G about McCoolle being a problem performer, he suggested seniors, because they are at management level, could debrief with each other and discuss workers. They were not restricted like youth workers who could ethically only debrief with someone more senior.

Ms Decoster considered there was a 'very big difference' between gossiping and debriefing. She explained that if a staff member needed to debrief about something they needed to go to 'the right person', their senior as a first point of call, or their supervisor or a manager. She regarded it as inappropriate for a staff member to discuss with a colleague difficulties they have experienced with another staff member, because the reputation of the other person could be tarnished.

Ms Decoster initially suggested that if she needed to debrief she would always speak with her manager and maintained she had never talked with a friend about something that had annoyed her at work. Ms Decoster soon retreated from this position conceding she had also spoken with colleagues at her own level. She then conceded it was not inappropriate for staff members to speak with their colleagues and debrief.

Ms Decoster was anxious to suppress a culture of staff discussing their grievances and concerns. As a conduit between Ms Decoster and the OPS3 staff, it was apparent Mr Knight agreed with this approach. Mr Knight's evidence gave a clear illustration of why such a stance endangers a supportive and healthy reporting environment.

When Ms Ball raised her concerns with Mr Knight about McCoolle, but did not want to pursue a formal complaint, Mr Knight said that Ms Ball 'just wanted to debrief'. Mr Knight felt that sometimes the term 'debrief' is used instead of gossip. Mr Knight explained that a

cultural issue existed where staff would gossip between themselves but would not want to pursue formal avenues. Ms Decoster encouraged complaints being recorded in writing.⁴⁹¹

Even though youth workers raised concerns about McCoolle's workplace conduct they were never addressed. As they were not put in writing it can be inferred they were dismissed as gossip and not worthy of a response.

Gossip is an organisational culture issue that remains of concern to manager Ms Harman. When a youth worker raised third party issues with her, Ms Harman told the staff member gossip was 'rife'.⁴⁹² While Ms Harman did not dismiss the possible cause of gossip as the existence of barriers to formally reporting concerns, she suggested it might also be related to staff working in isolation, on differing shifts and the relay of information being delayed. Ms Harman recognised the need to balance the deterrence of gossip with bringing important or useful information to the attention of senior staff.⁴⁹³

Complaint resolution processes

An expectation had developed among seniors that complaints raised by workers about other employees should be dealt with by face-to-face meetings in which workers voiced their complaints. This approach was referred to as 'mediation', although there is no evidence that any independent or qualified mediator was involved.

Various reasons were given for the practice, including a belief that natural justice principles gave a person the right to face their accuser and defend oneself; to allow the senior to ascertain the truth of the situation, or because it was a 'no win' situation for the senior.⁴⁹⁴

These reasons demonstrate a misunderstanding, or sheer disregard, for an appropriate complaint resolution processes. Fundamentally, mediation is not an appropriate tool to be used to ascertain the truth of a worker's assertion. There will always be relatively minor workplace issues able to be dealt with by a senior member working together with staff but the evidence suggests that efforts were made to employ mediation in inappropriate circumstances.

Such a process could prevent genuine concerns or grievances about a worker coming to the attention of the person's manager, because the worker is not willing to participate in the 'mediation' process.

The Commission observed examples of the latter in complaints received about Mr Norman. On three occasions workers complained about his conduct to Mr Sterzl and Ms Harman. In some instances the complaints related to serious concerns about workplace performance. In each case the complaints were not

pursued by the worker, or by the directorate, because workers did not want to participate in the 'mediation' process.

The practice served also to deter workers from even raising concerns, as they were not prepared to participate in the process.⁴⁹⁵

Particularly where there is a concern about anonymity, where concerns are serious in nature and require further enquiry, or where there is a power imbalance, such as a complaint about a more senior worker, mediation is an inappropriate method to resolve a complaint.

Losing faith in the grievance process

Many staff considered raising concerns and complaints to be an exercise in futility. This was particularly so for staff working under Ms Decoster in the southern transitional accommodation area.

One experienced youth worker spent significant time as a union representative, a role in which she made complaints about seniors, supervisors and managers. After seeing complaints go unaddressed, she lost faith in the process.⁴⁹⁶ Ms O, a youth worker with 10 years' experience, described not trusting her supervisor Ms Decoster and this lessened her willingness to raise concerns. This was a consensus across the team of youth workers.⁴⁹⁷

Ms Decoster's conduct and management style caused many of the staff she supervised to lose faith in the grievance procedure. She would respond to concerns or grievances brought to her attention by suggesting, for example, that the staff member raising the complaint was not coping or by giving the staff member an 'opportunity'—the transfer of the complaining staff member to a different house. The reputation of staff who complained could be damaged, for instance, by being labelled as a person who could not be trusted. Staff were left questioning the efficacy of raising grievances as they felt they risked being punished for so doing.⁴⁹⁸

In mid-2012, with the support of union representatives, a majority of staff in Ms Decoster's area met with manager Ms Lamont to raise longstanding grievances about her conduct. At the meeting, Ms Lamont discussed moving Ms Decoster to another area as an option. This did not happen. Ms Decoster was placed on a performance development plan, but her conduct did not improve. In fact, staff thought it became worse.⁴⁹⁹ This is not surprising given Ms Decoster viewed the concerns raised as unfounded.⁵⁰⁰ In the absence of their grievances being addressed '[e]veryone had lost faith in the system, in the grievance procedure. And in management'.⁵⁰¹

Treatment of staff who complain

Ms Roberts raised a complaint about McCooles coming to work at 6 S Street following his return to work after his suspension. This was one of the four complaints raised by female youth workers which led Ms Decoster to arrange a supervision session with McCooles in April 2014.

The complaint was based on concern that McCooles's presence would be detrimental to the team because of his personality traits. Ms Roberts also said a child at the placement expressed fears on learning McCooles was coming to the house. Her concerns were set out in an email to Ms Decoster and seniors. Unfortunately, it was phrased in rather emotional terms.⁵⁰² Ms Roberts forwarded the email to other team members to keep them informed of events.⁵⁰³ Ms Roberts also emailed the child's therapists about the child's concerns without naming McCooles.

At the time of receiving the email Ms Decoster was not aware of the Mikayla Bates care concern but was aware of the complaints of the other female workers. Mr Knight had also raised his own concerns about McCooles moving to the house. He, too, thought McCooles might be a poor fit. His concerns did not change the situation. Ms Decoster informed him the decision had already been made.⁵⁰⁴

On 12 March Ms Decoster and Mr Knight met with Ms Roberts. It might be anticipated that the meeting would deal with Ms Roberts' concerns about McCooles, but it failed to do so. Instead Ms Decoster focused her attention during the meeting on raising a litany of criticisms of Ms Roberts' conduct which were founded on Ms Decoster's incorrect understanding of both the facts and appropriate workplace practices.

For instance, she cautioned Ms Roberts for sending the email to the child's therapist. This and other emails were said to be inappropriate use of a government communication medium which denied McCooles natural justice, as they published information relating to McCooles to which he could not respond. Ms Decoster told Ms Roberts this would reflect poorly on her professional reputation. The criticisms were made despite the email not identifying McCooles by name.

In addition to Ms Decoster's unfounded criticism of Ms Roberts' conduct, she criticised Ms Roberts for raising concerns by email, a curious position given her focus in other instances on complaints being documented in writing.⁵⁰⁵

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The conduct of the meeting was also procedurally unfair. Ms Decoster advised Ms Roberts at the outset that the meeting was not intended to be a performance management session, yet then went on to treat it as such, advising Ms Roberts at the end that she would receive a formal letter.⁵⁰⁶ Further, despite noting that Ms Roberts was struggling during the meeting she continued to raise her unjustified set of complaints over a period of four hours.

Ms Roberts was offered the 'opportunity' to move houses at the meeting's close.⁵⁰⁷ This was not so much an opportunity as a punishment for Ms Roberts' perceived poor conduct.

Ms Decoster's evidence about the conduct of this meeting and her purpose in holding it was internally conflicted and not substantiated by the meeting minutes and evidence of other participants. Her assertion that she did not raise Ms Roberts' concerns about McCoolle in interview because of advice received by the Human Resources section is not accepted. The weight of the evidence supports the conclusion that Ms Decoster never intended to raise these matters with Ms Roberts. Ms Decoster's sole purpose of the meeting was to performance manage Ms Roberts.

Ms Roberts said she felt targeted in the meeting. This reaction is understandable. The conduct of Ms Decoster in this meeting, if known to other workers, would cause legitimate concern about the effect on their careers of raising legitimate workplace concerns. Such conduct has the effect of suppressing communication between supervisors and workers about the true state of play in the workplace.

The issues raised by Ms Roberts' email relating to McCoolle were not addressed by Ms Decoster at any later point, either with McCoolle, or by making broader enquiries about his conduct in the workplace, by accessing information available to her in his supervision file or by enquiring into the circumstances of the Mikayla Bates care concern. However, she had been made aware of the care concern's existence by Ms Roberts' email.⁵⁰⁸

Less than a fortnight later Ms Decoster contacted McCoolle and asked him to attend 10 S Street and obtain a mobile phone on which Jayden Conti had taken pictures of his own erect penis. She asked McCoolle to email the images to a social worker.⁵⁰⁹ Other workers at 10 S Street (where McCoolle was not employed at the time) could have helped Ms Decoster with this task.

The decision to entrust McCoolle with such responsibility, unsupervised, is indicative of the lack of regard Ms Decoster had to any of the complaints and information available to her about McCoolle's workplace conduct.

OBSERVATIONS

The organisation, and the individuals working in it, failed to respond to red flags at a number of stages. Information that should have been actioned was not actioned, reports of concerning behaviour were not made or not adequately actioned, and the behavioural communications of children in care were ignored. Had the various red flags been tracked and viewed together, or investigated in a more cohesive and comprehensive way, McCoolle's behaviour would have received greater scrutiny.

Many features that render an institutional environment vulnerable to infiltration by adults who offend against children were present in the directorate during the period McCoolle was engaged to care for children.

Deficits in individual and organisational practice were identified in each of the organisations through which McCoolle accessed children, in:

- recruitment and training;
- barriers to recognising and reporting red flags;
- the weight given to understanding children's experiences in care; and
- the response to the Mikayla Bates care concern.

RECRUITMENT AND TRAINING

It is clear from the evidence about recruitment and training in OSHC, nannySA and Families SA that recruiting and retaining appropriate staff to care for children presents substantial challenges. None of the relevant roles offered by the three organisations required any formal qualifications in child development, child care or youth work. Staff of each agency raised concerns that the workers they hired were sometimes not adequately skilled for the work they were required to do.

RECRUITMENT AND SUPERVISION AT THE OUT-OF-SCHOOL HOURS CARE SERVICE

Although OSHC had policies which required a formal merit-based recruitment process, the evidence demonstrates that, at least for casual staff, those processes were not applied. Rather, the informal process for applicants to the casual pool applied little rigour to selection. At times, even this informal process was abandoned when applicants were known to current employees.

Viewed objectively McCoolle appeared a suitable candidate for casual employment at OSHC. The evidence indicates that the selection process did depart from the norm. Unlike the usual practice, Ms E played no role in the assessment of McCoolle as an employee. This was of particular concern as McCoolle's friend, Ms A, conducted the recruitment.

There is nothing unusual or improper per se about employing a staff member with whom there is a personal relationship. However, in such circumstances the relationship should be acknowledged and the recruitment should follow a formal process, and be conducted by a person independent of the relationship with the applicant.

After engaging McCoolle, Ms A should have acknowledged the relationship and put in place supervision structures that guarded against her personal relationship with McCoolle affecting her objective assessment of his work and conduct.

In addition to Ms E's generalised concerns about McCoolle's suitability, a number of matters were brought to Ms A's attention which should have caused alarm about his professionalism and attitude to working with children. They included inappropriate comments about children, inappropriate physical contact with children and sharing images of children in state care with other staff.

McCoolle's unattractive personality clearly obfuscated real concerns held by his colleagues. Ms A dismissed concerns expressed by Ms E with the observation McCoolle had a tendency to 'babble'. His clashes with another senior worker were put down to personality differences rather than a deficit in McCoolle's interpersonal skills. Ms A's level of faith in McCoolle's conduct was so great that, on being notified that he had been suspended from Families SA, she made no effort to obtain more information or detail about the circumstances, nor did she make a firm decision not to engage him at OSHC. She accepted McCoolle's statement that the matter was cleared and he was able to return to work.

It cannot be said that any single incident brought to Ms A's attention called for a decision to no longer employ McCoolle at OSHC. However, their accumulated effect should have at least raised in Ms A's mind the question of McCoolle's ongoing suitability to work with children. They justified far greater vigilance and oversight of his professional conduct than occurred.

Ms A's personal relationship with McCoolle clouded her judgement of his professional conduct and influenced her management of him. It is unlikely that she would have exhibited the same leniency towards a less familiar staff member about whom others had such strong views.

It is appropriate to take account of the fact this was Ms A's first management position and she did not have a great deal of experience in the performance management of staff. The supervision of McCoolle in those circumstances was particularly problematic and allowed an unjustified tolerance of unprofessional behaviour. The attention paid to supervision and performance management was inadequate and the perspectives of other workers on McCoolle and his work standards were not considered.

In a highly casualised workforce, the same behavioural standards and professionalism should be expected of both casual and full-time staff. In environments where the wellbeing of children is at stake, it is critical that performance standards are clearly set, and consistently and rigorously enforced, for all staff.

RECRUITMENT TO NANNYSA AND SUBSEQUENT TRAINING

On 7 December 2010, Ms A gave a reference to nannySA which described McCoolle's work performance in glowing terms.⁵¹⁰ McCoolle had been working at OSHC service for just under 12 months. Ms A was not yet aware of concerns about McCoolle's behaviour.

The questions posed in the referee report did not open the discussion to considering the applicant's engagement or behaviour with children. None of the questions had an overt child focus nor did they invite the referee to consider whether they had any concerns about the applicant's interactions with, or attitude towards, children in their care. There was no direct prompting to raise concerns held by others.

nannySA's selection process for hiring emergency care workers did not reflect the complexity of work, or level of trust, required of those applicants ultimately engaged. The standards applied were not rigorous. The interviewer had no particular experience in the emergency care worker role herself and no selection criteria for rating applicants' answers against. The skills and knowledge expected of an applicant to the position were not identified, and no psychometric testing was required.

Ms T told the Commission the pressure to hire sufficient workers to satisfy nannySA's contractual obligations with Families SA at times led to applicants being hired when she was not entirely comfortable with their level of experience.⁵¹¹

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Recruiting and training staff to the emergency care worker role carried a number of challenges. The work available through nannySA was casual and no particular level of work or income could be guaranteed from week to week. The work was highly specialised and challenging, and required a level of skill and knowledge beyond that expected of a worker with experience caring for children in other environments. Workers in the casual pool could register with other agencies or apply to work directly with Families SA. The resultant lack of stability and consistency in the workforce made it difficult to justify a substantial investment in pre-service training for staff appointed to the casual pool.

Although McCoole had no experience or formal training in caring for infants and preschoolers when he started work with nannySA, he was tasked to work with very young children after only a four-and-a-half hour course in infant care and nutrition. A course of that length is unlikely to equip a worker with the knowledge they would need to care for infants in an emergency or residential care environment. Ms Cole, Managing Director of Hessel, having reviewed the documents, agreed that McCoole was not well suited to work caring for infants.⁵¹²

Ms Cole also agreed nannySA did not have the expertise in-house to manage children with complex trauma needs. In the absence of rigorous training and overarching principles of care operating in emergency and residential care homes, workers were left to draw on their own experience and knowledge of caring for children. Houses where teams of workers were left to make decisions without the structure of a clear line of authority showed inconsistent standards and approaches to care.

CONTRACTUAL ARRANGEMENTS GOVERNING THE ENGAGEMENT OF COMMERCIAL CARERS

The contractual arrangements governing the terms of engagement of commercial carers were premised on them being used in short-term interim arrangements. They were also based on a ratio of one worker to one child, and on certain restrictions on the hours and shifts worked. However, the evidence supports the conclusion that the use of agency staff grew and changed beyond the model contemplated in the contractual agreements without proper planning. Children in emergency care placements were remaining beyond what could properly be described as 'generally unplanned and requiring an immediate response'.⁵¹³ Workers engaged through the agency became, in effect, long-term carers for some children.

By the time agency staff began to be engaged in Nation Building and transitional accommodation houses, staff to child ratios were set at one staff member to three children as the norm and, beyond providing care, staff were also responsible for household chores such as

shopping and cleaning. Children in these placements were not considered to be in 'interim emergency' arrangements.

The move to using agency staff in this more extended style of care required reconsideration of the training and conditions set out in the contractual arrangements. No such consideration was given. Day-to-day arrangements for engaging commercial carers grew unplanned without the oversight and clarity of a contractual agreement that accurately reflected operational practice.

After Families SA introduced senior youth workers and supervisors to oversee Nation Building houses, there was no planning or documentation about the division of supervisory responsibilities. Confusion naturally followed about responsibility for supervision and professional development of agency staff engaged to provide ongoing care for children in these houses.

RECRUITMENT INTO FAMILIES SA

By 2010 there was a clear acknowledgment of the need to build an appropriately qualified and trained workforce to match the growth in the residential care sector. The need was urgent to arrest the growing use of agency staff to cover workforce deficits and to invest in developing a Families SA workforce which could offer higher standards of care, and a greater level of supervision and oversight, at a more modest cost.

Recruitment processes in the directorate originated when recruitment was intended to maintain, rather than increase, the workforce. The processes had been reviewed and considered regularly by senior Families SA staff. In particular, frequent discussions mentioned the need for an organisational psychologist in the process and the suitability of the AIFP testing for the recruitment of youth workers to care for vulnerable children. In the absence of a suitable alternative the organisation had determined to continue to use the AIFP test.⁵¹⁴

Three major barriers stood in the way of efficiently recruiting the necessary numbers of *quality* staff to the residential care sector:

1. availability of the requisite numbers of suitable candidates in the job market;
2. quality of the job on offer, in remuneration, conditions and stability of employment; and
3. knowledge, expertise and recruitment tools for helping decision making by selection panels.

These difficulties were magnified when demand for staff escalated. Pressure to fill positions and reduce reliance on agency staff was felt throughout the directorate, including by the recruitment coordinator Mr F.

At the same time, the nature of the work was changing. Children in residential care included younger children and infants who needed a workforce with different expertise and knowledge. Historically, residential care workers were hired and trained to work with older children. Some existing workers felt they were not qualified to care for infants and young children and did not consider this the role for which they were hired.

This shift required a re-evaluation of the recruitment processes and criteria being applied. No consideration was apparent of whether the AIFP testing was a suitable assessment tool for workers caring for very young children. Also apparently not considered was whether residential care worker positions could be separated into specialists in early and later years care.

Mr Waterford favoured the development of a higher level of expertise in the residential care workforce. Families SA's capacity to implement this change was challenged by the disparate nature of the role. Mr Waterford observed:

For a cohort within this population the level of trauma that they had experienced I think necessitated a higher level of expertise. The challenge in this space is that a lot of the work is cleaning, cooking, bottom wiping, and getting the right mix of operationally classified staff and professionally classified staff is vexed.⁵¹⁵

Residential care workers were hired to either an OPS2 or OPS3 position. Advertised positions attracted a large number of applicants, but only a low number were ultimately appointed. When McCoole was first hired, 19 applicants were interviewed from 104 applications. Of those 19, 12 were appointed to the casual OPS3 pool and three to the casual OPS2 pool.⁵¹⁶

Between 2010 and 2013, Families SA was unable to offer ongoing positions. Any vacancies were filled on short-term contracts. Even after Families SA received approval to hire new staff there was a three-year cap on the positions offered because of the requirement to test the capacity of the non-government market to take over the Nation Building area of residential care. The fact that positions on offer were not ongoing had an impact on the quality of applicants.⁵¹⁷

There was evidence that less suitable applicants were appointed to the casual pool because of a perception that the skills required for that work differed from full-time positions. The casual workforce was seen as being available to fill short-term gaps in the roster. The workers could be of a lower standard because they were not being asked to provide long-term ongoing care to children. When Ms Stasiak took on the role as Director she formed the view, against the background of demand for staff, that appointing some applicants to a casual pool allowed the directorate to closely examine their work performance with a view to determining whether they were suitable for ongoing work.⁵¹⁸ Some applicants were already working in Families SA houses through agencies, and appointment to the casual pool gave Families SA an opportunity to more closely train, supervise and assess their work than might otherwise have been the case.⁵¹⁹

The difficulty with this approach is that once staff were appointed to the casual pool, even on a short-term contractual basis, their performance was not regularly reviewed. Rather, the view was taken that casual staff were entitled to have their contracts renewed unless some performance issue was identified.⁵²⁰

THE SELECTION PROCESS

In 2012 recruitment of youth workers was coordinated in the directorate by the recruitment coordinator. Mr F had minimal recruitment experience, no formal training in the area and little expert support available to him. He inherited a recruitment process that he understood had the imprimatur of senior members of Families SA staff. It was not within his power to depart from the process.

Selection panels were assembled solely from people working in the field and contained no human resources or psychological expertise. No panel members had qualifications or training that would permit them to adequately interpret the results of the psychometric tests used. McCoole was hired to the Families SA casual pool on his first application under this method.

Mr Waterford acknowledged the danger in continuing to use an unsatisfactory psychometric test as good candidates might be excluded. He thought the best approach, in all the circumstances, was to ensure issues raised by the testing were carefully explored at interview. He agreed the organisation's ability to do this depended on the skill and experience of the selection panel. At the time of McCoole's appointment, the selection panel did not have the skill or knowledge to use the AIFP test results in the nuanced way contemplated by Mr Waterford.

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Insight into the value of psychological expertise was obtained from the evidence of departmental organisational psychologist Dr Jane Richards, who reviewed McCoolle's AIFP results after his arrest. Dr Richards explained the accumulation of items of concern identified in the AIFP battery of tests:

all that I can get from here is there is a profile of a person that would be a risk to us, possibly a risk in not caring adequately for children ... possibly some depression/anxiety, but certainly someone who is unconventional, who resists being directed, who improvises, who is disorganised. So from those things, loner, socially isolated is also a concern. So I'd be looking at this instrument, the results of that, with his resume, and then trying to piece things together. So now I think he'd be screened out, but if he went to psychological interview he'd definitely be screened out by then.⁵²¹

Even without the assistance of an expert psychologist, the AIFP test made it clear that advancing McCoolle should be done only with extreme caution. Mr F did not give this warning the weight it deserved because of concerns about his own ability to interpret the test and, in particular, the potential he may be unfairly excluding worthy candidates on the basis of the test results. The weight placed by Mr F on the test results was influenced by his perception that the test was not designed for recruiting residential care youth workers.⁵²²

It was unusual, but not unheard of, to advance candidates who had been assessed as 'Caution—High Risk' by the AIFP testing.⁵²³ In the selection processes led by Mr F the AIFP test was used solely to screen out unsuitable applicants. Once candidates were advanced past this stage, even if that occurred against the recommendation of the AIFP results, the results played no continuing role.⁵²⁴

The residential care worker position was unique. It attracted high numbers of unqualified applicants who were heavily scrutinised during recruitment. This scrutiny was essential, given the position of trust staff were placed in and the risk associated with placing such vulnerable children into the care of a worker who turned out to be unsuitable. The risk was especially great in an environment where single-handed shifts were still common and where the chances of abuse being detected were remote. The challenges of recruiting to a position of this kind demanded a skilled recruitment panel with the capacity to use the results of the AIFP test in a way that informed recruitment to this specialised staff group.

The use of a selection panel of youth workers, led by a more experienced worker, but inexperienced recruiter, positioned this important task too low in the organisational structure. Recruitment of the vast number of workers required to staff the Nation Building houses,

and take over emergency care, required a carefully planned recruitment process with clearly identified selection criteria reflecting the changing demographic of children in residential care.

The high levels of responsibility placed on residential care workers, and the potential for abuse of the trust placed in them, required the character of potential applicants to be carefully assessed. A number of concerns existed about the suitability of the AIFP test to deliver this assessment. Even putting those concerns aside, the AIFP test was not properly used. The selection panel's lack of training and knowledge about the test meant the available information was not properly scrutinised and interpreted.

Mr F made a poor decision to ignore the clear warning of the AIFP test. However, his decision cannot be divorced from the organisational setting in which it was made. That is, Mr F was given no relevant training and no support from a suitably qualified psychologist or human resources specialist. All these factors contributed to the red flag of the AIFP test results being ignored.

The AIFP test at no time claimed to determine if a candidate was at risk of abusing children. The warning that McCoolle was 'high risk' did not identify such a risk. There is no validated, reliable psychological test that reveals a person's risk of abusing children. People who sexually abuse children are such a heterogeneous population that it is difficult to identify, by reference to a reliable constellation of features, a heightened risk to children. Further, as most sexual offences against children are not committed by paedophiles, excluding paedophiles from a particular environment would not necessarily protect children.⁵²⁵

The future for Families SA includes a continued need to place children in residential care environments and thus the need to develop and give effect to appropriate recruitment practices.

Excluding unsuitable candidates from entering the residential care workforce at the recruitment stage is critical. Recruitment processes present the best opportunity to rigorously examine aspects of an applicant's psychological profile.

Appropriately focused and interpreted psychometric testing should help Families SA identify applicants who for various reasons would be unsuitable workers in residential care environments. It is unlikely that such testing would be able to recognise with any precision or reliability a tendency to offend against children in care. However, residential care should be staffed with psychologically resilient staff. Testing of candidates for psychological features which ensure they are the best fit for the environment is critical to the development of a robust and reliable workforce.

A robust recruitment process must include the checking of references and reports from previous employers, including speaking personally with the referee and asking specific, direct questions about the applicant's interaction with children. Concerns are rarely committed to writing in a formal referee report, but personal contact and asking targeted questions are more likely to uncover information that helps the process.⁵²⁶ There remains value in verbal communications being accompanied by the formality of a written response to targeted questions.

Following the arrest of McCoole, and identification of the deficits in the process by which he was recruited, substantial changes have been made to recruitment processes. The AIFP tests are no longer used for youth worker recruitment. Current psychological assessment practices are discussed in Chapter 12. They are more rigorous and should continue.

TRAINING INVESTMENT

The evidence establishes a deficit of well-trained suitable workers in the child care industry. More specifically, working with children in state care carries with it challenges and complexities well beyond those faced by child care workers or nanny staff working in a traditional family environment.

In these circumstances it is difficult to justify the lack of formal qualifications required at the entry level for work as an emergency care worker with nannySA or a youth worker with Families SA. However, imposing a requirement for a formal qualification would affect recruitment in two ways:

- it would exclude candidates who lack formal qualifications but nevertheless have the skills and life experience to make them excellent youth workers; and
- it would narrow the potential field of candidates even further, and might lead to insufficient numbers of staff being available.

The answer to this dilemma lies in an increase in the intensity of in-house, pre-employment and ongoing training requirements for new workers. New Families SA youth workers undertake a six-week induction and training course. They are then obliged to complete a certificate in youth work within the first 12 months of their employment. It is not clear whether there is any consequence to their ongoing employment if the qualification is not completed in the time stipulated.

A greater investment in training on the topic of child sexual abuse is also required. This is discussed below.

BARRIERS TO RECOGNISING AND REPORTING RED FLAGS

In the course of the evidence a number of themes emerged to explain why workers failed to report or take adequate action when they observed concerning behaviour from children and McCoole. These themes go beyond blaming individual failures and demand an examination of the system in which the individuals were working. Consideration must be given to:

- staff knowledge and training in recognising and responding to children with concerning behaviours;
- staff knowledge and training in recognising and responding to staff who behave in concerning ways;
- the clarity of reporting pathways for staff who become concerned about the behaviour of a colleague in the workplace;
- the degree of organisational interest in receiving information about concerns; and
- the lack of clarity about the policies and protocols governing interactions between workers and children in residential care, and lack of consistency in their enforcement.

KNOWLEDGE AND TRAINING—RECOGNISING AND RESPONDING TO CHILDREN WITH CONCERNING BEHAVIOURS

Psychiatrist Dr Sarah Mares assisted the Commission on the topic of the responses of children to sexual abuse. Dr Mares' has a longstanding practice and academic focus on the impact of early adversity and therapeutic intervention with high-risk infants and young children and their families. Her evidence informed the Commission's consideration of the significance of children's behaviours.

In a number of instances, staff were ill-equipped to understand the significance of behaviours they observed. Children in residential care by definition have been exposed to abuse or neglect. Their care setting should not only provide safe day-to-day care, but a therapeutic environment in which to heal past trauma. Non-verbal children, in particular, rely on adults around them being attuned and sensitive to behavioural and emotional changes which may indicate distress from current or past abuse or neglect. Where a child's behaviours indicate continued distress at their circumstances, serious questions need to be asked about the source of that distress. Staff in residential care facilities charged with understanding the experience of children in their care need to be especially curious, skilled and knowledgeable to overcome the fragmentation of information across workers and shifts.

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The most obvious and serious example of this barrier to reporting emerges from the various behavioural observations made of Chelsea Floros. According to Dr Mares, Chelsea demonstrated behaviours that should have raised a high level of concern about probable sexual abuse. Some of Chelsea's comments, in the particular context, amounted to a disclosure and should have been investigated.⁵²⁷

Chelsea's social workers were made aware of observations of her distress and other behavioural indicators. Her behaviours were dismissed as being attributable to events before Chelsea entered care. Mr Beltman was made aware of a range of concerning behaviours by staff in the residential care environment and by Chelsea's foster parents. He was in the best position to accumulate the various pieces of information available to him.

Mr Beltman's knowledge and experience was inadequate for the task of providing case management to an infant with these challenges. On his own admission, his management of her case was compromised by other work pressures. Mr Beltman attributed Chelsea's behaviours to her pre-care experiences. He failed to consider the potential of current abuse, even though he knew there was no known history of sexual abuse in her past.

As a result, the accumulated force of the observations made was never properly understood.

On other occasions workers overheard children who had been exposed to McCoolle making statements which should have raised serious questions about sexual abuse. Seven year old Paige Thomson was heard to make statements in her sleep possibly indicative of distress originating in sexual abuse. Caitlin and Claire Pham were overheard discussing matters which raised the same possibility. On each occasion the worker dismissed the potential seriousness of their observations by attributing the statements to previous abuse outside the residential care environment.

Neither worker countenanced the possibility the statements related to more contemporary events. On that basis the observations were not escalated or investigated, despite workers understanding their obligation to make a report to CARL.

Neither worker questioned the children about what they had said. The youth worker job and person specification anticipates that candidates will perform some counselling of the young people in their care.⁵²⁸ The two youth workers were ideally placed to discuss the statements with the children, having overheard them and being present at the relevant time. However, neither felt adequately trained or supported by the organisation to ask questions in a way that might put the statements in

context or identify concerns that could be followed up. Ms Pinos said she had been trained not to speak with a child, but to pass information on through a senior youth worker.

In an organisational environment where workers are specifically prohibited from asking the most basic clarifying questions about disclosures of this kind, there is a danger that assumptions will fill the knowledge gap.

The same pattern was evident in the manner in which Anna Pham's reference to McCoolle as a paedophile was managed. Ms V accepted an assurance that Families SA staff were aware of Anna's use of the term and took no further action.

When children make statements of this type there must be a prompt response. Workers must be empowered to enquire sensitively to explore the significance of such statements. Querying the meaning of a comment is not the same as gathering evidence when a disclosure of sexual abuse is made. That more complex and comprehensive task is one properly reserved for experts in CPS or SAPOL.

Jayden Conti was a boy with highly sexualised behaviours. The manner in which his behaviours were addressed highlights the themes observed for a number of children with whom McCoolle came into contact.

Jayden's constant drawing of penises was identified by Dr Mares as communicative, potentially a re-enactment of past trauma or behaving in a provocative way to attract attention against a background of neglect or being consistently ignored.⁵²⁹ Dr Mares considered someone should have asked Jayden about the meaning behind his drawings, rather than addressing the behaviour in isolation from the reasoning behind it.

Staff caring for Jayden day-to-day were given specific instructions not to deal with these behaviours because they did not have psychological qualifications. This practice again removes an opportunity to develop a natural conversation about a child's behaviour in a timely way and in a comfortable setting.⁵³⁰

Jayden demonstrated specific reactions to McCoolle, such as the removal of his photograph. There was no attempt to understand the reasoning for his behaviour or to escalate it to a psychologist to investigate it more expertly.

Other workers noticed certain children would avoid McCoolle when he was on shift. As a matter of common sense, some children will have preferred workers, and workers who consistently enforce boundaries might be less likely to be favoured. However, where these reactions go beyond natural preferences, such as Ms Purton's

observations of Nicky Schultz's distress related to McCooles, there should be a discussion with the child about the meaning of the observations.

The potential significance of these isolated observations is easier to recognise when the events are viewed cumulatively, and with the benefit of hindsight. Without these advantages, each decision when considered in isolation is understandable, particularly in light of an organisational setting that discouraged any enquiry about the meaning of such behaviours.

In reforming residential care to reduce the risk of child sexual abuse it is necessary to make a substantial investment in increasing the workforce's knowledge and confidence about trauma, sexualised behaviours, signs of distress and how to talk to children about their distress. Families SA also needs to reconsider the restrictions on information provided to workers, including commercial carers.

Therapeutic responses to difficult behaviours need some understanding of the communicative intent that sits behind the behaviours. Dr Mares observed that when children who have experienced trauma are in a safe situation, where they are given consistent and appropriate care, their behaviours should attenuate. Such an environment acknowledges the inappropriateness of what has happened to them in the past. If workers have a good knowledge of what has brought the child into care in the first place, they will be much better placed to assess the potential significance of behaviours they observe and to respond in an empathetic way.

Training workers to enable them to provide this standard of care, and giving them permission to refer to a child's past trauma in the course of providing empathetic care, is critical to improving the chances of a child confiding in a worker when events are causing them continuing distress. Obviously this will always be subject to the specific advice of a mental health professional caring for a particular child.

The evidence establishes a need to increase knowledge in the residential care workforce, and more broadly within the Agency, in identifying and managing trauma-related behaviours, including behavioural indicators of sexual abuse. Such training must highlight barriers to complaining for children and young people. Dr Mares emphasised that training must be accompanied by allowing workers to discuss the application of theory to their day-to-day work and to review their learning by applied discussion. The evidence shows that some Families SA-approved training is delivered to nannySA workers by non-expert staff. Training must be delivered by experts in the field who are equipped to address questions and discuss the practical application of theory.⁵³¹

In addition to training, Dr Mares emphasised the importance of quality professional supervision. Workers need an outlet to discuss difficult issues they are experiencing and to reflect on whether they have responded to those situations in the right way. The supervisor therefore must be knowledgeable and skilled in the area of child development and trauma. Supervision must transcend operational matters and the identification of performance deficits, and allow genuine reflection about the work.⁵³² Such supervision should also address the traumatic nature of the work. Vicarious trauma can impair professional competence over time.⁵³³

In addition, supervision from providers external to the Agency should be available to workers to allow discussion of concerns about children or staff in the workplace. Supervisors who are not involved in daily management of the residential care environment could focus consideration on the child's experience.

KNOWLEDGE AND TRAINING—RECOGNISING AND RESPONDING TO CONCERNING BEHAVIOURS FROM STAFF

It is apparent that awareness was low in the directorate of the vulnerability of children in care to be re-abused. Some witnesses simply did not consider the possibility of sexual abuse or demonstrated poor understanding of the dynamics of child sexual abuse. Others assumed the recruitment processes in place were robust enough to exclude child sex offenders.

When senior youth worker Mr Griffin was faced with an accusation made against McCooles by 13 year old Brooke Anderson, he dismissed Brooke's version, in part because he trusted in the rigours of the selection process. He assumed that someone who had obtained work in a residential care environment could not be a child sex offender. He was not the only senior to hold this view.

The dynamics of grooming and the vulnerability of children in institutional settings to sexual abuse were also poorly understood. When McCooles was found to have brought the movie *Young people fucking* into a residential care house, the response was ill-conceived and inadequate. No senior staff member turned their mind to the grooming potential of a movie that contained strong sexual content. The focus of concern was on breach of policy surrounding the bringing of personal items to work, video piracy and breaches of copyright.⁵³⁴ The circumstances warranted close investigation, including specific and robust questioning of McCooles.

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Potential grooming can be addressed by the enforcement of clear boundaries between adults and children in the care environment. Those boundaries signal what is and is not acceptable and set a clear standard against which conduct can be assessed. Caring for children with sexualised behaviours can be especially challenging. Training in how to establish boundaries and deal with sexualised behaviours is critical.⁵³⁵

When Ms Hams raised a complaint with Mr Norman about McCoolle permitting Georgie Pham to sit on his lap, Mr Norman did not understand the complaint to be about McCoolle's behaviour, rather that Georgie was indiscriminately physically affectionate towards male carers. He also failed to understand the significance of a worker's failure to consistently enforce boundaries with a child with sexualised behaviours. Mr Norman's introduction of an across the board no-touch policy did not address the concerning features of the complaint nor properly reflect the best interests of the Pham children.

Professor James Ogloff gave evidence to the Commission to assist in the consideration of issues related to the behaviour of child sex offenders. Professor Ogloff is a registered psychologist with endorsement in clinical and forensic psychology, and has a long research and practice interest in the psychology of sexual offenders. His evidence informed the Commission's consideration of organisational aspects of preventing child sexual abuse.

Professor Ogloff told the Commission about his training of child protection staff in Victoria addressing the dynamics of child sexual abuse and the diverse characteristics of child sex offenders. The training identifies risk factors for sexual abuse and strategies for intervention.

Training of child protection staff is critical for dispelling widely held stereotypes of child sex offenders and the erroneous thinking that a paedophile is easily recognised. Front-line staff, especially residential care workers, need help to understand the complex dynamics of grooming. They need to openly discuss the challenges of distinguishing grooming with a sinister purpose from genuine engagement with children who need consistent loving relationships with adults in their lives. Such training must be carefully designed not to alarm, but to challenge stereotyped thinking and encourage workers to have an open mind about the risks to children in institutional environments.

THE CLARITY OF REPORTING PATHWAYS

The Commission heard consistent evidence that concerns were not reported because of a lack of certainty about reporting pathways. Handwritten logbooks were the primary method for recording observations in the residential care setting. They were necessarily accessible to all workers within the house and were thus an inappropriate place for recording confidential

information. There was a high level of uncertainty about whether, and when, observations about the conduct of other workers should be recorded.

Workers gave a number of reasons why they did not record observations, for example:

- concern that the worker who was the subject of the observation would see the logbook record;
- general reluctance to log events that reflected poorly on workers; and
- belief that observations which were potentially critical of a worker should not be included in the logbook.

Where observations themselves are not included in logbooks the chance of important observations about the conduct of adults in the environment receiving any scrutiny or critical attention is lessened.

The other available pathway was to report the behaviour to a senior or a supervisor. Workers adopting this path had to have confidence their report would be taken seriously and actioned in some way, and confidence their own professional position would not be compromised by making the report. The reporting of concerns about McCoolle to senior staff was hampered by a belief that reports would not be taken seriously, as senior staff were perceived to be friends with McCoolle.

The lack of clarity around supervision responsibilities between nannySA and Families SA also lessened information sharing about commercial carers. The information obtained by nannySA from the anonymous call was not communicated in any form to Families SA. Even if it had been, Families SA was not responsible for the supervision of agency staff, and did not keep files in which accumulated concerns might be tracked. This was the case even for agency staff working directly with Families SA.

The potential for poor outcomes from unclear reporting and other pathways is discussed further below in the context of the Mikayla Bates care concern.

ORGANISATIONAL INTEREST IN RECEIVING INFORMATION ABOUT WORKER CONDUCT

The Commission received a great deal of evidence which described a hierarchical, conflict laden, toxic culture within southern residential care. It was a culture where complaints about a colleague's ability to work in a team environment were easily dismissed as 'personality issues' irrelevant to work performance.

Some seniors and supervisors exhibited a preoccupation with official grievance procedures, the rights of the worker being complained about and the need to stamp out 'gossip'. All contributed to an environment where

workers were reluctant to complain, knowing they would not be taken seriously, no action would be taken or their professional position would be compromised.

McCoole was almost universally disliked in his workplace. Senior youth worker Mr Calvert described McCoole as having the 'emotional IQ of a peanut'. Alarming, Mr Calvert observed that poorly functioning teams in the residential care setting were not uncommon.

However, it is not apparent that seniors and supervisors actively took steps to address dysfunctional teams or dysfunctional individual employees. Team dynamics are not fixed by the relative strengths and weaknesses of the staff, but depend on strong leadership, clear expectations, and retraining or other measures for staff who consistently show themselves incapable of working as an effective team member.

McCoole's personality deficits were well known, but his supervision file reveals that very few issues were ever raised with him. Senior staff members did not appear to consider that an inability to work harmoniously as part of a team was a performance issue that required consistent monitoring or action.

Even when supervisor Ms Decoster was alerted to McCoole's frequent unappreciated racist and sexist jokes, these matters were not raised with him. Workers were told senior staff were not interested in hearing about personality issues and could act only if genuine work performance issues were raised.

The evidence suggests a focus on the processes relevant to raising grievances about workers, rather than creating an open workplace where grievances could be aired and dealt with. Senior staff were unprepared to act on complaints or information that were not 'official'—a term that appeared to mean formal, in writing and accompanied by a willingness to be identified as the source of the information.

Concurrently, senior staff had a preoccupation with stamping out negative communication about other workers. The term 'gossip' was used to describe any communication between workers which contained negative observations about colleagues. Mr Norman held a particularly strong view about the potential for gossip to hinder a worker's professional progress. He appeared to dismiss as gossip any information that came to him which conflicted with his own positive perception of McCoole.

Mr Norman went so far as to suggest to the Commission that debriefing with a colleague rather than a supervisor or senior about a difficult shift with a difficult co-worker would be a breach of the public sector code of ethics.

He and other senior staff took the position that any worker who wanted a complaint about a colleague to be actioned must be willing to engage in 'mediation' with the other employee. Given the power imbalance that might sometimes be present between seniors and youth workers, and the precarious position of commercial agency staff if reporting about Families SA staff, it is little wonder complaints were not made official and many observations did not reach the ears of anyone who could take action.

The strong emphasis on compliance with a formal process, and the strict hierarchical nature of that process, restricted the flow of important information to seniors and supervisors. An organisational malaise about the utility of reporting concerns and complaints developed. There was little confidence that information would be actioned, and if it was it would require the accuser to face the accused, regardless of the respective power of each party. Thus, information flow was suppressed and the organisation was unable to build a picture of accumulated concerning behaviours.

The toxic workplace culture is typified in the response of supervisor Ms Decoster to the complaint Ms Roberts made about McCoole. Ms Decoster's reaction to the matters raised by Ms Roberts was unwarranted. Ms Robert's email contained at its heart a number of legitimate child-centred concerns, yet Ms Decoster made no effort to consider the merits of the underlying issues raised. Instead she focused on her own inaccurate perception of inappropriate conduct on the part of Ms Roberts over the course of a four-hour meeting.

Ms Decoster claimed that a number of the matters she raised with Ms Roberts were issues on which she took advice from the Human Resources section. She was unable to provide the name of the consultant on whose advice she claimed to have relied. It is difficult to accept that any competent human resources consultant with all the relevant information would have given advice supportive of the action Ms Decoster took in the course of that meeting.

Ms Decoster advised Ms Roberts that if she remained concerned about working with McCoole she could move houses. This suggestion overlooked the need for continuity of staff for the children in care and minimised the significance of the relationships she would have built with those children. This proposal did not help Ms Roberts, as Ms Decoster claimed; it acted as a punishment for her conduct. Further it stands as an example of the manner in which supervisory staff failed to properly deal with (in this case, perceived) poor performance, or a staff member who was experiencing difficulties.

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The way Ms Roberts was treated, if known to other residential care workers, carried a strong message about the professional danger of raising concerns, especially outside the strongly enforced grievance pathway. It told workers that the priority of senior staff was the protection of workers' rights and procedural niceties, rather than children's rights and experiences.

Multiple complaints had, by this time, been raised about McCoolle and over the course of more than two years nothing had been done to act on his behaviour. It appeared very clear that the organisation had little interest in hearing about McCoolle's continuing substandard performance.

POLICIES AND PROTOCOLS GOVERNING INTERACTIONS BETWEEN WORKERS AND CHILDREN IN RESIDENTIAL CARE

The conduct of workers in residential care settings is governed by a series of operating procedures and practice guides.⁵³⁶ The guide to Building and Maintaining Positive Relationships includes information about maintaining appropriate boundaries with children and young people.⁵³⁷

The guide identifies examples of behaviour that would breach personal and professional boundaries. For physical contact, a boundary violation is described as including 'unwarranted and/or inappropriate touching of a child or young person (personally or with objects)'.⁵³⁸ This gives very little guidance to workers about what level of physical contact with children is and is not acceptable; it doesn't help workers who detect what they observe as problematic behaviour to identify with precision which workplace policy or process has been breached.

The ambiguity can be exploited by workers who consciously or subconsciously use physical playfulness to accustom a child to touch, for the purpose of sexual exploitation.

Introducing excessive prescription for acceptable levels and types of physical contact in a residential care environment can be counterproductive. Children in rotational care, especially young children, need physical affection and care that is as natural as possible. Removal of all forms of physical engagement with children in these environments is out of the question.

Instead, greater specificity for considerations that might inform a decision about what are appropriate interactions would help consistent judgement by workers. Discussing and addressing the issue of boundaries regularly and openly at staff meetings would also support more candid engagement between staff about these challenges.

In a number of instances Mr Norman's response to individual deviations from behavioural standards by McCoolle was to impose blanket prohibitions that applied to all staff. He took this option rather than address McCoolle's behaviour at an individual level. For instance, he imposed a 'no touch' policy at 14 R Road with the Pham sisters which encouraged workers to use high fives and pats on the back and prohibited other forms of physical affection. Mr Norman explained he put the policy in place out of concern that staff were worried about excessive affection from Georgie Pham and a concern about nepotism. Mr Norman's decision reflected concern for the comfort of workers, rather than the interests of the children.

A blanket ban on staff bringing movies to work followed McCoolle bringing the *Young people fucking* movie to 14 R Road, and sitting or lying on beds was prohibited following the Mikayla Bates care concern.

Other policies were inconsistently applied throughout the directorate. For example, workers were prohibited from taking photographs of children on their personal devices. Staff at OSHC knew McCoolle had photographs he had taken of children on his personal mobile telephone. When Mr Sterzl was informed, immediately after McCoolle returned from suspension, he appears not to have dealt with the conduct in any way.

The few attempts to manage deficits in McCoolle's work performance through 'supervision' were inadequate. Senior staff had a narrow repertoire of performance management tools. Mr Calvert said the usual starting point for staff about whom there were concerns was fortnightly supervision sessions. The utility of that approach depends on listening to others in the work environment to identify whether the worker has modified and improved their behaviour. Even when fortnightly supervision was instituted, it was short lived and did not focus attention on monitoring McCoolle or his skill development in the precise areas identified. McCoolle was never placed on performance management or probation of any kind, nor required to attend for retraining.

A National Crime Agency (UK) thematic assessment on institutional child abuse (see Chapter 12) identified that inconsistently applied standards in care environments can normalise poor behaviour and breaches of rules.⁵³⁹ On at least two occasions the significance of McCoolle's behaviour, when brought to the attention of seniors, was dismissed as part of his idiosyncratic personality. When Ms A at OSHC was faced with staff reporting criticisms about McCoolle, she dismissed them, saying he had a 'tendency to babble'.⁵⁴⁰ Similarly when Mr Norman was told about McCoolle's statements referring to Mikayla Bates 'exposing herself' to him, he commented they sounded like 'Shannonisms' and did not need to be brought to his attention.⁵⁴¹

McCoole's personality and his unpopularity with colleagues obscured the ability of senior staff to take legitimate complaints about his conduct seriously.

THE WEIGHT PLACED ON THE CHILD'S EXPERIENCE OF CARE

Children in institutions that do not value their voice or point of view, are especially vulnerable to exploitation and abuse. Some child sex offenders target children who, if they complain, are less likely to be believed by adults. Children in residential care with a history of lying, and therefore less likely to be believed if they complain, are especially vulnerable.⁵⁴² Further, offenders who hold a position of power in an institutional setting often take advantage of what is known as 'positional grooming'—the assumption that their position in the organisation of itself brings with it an inherent level of trustworthiness.⁵⁴³

Children in institutional care can become vulnerable when they are isolated from consistent caregivers who can listen to them and advocate on their behalf. Their vulnerability is exacerbated if the organisation does not have formal and informal mechanisms to ensure their experiences of care are heard and understood. In South Australia, the regulatory safeguards on the use of restraint in residential care facilities are an important formal mechanism for ensuring children's perspectives are heard (see Chapter 12).

Given the breadth of circumstances in which it is permissible to use force under the Regulations, any use of force must be accompanied by strict requirements about its documentation, including the recording of a contemporaneous and independent account of the child's point of view.

Residential care staff use a pro forma to comply with the regulatory requirements. Although the pro forma includes space to record the views of the child, the critical incident reports examined by the Commission did not record any such details.

The pro forma includes a field for recording the names of all witnesses to the relevant incident. The structure of the form gives the impression the version put forward is common to all witnesses to the incident. A worker who has physically restrained a child can complete the critical incident report and forward it to senior staff without seeking input or approval from other staff present. As there appears to be systemic disregard for the child's account, this leaves the person whose conduct is under scrutiny entirely responsible for authoring the version to be examined.

Three critical incident reports authored by McCoole were examined by the Commission. In two of the incidents (Jayden Conti and Anna Pham) other workers expressed concerns about the manner in which McCoole performed the restraint and regarded his actions as excessive. In

the third (Brooke Anderson), careful consideration of the child's version of events was called for to examine the propriety of McCoole's actions leading to the critical events. In each instance the staff identified by McCoole as witnesses to the incidents would not have endorsed the reports as an accurate record of their observations, had they been asked.⁵⁴⁴ In all reports McCoole's ability to deal with the situation was praised.

In the report describing his restraint, Jayden was recorded as complaining McCoole was hurting him. That information reached the attention of supervisor Ms Decoster. If NVCI techniques are correctly applied a child should never experience pain.⁵⁴⁵ In Ms Decoster's assessment of the report, no weight was placed on Jayden's complaint of pain, the only reference to his experience. No follow-up enquiry was conducted. Instead, Ms Decoster recorded her satisfaction that the incident was managed well.⁵⁴⁶

Families SA systemically failed to comply with the regulatory safeguards on the use of force. The total failure to record the child's perspective in the manner required by regulation evidences a low level of interest in the child's experience. On two occasions when a child's version reached the attention of senior members of staff (Brooke and Jayden), it was either assumed to be untrue, or simply ignored.

While children who have experienced abuse and neglect may well have developed unhelpful behavioural habits such as lying, it is dangerous to automatically prefer the voice of adults over children where versions collide. Formal and informal mechanisms to enable children to have their versions heard and respected improve the chances that a child will share their experiences. They also act as a deterrent to would be offenders who know that the potential victim is surrounded by well-informed adults who are keen to listen to, and understand, what the child has to say.

A PERFECT STORM: THE MIKAYLA BATES CARE CONCERN

It is difficult to fathom the concurrence of poor decisions and lack of action which culminated in McCoole's return to work, in circumstances where his supervisor took the view he had been 'declared innocent'.⁵⁴⁷ The series of decisions that followed nannySA worker Ms H's initial report of her observations of McCoole's conduct towards Mikayla Bates focused on McCoole's rights, reasons why Ms H might have fabricated the allegation or misinterpreted her observations, and adherence to process and policy. At no stage was clear focus drawn to the high level of vulnerability of a six year old child in care. Mikayla's biological father, who retained a close and continuing interest in her welfare, was not informed about the allegations. This denied Mikayla the one person who might have advocated strongly on her behalf.

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A state framework, in existence in 2013, brings together the respective investigative expertise of CPS, SAPOL and Families SA. The Interagency Code of Practice establishes a robust system for agencies to offer a coordinated approach to suspected child abuse. If the system had functioned in the way it was designed to, the disastrous failures outlined and discussed below may well have been avoided.

The response to Ms H's notification to CARL was thwarted by the categorisation of the information as a minor care concern. The notification desperately required an inter-agency investigative response from a team of skilled and experienced investigators and practitioners. Instead the categorisation attracted a hybrid investigation/case management response, conducted by ill-equipped and misguided practitioners.

The following significant aspects of the mismanagement of the care concern were a result (directly or indirectly) of the initial categorisation:

- No inter-agency strategy or initial planning meeting was held to coordinate and guide the response.
- CCIU staff with investigative skill were not involved in the management of the matter.
- Investigative tasks were allocated to staff at the local office who lacked the experience and skills to conduct a highly specialised interview of the child.
- The matter fell to be addressed collaboratively between the local office, the directorate and nannySA. It was inappropriate for the matter to be cooperatively managed.
- The positioning of the investigation at this level allowed seniors and supervisors from the directorate to influence the conduct of the investigation in an inappropriate manner.

THE BARRIERS TO REPORTING CONTEMPLATED BY MS H

Ms H's capacity to recognise cognitive distortions in the way McCoole spoke about Mikayla, and to identify inconsistent lavishing of attention through the tickling 'game', revealed a sophisticated understanding of the dynamics of child sexual abuse. Nevertheless, Ms H still grappled with the implications of reporting such a matter. She told the Commission:

To begin with I was working in child protection and the disbelief that someone who was in child protection was a paedophile was quite shocking. I had had conversations with seniors who were at the house and I did not find them to be approachable in situations much much less of concern than this and I had been working in the [nannySA] agency staffing arrangement for a period of time. It was a very clear understanding amongst agency workers that we were not given very much credit for our ability and there was an incident

I heard of coming into work at the agency where an agency staff member was set up, falsely accused of something and then taken off the line. So there were many factors involved in why I didn't present it in a more timely manner to my seniors.⁵⁴⁸

Ms H understood that as a Families SA employee McCoole was regarded as 'one of ours'. She was well aware of the power imbalance and potential personal consequences of raising her concerns.

Ms H's concerns were realised in the conduct of Mr Norman upon her initial report. Mr Norman's response resorted to the grievance process, referring to McCoole's language about Mikayla as a 'Shannonism' and indicating Ms H should have raised it with McCoole directly. His immediate reaction was to minimise the seriousness of the issue, influenced by his view that McCoole had a history of being 'targeted'. Mr Norman proposed to speak to McCoole, not about the possibility he had sexually assaulted a child, but about 'pulling his head in'.⁵⁴⁹

It was necessary for Ms H assert her understanding of the seriousness of the matter and the way it should be dealt with. Ms H was left with the impression that Mr Norman felt she was overreacting.⁵⁵⁰

Mr Norman's response revealed he did not understand the seriousness of the allegation nor the process that should be followed to properly investigate it. Mr Norman genuinely thought it would be possible to address the issue simply by speaking to McCoole without raising a formal care concern.

Ms H also spoke with the supervisor Mr Sterzl. His response to being told Ms H had notified CARL demonstrated his displeasure that the formal complaint had been made and the chance to deal with it quietly within the directorate was lost. Alarming, during the course of his conversation with Ms H, Mr Sterzl suggested that the actions Ms H had taken to formalise the matter could be undone.

The residential care practice guide, Understanding and Responding to Abuse and Neglect, instructs workers who become aware of an allegation of abuse or neglect made by a child against a staff member. They require the worker to:

*Inform your supervisor immediately. You should contact your supervisor or manager immediately **before you make a notification or document the allegation**. Your supervisor should be able to direct you as to what is the most appropriate response. It is your supervisor's role to balance the needs and safety of the child or young person and the accused staff member and they will advise you of what action to take next and how to document the incident.⁵⁵¹ [Emphasis in original]*

This advice creates an expectation that youth workers will permit senior staff to manage the response to allegations. Further, it implies that workers are obliged to act in accordance with the directions of senior staff, who will be considering the rights of the accused worker when determining how to act, rather than in accordance with their own conscience, training and knowledge. The advice insinuates it would not be improper for senior staff to require a worker to document allegations in a particular way or refrain from reporting matters.

If the approach taken by Mr Norman and Mr Sterzl is representative of the attitude of seniors and supervisors in the directorate to allegations of this kind, the advice in the practice guide is exceptionally dangerous.

THE MINOR CATEGORISATION AND DEMARCATION OF RESPONSIBILITIES BETWEEN CCIU AND SIU

When a notification to CARL alleges abuse of a child not in the care of the Minister, the investigation is conducted in accordance with the Interagency Code of Practice. An initial strategy meeting must be held and usually guides the respective actions of the relevant agencies. For children in care, the process is different. A strategy meeting is not mandated, but in response to most serious care concerns, an initial planning meeting does occur.⁵⁵² At these meetings all relevant agencies discuss the matter and prepare a joint response. Initial planning meetings are potentially a powerful tool for bringing parties together, sharing information and planning a coordinated response.⁵⁵³ An initial planning meeting was exactly what was required to plan an appropriate response to Ms H's information.

It is difficult to justify the characterisation of the concerns raised in the report as 'minor'. Ms Harman was unable to identify any circumstances in which a disclosure of sexual abuse of a child in care should be so categorised (apart from historical allegations that had already been addressed).⁵⁵⁴ Circumstances are unlikely to arise where the response prescribed for a minor care concern, which focused on supervision, development and training by discussion-based processes, is appropriate for an allegation of sexual abuse.⁵⁵⁵

Ms Harman conceded in hindsight that the accumulation of circumstances made it possible to infer that Mikayla had been sexually assaulted and that the minor categorisation was inappropriate.⁵⁵⁶ She agreed that, in the absence of a specific disclosure from Mikayla, it was even more critical that a careful investigation occur, because those with the power to protect Mikayla were unable to consider her account of what had happened.⁵⁵⁷

The categorisation was a gross error which persisted, even in the face of Ms Lamont agitating for a reclassification. It is most likely that Ms Harman was influenced by her understanding, from Ms Lamont's email, that McCoole was an agency worker and was

unlikely to receive any further shifts.⁵⁵⁸ However, this does not explain why the categorisation persisted after it became clear McCoole was also employed by Families SA.

Ms Harman held the view that, if SAPOL determined an investigation was warranted, CCIU's approach might change. This shows a misunderstanding of the differing focus and questions for the two investigatory bodies. Misconduct investigations have a different standard of proof and investigative powers to criminal investigations. They are potentially less constrained by procedures. A misconduct inquiry had greater capacity to achieve an outcome, such as McCoole's exit from the workforce, without the greater restraints imposed on a criminal investigation.

The evidence disclosed a persistent and incorrect view among departmental staff involved in care concerns that on SAPOL declining to undertake a criminal investigation, the allegation of a sexual assault could not be considered in any internal investigation. Ms N, the manager of SIU, believed that the decision by SAPOL not to investigate meant that SIU had to divorce any suspicion of sexual misconduct from its consideration of the allegations, leaving only practice concerns.

The evidence given by Ms N on this topic was, at times, difficult to follow. She appeared to take the view that responsibility for investigating sexual assault allegations sat with CCIU because the child was in care. That is, depending on the care status of the child, the investigation of employee misconduct would be approached in a different way.⁵⁵⁹

Any potential for SIU to properly investigate the matter was precluded by the 'category C' classification. Category C was reserved for minor instances of misconduct, such as being absent without cause or failing to comply with a manager's directions. Category A encompassed serious or significant breaches of duty of care and category A* actually contemplated incidents of sexual contact or behaviour or sexual abuse of a child. It is difficult to see how the evidence available to Ms N could properly be described as falling into category C rather than category A.

At the time the respective functions of CCIU and SIU were not clear. No document existed governing their respective responsibilities and little planning had been devoted to integrating the two investigatory bodies. Their independent operation was not the best use of the Department's resources.

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SIU's determination that misconduct of a Families SA employee should be approached differently to that of any other departmental employee, particularly where allegations of sexual misconduct are involved, defies logic. The most rigorous and efficient investigative processes should be applied. This approach, and the separate functioning of the two bodies, meant that more robust investigatory systems were not brought to bear on resolving Mikayla's care concern.

Once both investigative units disavowed responsibility, the directorate's Ms Lamont was left to deal with the care concern without the help of investigative expertise or an interagency cooperative approach. Her management of the matter was supported only by advice from the Department's Human Resources section. The directorate's response was stymied by lack of planned action by the Human Resources section. The failure to send the letter of allegations to McCoolle, and corresponding poor advice by Ms R to Ms McKenna, saw McCoolle interviewed by nannySA while Ms Lamont's response stood on hold, awaiting action from the Human Resources section.

The final involvement of Ms Kuehn of the Human Resources section, who was asked to take responsibility for the section's response when Ms R went on leave, lacked even the most basic understanding of McCoolle's employment relationship with the Department. She incorrectly assumed that McCoolle was engaged solely as a nannySA employee, and took the position that Families SA should be persuaded in its own decision making by nannySA's opinion about McCoolle's return to work. Even with that misunderstanding, it is difficult to understand how an experienced human resources consultant could consider that nannySA's actions had adequately addressed the concerns raised and, without a more convincing explanation from McCoolle, that a 'refresher in standard operating procedures' might be adequate to address the concerns.⁵⁶⁰

These actions were, in effect, the final nail in the coffin of any attempt to resolve the issues in a robust way. As the investigation experts in the Department refused to apply their expertise, less qualified staff were left to manage the matter with inadequate knowledge and skill. The deficiencies of the eventual investigation need to be viewed against the background that those with the knowledge and expertise to do better had not.

The relevant events were witnessed by three people: Mikayla, McCoolle and Ms H. The Department did not interview either of the adults; and the 'interview' with Mikayla could hardly be characterised as a serious attempt to obtain her story. It is astonishing that an investigation into potential child sexual abuse could be finalised without taking such important basic steps.

The obvious steps of comprehensively checking logbooks, investigating Mikayla's behaviour in the days after 5 June with workers, and examining McCoolle's supervision records for any similar conduct, were never taken.

Of course the investigation stalled, when the Department failed to recognise the need for, or undertake, basic investigatory processes and to consider its own information.

THE CONDUCT OF SAPOL AND CPS

The care concern documentation was referred to SAPOL at an early stage. It is significant SAPOL was never given the logbook entry evidencing Mikayla's sexualised behaviours towards Ms Dimond. Both Det S/Sgt McLean and Det Sgt Martin considered this information relevant to their decision. Det S/Sgt McLean thought it would have changed his opinion.⁵⁶¹

To conduct a criminal investigation, Det Sgt Martin required sufficient information to be satisfied that a criminal offence may have been committed.⁵⁶² She did not believe that the accumulated circumstances observed by Ms H, and the inferences that could be drawn from them, reached the standard to justify a criminal investigation. She accepted that an inference that a sexual assault had occurred in the bedroom could be drawn, but was concerned that such an inference was 'speculative'.⁵⁶³ She put SAPOL's position as: 'We're not saying that the door's closed. What we're saying is perhaps Families SA need to do some further inquiries or collate further information'.⁵⁶⁴

Det S/Sgt McLean took a similar approach. He believed the information given to the police revealed an employee with an unhealthy sexual interest in children. He felt heightened concern that McCoolle had the intent to do something, but there was insufficient evidence of actual offending. According to Det S/Sgt McLean, a report of such observations by a parent would justify a conversation with the parent to draw out more information on which an investigation might be based. He considered that the communication back to Families SA, indicating it would be reviewed if further information arose, was the equivalent of such a conversation.⁵⁶⁵

The information available to SAPOL suggested more than grooming. Contrary to the opinions expressed by the two SAPOL officers, there was sufficient evidence to draw an inference, which was not speculative or fanciful, that a vulnerable child in rotational care had been sexually assaulted. A caring and attentive parent who made the same observations would be unlikely to accept it was insufficient to justify an investigation. A caring parent would pursue the matter to advocate for the safety and best interests of their child. Mikayla did not have the benefit of any such advocacy.

SAPOL's decision not to investigate was used by CCIU and SIU in a way SAPOL could not possibly have anticipated. Each agency that could have applied its expertise to conduct a proper forensic investigation believed it was the task of another. Responsibility for the care concern was shifted between different parts of the one organisation until it reached those with the least capacity, qualification and authority to respond appropriately.

CPS offers a unique forensic investigative service. For six year old Mikayla, they were the agency with the expertise to give her the best chance to disclose what had happened. Her disclosure would not only have contributed to a potential prosecution, it would have also secured a greater level of safety for Mikayla and other children in the residential care environment. A prompt referral to enable Mikayla to be interviewed as soon as possible after the relevant events was critical. The referral of the matter to the local office in preference to an inter-agency strategy meeting or initial planning meeting meant CPS received its referral on 5 July 2013, more than two weeks after the relevant events.

Ms Macdonald, an experienced and knowledgeable social worker, was Director of CPS at that time. She conceded in her evidence that she did not know how the decision came to be made not to accept the referral. She thought the information available would justify, at the very least, an interview with the care giver to understand more about the child and their experience. Ms Macdonald considered if the care giver spoken to was also the notifier, both perspectives could be obtained in a single interview.⁵⁶⁶

The overwhelming conclusion from all the circumstances is that an initial planning meeting, attended by CCIU, SIU, SAPOL and CPS was critical to the proper handling of this difficult matter. The matter was complex because it sat outside the norm. An insight into Mikayla's experience relied on being able to properly and carefully analyse the accumulation of suspicious circumstances. McCoole's statements and behaviour in the lead up to the critical events had significance to the dynamics of sexual abuse and the distortions that can be part of a sex offender's cognitive processes when thinking about children and sexuality. The matter needed experts from all the agencies to remind one another what they knew about these issues. An investigation plan which took advantage of the best that each of the agencies had to offer was essential. Further, to avoid assumptions being made about the reasoning behind the actions of others, each agency needed to be aware of the planned activities and responses of all other agencies.

Ms Macdonald made the important point it was not only the *outcome* of the strategy or initial planning meeting that was of significance to the quality of an investigation, but also the *process* of engagement:

they give people an opportunity to learn from a matter that they might not know because ... something that's written is sometimes quite different when it's spoken to ... quite often in strategy discussions police will have additional information, Families SA might have additional information, sometimes it's in the questions that are asked that the information becomes richer ... It is ... agencies genuinely engaging with each other to look at what's the possible pathway here.⁵⁶⁷

THE 'INVESTIGATION' CONDUCTED BY THE LOCAL OFFICE AND THE DIRECTORATE

The care concern was referred to the local office for a case management response. Given the concern in question arose in the residential care environment, the response was to be planned in conjunction with the directorate. A less appropriate example than such a care concern being dealt with by a 'case management response' is difficult to imagine.

Allocation to the local office allowed seniors and supervisors in the directorate to exercise their influence over the process by sharing their own conclusions and impressions as to the veracity of the information being investigated.

Senior staff within the directorate did not wait for advice that SAPOL was not prepared to undertake a criminal investigation. Mr Sterzl's initiation of the process led to Ms Jezeph interviewing Mikayla on 18 June 2013, the day before SAPOL informed the Department it did not want to conduct a criminal investigation. The email that advised all parties about the 'minor' determination, sent on 14 June 2013, did not make clear that any action should await advice from SAPOL. This was a serious oversight. If SAPOL had become involved, the interview performed by Ms Jezeph could have compromised the criminal investigation.

Allocation to the local office brought about an 'investigation' conducted by staff with no skills or experience in forensic interviewing and who did not appreciate or understand the sensitivities that might prevent Mikayla from disclosing, if she had experiences to share.

Ms Macdonald referred to the following matters which guide expert forensic interviews of children and which do not appear to have been factored into the local office's management of the matter⁵⁶⁸:

- Whether a child will disclose does not depend on whether they have an otherwise open and outgoing personality.

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- Sexual abuse can be particularly difficult for children to disclose as they have a sense of the secrecy surrounding it.
- If a child is not certain whether the person responsible for the abuse might come back to the house to provide care, they may be especially reluctant to disclose.
- A child is not necessarily more likely to disclose to someone with whom they have an existing relationship. They may well not talk about sexual abuse if they are uncertain about whether it is the right thing to do.
- A child may not feel comfortable disclosing when the interview is held in the same environment in which the abuse occurred.

A number of features of the interview undertaken by Ms Jezeph were also identified by Ms Macdonald as being relevant⁵⁶⁹:

- Questions which direct a child to occasions they have felt 'uncomfortable' or whether they are 'happy living here' are potentially unhelpful because of the lack of clarity in the meaning behind 'uncomfortable'. Rather than using confusing generalities, a proper forensic interview would gain insight into the child's world, understanding the way the child's day is structured and experienced, and employing the language the child might use. A trained interviewer is able to reach an appropriate balance between avoiding leading questions and enabling the child to understand what the interviewer is interested in talking about.
- Children sometimes, in advance of making a disclosure, throw out information to test whether they are being listened to and the potential reaction of the listener to the information they are considering sharing. If the child is not listened to at this point, or if disapproval is indicated, they may well choose not to disclose the abuse.
- Interviewing Mikayla in a residential care house might be problematic as she might be uncertain when McCooole was returning, indeed, whether he was about to walk in the door.
- Interviewing Mikayla in the presence of other residential care workers is likely to be distracting and might discourage disclosure, given the potential association of those staff with McCooole.

It is clear the 'interview' conducted by Ms Jezeph was poorly conceived and executed. Mikayla was not given the best chance to understand what the adults charged with caring for her were interested in talking with her about. The idea Mikayla would necessarily disclose abuse to someone she knew, in an informal but familiar environment, was contrary to expert knowledge about children and the factors that prevent disclosure of sexual abuse.

Ms Jezeph, a social worker, had neither the training nor the experience to conduct the interview in the skilled way that was required. The assistance Ms Jezeph received from more senior staff at the local office was in part ignored by her and in part insufficient to equip her to undertake the task at the requisite standard.

Ms Jezeph's conclusion that the level of concern was ameliorated by Mikayla's failure to disclose reflected an unsophisticated understanding of the dynamics of child sexual abuse and the barriers to disclosure. Her approach highlights the dangers of untrained staff undertaking such sensitive and specialist work. Ms Jezeph's failure to understand the possible significance of Mikayla's reference to McCooole (on the dessert issue), and the lack of interest demonstrated in her response, potentially shut down further discussion about the very topic she had been tasked to investigate. Ms Jezeph inadequately documented Mikayla's comments about McCooole which prevented those who later relied on her record from identifying potentially significant statements.

Beyond the interview of Mikayla, no action was taken by directorate or local office staff to gather any evidence. As it turned out, Ms Dimond held information relevant to the matter, but did not understand its significance until she had a chance conversation with Ms H. Had Ms H not spoken about the matter with her colleague (which according to seniors and supervisors was prohibited) Ms Dimond's observations may never have emerged. At no stage was there clarity about *who* should conduct any investigation beyond interviewing the child concerned.

Although the minor determination of the care concern dictated a collaborative case management approach between the directorate (tasked with supervision of the worker) and the local office (tasked with managing the wellbeing of the child), there was no documented guidance about how the two sections would manage an *investigation*. The system in place did not contemplate that a complex *investigation* would be managed collaboratively, because any such *investigation* should have been conducted by CCIU.

THE CONDUCT OF SHANE STERZL AND LEE NORMAN
Some observations about the effect of the conduct of Mr Norman and Mr Sterzl must be made.

Mr Sterzl maintained in evidence that at no time did he express a view about the strength of the allegations against McCooole. He described his approach as 'neutral' and that he did not even hold a private view about the strength of the allegations. The evidence of Ms Jezeph, Ms Rowley, Ms Lamont and Ms H is to the contrary. Their evidence demonstrates Mr Sterzl's belief that the allegations were baseless and that he made various statements designed to convince others tasked with the investigation to adopt this view.

In particular, Mr Sterzl asserted to Ms Jezeph and Ms Rowley that Ms H had a motive to fabricate the allegations. Such claims were baseless and untrue. He told Ms Rowley that there were no previous concerns about McCooles, no behavioural changes observed in the children that would support the allegations and that the notifier had been uncertain about her observations causing her to delay her report. This information was also untrue.

Mr Sterzl informed his manager, Ms Lamont, that he regarded the allegations as originating in a personality clash between the notifier and McCooles, communicating a similar if more understated message.⁵⁷⁰ The allegation was baseless. However, Ms Lamont was not influenced in her approach by Mr Sterzl's characterisation.

Mr Norman approached the allegations in the same way. He reinforced the message being promoted by Mr Sterzl when he spoke with Ms Jezeph after her interview with Mikayla.

In concluding she was satisfied that nothing had happened, Ms Jezeph said she was influenced by statements made by the people she considered knew McCooles best. She did not think there was an innocent explanation for what Ms H had reported, but accepted what she heard from others that Ms H had embellished her account or taken her observations out of context. Ms Jezeph said she 'trusted what people told me'.⁵⁷¹

Mr Norman's uncritical support of McCooles began before the care concern. The accuracy of the work report by Mr Norman on the initial Families SA application by McCooles is questionable. Mr Norman maintained it was an accurate reflection of his view of McCooles's performance at the time, despite knowing the identified need for McCooles to work on his communication skills and voice control. Supervision records made by Mr Norman from after the work report contradict Mr Norman's assertion that these issues had been dealt with by that time.⁵⁷²

The conduct of Mr Sterzl and Mr Norman was unethical and improper. It was designed to influence the course of the investigation, and that succeeded. Their conduct evidenced an alarming willingness to disregard evidence of the sexual abuse of a child in the houses they were charged with supervising.

Mr Norman and Mr Sterzl drew on unfounded and incorrect assumptions about the notifier and McCooles. Neither exhibited any preparedness to investigate the truth of their statements with any rigour, even though their own experience, and the documents available to them, highlighted McCooles's history of questionable workplace conduct and some concerning behavioural observations of Mikayla in the aftermath of the events. The Commission accepts that Mr Sterzl and Mr Norman genuinely held their beliefs, but neither had any reasonable factual basis on which to hold them.

Their conduct also affected the notifier Ms H. No-one in the official investigation gave her feedback or advice about the response to her report, thus neglecting to consider her significant contribution, and the need for her to be informed about what would follow (within appropriate confidentiality bounds). The disregard for her wellbeing is demonstrated by Ms H discovering McCooles was returning to the workforce when she 'overheard' Mr Norman's phone call to McCooles, offering him shifts.

The conduct of these senior staff members contributed to the organisational culture of the southern residential care directorate where workers considering reporting matters held legitimate concerns for the professional consequences of so doing. For an organisation tasked with the care of vulnerable children in institutional settings, such a culture is dangerous in the extreme.

Seniors and supervisors must contribute to a healthy organisational culture by modelling appropriate behaviour. In one respect Mr Sterzl and Mr Norman were correct; prolific and malicious gossip within the workplace has the capacity to damage the reputation of a worker. Their conduct towards Ms H demonstrates this point.

Mr Norman made a number of statements to members of staff which denigrated Ms H and undermined her professional standing. He sent senior staff in southern Nation Building an email on 20 August 2013, which condemned Ms H's continued advocacy against McCooles being cleared to return to work. Mr Norman's campaign was waged in circumstances in which he had not ever taken the trouble to read Ms H's complete account of what she had seen.⁵⁷³

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THE CONTRIBUTION OF NANNYSA

At the relevant time, there was no written contract in place which included terms governing how nannySA staff would be supervised or managed when working in Nation Building or transitional accommodation facilities.⁵⁷⁴ However, previous and subsequent agreements did refer to the role to be played by nannySA in the management of care concerns.

The agreement which governed the relationship between Families SA and nannySA from 2008 to the end of 2011 limited nannySA's role in care concerns or special investigations to support of the worker concerned.⁵⁷⁵ On 8 January 2015 a contract was entered into which outlined in greater detail the role to be played by nannySA. This agreement required the agency to 'work in partnership with Families SA regarding care concerns and special investigations' and 'follow up allocated actions resulting from care concern and special investigation processes'.⁵⁷⁶ In each agreement unfettered power was vested in Families SA to require the agency not to engage certain personnel. That is, it was entirely within the power of Families SA to decline to have any particular agency staff member work in residential care or emergency facilities.

As the care concern was given a minor classification it was to be 'dealt with jointly by the contracting agency/alternative care service provider and Families SA'.⁵⁷⁷ In contrast, commercial care agencies had no role to play in the management of serious care concerns.

The initial 'minor' classification created a situation in which nannySA was asked to contribute to an 'investigation' where there was a clear conflict of interest as a result of its own financial interest in returning McCoolle to work, and where Ms McKenna was faced with concerns about potential litigation from McCoolle. nannySA provided an informal advocacy role for McCoolle during its dealings with him. Of itself, that was not inappropriate but it created a further potential conflict when the advocate was required to assume a role in the conduct of the investigation.

nannySA had no expertise or training in investigating sexual abuse or identifying problematic grooming behaviours. It was inappropriate to ask it to play any part in the response. Had the matter been properly classified as a serious care concern it would not have been placed in that position. An agency's role in care concerns should be limited to circumstances that require only staff development and training to prevent recurrence.

The clumsy back and forth process that ensued between Families SA, the Department's Human Resources section and nannySA arose from lack of clarity about the role of each in resolution of the matter. McCoolle's unusual employment circumstances appear to have flummoxed both agencies and stymied progress. When nannySA

was finally given permission to interview McCoolle it did so swiftly, uninhibited by the weight of process and procedural confusion that had stalled the Department.

However, the interview was inadequate. All it did was present the allegations to McCoolle and ask him to respond. His responses were then accepted at face value. He was not pressed to answer the most concerning aspects of the observations—what happened in the bedroom to cause Mikayla to be on her hands and knees complaining her bottom hurt? Without testing McCoolle's explanations against the recorded observations of Ms H, or directly with Ms H, Ms McKenna's opinion that there had been a misunderstanding was critically flawed.

The cognitive distortions, the hallmarks of grooming and the accumulation of disturbing circumstances about the events in the bedroom were lost on Ms McKenna. Following the interview, she was prepared to return McCoolle to work caring for children in other parts of the nannySA business, notwithstanding her lingering doubt about his denials.⁵⁷⁸

Ms McKenna's interview focused too much on compliance with process and too little on child safety. It was conducted with a naïve optimism that the interview would finalise the matter neatly before she left her employment.

The investigation of alleged grooming and child sexual offences is a highly specialised field. Such investigations should be conducted only by staff with the highest level of expertise. It is highly unlikely those staff would be located in the private labour supply companies with whom Families SA contracts. It is not appropriate that investigations are conducted 'collaboratively' with staffing agencies. Agencies should be obliged to cooperate with investigations, but never collaborate.

MCCOOLE'S RETURN TO WORK

Faced with an entirely inadequate investigation and unhelpful advice from the human resources consultant Ms Kuehn, Ms Lamont, the manager, permitted McCoolle to return to work. She did so despite understanding the seriousness of the allegations and having some lingering doubts about the veracity of his denials.⁵⁷⁹ She believed she could do nothing to prevent him returning to work in the absence of factual findings from a properly conducted investigation.⁵⁸⁰

Notwithstanding the remaining concern about McCoolle's conduct, no clear process was adopted by Families SA to determine whether they could simply decline to renew McCoolle's contract. By the time he returned to work he had no written contract of engagement. There may have been a basis on which they could have declined to offer him a further contract. Ms Lamont thought she might have discussed the issue with a business manager in the

directorate, and considered there might be difficulties if McCooles contract was not renewed. They did not seek formal advice.

Ms Lamont's decision to return McCooles to work was based on incomplete information and inadequate understanding in two areas. The first was McCooles full work history. In the course of evidence a number of matters identified as 'red flags' were put to Ms Lamont. She said that if she had been aware of these issues her level of concern about McCooles remaining in the directorate would have been elevated. No comprehensive picture of McCooles previous workplace conduct was available to Ms Lamont or other senior staff because recording of information about residential care workers was not systematic. Some information had not been recorded at all. Other information dealt with in supervision was not considered. The second misunderstanding was that Ms Lamont believed that, in directing that he work double-handed shifts, McCooles would not be left alone with children.

The circumstances of McCooles return to work were unsatisfactory. The supervision regime lacked clarity and was poorly communicated to the staff who were expected to supervise him. Carers working with McCooles were not advised why he was obliged to work double-handed shifts, nor that there was any requirement to ensure he was not left alone with children. There was no retraining nor any program of intensive supervision over a defined period of time. No review of McCooles progress after his return to work was scheduled or conducted. McCooles disregard for the rules in the residential care environment continued. Coming as it did after the care concern, McCooles photographing of Nicky Schultz on his personal device required a serious response.

If the message to the workplace about McCooles being 'bulletproof' was not plain enough following his return to work, it was made perfectly clear after his January 2014 elevation to the acting OPS4 senior youth worker position. At that time Mr Norman was acting in the OPS5 supervisor role and was responsible for the decision. McCooles was objectively an extremely poor candidate for the role, because of accumulating concerns about his work performance and poor teamwork, and the tension about his return to work following the care concern. In making this decision Mr Norman was clearly influenced by his disapproval of the actions of Ms H, and those who supported her, in speaking out against McCooles.

FINAL COMMENTS

Ms H's notification of McCooles actions provided the best opportunity for Families SA to investigate McCooles and rigorously consider the risk he posed to children in the residential care context.

The opportunity was squandered because the systems in place to respond to this exact situation were not used. Rather, those with decision-making responsibility made their decisions on considerations other than the paramountcy of the safety of the child.

Decision making failed to give weight to the extreme vulnerability of young children in rotational care environments, and the disastrous consequences of permitting a person who proved to be a child sex offender access to children in that environment. The system response also failed to have regard to the high risk posed by an adult who was engaged in behaviours that might precede child sex offences, in a residential care environment.

The underlying sense was that compliance with process was more important than understanding the child's experience. As each part of the system shrank away from shouldering any responsibility for this difficult matter, the response was left in the hands of staff who were the least qualified to deliver it.

It is tempting to place blame at an individual level for each decision in the process which contributed to the disastrous outcome. For some individuals, the lack of judgement evident in their actions calls into question their capacity to continue in the important roles they have been assigned. That is not a matter for the Commission to resolve. What is more important are the lessons that can be learnt from both individual and system failures.

CONCLUSION

Workplaces that provide services to children must consciously and deliberately protect against the risk of child sexual abuse. In organisations such as Families SA, where intimate care is provided to particularly vulnerable children, all aspects of organisational practice and culture must come under routine, rigorous scrutiny, informed by an understanding of child sexual abuse, child sex offender behaviour and the effects of abuse on children.

It cannot be said definitively that at any one point in time McCooles offending could have been prevented. However, it can be said that the accumulation of all the deficiencies revealed in this case study culminated in a workplace that failed to properly protect children against the risk of child sexual abuse from within.

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This situation developed in circumstances where the risk of abuse within institutional environments had long been part of the public consciousness, where a body of understanding had developed about preventative practices, and where warnings from within the organisation identified ongoing risk. Financial pressures restricted the capacity to change where needs were identified, and the unplanned advancement of residential care provision contributed to the situation. However, these matters are not solely responsible for what occurred.

Serious deficits within the child protection system permitted McCoolle to begin employment at nannySA, and to offend at work over a period of about three-and-a-half years. At the time he started working with children, McCoolle had a clearly developed sexual interest in children, and predatory motives towards them. The characteristics of McCoolle's offending, and his characteristics as an offender are particularly heinous. However, those working in environments which provide services to children require an understanding that McCoolle's activities only represent one form of offending. Systems must be capable of protecting against the variety of circumstances in which child sexual offenders offend. Restricting opportunities to offend can be the most effective means of achieving this result.

Recruitment processes for nannySA and Families SA failed to apply the degree of rigour required in services that care for vulnerable children and without any apparent consideration of the potential risk of engaging people who may offend. The positive reference from the OSHC Director was accepted on face value, without considering that OSHC's supervision of McCoolle's conduct might not have been as rigorous as it should. Within Families SA, McCoolle was engaged despite warnings in a psychometric test that recommended caution, and indicated McCoolle posed a high risk as a potential employee, even though it did not disclose a potential for sexual abuse. Families SA systematically misused test results because recruitment teams were not given the capability to understand the tests they were supposed to interpret.

Screening of applicants at the recruitment stage is fallible. It is but one of many systems that organisations need to protect against child sexual offending. Deficits in the practices of nannySA and Families SA beyond recruitment also failed children in their care.

Some practices in staffing residential facilities failed to provide adequate supervision and support for staff, including high child to staff ratios, the use of single shifts, and lack of oversight of operational staff by supervisors. The genesis of some of these deficiencies was an absence of service agreements, or inadequate provision in such agreements between nannySA and Families SA.

Lack of consistency or an absence of clear practice and procedure in the following areas contributed to inadequate scrutiny of McCoolle's behaviour in the workplace and allowed him to continually stretch the boundaries of what was appropriate:

- an absence of a clear approach to youth work generally;
- lack of clarity on permissible and impermissible contact with children;
- lack of clarity on conduct permitted and not permitted within residential care facilities;
- inconsistent practices of reporting observations of inappropriate conduct by a co-worker, including whether they can be named in a logbook, whether reports must be in writing, and the means by which the directorate addressed staff disputes;
- inconsistent practices for recording observations of children in care, including the logging of observations, critical incident reports, notifications to CARL, and the appropriateness of contact by workers with caseworkers or treating therapists;
- inadequate understanding and attention to the need to record and consider what children say about their experiences, including in critical incident reports;
- inadequate supervision of staff, including the conduct of supervision sessions and ongoing performance management;
- inadequacies in the conduct of care concern investigations regarding an allegation of abuse of a child in care by a worker; and
- lack of guidance on decisions about the continued employment of workers whose conduct is found to be of concern.

Combined with these deficiencies, a toxic workplace culture in parts of southern residential care discouraged staff from raising their concerns about children and colleagues, and punished those who did step forward. The conduct of some staff was inappropriate to the point that their continuing suitability for employment should be reviewed. The Commission recommends that the conduct of Ms Decoster, Mr Norman and Mr Sterzl be considered by the Department in this regard.

An organisation such as Families SA must have the capacity to monitor the conduct of staff and children for indicators of child sexual abuse, and act as a protection against such conduct. The inadequate understanding of the dynamics of child sexual abuse, the nature and behaviour of sexual offenders and the effects of such abuse on children, on the part of workers, including senior staff and those involved in investigations, was observed throughout the case study. There was inattention to the possibility of McCoolle committing or contemplating sexual offences against children, even

from those responsible for scrutinising his conduct. Comprehensive training of Families SA staff and nannySA staff on these topics is necessary.

Closely related to this knowledge is the ability of the organisation to record and consider information about children and workers. Structures that consolidate such knowledge across large organisations such as Families SA, where staff and children frequently move from place to place and where knowledge is held in multiple areas, are particularly important. Deficiencies were identified by the Commission in these systems. They were starkest in relation to commercial agency staff, who do not have access to Families SA data management systems, and whose conduct is subject to minimal oversight.

Ultimately, the lack of scrutiny which attends the recruitment and employment of agency staff, combined with training inadequate to equip them for their role, establishes that the engagement of agency staff to provide care to children in residential care facilities bears an added unacceptable risk to children, particularly where they are engaged on single-handed shifts.

Positive changes have begun in Families SA, but the problems identified in this case study are by no means resolved. Many high-risk factors remain, not least of which is that children are still cared for on single-handed shifts, commercial carers are still engaged in the care of those children and problems appear to persist with the organisational culture.

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NOTES

- 1 *R v Shannon Grant McCoolle* (2015), DCCRM-15-64.
- 2 The primary school was run under the auspices of the Department for Education and Child Development (DECD). Although physically located at the primary school, the OSHC service was not governed by DECD. It was governed by the OSHC Advisory Committee, a subcommittee of the schools' governing council.
- 3 Name withheld Out of School Hours Care, 'Staff weekly roster', internal unpublished document, 18 January 2010 to 17 January 2014.
- 4 S McCoolle, curriculum vitae, 16 February 2012, application to Families SA.
- 5 Oral evidence: Ms A.
- 6 *ibid.*
- 7 Oral evidence: Ms E.
- 8 Oral evidence: Ms A.
- 9 *ibid.*
- 10 Oral evidence: Ms A; Ms E.
- 11 Oral evidence: Ms A.
- 12 *ibid.*
- 13 Oral evidence: Ms E.
- 14 Name withheld Primary School, Out of School Hours Care, 'Policy statement on staffing objectives', internal unpublished document, 3 November 2009, p. 1.
- 15 Name withheld Primary School, Out of School Hours Care, 'Policy statement on staff recruitment', internal unpublished document, no date, p. 2.
- 16 Oral evidence: Ms A; Ms E; Name withheld Out of School Hours Care, 'Staff weekly rosters', internal unpublished document, 18 January 2010.
- 17 Oral evidence: Ms A.
- 18 Oral evidence: Ms E.
- 19 Oral evidence: Ms A.
- 20 *ibid.*
- 21 nannySA, reference check conducted by Ms T: S McCoolle, internal unpublished document, 7 December 2010.
- 22 *ibid.*
- 23 *ibid.*
- 24 Oral evidence: Ms A.
- 25 Oral evidence: Ms E; Ms A.
- 26 Oral evidence: Ms E; Witness statement: Ms AB.
- 27 Oral evidence: Ms E.
- 28 *ibid.*
- 29 Oral evidence: Ms E; Ms A.
- 30 Oral evidence: Ms A.
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- 33 S McCoolle, internet relay chat logs, January 2011–May 2013.
- 34 Oral evidence: T Cole.
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- 37 Oral evidence: T Cole.
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- 39 Oral evidence: Ms T.
- 40 Oral evidence: A Abela.
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- 43 Families SA, 'Certificate of Attendance: Introduction to Working with Families SA: S McCoolle', internal unpublished document, Government of South Australia, 3 May 2011.
- 44 Oral evidence: T Cole.
- 45 Oral evidence: Ms L.
- 46 Oral evidence: T Cole.
- 47 Oral evidence: T Cole; A Abela.
- 48 Oral evidence: T Cole; A Abela.
- 49 Oral evidence: S Sterzl.
- 50 Oral evidence: P Cross.
- 51 Oral evidence: R Packer.
- 52 *ibid.*
- 53 *ibid.*
- 54 *ibid.* nannySA, note on anonymous complaint regarding S McCoolle, internal unpublished document, 16 March 2011.
- 55 Oral evidence: J Lamont; Ms L.
- 56 Oral evidence: J Pinos; Ms K; Mr Z.
- 57 Families SA, 'Nation Building houses relocation project', project brief, draft internal unpublished document, 12 October 2010.
- 58 For example, Department for Education and Child Development (DECD), Service agreement between Minister for Education and Child Development and Hessel Pty Ltd (1 October 2012 – 30 December 2014), internal unpublished document, Government of South Australia, 26 September 2013.
- 59 For example, Department for Families and Communities (DFC), Service agreement between Minister for Families and Communities and Hessel Pty Ltd (July 2008 – 31 December 2011), internal unpublished document, Government of South Australia, no date, pp. 8–9.
- 60 Oral evidence: Mr F; D Shen. Witness statement: Mr F.
- 61 Oral evidence: Mr F; D Shen.
- 62 Oral evidence: Mr F; D Shen. Witness statement: Mr F.
- 63 Families SA, Role description; Child and Youth Worker, approved December 2010, reviewed December 2011, p. 1.
- 64 *ibid.*, pp. 2–3.
- 65 *ibid.*, p. 4.
- 66 S McCoolle, online application for the position of OPS3 Child and Youth Worker (Families SA), 16 February 2012.
- 67 S McCoolle, curriculum vitae, application to Families SA, 16 February 2012.
- 68 Oral evidence: Mr Q; Ms M; Mr F.
- 69 Oral evidence: Mr F. Witness statement: Mr F.
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- 77 *ibid.*
- 78 *ibid.*
- 79 *ibid.*
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- 93 Oral evidence: Mr F. Jobfit Health Group (Dr T Drew), 'Confidential Medical Report': S McCoolle, internal unpublished document, April 2012.
- 94 Oral evidence: Mr F. Witness statement: Mr Q.
- 95 Witness statement: Mr F.
- 96 Oral evidence: Mr F. Mr F, internal memorandum to D Shen, 11 April 2012.
- 97 Mr F, internal memorandum to D Shen, 11 April 2012.
- 98 Oral evidence: Mr F; D Shen.
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- 100 Mr F, internal memorandum to D Shen, 11 April 2012.
- 101 Oral evidence: Mr F. Families SA, 'February 2012 intake—child & support worker (OPS3 external) summary', internal unpublished document, no date.
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- 103 Oral evidence: Ms I; Ms U.
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- 122 Oral evidence: J Creek; S Sterzl.
- 123 Oral evidence: D Shen.
- 124 Oral evidence: J Creek; L Norman; D Shen; S Sterzl.
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SHORTENED FORMS

AFSS	Aboriginal Family Support Services
AIFP	Australian Institute of Forensic Psychology
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principle
C3MS	Connected Client and Case Management System
CaFHS	Child and Family Health Service
CARL	Child Abuse Report Line
CCIU	Care Concern Investigations Unit
CPS	Child Protection Services
CRC	community residential care
DCP	Department for Child Protection [Western Australia]
DCSI	Department for Communities and Social Inclusion
DECD	Department for Education and Child Development
FMC	Flinders Medical Centre
FNR	Full Investigation Not Required
FTE	Full time equivalent
GCYP	Office of the Guardian for Children and Young People
HR-MIU	Human Resources Misconduct and Incapacity Unit
ITC	intensive therapeutic care
LWB	Life Without Barriers
MAS	Manager—administrative services
NCA	National Crime Agency [United Kingdom]
NOC	Notifier Only Concern
NVCI	non-violent crisis intervention
OPS	operational services
OSHC	out-of-school-hours care
PAC	principal Aboriginal consultant
PSU	Placement Services Unit
PSW	principal social worker
RAN	Responding to Abuse and Neglect
SAPOL	South Australia Police
SIU	Special Investigations Unit
SSO	school services officer

