Ombudsman
New South Wales

The JIRT Partnership - 20 years on

NSW Ombudsman inquiry into the operation of the JIRT Program

August 2017

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ISBN 978-1-925569-43-8

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Executive Summary

The Joint Investigation Response Team (JIRT) is a tri-agency program in NSW – delivered by the Department of Family and Community Services, the NSW Police Force and NSW Health. JIRT provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have suffered sexual abuse, serious physical abuse or extreme neglect. The program has existed in one form or another for more than 20 years.

Our December 2012 report, Responding to child sexual abuse in Aboriginal communities, highlighted the fundamental challenges facing the JIRT program at that time.[1] The report made recommendations to strengthen accountability, data collection and case management systems, so as to facilitate better monitoring of and reporting on JIRT outcomes. We recommended enhanced resourcing of the JIRT program, and that a comprehensive review of the JIRT program be carried out. Although an internal review by JIRT partner agencies was conducted in 2006, the last major independent review of the JIRT program was undertaken in 2002. The need for an independent review has been strengthened by the ongoing consideration of the JIRT program and similar Australian models by the Royal Commission into Institutional Responses to Child Sexual Abuse.

Against this background, the JIRT agencies requested that the NSW Ombudsman's office conduct an independent review of the operation of the JIRT program. The review was to examine key areas of interagency success and challenges for the JIRT partnership; the performance of each partner agency in executing its role and responsibilities in the JIRT program; and whether the JIRT program is optimal, or alternative arrangements would be more effective.

At the time of commencing our inquiry the JIRT program was undergoing significant change; the future direction of several components was the subject of ongoing negotiation. The agencies recognised the value of having an independent body – with knowledge of the JIRT model and the systems underpinning it – conciliate a range of issues which had become contentious for the partnership. During this inquiry, we were able to work with the agencies to develop agreed positions on a number of core components of the JIRT model. These were ultimately reflected in a Joint Communication settled by the JIRT State-wide Management Group (SMG) in December 2016. A focus for our inquiry was therefore on ensuring future compliance with the important commitments contained in the SMG Communication and strengthening the overall governance of the program.

As we detail in Chapter 2, we employed a comprehensive methodology to inform our findings and recommendations. One of the most valuable sources of evidence was the JIRT workforce survey, with exceptionally high response rates from each agency, the insights it provided into operational practice were significant. We thank the JIRT workforce for their important contribution to our inquiry.

We also acknowledge the dedication and commitment shown by the members of the JIRT SMG and their respective management teams. They were responsible for providing us with their agency's evidence, ongoing advice and working to broker solutions throughout this inquiry.

Key achievements of the JIRT program

The JIRT program is one of the most significant interagency service delivery models in NSW. Its success is due in part to an ongoing process of review and reform, in response to the frequently changing context of its operation. Our observations and recommendations should be considered in this light.

To inform our inquiry, we commissioned the Australian Centre for Child Protection (ACCP) to undertake a comprehensive and up-to-date review of similar specialist and multi-disciplinary models for investigating and responding to child abuse in Australia and overseas. The ACCP's research confirmed that 'Compared to Australian and comparable international jurisdictions, the JIRT model represents a comprehensive, consistent and coherent state-wide strategy for structuring the cross-agency response to severe child abuse'.[2] This summation is supported by our examination of the evidence provided during our inquiry.

1 NSW Ombudsman, *Responding to Child Sexual Abuse in Aboriginal Communities, December 2012, Chapter 9.*

2 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office, Australian Centre for Child Protection, August 2017, section 2.1.*

To date, significant achievements and structural developments relating to the JIRT program include:

- The permanent establishment of the JIRT Referral Unit, which improved the quality and consistency of assessments compared to the previous de-centralised model and significantly expanded access to the program.
- The permanent establishment of the Bourke JIRT, which has delivered an improved service to Aboriginal children and families in Western NSW.
- The establishment by NSW Health of JIRT Health clinician positions, which has significantly improved its capacity to better meet its obligations under the partnership.
- Improved arrest and charge rates flowing from increased Police resourcing and improved productivity and accountability measures introduced following our review of the Child Abuse Squad in 2012.
- The implementation, led by FACS, of a shared JIRT database, which has strengthened joint case management across the JIRT program.
- Significant work to enhance access to the JIRT program for Aboriginal children and young people, leading to a sustained increase in referrals for this cohort.
- The development of the JIRT Local Contact Point Protocol to better coordinate and support agencies in responding to institutional child abuse and providing information to families. The protocol garnered praise from the Royal Commission and has been held out as an example of best practice for other jurisdictions.
- The ACCP research we commissioned found that, nationally, the NSW JIRT has the most comprehensive training and professional development programme supporting a multi-disciplinary response to child abuse.
- With the Department of Justice, the JIRT agencies (and in particular the NSW Police Force Child Abuse Squad) have played a critical role in implementing the Child Sexual Offence Evidence pilot. This has assisted a significant number of children to give their best evidence to police and the court, including children with disability who were outside the pilot sites.

Having regard to the considerable body of evidence we examined, and the research conducted by the ACCP, we recommend that the JIRT partner agencies should continue to jointly deliver and strengthen the JIRT program. However, we also identify a number of changes and improvements that, in our view, are necessary to secure the ongoing viability and effectiveness of the program into the future. These include changes to the program as a whole as well as the performance of individual partner agencies, as detailed in Part 4.

The JIRT Referral Unit – enhancing capacity and quality

The JIRT Referral Unit (JRU) has been the single entry point for the JIRT program since 2008. It is one of the most successful developments in the history of the JIRT program. The JRU was originally established on a trial basis to improve the quality and consistency of assessment decisions about reports referred to the JIRT program (previously, individual JIRT units had assessed incoming referrals). Our 2012 report recommended that the JRU be permanently funded – and the NSW Government subsequently agreed to do so.

The centralised assessment and decision-making role that the JRU performs is central to the overall effectiveness of the JIRT program, and is unique when compared to other Australian and international specialist and multi-disciplinary models of responding to child abuse. The JRU facilitates joint information gathering and analysis by all three agencies. It is one of the most effective examples of genuinely integrated interagency practice in NSW.

Our inquiry reveals the challenging environment that the JRU currently operates in. It receives around 9,000 referrals each year. Reports screened by the Helpline as requiring referral to the JRU have increased by almost 60% over the last eight years. This reflects increased demand on the child protection system in NSW more generally, but has not been accompanied by a corresponding increase

in JRU resourcing. Nor has the ongoing viability of the JRU's 'single decision-making table' structure been thoroughly examined. Increased demand on the JRU without an injection of additional resourcing and a realignment of the operating model will inevitably impact adversely on the quality of its decision-making.

Notwithstanding arrangements that exist for an operational response to urgent 'after-hours' reports, all reports are sent by the Helpline[3] to the JRU for a decision. This includes 'after-hours' reports that must be processed by the JRU on the next business day. JRU staff report that particularly on Mondays, this creates a substantial backlog of work that is often not cleared until Wednesday. Staff also spoke of the pressure resulting from a significant influx of reports late on Friday prior to the JRU's closure at 5pm. They observed that these reports at times lack sufficient detail, requiring the JRU to undertake more intensive information gathering than at other times.

To better equip the JRU to meet demand we recommend additional funding to enable a second interagency table of decision-makers at the JRU to be established. We recommend that the JRU's operating hours be significantly expanded to address the backlog created by its Monday to Friday, 9am to 5pm operating hours.

We also identify a range of ways that Helpline and JRU referral processes, and related data recording and monitoring issues, could be improved to create greater efficiency, transparency and quality of decision-making.

To complement the JIRT referral criteria, we recommend the development of a set of 'factors to consider' to inform professional judgement by the Helpline and JRU.[4] These factors could include a child or young person's child protection and/or criminal history; emerging patterns relating to disclosures or evidence of abuse (including 'non-contact' sexual abuse and behaviours indicative of grooming offences); and whether a victim has been re-reported (involving the same or different persons of interest). In our view, the absence of a transparent and documented mandate for JRU/Helpline decision-making increases the risk of inconsistency and is more likely to leave its professional judgement open to question.

We recommend that the 'JIRT rejected' category be rebranded as 'referred for local resolution'. This emphasises the need for joined-up responses regardless of whether a matter is handled through the JIRT program.

Finally, we make recommendations about how the Helpline and JRU should handle reports involving strangulation. Strangulation reports have been a contentious issue for the JIRT program in recent times. Since there may be no apparent injuries at the time of the report, and no other corroborating information, a referral may be rejected for a JIRT response. Health put forward the view that strangulation reports should be accepted for a JIRT response because of the serious clinical risks for the child and the need to arrange and coordinate urgent medical assessment and treatment. Health proposed that all reports of strangulation of a child made to the Helpline be automatically referred to and monitored by the JRU until the results of a skilled forensically-oriented medical evaluation is known. We support Health's position, based on our assessment of the clinical advice it presented and the risks associated with the Helpline/JRU making determinations without the benefit of supporting medical evidence.

Strengthening responses to particularly vulnerable children and young people

Our inquiry focused strongly on improving access to the JIRT program for particularly vulnerable cohorts of children, including Aboriginal children, children with disability, children from culturally and linguistically diverse backgrounds, and children in out-of-home care (OOHC). These children are at increased risk of sexual abuse and/or face significant challenges in disclosing abuse.

The JIRT referral criteria have not changed for many years, apart from trial amendments to the physical abuse referral criteria. Over time there has been a significant increase in the number of reports referred to the JIRT program. Currently, too much of the JRU's time is taken up in assessing

3 Or 'decentralised' Helpline models, such as those operating in the Central Coast District (CC-MARC) and Western Sydney District (Macarthur Intake and Referral Service).

4 See section 9.1.

certain types of matters that could be adequately responded to at a local level, outside of the JIRT program. The JRU's capacity could be boosted, and the JIRT program could focus its limited resources on responding to the most vulnerable children and young people, if the referral criteria were amended, on a trial basis initially. We recommend that, in the absence of other clear risk factors, the criteria no longer require automatic referral to the JRU of sexual abuse reports that involve young people over the age of 16, Aboriginal young people and/or adolescent peer sex. In 2016, adolescent peer sex matters alone made up as many as 1,000 referrals to the JRU in 2016.

The research clearly indicates that children and young people with cognitive impairment and/or other communication support needs, and those placed in residential OOHC, are at elevated risk of sexual assault. They also face particular challenges in disclosing abuse and receiving an appropriate response. Against this background, we recommend that the JIRT referral criteria be expanded to require reports involving these cohorts in the following two circumstances: where there is no clear disclosure of sexual abuse but there is reason to believe there may be barriers to the child or young person making a disclosure; and/or information that suggests behavioural changes or other indicators of abuse.

The progress made by the JIRT agencies over the past decade in implementing measures to improve the response to Aboriginal children and young people is impressive. The measures include more flexible assessment processes for sexual abuse reports involving Aboriginal children; guidelines for JIRT units to use in engaging with the Aboriginal communities in their local area; and new Aboriginal cultural consultation protocols. However, the steps taken to ensure that children and young people from other vulnerable groups receive a high quality response have been more piecemeal. The responses to the JIRT workforce survey indicate that there is a particular need to focus on improving the quality of the response provided to children with disability, and children in OOHC.

Importantly, our inquiry found that there is limited information about the outcome of JIRT referrals involving children and young people across all these vulnerable cohorts (including Aboriginal children), and how the outcomes compare to those for children generally. We recommend that the JIRT agencies ensure that data about outcomes facilitated by the JIRT program is disaggregated by each of these vulnerable groups, and that it is actively monitored. This will support the agencies to assess the efficacy of existing initiatives and develop more tailored responses when required. In this regard, the JIRT agencies have already taken steps, in response to the work of the Royal Commission, to improve their data in relation to children in OOHC; however, this is still in the early stages.

Staff from across the JIRT agencies also identified a need for further training in how to respond to matters involving particularly vulnerable cohorts of children. We recommend that the JIRT agencies work with relevant stakeholders to review and enhance the training and guidance provided to staff about identifying and responding to reports involving each of these vulnerable groups. We also recommend that the Child Abuse Squad (CAS) review the specialist interview training provided to police officers to ensure it includes adequate guidance on interviewing particularly vulnerable cohorts of children.

We have identified other opportunities to strengthen the JIRT response to vulnerable groups by leveraging off the relationships that each agency has built with the communities they serve, through the agency's local service 'outlet' (respectively, Community Service Centres, Local Area Commands and Local Health Districts). The JIRT response is largely reactive; whereas the local agencies are well placed to establish strong relationships with their communities that will ideally help encourage people to feel safe in coming forward to report abuse. In this way, local agencies can be an initial point of contact and can act as conduits for the JIRT program in delivering messages about what to expect from a JIRT response. We profile some of the excellent work carried out by all three agencies in building relationships with local communities in Part 5.

Improving the response to children and young people with harmful sexual behaviours

While the primary focus of the JIRT program is on the child victim, each of the JIRT agencies also has a strong mandate to work with children and young people (aged ten years and over) who come to their attention through the JIRT program due to their harmful sexual behaviours towards other children.

The need for a well coordinated therapeutic response for children and young people who engage in harmful sexual behaviour was identified as a key concern by each agency, by around one third of all respondents to the JIRT workforce survey, and by a number of other stakeholder groups that we consulted. In particular, frontline staff expressed frustration about the limited availability of therapeutic services for this cohort. Examples are the absence of Health's New Street program in some parts of the state, and the limited capacity of existing New Street and other services to accept new referrals. Concerns were also raised about gaps in the current service system for young people who are the subject of charges. Many services cannot be accessed while criminal proceedings are pending, which can leave children and young people without access to services for a lengthy period of time.

Our 2012 audit report identified an urgent need for NSW to review its arrangements for providing therapeutic treatment for children and young people with harmful sexual behaviours. We drew attention to a therapeutic scheme that had just commenced in Victoria at that time. We recommended that all agencies and services with responsibilities in this area come together to consider creating a cohesive legislative and policy framework. It would explicitly set out the respective roles of police, child protection, accommodation providers, and support agencies and treatment services, in supporting effective treatment strategies – including the use of treatment orders. While there was support for the recommendation, it was not substantially progressed.

While there have been some changes since our 2012 report, the same gaps and risks essentially remain. We once again recommend that the JIRT partner agencies, together with other key stakeholders, develop an integrated service response framework for children and young people with harmful sexual behaviours. This would address a number of structural issues in the current service system. Importantly, it would enable therapeutic support to be immediately provided to a child or young person, irrespective of criminal charge, and for that treatment to continue after the expiry of any sentencing.

The work of the Royal Commission has put the spotlight back on the issue of young people who engage in harmful sexual behaviours, particularly in the context of residential OOHC and other institutional settings. The NSW Government has advised the Royal Commission that it supports consideration of rehabilitative sentencing options for children who sexually harm their peers, and will further consider this issue in responding to the Royal Commission's final report.[5]

We have also highlighted the need for improved training and guidance for JIRT staff in responding to reports that involve sibling sexual abuse. We make a range of practice suggestions aimed at improving the JIRT response to referrals of this kind.

Establishing a Child and Family Advocate role within the JIRT program

At the outset of our inquiry, the JIRT agencies indicated that, while they were of the view that the JIRT model compared favourably to similar models here and overseas, there would be merit in examining how a stronger advocacy component could be embedded within the model.

We arranged to visit Western Australia with the JIRT agencies to gain a practical understanding of the Child and Family Advocate role operating out of the George Jones Child Advocacy Centre. We considered how the role could be potentially adapted for the NSW JIRT context.

The visit confirmed the value of the Child and Family Advocate role, as did the research we commissioned from the Australian Centre for Child Protection. The research found that the most effective multi-disciplinary team responses to child abuse incorporate advocacy services, and that consideration should be given to incorporating the core functions of Child and Family Advocates into the JIRT program.[6]

There are a number of ways that the addition of a Child and Family Advocate could strengthen the existing service response provided through the JIRT program. The Royal Commission has heard evidence about the distress families experience due to the absence of a primary contact person who could provide information and updates on the status of their child's case throughout the process.

5 NSW Government, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse *Consultation Paper – Criminal Justice, October 2016, p.22.*

6 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office, Australian Centre for Child Protection, August 2017, section 3.1.*

In our view, an advocate could play this role. Free of the core investigation, care and protection, and medical and therapeutic responsibilities facing frontline JIRT staff, an advocate could provide a stronger focus on addressing the child and their family's holistic support needs, and on strengthening follow up and coordination of services after early engagement with the JIRT program. Advocacy, while of benefit to children and their families generally, is likely to particularly benefit vulnerable groups of children and young people who are accepted into the JIRT program, such as Aboriginal children and children with disability.

We recommended that the agencies trial the establishment of a Child and Family Advocate role within the JIRT program. The stakeholders we have consulted, together with the JIRT partner agencies, all support such a trial taking place. In suggesting a trial, we cautioned that an Advocate will need to be used judiciously. We envisage the Advocate playing a minor role in many cases where there are no ongoing support needs (other than health needs) or where children and young people and their families do not want ongoing advocacy support. We also recommend that, if the trial proves successful and the role is implemented more widely, there would be merit in designating a certain number of the Child and Family Advocate positions as 'Aboriginal'.

Legislative issues and potential law reform

The terms of reference for this inquiry require that we consider any legislative issues that impact on the operational response of the JIRT program, as well as law reform options for improving the systemic response to victims of criminal child abuse.

The Child Sexual Assault Evidence Pilot – witness intermediaries and expansion of pre-recorded evidence

In NSW, a number of special measures have been in place for some time to support children and vulnerable witnesses to give evidence in criminal proceedings. Examples are the pre-recording of a child's evidence, evidence being given by closed circuit television, and the presence of a support person when giving evidence. These special measures aim to reduce attrition from the criminal justice system – as such, they are directly relevant to a review of the JIRT program.

Our 2012 audit report recommended that consideration be given to the following two matters: allowing a child's entire evidence to be pre-recorded in certain sexual assault proceedings; and the viability of establishing a registered intermediary scheme to facilitate enhanced communication between vulnerable witnesses and police or the court. In response, a three-year Child Sexual Offence Evidence Pilot commenced in March 2016 in the Downing Centre (Sydney) and Newcastle District Courts (including proceedings commenced by the CAS in the Bankstown, Kogarah, Chatswood and Newcastle JIRT locations). The pilot involves the use of witness intermediaries as well as an expansion of the use of pre-recorded child evidence in court proceedings for prescribed sex offences.

The CAS has worked closely with the Department of Justice in the implementation of the pilot. Between the start of the pilot and 31 January 2017, just over 600 children and young people were referred to the intermediary scheme; of those, 90% were matched to an intermediary who was able to assess the child prior to a recorded criminal interview, and/or make an assessment of the child for the court. Importantly, the pilot has included children with disability from non-pilot locations, due to their particular vulnerability.

We received overwhelmingly positive feedback about the benefits of the intermediary scheme, with strong support from police. The Office of the Director of Public Prosecutions (ODPP) also indicated that the small number of matters that have progressed through the pilot, suggests that the use of intermediaries has significantly improved the court process for child victims, and the quality of the evidence they have given. While the pilot is still in its early days, the feedback suggests that it is contributing to improved communication, police evidence gathering, and the ability of the JIRT response to better meet the needs of children.

The CAS also observed that the intermediary scheme, together with the use of pre-recorded child evidence, are beneficial as they compress the timeframe from the initial report through to the recorded criminal interview, and then any court proceedings that ensue. Minimising the time taken for matters to proceed through the criminal justice system has significant potential benefits both to minimising the impact of proceedings on children and young people, and reducing attrition from the criminal justice system.

In the longer term, we believe there is value in the scheme being implemented state-wide. Consideration should also be given to expanding the scheme to include other vulnerable cohorts, including adults with cognitive impairment and other communication support needs. An independent evaluation of the pilot is currently underway and the Department of Justice has indicated that it will provide a copy of our report to the evaluation team for its consideration.

In the meantime, we recommend some practical changes to the process by which the CAS currently engages witness intermediaries. CAS should share information with and consider information from FACS and Health JIRT staff before requesting an intermediary. CAS should also defer interviewing a child until an intermediary is available, unless satisfied that the child has no communication needs that would warrant the use of an intermediary, or there are exceptional reasons why the interview cannot be deferred.

Broader issues impacting on the effectiveness of the criminal justice response to child abuse

A number of additional legislative issues were raised during our inquiry. One relates to the operation of the information exchange provisions in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*. Those provisions can impede the effective exchange of interstate information, with a particular impact on the operation of the JIRT in 'border towns'. There is also a need to expand the reach of the Chapter 16A information sharing provisions to include organisations that exercise management responsibilities in respect of prescribed bodies, so as to enable those organisations to readily receive and disclose child protection-related information. An example is religious organisations such as Catholic dioceses.

We have provided our views on these issues to the Royal Commission to inform its consideration of information sharing in its final report.

As in our 2012 audit report, this report supports a presumption of joint trials for sexual assault prosecutions. This would facilitate greater admissibility of tendency and coincidence evidence. We also support a review of s 66EA of the *Crimes Act 1900* (NSW), with respect to the offence of persistent sexual abuse of a child. Both issues are being considered by the Royal Commission, and we have conveyed our views to the Commission.

Police raised concerns during this inquiry about the adequacy of existing offences in NSW for dealing with matters involving the serious criminal neglect of children. Police argued that the available neglect offences are not appropriate in all circumstances and it can be difficult to prove each element of the offences beyond reasonable doubt. They suggest an additional offence – modelled on a Western Australian provision – and have made a detailed submission to the relevant Ministers. We welcome consideration of an offence of this type, and understand that the Police submission is currently being considered by the Department of Justice.

We also revisited the recommendations in our 2012 report for a 'similar age defence' in relation to adolescent sexual activity between children of a similar age. Currently, police have an obligation to investigate all reports involving sexual activity by children under 16 years of age, irrespective of the circumstances. The JIRT partner agencies raised a concern during this inquiry about the adverse impact of a police response to reports of adolescent peer sex where there is no evidence of coercion. Police involvement can cause further trauma, it may damage the relationship between the adolescents involved, and may inhibit their engagement with agencies that could provide them with valuable supports, such as sexual health checks.

There are four Australian jurisdictions, as well as other international examples, that currently have a defence of similar age. While reform in this area is controversial, we share the concerns of the JIRT agencies and adhere to our view that an appropriately constructed similar age defence would be of benefit in NSW.

The performance of the individual JIRT agencies

Our inquiry terms of reference require us to examine whether each JIRT partner agency is meeting its operational responsibilities and complying with relevant policies and procedures; whether agencies adequately resource their JIRT obligations; and whether agencies appropriately monitor and measure JIRT performance. Our observations and recommendations are detailed in Part 4.

NSW Police Force

In assessing Police performance, we compared the findings from this inquiry with our 2012 review of the Child Abuse Squad. That review was conducted during our three year legislated audit into Aboriginal child sexual abuse.

Our 2012 report recommended that CAS resourcing be enhanced so that it could respond effectively to the increased number of matters that were being accepted by the JIRT program. We also stressed that an injection of resources alone would not lift the performance of the CAS, and recommended that any additional resourcing be accompanied by strengthened accountability mechanisms to drive ongoing performance improvements. The former CAS Commander put a number of strategies in place to improve the supervision and reporting processes for individual CAS teams, which the current Commander has continued to build on to strong effect.

The results achieved by CAS over the last five years are impressive. As a proportion of JIRT referrals, the number of arrests by CAS was higher in 2016 than at any previous time; overall, the number of arrests almost doubled between 2010 and 2016. CAS reports that conviction rates in matters referred to the JIRT program are on the increase, as are the use of apprehended violence orders (AVOs) and covert investigative measures.

A suite of criminal justice reforms has also been introduced in response to our 2012 audit report. The most noteworthy of these are the pre-recording of children's cross-examination, and the use of witness intermediaries to enable children to give 'their best evidence' as part of the Child Sexual Offence Evidence Pilot. CAS's efforts in working closely with the Department of Justice to implement the pilot are commendable.

Notwithstanding these significant achievements of the last five years, this inquiry has identified scope for CAS's operations to be further refined.

Criminal Justice case studies published by the Royal Commission have highlighted areas of practice where the Police response to child abuse could be strengthened. Examples are interviewing techniques and responding more effectively to particularly vulnerable cohorts of children (including those with a disability). We detail the steps taken by CAS during this inquiry to enhance its interviewing practice and related training in Chapter 22.

From an accountability perspective, we believe there is potential for the CAS to enhance its reporting capabilities to allow it to more meaningfully report on the outcomes it is achieving for individual children accepted into the JIRT program. This is particularly important given the limitations of the publicly available criminal incident and court data for child abuse. In our view, the available data does not adequately reflect CAS (or Local Area Command) productivity in relation to its response to criminal child abuse allegations.

We also recommend a review of the current chain of command under which the CAS operates. There has been significant growth of the squad over recent years and an expansive set of responsibilities now falls on a single Commander. This review could also consider a transfer to CAS of the child-abuse related functions and related resources that currently sit within the Sex Crimes Squad, including the Child Protection Register and Child Exploitation Internet Unit. While this is ultimately an operational matter for the Police executive, bringing all major crime functions relating to child abuse under the one umbrella would appear to have benefits. This could enhance the scope for joint strategic planning and operational tasking across related business units.

More broadly, we discuss whether there is scope for specialist officers in CAS to have broader responsibility for providing advice and investigative support to Local Area Commands (LACs). This could improve the response to vulnerable adults with cognitive impairment or other communication support needs who come in contact with the criminal justice system. It would utilise CAS's experience in working with witness intermediaries when conducting interviews.

Another important issue in this inquiry was the extent to which LACs are involved in delivering the first response to reported child abuse and allegations of criminal child abuse that fall outside the JIRT program. LACs handled almost 2,000 reports in 2016 that were referred to the JRU but rejected for a JIRT response. They also handle a large number of other serious child abuse reports that, for various reasons, do not meet the JIRT referral criteria or which the JRU decides LACs should retain due to their 'prior involvement'. LACs also investigate almost all historical child sexual abuse reports made by adults. We discuss the potential for LACs to play a greater role in certain types of matters currently investigated by the CAS, and identify areas where LACs could be better supported to do so.

Finally, we recommend that Police examine how it can strengthen its operational crime reporting processes in response to child abuse, and in doing so, appropriately distinguish the work of the CAS from LACs. This recommendation is timely against the background of the Royal Commission's observations in its 2016 Criminal Justice paper about the need to strengthen the response when victims first report abuse to police – that is, at their 'point of entry' to the criminal justice system.

Family and Community Services

FACS's contribution to the JIRT program is one of the stronger components of its overall statutory child protection response. The FACS arm of the JIRT program has attracted highly skilled and experienced staff, and has had greater success in retaining frontline staff than other parts of FACS. Notwithstanding significant resource limitations, FACS JIRT has maintained high face-to-face response rates to child protection reports, when compared to the child protection system more broadly.

Staff from all three JIRT agencies responding to the workforce survey viewed the statutory child protection role played by FACS as essential to achieving quality safety and wellbeing outcomes for children and young people referred to the JIRT program. Irrespective of whether a JIRT referral results in criminal charges, FACS's broad mandate requires that it assess the allegations giving rise to the referral as well as the overall circumstances of the child or young person the subject of the JIRT referral. FACS is thereby able to take a range of protective actions in circumstances where there is insufficient evidence of weight that abuse has occurred, or police are unable to make an arrest.

FACS has taken steps over recent years to strengthen its casework practice and training and mentoring of the FACS JIRT workforce. FACS has also made significant contributions to the effective functioning of the JIRT partnership as a whole – most notably, the funding, development and ongoing management of the JIRT database and, more recently, the development of the ChildStory database, which it is hoped, will provide a more efficient and seamless solution to the agencies' joint case management needs.

In the latter part of our inquiry it was announced in the NSW Budget for 2017-18 that FACS would receive a significant injection of funding, allowing it to increase its JIRT resourcing by 52% over the next two years. We have urged an increase in FACS JIRT resourcing since our 2012 report. Over this period there was a significant injection of additional resources for CAS, which made it harder for the FACS JIRT staff to 'keep up' with their police counterparts. The impact of FACS resourcing constraints was particularly acute when there was a need for its staff to provide an urgent or after-hours joint response. Accordingly, we welcome this enhanced resourcing.

Going forward, the additional resourcing must (as noted above in relation to CAS) be accompanied by strong accountability mechanisms to drive the agency's JIRT performance. FACS recognises this and has advised us that it is strengthening its performance measures having regard to the observations in this report.

While a number of performance indicators developed by FACS JIRT over recent years are valuable, they do not provide a complete picture of the performance of individual JIRT units, or of FACS JIRT as a whole. We recommend that FACS should decide which performance and productivity indicators

it will include in the overall JIRT Performance Monitoring and Reporting Framework and develop a timeframe for reporting against these indicators. As well, FACS should decide the additional indicators it will use for internal monitoring and reporting purposes.

Our inquiry has identified that FACS should also strengthen its governance and accountability processes to track its JIRT performance. In this regard, we recommend that FACS implement a business review process on a six-monthly basis for its JIRT managers, overseen by the Executive Director State-wide Services and the JIRT Directors. This would better enable comprehensive analysis in a group setting of key output and outcome measures (similar to the CAS team development review process). We also recommend that this process be complemented by periodic case reviews of JIRT matters by FACS's Office of the Senior Practitioner to assess the quality of casework practice. In addition, we recommend that FACS consider how to better integrate reporting of its role in the JIRT program with its existing FACS Quarterly Business Review process (or a separate robust process) to ensure sufficient accountability processes for FACS JIRT at a senior executive level.

FACS should also ensure that any injection of new resources delivers tangible results where they are most needed. Gaps in service provision currently exist as a result of CSCs being unable at times, due to competing demands, to adequately respond to reports transferred by FACS JIRT. We recommend that FACS develop a proposal for determining the most effective way to deploy these new resources, with particular consideration being given to developing a FACS JIRT after-hours service, and exploring how FACS JIRT can better support CSCs in responding to matters that are referred for further child protection casework. For example, there is a need for a more flexible approach to transferring JIRT matters to CSCs for a further response, if a CSC is not immediately able to allocate the matter.

During the inquiry we also examined FACS's practice for making person causing harm (PCH) determinations. While all referrals accepted by the JIRT program are assessed as involving criminal allegations of child abuse, only one fifth of referrals will in practice involve a criminal prosecution. The police investigation of a JIRT matter may intersect with a FACS assessment of whether to make a PCH determination. It is critical that FACS and Police liaise closely with each other about the nature of any contact with the individual so as not to compromise the police investigation or child protection response.

FACS agreed to make adjustments to its practices for making PCH determinations after we raised a number of issues to do with the adequacy of its current guidance (as detailed in Chapter 11). We recommend that, in consultation with Police and our office, FACS should update its PCH practice mandate to reflect when and how it will confer with police before conducting PCH interviews, and related escalation processes. We also note that it will be critical for clear advice to be given to FACS staff about informing individuals of their PCH status once criminal proceedings have been finalised (particularly where the individual is not convicted and they remain unaware of their PCH record). This will enable the person to consider seeking a review of the determination. It is important that FACS's existing procedural fairness requirements also continue to be observed even though charges have not been laid or there is no ongoing criminal investigation. We also recommend that additional safeguards be put in place FACS-wide when PCH determinations are made in relation to children under the age of 16 years, including elevating the level of decision-making to bring it in line with FACS JIRT practice.

NSW Health

Health contributes to the JIRT program in two ways. One is through its JIRT health clinician workforce, who participate in assessment, planning and decision-making processes, and provide direct services (for example, crisis counselling) to clients in the period immediately after a JIRT referral. The other is through the work of its specialist health services, which may provide support, assessment, treatment and/or therapy to JIRT clients and their families past the crisis stage over a lengthy period of time. The role of JIRT health clinicians in coordinating access to ongoing health care is complex due to the variation of service delivery across the 15 local area health districts (LHDs), and the flexibility that health districts have in meeting local client and community need.

Health's positive contribution to the JIRT program is reflected in comments in the JIRT workforce survey from all three JIRT agencies. Many people commented that Health is performing well in advocating the health and wellbeing needs of children and families.

Health has been more closely involved in the JIRT program since becoming a formal partner in 2006. Since then, it has moved closer to the centre of JIRT operations with the introduction of three Health workers at the JRU in August 2008 and an initial JIRT health clinician workforce of 25 positions in 2010-2011 that has almost doubled to the current number of 48.5 positions. Despite a significant investment by Health in expanding its JIRT workforce, JIRT health clinicians in the field are outflanked by the significantly greater numbers of police and FACS officers on the ground – we discuss the practical impact of the disparity of JIRT resourcing across all three agencies in Part 7.

Our 2012 audit of Aboriginal child sexual abuse closely examined the role and capacity of Health in delivering critical counselling and forensic services to children and young people who have been abused; we made recommendations for improvement. In this inquiry we have been able to compare progress by Health five years on, and pleasingly, while further refinements are needed, the progress made has been substantial. This work initially took place under the former statutory health corporation, NSW Kids and Families. During the past two years, the Director, Prevention and Response to Violence, Abuse and Neglect (PARVAN) in the Ministry of Health has been responsible for leading Health's strategic and policy direction for the JIRT program.

Health has acknowledged that challenges remain in monitoring and meeting the demand for its counselling services. At the time of our 2012 audit report, a number of comprehensive reviews of the capacity of sexual assault counselling services each found that the demand for services significantly outstripped supply. There is significant demand for services across the health system as a whole, and the available data does not support a clear business case for an increase in the budget of the sexual assault services (SAS), which is the primary provider of specialist counselling services in NSW. In this regard, Health should be commended for its significant investment in the development of a new shared data system linking SASs and the JIRT Health program, which became operational on 1 July 2017. Health has recently advised that funding for frontline sexual assault counselling positions has still not been enhanced.

Health has managed to maintain a broad organisational involvement in responding to children and families who come into contact with the JIRT program. Its capacity to do this work has been strengthened in the 2017-18 State Budget by the allocation of an additional $10 million in recurrent funding to improve Health services that respond to victims of violence, abuse and neglect. Health has advised that this funding will enable the Ministry of Health to work collectively and individually with LHDs and the Sydney Children's Hospitals Network (SCHN) on clinical redesign and system reforms of specialist Health services that respond to child abuse and neglect, sexual assault, and domestic and family violence. The funding will also enable LHDs and SCHN to employ additional clinical staff to fill critical service gaps, and enable SCHN to increase its state-wide clinical leadership of the New Street Services – Health's treatment program for children and young people with harmful sexual behaviour. The funding boost is a significant and welcome development.

Since our 2012 report, Health has also shown strong leadership and injected additional funds to support better access to medical forensic examinations for sexual assault and physical abuse and neglect in rural and remote areas. Of note, Far West LHD has significantly increased the proportion of Aboriginal clients referred to its SAS for forensic examinations; and Hunter New England LHD has managed to double the proportion of clients receiving a forensic examination within four hours, at the same time as decreasing the proportion of clients waiting more than 72 hours. At the time of our 2012 report, we noted the lack of reliable data about the number of forensic examinations conducted on children each year, and the period of time between the alleged incident and the forensic examination, given how far child victims often had to travel to undergo a forensic examination due to the unavailability of suitable practitioners near to where they live.

Our 2012 report was also critical of the large number of Health policies that applied to counselling, forensic procedures and medical examinations, and that many of these policies were out of date and inconsistent. Since then, Health has made considerable progress in developing, revising and consolidating policies relevant to the work of the JIRT program, although a number remain in draft form. Health has advised us that finalising the consolidated policies is a high priority and they expect to do this by July 2018. It is essential that this occurs, and that Health develops specific guidance in relation to the provision of forensic services to children under 14 years – a key policy gap that remains unaddressed.

The Ministry also funds the NSW Health Education Centre Against Violence (ECAV) to produce a range of impressive resources and training courses to JIRT staff in the three partner agencies, other health practitioners, other government agencies, the NGO sector and the community. And as we outline in Chapter 13, ECAV has continued to demonstrate outstanding leadership in building workforce capacity in the Aboriginal Specialist Violence, Abuse and Neglect, Health and NGO sectors.

At the outset of this inquiry Health acknowledged that its devolved and complex organisational structure presents considerable internal governance challenges for the JIRT program. As a result, Health has proposed a number of initiatives, to strengthen its internal governance and accountability arrangements (that we discuss in Chapter 12). We also outline the data currently available within Health to enable performance monitoring of its obligations under the JIRT program, consider Health's proposals to strengthen its data collection, and discuss the need for key health outcome data to feed into the shared JIRT agency database. While the effectiveness of the proposed governance arrangements are yet to be seen, Health's efforts during this inquiry to examine how it can strengthen accountability across its organisation for delivering its JIRT response are commendable.

Addressing key operational issues across the JIRT partnership

At the outset of our inquiry, the JIRT agencies flagged a number of contentious operational issues for the partnership and indicated their keenness for the inquiry to resolve them. Through conciliation, agreements were reached and positions settled in relation to child interviewing; JIRT accommodation; joint training; and the implementation of the local planning and response process. These agreements were ultimately reflected in a Joint Communication – released by the SMG in December 2016. (During the inquiry, our office separately resolved issues relating to the implementation of the JIRT Local Contact Point Protocol.)

We have emphasised to the agencies that it is now critical for the agreements to be well executed in the field. This will require strong leadership on the part of the JIRT State-wide Management Group (SMG) and at the executive governance level of the partnership.

Co-location

Most JIRT sites across the state are at least partly co-located. Our survey of the JIRT workforce indicated that many JIRT staff view co-location as being central to JIRT's success. We also consider it to be an important characteristic of the JIRT model.

When we commenced our inquiry there was uncertainty about whether the Child Abuse Squad intended to move away from the present model of co-location, having closed its offices in certain sites. This was causing considerable concern for FACS and Health staff, particularly as other significant changes to JIRT practice were unfolding at the time.

The CAS advised us that it had made a decision to consolidate its premises in the Sydney metropolitan area largely due to operational and budgetary issues informed by a broader human resources review conducted by the Police executive. A key rationale for consolidation was that economies of scale better enabled the Police to cover vacant positions or temporary staff absences across CAS – a particular necessity given the significant amount of maternity leave in the squad, and the need to share resources such as police vehicles. In addition, CAS highlighted that co-location can make it difficult for police to comply with legal and operational requirements when using covert methods of investigation (for example, surveillance devices or telecommunications interception) and to maintain confidentiality and information security within an integrated workspace.

During our visit with JIRT agency representatives to the George Jones Centre facilities in Western Australia, we were able to hear first hand from practitioners about changes they were making to their co-located accommodation. The police involved in the Multi-Agency Investigation and Support Team (MIST) spoke about their desire to continue working in the same building as their child protection and NGO MIST colleagues, but also stressed the need to have a separate, dedicated space for police to discuss sensitive operational issues. This need – for both shared and separate work spaces – was supported by the non-police members of MIST. The visit provided us with the opportunity to facilitate discussions with the SMG, which resulted in a common position being reached on issues relating to co-location. This position was subsequently reflected in the December 2016 SMG Communication.

The SMG agreed that 'future accommodation should preferably be located in the same building, ideally on the same floor, or at least within close proximity', and affirmed its commitment to interview, monitor, family and meeting rooms remaining available for use by each agency at relevant points of the JIRT process.

We recommended a set of considerations be developed to guide future accommodation decisions, and that agencies should consult each other at the earliest possible stage about any proposed changes to accommodation arrangements to allow the other agencies to concurrently plan for any impact on their own accommodation needs. We also supported Health's suggestion that the agencies review the impact of changed accommodation arrangements on service delivery after a reasonable period, and if necessary, jointly devise strategies for minimising any adverse impacts identified.

Local Planning and Response (LPR)

The Local Planning and Response (LPR) process is the structured process used by the JIRT partner agencies to facilitate a coordinated, tri-agency response to referrals that have been accepted by the JRU. Two areas of concern identified at the outset of this inquiry were compliance with the LPR, and the extent to which LPR procedures reflect the current operating environment.

CAS highlighted that the urgent evidence-gathering requirements associated with some JIRT referrals, combined with the difficulty for the JIRT arms of FACS and Health to 'match' the after-hours workforce capacity of police, meant that it is not always appropriate or possible to implement the LPR as prescribed. Conversely, FACS and Health argued that while they appreciate the need for police to take a range of urgent criminal investigative actions when a report of serious child abuse is made (such as crime scene evidence collection, taking out AVOs etc), there are certain aspects of the investigation that are now occurring too quickly to enable them to participate in the process or provide input into the approach. An example is the child's recorded criminal interview.

There is no question that, at a conceptual and practical level, the LPR lies at the heart of the JIRT program. Without it, the JIRT program would cease to embody the model of 'shared responsibility' for the safety, welfare and wellbeing of children and young people that was envisaged by the Wood Inquiry and has been endorsed by successive NSW governments. A challenge for the JIRT agencies is to balance responsiveness to the individual needs and situation of the child with the requirement to execute a timely response.

The JIRT workforce survey revealed that the LPR appears to be adequately functioning in most areas, most of the time. However, it is clear that there are several issues that need to be promptly addressed by the partner agencies to ensure that the LPR has sufficient structure as well as flexibility to operate with maximum effectiveness to achieve the intended purpose of a coordinated JIRT response. The survey also pointed to a need for effective escalation processes to be in place.

Strengthening and monitoring compliance with the LPR should be a key priority for the partner agencies. We recommend that the partner agencies collect, monitor and record data about concerns relating to LPR compliance, and systematically capture information in relation to disputes with key aspects of the LPR process and their resolution. Data about dispute resolution should be tracked locally and state-wide by JIRT Local Management Groups and the SMG, and reflected as a specific indicator in the JIRT Performance Monitoring and Reporting Framework.

Our consultations with the SMG have confirmed their commitment to the LPR process as reflected by the statement in the December 2016 SMG Communication that: 'the LPR is the basis for a quality, coordinated and planned response to allegations of child abuse'.

It is essential that the *Local Planning and Response Procedures* are revised and updated to reflect current operational practice and provide greater clarity and accountability. In particular, we recommend that more detailed, practical guidance be provided for frontline JIRT staff on a number of matters. These include the role that each agency should have in interview planning; mobilising tri-agency responses to urgent and/or after-hours referrals; and the responsibilities of agencies at key junctures in the joined up response, for example, the timing and nature of FACS interviews with suspects when making 'person causing harm' determinations at the same time that criminal investigations are underway.

We also stress that the LPR procedures should clearly indicate that there will be circumstances when a more flexible approach to implementing the LPR will be required. The agencies should not focus on compliance with processes at the expense of a focus on achieving the purpose of the LPR. However, in suggesting greater flexibility, we also note that this should not be seen as cause for JIRT agency staff to routinely depart from the procedures.

Interviewing

When the JIRT program was established in 1997, interviews of children and young people were generally conducted jointly by Police and Community Services. The local managers of each agency jointly determined who would lead each interview, having regard to the circumstances of the individual matter.

In December 2015 the Commander of the Child Abuse Squad issued a directive to CAS officers indicating that police would solely conduct all recorded criminal interviews with children and young people in matters accepted by the JIRT program. The explanation was that CAS had received feedback from the ODPP and members of the judiciary that questioned why recorded criminal interviews were not necessarily being led by police officers. In essence, the views put forward by Police are that the risks associated with traversing care and protection issues in the pre-recorded evidence of a child about a criminal matter are appreciable; that police are best placed to ensure the integrity of a child's evidence in chief by controlling the way in which the interview is conducted; and that police have an implicit duty to do so as a result of their primary role to detect and investigate crime.

Since the directive was issued, the Royal Commission has confirmed its view that specialist police should undertake investigative interviews in child abuse matters. The Royal Commission's research has emphasised that considerable skill is needed to ensure that the interviewing methods do not reduce the reliability and credibility of a child's evidence at trial.[7] In particular, canvassing details not central to proving the criminal offence, or 'over particularisation' in relation to establishing the offence, can create inconsistencies in a child's evidence that may lead to extensive cross-examination and 'adversely affect the jury's view of the complainant's reliability and credibility'. It is for this reason that child interviewing in relation to criminal matters is a highly specialised skill. The research we commissioned from the Australian Centre for Child Protection confirmed that police officers now conduct the forensic child interview in the majority of jurisdictions in Australia.

There was significant tension between the partner agencies about this change in practice and how it was executed leading up to and during our inquiry. In particular, FACS and Health were concerned that the criminal investigation was being prioritised over other components of the JIRT response. During our inquiry and after conciliation with our office, the SMG resolved new arrangements for interviewing that were documented in its December 2016 Communication. It states that police are responsible for conducting recorded criminal interviews with victims and witnesses, but that this 'should in no way detract from the equally important, albeit separate functions, that FACS and Health perform in relation to assessing issues of safety, risk, health and wellbeing'.

Having considered the available evidence, and consulted members of the judiciary, the ODPP and the Royal Commission, we believe the reasons for police solely conducting the criminal interview are sound. Our focus during the inquiry was therefore on ensuring that the new arrangements are effectively executed.

A key outcome from our conciliation on interviewing practice was to secure an agreement that CAS, as a matter of best practice and in the interests of the child, will identify an appropriate point during interviews for a break to occur in order to consult with FACS and Health about any additional care or protection matters, or clinical issues that may have arisen. The introduction of a structured break during the recorded criminal interview is an important opportunity for FACS and Health to provide input at this stage of the JIRT process. This practice is recorded in the December 2016 SMG Communication.

We also recommend that local JIRT managers should escalate concerns to the SMG when interviewing practice is not being adhered to. As well, interview participation data should be collected, analysed, and reported on, to allow the SMG to identify those sites where the new arrangements are being well implemented, and where prompt action needs to be taken to address any problematic practice.

We also recommend that CAS revises its interview training course after considering the recommendations from this inquiry. CAS should consider adopting a similar approach to Victoria Police in conducting 'interview refresher training' informed by an ongoing program of reviewing CAS officer interview transcripts. We emphasise the importance of police having regard to relevant information provided by FACS and Health before and during the recorded criminal interviews, and we recommend that the Police Child Interviewing Course include guidance about the purpose of the structured interview break.

7 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, Royal Commission into Institutional Responses to Child Sexual abuse, *An evaluation of how evidence is elicited from complainants of child sexual abuse*, August 2016, p.45.

The change in interviewing practice should not be seen as a move away from the partnership or a 'green light' to work in silos. Rather, it presents JIRT practitioners with a new challenge that requires them to execute their respective roles in an integrated way while als o taking the lead at appropriate points. If this does not occur, the agencies risk fracturing their relationship and weakening the quality and reputation of the JIRT program.

Local Contact Point Protocol (LCPP)

The JIRT *Local Contact Point Protocol*, which was jointly developed by the JIRT partner agencies and released in March 2014, was a significant initiative to improve the JIRT program's response to reports of institutional child sexual abuse. Introduced in the wake of the Royal Commission's examination of the Jonathon Lord/ YMCA NSW matter, the objective of the LCPP is to provide clear operational guidelines for staff from the JIRT agencies, the Helpline, CSCs, and relevant stakeholders in communicating with parents, caregivers and other parties during a JIRT investigation of allegations of child abuse in an institutional setting.

At its public Roundtable on multi-disciplinary and specialist policing responses, the Royal Commission commended the JIRT partner agencies for their leadership in developing the LCPP. Other states, including Western Australia and Victoria, have indicated they will now consider developing similar protocols.

In operation for over three years, it is now timely for the LCPP to be updated. Our work in the employment-related child protection area has informed our views as to how the LCPP can be further strengthened. We found that there is scope to increase awareness of the protocol, particularly (but not limited to) the schools and early childhood sectors; to enhance aspects of the guidance the protocol provides to both JIRT staff and institutions; and to improve the monitoring of its application.

We also identified issues with the threshold for activation of the LCPP. This relies on a matter being JIRT accepted and there being sufficient evidence to indicate that further children are at risk or there is potential broader community concern. This means that historical allegations of child sexual abuse are not covered by the protocol because they are investigated by Local Area Commands. We recommend that the LCPP should be extended to include historical allegations of child sexual abuse, and that the role of LACs in liaising with institutions is specifically addressed in the protocol.

A significant issue which emerged just prior to our inquiry commencing was the question as to which entity is best placed to publicly release information in accordance with the LCPP. In June 2016, we hosted a Roundtable with privacy experts, lawyers and stakeholder agencies to consider what might constitute best practice in relation to the public release of personal information by agencies within our child-related employment jurisdiction.[8] Our Roundtable was prompted by a reportable conduct matter that involved a release of information to parents within 'an agency's community' in accordance with the LCPP, which subsequently led to the subject of the allegation commencing a defamation action.

We brokered an agreement at the Roundtable that, for any future applications of the LCPP, Police would prepare information for dissemination to an agency's community. We proposed this practice change because of the specific exclusion that Police have in privacy legislation from the legal constraints on disclosure of personal information that apply to other agencies. Police are not required to comply with the NSW Information and Privacy Principles, except in the exercise of administrative and educative functions. As well, Police are best placed to ensure that the disclosure promotes, rather than interferes with or compromises, any investigative or judicial process.

When timely disclosure cannot reasonably be made by Police, and FACS is discharging its investigative functions under its statutory child protection responsibilities, it may be appropriate for FACS to make the disclosure. FACS is an investigative agency for the purpose of privacy legislation and it can communicate specific information about a reportable conduct allegation to an agency's community, if this is required for the effective discharge of its complaint handling or investigative functions. Disclosure by FACS also helps avoid any child protection investigation being compromised.

We recommend that the JIRT agencies revise the protocol to take account of our observations and recommendations relating to the making of disclosures.

8 The LCPP is principally concerned with disclosures of information to parties who are not directly involved in a matter. This wider group includes agency staff and volunteer workers, parents or carers of other children receiving services from the agency, and in the case of historical allegations, former service receivers such as former students or adults who were in care as children.

Joint training

The research we commissioned from the Australian Centre for Child Protection found that NSW JIRT has the most comprehensive training and professional development programme supporting a multi-disciplinary response to child abuse in the nation.

While joint training has been a hallmark of the JIRT program for many years, at the outset of our inquiry there was a question mark about the ongoing delivery of certain aspects of the joint program. The future of the interviewing component in particular was flagged as an issue that the JIRT agencies were keen to resolve during the inquiry.

The adequacy of investigation and interview training for specialist police who respond to child abuse has been of considerable interest to the Royal Commission. Against this background, CAS advised the other JIRT agencies that the Joint Foundational Skills Program (JFSP) was no longer able to meet the needs of the NSW Police Force, including that it did not deliver instruction to the requisite standard for CAS investigators nor did it reflect the changes which see police now leading all recorded criminal interviews with children. CAS commenced delivering a Police-only Child Interviewing Course aimed at providing its officers with more specialised training. CAS withdrew its officers from the modules of the JFSP focusing on the JIRT investigative interviewing framework. However, CAS indicated that it continues to maintain a strong commitment to other aspects of the joint training program.

We facilitated a meeting with the partner agencies in November 2016 to discuss the issue of joint training. All agencies confirmed the value of maintaining an element of joint training for the JIRT workforce. While FACS and Health staff may not require the same detailed level of training about criminal investigation and interviewing techniques, they still require a comprehensive understanding of this aspect of the JIRT program's response to perform their interview monitoring role effectively. Equally, it is important that police officers understand the obligations of FACS and Health to assess and respond to a child's safety, wellbeing and therapeutic needs.

As a result of the meeting, the agencies agreed that the JIRT Statewide Training Subcommittee should review the structure of the JFSP and consider how the course content and delivery could be refined to better meet joint training needs about core areas of practice. In doing so, the agencies identified a need to consider ways of providing more dynamic and effective scenario-based training that demonstrates the separate yet interconnected role of each agency in planning and executing a 'JIRT response'.

While accepting that CAS has developed its own separate child interviewing course, we recommend that the JFSP should be amended to include an additional day-long joint session, rather than the proposed one-hour session. This would give both FACS and Police officers a practical understanding of the new interviewing process. A session of this type would allow officers to gain an appreciation of where care and protection issues are likely to intersect with establishing the evidentiary proof for an offence. Staff could also better identify when it may be appropriate to canvass care and protection issues during the recorded criminal interview. We also highlight the value of inviting the ODPP to participate in the session to share their insights from a prosecutorial perspective.

Significantly, during the inquiry the agencies also developed a new component of the JIRT training program – the JIRT Simulated Exercise (JSE) – which is designed to support the development of strategic and critical decision-making skills in a team-based environment. The JSE is being developed by the NSW Police Force's Education and Training Unit in conjunction with FACS and Health. The JSE is expected to commence in August 2017. This new training component creates a valuable opportunity to help re-focus the JIRT partnership at a critical time in its evolution.

Strengthening leadership and accountability

The research we commissioned from the Australian Centre for Child Protection for this inquiry confirms that the JIRT partnership includes several features of good governance and accountability. However, while largely solid, the governance and accountability framework can and should be further strengthened and consolidated.

Clarifying the desired outcomes of the JIRT program and updating procedural guidance

The foremost task for the partner agencies is to review and clarify the desired outcomes of the JIRT program, and embed them in an updated Memorandum of Understanding (MoU) as the overarching document that governs the JIRT partnership.[9] The MoU should clearly articulate the shared objectives of the JIRT program, and the governance and accountability arrangements that oversight the JIRT partnership.

To support the effective implementation of the MoU, key JIRT policies and procedures need to be updated and made easily accessible to all JIRT agency staff.

As the JIRT arrangement has evolved over the last 20 years, the number of related policy and procedural documents has proliferated. Having reviewed a multitude of documentation for this inquiry, we do not believe that an updated version of the *JIRT Policy and Procedures Manual* is needed. Instead, the partner agencies should create an electronic portal/intranet site where all up-to-date JIRT policies and procedures can be readily accessed by JIRT agency staff. Our consultations with the agencies during this inquiry have helped us to document current practice in this report.

The SMG has previously recognised the need to review and update a number of key documents, but has been unable to prioritise this work. During our inquiry, they have committed to updating and better integrating joint policies, having regard to the observations and recommendations in this report.

Enhancing performance monitoring and reporting

The SMG identified and endorsed a JIRT Performance Monitoring and Reporting Framework in 2013 in response to a recommendation in our 2012 report. However, most of the indicators contained within the Framework have not been utilised and, to date, there has been limited performance monitoring and reporting.

We recommended in our 2012 report that the SMG should enhance the output/performance data that was reported to the respective heads of the JIRT agencies. In response, during 2012-13 FACS led the development of the Joint Investigation Response Tracking System (JIRTS), which is a tri-agency database to support the JIRT program. While JIRTS has helped improve joint case management and enabled more consistent data to be collected on incoming JRU referrals and related assessment decisions, its use as primarily a case management tool has meant that its full capacity to collect and facilitate analysis of performance data remains unrealised.

Although a number of the indicators set out in the JIRT Performance Monitoring and Reporting Framework are sound, what is missing is an attempt to collect data in a way that allows the relationship between outcomes achieved for children and young people and the various components of the JIRT response they received to be measured. For example, of those matters accepted by the JIRT program that were prosecuted, how many involved the child or young person receiving counselling and/or a protective intervention by FACS? The agencies agreed that child-focused data of this type was critical.

During our inquiry, we were advised by FACS that JIRTS was developed as an interim measure until its functionality is incorporated into FACS's new ChildStory database. The first release of the JIRTS component of ChildStory is due to be implemented in October 2017, with further rollout of the 'shared' functions in 2018. However, FACS also advised that ChildStory would not immediately be able to act as the platform for collecting and reporting on 'joined up agency outcomes' for children accepted into the JIRT program.

Unless and until a data solution is developed for recording agreed outcomes per child, it is difficult to see how the JIRT program can demonstrate the outcomes it is achieving for children who receive a JIRT response. This weakness in the evidence base for the JIRT program is exacerbated by the current poor alignment of child protection and criminal justice data, which we discuss in Chapter 10. We highlighted the need for better accountability over the JIRT program five years ago. Development of a more robust monitoring and reporting capability remains a key priority for the partnership.

9 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006 (incorporating February 2013 interim changes).

We recommend that the SMG have regard to our observations about what we consider to be critical child protection, criminal justice and health indicators in formulating its performance and monitoring framework for the JIRT program. Better demographic data must also be captured to enable outcomes for particularly vulnerable cohorts of children to be measured.

We draw attention to the absence of a position with dedicated responsibility for data collection, analysis and reporting. It is not realistic to expect that the SMG – whose representatives have direct, day-to-day operational responsibilities – to be responsible for undertaking this work. We recommend that the partner agencies give consideration to establishing a senior position with responsibility for providing executive support to the SMG to develop and implement the performance monitoring and reporting framework, supported by whatever additional resourcing is deemed necessary. The position could also support other governance and accountability requirements, such as updating JIRT-related policies and procedures and providing ongoing secretariat support to the SMG, Local Management Groups and the meeting of JIRT agency deputies.

Dispute resolution and escalation

It is essential that the JIRT partnership has transparent and efficient processes for both resolving and escalating disputes between the agencies at each level of the partnership, including disputes relating to the LPR and the systemic case practice review process we have proposed. Each stage of the escalation process should be reflected in the MoU.

In our view, it is also critical that JIRT agencies consult each other when they plan to issue formal directives to their own staff, if a directive is likely to impact on the operations of partner agencies. During our review, FACS and Health strongly criticised CAS for having issued directives to its officers without adequate prior consultation with the JIRT SMG despite the significant operational impacts and cultural change involved.

The current JIRT MoU states that: 'Any significant policy change being considered by any of the three departments that may impact on the JIRT service delivery must involve full consultation with each department prior to implementation'. In our view, it is critical that this aspect of the current MoU be retained, and faithfully adhered to by the partner agencies.

If an agency is unable to resolve internally the nature of a proposed communication to its own staff that may impact on the operations of another, the issue should be escalated to the JIRT agency deputies for resolution. This component of the escalation process should also be reflected in the SMG's Terms of Reference and the MOU.

As well, consideration should be given by the partner agencies to the benefits of including a provision for requesting mediation from an external source when significant strategic issues are unable to be effectively resolved by the partner agencies at the executive level.

The leadership of the JIRT SMG

The most critical factor to the future success of the JIRT program is strong and constructive leadership by the SMG. While it is expected, and indeed healthy, that contentious issues will arise in any interagency partnership, how the agencies resolve them matters most in maintaining a good relationship. Of the 313 responses to the JIRT workforce survey, almost half discussed the 'culture' of the JIRT partnership. Feedback centred around tension between the JIRT partner agencies affecting staff morale, and concern that a growing 'power imbalance' is undermining the health of the partnership.

Throughout this report, there are many examples of excellent leadership shown by members of the current SMG and their senior management teams in improving their own agency's performance. There are also many examples of these (and other) JIRT leaders having worked constructively over the last ten years on joint initiatives.

However, our inquiry has demonstrated that, moving forward, more cohesive leadership from the JIRT agencies is required. It is apparent, at least in some areas, that there are cultural issues impacting on the wellbeing and productivity of JIRT agency staff. There is a particular need for decisive leadership in relation to providing clear and consistent communication about the agreed roles and responsibilities of each partner agency to the JIRT workforce and the collaborative and respectful behaviours expected of staff.

Executive governance

Despite the JIRT MoU envisaging that the JIRT CEOs would meet at least twice yearly to 'monitor service quality, budget allocation and make recommendations and adjustments as required', there has been no formalised JIRT governance structure at CEO level for several years, and no joint annual CEO report card since 2013-14. While the partner agencies individually report to their respective CEOs, the absence of a tri-agency executive oversight mechanism has created a gap in governance and accountability for the JIRT program. In our view, this gap has weakened the partnership, contributing to issues of interagency contention remaining unresolved, and in some cases intensifying for lengthy periods of time.

We recommend that a formal arrangement for ongoing executive leadership and oversight of the JIRT program should be reinstated as an immediate priority. During the inquiry, the deputies from each agency agreed to at least bi-annual meetings, in alignment with the SMG's quarterly meeting schedule, with additional meetings to be convened as required. The meetings would provide a forum for decision-making about tri-agency JIRT issues unable to be resolved by the SMG, or requiring strategic endorsement at an executive level. We suggest that, initially, there would be value in the CEOs of the partner agencies joining the meeting to determine key priorities, including settling arrangements for the collection of enhanced JIRT outcome data and an agreed set of performance indicators, to enable the implementation of the JIRT Performance Monitoring and Reporting Framework.

Conclusion

There is strong public interest in the ongoing effectiveness of the JIRT program, and the agencies have agreed to make a copy of this report public. We recommend that the JIRT agencies publish their response to the recommendations in this report within 12 months of its release.

We are also of the view that the JIRT agency executives should examining what arrangements are needed to support the JIRT SMG in responding to the issues raised in this report. The JIRT program has not been the subject of a comprehensive independent review for over ten years. There are understandably a range of areas, as recommended in this report, where improvements are needed to enhance the program. The SMG cannot alone implement those reforms, given their already significant operational responsibilities. In our view the JIRT agency executives should take a continuing interest in responding to the issues in this report.

Summary of Recommendations

1. **The JIRT partner agencies should continue to jointly deliver and strengthen the JIRT program, having regard to the recommendations contained in this report.**
2. **The JIRT partner agencies should consider developing a business case for trialling the establishment, within the JIRT program, of a Child and Family Advocate role. The business case should give consideration to the role performing the types of functions (outlined below) that are commonly performed by advocates in other jurisdictions:**
    a) **Providing immediate support to children and their families throughout the interview process and providing flexible ongoing support until the conclusion of the criminal justice process, or until such time as advocacy services are no longer required.**
    b) **Empowering children and their family members to participate in decision-making about their cases.**
    c) **Understanding and conveying the views and wishes of children and their family members to other professionals involved with their cases.**
    d) **Acting as a consistent contact point for children and their family members for information about the JIRT process, the status of their case (to the extent that information can be provided) and the different service systems they may need to navigate.**
    e) **Building relationships with a broad range of child and family services (for example, mental health, victim support, financial, housing, schools, disability services), as well as other advocacy services, and serving as the JIRT program's general ongoing contact point for those services.**
    f) **Facilitating referral of children and their families to necessary services, including working to reduce barriers to accessing those services.**
    g) **Following up on service referrals to promote, and improve data on, service uptake – and establishing systems with service providers to notify the advocate when children and their family members discontinue services.**
    h) **Engaging in case consultations and information sharing with JIRT agencies and other organisations that provide, or may provide, services to children and their families.**
3. **If recommendation 2 is accepted, the JIRT partner agencies should also give consideration to the observations contained in Chapter 6 about the following:**
    a) **How certain current functions of NSW JIRT health clinicians could be shared with and/or complemented by a Child and Family Advocate role.**
    b) **The need for a clear role description to be developed to avoid role confusion.**
    c) **The most suitable entity to 'sponsor/employ' the Child and Family Advocate role.**
    d) **The most suitable physical location for the Child and Family Advocate in non-co-located JIRT sites.**
    e) **Ensuring that whichever entity/s houses the Child and Family Advocate role is embedded within the JIRT governance structure at a strategic state-wide and local level.**
    f) **Designating a certain number of Child and Family Advocate positions as Aboriginal, and in doing so, giving careful consideration to identifying suitable capabilities for these roles to expand the pool from which qualified and/or otherwise experienced Aboriginal applicants can be drawn.**
    g) **Ensuring that one of the Child and Family Advocate's core capabilities involves demonstrating cultural competency.**

h) As part of any trial, giving consideration to identifying one co-located metropolitan JIRT site and one non co-located rural JIRT site to specifically examine how the role should be adapted to suit differing operating environments and local conditions, and to assess potential workloads.

4. The JIRT partner agencies should develop a business case in relation to:
    a) Funding the creation of an additional three 'decision-making' positions at the JRU to enable two simultaneous decision-making tables to operate.
    b) Extending the hours of operation for the JRU (7am-11pm weekdays and/or weekend hours of operation).
    c) Any additional staffing required for each agency to conduct information checks to inform assessment decisions.
5. The JIRT partner agencies should replace the 'Rejected' decision category with a new decision category of 'Referred for local response' for reports 'rejected' by the JRU, but referred to an agency/s for a local response.
6. The JIRT partner agencies should develop, having regard to the observations in section 9.2, a formal set of 'factors to consider' to assist the Helpline and JRU to exercise professional judgement when applying the JIRT referral criteria.
7. The JIRT partner agencies should amend the JIRT Referral Criteria (and related line agency policies) to reflect that the Helpline will only:
    a) refer sexual abuse reports involving alleged victims aged 16-18 years to the JRU if:
        i the young person is at further risk of ongoing harm and the alleged offender is a family member, close adult friend, neighbour or person in authority, OR
        ii having regard to the recommended 'factors to consider' (recommendation 6), available information indicates that the young person should receive a JIRT response.
    b) refer sexual abuse reports involving adolescent peer sex to the JRU if:
        i the young person is at further risk of ongoing harm, OR
        ii having regard to the recommended 'factors to consider' (recommendation 6), available information indicates that the young person should receive a JIRT response.
8. The JIRT partner agencies should:
    a) on a trial basis, amend the JIRT Referral Criteria to allow referrals involving children and young people with cognitive and/or other communication impairment, and children and young people in residential out-of-home care, to receive a JIRT response in circumstances where there is no clear disclosure of sexual abuse but where there is:
        i reason to believe that there may be barriers to the child or young person making a disclosure, and/or
        ii information that suggests behavioural changes or other indicators of abuse.
    b) consult with peak disability advocates to determine the 'behavioural changes or other indicators of abuse' that will be prescribed for the trial.
9. The JIRT partner agencies should, on a trial basis:
    a) amend the *Enhanced JIRT services to Aboriginal children and young people protocol* (EASP) to remove the requirement to automatically suspend the '16-18 policy' for sexual abuse reports involving Aboriginal young people, and
    b) allow the JRU to suspend the '16-18' policy in relation to a sexual abuse report involving *any* young person over 16, if available information (rather than Aboriginality alone) indicates that the young person would benefit from a JIRT response.

10. **The JIRT partner agencies should amend the *Enhanced JIRT services to Aboriginal children and young people protocol* (EASP) to remove the requirement for automatic suspension of the 'Prior LAC' practice for reports involving Aboriginal children and young people.**
11. **The JIRT partner agencies should amend the JIRT physical abuse criteria to allow:**
    a) **all reports to the Helpline involving the alleged strangulation of a child or young person to be automatically referred to the JRU**
    b) **where necessary, the JRU to seek the assistance of a CSC to obtain medical forensic evidence to inform the JRU's assessment and decision.**
12. **To support the implementation of recommendation 11 above, NSW Health and FACS should settle advice for CSCs to guide their actions in responding to strangulation reports referred by the JRU.**
13. **NSW Health should formally distribute its clinical advice and recommendations relating to the JIRT physical abuse criteria to FACS and the NSW Police Force to inform their consideration of Health's proposed strategies to improve the handling of strangulation reports, contact burn reports and other physical abuse matters as soon as practicable.**
14. **The NSW Police Force should consider options for enhancing the data collection processes for the Child Abuse Squad to enable reliable reporting on:**
    a) **the number (and proportion) of children accepted into the JIRT program where an arrest is made in connection with the JIRT report, and**
    b) **the number (and proportion) of matters involving arrests that result in a conviction.**
15. **The NSW Police Force should collect the data detailed in recommendation 14 in such a way that it can be disaggregated by:**
    a) **individual Child Abuse Squad teams, and**
    b) **particular cohorts of victims and types of matters (for example, matters involving juvenile defendants; allegations of abuse in an institutional context; and matters involving sibling sexual abuse).**
16. **The NSW Police should, having regard to the observations in section 10.5 and 10.6 of this report, determine which criminal justice outcomes for children and young people referred to the JIRT program will be included in the overall JIRT performance monitoring framework and recorded in the shared JIRT database.**
17. **The NSW Police Force should implement COMPASS reporting on key performance measures already being collected by the Child Abuse Squad (and any future enhanced measures).**
18. **The NSW Police Force should work with FACS and the out-of-home care (OOHC) sector to consider options for developing and implementing an interagency model (informed by the Victorian and UK approaches discussed in section 10.11) for responding to the sexual exploitation of children and young people in residential OOHC.**
19. **The NSW Police Force should enhance the COMPASS reporting requirements of Local Area Commands in relation to the number of child sexual abuse matters they receive and investigate each year, and the related legal actions.**
20. **The NSW Police Force should consider the benefits of establishing a permanent training position within the CAS, staffed by an officer with solid operational experience, to provide regular, specialist 'refresher training' to CAS police; support the skill development of Local Area Commands; and inform the development and implementation of a JIRT program training strategy for external stakeholders.**
21. **Having regard to the recently allocated funding for FACS JIRT, FACS should develop a proposal for determining the most effective way to deploy these resources with particular consideration being given to:**
    a) **Developing a FACS JIRT after-hours service.**

b) **Supporting CSCs in responding to matters that meet the JIRT threshold but have been rejected for a JIRT response due to 'Prior LAC' involvement.**

c) **Supporting CSCs in responding to matters involving serious physical abuse allegations which fall short of the JIRT criteria, but which involve a child with additional vulnerabilities, for example, a child with a disability or a child in out-of-home care.**

d) **Developing a more flexible approach to the timing of the transfer of JIRT matters to CSCs for a further response, in circumstances where a CSC may not immediately be able to allocate the matter.**

22. **FACS, in consultation with Health and the NSW Police Force, should refine its JIRT Work Health and Safety Plan to include further measures aimed at addressing staff welfare issues, including consideration of a compulsory WellCheck program and rotation policy similar to that implemented by the NSW Police Force.**

23. **FACS, having regard to the issues raised in section 11.6.2 of this report, should review its casework practice mandate in relation to sibling coordination.**

24. **FACS should ensure that the assessment training package being developed by the Office of the Senior Practitioner and tailored for delivery to FACS JIRT staff has regard to the analysis of available casework activity and outcome data discussed in section 11.7.**

25. **FACS should review, having regard to the observations in section 11.6.4, and in consultation with the NSW Police Force and the Ombudsman's office, the casework practice mandate for 'Identifying and recording POI and PCH' and the 'Person Causing Harm resource pack'. In doing so, FACS should update the guidance for staff on the:**

    a) **Standard of proof required to make a Person Causing Harm determination to reflect current case law and to include guidance on the type of evidence that should be considered by FACS staff in the context of making a Person Causing Harm determination.**

    b) **Processes for making a Person Causing Harm determination in circumstances where there is a concurrent criminal investigation, including the importance of informing individuals of a decision to record them as a Person Causing Harm once criminal proceedings have been finalised; and the importance of affording procedural fairness to individuals in matters where charges have not been laid and there is no ongoing criminal investigation.**

    c) **Importance of documenting the rationale for decisions that an individual is a Person of Interest or a Person Causing Harm.**

26. **FACS should, consistent with FACS JIRT practice, require Director level approval for all Person Causing Harm determinations involving a child under the age of 16 years, and if accepted, update the related casework practice mandate accordingly.**

27. **FACS should, having regard to the observations in section 11.7 of this report:**

    a) **Determine which FACS performance and productivity indicators will be included in the overall JIRT performance monitoring framework and develop a timeframe for reporting against these indicators.**

    b) **Finalise the additional FACS performance and productivity indicators that it intends to capture for internal FACS reporting purposes.**

    c) **Implement a business review process, on a six-monthly basis, for its JIRT managers, overseen by the Executive Director State-wide Services and the JIRT Directors, to enable comprehensive analysis in a group setting of the output and outcome measures captured via the JIRT register.**

    d) **Utilise the office of the Senior Practitioner to conduct periodic case reviews of JIRT matters with a view to assessing the quality of casework practice.**

e) **Consider how to better integrate reporting of its role in the JIRT program with the existing FACS Quarterly Business Review process, or a separate robust process, to ensure sufficient accountability processes for FACS JIRT at a senior executive level.**

28. **NSW Health should:**

    a) **Ensure that the core elements of its JIRT workforce development strategy continue to be delivered in a way that is consistent with Health's broader workforce development and governance priorities.**

    b) **Consider further enhancing the support provided to its JIRT workforce, having regard to the staff welfare and wellbeing model developed by the NSW Police Force.**

29. **NSW Health should take steps to ensure that the fields in the shared JIRT database for recording referrals by the JRU Health team and JIRT health clinicians are made mandatory, and require the reason for no referral to be recorded.**

30. **NSW Health should closely track, for each LHD/SCHN, the rate of referral of JIRT clients (broken down by Aboriginality) to other services, and take action to address low referral rates in identified LHDs.**

31. **NSW Health should ensure that the new Sexual Assault Service database collects robust data about:**

    a) **The age of JIRT clients, ensuring that children under 14 years of age are captured as a discrete cohort, to allow monitoring of counselling service uptake and provision of forensic examinations.**

    b) **The number of children and young people referred to counselling where the alleged abuse had not been substantiated by a FACS (care and protection) and/or Police (criminal) investigation.**

    c) **The number of forensic examinations assessed as 'required' by a qualified forensic examiner and the number of required examinations actually conducted.**

    d) **Delays impacting on the viability of forensic evidence and/or waiting times for forensic examinations of children and young people referred via the JIRT program, including delays which occur prior to notifying a forensic examiner, and the reasons for delays.**

    e) **Indicators of service capacity, such as counselling position numbers, vacancy rates and waiting lists for relevant counselling services.**

32. **NSW Health should review the capacity of the Sexual Assault Service to provide counselling services to JIRT clients.**

33. **In relation to physical abuse and neglect referrals to the JIRT program, NSW Health should:**

    a) **Assess the adequacy of existing counselling referral pathways available to JIRT clients, to determine whether an expansion or realignment of services may be required to meet demand.**

    b) **Ensure a process is developed with FACS and the NSW Police Force to record the use of 's.173 notices' in connection with physical abuse referrals made to the JRU.**

    c) **Review the use of its SCAN Protocol.**

34. **NSW Health should consider including specific performance indicators for the JIRT program in the Service Agreements between the Secretary and the LHDs/Specialist Health Networks.**

35. **NSW Health should, having regard to the observations in section 12.6.2 of this report:**

    a) **Determine which health outcomes for children and young people referred to the JIRT program will be included in the overall JIRT performance monitoring framework and recorded in the shared JIRT database.**

    b) **Finalise the health outcomes for children and young people referred to the JIRT program that it intends to capture for internal Health reporting purposes, and adjust its reporting process accordingly.**

36. **The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 13.4, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by Aboriginality and monitored.**

37. **The JIRT partner agencies should, having regard to the observations and recommendations contained in Chapters 9 and 13, finalise their position on the recommendations made by the 2015 IAB audit of the implementation of the *Enhanced Aboriginal Services Protocol.***

38. **The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 14.2 and in consultation with peak disability advocates, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by disability status and monitored.**

39. **The JIRT partner agencies should, in consultation with peak disability advocates and other appropriate bodies (such as Speech Pathology Australia and Communication Rights Australia), review and enhance the training and guidance provided to Helpline and JIRT agency staff (including the JRU) about identifying and responding to reports involving children and young people with disability, including appropriate consultation with disability experts and accessing specialist clinical and community resources.**

40. **The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 15.1, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by CALD status and monitored.**

41. **The JIRT partner agencies should, in consultation with relevant expert advisors (such as the specialist cultural diversity resources existing within each partner agency, Multicultural NSW and Ethnic Community Services Cooperative), review the adequacy of the training that is provided to frontline JIRT staff about working with CALD children, young people and families.**

42. **The JIRT partner agencies should, having regard to the observations in sections 16.3 and 16.4, and in consultation with ACWA and AbSec, consider how best to improve engagement and communication with the OOHC sector and expand the reach of JIRT (endorsed) training for foster carers about responding to disclosures of serious abuse.**

43. **The JIRT partner agencies should ensure, having regard to the successful training program rolled out by FACS, Police and ACWA to support the implementation of the *Joint Protocol to reduce the contact of young people in residential care with the criminal justice system*, that training and induction for JIRT staff includes relevant information about:**

    a) **The heightened vulnerability of children and young people in OOHC, particularly residential care, to sexual abuse.**

    b) **The impacts of trauma on children and young people in OOHC; the link between trauma and challenging behaviours; the principles underlying therapeutic care; and strategies for engaging effectively with these children and young people.**

    c) **The role of OOHC providers and how JIRT should engage them when responding to reports involving children or young people in OOHC.**

44. **The JIRT partner agencies should consider, together with other key stakeholders (such as the departments of Justice and Education) and having regard to the observations in Chapter 17 and relevant recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse, implementing recommendation 65 of the Ombudsman's 2012 report to Parliament, *Responding to child sexual assault in Aboriginal communities*, in relation to the development of an integrated service response framework for children and young people with harmful sexual behaviours.**

45. **The JIRT partner agencies should develop, in consultation with relevant experts, guidance about responding to reports involving sibling sexual abuse building on FACS' *See, Understand and Respond to Child Sexual Abuse – A practical kit*. This guidance should be referenced in, and linked to, both the *Local Planning and Response Procedures* and JIRT interagency training materials (with training and resources being made available to Community Services Centre staff).**

46. **The NSW Police Force should ensure that, in relation to the witness intermediary scheme, the Child Abuse Squad:**
    a) **Shares information with and considers information from FACS and NSW Health JIRT staff before requesting a witness intermediary from Victims Services.**
    b) **Defers interviewing a child until a witness intermediary is available, unless the relevant CAS Team Leader (having requested any relevant information from FACS and Health) is satisfied that the child or young person has no communication needs that would warrant the use of an intermediary, or that there are exceptional reasons why deferring the interview is not appropriate.**
47. **The JIRT partner agencies should review the accommodation needs of the JRU, taking into account any planned expansion of JRU resourcing as a result of the recommendations in this report.**
48. **The JIRT partner agencies should, as far as possible, co-locate JIRT agency staff in the same building, ideally on the same floor, or at least within close proximity to each other, with CAS officers having their own dedicated work area in accordance with the December 2016 SMG Joint Communication. Relevant future considerations relating to accommodation arrangements might include the following for specific JIRT sites:**
    a) **The scale and demand for services; service area size and population; workforce issues; the availability of suitable accommodation; and the delivery of satellite or outreach services.**
    b) **FACS and NSW Health staff at co-located JIRT sites also having separate and secure workplaces, where considered desirable and appropriate, but in any event, they should have access to separate and secure areas to appropriately perform their roles and functions.**
    c) **Ensuring that interview, monitoring, family and meeting rooms are available for use by each agency at relevant points of the JIRT process.**
49. **The JIRT partner agencies should ensure that:**
    a) **Each agency discusses with the other partner agencies, at the earliest possible stage, any proposed changes to JIRT accommodation arrangements to allow the other agencies to concurrently plan for any impact on its own accommodation needs.**
    b) **JIRT agency staff are consulted about, and kept informed of, proposed changes to accommodation arrangements that affect them.**
50. **The JIRT partner agencies should put in place appropriate governance arrangements to ensure joint practice is not adversely impacted by accommodation changes, and that decisions are jointly communicated to JIRT agency staff.**
51. **The JIRT partner agencies should amend the *Local Planning and Response Procedures* to ensure they reflect current operational practice, provide clarity about the purpose of the LPR and give practical guidance to JIRT agency staff in relation to the following critical areas:**
    a) **The purpose of the LPR; the SMG's endorsement of the LPR and expectations about its implementation; and the risks to children when effective collaboration does not occur.**
    b) **That there will be a range of circumstances where the partner agencies agree a more flexible approach to implementing the LPR will be collectively required by local teams. (However, allowing for greater flexibility should not lead to routine departures from the LPR).**
    c) **The roles and responsibilities of each partner agency (and their non-JIRT arms) that apply to mobilising a tri-agency response to urgent referrals during the Helpline/ JRU assessment phase, and/or referrals which arise after-hours.**
    d) **The role of the NSW Health 'JIRT contact point' and the escalation process to the Health Ministry if agencies experience problems accessing the contact point or receiving appropriate assistance in the absence of a JIRT health clinician.**

e) **The purpose of information sharing, including examples of scenarios where the exchange of certain types of information has been critical in informing the JIRT response.**

f) **Current agreed processes for conducting recorded criminal interviews as set out in the December 2016 SMG Joint Communication, and the role each agency should play in having input to recorded criminal interviews. (See also related recommendation 52).**

g) **The high level principles (having regard to the observations in section 21.2.7) document that agencies should be guided by when executing their responsibilities during the following key stages of the JIRT response:**
   - i **conducting care and protection interviews during the course of a criminal investigation**
   - ii **conducting Person Causing Harm interviews during the course of a criminal investigation, and**
   - iii **the timing of crisis interventions by Health during the course of a criminal investigation**

h) **The need to identify, liaise and exchange information with relevant external stakeholders (including but not limited to schools, out-of-home care agencies, and early childhood services) during the LPR to inform child protection and criminal investigations, and promote a holistic approach to addressing the wellbeing of children and young people accepted into the JIRT program.**

i) **The role and responsibilities of the Child and Family Advocate (if recommendation 2 is accepted) during the LPR.**

j) **The role and responsibilities of each agency in informing the work of witness intermediaries.**

k) **The process for recording and escalating concerns about the implementation of the LPR in individual matters.**

52. **As part of implementing a broader JIRT performance monitoring and reporting framework, the JIRT partner agencies should, until jointly satisfied that it is no longer required, collect data that enables regular monitoring of the participation by FACS and NSW Health in attending/monitoring child victim recorded criminal interviews (and other child interviews conducted by Police), including but not limited to the following data:**

    a) **The number of child victim and other child interviews where FACS and/or NSW Health were notified prior to the interview**

    b) **Of the total number of interviews conducted, the proportion which occurred before or after medical forensic examinations and/or crisis counselling.**

    c) **The amount of notice provided to FACS/NSW Health prior to the proposed interview time where contact was made.**

    d) **The number of child victim and other child interviews where contact was made that were attended/monitored by FACS and/or NSW Health.**

    e) **Where FACS/NSW Health did not attend/monitor the interview, the reasons provided by each agency for this.**

53. **The NSW Police Force should ensure that the Child Abuse Squad reviews and revises its Child Interviewing Course, having regard to the observations in this report about:**

    a) **The importance of Police considering relevant information provided by FACS and Health to inform the recorded criminal interview (Chapters 21 and 22).**

    b) **The purpose of providing a structured interview break and how this should be implemented.**

    c) **Factors to consider when interviewing particularly vulnerable cohorts of children (Part 5).**

d) **The benefits of adopting a similar approach to Victoria Police in conducting 'interview refresher training', informed by an ongoing program of reviewing child interview transcripts (Chapter 22).**

54. **The JIRT partner agencies should further refine the JIRT Foundation Skills Program and, in particular, training about interviewing, having regard to the observations in Part 5 of this report about improving the response to particularly vulnerable groups of children and young people.**

55. **The JIRT partner agencies should:**

    a) **Review the *Local Contact Point Protocol*, having regard to the observations and recommendations contained in section 23.4 and any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse, to evaluate its implementation and inform its future direction.**

    b) **Ensure, to inform the review, that JIRT LMGs brief the JIRT SMG about the outcome of their evaluations of Local Contact Points.**

56. **The JIRT partner agencies should take an approach of 'continuous improvement' to the JIRT Foundation Skills Program, which includes but is not limited to the following:**

    a) **Updating the course materials to ensure they reflect current operational practice and any changes made as a result of the recommendations in this report.**

    b) **Developing an additional joint session (which could occur either mid-way or at the end of the separate Police and FACS child interviewing courses), to give both agencies a practical understanding of the new interviewing process, and of how each agency can add value at each key stage.**

    c) **Engaging external experts (including but not limited to the Office of the Director of Public Prosecutions) to provide advice about whether and how to ensure that the training, particularly in relation to conducting child interviews, reflects best practice.**

    d) **Enhancing guidance, having regard to the observations and recommendations contained in Part 5, about responding to particularly vulnerable children and young people.**

    e) **Undertaking a review of the new JIRT Foundation Skills Training Program in 12 months time, informed by participant evaluations and expert feedback, to assess whether it is operating effectively.**

57. **The JIRT partner agencies should amend the JIRT Memorandum of Understanding, ensuring that the document:**

    a) **Clearly states the respective roles and responsibilities of each partner agency (and the Child and Family Advocate, if recommendation 2 is accepted).**

    b) **Identifies the desired outcomes of the JIRT arrangement.**

    c) **Links to the performance monitoring and reporting framework containing the indicators that will be used to measure the desired outcomes.**

    d) **Clearly articulates the 'core' and 'adaptive' elements of the JIRT arrangement.**

    e) **Makes clear that the child protection and specialist health services provided by the NSW Police Force, FACS and NSW Health, beyond the JIRT arrangement, support the desired outcomes.**

    f) **Outlines the purpose of each governance mechanism and links to their terms of reference.**

    g) **Maintains the requirement in the existing MoU that any significant change to the operation of the JIRT program must involve full consultation between all three agencies prior to implementation, and articulate a process for communicating such changes to the field.**

h) Includes a dispute resolution and escalation mechanism which covers each stage of the JIRT partnership, including disputes relating to the *Local Planning and Response Procedures* and systemic case practice review process we have proposed.

i) Includes external facilitation for disputes that cannot be resolved by the JIRT partner agencies.

j) Specifies when the MoU will be reviewed.

58. The JIRT partner agencies should update the JIRT performance monitoring and reporting framework, having regard to the observations in Chapter 25 and ensuring that the framework:

a) Includes appropriate performance indicators for measuring whether the JIRT arrangement is meeting the desired outcomes and demonstrating the relationship between the outcomes achieved for children and young people and the components of the JIRT response they received.

b) Identifies, having regard to relevant cross-government data and information technology initiatives, the necessary data to support each performance indicator, how the data will be sourced, the frequency of reporting and the related governance processes where results will be analysed.

59. The JIRT partner agencies should:

a) Update the shared policies and procedures supporting the JIRT program, having regard to the observations and recommendations throughout this report.

b) Store the shared policies and procedures on an electronic portal/website that is accessible to staff from all three JIRT agencies.

60. The JIRT partner agencies should amend the terms of reference for the SMG to:

a) Align with the JIRT performance monitoring and reporting framework.

b) Clearly articulate the SMG's reporting responsibilities to LMGs and relevant Deputy Secretaries/Commissioner, including the provision of relevant data and related analysis and the process to be followed in relation to the recommended meetings of partner agency deputies.

c) Specify an agreed process for the JIRT agencies to consult each other when they plan to issue formal directives to their own staff if these directives are likely to impact on the operations of partner agencies; and, where agreement cannot be reached about the nature of proposed communications by one agency (to its own staff) which will impact on the operations of another, to escalate the issue to the Deputy Secretaries/Commissioner of the partner agencies.

d) Requires the SMG to regularly review data relating to 'escalated concerns' about the implementation of the LPR in individual matters, to assess the frequency and nature of concerns, and any location trends.

61. The JIRT partner agencies should:

a) Support the continued operation of LMGs.

b) Amend the LMG terms of reference (and agenda template) to align with the JIRT performance monitoring and reporting framework; include a stronger focus on routine case reviews; provide practical guidance about the outcomes that LMGs should aim to demonstrate against relevant performance indicators; and create a simple pathway for matters to be escalated to the SMG.

c) Require LMGs to report to the SMG, using the amended LMG agenda template, against the relevant performance indicators and the outcomes of case reviews.

d) Require the SMG to verify, by quarterly receipt of LMG meeting records, whether all LMGs have occurred as scheduled.

e) Require the SMG to identify if an LMG is regularly failing to meet as required, take steps to determine the reason for this, and jointly address it.

62. The relevant Deputy Secretaries/Commissioner of the partner agencies should:

    a) Meet biannually, and additionally as required, to provide a forum for executive oversight of the JIRT arrangement, having regard to relevant data and related analysis against the agreed performance indicators set out in the JIRT performance monitoring and reporting framework.

    b) Convene, within three months of the agencies' receipt of this report, to determine terms of reference and an ongoing meeting schedule aligned with the SMG quarterly meetings.

63. The JIRT partner agencies should give consideration to establishing a senior position with responsibility for:

    a) Supporting the SMG to implement the performance monitoring and reporting framework through undertaking regular data analysis and reporting against the jointly agreed performance indicators.

    b) Undertaking other tasks related to the governance and accountability of the JIRT arrangement, including updating and maintaining the shared policies and procedures supporting the JIRT program and providing secretariat support to the JIRT Deputies, SMG and LMGs.

64. The JIRT partner agencies should review the adequacy of the shared JIRTS database (or any shared other data platform), having regard to our observations about the need for the database to enable:

    a) Systematic and non-exclusive 'flagging' of referrals that involve Aboriginal children and young people; children and young people with disability; children and young people from CALD backgrounds; and children and young people in OOHC.

    b) Systematic flagging of children and young people identified as causing sexual harm in JIRT referrals, including their OOHC status and other demographic data (where known).

    c) Abuse or neglect type to be selected against the relevant primary referral category of sexual abuse, physical abuse or neglect.

    d) Systematic recording of escalated concerns about the implementation of the LPR in individual matters (and the related outcomes), and interview participation data by each agency.

    e) Relevant data to be systematically recorded, extracted and analysed against agreed child protection, criminal justice and health outcomes for individual children and young people referred to the JIRT program, having regard to the observations and recommendations in this report.

65. The JIRT partner agencies should continue to liaise with FACS to determine whether the enhancements specified in recommendation 64 can be incorporated into the JIRTS functionality, once it is transferred to ChildStory, in future releases of ChildStory. If the enhancements cannot be incorporated in the short to medium term, the agencies should identify a solution for obtaining and reporting on the data needed to support the agreed key performance indicators for the JIRT program, having regard to the benefits of 'enduring data linkage' and the need to minimise the administrative burden on frontline JIRT staff.

66. The JIRT partner agencies should finalise a Memorandum of Understanding to support the shared JIRTS database (or any other future shared data platform).

67. In light of the public interest in the ongoing effectiveness of the JIRT program, the JIRT partner agencies should make public their response to this report within 12 months of it being released to the agencies.

PART 1

Background

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Chapter 1. Our inquiry

In 2012, as part of our audit of the implementation of the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*, we conducted a high level review of the operation of the Joint Investigation Response Team (JIRT) program. Our December 2012 report, *Responding to Child Sexual Assault in Aboriginal Communities*, was tabled in Parliament in January 2013.[1] While the report focused on responses to the sexual abuse of Aboriginal children, it included findings and recommendations that apply to all children and families who have contact with the JIRT program.

Our 2012 report highlighted the fundamental challenges facing the JIRT program at the time, which were, in part, due to chronic staffing shortages across the JIRT partnership. We made a range of recommendations aimed at strengthening accountability, data collection, monitoring of – and reporting on – JIRT outcomes, and the resourcing of the JIRT program. We also recommended that a comprehensive review of the JIRT program be carried out – noting that although an internal review by JIRT partner agencies had been conducted in 2006,[2] the last major, independent review of the JIRT program was undertaken in 2002.[3] Our 2012 report, and our recommendations for further review, are summarised in Chapter 3.

In 2013, the JIRT partner agencies conducted their own evaluation of the JIRT Referral Unit (JRU). The JRU has been the single entry point for the JIRT program since 2008.[4] The evaluation was conducted to inform future policy and budget directions for the JRU as a *Keep Them Safe* (KTS) funded program,[5] but did not consider the operation of the JIRT program more broadly. The JRU evaluation report found that, 'In order for the unit to continue to run in an effective, efficient and timely manner and to keep functioning as a specialist unit, an increase in staff is required'.[6]

In response to the resourcing recommendations contained in our 2012 report, the Department of Family and Community Services (FACS) engaged Ernst & Young in September 2013 to review the workload of FACS JIRT caseworkers. Ernst & Young provided its report in February 2014.[7] We discuss FACS' current resourcing further in Chapter 11.

Since October 2013, the Royal Commission into Institutional Responses to Child Sexual Abuse has considered the operation of the JIRT program in a number of its case studies (Case Studies 2, 37 and 38) through inviting submissions in response to its *Issues Paper 8: Experiences of Police and Prosecution Responses* (May 2015), during its public Roundtable on multi-disciplinary and specialist policing responses (June 2016) and in its *Criminal Justice Consultation Paper* (September 2016).

In July 2016 – mindful that the JIRT program's operations had not been comprehensively reviewed for over ten years, and in light of the Royal Commission's ongoing consideration of issues related to the operation of the JIRT program and components of similar models for national application – the JIRT partner agencies (FACS, NSW Police Force and NSW Health) requested that the Community & Disability Services Commissioner and Deputy Ombudsman, Mr Steven Kinmond, conduct an independent review of the JIRT program.

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1 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, a report under Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993,* December 2012.

2 NSW Health, NSW Police, NSW Department of Community Services, *NSW Joint Investigative Response Team (JIRT) Review*, November 2006.

3 J. Cashmore, J. Taplin and V. Green, *Evaluation of the Joint Investigation Team (JIT)/Joint Investigation Response (JIR) Strategy – Summary Report*, June 2002.

4 NSW Department of Family and Community Services, NSW Police Force, NSW Health, *JIRT Referral Unit: Keep Them Safe Evaluation,* December 2013.

5 *Keep Them Safe: A shared approach to child wellbeing* was the NSW Government's five-year (2009-14) action plan to re-shape the way family and community services are delivered in NSW to improve the safety, welfare, and wellbeing of children and young people. The goal of *Keep Them Safe* was that 'all children in NSW are healthy, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential'. In particular, *Keep Them Safe* included actions to enhance the universal service system, improve prevention and early intervention services, better protect children at risk, support Aboriginal children and families, and strengthen partnerships with non-government organisations in the delivery of community services.

6 NSW Department of Family and Community Services, NSW Police Force, NSW Health, *JIRT Referral Unit: Keep Them Safe Evaluation,* December 2013. p.20.

7 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources*, 19 February 2014.

The original review timeframe was to be 12 months from 1 July 2016. However, in order to ensure that key structural issues identified from the review could be considered by the Royal Commission ahead of its final report on criminal justice, we agreed to reduce the timeframe for preparing our draft report to six months.

After initial discussions during August and September 2016 with each of the JIRT partner agencies about the nature and scope of the review, the Community & Disability Services Commissioner and Deputy Ombudsman initiated an inquiry into the operation of the JIRT under section 11(1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) on 16 September 2016.[8]

Together with Mr Kinmond, the inquiry has been led by the Assistant Ombudsman, Strategic Projects, Ms Julianna Demetrius.

1.1. Inquiry terms of reference

The inquiry was initiated to examine:

(a) the operation of the JIRT program in accordance with the JIRT Memorandum of Understanding (MoU), having regard to changes in policy and practice since the MoU was last updated, including processes, governance and resourcing

(b) key areas of interagency success and challenges for the JIRT partnership

(c) the roles and responsibilities of each JIRT partner agency, and whether each partner agency:

  (i) is meeting its responsibilities under the JIRT program

  (ii) is adequately resourcing its obligations under the JIRT program

  (iii) has adequate accountability mechanisms in place to measure its performance under the JIRT program

  (iv) complies through its actions under the JIRT program with intra-agency and broader NSW government policy, procedures and guidelines

  (v) is having its 'needs and expectations' met by the other interagency partners under the JIRT program, and

  (vi) has identified any legislative issues impacting on the operational response under the JIRT program

(d) whether the JIRT program is optimal, or whether alternative arrangements would be more effective and provide better outcomes for children and young people, non-abusive family members, partner agencies, other stakeholders and the community.

8 Section 11(1)(e) of CS-CRAMA provides for the Ombudsman to inquire, on his or her own initiative, into matters affecting service providers within the meaning of the Act and persons receiving, or eligible to receive, community services. The manner in which JIRTs operate affects FACS and children and young people who receive, or are eligible to receive, services under the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Section 14A(1) of CS-CRAMA provides that the Ombudsman may, during the completion of a review or any other inquiry carried out by the Ombudsman under CS-CRAMA, report on any systemic issues relating to the provision of community services by service providers, and make such recommendations as the Ombudsman sees fit.

Chapter 2. Our methodology

We have utilised a range of research methods to inform this report. They are discussed below.

2.1. Requests for information from JIRT partner agencies

We requested that all JIRT partner agencies provide us with JIRT workforce, productivity, resources and outcomes data.

JIRT partner agencies were asked to provide a range of documentation and advice relating to current practice and procedures, workflow, training, accountability and governance mechanisms (intra-agency and interagency); as well as documents relating to previous reviews of the JIRT program. The JIRT partner agencies were also asked to provide submissions and supporting evidence addressing our inquiry's terms of reference.

FACS was asked to provide additional information including data for JRU accepted and rejected matters and data from the Joint Investigative Response Tracking System (JIRTS) database,[9] on behalf of the JIRT partner agencies.

NSW Health (Health) was asked to provide additional information about Aboriginal community engagement training delivered by the Education Centre Against Violence (ECAV) on behalf of the JIRT program, and the New Street Services (which provides therapeutic services to children and young people with harmful sexual behaviours).

The NSW Police Force (Police) was asked to provide additional information, gained during a visit by the Acting Commander of the Child Abuse Squad (CAS) to the United Kingdom in 2016, about international strategies aimed at addressing the sexual exploitation of vulnerable young people, and the results of a survey issued by the A/Commander CAS to all Local Area Command crime managers about their knowledge of the role of the CAS and the handling of child abuse matters more generally.

2.2. Consultation with JIRT partner agencies

The Assistant Ombudsman regularly met and had telephone briefings with senior officers of the JIRT partner agencies, both individually and collectively.

Joint agency meetings were held to discuss key issues for the inquiry, including:

- the role of the JRU
- whether JIRT referral criteria are appropriately targeted
- JRU and JIRT workforce issues
- improving the quality and accessibility of JIRT agency policy and procedural guidance
- better engaging Aboriginal children, children with disability, children from culturally and linguistically diverse backgrounds, and children and young people in residential out-of-home care in the JIRT program
- mutual recognition of the critical roles played by each JIRT partner agency and addressing related workforce culture and staff morale concerns, and
- strengthening governance, accountability and dispute resolution in the JIRT program.

Early on in the inquiry, the agencies agreed that the most effective way to address a number of issues of contention was for our office to facilitate formal discussions with the JIRT State-wide Management Group (SMG) and other senior representatives from each agency. These discussions primarily focused on the degree of compliance with the Local Planning and Response (LPR) process; the conduct of recorded criminal interviews of children; and arrangements for co-location and the delivery of joint training.

9 The JIRTS database was created in response to our 2012 audit report, and has been operational since July 2014. The JIRTS database is the tri-agency database for the JIRT program.

After productive discussions, the partner agencies continued to seek common ground on these issues and were able to reach a position, reflected in a Joint Communication issued by the JIRT SMG on 21 December 2016.

2.3. JIRT workforce survey

We developed an online survey to obtain the views of frontline JIRT staff from each of the partner agencies about the operation of the JIRT program. The survey was distributed to:

- 152 Police CAS staff (investigators, Team Leaders, Zone Managers and senior management)
- 141 FACS JIRT staff (senior administration officers, caseworkers, Managers Casework and Managers Client Services), and
- 63 Health JIRT staff (JIRT health clinicians, senior health clinicians and managers).

The survey included general questions about the operation of the JIRT program, and questions about specific aspects of the JIRT process and response, including the practical application of the LPR; the operation of Local Management Groups (LMGs); the adequacy of the response to particularly vulnerable cohorts of children and young people;[10] processes used by JIRT staff to refer matters on to their line agencies; and staff training. The survey also asked open questions which allowed JIRT agency staff to comment on the strengths and weaknesses of their own agency's and other agencies' performance, and how the JIRT program could be strengthened.

The response rate from each agency was very high. We received a response from 93% of CAS staff, 89% of FACS staff and 73% of Health staff (a total of 313 responses).

The survey responses for each agency were collated and analysed using SPSS Statistics and Excel. Analysis was conducted by location, position and tenure of staff. The survey feedback is discussed throughout this report and was a valuable source of information for our inquiry.

2.4. Bourke JIRT visit

The Bourke JIRT was established in July 2009 for the specific purpose of enhancing the JIRT program's response to Aboriginal communities in the Orana Far West. Our visit to Bourke in December 2016 allowed us to meet with the representatives from each of the JIRT partner agencies and seek their views on the particular operational and community-related challenges facing the only JIRT located in remote NSW. We also met with a number of Aboriginal community leaders to receive updated feedback about the Bourke JIRT and its impact on addressing child sexual abuse in the community.

2.5. Consultation with other stakeholders and experts

We have consulted with a range of external stakeholders to inform our inquiry. To guide our assessment of the extent to which the JIRT program is meeting 'the needs and expectations' of victims, their families and other key stakeholders, we consulted the Judiciary,[11] the Office of the Director of Public Prosecutions (ODPP),[12] the Commissioner for Victims Rights, representatives of the schools and out-of-home care (OOHC) sectors, disability advocates and Aboriginal leaders.

10 Children and young people with disability, Aboriginal children and young people, children and young people from culturally and linguistically diverse backgrounds, children and young people in out-of-home care, children and young people who are victims of intra-familial abuse, and children and young people who sexually abuse or engage in harmful sexual behaviour towards other children and young people.

11 Judge Jennie Girdham SC and Judge Catherine Traill – Specialist District Court Judges for child sexual assault matters across NSW.

12 Including the Witness Assistance Service and Crown Prosecutor Ms Gina O'Rourke SC.

In light of the prevalence of the reporting of harmful sexual behaviour by children and young people towards other children and young people, we also sought expert advice on how the service system can respond more effectively to this cohort from Dale Tolliday, Clinical Advisor, New Street Services; the Victorian Department of Health and Human Services; and Juvenile Justice (NSW).

The key external stakeholders and experts we consulted are listed at Annexure A to this report.

2.6. Survey of Police Local Area Commands

The Child Abuse Squad (CAS) distributed a brief survey to all Crime Managers at the 76 Local Area Commands (LACs) in NSW in 2016. The purpose of the survey was to ascertain the practices and procedures within each LAC for dealing with child abuse investigations, and to review their level of knowledge and understanding of their own role and responsibilities as well as those of the CAS and the broader JIRT program. The survey also sought to elicit the LACs' understanding of the role of the JIRT Referral Unit and how cases that have not yet been accepted or rejected for a JIRT response should be dealt with by LACs.

A total of 36 out of 76 (47%) LACs across NSW responded to the survey, which included questions about procedures relating to the interview of victims, the management of crime scenes, arrangement of medical examinations and investigation of consensual peer sex matters, and matters involving young people aged 16-18 years. The survey was completed by the Crime Manager at each LAC.

We assisted the CAS to collate and analyse the responses. The Assistant Ombudsman and the Acting Commander CAS assessed the adequacy of the LAC responses and identified issues that needed to be addressed through this inquiry.

2.7. Consideration of previous reviews and inquiries

In addition to having regard to our 2012 report, *Responding to Child Sexual Assault in Aboriginal Communities*, we considered the following reviews and inquiries insofar as they are relevant to the JIRT program:

- the 1996 evaluation of the pilot of Joint Investigation Teams, the precursor to the JIRT program[13]
- the 1997 report of the Royal Commission into the New South Wales Police Service Paedophile Inquiry (Wood Royal Commission)
- the 2002 *Evaluation of the Joint Investigation Team (JIT)/Joint Investigation Response (JIR) Strategy – Summary Report*
- the 2006 review of the JIRT program, undertaken by the JIRT partner agencies
- the 2008 report on the *Special Commission of Inquiry into Child Protection Services in New South Wales* (Wood Inquiry)
- the 2013 review of the JRU, undertaken by JIRT partner agencies, and
- the 2014 Ernst & Young review to assist FACS develop a JIRT caseworker caseload benchmark, *Review of Joint Investigation Response Team (JIRT) Resources*.[14]

We discuss previous reviews and ongoing developments relating to the JIRT program in the next chapter.

13 R. Cant and R. Downie, *The Joint Investigation Team (JIT) Evaluation Report*, 1996.
14 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources*, 19 February 2014.

2.8. Comparison with models in other jurisdictions

We commissioned the University of South Australia's Australian Centre for Child Protection (ACCP) to prepare two research reports to inform our inquiry. The research was conducted by Dr James Herbert and Professor Leah Bromfield.

The first report, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse*, compared the features of the JIRT program alongside the features of multi-disciplinary child abuse responses operating in comparable Australian and international jurisdictions. The second report, *Components of Effective Cross-Agency Responses to Abuse*, synthesised research information to suggest the most important components of different multi-disciplinary responses, with a particular focus on models of child advocacy.

At the outset of the inquiry, both our office and the JIRT partner agencies agreed that there would be benefit in exploring multi-disciplinary responses to child abuse in other jurisdictions. For this reason, we visited Western Australia, along with representatives of the JIRT partner agencies and Dr Herbert from the ACCP, to discuss the operation of Western Australia's Multi-Agency Investigation and Support Team (MIST) pilot project.

The MIST, established in 2015, is a Perth metropolitan area based joint services team that responds to child sexual abuse reports. It is based on the methodology of Child Advocacy Centres, which operate in the United States, Canada and Scandinavia. The MIST includes police investigators, child protection workers, specialist child interviewers, medical services, psychological therapeutic services and two Child and Family Advocates employed by a not-for-profit organisation. The Advocates guide children and families through the investigation and criminal justice and child protection processes.

Our assessment of the ACCP reports and child and family advocacy models are discussed in Chapters 5 and 6 of this report.

2.9. Integrating our work with the Royal Commission into Institutional Responses to Child Sexual Abuse

We discussed the focus and scope of our inquiry with senior officers of the Royal Commission to ensure that it complemented the Commission's related examination of specialist and multi-disciplinary child abuse responses.

The Royal Commission's public Roundtable and *Consultation Paper – Criminal Justice* (2016)[15] were informed by a review of international literature, commissioned by the Royal Commission, to evaluate:

- what is known about the efficacy of specialist police child abuse investigative units in Australia, the United Kingdom and United States, compared to traditional responses, and
- what features of specialist units might determine their effectiveness.[16]

The Roundtable and Consultation Paper have been key sources for our inquiry. In addition, we have considered a number of other research papers commissioned by the Royal Commission including:

- *An evaluation of how evidence is elicited from complainants of child sexual abuse*[17]
- *A systematic review of the efficacy of specialist police investigative units in responding to child sexual abuse*[18]

15 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016.
16 Nina Westera, Elli Darwinkel and Martine Powell, *A Systematic Review of the Efficacy of Specialist Police Investigative Units in Responding to Child Sexual Abuse*, March 2016.
17 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, *An evaluation of how evidence is elicited from complainants of child sexual abus*e, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Deakin University, Griffith University, Charles Sturt University, August 2016.
18 Nina Westera, Elli Darwinkel and Martine Powell, *A systematic review of the efficacy of specialist police investigative units in responding to child sexual abuse,* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, March 2016.

- *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*[19]
- *Principles of trauma-informed approaches to child sexual abuse: A discussion paper*[20]
- *Feeling safe, being safe: What is important to children and young people with disability and high support needs about safety in institutional settings?*[21]
- *Safe and sound: Exploring the safety of young people in residential out of home care*[22]
- *Disability and child sexual abuse in institutional contexts*[23]
- *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended.*[24]

We provided the Royal Commission with a draft copy of our report and those we commissioned from the ACCP to inform the Commission's final Criminal Justice report.

2.10. Consideration of information obtained through the exercise of the Ombudsman's community services, employment-related child protection and police conduct jurisdictions

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) we are responsible for:

- monitoring and reviewing the delivery of community services and related programs (which includes the JIRT program)
- inquiring into matters affecting community service providers and persons receiving, or eligible to receive, community services
- making recommendations for improvements in the delivery of community services and for the purpose of promoting the rights and best interests of persons using, or eligible to use, community services
- receiving, assessing, resolving and investigating complaints about community services providers (including complaints made under the *Ombudsman Act 1974*)
- promoting access to advocacy support for persons receiving, or eligible to receive, community services to ensure adequate participation in decision-making about the services they receive, and
- reviewing the situation of a child or a person in care, or a group of such children or persons (children and young people in care are over-represented among victims of child abuse and neglect and are a vulnerable JIRT program client group).[25]

We consult with a range of bodies and persons in exercising these functions and have regard to the needs of those who are receiving, or are eligible to receive, community services and are least likely able to complain (including children).[26] We regularly report on, and make recommendations in respect of, systemic issues relating to the provision of community services.[27]

19 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016.
20 Dr Antonia Quadara and Cathryn Hunter, *Principles of trauma-informed approaches to child sexual abuse: A discussion paper,* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Australian Institute of Family Studies, 2016.
21 Sally Robinson, *Feeling safe, being safe: What is important to children and young people with disability and high support needs about safety in institutional settings?* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Centre for Children and Young People, Southern Cross University, February 2016.
22 Tim Moore, Morag McArthur, Steven Roche, Jodi Death and Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016.
23 Professor Gwynnyth Llewellyn, Dr Sarah Wayland and Ms Gabrielle Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney, November 2016.
24 Professor Aron Shlonsky, B. Albers, D. Tolliday, Dr S. Wilson, J. Norvell and L. Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended,* Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, May 2017.
25 These functions, as well as others, are provided for in section 11(1) of CS-CRAMA.
26 See section 11(2) of CS-CRAMA.
27 See section 14A(1) of CS-CRAMA.

Our separate (but complementary) employment-related child protection function involves our office overseeing the handling of reportable child protection allegations that are made against employees and certain volunteers of thousands of government and non-government agencies in NSW.

Section 25A of the Ombudsman Act defines 'reportable conduct' as any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence); or any assault, ill-treatment or neglect of a child; or any behaviour that causes psychological harm to a child; whether or not, in any case, with the consent of the child.

Part 3A of the Act involves the Ombudsman:

- receiving and assessing notifications concerning reportable allegations or convictions against an employee[28]
- scrutinising agency systems for preventing reportable conduct by employees, and for handling and responding to allegations of reportable conduct and convictions
- monitoring and oversighting agency investigations of reportable conduct
- responding to complaints about inappropriate handling of any reportable allegation or conviction against employees
- conducting direct investigations concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable notification or conviction
- conducting audits and education and training activities to improve agencies' understanding of, and responses to, reportable allegations, and
- reporting on trends and issues in connection with reportable conduct matters.

When an allegation of 'reportable conduct' is made against an employee of a relevant government or non-government agency, the head of agency is required to notify the Ombudsman of any reportable allegations or convictions involving their employees. We encourage agencies to notify us at the earliest possible opportunity so that we can play an early role in guiding them through their initial response. Agencies are expected to respond to allegations by conducting an investigation, and undertaking any risk management or other action which may be required.

We currently have 398 open cases involving matters where the alleged conduct is, or has been, the subject of a police investigation. Of these matters, 158 concern individuals who have been charged with criminal offences relating to children, the majority of which relate to sexual offences. Of the allegations that are notified to our office, almost a quarter of them result in a sustained finding.[29]

Our office is in a unique position to contribute to identifying child protection risks through our direct access to the policing and child protection databases combined with our own reportable conduct database. This access often provides us with a 'helicopter' view of critical information which is not readily accessible to other agencies. For example, when new notifications are received, we check the Police and FACS databases and assess the adequacy of the response to any risk which we can identify from analysing the totality of the information we review. Our immediate priority is to assess whether the information meets the threshold for a report to Police and/or FACS and, if so, establishing whether or not this has already occurred. Where additional action is required, we make telephone contact with the involved agency to explain our concerns and canvass potential options for strengthening the response.

The timely reporting of criminal allegations to Police, and where appropriate, the reporting of risk of significant harm (ROSH) concerns to FACS, are critical to ensuring that any criminal and/or child protection responses, are not compromised. In this regard, we work closely with employers who have not recognised their responsibility to refer allegations, or certain evidence, to the Police – guiding them through the process and ensuring that their workplace response to these matters does not

28 Under Part 3A of the Act, an 'employee' is defined broadly as including any employee of the agency, whether or not employed in connection with any work or activities of the agency that relates to children, as well as any individual engaged by the agency to provide services to children (including in the capacity of a volunteer).

29 Data current as at April 2017.

compromise any police investigation. Increasingly, we fulfil this critical role at an early stage of our oversight of matters because of the imperative to act promptly when children are at risk. We also work closely with the Office of the Children's Guardian and employers to ensure that critical child protection information is identified, appropriately shared and managed.

The support we provide to agencies also includes our most experienced investigators regularly liaising with the CAS and senior police from Local Area Commands. In addition, we routinely refer detailed briefings to Police and FACS which often results in the commencement and/or enhancement of police investigations and the preferment of criminal charges, and related child protection action.

Information obtained and considered by our office in exercising the functions described above has informed our inquiry.

2.11. Limitations of methodology

Due to the short timeframe for our inquiry, we were unable to undertake a detailed review of the handling of cases dealt with by the JIRT program. However, our role in reviewing the delivery of community services, including reviewing the deaths of certain children; our three year audit into Aboriginal child sexual abuse; and our employment-related child protection oversight function, have given us direct insights into the handling of numerous individual cases – including assessment decisions by the JRU and the Child Protection Helpline, and systems and practice issues relevant to the overall JIRT program.

2.12. Preliminary views and recommendations

During our inquiry, we have sought the views of the JIRT partner agencies on a range of issues, and provided a copy of our draft report to each of the partner agencies for comment. Throughout this report we refer to the views of the individual agencies and, where they have provided a collective view as the JIRT SMG, this has also been reflected.

Chapter 3. JIRT development, review and reform

3.1. Early developments in joint child abuse investigation in NSW

In 1993, the NSW Child Protection Interagency Conference recommended the establishment of co-located Police and Department of Community Services (DoCS) teams to enable a more coordinated response to child abuse. Co-location was recommended to enable a more coordinated response and to promote collaborative work with other key child protection agencies.[30]

In 1994, two co-located Joint Investigation Teams (JITs) were piloted at Bankstown and The Entrance. According to the JIRT agencies, a 1996 evaluation of the JITs[31] concluded that the overall joint investigation experience for children and their families was positive due to:

- the reduction of emotional trauma to children – with fewer interviews, an appropriate interview environment and only one contact point for the investigation
- more effective investigations – criminal briefs were of a higher standard and investigations were more timely, and
- improved levels of cooperation between DoCS and Police.[32]

In 1996, the NSW Government endorsed the JIT as the preferred model for investigating serious child abuse, with eight permanent JITs established in Sydney metropolitan areas as well as Newcastle, Wollongong and The Entrance in 1997. In August 1997, the Wood Royal Commission into the NSW Police Service welcomed the rollout of the JIT model and the government's plan to provide for non-co-located joint investigations in rural areas.[33]

In 1998, an additional JIT was established at Chatswood and police and DoCS officers in rural NSW were trained to undertake joint investigations without being co-located (this model was known as the Joint Investigation Response or JIR). The same year, JITs started electronically recording children's evidence in accordance with the *Evidence (Children) Act 1997*. In 2000, audio-recording of child interviews commenced in rural locations.

3.2. Evaluation of the Joint Investigation Team (JIT)/Joint Investigation Response (JIR) Strategy (2002) and subsequent reforms

The 2002 evaluation of the JIT/JIR Strategy set out to assess whether the response reduced trauma for victims, improved investigations, improved safety and family functioning, improved cooperation between agencies, and whether appropriate processes and resources were in place.[34]

As noted by the authors, the evaluation had a number of limitations that reduced the extent to which conclusions could be made about the benefits of the joint response, including that it did not compare the JIT/JIR and other practices, or performance data before and after implementation of the joint response. The review was a process evaluation that focused on performance against the planned strategy, rather than an outcomes evaluation. It also lacked data on the delivery of support services, counselling and court support, and the reoccurrence of abuse notifications.

30 NSW Health, NSW Police Force, NSW Department of Family and Community Services, *Joint Investigation Response Team (JIRT) Induction Package*, 4 September 2013, p.6.
31 R. Cant and R. Downie, *The Joint Investigation Team (JIT) Evaluation Report*, 1996.
32 NSW Health, NSW Police Force, NSW Department of Family and Community Services, *Joint Investigation Response Team (JIRT) Induction Package*, 4 September 2013, p.6.
33 Royal Commission into the New South Wales Police Service, *Final Report Volume IV: The Paedophile Inquiry*, August 1997, p.262.
34 J. Cashmore, J. Taplin and V. Green, *Evaluation of the Joint Investigation Team (JIT)/Joint Investigation Response (JIR) Strategy – Summary Report*, June 2002.

While the evaluation sought the views of children and non-abusive caregivers regarding their experience of the JIT/JIR, response rates were very low.

The evaluation relied heavily on worker perceptions of the quality of the response. Concerns were identified around:

- organisational differences that slowed the response down (that is, regular business hours for DoCS workers and shift work for police)
- the unavailability of experienced medical staff to undertake examinations
- lack of referrals to NSW Health to put services in place for families
- concern from JIT/JIR workers about Health sexual assault counsellors and the accuracy of information they provided about the police and child protection response
- observations that police tended to leave it to the child and family to decide whether to pursue charges, and that in some situations police had talked people out of pursuing charges, and
- excessive workloads and lack of resources.

Comparing the JIT and the JIR, the co-located JIT workers reported having higher levels of role clarity, and reported finding it easier to arrange joint briefings, than JIR workers.

The JIT/JIR Strategy was renamed the Joint Investigation Response Team (JIRT) in 2001.

Following the 2002 evaluation of the JIT/JIR strategy, the NSW Government trialled a co-located, rural JIRT in Tamworth (in 2004), and a co-located NSW Health worker at The Entrance JIRT (in 2005).

3.3. JIRT Review (2006), the Wood Inquiry (2007–2008) and subsequent reforms

In 2006, JIRT partner agencies conducted an internal review to identify potential improvements in the JIRT response.[35] Broadly, the tri-agency working group which carried out the review agreed that:

- *the premise of joint work and the JIRT program area is sound and viable*
- *the primary rationale of JIRT is offering support and safety to children and families and minimising trauma, including driving better societal outcomes, dealing with offenders and creating safer communities*
- *with time, JIRT practice has drifted from the original codified policy and there has been a disproportionate focus on the aspect of criminality*
- *NSW Health's JIRT role has been codified as one of supporting the investigations conducted by Police and DoCS, rather than as a "full" partner.*[36]

The following significant issues were identified as requiring improvement:

- the inconsistent application of JIRT criteria, evidenced by significantly different acceptance rates between individual JIRTs (each JIRT was responsible for assessing referrals from its area)[37]
- Health not being an equal partner in the JIRT
- low rates of acceptance of referrals for physical abuse
- intake processes focussing on the most recent incident, rather than on a child's history
- delays in interviewing children
- a 'focus on criminality' and overdependence on the need for a disclosure from the victim rather than a holistic approach to child safety, welfare and wellbeing

35 NSW Health, NSW Police, NSW Department of Community Services, *NSW Joint Investigative Response Team (JIRT) Review*, November 2006.
36 NSW Health, NSW Police, NSW Department of Community Services, *Joint Investigation Response Team (JIRT) Review*, November 2006, p.14.
37 Our office had raised concerns about inconsistent assessment of JIRT matters since 2005.

- a lack of reliable and accessible data on JIRT processes and outcomes
- a lack of timely referral to forensic medical and counselling services
- difficulties in engaging Aboriginal children, and
- insufficient integrated decision-making and input from partner agencies.

Concerns with cross-agency communication, governance and data were raised and, in response, the review recommended clear governance structures across partner agencies and improvements to data systems.

The review also recommended more proactive engagement with Aboriginal communities, increased employment of Aboriginal staff in areas with significant Aboriginal populations, provision for culturally appropriate support people for interviews, and increased cultural awareness training for staff. It pointed out that Aboriginal children and children from diverse cultural backgrounds may be more responsive to interviewers where they can develop a degree of trust with the worker before the interview commences.

The Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry) commenced early in the implementation of the recommendations of the 2006 review. Justice Wood supported the continuation of the JIRT program and the plans to complete the reform process set down by the 2006 review:

> *The Inquiry accepts that there are strong reasons in principle and in practice, for the use of the JIRT model. They lie in its ability to:*
>
> *(a) Provide a timely and comprehensive process, drawing upon the combined expertise and experience of the team members*
>
> *(b) Enhance the quality of investigations and the preparation of briefs of evidence*
>
> *(c) Pave the way for the victim and non-offending family members (where the case involves intra-familial abuse), to have timely access to therapeutic interventions and counselling*
>
> *(d) Lessen the stress for victims by providing a more focussed interview structure that should avoid the need for repetitive interviewing*
>
> *(e) Allow, in conjunction with the investigative process, case planning for the well-being and welfare of the victim*
>
> *(f) Provide an effective basis, subject to [enactment of Chapter 16A], for a more comprehensive exchange of information*
>
> *(g) Provide a platform for greater interagency cooperation and cross jurisdictional training in the complex and challenging issues that arise in relation to child sexual and physical abuse, and neglect.*
>
> *In the light of these considerations…this Inquiry supports its continuation and action to complete the reform process that was instituted following the 2006 Review.*

Justice Wood also observed:

> *the full involvement of Health as a JIRT partner, enhancement of the Forensic Medical Service, and implementation of the strategies designed to make the JIRT process more accessible and productive in relation to the Aboriginal community, will involve a substantial commitment of resources on the part of all partners that will have financial implications. The Inquiry, however, considers that there is no alternative other than to complete the reform program, and to maintain an auditing and monitoring process in order to identify whether any of the issues mentioned above continue to emerge, or whether new problems arise that need to be solved.*[38]

38 Hon James Wood AO QC, *Final Report of the Special Commission of Inquiry into Child Protection Services in NSW, November 2008*, Vol.1, pp.320-321. Justice Wood also recommended reforms to facilitate the free exchange of information between JIRT partner agencies, which have since been superseded by the information exchange provisions of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1988* ('Care Act').

3.4. *Responding to Child Sexual Assault in Aboriginal Communities* (2012 NSW Ombudsman report) and subsequent reforms

Our December 2012 report, *Responding to Child Sexual Assault in Aboriginal Communities*, focused on responses to the sexual abuse of Aboriginal children and young people, but also put a spotlight on the capacity and effectiveness of a range of frontline services for all child sexual assault victims. In addition to highlighting FACS' ongoing staffing shortages in high-need locations, we noted that NSW Health's sexual assault services were unable to meet the current demand for counselling. We also examined, in some detail, the impact of the serious staffing challenges facing the JIRT program – in particular, the Child Abuse Squad (CAS) – at that time.

Our report highlighted a range of significant initiatives that had been developed over recent years to make the JIRT program more responsive to the needs of Aboriginal children (and children generally). These included:

- Health being made a full partner in the JIRT, with 25 Senior Health Clinicians being rolled out across the state from 2010/11 – contributing to a 19% increase in the number of children who received sexual assault counselling between 2007 and 2011. In addition, the establishment of seven designated Aboriginal child sexual assault counselling positions resulted in a 250% increase in Aboriginal children receiving sexual assault counselling in the Hunter New England area where these positions were located.
- An additional New Street Service was established at Dubbo, and the Hunter New England service was expanded, providing additional JIRT treatment referral options for children with sexually abusive behaviours.
- After a nine month pilot, the JRU was established (on an ongoing trial basis) from 2009 to improve the quality and consistency of assessment decisions and free up local JIRT agency staff from performing an assessment function – the JIRT acceptance rate increased by 25% from 2009 to 2011.
- JIRT referral criteria were clarified, with a protocol for the inclusion of allegations of serious physical abuse adopted.
- The *JIRT Aboriginal Community Engagement Guidelines* were introduced across the state by April 2010.
- The *Enhanced JIRT services to Aboriginal Children and Young People* protocol was introduced in May 2010 to provide more flexible JIRT referral processes for Aboriginal children and young people, having regard to additional difficulties encountered by some Aboriginal children and young people in disclosing abuse – the acceptance rate for Aboriginal children increased to 80% by 2011 – which was substantially more than the 66% acceptance rate for all children.
- The Bourke JIRT was established in 2009, delivering an improved service to children and families, particularly Aboriginal families, in Western NSW.
- An induction kit was prepared for JIRT staff and the JIRT Foundation Skills Course, with participation of staff from the three partner agencies, was introduced in 2012.
- FACS established a JIRT Director, with central reporting and accountability for JIRT units (previously, responsibility for the JIRT program lay with FACS regions).
- More senior officers were appointed to the JIRT State-wide Management Group (SMG) and Local Management Group (LMG) arrangements were revised.

Our audit report stressed that the success of these initiatives was dependent on the JIRT program continuing to operate effectively as a partnership. Due to the multi-faceted and complex nature of the JIRT program, there were a myriad of practice issues that we could have canvassed in our report but instead, we sought to highlight the fundamental challenges that were facing the JIRT partnership at that time. We argued that if these challenges were not given sufficient attention, it would be difficult for many of the positive reforms implemented by the JIRT SMG to achieve the intended outcomes.

Our report identified that the majority of the problems stemmed from chronic staffing shortages across the JIRT partnership and highlighted the need to strengthen accountability, data collection and case management systems in the monitoring of, and reporting on, JIRT program outcomes.

While the introduction of the JRU had been one of the most successful developments resulting from the 2006 review, it had also led to a much higher than anticipated increase in the number of cases accepted into the JIRT program, resulting in an increased workload that was not matched by an increase in resources. In various ways, the resourcing problems present at that time impacted on core practice issues which went to the heart of the JIRT partnership; for example, the ability of CAS and FACS JIRT staff to meet their (then) commitment to jointly conduct/attend child interviews and conduct local planning and response (LPR) briefing and debriefing meetings.

We recommended a cross-agency review of the level of JIRT resourcing required against the current demand. However, we stressed that it would be inappropriate to suggest that reviewing the capacity of the JIRT program should only be about ascertaining whether there was a need for more resources. We argued that it would be counter-productive to examine resourcing without also examining productivity. In the case of the CAS, this fact was well illustrated by our examination of police workload and outcome data, which highlighted significant performance variance across squads in relation to child interview and arrest rates.

Our report had a particular focus on the performance of the CAS due to our office receiving a complaint about the investigative practices of the CAS at that time. To support their concerns, the complainants provided us with data pointing to a marked decrease in arrests in a number of high volume locations.

Encouragingly, the CAS leadership acknowledged the significant performance challenges it was then facing and the former Commander set about an ambitious program of reform, leading to marked improvements across a range of indicators. In particular, we highlighted the need for the CAS to enhance its monitoring systems for individual squads; consider the sufficiency of its supervisory positions; develop strategies for making the CAS a more attractive operational policing unit; and consider the scope for Local Area Commands carrying out increased work in relation to serious cases of child abuse.

We also acknowledged that improvements to police productivity and resourcing would inevitably place a greater resource burden on the other JIRT partners. For this reason, in addition to our recommendations in relation to the review of the CAS, we recommended that a comprehensive review of the JIRT program be carried out.

> **Recommendation 20:** *That the respective heads of the three JIRT partner agencies should individually and severally carry out a review of the JIRT program that focuses on:*
>
> *(a) Whether the resources available to deliver on the key components of the JIRT program are adequate.*
>
> *(b) Establishing a solid framework (and related evidence base) for better ongoing monitoring of the performance of the key components of the JIRT program. In establishing the framework, the respective heads of the three JIRT partner agencies should pay particular attention to the following:*
>
> *(i) Enhancing the JIRT program's case management information system(s).*
>
> *(ii) Effectively utilising the CAS's state-wide workload analysis reports.*
>
> *(iii) Continuing to strengthen the role of the JIRT State-wide Management Group in relation to its audit role and its leadership, and evaluation of, cross-agency JIRT-related development initiatives.*
>
> *(iv) Enhancing the output/performance data currently reported to the respective heads of the partner agencies by the JIRT SMG.*
>
> *(v) Ensuring that there are adequate systems in place for assessing the ongoing impact of the Enhanced JIRT Services to Aboriginal children and young people protocol (and its potential applicability to non-Aboriginal children).*

(vi) *Whether there is ongoing practice improvement in relation to the exchange of critical information between JIRT partners.*

(vii) *The extent of compliance with LPR Procedures.*

(viii) *Whether there is ongoing progress in relation to the implementation of the Aboriginal Community Engagement Guidelines.*

(ix) *Whether there is continuing high quality performance in relation to the operations of the JRU.*

Recommendation 21: *In consultation with its JIRT partners, the NSW Police Force should continue its ongoing review of its practices and performance as the lead criminal investigative body of JIRT. In doing so, the NSW Police Force should seek to:*

(a) Enhance its monitoring systems of its individual JIRT teams in line with the rigorous monitoring system it already has in place under the COMPASS performance management system.

(b) As previously noted, seek to effectively utilise the CAS's state-wide workload analysis as a performance monitoring tool.

(c) Consider whether the allocation of supervisory JIRT positions is adequate.

(d) Consider innovative strategies for making JIRT a more attractive operational policing unit.

(e) Consider the scope for, and appropriateness of, Local Area Commands carrying out increased work in relation to serious cases of child abuse.

In responding to our 2012 report the following year, the NSW Government indicated its support for the above recommendations. As part of the current inquiry, we sought specific advice from the JIRT agencies about how they have implemented the recommendations; we discuss this throughout the report. We also revisit other recommendations contained in our 2012 report, including in relation to improving the criminal justice system, therapeutic services for young people with problem or harmful sexual behaviours, and areas of law reform, that have since been implemented.

3.5. Royal Commission into Institutional Responses to Child Sexual Abuse

The Royal Commission was established in January 2013 to inquire into institutional responses to allegations and incidents of child sexual abuse and related matters, in particular, what institutions and governments should do to:

- better protect children against child sexual abuse in institutional contexts in future
- achieve best practice in encouraging the reporting of, and responses to reports or information about, allegations, incidents or risks of child sexual abuse, and
- eliminate, or reduce, impediments that currently exist for responding appropriately to child sexual abuse and related matters in institutional contexts, including addressing failures in, and impediments to, reporting, investigating and responding to allegations and incidents of abuse.[39]

The following Royal Commission case studies are most relevant to our inquiry into the operation of the JIRT program.

39 Royal Commission into Institutional Responses to Child Sexual Abuse, Letters Patent, 11 January 2013.

3.5.1. Case Study 2: YMCA NSW's response to the conduct of Jonathan Lord (June 2014)

The hearings for Royal Commission Case Study 2 commenced in October 2013 and considered aspects of the JIRT program's operational response, in particular, the manner in which it handled reports of grooming and abuse by a YMCA employee, Jonathan Lord, in 2011. A focus of the hearing (discussed in Chapter 23), was the need for the JIRT to provide clear guidance to institutions on what they can and cannot communicate to staff and parents in matters where there is potentially a class of children at risk.[40]

At the time of the hearing, the Police were developing the JIRT Local Contact Point Protocol (LCPP) to guide JIRT agency staff on the establishment and operation of a 'Local Contact Point' to provide appropriate information to parents and concerned community members in a manner that does not risk compromising the criminal investigation or a child's safety.[41]

3.5.2. Case Study 37: The Response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse (January 2017)

The Royal Commission's Case Study 37 hearing (discussed further in section 9.3), criticised the Parramatta JIRT's 2007 investigation of child sexual abuse and grooming allegations against Grant Davies, a partner in, and dancing instructor for, RG Dance Pty Ltd. The Commission noted that the Parramatta JIRT should have interviewed two potential witnesses as part of the police investigation. The Commission found that the risks caused by the delay in executing a search warrant to obtain Mr Davies' computer was unacceptable. However, the Commission acknowledged that the squad's high workload and competing priorities were contributing factors to this delay.[42] (Our 2012 audit also found that CAS resourcing at that time was a serious problem.)

The Commission further considered the risks associated with not providing families or others involved in the dance school with information about the risk posed by Mr Davies, accepting that changes to agency practices under the JIRT program have involved establishing clearer escalation points likely to achieve faster resolution.[43]

Case Study 37 also heard evidence about Chatswood JIRT's handling of allegations of sexual assault against Victor Makarov, a teacher employed by the Australian Institute of Music, in 2003-04. The evidence praised the professional and supportive response of Police and FACS in responding to the allegations.[44] Makarov was eventually convicted of 26 charges involving offences against multiple victims.

3.5.3. Case Study 38: the Royal Commission's Criminal Justice Project (March 2016)

In May 2015, the Royal Commission sought submissions on people's experiences of reporting institutional child sexual abuse to police, the police investigation process, interacting with prosecutors, their preparation for court, and the criminal trial process as part of its Criminal Justice Project. In March 2016, the Royal Commission held its Case Study 38 hearing as part of this Project.[45]

40 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, p.8.

41 Department of Family & Community Services, New South Wales Police Force, NSW Health, *JIRT Local Contact Point Protocol 2014: A system for dealing with parental and community concerns when there are reports of child sexual abuse under investigation in an institutionalised setting*, 2014, p.3.

42 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The Response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse*, January 2017, p.21. Police resourcing of JIRTs has significantly increased since 2007-2008, with Police resourcing of JIRTs further discussed in Chapter 10 of this report.

43 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The Response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse*, January 2017, p.83.

44 Royal Commission into Institutional Responses to Child Sexual Abuse, Public Hearing – Case Study 37, Transcript for 3 March 2016, pp.16608-16956.

45 Royal Commission into Institutional Responses to Child Sexual Abuse, *Case Study 38 – Criminal Justice Project*, Transcript for 24 March 2016, pp.153-154.

In June 2016, the Commission held a Roundtable on multi-disciplinary and specialist policing responses, which discussed the interaction between police, the institution and the parents of children in the institution, including what information and direction parents and community members need from police and the institution when current allegations of institutional child sexual abuse are made.[46] The issues surrounding information sharing and the limitations imposed by privacy and defamation law are discussed further in Chapter 23. The Roundtable also considered child advocacy services within a multi-disciplinary response to child abuse; the need for ongoing training, including reviews of child interviews by Police; and children who display sexually abusive behaviours.[47]

3.5.4. Case Study 41: Institutional responses to allegations of the sexual abuse of children with disability (July 2016)

In July 2016, the Royal Commission held a public hearing which examined the responses of disability service providers Mater Dei School in Camden NSW, The Disability Trust, Interchange Shoalhaven and FSG Australia, to allegations of child sexual abuse. During the hearing, the Commission also heard evidence about the response by Wollongong JIRT to allegations that a casual worker in various programs run by the Disability Trust, as well as a casual employee of Interchange Shoalhaven, sexually abused CIE, a child with moderate autism. Case Study 41 is discussed further in Chapter 14.

46 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, 2016, p.145.
47 NSW Ombudsman record of meeting.

Chapter 4. How the JIRT model currently operates

The JIRT remains a state-wide partnership between Police, FACS and Health that provides a multi-disciplinary response to children and young people alleged to have suffered sexual abuse, serious physical abuse or extreme neglect by delivering a timely, comprehensive and coordinated safety, criminal justice and health response.

The Memorandum of Understanding (MoU) between the three JIRT partner agencies provides for a joint response to investigations of alleged child sexual abuse. The head of each agency 'formally agrees to foster cooperation between Departments for the mutual benefit of working effectively on creating relationships that provide the best outcomes for children, young people and their families'.

Under the MoU:

- the role of Police is to detect and investigate alleged child abuse and neglect and initiate criminal proceedings against alleged offenders, where appropriate
- the role of FACS is to receive and assess reports of risk of significant harm to children and young people, ensure the safety and ongoing care of children and young people, and initiate care and protection proceedings in the Children's Court, and
- the role of Health[48] is to identify and report risk of harm to children and young people, and provide treatment, crisis and ongoing counselling as well as medical examinations.

The JIRT program is based on a service delivery model that provides for officers of the Police Child Abuse Squad (CAS), FACS and Health staff being 'co-located', wherever possible.[49] Co-location involves multi-disciplinary team workers from different agencies being located 'within the same general location',[50] for example, in the same building or complex. It does not require those workers to share a workspace, although it is common for parts of the building/complex to be set aside for joint work or common use. We discuss co-location further in Chapter 20.

There are currently 22 JIRT locations across NSW, 11 of which have staff from all three partner agencies co-located and four of which have FACS and Health staff co-located. The CAS provides a 24 hour response and operates from 23 sites. The CAS has also established a Child Abuse Response Team which is based at Police Headquarters. In addition, each of the three agencies has dedicated staff based at the JRU, which assesses each referral against the JIRT criteria to determine whether or not a matter should be accepted for a JIRT response.

The breakdown of JIRT staffing is outlined in Table 1 below.

Table 1: JIRT program staffing

JRU staffing			
Location	**FACS Staff**	**Sworn Police Staff**	**Health Staff***
JIRT Referral Unit	7 (Including 1 Manager Client Services, 1 Senior Project Officer, 1 Senior Administrative Officer and 4 Caseworkers)	4 (Including 1 Manager at Senior Sergeant level and 3 Team Leaders)	5 (Including 1 Health Service Manager, 1 Senior Health Professional/Clinician, 2.5 Health Professionals/Clinicians, and 0.5 Administrative Assistant)
Total staff at JRU: 16			

48 Health has advised us that a more complete description in an updated MoU would be: 'the role of Health is to provide direct victim support and clinical advice on trauma during the JIRT process, conduct medical and forensic examinations, provide expert certificates and appear as expert witnesses in court, provide medical treatment, crisis and ongoing counselling for children and young people and their families, and refer children and young people and their families to other health services.' (Advice provided by NSW Health, 20 June 2017).

49 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006, (incorporating February 2013 interim changes) p.1.

50 Hon James Wood AO QC, *Final Report of Special Commission of Inquiry into Child Protection Services in NSW*, November, 2008, Vol.1, p.310.

JIRT agency field staff			
Location	**FACS Staff****	**Sworn Police Staff*****	**Health Staff******
Albury	3	5 (Including 1 Team Leader)	1.5 (1 Senior Health Clinician and 0.5 Health Clinician)
Ballina	5 (Including 1 Manager Casework)	7 (Including 1 Team Leader)	3 (1 Senior Health Clinician positions, and 2 Health Clinicians)
Bankstown	7 (Including 1 Manager Casework)	9 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
Bathurst	6 (Including 1 Manager Casework)	7 (Including 1 Team Leader)	2.5 (1 Senior Health Clinician and 1.5 Health Clinician)
Bourke	2 (Including 1 Manager Casework)	4 (Including 1 Team Leader)	1 (1 Senior Health Clinician)
Broken Hill	1	2	1.5 (1 Senior Health Clinician and 0.5 Health Clinician)
Chatswood	4 (Including 1 Manager Casework)	7 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
Coffs Harbour	2	7 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
Dubbo	4 (Including 1 Manager Casework)	5 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
Far South Coast	0	4 (Including 1 Team Leader)	1 (1 Health Clinician)
Griffith	1	3	1.5 (1 Senior Health Clinician and 0.5 Health Clinician)
Inverell	2	3	1.5 (1 Senior Health Clinician and 0.5 Health Clinician)
Kogarah	5 (Including 1 Manager Casework)	8 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician
Liverpool	11 (Including 2 Managers Casework)	14 (Including 2 Team Leaders)	3 (1.5 Senior Health Clinicians and 1.5 Health Clinicians)

JIRT agency field staff			
Location	**FACS Staff****	**Sworn Police Staff*****	**Health Staff********
Newcastle	12 (Including 2 Managers Casework)	17 (Including 2 Team Leaders)	4 (2 Senior Health Clinicians and 2 Health Clinicians)
Parramatta	6 (Including 1 Manager Casework)	11 (Including 2 Team Leaders)	2.5 (1.5 Senior Health Clinicians and 1 Health Clinician)
Penrith	8 (Including 1 Manager Casework)	14 (Including 2 Team Leaders)	2.5 (1.5 Senior Health Clinicians and 1 Health Clinician)
Port Macquarie	6 (Including 1 Manager Casework)	8 (Including 1 Team Leader)	3 (2 Senior Health Clinicians and 1 Health Clinician)
Queanbeyan	3 (Including 1 Manager Casework)	5 (Including 1 Team Leader)	1 (1 Senior Health Clinician)
Tamworth	5 (Including 1 Manager Casework)	7 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
The Entrance	7 (Including 1 Manager Casework)	11 (Including 2 Team Leaders)	2 (1 Senior Health Clinician and 1 Health Clinician)
Wagga Wagga	3 (Including 1 Manager Casework)	6 (Including 1 Team Leader)	2 (1 Senior Health Clinician and 1 Health Clinician)
Wollongong	7 (Including 1 Manager Casework)	12 (Including 2 Team Leaders)	2 (1 Senior Health Clinician and 1 Health Clinician)
Total	**110**	**176**	**47.5**

Table notes:

* The Director, Child Wellbeing (not counted in staffing table above) is based in the Sydney Children's Hospitals Network (SCHN) and spends 20% of their time leading, supporting and providing operational direction to the JRU Health Manager and their staff. The Director reports to the JIRT SMG via the Ministry of Health on JRU matters. The JRU Health Manager works alongside the FACS and Police JRU managers to assess whether referrals should be accepted or rejected for a JIRT response; and ensures relevant health information is obtained to inform assessments. The JRU Senior Health Professional/Clinician works collaboratively with the JRU Health Manager in overseeing the JRU Health Team responsibilities in sourcing, requesting and following up of relevant health information required for assessments. The JRU Health Professional/Clinicians contribute to fulfilling JRU Health team responsibilities in relation to gathering, reviewing and assessing child protection information to determine the suitability of referrals from the Helpline for entry into the JIRT program. The Administrative Assistant provides administrative services to the JRU Health team.

**Excluding the JRU, there are four FACS clusters and each cluster has a Manager Client Services (MCS) who reports to the two JIRT Directors. FACS also has 18 Senior Administration Officers and 1 Principal Project Officer. The FACS Senior Project Officer position is part of FACS JIRT Project Team at Head Office. This position was temporarily moved from Head Office to the JRU to meet demand for a FACS second in charge role. The position will remain at the JRU until a permanent solution is identified.

*** There are six CAS Zones. Each CAS Zone has a Manager at Inspector level who reports to the CAS Commander. There is an additional Inspector based at CAS HQ to provide strategic advice and management to the Commander and to allow the Zone managers to focus on operational issues. The NSWPF also has a Child Abuse Response Team (CART) at Police Headquarters. The total number of sworn CAS staff including CART, the Commander and other police personnel involved in management and administrative duties (other than those included in the table) is 21. The CAS also has four unsworn analyst positions.

****Senior Health Clinicians and Health Clinicians report to 21 Health Managers. These Managers are not dedicated JIRT staff; on average between 5% and 60% of their work is allocated to management of Health JIRT staff. These Managers report through the LHD structure. The NSW Health Director Prevention Violence Abuse and Neglect provides strategic policy leadership to the Health JIRT.

The *JIRT Policies and Procedures Manual* was developed in 2001 but as it has not been updated recently, it no longer reflects the current operating framework for the JIRT program, as endorsed by the JIRT State-wide Management Group's 2016 Joint Communication. While the JIRT agencies have recognised the need to update the document for some time, they have been unable to jointly do so against a background of competing operational priorities (in Chapter 25, we discuss the need for the JIRT agencies to have shared executive support to assist them to meet non-operational, strategic governance and accountability priorities). In the interim, a number of jointly endorsed key documents, which describe the critical processes underpinning the model have been developed:

- The JIRT MoU
- The JIRT referral criteria (and supporting documents)
- The *JRU Process Guidelines*
- The *Local Planning and Response Procedures*, and
- The *Local Contact Point Protocol*.

In addition, each agency has various policies, procedures and directives of their own to support the implementation of the joint procedures listed above.

As we discuss in Chapter 25, while the above documents need updating and must be readily accessible to staff from each JIRT agency, we do not believe it is necessary for an overarching JIRT manual to be developed/updated. The JIRT agencies have committed to refreshing and better integrating shared policies and procedures supporting the JIRT program, having regard to the observations and recommendations in this report, to ensure that they will reflect tri-agency planning and decision-making around the child/young person and agreed operational practice.

The following sections summarise the operation of the JIRT program having regard to our review of current documentation and up to date advice from the partner agencies about how practice in the field has evolved over recent years.

4.1. The referral and assessment process

The Child Protection Helpline receives reports about sexual abuse, physical abuse and neglect of children and young people.[51] Reports may be made by mandatory reporters[52] (including police, education and health workers), non-government organisations or members of the public. When the Helpline receives a report of sexual abuse, physical abuse or neglect, it applies its Structured Decision Making (SDM) screening tool to determine if the child or young person is at risk of significant harm (ROSH). The Helpline then determines if the report meets the JIRT referral criteria – if it does, the report is referred to the JIRT Referral Unit (JRU) for further assessment and a decision as to whether the referral will be accepted for a JIRT response. In this way, the Helpline essentially acts as 'gate-keeper' for entry into the JIRT program.

The current JIRT referral criteria are as follows:

Sexual abuse reports:

- Disclosure and/or evidence of sexual assault.

51 It should be noted that in October 2014, South Western Sydney FACS District commenced trialling the Macarthur Intake and Referral Service, a 'local Helpline' model (covering Campbelltown, Camden and Wollondilly Local Government Areas), which refers reports to local services when FACS determines that there is no risk of significant harm. Similarly, in mid-November 2015, Central Coast FACS District began trialling the Central Coast Multiagency Response Centre (CC-MARC), which covers the Gosford and Wyong Local Government Areas. During business hours, reporters who contact the Child Protection Helpline are able to select an automated option to speak to a CC-MARC case worker, with local knowledge for a local response. Calls outside of business hours are diverted to the Helpline. These 'decentralised Helpline' models follow same process as the Helpline for assessing and referring reports that meet the JIRT Referral Criteria to the JRU for a decision.

52 Section 27 of the *Children and Young Persons (Care and Protection) Act 1998* establishes that mandatory reporting applies to: (a) 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 (b) a person who holds a management position in an organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children.

- Any reports of sexual abuse of a child under the age of 18 years where the alleged offender is over the age of criminal responsibility i.e. 10 years.
- Presentation of physical indicators consistent with sexual abuse, for example, venereal diseases, pregnancy, unexplained bruising on or bleeding from genitals, presence of semen on child, unexplained bruises to breast, and
- The CSC will assess reports of sexualised behaviour and allegations where offenders are 10 years and under.

Neglect reports:

- Extreme neglect resulting in physical harm, for example, burns from nappy rash, and
- Malnutrition and/or dehydration from withholding of food and fluids.

Physical abuse reports:

Severe or serious physical injury (see JIRT Injury Guide Table[53]) to a child or young person under the age of 16 years which is:

- Unexplained or inconsistent with the explanations provided and/or
- Inflicted (non-accidental) or suspicious, and
- Caused by another person aged 10 years or over

Consideration should also be given to a history of recurrent bruising or injury. The presence of one or more injuries does not automatically denote a referral to the JRU. You must consider the above criteria and the level of severity of the injuries/indicators listed below.

NB: The JRU retains discretion to accept cases raising child protection concerns for young people aged 16-17 years of age (that is, between 16 years and under 18 years).

The primary role of the JRU is to obtain further information to inform the assessment of reports, and to make tri-agency decisions about whether reports should be accepted or rejected for a JIRT response. Where the acceptance criteria are met, the JRU refers matters to the relevant JIRT/CAS for investigation. The JRU also plays a role in referring matters which do not meet the acceptance criteria to Police Local Area Commands (LACs), FACS Community Services Centres (CSCs) and/or local health services for further action, as appropriate. In addition, the JRU Health team may make 'direct referrals' to health services (such as Sexual Assault Services) regardless of whether a report is accepted or rejected.

The JRU is staffed by the three partner agencies and operates during business hours (Monday-Friday, 9am-5pm). The *JRU Process Guidelines*[54] outline the processes followed by the JRU, including the specific responsibilities of JRU staff attached to each of the three JIRT partner agencies, when the JRU receives a report from the Helpline (or in a small number of cases, a CSC). The JRU's 'decision-making' or 'management team' currently consists of one staff member from each partner agency. They are supported by a team of staff from across the three agencies (see Table 1).

4.1.1. The referral and assessment process for reports received outside of business hours

Outside of the JRU's operating hours, all reports that meet the ROSH threshold are in the first instance assessed by the Helpline to determine whether they require a response before business hours resume. If it is determined that a report does not require an after-hours response, it is assessed against the JIRT referral criteria, and forwarded to the JRU or relevant CSC as required.

53 The JIRT Injury Guide Table is reproduced in Chapter 9.
54 Endorsed May 2016.

If an after-hours response is required, the Helpline refers the report to its Crisis Response Team (CRT). The CRT considers the information to determine whether the report meets the JIRT referral criteria and, if so, contacts the local CAS on-call Investigator (who contacts the on-call CAS Inspector if further advice is needed). The CRT Manager Casework and the CAS Investigator liaise with one another about any response they intend to initiate. The on-call Sexual Assault Coordinator or Tertiary Child Protection Unit/emergency department senior clinicians act as Health's after-hours contact for JIRT (in Chapter 8, we discuss the need for greater clarity about whether the CRT or CAS should contact Health after-hours, where required).

Once any relevant actions by the agencies have been completed, the CRT forwards the report, along with information about the action it has taken, to the JRU. The on-call CAS Investigator also forwards information to the JRU about any relevant action taken. The JRU then assesses the report according to its usual processes, with the exception that it will also consider any information arising from the after-hours response.

The processes for responding to matters after-hours, and issues relating to how the JIRT program currently operates after-hours, are discussed further in Part 3.

4.2. The Local Planning and Response (LPR) process

Once a matter is received by local JIRT agency staff, it is subject to the Local Planning and Response (LPR) process. Under the LPR presently:

- the partner agencies should confer to discuss what contact needs to be made with the child or young person and their family before a more comprehensive briefing meeting
- each agency should review its information holdings on the matter
- a briefing meeting should be held, at which the agencies share their information to inform their respective responses and develop a Safety Welfare and Wellbeing Summary for the child or young person (in practice these 'meetings' can be telephone discussions depending on the urgency)
- the agencies should share information to inform the recorded criminal interview[55] conducted by Police and any related care and protection action required, and
- the agencies should hold a debriefing meeting following the initial field response (including the recorded criminal interview) to discuss the outcome and any additional action required.

According to the most recent JIRT SMG Joint Communication, the LPR is the basis for:

> *a quality, coordinated and planned response to allegations of child abuse.*
>
> *A key element of this is the exchange of information under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998. The timely and consistent exchange of such information is critical to the field response and overall success of the JIRT arrangement.*[56]

The information that is gathered by each agency and exchanged at a briefing meeting should include:

- FACS information relating to the child or young person's child protection history (or that of other children identified in the report); information about the child's community and any other relevant local information (for example, worker safety issues); and current issues for the child and/or family if local FACS staff are actively working with the family.
- Health information relating to their involvement with the family and/or others named in the report; and medical advice (if required).

55 In this report we use the term 'recorded criminal interview' to refer to the electronically-recorded interview of a child victim conducted by Police. Section 306U(1) of the *Criminal Procedure Act 1986* states that 'A vulnerable person is entitled to give, and may give, evidence in chief of a previous representation to which this Division applies made by the person wholly or partly in the form of a recording made by an investigating official of the interview in the course of which the previous representation was made and that is viewed or heard, or both, by the court.'

56 JIRT SMG, *Joint Communication*, 21 December 2016.

- Police information holdings relevant to the safety, welfare and wellbeing of the child – for example, relevant history regarding the child and non-offending carer(s), alleged perpetrator, known associates of the family, and known associates of the alleged perpetrator.

Briefing meetings should generally be scheduled to ensure that the field response occurs within the 'required response time' allocated by the Helpline (or revised by the JRU). However, it is important to note that in practice, regardless of the allocated timeframe, response times will also be driven by any urgent child safety concerns, immediate health needs of the alleged victim or their siblings and criminal investigation imperatives that are identified by local JIRT agencies tasked with responding.

The JIRT agencies should consult each other prior to any contact with the child, young person and/or non-offending carer(s) – except where the report is made directly to a partner agency. In these circumstances, it is reasonable for the agency who received the report directly (for example, where a report is made at a police station), to make contact and meet customer service expectations by confirming that the report has been received and to explain what the joint process involves.[57]

An important early component of the JIRT response is the recorded criminal interview. Under section 306U of the *Criminal Procedure Act 1986*, a recorded interview of a child or young person less than 16 years of age[58] may be admitted as their evidence in chief during court proceedings.

Until January 2016, these interviews were conducted by the CAS and/or FACS officers,[59] and the LPR involved FACS and the CAS jointly developing an interview plan. Police now conduct all recorded criminal interviews. The change was initiated by the CAS on the basis that, as custodians of the brief of evidence, Police are responsible for protecting the integrity of recorded criminal interviews. In communicating the rationale for the change, the CAS referred to feedback they had received from the ODPP and judiciary about previous JIRT interviews of children, including concern about the potential for certain questions to contaminate a child or young person's evidence and/or increase the risk of attacks on the child or young person's reliability and credibility at cross-examination.[60] As discussed in Chapter 18, the change was also initiated in the context of planning for the implementation of the Child Sexual Offence Evidence Pilot which includes the use of witness intermediaries to assist children to provide best evidence during recorded interviews (and at court).

The SMG's 2016 Joint Communication makes clear that FACS and Health staff are able to electronically monitor interviews for the purposes of listening and observing children to inform an assessment of whether a child or young person is at risk of significant harm, as well as other issues concerning safety, risk, health and wellbeing. In the interests of the child or young person, Police are to identify an appropriate point during the interview for a break to occur, for the purpose of consulting FACS and Health about any additional care and protection or clinical matters that have arisen. FACS and Health staff are able to seek further information from the child or young person after the conclusion of the forensic interview, if required.[61] FACS and Health staff who are unable to observe an interview, may review interviews via electronic media, request written or verbal summaries of various aspects, or arrange transcripts for care and protection proceedings.[62]

In their December 2016 Joint Communication, the JIRT SMG specifically recognised:

- the value of the information obtained via recorded police interviews in achieving positive care and protection outcomes for children
- the need for interviews to be conducted in a manner that reduces the risk of further trauma to the child,[63] and

57 NSW Health, NSW Department of Community Services, NSW Police Force, *Local Planning and Response Procedures*, 2013.
58 A recording of a child under 16 years of age may be admitted as evidence regardless of the age of the person when the evidence is given (s.306U(2)).
59 NSW Police Force, Child Abuse Squad Directive, *Interviewing Child Victims*, 21 December 2015.
60 See Chapter 22 of this report for the findings of research, commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse, on the importance of recorded criminal interviews being confined to matters central to proving the criminal charge.
61 FACS workers in the JIRT assess child safety and take care and protection action, where appropriate. Longer term engagement with children and their families, where needed, is generally undertaken by CSCs.
62 Current interview arrangements are outlined in the JIRT SMG, *Joint Communication,* 21 December 2016.
63 Including by reducing the need for interviews to occur on multiple occasions.

- the important support provided by FACS and Health to non-offending parents and family members during this stage of the JIRT process.[64]

We discuss the interviewing process in further detail in Chapter 22.

The LPR should continue after the recorded criminal interview (and any initial action taken by FACS and Health), with agencies holding a debriefing meeting (either in person or via phone calls/emails) to discuss the outcome and any further actions required. Agencies still involved with the case will often hold additional case meetings to further discuss and plan the ongoing responses of their agencies. While much of the work that takes place after the initial response is executed by each agency in accordance with their respective mandate rather than 'jointly', the expectation is that they will keep each other informed of key developments and proposed actions to ensure that they are complementing, and not undermining, their collective primary objective – that is, acting in the best interests of the child.

In all but a few circumstances, the LPR will also involve field action by FACS for the purpose of conducting a secondary risk of harm assessment, regardless of a police determination not to pursue a criminal investigation. The field action may involve FACS undertaking a 'care and protection' interview of the child or young person to inform their risk assessment.

The CAS maintains carriage of cases from the point of referral to the conclusion or suspension of the criminal justice process in circumstances where charges have been laid. Where their risk assessment concludes that Children's Court action is required, FACS JIRT initiates this action and maintains carriage of the case until such time that the court determines that the child or young person is 'in need of care and protection'. Otherwise, the role of FACS JIRT usually ends after it has completed its risk assessment, with cases then transferred to a CSC if ongoing case management is required. In this regard, it is critical that once a CSC has assumed case management responsibility from FACS JIRT that it, too, continues to liaise with the CAS (and vice versa) about care and protection actions that are likely to intersect with any aspects of the ongoing criminal investigation.[65]

The primary role of JIRT health clinicians is to attend to and prioritise the emotional, psychological and physical health and wellbeing of children and young people who enter the JIRT program.[66] JIRT health clinicians participate in joint planning, provide health information and specialist advice to Police and FACS, provide child protection advice to health practitioners, conduct health assessments of children and young people referred to the JIRT program, and provide support to children and young people and their families before and during the interview process. JIRT health clinicians promote a trauma informed process where victims and their families are encouraged to participate in the investigation. JIRT health clinicians facilitate the referral of children and young people to medical forensic examinations,[67] and medical treatment and counselling services.

We discuss the LPR and how each JIRT agency executes its responsibilities in further detail in Chapter 21.

4.3. JIRT program governance

The JIRT program is governed by the JIRT SMG, comprised of senior Police, FACS and Health officers. The SMG – which has met at least quarterly since 2014 – drives, monitors and develops JIRT governance, reporting mechanisms, practice and operational policy and procedure.[68] The SMG has three interagency sub-committees: State-wide Training, Property and Aboriginal Community Engagement.

64 We note that JIRT health clinicians, in particular, play an important role in relation to building rapport with and supporting non-offending family members around the interview process, where required and appropriate, while enabling police to focus on building rapport with the child prior to the interview. This focus on supporting families means JIRT health clinicians do not usually monitor a recorded criminal interview.

65 FACS JIRT maintains carriage until the SARA or SAS2 is complete (benchmark is 60 days, actual average for JIRT is 70 days). They may, in the course of that assessment, initiate emergency child protection action, for example removing a child. But essentially the role of FACS JIRT is to determine if a child is at ROSH and/or in need of care and protection.

66 NSW Health Education Centre Against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response*, 2013, p.8.

67 NSW Health has recently decided to refer to 'medical forensic examinations' rather than the previous term 'forensic medical examinations' to highlight its focus on serving the medical needs of clients in this process (Advice provided by NSW Health, 20 June 2017).

68 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006 (incorporating February 2013 interim changes), p.3.

Previously, the SMG reported to the JIRT CEO Committee (the Commissioner of Police and the Secretaries of Health and Family & Community Services), which met at least twice a year to monitor service quality and budget allocation and to make recommendations and adjustments.[69] However, in practice, the committee has not operated for several years.

Local management issues in each JIRT are addressed by a Local Management Group (LMG), comprising representatives of each partner agency, which meets at least every two months. The LMG addresses any problems with interagency collaboration, examines case studies for quality improvement, receives monthly data, and identifies policy issues and prepares reports for the SMG.[70]

The JIRT MoU provides that any significant policy change being considered by a JIRT partner agency that may impact on JIRT service delivery must involve full consultation with each agency prior to implementation.[71]

69 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006 (incorporating February 2013 interim changes), p.2.

70 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006 (incorporating February 2013 interim changes), pp.2-3.

71 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding*, August 2006 (incorporating February 2013 interim changes), p.3.

PART 2

Specialist and multi-disciplinary responses to child abuse – a review of models in other jurisdictions

How does the JIRT compare to other Australian and international models | Establishing a Child and Family Advocate role within the JIRT

Contents

Chapter 5. How does the JIRT compare to other Australian and international models

As noted in Chapter 2, the JIRT partner agencies were keen to ensure that the review of the JIRT program included a comprehensive and up-to-date review of similar specialist and multi-disciplinary models for investigating and responding to child abuse in Australia and overseas.

This section focuses on models for investigating and responding to child abuse in other Australian jurisdictions, with comparisons between the Australian models (including the JIRT program) made across a number of domains relevant to the operation of multi-disciplinary teams.

5.1. Specialist and multi-disciplinary responses to child abuse investigations

Criminal child abuse investigations are often complex. Historically, many victims have been reluctant to report abuse or participate in court proceedings. Abuse is frequently committed by a family member or a person known to the child's family, which can result in a victim receiving less support from their family than they might receive in respect of another crime. Where abuse occurs in an institutional setting, some victims and family members feel they are up against 'the system', not just an individual offender. There is often limited physical or eyewitness evidence in child abuse cases, with police and prosecuting authorities heavily reliant on the evidence of the victim – and children face particular challenges in giving sufficiently clear, particularised and consistent evidence.

The complexities associated with child abuse investigations have resulted in many jurisdictions establishing specialist policing units to investigate child abuse. Since the 1990s, police have increasingly coordinated their response with that of people from other professions and organisations, including (depending on the jurisdiction) child protection workers, medical and forensic examiners, forensic interview specialists, prosecutors, victim and family support services and advocates, counsellors and mental health professionals and, in some European civil law jurisdictions, judicial officers.[72]

Sometimes police form multi-disciplinary teams (MDTs) with other professionals, as occurs in NSW with the JIRT program. The degree to which these teams are integrated varies, but MDTs usually have a process of information sharing and/or case review to plan and coordinate a cross-agency response to relevant reports of abuse.[73] Staff within some MDTs are fully or partially co-located, while others share a workplace with staff from their own agency.

Jurisdictions vary as to the types of offending that are dealt with by an MDT response, with some confining the response to more serious cases (for example, Queensland) or more complex cases (for example, the Northern Territory). Some jurisdictions confine their MDT response to particular geographical areas, or limit the scope of the response in some areas, with staffing and resourcing in more remote areas possibly limiting factors.

72 For example, between 1992 and 2014 the number of accredited multi-agency response units for child abuse in the United States grew from 22 to more than 500 (http://www.nationalchildrensalliance.org/cac-coverage-maps). These United States Child Advocacy Centres, discussed later in this chapter, were developed partially in response to the lack of specialist police units in the United States, a product of the United States' many small and localised law enforcement bodies.

73 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.1. Some jurisdictions that do not have MDTs still have interagency information sharing and case review, although the agencies formulate their own individual responses to cases.

5.2. Australian models for investigating and responding to child abuse

The information in this section is drawn from the two reports we commissioned from the Australian Centre for Child Protection (ACCP), Royal Commission publications and other publicly available sources.

5.2.1. Tasmania

Tasmania is the only Australian jurisdiction that does not have specialist police investigating child abuse or sexual assault matters (although some other jurisdictions employ a general policing response in some rural or remote areas, or for certain types of offending).

Tasmanian police do not participate in joint investigations, but there is interagency case discussion and information sharing between police and Child Safety Services (part of the Department of Health and Human Services). Child Safety Services officers may participate in child interview planning and observe the interview, with other professionals also able to observe the interview, where appropriate.

Police may facilitate referrals for medical forensic examinations and medical treatment and suggest referrals to counselling/support services.

5.2.2. Australian Capital Territory (ACT)

In the ACT, Police Patrol Teams (which form part of ACT Policing – the community policing arm of the Australian Federal Police) – generally provide the first response to child abuse and sexual assault matters. The specialist Criminal Investigations unit may also provide this response, for example, in response to referrals from client agencies.

The Sexual Assault and Child Abuse Team includes the Adult Sexual Assault Team and the Child Abuse Team. The Child Abuse Team responds when the victim is less than 16 years of age and also investigates physical assaults upon children under ten years of age.

There is no joint investigation in the ACT, but Community Services workers may be consulted in interview planning and, in some instances, observe interviews from a monitoring room. Canberra Rape Crisis Centre workers provide support to children during interviews, as well as mobile counselling services, and continue to provide support and advocacy services for children and their families throughout their interaction with the criminal justice system.

There is an interagency 'wraparound response' to providing support services to victims who consent, or whose parents consent, to this arrangement. Representatives of the Sexual Assault and Child Abuse Team, ACT Community Services, health/medical services (Children at Risk Health Unit & Forensic and Medical Sexual Assault Care), supportive and therapeutic services (Canberra Rape Crisis Centre, Domestic Violence Crisis Service, Service Assisting Male Survivors of Sexual Assault), and the Office of the Director of Public Prosecutions meet monthly to share information and facilitate the referral of child and adult victims of sexual abuse to appropriate services.

5.2.3. Northern Territory

The Child Abuse Taskforce is a joint initiative between Northern Territory Police, the Department of Children and Families and the Australian Federal Police, operating out of Darwin and Alice Springs, with a mobile team operating in rural and remote areas. The Taskforce investigates allegations of serious and complex child abuse and neglect, including matters involving multiple victims or abusers, with co-located investigators from the Northern Territory Police Sex Crimes Unit and Department of Children and Families working together on investigations. Police and child protection taskforce staff have separate workspaces, with some shared areas.

Interviews are conducted by the police investigating officer, but Department of Children and Families workers may observe interviews conducted in Darwin and Alice Springs centres.

Although support services are not part of the joint response, children and families may receive recommendations for referral to Sexual Assault Referral Centres (Northern Territory Health) and NGO services.[74] However, forensic medical examination and treatment services are facilitated through the taskforce.

The taskforce also has a community engagement role, developing a sustained presence in Aboriginal communities to build confidence in reporting child abuse and neglect.

Less complex matters (for example, matters where there are no concurrent child protection investigations) are investigated by local police officers.

5.2.4. Queensland

The Queensland Police Service's 37 Child Protection and Investigation Units (CPIUs) investigate criminal child abuse matters where the complainant is a child at the time of the report and investigation, although general duties police will often provide the first response to reports of abuse. CPIUs receive reports from general duties police, child protection services, non-government institutions and others.[75]

The Police Service's Child Safety and Sexual Crime Group may investigate, or assist in the investigation, of some child abuse matters. The Child Safety and Sexual Crime Group houses Task Force Argos, which investigates computer-facilitated crimes against children, and the Child Protection Offender Registry.

The investigating officer conducts child interviews, with scope for Child Safety Services officers to assist in planning interviews, and participating in them to a degree, for matters where there are joint child protection concerns.

CPIUs are also the Queensland Police Service's primary interface with the Suspected Child Abuse and Neglect (SCAN) system. The SCAN system, led by Child Safety Services,[76] is established under the *Child Protection Act 1999* (Qld). The purpose of the SCAN system is to enable a coordinated response to the protection needs of children by facilitating:

- the sharing of relevant information between members of the system
- the planning and coordination of actions to assess and respond to children's protection needs, and
- a holistic and culturally responsive assessment of children's protection needs.[77]

Thirty SCAN teams have been established in Queensland.[78] SCAN teams are involved with cases where Child Safety Services has a reasonable suspicion that a child is in need of protection, Child Safety Services is responsible for ongoing intervention with the child (that is, if there is abuse within a family – including foster care – setting), and coordination of multi-agency actions is required to effectively assess and respond to the protection needs of the child.[79] The teams bring together representatives of Child Safety Services, the CPIUs/Child Safety and Sexual Crime Group, and health and education agencies. Representatives of the Queensland Aboriginal and Torres Strait Islander Child Protection Peak are invited to SCAN meetings when an Aboriginal or Torres Strait Islander child is discussed. Representatives of other agencies may also be invited to SCAN meetings to discuss particular children.

74 Anglicare is funded to provide short-term support and counselling to victims under the *Victims of Crime Assistance Act* (NT).
75 CPIUs have a broader role in investigating crimes committed by children. Wherever possible, when children come to the adverse notice of police, such matters should be investigated by, or in consultation with, a CPIU officer.
76 Child Safety Services is the part of the Queensland Department of Communities, Child Safety and Disability Services with primary responsibility for child protection.
77 Section 159J of the *Child Protection Act 1999* (Qld).
78 SCAN (teams) in Queensland are distinct from the SCAN (Protocol) in NSW which provides medical officers with a standard template and clinical guidance to record a forensically oriented medical assessment of a child or young person.
79 Queensland Government, *Information Coordination Meetings (ICM) and the Suspected Child Abuse Neglect (SCAN) Team System Manual*, Version 3, 20 August 2010, p.12.

SCAN teams are not co-located and are not focused on the joint investigation of child abuse, but on information sharing and discussion to support each agency effectively fulfilling its own responsibilities in meeting the ongoing needs of a child in need of protection (although SCAN teams can make recommendations that do not infringe on the core business of an agency). However, a Child Safety Services officer normally observes police interviews of children subject to a SCAN response.

SCAN team cases remain open and subject to regular review for as long as multi-agency actions to assess and respond to the protection needs of a child are considered necessary.

Police and other agencies may also participate in Information Coordination Meetings to discuss services that may be provided to a child or family where a notification has not been accepted by Child Safety Services, but where a child concern report has been made. These meetings may also result in a matter being elevated to the SCAN team for review.

CPIUs and other police units may work collaboratively with Child Safety Services outside the SCAN system, through more informal arrangements. CPIUs may assist children and families access support services through the Police Referrals System, which generates a prompt for an external support service to directly contact children and families about available services. Queensland Health will also identify appropriate services, and facilitate appropriate referrals, as part of its participation in the SCAN response, or after a child abuse victim is otherwise referred for health services. Other agencies participating in the SCAN process (for example, Education/NGOs) may also refer children and families to services.

5.2.5. South Australia

South Australia's *Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect* (ICP) provides for the assessment and investigation of suspected child abuse or neglect within an MDT framework.[80]

South Australia Police (SAPOL) receives reports of abuse and neglect through a number of channels, including direct reports to police, reports to the Department for Child Protection (DCP-SA) Child Abuse Report Line and reports from other agencies. Less serious physical abuse and neglect matters will be dealt with by DCP-SA within a child protection framework.

A strategy discussion between key agencies is held for urgent notifications of child abuse or for 'serious' notifications to identify the actions to be taken by involved agencies and result in a single plan to guide a timely and effective response. DCP-SA generally convenes strategy discussions for intra-familial matters and SAPOL generally convenes them for extra-familial matters. SAPOL and DCP-SA participate in most strategy discussions, with the relevant Child Protection Service (Flinders Medical Centre or Adelaide Women and Children's Hospital) and representatives of other government and non-government bodies that hold critical information, or that are/will be involved with the matter.

Strategy meetings facilitate access to medical treatment and forensic medical services at a Child Protection Service or, in rural areas, by a local medical practitioner.

The ICP emphasises that collaborative interagency investigations are likely to provide optimal outcomes, with a continuous flow of information between SAPOL, DCP-SA and Child Protection Services.

SAPOL is responsible for criminal investigations of child abuse or neglect. SAPOL Local Service Areas generally respond to allegations of suspected child abuse or neglect, but the nature of offending will determine whether the LSA has ongoing conduct of the investigation or whether the Family Violence Investigation Section (FVIS), Criminal Investigation Branch (CIB) or Special Crime Investigation Branch (SCIB) assume that role.

Specially trained Child Protection Service (health) workers are responsible for psychosocial forensic assessments of children under seven years of age, older children with complex communication needs at the request of SAPOL or DCP-SA, and Aboriginal children in rural/remote communities up to 12 years of age. This may involve parent/caregiver interviews (which generally take place before child interviews to better understand the context of the family and allegation), forensic interviews of children, interviews with perpetrators in intra-familial matters, parenting assessments and the gathering of additional information.

80 Government of South Australia, *Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect*, July 2016.

The Child Protection Service assesses the appropriateness of interviewing all children older than three years of age, depending on a range of factors, including the nature of the allegation, the child's safety, and the child's language ability and attentiveness. Where the Child Protection Service conducts forensic interviews, it is not responsible for the criminal investigation (a SAPOL responsibility), but provides evidence to assist that investigation. SAPOL and DCP-SA staff observe forensic interviews conducted by Child Protection Services. Child Protection Services provides referrals to supportive and therapeutic services that are integrated within the Adelaide Women and Children's Hospital.

Specialist police from the Victim Management Section of SAPOL conduct interviews of children aged 7-12 who have identified communication difficulties. Otherwise children in this age group will be interviewed by the investigator.

The investigating officer may observe interviews conducted by other persons. Child protection workers may observe interviews of children under the age of seven and, with the investigating officer's permission, receive a recording of an interview of a 7-14 year old child.

Volunteer communication partners assist in communicating with children under the age of 14 and children and young people with disabilities. Aboriginal or culturally and linguistically diverse consultants, or members of the child's community, may also provide assistance.

The Child Protection Service at Adelaide Women and Children's Hospital provides in-house mental health services and facilitates child and family referrals to other services. SAPOL's Victim Management Section may also recommend services to victims, while DCP-SA can refer family members to services.

After investigations are completed, the agencies discuss investigation outcomes, share the opinions of practitioners involved with the case, and collectively agree on ongoing case management arrangements for the continued support of a child and non-abusive family members. DCP-SA initially leads the case management of families where abuse or neglect has been confirmed, coordinating its service provision with other agencies. SAPOL initially leads case management in other matters. Case management may be transferred to another government or non-government agency (for example, a health or education body, community youth justice services, or a non-government service provider). Where a child has engaged in serious sexual behaviour with other children, ongoing case management is provided to all children involved.

5.2.6. Victoria

In Victoria, most sexual offences against both children and adults are investigated by 28 specialist police Sexual Offences and Child Abuse Investigation Teams (SOCITs). SOCITs also respond to incidents of non-sexual child abuse within a family setting. The Sexual Crimes Squad investigates serious and life-threatening sexual offences, particularly sexual assault offences by a stranger. Specialist task forces may also be established to investigate particular sexual offences.

SOCITs receive reports of child abuse from a variety of sources, including the Department of Health and Human Services (DHHS), police stations, schools and Centres Against Sexual Assault (CASAs).

CASAs are the 15 non-profit NGOs funded by the government to provide support, intervention and advocacy services for adult and child victims of sexual assault (for example, counselling, medical care, legal services, witness support). They also work towards the elimination of sexual violence through professional and community education, informing government policy, advocating for law reform and facilitating research to increase community understanding of the nature and incidence of sexual assault.[81]

SOCITs consult other agencies, as they consider appropriate, and DHHS child protection workers should be present during the SOCIT interview of a child (there is provision for a child protection worker to conduct forensic interviews, but this rarely occurs). SOCITs may refer children and family to advocacy, support, health and other services (SOCITs facilitate child referrals to the Victorian Institute of Forensic Medicine and Victorian Forensic Paediatric Medical Service for forensic medical examination and suggest referrals to other advocacy, support and health services, primarily CASAs).

81 Victorian (Australia) Centres Against Sexual Assault (CASAs). http://www.casa.org.au/about-us/what-are-the-victorian-casas.

Pilot Multi-Disciplinary Centres (MDCs)

Police collaboration with other agencies is most notable in the six Victorian pilot MDCs (Barwon, Dandenong, Melbourne Metro, Frankston, Tamar Valley, La Trobe Valley). Each MDC co-locates a SOCIT, DHHS child protection workers and a CASA to facilitate consultation; however, staff from each agency work in their own designated area and each agency makes its own decisions in respect of each case. Police and child protection officers should both plan and attend child interviews, although child protection workers generally observe interviews.

MDCs deal with some matters where there has been no disclosure of abuse. These matters are managed by CASA counsellors/advocates, whose primary focus is to assist in the recovery of victims and non-abusive family members.

The counsellor/advocate role varies depending on the circumstances of the case. In pre-disclosure matters, the counsellor/advocate can provide an 'options talk' and introduce some of the on-site police and child protection workers, which may facilitate disclosure. In the forensic response, the counsellor/advocate provides information, support and acute counselling to children and non-abusive family members during the interview process;[82] facilitates provision of in-house, or referral to external, therapeutic and support services (for example, legal, medical, social); provides information about how the matter will be handled; advocates for the interests of children and non-abusive family members; and provides a holistic follow up service.

We discuss MDCs/SOCITs further in Chapter 10 in the context of responding to sexual exploitation of young people in out-of-home care.

5.2.7. Western Australia

Perth metropolitan response

The Western Australia Police Child Abuse Squad (CAS-WA), which operates in the Perth metropolitan area, investigates:

- sexual abuse of a child where the alleged offender is a member of the child's family or a person in authority over the child
- sexual abuse of a child under 13 years of age by a known offender outside of the family
- sexual abuse of children within the care of the Department for Child Protection and Family Support (DCPFS) when the offender is linked to DCPFS
- criminal neglect of a child under 13 years of age
- familial physical abuse of a child resulting in a serious injury, or
- physical abuse of a child where the offender is a person in authority over the child or where the child is within the care of DCPFS and the offender is linked to DCPFS.[83]

The Western Australia Police Sex Assault Squad, which also operates in the Perth metropolitan area, investigates historical child sexual abuse offences committed by an unknown person, reports of sexual penetration of a child under 13 years of age by an unknown extra-familial offender, reports of sexual penetration of a child who is over 13 and under 16 years of age by an extra-familial offender, and reports of extra-familial sexual penetration offences committed against incapable persons over 13 years of age.

Child Abuse Squad/ChildFIRST (CAS/ChildFIRST) – until recently known as the Child Assessment and Interview Team (CAIT) – is a multi-disciplinary response from Western Australia's Police (CAS-WA) and DCPFS. CAS-WA and DCPFS interviewers work on separate floors, but have shared spaces for interviewing and for families attending interviews.

82 As is the case with NSW JIRT health clinicians, CASA counsellors/advocates do not usually attend the interview, but are available to provide support if a child becomes distressed.

83 CAS-WA will also investigate sexual and physical abuse matters arising from a serious incident planning meeting initiated by the Child Protection Unit at Princess Margaret Hospital. These meetings, which typically involve cases of pre-verbal children, are called by the hospital when a child patient has injuries that are highly suspicious or diagnostic of inflicted injury.

CAS/ChildFIRST assesses those allegations of child sexual abuse in the Perth metropolitan area, where the complainant is still a child or is a vulnerable adult, that are not responded to by the pilot MIST (see below). CAS/ChildFIRST receives reports from police stations, DCPFS district child protection officers, Health and mandatory reporters.[84]

When CAS/ChildFIRST receives an allegation of child sexual abuse, CAS/ChildFIRST police and DCPFS officers and relevant district DCPFS officers hold a joint strategy meeting. Representatives of the Child Protection Unit at Princess Margaret Hospital will usually also participate in strategy meetings by phone. The purpose of strategy meetings is to determine whether:

- immediate medical attention is required for the child
- a plan needs to be developed to manage the child's immediate safety needs
- a joint investigation/assessment by WA Police and DCPFS is required, or
- a single agency DCPFS assessment or WA Police investigation is required.[85]

The joint strategy meeting may also consider:

- whether a medical or forensic examination is required for the child and, if so, the timing of the examination (examinations are conducted by the Child Protection Unit at Princess Margaret Hospital)
- how to manage the child's ongoing safety needs during the forensic investigation
- who needs to be interviewed (for example, the child, parents, other children or siblings, or other persons who may have knowledge relating to the investigation)
- in what order the interviews will be conducted, where and by whom
- whether the parents will be informed prior to interviewing the child, and
- factors surrounding the safety of workers.[86]

Police and DCPFS members of CAS/ChildFIRST also plan and conduct joint interviews of alleged victims of child abuse (both children and vulnerable adults).[87] Interviews, where a joint response is required, will be conducted by both a police and child protection interviewer – the criminal interview is video-recorded, while child safety and wellbeing questions are typically asked off-camera. Following the passage of the *Evidence Amendment Act 2016* (WA), CAS/ChildFIRST has, at the request of police districts and major crime detectives, interviewed child victims and witnesses for a broader range of offences, in particular domestic violence assaults.

The CAS/ChildFIRST response is separate from the investigative/safety and wellbeing assessment response. Historically, the investigating detective and district child protection worker responsible for any child safety and wellbeing assessment have generally not attended the interview, but received the recorded interview and a summary of child protection issues. CAS-WA is now trialling locating police interviewers on the CAS floor and ensuring the investigating detective attends interviews, with the district child protection worker able to observe the interview (district child protection workers are not co-located). DCPFS has recently introduced an advocate to the common area of the interview unit to provide support to families attending CAS/ChildFIRST for an interview (the advocate does not have a longer term role in assisting children and families navigate the child protection, criminal justice, health and support service systems).

A CAS/ChildFIRST worker must meet with the child's parent(s)/carer(s) after the interview. The parent(s)/carer(s) must be provided with sufficient information to keep the child safe; be informed of the next steps in the investigation; have their questions or concerns answered; and be provided with relevant contact information (subject to restrictions in dealing with parents/carers suspected of abuse).

84 CAS/Child First must also be engaged if, at any time during a DCPFS assessment, it becomes apparent that the case involves serious physical abuse or neglect likely to result in police laying criminal charges, with the matter referred for forensic investigation.
85 Any DCPFS assessment must cease if a child makes a disclosure of sexual abuse.
86 Information on joint strategy meetings and the CAS/Child First CAS/Child First process can be found in the Western Australian Department for Child Protection and Family Support's *Casework Practice Manual* (Chapter 4.1 Assessment and Investigation Processes and Chapter 4.4 Child Sexual Abuse), version as at 6 February 2017.
87 Some children aged 16 or 17 years will be interviewed by Sexual Assault Squad detectives, although CAS-WA has advised that a majority of these older children would have a CAS/ChildFIRST interview.

Until recently, CAS/ChildFIRST interviewers would provide the child/family with a list of sexual assault support services, with the new advocate now taking on this role. District child protection workers or CAS-WA officers may also make referrals to supportive and therapeutic services.

MIST pilot

The Multi-Agency Investigation and Support Team (MIST), established in 2015 to service the high-need Armadale and Cannington districts of Perth, is a three year pilot MDT that responds to offences that meet CAS-WA criteria.[88] The MIST, modelled on Child Advocacy Centres (CACs) and located in the George Jones Child Advocacy Centre, includes CAS-WA investigators; DCPFS child protection assessors (working across two districts); specialist child interviewers (child protection and police); and therapeutic staff and two Child and Family Advocates (social workers or psychologists) employed by Parkerville Children and Youth Care. CAS-WA detectives share a workspace, and DCPFS workers and the police interviewer are housed in two monitoring rooms, with Parkerville staff housed on a separate floor.

The MIST provides a holistic response to abuse through its cross-agency, cross-disciplinary team tasked with undertaking criminal investigations, child protection assessments,[89] facilitating health services for a child, and providing or facilitating therapeutic treatment and support for the child and non-abusive family members.

Strategy meetings involve the investigating officer, child protection assessor, interviewer (child protection or police), and CAS/ChildFIRST team leaders. Representatives of the Child Protection Unit at Princess Margaret Hospital are often involved in strategy meetings, particularly where forensic medical services are required. The strategy meeting supports information exchange, interview planning and the development of a cross-agency response.

Police and DCPFS interviewers are used interchangeably – the officer not conducting the interview will observe by closed-circuit camera. The investigating police officer and child protection worker will also observe the interview by closed-circuit camera and provide feedback during a scheduled interview break, while the advocate stays with the family. The forensic interview is video-recorded and any additional child protection questions that are not relevant to the criminal proceedings should be asked at the end of the interview off-camera.

A Child and Family Advocate guides children and families through the interview, investigation, criminal justice and child protection processes, greeting the family immediately before the child interview to build rapport, and engaging the family with on-site services and other services and supports. They work with the child and family for as long as is needed.

Weekly multi-disciplinary care team meetings involving the advocates, the director of Therapeutic Services at Parkerville, and the DCPFS worker, are held to provide updates and discussions on cases and to determine how best to respond to the longer-term needs of children and families by linking them with appropriate services. Police and other CPFS workers sometimes attend these meetings.

Regional/remote response

District police detectives investigate most matters in rural and remote areas, in coordination with district child protection workers (there should still be a joint strategy meeting between police and child protection workers, which may take place by telephone or video-call). Interviews are conducted by district detectives who have received specialist child interview training, with there being capacity for the investigator to also conduct interviews – hand-held cameras are commonly used. Child protection workers may be involved in interview planning and observe the interview. Referrals may be made to Western Australia Health and NGO services, but there is limited capacity for local medical forensic examinations (with matters referred to the Child Protection Unit at Perth's Princess Margaret Hospital, as needed), given the vast geographical distances between many communities and the necessary health services, and lack of resources/adequate training of medical staff in rural/regional areas.

In more serious or complex matters, children may be flown to Perth for an interview or CAS/ChildFIRST interviewers and CAS detectives may be sent to a regional/remote area to provide a response.

88 The pilot was initially for one year, but was subsequently extended.
89 Ongoing child protection interventions are carried out by DCPFS districts.

5.3. Comparing Australian models for investigating and responding to child abuse

The Australian Centre for Child Protection (ACCP) makes the following observations about the child abuse responses of Australian jurisdictions:[90]

- NSW has the most comprehensive crossagency protocols for how the JIRT program should undertake joint investigations locally, with collaboration between agencies over the course of the case.[91] Queensland, Victoria, the ACT, the Northern Territory, South Australia and Western Australian MIST pilot also have comprehensive cross-agency protocols and guidelines around the operation of their responses.
- Information sharing legislation differs between jurisdictions. NSW has the widest information sharing provisions; South Australia and Tasmania have comprehensive schemes; Queensland and Western Australia have more restrictive schemes; while Tasmania, the ACT and Victoria all limit information exchange between professionals and their statutory child protection authority.
- NSW has a comprehensive and prescriptive process in the local planning response, while most other jurisdictions have much more informal arrangements.
- NSW's decentralised response is supported by centralised intake and initial assessment through the JRU. Other Australian jurisdictions, such as Western Australia and South Australia, have a much more centralised response, with specialist resources centred around capital cities.
- NSW is unique in having an intake and assessment process in which all three agencies are involved in making the decision to accept a referral for a JIRT response, although Western Australia (police, child protection and health), South Australia (police, child protection, health and other relevant agencies) and the Northern Territory (police and child protection) have a cross-agency strategy discussion process to inform their intake. Queensland SCAN teams had a different process for intake compared to other jurisdictions and were much more restrictive in the cases included. The Victorian MDC pilots, through their incorporation of a CASA, provided services to children where abuse has not yet been reported.
- Half of the JIRT locations in NSW, the MDC pilots in Victoria, the standard Perth metropolitan response and the MIST pilot in Western Australia, and the Northern Territory all have co-located integrated teams responding to severe child abuse cases. While not colocated, Queensland SCAN teams, Victorian non-MDCs and the other half of the JIRT locations in NSW, work similarly as integrated teams.
- NSW and SA have specific protocols to guide areas of joint decision-making and to inform the related criminal investigative and child protection/wellbeing processes whereas other jurisdictions have more of a parallel process of planning, information sharing and communication (for example, Victoria and WA).
- All jurisdictions have close links between the investigative response and medical forensic examinations, with NSW, Western Australia, South Australia, the ACT, Victoria and Queensland all directly including health agencies in their responses to promote a smooth referral for examination.
- Three responses integrate NGOs as a matter of course: the MIST pilot (WA), MDC pilots (Vic) and the ACT response.
- In all responses except for those in Western Australia, South Australia and Tasmania, the investigating police officer from a specialist police unit is responsible for conducting the 'forensic' (recorded criminal) interview of the child. A number of jurisdictions have provision for child protection workers to conduct forensic interviews, but in practice almost all forensic interviews are conducted by police. In Western Australia, interviewing is undertaken by a joint

90 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.3.

91 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office,* Australian Centre for Child Protection, August 2017, section 5.5.

police and child protection interviewing team. In South Australia, depending on the age,[92] and ability of the child to communicate,[93] interviews may be conducted by the Child Protection Service (SA Health) or by Police. Tasmania does not have a specialist unit but interviews are undertaken by police attached to the Central Investigations Branch responsible for investigations.

- Most jurisdictions have provision for child protection authorities to observe interviews in which they do not directly participate.
- All jurisdictions use recorded interviews as the child's evidence in chief. All jurisdictions have provision for children to pre-record their cross-examinations, with NSW currently piloting the pre-recording of cross-examinations for matters being heard by two District Courts.
- NSW and South Australia both have witness intermediary schemes. A pilot scheme began in NSW in two District Court areas in 2016, and a scheme has operated state-wide in South Australia since 2015. Western Australia has a similar scheme, which has been rarely used. In May 2017, the Victorian Government also announced that it would fund a state-wide intermediary scheme for children and adults who are vulnerable witnesses.
- Only four responses directly involve advocacy services (Victoria's MDC pilots, Western Australia's Perth metropolitan and MIST pilot responses, and the ACT response). The MDC and MIST pilots have the most comprehensive advocacy services, with end-to-end support for children and families. The ACT response focused more on supporting children and families through the criminal justice system. The Perth metropolitan response was much more short-term, being focused on supporting families during the child forensic interview.
- All jurisdictions have some connection between the investigative response and support and therapeutic services (primarily the peak sexual assault not-for-profit or government funded sexual assault service), irrespective of the report of abuse being substantiated. Few responses have in-house capacity to provide support and therapeutic services, with Western Australia's MIST pilot, Victoria's MDC pilots and some South Australian responses being exceptions (although health clinicians may provide some crisis counselling to non-offending parents/carers as part of the NSW JIRT response).
- NSW has the most comprehensive training and professional development for cross-agency work, with an induction and foundational skills course run across professional and agency groups. South Australia also provided significant cross agency training. While a few other jurisdictions run some cross-agency training, mostly agencies provide training and professional development on working with other agencies within their own professional groups.[94]

92 The Child Protection Service conducts the psychosocial forensic assessment of children under 7 years of age and Aboriginal children up to the age of 12 years in rural/remote communities. The assessment included the appropriateness of interviewing children, which can also be conducted by the CPS on behalf of SAPOL. Children aged 7-14 years are interviewed by police who are prescribed interviewers. For children over 14, the interview occurs in the form of a written statement verified by declaration (conducted by the investigating police officer).

93 If children 7-14 years are identified as having cognitive or communication difficulties, interview will occur at the Victim Management Section of South Australia Police. The Child Protection Service will also conduct assessments with children over 7 years of age with complex communication needs on request (the CPU conducts the psychosocial forensic assessment for all children under 7 years).

94 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 5.5.

5.4. International MDT models for investigating and responding to child abuse

We also requested that the ACCP examine prominent international MDT models in conjunction with the literature surrounding the components of effective multi-disciplinary responses to provide insight into how the JIRT model compares.[95]

The following international MDT models were examined by the ACCP – see Part four, Report 1:[96]

- Child Advocacy Centres (CACs) – United States
- Child Advocacy Centres – Canada
- Barnhaus (Children's Houses) – Sweden, Denmark, Finland, Iceland and Greenland
- Multi-Agency Safeguarding Hub (MASH) – United Kingdom
- Joint Child Abuse Investigation Teams – Scotland, and
- Puawaitahi – Auckland, New Zealand.

The ACCP found that the JIRT model is comparable to the broader range of international MDT models. It should be noted that there is considerable variation between local adaptations of some of these models, making detailed comparisons with the JIRT model difficult. For example, the United States' CACs and some other international MDCs evolved from NGO-operated victims services and, in the United States, there are many local law enforcement agencies that operate under different legal frameworks and have different capacities.

The JIRT model and other Australian MDTs differ from many international MDTs in terms of who from the MDT conducts interviews with children. In Australia, with the exceptions noted in section 5.3, police (and in some states, child protection or government health workers in certain scenarios) are responsible for conducting the criminal interview with the child. Other international models, such as US CACs, use specialist NGO 'forensic' interviewers who refer appropriate matters for police investigation. While many international models have continued to include NGO led interviews, police-led interviews conducted by officers trained in child interviewing are more appropriate in Australia, as the structure and scale of our police forces better support specialisation in areas such as child abuse and sexual assault offences.

Most MDT models operate in urban settings, although the American CACs have a significant number of rural centres with similar resources and services to their urban counterparts.

The main variation between models is the extent of co-location, with some models operating from a purpose-built centre. Internationally, few MDTs have police and child protection authorities co-located onsite, as occurs with JIRT and some other Australian models. Most international MDTs have onsite therapeutic services as part of the response, as do the Australian MDCs and MIST. Some CACs and the Barnhaus model incorporate prosecutors and legal professionals into their MDTs. Incorporating magistrates into an Australian MDT, as occurs in Barnhaus, is inconsistent with the common law system in Australia and many other Commonwealth countries. While there need to be links between police investigators and ODPP prosecutors in Australia, the ODPP was established to operate independently of the police and from government.

Models like MASH and Puawaitahi were established to respond to all forms of child maltreatment across different levels of risk, including planning for vulnerable children whose circumstances fall below the statutory threshold for intervention. A key advantage of some of these broader focused MDTs is the management and oversight of cases that may escalate over time, and potentially the management of cases that may allow children to be in a position to disclose abuse (as occurs in Victorian MDCs).

95 It should be noted that there is considerable variation between local adaptations of some of these models, making detailed comparisons difficult.

96 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, sections 4.1-4.7.

5.5. Effectiveness of Multi-Disciplinary Teams

The ACCP notes that there is a lack of systematic research on MDTs and a lack of evidence comparing different cross-agency responses.[97] Much of the published research relates to US CACs and is quite old. These factors may limit the applicability of some of the ACCP's findings, with the prevalence of CAC research skewing some of the key messages identified by the ACCP in favour of the United States' CAC model (for example, the use of interviewers independent of police).

The ACCP found evidence to support the idea that MDTs can result in improvements on some outcomes. MDTs were consistently associated with improved criminal justice outcomes and better access to mental health and support services. Some support was found for increased child protection substantiations and increased referral to medical services. Findings were mixed around the satisfaction of service users and staff.[98] A summary of the ACCP's research findings follows:[99]

1. MDT approaches consistently resulted in increased police involvement in cases and increased joint investigation and interviews.
2. Across those MDT sites found to be effective in improving criminal justice outcomes, almost all had provision for cross-agency *observed* interviews of children, which were usually conducted by an independent interviewer supervised by statutory agencies (for example, police/child protection), this being the most common US CAC model.
3. Older studies tended to find reductions in the number of interviews children were exposed to, while newer studies tended not to find any difference between the MDT and standard practice. This may be attributable to greater awareness of child victim needs and/or evidence-based interviewing protocols being adopted in standard practice.
4. Most studies found a significant positive effect of MDT approaches in increasing mental health and support service referrals, with many studies finding that children and families were more likely to receive support services where more agencies tried to direct them into services.
5. No studies compared the completion of mental health and counselling services in MDT and non-MDT models, and there is no comparative research examining improvements in trauma symptoms as a result of MDTs.
6. Most studies which included child protection outcomes found faster child protection responses.
7. Many studies included variables that were more like outputs (for example, number of interviews) than outcomes (for example, charges). Results were mixed in terms of measures of collaboration between agencies participating in the MDT response.
8. An MDT response was consistently associated with increased staff satisfaction.
9. Many studies did not evaluate individual MDTs, but evaluated thousands of cases from different types of multi-disciplinary responses – finding in particular, that increased elements of MDT practice (for example, having a care coordinator, co-location of agencies) was associated with increased mental health service receipt.
10. Most models found to be effective included advocacy. Advocates tended to be located on-site and be independent, although there were examples of advocacy staff being provided by child protection and prosecuting authorities.

97 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 2.2.

98 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.2; J. Herbert and L. Bromfield, *Better Together? A Review of Evidence for Multi-Disciplinary Teams Responding to Physical and Sexual Child Abuse*, Trauma Violence & Abuse, Advance online publication. doi: 10.1177/1524838017697268

99 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 4.1. J. Herbert and L. Bromfield, *Better Together? A Review of Evidence for Multi-Disciplinary Teams Responding to Physical and Sexual Child Abuse*, Trauma Violence & Abuse, Advance online publication. doi: 10.1177/1524838017697268

11. Very few studies examined outcomes related to medical referral and improvement in symptoms, but all those that did, found that an MDT was significantly more likely to result in the receipt of medical services.
12. Sites that were effective in improving the receipt of medical services tended to have medical personnel co-located, and other therapeutic and support services on-site, while relatively few sites had police and child protection agencies co-located.

The ACCP synthesised existing research to identify common characteristics of multi-disciplinary responses to child abuse and their theorised contribution to cross-agency collaboration. The ACCP report details the characteristics of multi-disciplinary responses. These are:[100]

- involvement of workers/agencies in MDT Case Review Meetings/Discussions
- co-location of workers/agencies at the MDT[101]
- services provided on-site at the MDT (forensic interviewing; victim advocacy; mental health services/medical examinations; rape crisis services; domestic violence services; other)
- non-statutory workers employed by the MDT (forensic interviewer; victim advocate; mental health services; medical services/medical examinations; rape crisis services; domestic violence services; other)
- joint training and professional development
- more frequent reviews of the status of each agency's response
- underpinned by a protocol or interagency agreement
- state legislation supporting collaboration and information exchange
- cross-agency steering group with senior representatives from partner agencies
- presence and frequency of forums to address interagency conflict
- cross-agency case tracking systems, and
- joint performance measurement and evaluation of practice.

The JIRT model includes almost all of the characteristics of multi-disciplinary responses apart from child victim (and family) advocacy.

5.6. The ACCP's conclusions relating to the JIRT Program

The JIRT program has evolved over the years, with ongoing improvements having strengthened the overall response. The ACCP attributes these ongoing improvements to a strong history of cross-agency review and reform.[102] Notwithstanding the successes of the JIRT model, continuing cross-agency review and reform is critical.

The Royal Commission has highlighted the need for all jurisdictions to improve their response to child sexual abuse within institutions, with particular attention required with respect to children in out-of-home care (OOHC), children with disability, the school setting and children with sexually abusive or harmful sexual behaviours[103] – these cohorts are all a focus of our inquiry and are discussed in Part 5 of this report.

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100 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 2.2.

101 As discussed in Chapter 4, 'co-location' refers to staff from different agencies being located 'within the same general location', for example, in the same building or complex.

102 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.

103 Although the majority of cases referred to JIRTs involve abuse by a family member or trusted friend, the Royal Commission estimates that between 13 and 18 per cent of child sexual abuse involves institutional abuse. A recent FACS audit of a random sample of one hundred 2014-2015 JRU case files, commissioned by the Royal Commission, found that 19 cases involved possible institutional abuse. Of those 19 cases, ten involved OOHC and five involved schools. In eight of the 19 cases, the offender was another child – Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.98-99.

The comparison undertaken by the ACCP of the JIRT model with other Australian and international jurisdictions found that it 'compared very favourably among Australian jurisdictions'[104] and went on to note that:

> *the JIRT program was fairly unique in terms of having a state-wide localised response, with the benefit of centralised and standardised intake assessment involving the three partner agencies. The JIRT program is also fairly distinctive internationally in terms of the degree to which statutory agencies are co-located in the centre* [for co-located sites].[105]

The ACCP found that while the co-location of police and government child protection workers is not common in international MDTs (although it is increasingly common in Australia), and the involvement of the government health agency as a joint partner in the assessment and investigative responses is unique to the JIRT, the state-wide tripartite response has served NSW well.

The ACCP also found:

> *In terms of a comprehensive response, the JIRT model is comparable to the international body of practice of MDT responses.*[106]

It concludes:

> *Compared to Australian and comparable international jurisdictions, the JIRT model represents a comprehensive, consistent and coherent state-wide strategy for structuring the cross-agency response to severe child abuse. New South Wales also has information sharing and criminal evidence legislation supportive of the cross-agency response.*[107]

Notwithstanding the ACCP's acknowledgment of many positive aspects of the JIRT model, it noted:

> *the JIRT model differs in some ways from other Australian and international models. Some of the comprehensive Australian and international models included the co-location of support services, presence of independent advocates, embedding support service providers into the response from the point of interview, and potentially providing a mandated cross-agency response for cases that don't meet the threshold for intervention at the point of intake.*[108]

Incorporating child and family advocacy functions into the JIRT program would enhance child wellbeing.[109] In the following chapter we discuss the benefits of embedding child and family advocacy and other supports within the JIRT model.

Recommendation

1. **The JIRT partner agencies should continue to jointly deliver and strengthen the JIRT program, having regard to the recommendations contained in this report.**

104 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.

105 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.3. This inquiry finds that standardised and centralised intake assessment, facilitated by the Child Protection Helpline and JRU, is a positive feature of the JIRT program, although reforms are needed to improve intake assessment.

106 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.2.

107 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office,* Australian Centre for Child Protection, August 2017, section 2.1.

108 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 2.1.

109 The generic MDT program logic developed by the ACCP considers increased family referral and engagement with needed services (referral being a key advocacy function) as contributing to improved family functioning, which promotes child and young person wellbeing.

Chapter 6. Establishing a Child and Family Advocate role within the JIRT

At the outset of our inquiry, the JIRT partner agencies jointly indicated that, while they were of the view that the JIRT model compared favourably to similar models here and overseas, there would be merit in examining how a stronger advocacy component could be embedded within the model.

We agreed with the JIRT partner agencies that there would be value in visiting Western Australia to gain a practical understanding of the Child and Family Advocate role operating out of the George Jones Child Advocacy Centre, and how the role could be potentially adapted for the NSW JIRT context.

Accompanied by senior representatives of the JIRT partner agencies and Dr James Herbert of the ACCP, in October 2016 we travelled to Western Australia to meet with the CEO and staff from the George Jones Child Advocacy Centre, together with police and child protection staff involved in delivering the Multi-Agency Investigation and Support Team (MIST) response to child abuse. We also met with senior police and child protection representatives involved in delivering the standard Perth metro child abuse response. In addition, we met with staff from the Child Protection Unit at Princess Margaret Hospital, responsible for medical forensic examinations of child abuse victims in the Perth metro area, and the Child Witness Service (CWS-WA), which provides support and preparation for children and young people involved with the Western Australian court system.

Our observations from the Western Australian visit, along with those of the JIRT agencies, are reflected in this chapter, which has also been informed by the research undertaken by the ACCP.

6.1. Child and family advocacy for victims of child abuse and neglect

Action for Advocacy – a support and resource agency for the United Kingdom's advocacy sector – explains advocacy in the following terms:

> *Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side.*[110]

Clients must voluntarily engage with advocacy services. Advocacy will not be wanted by, or appropriate for, all clients.

The ACCP notes that the most effective Multi-disciplinary Team (MDT) responses to child abuse incorporate advocacy services.[111] These services are generally directed to both victims and family members, in recognition of the importance of the family environment in facilitating recovery for children.[112] Family members who are receiving counselling or other support are also more likely to encourage the child or young person to access support. However, broader family advocacy services always need to be delivered with the child or young person's best interests in mind.

Child and Family Advocates, like other advocates, are generally employed by NGOs (although there are examples of advocates being employed by child protection authorities and state prosecutors' offices).[113] The provision of advocacy services by an NGO, according to literature on advocacy and MDTs:

110 Action for Advocacy, *Quality Standards for Advocacy Schemes in Action: Based on the Advocacy Charter*, May 2006, p.5.
111 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 5.5.
112 N.J. Hochstadt and N.J. Harwicke, *How effective is the multidisciplinary approach? A follow-up study*, Child Abuse & Neglect, 9(3), 1985, pp. 365-372; D.A. Shepler, *Re-victimization among victims of childhood sexual abuse: The impact of a child advocacy centre*, University of Alaska Anchorage, Ann Arbor, ProQuest Dissertations & Theses Global Database.
113 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.3.

- minimises the risk of advocates acting in the interests of a government agency, rather than their clients'[114]
- provides clients with an independent voice, making them feel more confident,[115] and
- increases the willingness of clients to make use of the service in communities that may have negative perceptions of police and child protection statutory agencies.[116]

Advocates' roles vary across MDTs that respond to child sexual abuse.[117] Some take a shorter-term role in supporting children and young people and their families when they attend forensic and/or child protection interviews. Some focus on advocacy in particular areas (for example, victim support to reduce attrition in the criminal justice system or therapeutic service referral to improve health outcomes). Others provide long-term holistic support towards improved child, young person and family wellbeing across domains and engage with children, young people and families from the time of the child or young person's initial forensic interview (or earlier in models where the MDT responds to pre-disclosure matters) to the end of the child or young person's contact with the criminal justice system ('end-to-end advocacy').[118]

The advocacy services that provide holistic support commonly involve:

- providing support to children and young people and their families from the point of interview through to the completion of the criminal justice process empowering children and young people and their families to be able to participate in decision-making about their cases
- understanding and conveying the needs of children and young people and their families to other professionals involved with their cases
- acting as a consistent contact point for children and young people and their families for information about their cases
- assisting children and young people and their families navigate the different systems (for example, legal, child protection, mental health)
- facilitating referral of children and young people and their families to needed services, working to reduce barriers to accessing services, and working to build engagement with services, and
- working to reduce barriers to children and young people accessing the justice system.[119]

In 2013, Parkerville Children and Youth Care commissioned a comprehensive review of advocacy roles, standards and training for staff working with victims of sexual violence. The review identified nine domains of advocacy which inform the work of the MIST Child and Family Advocates:

- *Accessible and Known*: Known in the local community and professionals for their work.
- *Client led*: Listens to victims/survivors to identify their views and wishes.
- *Facilitates informed decision-making*: Provides relevant information and provides options for families.
- *Facilitates empowering opportunities*: Find opportunities to re-empower children through their interactions with various systems.
- *Provides emotional and practical supports*: Ensuring that children and families feel understood and welcome at the service, and receive support based on their needs and wishes.

114 Action for Advocacy, *Quality Standards for Advocacy Schemes in action: Based on the Advocacy Charter,* May 2006, p.8. Action for Advocacy also argues that advocacy services should ideally be independent of service providers, or at least have functional autonomy under a service provider's internal governance arrangements, to minimise conflict of interest risks. However, advocacy services are frequently integrated with other services within an organisation, and advocates may sometimes have other roles (e.g. advocates also act as counsellors in Victoria's pilot MDCs).

115 Home Office (United Kingdom), *Multi Agency Working and Information Sharing Project: Final Report*, July 2014, p.11.

116 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.4.

117 Some MDTs that respond to child sexual abuse do not respond to other forms of abuse and neglect.

118 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 2.4.

119 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, sections 2.4 and 6.4.

- *Independence*: Ensuring that children and families have their needs and wishes heard and are represented free of agency bias.
- *Support through the criminal justice system*: Provision of end-to-end support through the justice system.
- *Multi-agency collaboration and representation*: The advocate represents the interests of children and their families to other agencies and members of the multi-disciplinary team.
- *Seeks and progresses positive and negative feedback and suggestions*: Openness in receiving feedback about advocacy and the process involved in accessing other services and acting on this to facilitate systems improvement.[120]

Effective advocacy services improve child, young person and family wellbeing outcomes as well as criminal justice outcomes. The Australian and New South Wales Law Reform Commissions reported:

> *It is clear that the most positive experiences of the criminal justice system for victims arise when they are 'treated respectfully … listened to, believed and taken seriously' as well as being provided with timely and accurate information. In addition it is said that 'ensuring the complainant is well informed and well supported can improve not only their wellbeing and experience as a witness but their capacity to testify confidently'.*[121]

The effectiveness of advocacy services is dependent on the availability of support services for children, young people and families. We highlighted the limited availability of sexual assault counselling and therapeutic treatment programs for children and young people who have harmful sexual behaviours in our 2012 report, *Responding to Child Sexual Assault in Aboriginal Communities*. We revisit these issues in Chapters 12 and 17.

The Royal Commission has heard evidence about the lack of quality support services, as well as a range of difficulties that victims and survivors face when seeking support and therapeutic treatment services. The Royal Commission is therefore investigating the adequacy of advocacy and support services for victims and survivors of child sexual abuse.[122]

6.2. Distinguishing Child and Family Advocates from witness intermediaries and interview support persons

Advocates and witness intermediaries have distinct roles. Witness intermediaries are impartial officers of the court whose role is to make an assessment of a child for the purpose of assisting an interviewer to elicit the child's best evidence. Witness intermediaries do not advocate on behalf of a child or young person or their family.

Advocates should also be distinguished from persons who may provide support to children and young people during interviews. Interview support persons provide emotional support to victims during the often stressful interview process – they do not actively advocate for victims. Interview support persons are generally already known to, and trusted by, the child or young person. However, as we discuss later in this chapter, there have been cases where advocates, or persons performing limited advocacy functions, have provided support to children during the interview process.

120 Parkerville Children and Youth Care Inc, *Literature Review: Advocacy roles*, 2013.
121 Australian Law Reform Commission and New South Wales Law Reform Commission, *Family Violence - A National Legal Response*, ALRC Report 114, NSWLRC Report 128, 2010, p.1205.
122 Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues Paper 10 – Advocacy and Support and Therapeutic Treatment Services*, 1 October 2015.

6.3. Child and family advocacy in international MDTs

The vast majority of international MDTs are Child Advocacy Centres (CACs) or were developed with reference to the CAC model. The CAC model was developed by the non-government sector and many of the early CACs evolved from victim advocacy and support services. Victim support and advocacy are central elements of the CAC model, with over 99% of CACs providing advocacy services.[123]

Most international MDTs provide holistic advocacy services, with the performance of United States and Canadian CACs assessed against the following victim support and advocacy standard:

> *The victim advocate serves as the primary contact point for the victim and their family. As well as being the person that greets them when they arrive at the centre, they also represent their interests to the multidisciplinary team.*[124]

In the United States:

- 78% of Child and Family Advocates are employees of the CAC, with the remainder contractors or employees of partner agencies
- 70% of CAC advocates are co-located on-site with other members of the CAC team and 71% of forensic interviewers are co-located
- 76% of CACs provide on-site advocacy services and 90% provide on-site forensic interviews (that is, some workers whose principal place of work is off-site attend the CAC to provide those services)
- 16% of CACs provide both on-site and off-site advocacy services and 9% provide on-site and off-site forensic interviews
- 7% of CACs provide only off-site advocacy services and 1% provide only off-site forensic interviews, and
- 95% of advocates and 95% of forensic interviewers routinely attend MDT case review meetings.[125]

The high degree of integration of advocacy and forensic interview functions within the CAC model, and the involvement of advocates in case review, provides the foundation for 'end-to-end' advocacy.

6.4. Child and family advocacy in Australian jurisdictions other than NSW

6.4.1. Victoria

Through its six Multi-Disciplinary Centres (MDCs), Victoria is piloting an MDT model that integrates holistic advocacy and support services with the criminal investigative and child protection responses to child sexual abuse (and some other offences). The model most closely resembles that of some larger 'one-stop shop' Canadian CACs, in that it is government-led, has on-site law enforcement officers conducting interviews, and co-locates therapeutic services with the investigative response.

MDCs deal with some matters where there has been no disclosure of abuse. These matters are managed by counsellors/advocates who work for NGO Centres Against Sexual Assault. The primary focus of the counsellor/advocates, who are co-located with other staff in MDCs, is to assist in the recovery of victims and non-abusive family members.

The counsellor/advocate role varies depending on the circumstances of the case. In pre-disclosure matters, the counsellor/advocate can talk to children and families about options for progressing their case and introduce some of the on-site police and child protection workers, which may facilitate disclosure.

123 Data sourced from J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017.
124 National Children's Alliance, *Standards for accredited members*, revised 2011.
125 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 4.2. These statistics are drawn from a March 2016 survey of 349 directors of registered United States CACs.

In the forensic response, the counsellor/advocate provides information, support and acute counselling to children and family members during the interview process;[126] facilitates provision of in-house, or referral to external, therapeutic and support services (for example, legal, medical, social); provides information about how the matter will be handled; advocates for the interests of children and young people and their families; and provides a holistic follow up service.

6.4.2. Western Australia

The Department for Child Protection and Family Support (DCPFS) has recently introduced limited advocacy supports into the Perth metropolitan response to child sexual abuse. A DCPFS 'advocate' attends the common area of the interview unit to provide support to families attending CAS/ ChildFIRST for an interview. The advocate provides the child or young person and their family with a list of sexual assault support services, but does not make supported referrals or have a longer term role in assisting children, young people and families navigate the child protection, criminal justice, health or support service systems.

By contrast, child and family advocacy is integral to Western Australia's MIST pilot. MIST, like the Victorian MDCs, is modelled on CACs and integrates holistic NGO-provided end-to-end advocacy services with the criminal investigative and child protection responses to child sexual abuse (and some other offences). MIST is also government-led and co-locates therapeutic services with the investigative response. Unlike the Victorian model, the advocacy and therapeutic roles are distinct.

The two Child and Family Advocates employed by Parkerville Children and Youth Care guide the child or young person and their family through the interview, investigation, criminal justice and child protection processes; greet the family immediately before the child interview to build rapport; stay with the family during the interview; and work to engage the child or young person and their family with on-site services and external services and supports. They work with the child or young person and their family for as long as is needed, including for some matters that do not proceed to charge or child protection intervention.

The Child and Family Advocates have no role in the early assessment and response planning which takes place in pre-interview strategy meetings,[127] but are involved in weekly multi-disciplinary care team meetings with Parkerville's director of Therapeutic Services and the child protection worker. The care team meetings are held to provide updates and discussions on cases and to determine how best to respond to the longer-term needs of children and families by linking them with appropriate services.

Child and Family Advocates are on call after-hours to support the MIST response in urgent matters.

While the final evaluation of the MIST pilot is not yet available, we were able to gain some insight into MIST's operation through our visit to Western Australia.

The following positive observations were made by those involved in MIST about the operation of the MIST child and family advocacy model during our consultations:

- All agencies involved with MIST believe child and family advocacy benefits the response to child abuse, particularly in providing support to families during child interviews; providing information about, and referral to, services; and providing long-term follow-up and support.
- Police, while initially reluctant to embrace specialist child and family advocacy services, are now particularly positive about the advocates.
- Advocates were nearly always available during the interview process.

126 As is the case with NSW JIRT health clinicians, Victoria's Centres Against Sexual Assault (CASA) counsellors/advocates do not usually attend the interview, but are available to provide support if a child or young person becomes distressed.

127 ACCP has advised that this is a contentious matter, with differing views within the MIST as to the appropriateness of advocate involvement in strategy meetings. DCPFS states that information sharing restrictions prevent non-government advocates from attending strategy meetings, although ACCP advises that the *Children and Community Services Legislation Amendment and Repeal Act 2015* (WA) has removed information exchange barriers in this area. CAS-WA also has concerns about the advocate obtaining criminal investigation information through such meetings. The detective or interviewer will provide some information to the advocate after the strategy meeting, but most information exchange does not occur until a family representative signs a consent form. It is noted that Chapter 16A of the Care Act would support effective information exchange with advocates in NSW, without them participating in early stages of the LPR.

- Advocates have occasionally supported distressed children during interview breaks, and this is believed to have prompted children returning to the interview to make disclosures.
- Advocates help to reduce the risk of family members contaminating evidence during interview breaks, by explaining to them how certain types of discussion with a child or young person may contaminate evidence.
- Families seem to value the independence of the NGO advocates, who are seen to focus on their needs.
- Advocates are seen as particularly important in providing support to children and young people and families when no-one is charged (a decision not to charge may be extremely distressing for victims and their families).
- The work of advocates and DCPFS occasionally cross over – when the family has ongoing interaction with DCPFS and wants the advocate involved, the advocate liaises with the DCPFS case manager. Advocates have also enabled DCPFS to close some cases because child protection workers are confident that the advocates are monitoring and facilitating child or young person and family member access to services.
- The advocates, in linking families with services, can help identify service gaps and build service capacity.
- As NGO employees, the advocates are well-placed to perform a community engagement role in respect of the MIST response to communities that may be less willing to engage with government services.
- The longer-term contact that advocates have with children, young people and their families means they can link them with counselling and other services well after interviews and investigations have concluded – often, children and their families are not ready to engage with these services closer to the time of disclosure.
- The advocates work for an NGO that has close links with local schools and housing services, facilitating consideration of housing and education supports to meet the ongoing support needs of children, young people and families.
- Advocates have assisted the Child Witness Service WA (CWS-WA) contact and engage with families in the lead up to trial and have arranged child and young person counselling that would not otherwise have been provided before CWS-WA intervention.[128]

Our consultations also identified some risks with child and family advocacy model as implemented by the MIST that should be considered if adopted in NSW:

- In some cases, advocates have been perceived to be too closely 'allied' with family members and undermining the child protection and police response – role clarity is therefore critical.
- Information exchange restrictions mean that advocates may have limited information about a child or young person and their family when first meeting them (these restrictions would not exist in NSW due to our Chapter 16A information sharing provisions).
- In some cases, advocates sought to build a rapport with children and young people (rather than their family members) just before their interview, which interviewers said made it more difficult for them to build a rapport with the child/young person. Interviewers were also concerned about too many people greeting the child or young person (which can add to the stress of attending an interview).
- Advocates, in receiving information from children and young people and their families that had not been disclosed to police or child protection workers, were sometimes conflicted about whether to pass the information on, as doing so might damage their relationship with the child or young person and their family.

128 CWS-WA is generally involved with children and young people and their parents six to eight weeks before trial.

- CWS-WA highlighted the importance of advocates sharing information with them concerning whether children and young people and their families have received advocacy support, and the nature and extent of that support.
- CSW-WA emphasised the importance of advocates explaining the role of their service in only brief terms, as it is the role of CSW-WA to provide a fulsome explanation of the court process (this is also the case for the Witness Assistance Service in NSW).

6.4.3. Other Australian jurisdictions

Although the ACT does not integrate advocacy with child abuse investigations, Canberra Rape Crisis Centre workers can accompany children to police interviews (although involvement starts after the interview in most cases) and support and advocacy services are available throughout the criminal justice process.

The other jurisdictions (excluding NSW, which is discussed below) provide some child and family supports traditionally provided by advocates, but not to the same extent as advocates or within a broader advocacy framework. For example, Victorian non-MDC does provide a counsellor/advocate, but they are not located on-site.

South Australia provides support around interviews, having regard to age and capacity issues, while Tasmania may also provide support around interviews under less formal arrangements. All jurisdictions have links between investigative and support responses that vary in formality and scope.

6.5. Current JIRT child and family advocacy arrangements

The JIRT response is unique among MDT models considered during the course of our inquiry, in that health workers are involved at the earliest stages of the response. The involvement of JIRT health clinicians in JRU intake assessment and local planning and response (LPR) processes allow health-related issues to be identified and responded to earlier than they might otherwise have been. The availability of JIRT health clinicians at the point of interview allows crisis counselling and support to be provided quickly, helping to reduce child, young person and family trauma.

JIRT health clinicians currently provide some services traditionally provided by advocates under many other MDT models. For example, they:

- provide immediate support to family members, and may provide support to a distressed child or young person, throughout the interview process
- convey the health needs of children and young people and their families to other professionals involved with their cases, to ensure a trauma informed process
- encourage child and young person and family engagement with, and assist in their navigation of, the health system, and
- facilitate the referral of children and young people and their families to Sexual Assault Services, Child Protection Units, Child Protection Counselling Services and other health services.[129]

FACS JIRT caseworkers also refer some cases to CSCs, which may arrange other support services for children and their families. The ODPP's Witness Assistance Service, and Victims Services within the NSW Department of Justice, also assists victims to access a range of services. During the course of the criminal investigation, and where police instigate criminal proceedings (including Apprehended Violence Orders), the CAS Investigator maintains contact with the victim and non-offending family throughout. However, the CAS Investigator is not an advocate for the child or young person and their family.

129 According to the NSW Health JIRT CEO 2015-2016 Report Card, 38% of JIRT clients were referred to specialist health services in 2015-2016, down from 41% the previous year. It must be emphasised that not all children and young people wish to receive specialist health services. Also, JIRT staff will not need to make a health service referral if a child or young person is already receiving health services. Local service availability may also impact on referral rates. Limitations in Health data collection mean that nothing is known on referral uptake for 40% of 2015-2016 referred cases, although state-wide rollout of the Sexual Assault Database should improve data collection and reporting in this area.

6.6. How an advocate role could improve current child and family advocacy arrangements

There are a number of ways that the addition of a Child and Family Advocate could strengthen the existing service response provided through the JIRT program.

6.6.1. Providing a primary contact point for children and their families

The victim support and advocacy standard for CACs starts with the words:

> *The victim advocate serves as the primary contact point for the victim and their family.*[130]

The ACCP notes of JIRTs:

> *Rather than have a primary contact person who provides information and updates on the status of the case throughout the process, the JIRT response more or less depends on individual agencies to provide updates on the status of a case to the family.*[131]

Children, young people and their families often do not know who to talk to about particular concerns, with communication difficulties exacerbated by staff turnover during the life of a case. Families may feel they have been provided with inadequate information (as identified in Royal Commission Case Studies 2 and 38) or conflicting information (as identified in Royal Commission Case Study 38), which may cause distress and disengagement from JIRT and criminal justice processes.

In Case Study 2, the Royal Commission noted that some parents who were critical of JIRT's communication with them suggested that JIRTs provide a liaison officer to serve as a single point of contact with families.[132] The parent of a victim, in giving evidence to the Royal Commission in its Case Study 38 hearings, stated:

> *It would be helpful to have a person appointed as the sole point of contact for families navigating the various systems. This person needs to have a thorough understanding of the system and should serve as the liaison between families and the systems themselves. This person should provide advocacy within the systems and be available to accompany families to appointments if needed.*[133]

A primary contact point would be able to triage calls to JIRT staff from the child or their family, saving JIRT agency staff time in responding to multiple or misdirected calls. It would also be able to provide basic information to children and their families, and arrange other JIRT staff to call back to provide case-specific information (or provide that information themselves when authorised by relevant staff to do so). The primary point of contact would not operate to prevent other JIRT agency staff from contacting children and young people and their families.[134]

6.6.2. Delivering services within an advocacy framework

Although JIRT health clinicians provide some services provided by advocates in other MDTs, they do so within a medical and therapeutic, rather than a broader advocacy, framework. While JIRT health clinicians clearly have regard to the views and wishes of children and young people and their families, they do not act as advocates for those views and wishes within the JIRT or broader service systems. They differ from Victorian MDC counsellors/advocates, who provide limited therapeutic services within a broader advocacy framework.

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130 National Children's Alliance, *Standards for accredited members*, revised 2011.

131 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.4.

132 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, pp.8, 80-81.

133 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 38,* Transcript for 22 March 2016, p.18024.

134 The Royal Commission, through its Criminal Justice project, has identified the importance of police maintaining regular communication with victims and their families to keep them informed of the status of their report and any investigation, unless they have asked not to be kept informed. (Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.15-16, 20.)

6.6.3. Better support for children and their families at interview

Draft guidelines, currently in use within NSW Health, suggest that rapport-building and crisis counselling and other support that takes place around the interview of a child or young person is not given the same priority as other JIRT health clinician work.

> *The JIRT Senior/ Health Clinicians also provide wherever possible, and within their work load capacity, crisis counselling to non-offending parents / carers and build rapport with children, young people and families so to enhance facilitation into other health services.*[135]

In 2015-2016, JIRT health clinicians provided crisis counselling in about 20% of cases. While not all clients require crisis counselling, the fact that crisis counselling service provision levels varied between 3% in Southern NSW and 52% in Northern NSW suggests there is significant unmet demand in this area (as well as issues in data collection and reporting).[136]

According to NSW Health data, JIRT health clinicians provided rapport building and support to 22% of JIRT clients in 2015-2016, with service levels varying between 2% in Northern Sydney and 61% in South Western Sydney.[137] Higher levels of rapport building and support would be expected if JIRT health clinicians were regularly available when children were being interviewed.

In responding to our workforce survey, FACS staff raised broader issues about JIRT health clinicians' availability to perform all health clinician functions and noted that FACS caseworkers sometimes need to perform those functions when a clinician is not available. The recent expansion of the JIRT health clinician workforce should ideally improve performance in this area.

6.6.4. Addressing holistic support needs

JIRT health clinicians are understandably focused on health issues. It is not their role to conduct an assessment of the broader support needs of a child or young person or their family, or attempt to provide a holistic response to all of those needs. JIRT health clinicians, while familiar with local health services, may not be familiar with the broader range of services in the area.

As we noted in our 2012 report about responding to child sexual abuse in Aboriginal communities, in many communities there is a complex patchwork of services with different entry requirements, suitability, and likely different approaches and treatment modalities. Navigating these services requires local knowledge, time and a degree of specialist skill. Understanding their local service sector and having strong connections and relationships with relevant agency and NGO staff, should be a specific focus of the advocate role.

6.6.5. Strengthening follow up and coordination of services after early engagement with the JIRT

As noted by the ACCP, the involvement of JIRT health clinicians is mostly short-term, partly due to the volume of cases coming through the JIRT program and the capacity challenges facing the NSW counselling sector.[138] It is clear that the needs of the child and their family, and their willingness to accept services, may change after early contact with the JIRT program. However, current arrangements are not geared towards meeting ongoing needs in these cases, which may negatively impact on the health and wellbeing of children and their families, and the progress of matters through the criminal justice system.

135 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, pp.58-59. FACS has noted that rapport building is integral to client engagement by all agencies, not just NSW Health.
136 Data provided by NSW Health, June 2016.
137 Data provided by NSW Health, June 2016.
138 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report to the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 5.5. The capacity challenges facing the NSW counselling sector are discussed more broadly in Chapter 12.

While a CSC may provide ongoing support to a child and their family after a case has been transferred by FACS JIRT if there are continuing concerns about the safety and wellbeing of a child or their siblings, the available data suggests that provision of such support is unlikely to be a regular occurrence against a background of high closure rates by CSCs due to 'competing priorities'.

The responses to our workforce survey by FACS staff indicate concern about this situation. Thirty-three FACS JIRT workers raised concerns about CSCs closing or not allocating cases referred by FACS JIRT, with competing priorities and lack of resources commonly identified as reasons. A number of FACS workers identified the need for the JIRT program to provide more follow up and longer engagement with families. One respondent suggested that a JIRT caseworker should check on referral uptake and other safety compliance, with a phone call to check on the status of the child, young person or family member. Another respondent suggested that, rather than just providing an initial response, FACS JIRT workers should hold onto cases for longer and have an ongoing casework role – including the provision of ongoing support where matters are criminally dealt with.

While we discuss strengthening the connections between FACS CSC and JIRT caseworkers in Chapter 11, many of the concerns identified by FACS JIRT staff could be better addressed by incorporating holistic 'end-to-end' advocacy supports into the JIRT response.

6.6.6. The ACCP's conclusions on child and family advocacy limitations of the JIRT response

The ACCP concludes that the NSW JIRT model currently limits the effectiveness of the following MDT functions or activities that are typically performed or conducted by Child and Family Advocates:[139]

- engaging with, and developing knowledge of, available services and supports in the community
- ongoing and flexible support response beyond the interview and initial referral
- more comprehensive coordination of services for child and family, and relationship building with community-based service providers
- broader assessment of needs, beyond counselling and medical examinations
- support to engage with needed services, addressing barriers to engagement, and providing information about the benefits of services
- consults with and acts on the interests of the child and their family, bringing their interests and perspective to meetings with other agencies, and
- ongoing contact with families.[140]

In suggesting that consideration be given to incorporating all of the core functions of Child and Family Advocates into the JIRT program,[141] the ACCP states:

> *The inclusion of advocacy is theorised to improve the referral, uptake, engagement, and completion of needed services for children and families, while also assisting/supporting communication between families and statutory services. Advocates may also play an important role in linking the JIRT program to other local service providers, developing local knowledge of capacity, quality/fidelity of treatment models, eligibility criteria, as well as warm referrals to a broad spectrum of services that may benefit children and families. This enhanced knowledge of local services, may help to spread demand across the sector. … The role of the advocate in working to empower and represent the interests and perspective of family may also enhance the JIRT case review process.*[142]

139 These functions/activities are not solely performed/conducted by advocates in MDTs.
140 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.3.
141 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 1.5.
142 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.4.

6.7. Options for enhancing child and family advocacy within the JIRT response

6.7.1. Child and family advocacy functions

One of our roles under CS-CRAMA is to promote access to advocacy support for persons receiving, or eligible to receive, community services to ensure adequate participation in decision-making about the services they receive.[143]

Given the prevalence of MDTs that integrate child and family advocacy services with the criminal investigative and child protection responses to child sexual abuse, and the ACCP's analysis of service gaps in the JIRT response, we strongly recommend enhancing child and family advocacy within the JIRT response. All of the stakeholders we have consulted, together with the JIRT partner agency leads on this issue, support such an approach.[144]

We believe that the following functions, commonly performed by Child and Family Advocates in other jurisdictions, should be incorporated into the JIRT response. These functions should be exercised in accordance with the best interests of the child and, where there is no conflict of interest, with regard to the best interests of the child's family:[145]

- Providing immediate support to family members from the point of the recorded criminal interview[146] and providing flexible ongoing support to children and their family members after the interview until the conclusion of the criminal justice process, or until such time as advocacy services are no longer required.
- Empowering children, young people and their family members to participate in decision-making about their cases.
- Understanding and conveying the views and wishes of children, young people and their family members to other professionals involved in responding to the reported abuse.
- Acting as a consistent contact point for children, young people and their family members for information about the overall JIRT process, conveying general information (as approved by the relevant agency) about the status of their matter (to the extent that information can be provided) and the different systems they may need to navigate (for example, legal, child protection, mental health).
- Working to build engagement with a broad range of child and family services (for example, mental health, victim support, financial, housing, schools, disability services), as well as other advocacy services,[147] and serving as the JIRT program's general ongoing contact point for those services.
- Facilitating referral of children and their family members to services, including working to reduce barriers to accessing those services.
- Following up on service referrals to promote, and improve data on, service uptake – and establishing systems with service providers to notify the advocate when children and young people and family members discontinue services.[148]

143 Section 11(1)(j) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

144 In submissions in response to the Royal Commission's *Issues Paper 10: Advocacy and Support and Therapeutic Treatment Services*, a range of organisations, including CREATE (the peak body representing children and young people in out-of-home care) called for child and family advocacy services to assist child abuse victims and survivors and their families better navigate the criminal justice system.

145 There is always the potential for conflict in facilitating service referrals for children with harmful sexual behaviours who are not victims in matters being responded to by a JIRT (e.g. sibling abuse matters), even where there does not appear to be conflict at a particular point in time. Health clinicians should continue to facilitate referrals to the New Street Service program and other therapeutic services in appropriate cases, and FACS should facilitate other appropriate support to manage ongoing child protection risks.

146 As noted in section 6.4.2, if advocates seek to build a rapport with children and young people (rather than their family members) just before their interview, this may impede the ability of the interviewer to build a rapport with the child/young person, which is an important component of eliciting the child's best evidence.

147 For example, CREATE provides advocacy support for children and young people who are, or who have been, in out-of-home care.

148 The advocate may be able to assist children and young people and their families re-engage with services. CACs are accredited with reference to a case tracking standard that provides, 'Cases are managed through the centre to ensure appropriate referrals and the progress of cases'.

- Engaging in information sharing processes with JIRT agencies and other agencies that provide, or may provide, services to children, young people and families as required.
- Engaging with communities that may have negative impressions of child protection, police and/or broader government services, to improve community understanding and acceptance of the important services provided by the JIRT program.

Advocacy, while of benefit to children and their families generally, is likely to particularly benefit vulnerable groups of children and young people who are accepted into the JIRT program. Children with disability, Aboriginal children, children in out-of-home care (OOHC) and children from a culturally and linguistically diverse background (and their families), are especially likely to benefit from the provision of the more seamless and individualised support that advocacy can offer.

6.7.2. Distribution of advocacy functions between JIRT health clinicians and new Child and Family Advocates

The ACCP has identified three options for incorporating child and family advocacy into the JIRT response:

1. Incorporate the core functions of advocacy work into the roles of professionals who are already part of the JIRT response.
2. Introduce a new role of 'Child and Family Advocate', as per the MIST and CAC models, operating alongside the existing resources of the JIRT program.
3. A combination of options 1 and 2, with some advocacy work undertaken by existing staff and some undertaken by the new Child and Family Advocate.

The information we have considered during this inquiry suggests the first option is not viable. Advocacy is incompatible with the necessary objectivity of police investigations and FACS safety assessments. While we consider advocacy to be broadly compatible with the role of JIRT health clinicians, there are a number of challenges that assuming additional advocacy responsibilities into the JIRT health clinician role would present. For example, NSW Health resourcing of, and priorities for, JIRT health clinicians has not historically enabled clinicians to provide support for children and young people and their families at the time of interview, to the degree that they would like, with any expansion of the JIRT health clinician role likely to negatively impact on the fulfilment of critical clinician responsibilities. Also, it would be less cost-effective than engaging staff with general advocacy skills, as health clinician wages and allowances would usually be higher than those of people who have general advocacy skills.

While the second option identified by the ACCP would support 'end-to-end' advocacy, it is important that children and their families continue to benefit from the specialist skills of JIRT health clinicians, who do not have such an extensive role under the CAC, MIST or MDC models. The current NSW model, which involves JIRT health clinicians from JIRT intake assessment, supports clinicians being informed of issues relevant to the case at the time a child or young person and their family present at interview. This, combined with their clinical skills, expertise and networks, supports crisis counselling during the interview process and facilitates medical/health assessments and referrals.

Health is rightly concerned that the child and family advocacy role should not supplant the role of JIRT health clinicians in providing critical linkages with the public health system. Health also notes that JIRT health clinicians have significant expertise in identifying and responding to trauma impacts on victims and families and providing health and wellbeing advocacy in the JIRT process to minimise further trauma.

We therefore recommend that JIRT partner agencies pursue the third option, where JIRT health clinicians continue to perform their existing functions, and new Child and Family Advocate positions are established to supplement that role.[149] We believe that, if JIRT health clinicians and FACS caseworkers work collaboratively with Child and Family Advocates, such a model will support holistic 'end-to-end' advocacy.

149 We believe it is necessary to trial child and family advocacy within the JIRT response, as outlined at section 6.7.4 below, before the state-wide rollout of child and family advocacy services.

We note the ACCP's comments in respect of such a model:

> *Much of the evidence base emphasises … an 'end-to-end' type service, with advocates working from the point of contact with the child and family coming in for an interview. Currently the health clinicians take on the role of providing immediate support to children and families during the interview, and the referral to medical services and counselling. If a separate advocate role was to be established, then this person would have to interface with the health clinician, meaning some of the benefit of the initial contact and rapport building with families when they attend for an interview may be lost through a handover, particularly if the advocate is not part of the initial response.*

Our consultations suggest that multiple people initially engaging with a child or young person and their family members can be overwhelming and prevent the workers with primary responsibility in the initial response from developing optimum rapport. For this reason, there is merit in the following approach being considered:

- JIRT health clinicians having the minimum contact necessary with the child to perform their functions prior to the police interview, and focusing on developing a rapport with non-offending family members (this is consistent with allowing the interviewing officer to develop a rapport at this point).
- Briefly introducing the Child and Family Advocates to the child and their family members before the interview and explain their ongoing support role. They do not need to provide support to the family during the interview if a JIRT health clinician is doing so, but should provide such support if a JIRT health clinician is unavailable or has transferred the primary contact point role to them.
- JIRT health clinicians transferring the primary contact point role to Child and Family Advocates before the child or young person and their family leave the interview location (this may occur while the child is being interviewed if the JIRT health clinician has completed their assessments and crisis counselling).

The benefits of JIRT health clinicians being involved in the JIRT response at an early stage outweighs any risk of any potential disruption to advocacy services, particularly as risk is able to be minimised if handover occurs before the family leaves the interview location.

While JIRT health clinicians should participate in all stages of the LPR, it would appear that generally, it would only be necessary for Child and Family Advocates to participate in the debriefing meetings held after the child or young person's interview or other meetings focused on addressing the child or young person's wellbeing and therapeutic care. These meetings are used by the JIRT agencies to plan their ongoing response. Involving Child and Family Advocates at an earlier stage may be an inefficient use of resources and potentially result in unnecessarily disclosing to them sensitive information relevant to the criminal investigation or care and protection assessment, but not to the provision of ongoing support. However, where the JIRT agencies jointly consider that it is necessary, Child and Family Advocates should be able to participate in all stages of the LPR, subject to their availability.

Advocates should have the lead role in coordinating service supports after JIRT health clinicians have referred children and their non-offending family members to appropriate health services, although they should involve FACS and Health JIRT staff in case meetings, as required – for example, JIRT health clinicians should be informed of issues around mental health service take-up and be involved in decisions concerning the provision of alternative or additional mental health services.

In our view, there would appear to be a range of benefits that would result from the addition of an advocate role to the JIRT model. First, an advocate role should allow all JIRT staff additional time to focus on their core responsibilities. It should also provide greater capacity to respond to enquiries from children and their families and other agencies about the JIRT process and improve efficiency by saving the agencies' time, as they would mostly be responding to enquiries referred to them by the advocate.

JIRT health clinicians would no longer have to follow up on health referrals and, in some cases, would be able to transfer responsibility for family support at an earlier stage. The advocate would be able to provide family support when a JIRT health clinician is unavailable, with FACS JIRT staff no longer having to take on this role.

The longer term supports offered by an advocate are also likely to reduce the amount of active casework by a CSC required for some JIRT matters. If an advocate is working with a child and their family to engage them with appropriate support services, and where no broader child protection risks are in play, the CSC could close a case on referral if satisfied that the response being delivered via the advocate is appropriate. The CSC would be able to seek information on the support services that have been arranged by the advocate. The advocate and JIRT FACS worker would also be able to engage the CSC for those matters where the need for more intensive FACS supports is identified, and the advocate could be utilised by FACS and act as a conduit for engaging families.

It is important to note that, while not necessarily the case in other jurisdictions, Child and Family Advocates in NSW would be mandatory reporters.

6.7.3. Managing the risks of role confusion and role overreach

Our visit to Western Australia highlighted the risk of role confusion and role overreach in establishing new child and family advocacy services. This risk is acknowledged in Action for Advocacy's Code of Practice for Advocates, which provides:

> *Advocates should be clear about the nature and extent of their role. They should understand the boundaries of their own advocacy role and non-advocacy roles such as mediation and advice giving.*[150]

Advocates have a coordinating and linking, rather than decision-making role. While they coordinate access to services, they do not determine whether a child, young person or family member will receive a particular service – that remains the responsibility of service providers and funding agencies.

It is critical that the advocate does not intrude into areas that are the responsibility of other agencies. For example, the advocate should not provide advice on child protection, police investigation, charging, prosecution and court processes in respect of individual cases, which are the responsibilities of other agencies, but may convey approved information about these processes on behalf of responsible agencies. It is important that advocates do not inappropriately disclose sensitive FACS, Police or Health information – where such information is sought, the advocate should ask the officers from the relevant agency to make contact with the individual seeking the information.

The advocate may assist in linking the child and their family members to support services, but should then allow those services to provide support within their areas of expertise. For example, an advocate may assist a child to access disability advocacy services, with ongoing advocacy in respect of disability issues then becoming the responsibility of the specialist disability advocate. An advocate should have no role in respect of witness assistance, beyond encouraging engagement with the Witness Assistance Service (WAS) and broad advice on their role.

Where a child, young person or family is receiving case management or case coordination support from another agency (for example, a child in out-of-home care, a child receiving support from the NSW Department of Justice's Victims Services, or a family receiving support services from FACS), it is critical that the advocate only arrange additional supports in consultation with that agency.

6.7.4. A trial of the Child and Family Advocate role

Child and Family Advocates will need to be used judiciously given the large number of referrals accepted by the JIRT program and the need to make the most effective use of a limited resource. The Child and Family advocate will have a minor role in many cases where there are no ongoing support needs, other than health needs, or where children and young people and their families do not want ongoing advocacy support. In addition, they may play a much more limited role in matters where the child's family is protective. However, this will be counter-balanced by those cases where more extensive supports are required, and would include those cases where the child or young person's matter has not proceeded through the criminal justice system, but where they (and their family) may be particularly vulnerable. It is therefore difficult to accurately assess advocate workloads at this time.

150 Action for Advocacy, *Quality Standards for Advocacy Schemes in action: Based on the Advocacy Charter*, May 2006, p.7.

While we support – based on the available evidence about the inherent value of an advocacy function – a state-wide rollout of child and family advocacy services as part of the JIRT response, it would be prudent to first conduct a limited trial. In this regard, there would appear to be merit in designating at least two sites – for example, one co-located metropolitan and one non-co-located rural site – to examine the relationship between JIRT caseloads and advocate workloads, and explore how the role could be refined over time to suit different operational settings.

The ACCP has suggested that a policy of 'targeted universalism', rather than a triaged response, would enable advocacy support for a broader range of children, young people and families who would benefit from it:

> *Advocacy may particularly benefit cases that are rejected for a JIRT response and are referred to CSCs; similar to cases in the lower levels of risk for MASH, advocates may be able to play a role in reducing the risk level of cases and reducing the need for the involvement of statutory agencies.*[151]

However, particularly given the significant volume already being managed by the JIRT program, we suggest that the role of the Child and Family Advocate be confined at least for the duration of the trial, to referrals that are accepted for a JIRT response. Broadening the advocacy response would require advocates to establish different case coordination models and add complexity to the role. Once the workload of Child and Family Advocates can be assessed for JIRT accepted matters, consideration might be given to broadening the role to some non-JIRT accepted matters in the future. For example, children and young people whose cases are rejected by the JRU due to prior LAC involvement (but which otherwise meet the JIRT criteria) would benefit equally from an advocacy response.

6.7.5. Responsibility for Child and Family Advocates

NSW Health could establish child and family advocacy positions, separate to its health clinician workforce. This would facilitate the coordination of health and other supports.

FACS too could establish such positions, which would support the integration of advocacy services with child and family services provided or funded by FACS.

However, as noted earlier in this chapter, most MDTs (including those in Western Australia and Victoria) have advocacy services delivered by NGOs. The practitioners we consulted during our visit to Western Australia considered the advocate's independence from government agencies to be critical to the role's success. NGOs are also increasingly delivering early intervention, advocacy and support services in NSW.

Most NGOs don't provide state-wide child and family support services via a specific program – indeed their strength is often grounded in their strong local connections. One option would be to invite NGOs to tender to provide advocacy services in each JIRT catchment area. However, given the number of locations involved, it would seem more efficient to build on established state-wide service provision models.

Consideration could be given to expanding the role of the 11 NGO-run Family Referral Services (FRSs) – which are currently funded by NSW Health to assess the support needs of vulnerable children (and their families) who are below the threshold for statutory child protection intervention – and link them with appropriate support services in their local area.[152] The most common issues FRSs deal with are domestic violence, parenting issues and family breakdown,[153] which are also common in many of the more serious child abuse and neglect matters handled by the JIRT program.

FRSs have the following objectives:

- to improve access to services for vulnerable children, young people and their families by putting families in touch with services in the local area
- to improve coordination and collaboration in the delivery of local services to clients

151 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.4.
152 KPMG, *Evaluation of Family Referral Services: NSW Kids and Families*, December 2013, p.iv. NSW Health was appointed as the lead agency for FRSs to achieve a strong Health/NGO partnership based on holistically meeting the needs of vulnerable children and their families.
153 KPMG, *Evaluation of Family Referral Services: NSW Kids and Families*, December 2013, p.vi.

- to support optimal alignment of local services to meet local need, and
- to provide improved culturally appropriate and effective referral pathways for Aboriginal families.[154]

FRSs have a case coordination role, which involves telephone and face-to-face coordination and may involve home visits. FRSs commonly assist clients with:

- domestic violence experiences
- parenting struggles
- mental health concerns
- housing or accommodation access
- financial assistance, and
- counselling and mediation.

They also help vulnerable children, young people and their families access other services,[155] and are able to use brokerage funding to purchase goods or services to address immediate needs of their clients.[156]

FRSs use information sharing provisions to inform assessments and convene case conferences where families have multiple referral needs. KPMG found the FRS assessment tools it sighted to be holistic, strengths-based, child-focused and family centred.[157]

Western, New England North West and Mid North Coast FRSs have been funded to improve referral pathways for Aboriginal children, young people and families, while South West Sydney and South Eastern and Northern Sydney FRSs have been funded to improve referral pathways for CALD clients. Strategies for improving referral pathways include the employment of Aboriginal and CALD staff, connecting with client groups at community events, and attending interagency meetings supporting linkages.[158]

Engaging FRSs to provide child and family advocacy services would require a broadening of the FRS client base and a move beyond case coordination to more active advocacy. This would obviously have cost implications, but is likely to be more cost-effective than building a state-wide JIRT advocacy service from scratch. In our 2016 submission to the Legislative Council inquiry into child protection in NSW, we submitted that FACS (and partner agencies), should look for opportunities to better integrate existing structural components of the child protection system, including FRSs. In this regard, we noted that specific consideration should be given to expanding the role of FRSs from simply a service referral point for children and their families below the statutory threshold for reporting risk of significant harm (ROSH), to working in an integrated way with government agencies in supporting those families identified as being 'ROSH'.[159]

If the advocate role is adopted, and is delivered via an FRS or some other NGO-led model, the entity would need to be represented at JIRT LMGs and there would need to be a mechanism for FRS/NGO views to be represented at the JIRT SMG in relation to their brief.

6.7.6. Location of Child and Family Advocates

As long as they are available to attend interviews and meetings onsite, Child and Family Advocates can be accommodated offsite; they could also be accommodated with JIRT agencies in co-located sites. In non-co-located sites, they could be located with their employing agency or one of the JIRT agencies.

An advantage of accommodating a Child and Family Advocate with staff from their own agency (if an NGO model is selected) would be the ability for the advocate to leverage the agency's established linkages with local services, and engage agency staff with particular competencies (for example, the

154 KPMG, *Evaluation of Family Referral Services: NSW Kids and Families*, December 2013, pp.4-5.
155 NSW Family Referral Service, http://www.familyreferralservice.com.au/about.html.
156 *NSW Health, Family Referral Services Program Guidelines, Dec 2014*, p.8. http://www.health.nsw.gov.au/kidsfamilies/protection/Publications/frs-program-guidelines.pdf.
157 KPMG, *Evaluation of Family Referral Services: NSW Kids and Families*, December 2013, p.vi.
158 KPMG, *Evaluation of Family Referral Services: NSW Kids and Families*, December 2013, p.xvii.
159 NSW Ombudsman, *Submission to Legislative Council General Purpose Standing Committee No. 2 Inquiry into Child Protection*, July 2016.

advocate could seek the assistance of a specialist Aboriginal support worker). However, this may not be possible if the agency does not have an office reasonably close to the place where recorded criminal interviews are generally held.

To the extent that Child and Family Advocates are co-located with staff from JIRT partner agencies, the greatest benefits are likely to be realised in locating them with JIRT health clinicians.

The optimum location of Child and Family Advocates is likely to vary across NSW and should be determined by JIRT partner agencies, in consultation with any NGOs that provide child and family advocacy services.

6.7.7. Specialist Aboriginal supports in the provision of child and family advocacy services

Child and family advocacy is likely to be of particular benefit to Aboriginal children and their families. These benefits will be maximised if specialist Aboriginal supports are integrated with advocacy services.

If engaged to provide child and family advocacy services, FRSs that have been funded to improve referral pathways for Aboriginal children, should improve JIRT casework planning and decisions in respect of Aboriginal children, young people and their families. Other FRSs should also have links with local Aboriginal services. For example, the Bourke (Maranguka) FRS which is the only joint agency/community-led FRS in the state.

We also believe there would be merit in designating some Child and Family Advocate positions as Aboriginal, particularly in areas with larger Aboriginal populations if a trial of the role proves successful. If this is done, careful consideration will need to be given to identifying additional capabilities for these roles to expand the pool from which suitably qualified Aboriginal applicants can be drawn. However, as it would not be feasible to have Aboriginal designated roles in all JIRT locations (if the role is rolled out more widely), it will also be important for one of the Child and Family Advocate's core capabilities to be demonstrating cultural competency.

6.7.8. Helping young people have a voice through the JIRT process

As part of our inquiry, we consulted the NSW Advocate for Children and Young People.[160] The Advocate has spent the last two years consulting more than 9,000 children and young people across the state about the issues that affect them. One of the strongest themes arising from the Advocate's consultations with young people who are particularly vulnerable – such as those who are homeless, in out-of-home care or who are or have been in contact with the juvenile justice system – is their perception that they are not shown respect by the agencies and services responsible for supporting them. The Advocate told us that, while there were aspects of the system that young people believed were working well, what they wanted most from government and funded services was to be listened to and believed by their staff and consulted about their views.

In reporting his consultation findings, the Advocate stated that:

> *There needs to be a cultural shift in the way that services are provided to children and young people in NSW. Children and young people must be recognised as inherent rights holders who are entitled to information, support and a say in decisions that affect them, and their best interests must be the paramount consideration in determining how to respond to and support them.*[161]

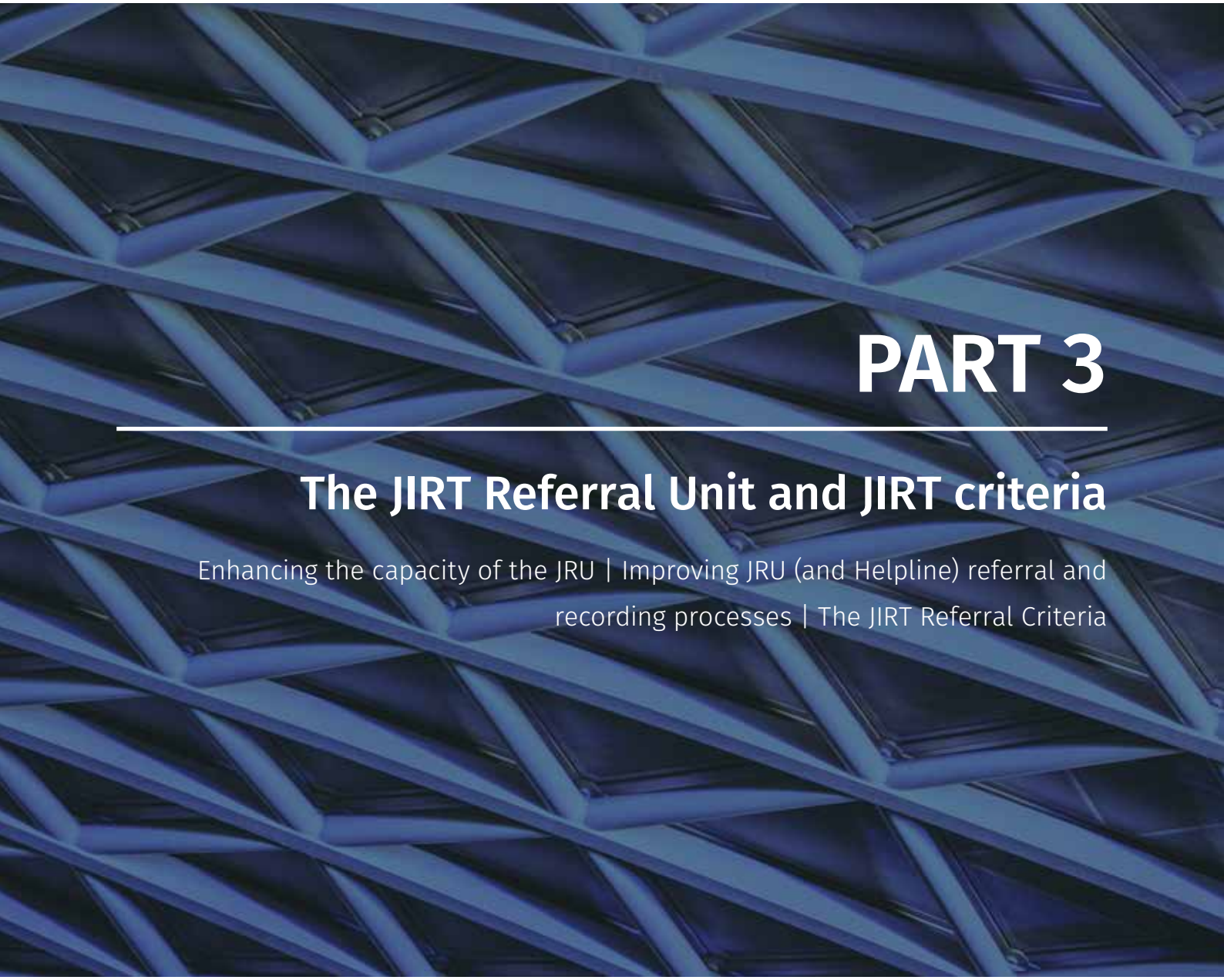
A key feature of any Child and Family Advocate role must include building a strong connection with the child or young person referred to the JIRT program, and ensuring that their voice is heard by those agencies tasked with supporting them throughout the process.

160 The Advocate for Children and Young People is an independent statutory appointment established by the *Advocate for Children and Young People Act 2014* and is overseen by the Parliamentary Joint Committee on Children and Young People. The Advocate's mandate includes promoting the safety, welfare and wellbeing of children and young people aged 0-24 years, and supporting their participation in activities and decision-making about issues that affect their lives.

161 Office of the Advocate for Children and Young People, *ACYP Consultation Findings: Listening, Believing and Explaining to Children and Young People in Need of Support Services*, March 2017.

Recommendations

2. **The JIRT partner agencies should consider developing a business case for trialling the establishment, within the JIRT program, of a Child and Family Advocate role. The business case should give consideration to the role performing the types of functions (outlined below) that are commonly performed by advocates in other jurisdictions:**
    a) **Providing immediate support to children and their families throughout the interview process and providing flexible ongoing support until the conclusion of the criminal justice process, or until such time as advocacy services are no longer required.**
    b) **Empowering children and their family members to participate in decision-making about their cases.**
    c) **Understanding and conveying the views and wishes of children and their family members to other professionals involved with their cases.**
    d) **Acting as a consistent contact point for children and their family members for information about the JIRT process, the status of their case (to the extent that information can be provided) and the different service systems they may need to navigate.**
    e) **Building relationships with a broad range of child and family services (for example, mental health, victim support, financial, housing, schools, disability services), as well as other advocacy services, and serving as the JIRT program's general ongoing contact point for those services.**
    f) **Facilitating referral of children and their families to necessary services, including working to reduce barriers to accessing those services.**
    g) **Following up on service referrals to promote, and improve data on, service uptake – and establishing systems with service providers to notify the advocate when children and their family members discontinue services.**
    h) **Engaging in case consultations and information sharing with JIRT agencies and other organisations that provide, or may provide, services to children and their families.**
3. **If recommendation 2 is accepted, the JIRT partner agencies should also give consideration to the observations contained in Chapter 6 about the following:**
    a) **How certain current functions of NSW JIRT health clinicians could be shared with and/or complemented by a Child and Family Advocate role.**
    b) **The need for a clear role description to be developed to avoid role confusion.**
    c) **The most suitable entity to 'sponsor/employ' the Child and Family Advocate role.**
    d) **The most suitable physical location for the Child and Family Advocate in non-co-located JIRT sites.**
    e) **Ensuring that whichever entity/s houses the Child and Family Advocate role is embedded within the JIRT governance structure at a strategic state-wide and local level.**
    f) **Designating a certain number of Child and Family Advocate positions as Aboriginal, and in doing so, giving careful consideration to identifying suitable capabilities for these roles to expand the pool from which qualified and/or otherwise experienced Aboriginal applicants can be drawn.**
    g) **Ensuring that one of the Child and Family Advocate's core capabilities involves demonstrating cultural competency.**
    h) **As part of any trial, giving consideration to identifying one co-located metropolitan JIRT site and one non co-located rural JIRT site to specifically examine how the role should be adapted to suit differing operating environments and local conditions, and to assess potential workloads.**



PART 3

The JIRT Referral Unit and JIRT criteria

Enhancing the capacity of the JRU | Improving JRU (and Helpline) referral and recording processes | The JIRT Referral Criteria

Contents

Chapter 7. Enhancing the capacity of the JRU

The JIRT Referral Unit (JRU) has operated since September 2008, when the partner agencies agreed to pilot a centralised decision-making team for referrals to the JIRT program as a result of 'quality and workload issues' facing local JIRTs. Prior to the establishment of the JRU, local JIRTs were responsible for assessing all referrals and Police decided whether a matter would be accepted for a JIRT response.

The review of the JIRT program in 2006 'identified a number of deficiencies in the management of referrals to JIRT across several regions, and in the way that the rejected referrals were being processed'.[162] Since 2005, our office had also been raising concerns with the JIRT agencies about inconsistent decision-making across local JIRTs, particularly in the context of initial assessment decisions. The centralised assessment trial was designed to achieve greater consistency of decision-making and provide local JIRTs with more time and resources to respond to individual matters.

Compared to the previous decentralised model, centralised intake and assessment through the JRU has reportedly increased the information considered in determining whether to refer a matter for a JIRT response and improved consistency in decision-making.[163]

Despite the Wood Inquiry's endorsement in 2008, the JRU had still not been permanently funded at the time of our 2012 report about responding to child sexual abuse in Aboriginal communities. The NSW Government subsequently accepted our recommendation that the future of the JRU should be secured and a decision was made to permanently fund it.[164]

The JRU is the gateway to the JIRT program. As we highlighted in Chapter 5, the centralised assessment and decision-making role that the JRU performs is central to the overall effectiveness of the JIRT program and is unique when compared to other Australian and international specialist and multi-disciplinary child abuse models. The joint information gathering and analysis that is facilitated by all three agencies sitting alongside each other is one of the most effective examples of genuinely integrated interagency practice in this state. The JRU also plays an important symbolic role for the JIRT program, with its operating model sending a clear message that child protection is a shared responsibility. However, as we discuss in this chapter, staff from the JRU and JIRT agencies across the board have expressed strong concern about the ongoing viability of the JRU if, against a significant increase in the referrals it must assess, it continues to operate within current resourcing.

While it was not realistic during our inquiry to audit a sufficiently large sample of the many thousands of decisions made by the JRU for the purpose of assessing their quality, the volume alone and dramatic increase in referrals without additional staffing paints a very clear picture of the challenging operating environment that the JRU is currently operating in. In turn, this environment has repercussions for JIRT agency staff in the field. Against a background of such high volume, it is inevitable that less than ideal assessment decisions will be made.

7.1. Increase in referrals to the JRU

Reports screened by the Helpline as requiring referral to the JRU have increased by almost 60% over the last eight years, but this has not been accompanied by a corresponding increase in resourcing of the JRU, [165] or an examination of the ongoing viability of its 'single decision-making table' structure.

162 NSW Health, NSW Police, NSW Department of Community Services, *NSW Joint Investigative Response Team (JIRT) Review*, November 2006.

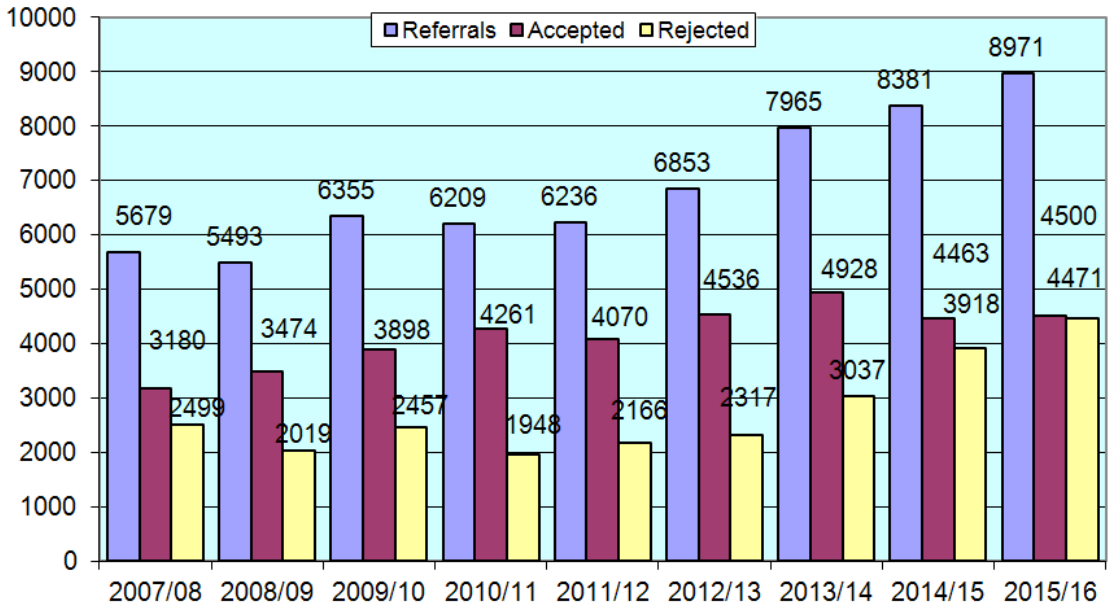
163 NSW Department of Family and Community Services, NSW Police Force, NSW Health, *JIRT Referral Unit, Keep Them Safe Evaluation*, December 2013.

164 Advice provided by FACS, July 2014.

165 While NSW Health agrees that JRU resourcing has not increased apace with increased referrals, it has noted that since 2008, the Health JRU team has increased by 40% from 3 FTE (comprising a Manager, a Senior Health Clinician and an Administrative Assistant) to current staffing of 5 FTE (comprising a Manager, a Senior Health Clinician, 2.5 Health Clinicians and 0.5 Administrative Assistant). This occurred due to enhanced Health funding to the JIRT program from 2010-2011 and a restructure to increase the clinical component in 2015. (Advice provided by NSW Health, June 2017.)

As Figure 1 shows that between 2012-2013 and 2013-2014 alone, the number of reports jumped by 16%.[166]

Figure 1: Number of reports that were referred to the JRU and the % of those that were accepted and rejected per financial year



It is not possible to say with certainty why the number of reports has increased so significantly over the past decade. However, the increase in referrals to the JRU has also occurred in the context of increased demands on the child protection system in NSW more generally – in the four years to 30 June 2016, there was a 23% increase in the number of children reported to be at risk of significant harm.[167]

Over the past eight years, there has also been significant fluctuation in the number of reports accepted into the JIRT program. In 2007-2008 – the year prior to the establishment of the JRU – 56% of reports were accepted. Following the nine month trial of the JRU, the acceptance rate increased to 64%. By 2010-2011, the acceptance rate had increased to 69% – the highest to-date. The acceptance rate then declined significantly between 2013-2014 (62%) and 2015-2016 (50.2%).

The acceptance rate is now sitting at around half of all referrals and is almost 6% lower than it was before the JRU was first trialled. (In making this observation, it should be noted that the number of accepted referrals in 2015-2016 – 4,500 – is still higher than the average annual number of accepted referrals – 4,145 – over the past nine years).

While there have been no comprehensive changes to the three core JIRT referral criteria in the past decade, there have been changes to the physical abuse criteria and to the way that adolescent peer sex reports have been handled by the JIRT program. Both of these changes have impacted on the fluctuating acceptance rate – we discuss this further in Chapter 9.

7.1.1. JRU decision timeframes

The Helpline assigns a priority response time to all referrals that it sends to the JRU.

Within business hours, the JRU aims to make a decision about whether or not JIRT will accept a report within:

- 2 hours – for reports assigned a priority response time < 24 hours
- 24 hours – for reports assigned a priority response time < 72 hours
- 72 hours – for reports assigned a priority response time < 10 days

166 Data provided by FACS, November 2016.

167 This included an increase of 14% from 2012-2013 to 2013-2014 alone. The figures have otherwise been reasonably consistent over the past three years, including a slight drop from 2013-2014 to 2014-2015. (Community Services caseworker dashboard, September 2016 quarter and September 2013 quarter. http://www.community.nsw.gov.au/about-us/community-services-caseworker-dashboard.)

At times it may be necessary to extend the JRU decision-making timeframe in order to gather additional pertinent information to inform decision-making. For example, we were advised that outside of school hours it can be difficult for the JRU to establish contact with school principals to obtain further information required to inform an assessment of the report. And, for some matters requiring an urgent response – for example, where immediate risks to children are evident, a crime scene needs to be quickly secured or there is a very limited timeframe within which forensic medical evidence is viable – even the shortest JRU decision-making timeframe may be too long for the agencies to await a decision prior to taking action to respond. We discuss this and related issues in Chapter 8. JIRTS[168] data indicate that in 2016, the JRU made a decision within the relevant decision-making timeframe for 91% of reports. However, proportionately fewer matters that were assigned the most urgent priority response (< 24 hours) were met within the assigned timeframe (83%, compared with 96% of reports < 10 days and 95% of reports < 72 hours). This trend has been consistent since at least July 2014.

FACS has advised that, of the 571 reports in 2016 where the < 24 hour timeframe was not met, 62% required additional information to be gathered before a well-informed decision could be made.[169] Notwithstanding this, given that reports assigned the most urgent priority response by the Helpline are likely to be the most serious, it is concerning that the JRU is less likely to make a decision about these matters within the corresponding timeframe. However, this is also unsurprising in the context of the current workload and resourcing constraints faced by the JRU.

Concern about delays in the JRU assessment process, and the impact of delay on the JRU's decision-making and the initial investigative response by police, was a strong theme in responses to the JIRT workforce survey and LAC survey issued by the CAS.[170] (While not specifically noted in survey feedback, JRU delays may also impact on child safety.) It is possible that delay perceived as being caused by the JRU may be influenced by delays prior to matters being received by the JRU. However, many respondents attributed the delays to the JRU's operating hours and workload, commenting that the JRU was not adequately resourced to handle the volume of referrals it is now receiving '24/7', and thought that additional resourcing was necessary to reduce delays in the assessment process and facilitate better informed – and more consistent – decisions about which matters should be accepted for a JIRT response.[171]

LACs in particular – which are required to maintain the continuity of the police investigation – argued that the timeframe for JRU assessment potentially impacts on the timely collection of forensic and other evidence, thereby jeopardising public confidence in police. In circumstances where abuse has been directly reported to them, LACs spoke about the frustration of having to wait – often for several days – to learn about whether they would ultimately have carriage of a matter and to be able to communicate this to victims and their families. Police respondents also raised concern about what they regard as the unusual situation of a law enforcement body being required to wait for a separate 'non-law enforcement entity' (that is, either the Helpline or the JRU) to notify them of whether they will be responsible for responding to a crime. Ordinarily, police are expected to respond immediately to reported crimes in line with public expectations.

Notwithstanding the arrangements that exist for operationally responding to urgent 'after-hours' reports, all reports (including those received after-hours) continue to be sent by the Helpline[172] to the JRU for a decision regardless of when they are received; 'after-hours' reports must be processed by the JRU on the next business day. JRU staff have reported that particularly on Mondays, this creates a substantial backlog of work that is often not cleared until Wednesday. They also spoke of the pressure resulting from a significant influx of reports late on Friday prior to the JRU's closure at 5pm – and observed that these reports at times lack sufficient detail, requiring the JRU to undertake more intensive information gathering than at other times.

168 JIRTS is the database utilised by all three agencies to record reference information and data.
169 Advice provided by FACS, May 2017.
170 The Ombudsman's office jointly assessed – with the CAS – the response from the LACs to the survey issued by the CAS to all Local Area Command's crime managers.
171 Of note is advice we received from NSW Health about delays to JRU assessment and decision making caused by the JRU being unable to contact school principals outside of school hours when additional information about a referral is required. This is reportedly a particular problem when the JRU receives a report late in the day, especially on a Friday. It is not clear whether the SMG has examined this reported issue to determine the extent of its impact on the JRU and/or has taken steps to identify an appropriate solution. In light of the feedback received from Health, we recommend that the SMG considers the issue further.
172 Or 'decentralised' Helpline models, such as those operating in the Central Coast District (CC-MARC) and Western Sydney District (Macarthur Intake and Referral Service).

Last year, the JRU received, on average, 174 reports a week (or 35 reports a day). While not all reports require the most urgent response, this equates to a 'handle time' of less than 15 minutes per report. If the JRU's decision-makers (and those who support the assessment process) have too little time to assess each referral, it is not possible for their decisions to be sufficiently thorough, and they are likely to be too strongly influenced by capacity. As we discuss in the chapters about each agency's performance, the increase in referrals has also had a significant impact on frontline agency resources.

In our view, the JRU's capacity should be strengthened by extending its operating hours beyond 9-5pm on weekdays and ideally, to provide coverage on weekends, so that urgent referrals can be processed with greater consistency, and to prevent a backlog of after-hours referrals impacting on the efficiency of the JRU. On its own, however, extending the JRU's operating hours (and/or increasing the number of JRU staff who support the operational management team by gathering additional information to inform assessments) would be insufficient.

As all decisions about whether a referral should be accepted or rejected for a JIRT response are made jointly by the JRU management team, we believe that an additional team of decision-makers is also necessary. A second management team or 'decision-making table', if established, would improve the efficiency and quality of referral decisions. In addition, establishing another 'decision-making table' would also provide scope to have a rotating roster of weekend staff. As well, increasing the number of JRU positions will help fill gaps quickly during periods of leave or when vacancies arise within the JRU management team. Ideally, the JRU would also be supported by a pool of designated back-up staff to form part of a broader 'JRU trained' workforce.

An injection of staffing would not represent a significant cost, but is likely to have an appreciable impact on timeliness; improving the quality of assessment decisions; and the ability to conduct more thorough information checks to inform assessments. It would also provide scope for the JRU to deliver advice and guidance to local agency staff, who are increasingly handling a significant number of child abuse matters 'rejected' for a JIRT response.

Enhancing the JRU's resourcing would also allow it to play a more active role in advising and training the Helpline. Currently, it is almost impossible for the JRU operational management team to take time out to perform other functions, including providing (and participating in) training and development, and reviewing their own decisions and processes.

While the JRU is the gateway to the JIRT program, the Helpline is effectively the gatekeeper. As the source of almost all referrals to the JRU, the Helpline decides which reports meet the criteria for referral to the JRU.[173] Some sources have suggested that following the Wood Inquiry, the Helpline has become more cautious, and is more likely to refer reports to the JRU for a detailed assessment against the JIRT criteria. However, in the absence of conducting a review of a substantial number of rejected referrals, it is difficult to ascertain whether 'over-referring' by the Helpline is a significant contributing factor to the increase in referrals – although the corresponding increase in the rejection rate tends to suggest that it is a factor worth exploring. Regardless, it is critical for there to be close cooperation between the Helpline and the JRU and to ensure that regular feedback is being provided to the Helpline about referral decisions.

During our consultation with the JRU management team, we learned that while training for Helpline staff about the JIRT referral criteria and role of the JRU has continued,[174] the bi-monthly Helpline/JRU meetings were no longer taking place.[175] In our view, ongoing meetings and joint training between the JRU and Helpline management teams is essential to the efficiency and effectiveness of centralised assessment. And, with FACS trialling a number of de-centralised Helpline models such as those operating on the Central Coast and Campbelltown, it will be critical for managers at those sites to also participate in training and liaison with the JRU – particularly given the high volume of ROSH reports handled by these locations.

173 NSW Department of Family and Community Services, *Screening and Response Priority, Policy and Procedures Manual*, updated November 2013.

174 FACS has advised us that training was provided quarterly in 2014 and 2015 and once in 2016, and that two sessions are planned for 2017 (Advice provided by FACS, May 2017).

175 These meetings were taking place at the time of the 2013 *KTS evaluation* of the JRU. We understand that meetings have recommenced between the Helpline and FACS JRU Manager/FACS JIRT Director only.

It is now more than three years since the partner agencies' evaluation of the JRU found that: 'In order for the unit to continue to run in an effective, efficient and timely manner and to keep functioning as a specialist unit, an increase in staff is required.'[176] It is inevitable that, against a background of ever increasing demand, the quality of decision-making will be impacted adversely without an injection of additional resourcing, and a realignment of the operating model.

The establishment of the JRU was a pivotal development in building the capacity of the JIRT program and has been highly successful in increasing the number of referrals it accepts, and achieving greater consistency in decision-making. The JRU has also helped to strengthen the working relationships between the three partner agencies**.** However, a key finding from our inquiry is that if JRU resourcing remains static, there is a real risk that the performance of the JIRT program will be significantly undermined. Without the type of additional resourcing and structural changes that we have outlined, it is unlikely that the JRU will be able to function effectively into the future. In seeking to enhance JRU resourcing, it will be critical that each agency employs staff with solid child protection experience – ideally with a background in the JIRT program.

As we discuss in the following chapters, through our consultations with the JIRT agencies and other key stakeholders, we sought to identify the types of matters that no longer need to be the subject of automatic referral to the JRU in the absence of other clear risk indicators. If the changes we have recommended are implemented, they will help reduce the number of matters the JRU is required to assess, and the corresponding workload for the JIRT workforce in the field.

Ideally, the recommended changes will enable the JRU and the JIRT program to target its resources towards particularly vulnerable cohorts of children and young people. In this regard, we examine the benefits of allowing automatic entry into the JIRT program for those children and young people the subject of referrals with cognitive and/or communication impairment, and those placed in residential out-of-home care (OOHC), where referrals involving these cohorts of children might otherwise be rejected if the reported concerns are assessed as not meeting the JIRT threshold.[177]

Recommendation

4. **The JIRT partner agencies should develop a business case in relation to:**
    - **a) Funding the creation of an additional three 'decision-making' positions at the JRU to enable two simultaneous decision-making tables to operate.**
    - **b) Extending the hours of operation for the JRU (7am-11pm weekdays and/or weekend hours of operation).**
    - **c) Any additional staffing required for each agency to conduct information checks to inform assessment decisions.**

PRACTICE SUGGESTION

- The JIRT partner agencies should:
    - Re-instate the bi-monthly JRU management team/Helpline meetings to inform practice and address systemic issues.
    - Continue to deliver joint training for Helpline staff about the Helpline's responsibilities in assessing reports for referral to the JRU (including adequately reviewing information holdings); the role of the JRU and the impact of inappropriate referrals on the JRU's capacity; and the amended JIRT Referral Criteria (if the related recommendations in this report are accepted).
    - Ensure that staff at any 'de-centralised Helpline' models are provided with the same type of training and guidance as Helpline staff to ensure consistency in referral practices.

176 NSW Department of Family & Community Services, NSW Police Force, NSW Health, *JIRT Referral Unit: Keep Them Safe Evaluation*, December 2013.
177 See Chapters 14 and 16.

Chapter 8. Improving JRU (and Helpline) referral and recording processes

The JIRT program's centralised assessment and decision-making model – which involves reports being made to and assessed by the Helpline[178] to first determine if they meet the 'risk of significant harm' (ROSH) threshold, and second, whether reports meet the JIRT referral criteria and require assessment by the JRU – is critical not only to the overall effectiveness of the JIRT model but also the functioning of the broader child protection system.

However, during our inquiry we received feedback from senior JIRT agency representatives and frontline JIRT agency staff about a range of ways Helpline and JRU referral processes could be improved. In addition, we identified a number of data recording and monitoring issues, relating to the JRU decision categories, which need to be addressed to provide greater transparency of the JRU's operation and matters referred to local community service centres (CSCs) and Local Area Commands (LACs) for a response.

8.1. Notification of Helpline and JRU decisions

Numerous police respondents to the LAC and JIRT workforce surveys indicated that the current process for notifying LACs of the JRU's decision either to accept a report for a JIRT response, or reject and refer it to a LAC/CSC for a local response, is inefficient. A number of LACs argued that the current processes are delaying their ability to respond to matters and, in some cases, that matters are 'falling through the cracks' entirely.

With the exception of reports that are assessed by police officers as 'immediate ROSH' (which are made via a phone call to the Helpline), police make child protection reports by creating a 'Child at Risk' report on the COPS system[179] which is automatically transferred to the Helpline. If the Helpline then refers the report to the JRU for assessment, the JRU will communicate its decision as to whether or not the report has been accepted for a JIRT response by updating the COPS Event narrative.[180]

If a report rejected by JIRT is urgent, the JRU Police Manager will telephone the relevant LAC. However, feedback received from LAC survey respondents suggests that most JRU decisions are communicated by the JRU Police Manager via COPS Event rather than verbally. The difficulty with using the COPS Event to convey decisions is that the process does not involve an automatic notification to the police officer (who may not even be on duty on the day that the event is updated) or to a designated position at the LAC whose role is to check COPS for 'jobs in the workstream' each day.

A similar email notification process is used by the Helpline when it receives a child at risk report from a police officer that is assessed as not meeting the criteria for referral to the JRU but requiring referral back to the LAC. In these circumstances, the Helpline communicates its decision via an email to the reporting police officer. Once again, the LAC will not necessarily learn of the Helpline decision if the relevant officer is off-duty at the time the Helpline makes its decision.

Police have proposed that an automated response from the relevant 'assessment entity' – that is, the Helpline or the JRU – should be developed to communicate assessment decisions immediately to the relevant LAC rather than the individual reporting officer. In this regard, Police have suggested that decisions should be accessible via the LAC 'Workstation' facility on COPS, which allows 'jobs' to go into a workstream that can be accessed by the responsible supervising police officer for each shift. This would allow the supervising officer to immediately see decisions by the Helpline and the JRU – something that is particularly critical when reports have been referred back to the LAC for a local response.

178 Or 'decentralised Helpline' models in some districts.
179 COPS is the NSW Police Force database.
180 NSW Department of Family and Community Services, NSW Health and NSW Police Force, *JRU Process Guidelines*, May 2016.

Ideally, FACS' new database – ChildStory – will be sufficiently integrated with the COPS system over time to enable automatic alerts to be made to the relevant LAC, thereby removing any double-handling of matters at either end. In this regard, FACS and Police personnel should explore further opportunities for cross-agency systems integration for the referral of matters both within and outside of the JIRT program.

In the meantime, FACS and Police will need to quickly develop a more efficient referral process. We understand that currently, the 'Workstation' facility on COPS can only be accessed directly by police, so notifications from FACS would need to be made via an email to a dedicated email address at the relevant LAC (known as a 'smack box') and the decision could then be uploaded into the 'Workstation' facility. This approach would require each LAC to use a generic email address when it reports to FACS, so that the FACS responses are seen promptly by a designated officer. While this proposed solution is only temporary, it has been endorsed by the NSW Police Force as an appropriate interim process.

More broadly, our office has undertaken work with FACS to improve the guidance it gives to Helpline and CSC staff about identifying and referring criminal allegations to police from any source (that is, reports not generated by police officers) that are not covered by the JRU referral process.[181] We have worked closely with FACS to develop a practice direction which gives FACS staff clear guidance about identifying serious and less serious offences and the appropriate pathways for reporting these offences to police. The practice direction was released in December 2016. When criminal matters are referred by FACS and police in these circumstances, FACS staff email a copy of the 'FACS Crime Report' to the relevant LAC and, prior to forwarding the report, phone the relevant police supervisor at the LAC to advise that the form is being sent. FACS has advised that as part of the ChildStory platform it will be possible to report on the number of FACS Crime Reports that are sent to LACs.[182]

It appears that, regardless of who the reporter is, it would make sense for reports from both the Helpline and JRU (Police representative) to be transferred to the relevant LAC via a designated 'portal/generic email' that can be immediately received by the supervising officer on the shift. While the potential impact on a police investigation of any delay in the assessment of a report can, in part, be remediated through ensuring LACs understand their responsibilities to take certain investigative steps during the assessment process, it is nonetheless essential that LACs are promptly and effectively notified of the outcome of Helpline and JRU decisions relating to child abuse reports made by police officers. We understand that FACS and the Child Abuse Squad (CAS) would welcome such discussions taking place between their respective executives, as closer systems integration and data collection about criminal child abuse is a priority. Similarly, Health has also emphasised the need for its 'acute child protection responders' (for example, hospital Child Protection Units) to also receive referrals as quickly as possible via the most appropriate electronic platform. We encourage the JIRT agencies to explore the most effective means for communicating JRU referral outcomes to the relevant 'responders' in each agency.

8.2. Response timeframes assigned by the Helpline

Before referring a report to the JRU, the Helpline uses the Structured Decision Making (SDM) response priority tool to assign a 'response priority' time for JIRT:

- < than 24 hours, where an immediate response is required
- < than 72 hours
- < than 10 days

According to the *JRU Process Guidelines*, the Helpline alerts the JRU to any urgent referrals (that is, those assigned a response priority time of < 24 hours) by telephone, pending the transfer of the plan to the JRU via the KiDS system.

181 The NSW Police Force has also reinforced the importance of any very urgent reports requiring police action to be made to 000.
182 Advice provided by FACS, 24 July 2017.

JIRTS data indicates that in 2016, 38% of referrals were assigned a priority response time of < 24 hours by the Helpline. A further 35% required a response within < 72 hours – that is, almost three quarters of all reports referred to the JRU require a response within three days. This trend has been consistent since at least July 2014.[183]

A criticism made during the review, particularly by Police, was that the response priority times assigned by the Helpline are 'FACS-centric'; that is, they reflect the urgency of child protection concerns but do not give sufficient weight to immediate risks that may exist from a criminal justice perspective – such as the need to obtain forensic evidence, secure crime scenes and respond to risks to the broader community. For example, Police suggested that a report of stranger abuse, involving a protective parent and no other apparent risk, may understandably attract a low response priority from a FACS perspective – however in a matter of this type, the public would reasonably expect that police would take urgent steps to investigate and apprehend an offender who may pose a risk to children in the community.

Similarly, Health also advised that in circumstances where there are no immediate safety concerns, there may be a need for an urgent medical forensic examination and/or health treatment, for example, where there is a risk of self-harm or suicide. Health said they have previously raised with the Helpline the need to override the response priority time assigned in these matters.[184]

Currently, the SDM response priority tool allows a 'mandatory override to < 24 hours' if there is a need to capture and document evidence for legal purposes; or if the reported incident is potentially criminal and there is a need for Police to quickly gather evidence before it is lost, deteriorates or is altered.[185]

Due to the limited timeframe for our inquiry, we did not examine the level of Helpline staff awareness of the mandatory override provision, or the extent to which the provision is consistently applied to reports that are referred to the JRU. Regardless, the potential difficulty lies with child protection staff, rather than police or health clinicians, ascribing a priority to a particular report based on their view of urgency from a criminal and/or health perspective. However, in the absence of police officers and health practitioners jointly assessing all ROSH reports received by the Helpline, it is inevitable that there will be matters which will continue to arrive at the JRU with suggested response timeframes that will not necessarily accord with the Police and Health view of urgency. In this regard, Police and Health may wish to consider working with FACS to provide additional guidance to Helpline staff on factors to consider in determining urgency from a criminal evidentiary, as well as a child protection perspective.

A related issue is how 'class of children' reports are dealt with by the Helpline in the context of referrals to the JRU. As part of its broad assessment role, the Helpline is required to assess whether a report may indicate that a class of children (in addition to, or rather than, the child to whom the report relates) is at ROSH and, if so, to create a separate 'contact' record for the class of children. However, class of children reports cannot be referred to the JRU as they do not meet the JIRT referral criteria, and it does not appear that there is any provision in the SDM (or associated guidance for Helpline staff) that requires ROSH to a class of children to also be taken into account when determining a response priority for reports that are referred to the JRU (that is, the report which also identifies a specific child/ren).[186]

There would appear to be benefit in amending the mandatory override discretion within the SDM in order to make clear that it should be applied if a report raises ROSH concerns about a class of children that may warrant a prompt response by police.

It is important to note that the JRU can amend the priority response time determined at the Helpline if, for example, the JRU obtains additional information indicating that the child or young person's level of immediate safety or risk is different from that known by the Helpline when the priority was first determined. Similarly, the JRU can change the JIRT response priority where crime scene considerations apply and/or where there are forensic/medical or other significant risks (such as where there is a stranger offender that police need to identify).

183 We only examined priority response data for the period since the JIRTS database commenced operating state-wide (1 July 2014 to 31 December 2016).
184 Advice provided by NSW Health, June 2017.
185 NSW Department of Family and Community Services, *Structured Decision Making Manual*, 2013, p.61.
186 NSW Department of Family and Community Services, *Structured Decision Making Manual*, 2013.

The JRU's discretion to amend the response priority assigned by the Helpline is important given that there will always be circumstances where the Helpline will not have access to all relevant information at the time of receiving and screening a report. Clearly, it is ideal that wherever possible, the Helpline assigns an appropriate timeframe, as the rating influences the front-end triage processes of the JRU.

In 2016, the JRU amended the priority response time allocated by the Helpline for about 9% of reports.[187] The proportion of reports assigned a different priority response by the JRU appears to have remained fairly consistent since at least July 2014. While information about the reason for the JRU changing a priority response time for an individual report is recorded in JIRTS, it is not possible to determine the reasons at a meta-data level. It would be useful for JIRTS to have the capacity to generate such a report so that the SMG can monitor it for trends and provide feedback to the Helpline where required.

8.3. Processes for responding to urgent matters during the Helpline/ JRU assessment phase

When serious child abuse is reported directly to local police, they must make a report to the Helpline. In addition, while a decision is being made about whether the referral will be sent back to the LAC to investigate, or referred on to the JRU to determine whether it will be accepted for a JIRT response, police are required to take a range of investigative actions. This is the case irrespective of whether a referral is ultimately accepted for a JIRT response, and is consistent with the role of police being 'first responders' to crime that may ultimately be taken over by a specialist unit (for example, homicide). Police therefore have a dual responsibility to discharge their mandatory reporting obligations and respond to a crime in accordance with their broader legislative responsibilities and community expectations. (Similarly, when ROSH reports are made to the Helpline by other mandatory reporters involving criminal allegations, they should also be reported to the Police.)

For certain matters, time will be of the essence and an urgent response may be required during the 'JIRT assessment' phase. As soon as they receive a report of serious child abuse that appears to meet the JIRT criteria, LACs are required to contact the CAS. This allows the CAS to assess the urgency of the matter and determine whether there is an immediate need for a CAS response, or to provide advice and assistance to the LAC until a decision about 'ownership' has been made. The process ensures that the management of the criminal investigation into a serious allegation of child abuse is continuous and appropriately resourced by both the LAC and the CAS.

During the assessment phase, the CAS should consult with FACS and Health personnel to facilitate a joined up response where required. In some matters, the urgent action required – such as securing and examining a crime scene, canvassing for witnesses, interviewing arrested persons in custody or urgently applying for and serving an AVO – may only need to involve police. However, other matters may also require the involvement of FACS and Health; for example, where an interview with the alleged child victim needs to be conducted[188] or a medical forensic examination needs to be arranged.

The CAS will generally respond immediately to matters brought to their attention by LACs where they determine an urgent CAS response is required, while FACS will prioritise, when necessary, matters requiring an urgent child protection response prior to the matter being accepted by the JRU.[189] The ability of JIRT health clinicians to respond to urgent matters prior to a JRU decision is influenced by their availability but also when and how they become aware of the specific details of a matter. For example, a response may have been initiated by another part of Health, such as a hospital or Sexual Assault Service. Without the name of the child or young person and case details, the JIRT health clinician is not in a position to respond.

187 Data sourced from JIRTS database.
188 An interview may need to be conducted urgently if, for example, a child has made a disclosure of abuse by a parent or carer at school and they are due to return home.
189 We discuss FACS and Health resourcing in Chapters 11 and 12.

While it is critical that the tri-agency assessment process is not undermined, it is equally critical that the system is geared towards responding effectively to urgent matters while a JRU assessment is still underway. Furthermore, when agencies appropriately respond jointly to very urgent matters during the JRU assessment phase, this reduces the burden on the JRU to make its decision within a very urgent timeframe.

In this regard, the CAS have noted that they make decisions to respond immediately to matters in the context of their Team Leaders (during business hours) and Zone Managers (after-hours through the on-call process) being well placed to know whether or not a matter meets the JIRT criteria; and in the context of there being a public expectation that once a crime has been reported, police will take swift action to respond. It is also worth noting that allowing frontline managers from the JIRT agencies to determine that certain matters warrant an urgent JIRT response, does not present the same risk as devolving assessment responsibility generally to the field (as occurred prior to the establishment of the JRU). The CAS also stressed that matters responded to after-hours are not those in danger of 'falling through the cracks' in the JIRT referral process.

As noted by Justice Wood in 2008:

> *There is … an imperative to avoid delay in these cases, given the relatively brief window available to obtain forensic evidence, and the possibility of witness collaboration or pressure on a complainant to retract an allegation of abuse. The adoption of a central gate keeping team* [the JRU] *should be contingent on it not being a cause for delay in the commencement of investigations.*[190]

While an immediate response by CAS will ideally involve engagement by FACS and Health JIRT, in circumstances where this is not possible, the CAS should engage the relevant CSC during business hours (or the FACS Crisis Response Team if the matter arises after-hours), and the relevant Local Health District (LHD) where required. (Ideally, enhanced resourcing would allow FACS JIRT to respond quickly to urgent matters during the JRU assessment phase, rather than relying on an already stretched CSC workforce.) Urgent police action – for example, to secure and examine a crime scene – should not in and of itself lead to a JRU decision to reject the matter for a JIRT response on the basis of 'prior LAC' involvement. As well, irrespective of whether local FACS and Health staff have been involved in a matter, once it has been accepted by the JRU (and FACS/Health JIRT allocate it for a response), any action that has occurred as part of an initial response should still feed into an LPR process – ensuring that the ongoing actions of each agency are appropriately coordinated.

The case study below is a good illustration of the JIRT agencies delivering a very effective joined up response to a matter received during business hours that had not yet been 'JIRT accepted', but was identified by police as urgent.

Case study 1 – Taking urgent action during the JIRT assessment phase

Around midday, a CAS Team Leader received a phone call from a police officer stationed at a nearby LAC. The police officer had just taken a statement from a woman who attended the station to report the suspected sexual abuse of a young girl. After obtaining a briefing from the officer, the Zone Manager accepted the job for a CAS response. In the ensuing five hours, the CAS, together with FACS and Health, completed the following tasks:

- attended the crime scene
- spoke to the alleged victim's mother
- took a statement of complaint from the alleged victim
- identified and spoke with the person of interest
- brought the mother to the police station to take her statement of first complaint

190 Hon James Wood AO QC, *Final report of the Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, Vol.1, p.306.

- Health provided support to the mother and assessed the need for any health referrals for the alleged victim and non-offending family members
- FACS immediately assumed all children into care (including an infant and the alleged victim), and
- Health liaised with the mother's mental health clinician and the mother was scheduled due to concern for her mental health and wellbeing.

All of the above actions were completed by 5pm the same day. According to the Zone Manager, the job was officially referred by the JRU to the JIRT agencies at 5.04pm that day. The Zone Manager noted that these actions could not have been completed that day if the job had been received after 5pm. In particular, he pointed to the deterioration in the mother's mental health over the course of the day, which would have made it very unlikely her statement could have been obtained later in the evening. In addition, although the FACS Critical Response Team and the CAS or relevant LAC could have responded after-hours, it may not have been appropriate to interview the child later in the evening, and child protection action would have also been delayed.

Currently, the process for responding urgently to matters during the JRU assessment phase is not clearly documented in the *JRU Process Guidelines* or any other JIRT procedure. Our consultations and survey feedback have revealed that the lack of clarity about when and how the JIRT (and non-JIRT arms) of the three agencies should respond during this phase creates confusion, and can also cause friction between the partner agencies.

For example, the LAC survey responses revealed that a number of commands were not aware that they are required to provide a 'first response' to child abuse reports while the Helpline/JRU assessment process is underway. As well, some CAS staff revealed during consultations that while they are sometimes able to secure responses from their FACS/Health JIRT counterparts prior to a matter being accepted for a response by the JIRT program, they often feel as though they are asking them to act 'outside of their agency's rules'. Survey feedback from FACS staff indicated they were concerned about their lack of capacity to respond to urgent matters, and that their unavailability at times can weaken their relationship with the CAS.

In seeking to ensure that there is clarity about the internal NSW Police Force processes for responding to reported abuse after-hours, the Acting CAS Commander issued a Directive in January this year to all LAC personnel.[191] The Directive notes that there have been instances where LACs have mistakenly believed that, once they report child abuse to the Helpline, their role is over because the CAS then 'owns the job'. It reminds LACs that making a mandatory report to the Helpline discharges their mandatory reporting obligations, but does not necessarily fulfil their policing obligations as first responders to reported crime.

The Directive advises LACs that they should make contact with the CAS when serious child abuse is reported, noting that the squad provides a 24 hour on-call response seven days a week for matters that meet the JIRT criteria. It makes clear that the CAS can provide advice and assistance to facilitate a coordinated NSW Police Force response.

The Directive is a positive step; however, internal Police guidance also needs to encompass matters requiring an urgent response during business hours. In this regard, we note that the NSW Police Force is in the process of developing a Mandatory Education Package, for delivery to all frontline police officers, aimed at reinforcing expectations in relation to what constitutes a 'best practice' response to criminal child abuse; in particular, the need to ensure these crimes are investigated in an appropriate and timely manner.

191 NSW Police Force, *Directive to all LAC personnel from the A/CAS Commander in relation to the After-hours On-Call Response by the CAS*, 17 January 2017.

In addition, guidance needs to be developed to ensure that there is tri-agency clarity about the process for delivering an urgent response both during and outside of business hours, and related agency obligations (including those of the non-JIRT workforce).

Currently, it is impossible to obtain a clear picture of these processes from a single policy. In gaining a practical understanding of urgent and after-hours responses, we had regard to the *JRU Process Guidelines,* relevant CAS directives, and the Helpline After Hours procedure (which covers FACS' role generally, not only for matters that meet the JIRT criteria). We also had to seek verbal advice from both FACS and the CAS. Even then, it was apparent that there is confusion about some practical responsibilities; for example, whether, when the CRT receives an urgent after-hours report from the Helpline and contacts the on-call CAS Investigator, the CRT or the CAS (or a hospital if the child the subject of the referral has already presented there) are responsible for initiating contact with Health's JIRT contact point.

In our view, the processes should be clearly articulated in both the *JRU Process Guidelines* and *Local Planning and Response Procedures*. In addition, they should be documented in the most relevant NSW Police Force operational policy. In this regard, we were pleased to receive advice during our inquiry that the CAS is in the process of updating the *NSW Police Force Operations Manual* to better reflect the role of LACs in responding to serious child abuse reports in the pre-Helpline/JRU assessment phase.

8.4. Re-branding the JIRT 'Rejected' category

It is critical to appreciate that the rejection of a report for a JIRT response does not mean the report is not serious, nor that it does not warrant a criminal and/or child protection and/or health response. LACs, CSCs and, where relevant, Health services, receive referrals of matters that are rejected for a JIRT response because they do not meet the criteria for acceptance into the JIRT program, but still require a local response.

An issue that arose during our inquiry was the use of the JRU decision category 'Rejected'. During our consultation with the JRU, senior JIRT agency representatives and the JRU management team agreed that the term 'rejected' is potentially misleading and may send a negative message to the field that is not conducive to encouraging quality local responses. In this regard, it was noted that while a report may not be accepted for a JIRT response, in many cases it will still require a tri-agency or bi-agency response and may in fact develop into more serious allegations after an initial response is provided.

For these reasons, it is our view that it would be appropriate to create a new decision category of 'Referred for local response' for reports 'rejected' by the JRU, but referred to an agency(s) for local response. This new category should be supported by documented guidance about the expectations on agencies to provide a collaborative or 'joined up' response to reports referred for local response – we discuss this issue further in Chapter 21.

8.5. Improving the recording and monitoring of JRU decisions

Reports that are referred to the JRU are almost as likely to be rejected as accepted for a JIRT response, with the current JIRT acceptance rate sitting at just over 50%.[192] As a result, we looked closely at the reasons for rejection recorded on the JIRTS database. Currently, the JRU records its decisions against the following ten categories (which are listed in the order in which they appear in the reject category document):[193]

192 Based on 2015-2016 JRU referral data.
193 Advice provided by FACS, November 2016.

Accepted categories	
1. Accepted category	Meet criteria and the child/young person resides in NSW.
Rejected categories	
2. JIRT Accept – Police Only	Requires a Child Abuse Squad response.[194]
3. Rejected	Does not meet criteria. With two exceptions,[195] all rejected reports are transferred to a Community Services Centre (CSC). Some may also be referred to a Local Area Command (LAC) and/or Health service.
4. JIRT reject – Police Response	Does not meet criteria but may require a LAC response.[196]
5. Previously considered and accepted	The information[197] has been previously considered and assessed as meeting criteria ***and*** does not require further assessment at the JRU ***and*** is a current case at a JIRT Unit.
6. Rejected – 16-18 Policy	Reports of sexual assault by a peer, stranger or acquaintance, where the alleged victim is between the ages of 16-18 years, are referred to the relevant LAC, and in some instances a Health service, when the person of interest is not in a position of authority ***and*** there is no evidence of ongoing risk of harm.
7. Rejected – Prior LAC Investigation	The LAC has started and/or will maintain carriage of the investigation.
8. Previously considered and rejected	The information[198] has been previously considered and assessed as not meeting criteria ***and*** does not require further assessment at the JRU ***and*** is an open case at a CSC.
9. Rejected – previously investigated	The allegations have been previously investigated.[199]
10. Cancelled	Recorded in error.

As is evident from the categories outlined above, apart from those matters where the JRU has decided that the referral does not meet the criteria (category 3), there are at least eight additional 'reject' categories. For example, a proportion of reject matters will involve referrals that have been previously responded to by the JIRT program (category 9) and/or previously assessed as not meeting the criteria (category 8) – in 2016, matters of this type accounted for 4% of rejected reports. Category 5 is reserved for referrals that have been 'previously considered and accepted' (that is, the referral is declined because the matter has already received a JIRT response) – these referrals account for 9% of all reject decisions.

194 Applies where 1) the report was previously investigated by JIRT but did not proceed criminally and the child/young person/family now wish to proceed or 2) child/young person resides interstate. An interstate report will be made or confirmation will be sought that an interstate jurisdiction is managing the matter before closure at the JRU by FACS.

195 With two exceptions, all rejected options are transferred by JRU FACS to a CSC. Exceptions:
- where the child/young person resides interstate, an interstate report will be made or confirmation will be sought that an interstate jurisdiction is managing the matter before closure at the JRU by FACS
- where the child/young person's identity and location cannot be determined following JRU checks.

196 Applies to reports of underage adolescent peer sex where there is no evidence of complaint (Source: footnote contained in explanation provided by FACS relating to JRU decision categories).

197 The JRU has previously assessed the same allegations involving the same parties.

198 The JRU has previously assessed the same allegations involving the same parties.

199 By JIRT, LAC or interstate authority.

All matters not accepted for a JIRT response are transferred to a CSC. In addition, matters are referred to LACs where they are assessed as:

- 'rejected referrals for a police response' – matters that involve adolescent peer sex and where there is no evidence of complaint or other risk factors evident at the time of referral (category 4) – 21%
- matters involving 16-18 year olds where the alleged perpetrator is a peer, stranger or an acquaintance, but not in a position of authority, and there is no ongoing evidence of ongoing risk of harm (category 6) – 9%
- matters where it is deemed that the nature of a LAC's prior involvement is such that it is considered preferable for them to maintain carriage of the matter (category 7) – 11%.[200]

Combined, the six categories noted above accounted for 54% of all rejected referrals in 2016. When contemplating the JIRT 'rejection rate', it is important to distinguish the rejected referrals against categories 4-10 from those referrals rejected on the basis of a 'judgement call' by the JRU (that is, those referrals captured in category 3), as this goes to how the criteria is being interpreted against the evidence and other supporting information at the time of the JRU's assessment.[201]

Equally, it is important to track changes over time in the number of matters that are being recorded against the various rejected categories, as significant variations will suggest either changes in practice at the JRU or in reporting patterns that should be further considered by the JIRT agencies. For example, the available data indicates that there was a notable increase between 2015 and 2016 in the number of adolescent peer sex matters referred to the JRU (discussed in the following chapter) and the number of 'Prior LAC' matters (discussed below).

As the JIRTS database only came into operation in July 2014, comparisons of reject trends over time are difficult to make. However, in light of the rejection decision data being captured, and the important story it can tell about the actual or likely response to certain categories of referral, it is critical that both the JRU and the JIRT SMG monitor reject patterns closely.

From an accountability perspective, an increasingly high rejection rate needs to be well understood and explained. Our own analysis of JIRTS data has shown that there are clear reasons for around 54% of the rejected referrals not being accepted into the JIRT program. It has also shown that a proportion of these matters are being referred for a local agency response for a specific reason. As we discuss further in Chapter 10, it is also important for rejection data against category 3 to be analysed in order to monitor how many of these matters are being referred to LACs for a response. Our analysis of 2016 LAC referral data across all 'reject' categories showed that LACs were receiving 47% of all rejected referrals. However, the nature of the response these matters ultimately receive is unable to be systematically retrieved (it is only available on a case-by-case basis).

The LAC referral data is also of interest because of what it can reveal about the Helpline's referral practices. Assuming that the assessment of criminality by the JRU is sound, the referral data suggests that the majority of referrals it rejects not only fail to meet the JIRT threshold but also do not require a criminal response by local police. This supports the possibility that the Helpline may be over-referring matters to the JRU. Having said this, it is important to bear in mind that the JRU undertakes a more detailed assessment of referrals. The data is nonetheless an indicator of potential over-referring and, as we have noted in Chapter 7, should be the subject of further examination.

200 Based on data from the JIRTS database for 2016 calendar year.
201 Based on data from the JIRTS database for 2016 calendar year.

8.5.1. Rationalising the JIRT decision categories

We believe there is scope to streamline the current JIRT decision categories to provide greater clarity about why certain referrals are rejected and reduce inconsistent data recording.

For example, as JIRT is a tri-agency response, the decision category 'JIRT Accept – Police Only' is contradictory and misleading. This category applies when:

1. the report was previously investigated by JIRT but did not proceed criminally and the child/young person/family now wish to proceed, or
2. where the child/young person resides interstate (in these cases, an interstate report will be made or confirmation will be sought that an interstate jurisdiction is managing the matter before closure at the JRU by FACS).

To reflect the two separate circumstances envisaged, it would be preferable to split the category into two new categories. Additionally, in circumstances where a matter is to be reinvestigated criminally, it would appear appropriate – particularly given the previous reluctance to proceed – for the child/young person and their family to receive a health response and for updated child protection checks to be conducted.

In our view, labelling referrals of this type 'Police only', and counting them as 'JIRT rejected' matters (when in fact the category is labelled 'JIRT accept' – Police only) does not make sense.[202] Further, there is no logical reason to group them with interstate referrals.

The JIRT decision categories will need to be reviewed in light of recommendations contained in this report about the JIRT referral criteria and the policies, guidelines and practices that currently inform its application. This would appear to be a good opportunity to consider more broadly whether the categories can be rationalised, better grouped, and/or labelled in a more intuitive way.

8.5.2. Reports that are rejected due to prior investigation by a Local Area Command

The *JRU Process Guidelines* state that matters which meet the JIRT referral criteria can be rejected for a JIRT response, and referred to the relevant LAC and CSC, in circumstances where 'a LAC has commenced and/or intends to maintain carriage of the criminal investigation'.

While the *JRU Process Guidelines* do not include any further information about the circumstances in which this category might apply, we expect that they would include:

- where a report is made directly to a LAC and, as part of providing the first response to that report, the LAC substantially progresses the criminal investigation in the time taken for the report to be referred to and assessed by the JRU, or
- where a LAC has commenced or substantially progressed a criminal investigation into a report that does not meet the JIRT criteria, and in doing so, has identified (and reported to the Helpline) additional concerns that meet the criteria.

In 2016, 452 matters were referred to LACs and CSCs in these circumstances – 5% of all reports assessed by the JRU in that year and, as noted above, 11% of all rejected reports. This was a significant increase from the year prior, where just 2% of all JRU referrals and 5% of all rejected reports (209 reports) were assessed as 'Prior LAC' matters.[203]

The reason for the increase is not clear. As we discuss in section 8.3, if a report that meets the JIRT criteria is made directly to a LAC (for example, if a victim presents at their local police station), the LAC is responsible for taking appropriate initial action in response until such time as the report has

202 According to FACS, the category was included at the request of the CAS to reflect their role in responding to consensual adolescent peer sex (Advice provided by FACS, May 2017).
203 Based on data from the JIRTS database for the 2015 and 2016 calendar years.

been accepted for a JIRT response.[204] It is possible that greater awareness by LACs of their roles and responsibilities has led to an increase in the number of matters for which they have completed substantial investigative work by the time of a JRU assessment.

As we discuss in section 10.10.4, while the NSW Police Force requires LACs to support the 'first response' to criminal child abuse allegations, this early involvement on its own, should not be used by the JRU as the basis for determining that a matters should be rejected for a JIRT response due to 'prior LAC involvement'. Given the lack of specific guidance for JRU staff about the use of this category, it is also possible that there has been a change in how the JRU is making decisions where a matter has had prior LAC involvement.

We support the efforts that have been made to raise awareness among LACs of their obligations as 'first responders', and note that there are potential benefits, including efficiency and continuity for a victim, to a LAC maintaining carriage of a matter where it has already taken substantial actions. However, it is important that the JRU makes appropriate, well-informed decisions about when it is appropriate for a LAC to retain carriage of a matter. In this regard, there should be substantive reasons, beyond simply the action that the LAC has taken by the time of the JRU's assessment, for rejecting a referral on the basis of prior investigation by a LAC.

In addition, as 'Prior LAC' matters have been assessed by the JRU as otherwise meeting the JIRT Referral Criteria – and therefore warranting a joint approach – it is important that a referral back to a LAC does not prevent an effective interagency response from occurring. In Chapter 21, we discuss the importance of Police, FACS, and Health working together effectively to respond to all reports of child abuse – irrespective of whether or not they are accepted for a JIRT response.

The JIRT agencies should consider the potential causes of the significant increase in 'Prior LAC' matters. As part of documenting the processes for responding to urgent referrals prior to the JRU assessment, the agencies should also develop a set of factors for the JRU to consider when 'rejecting' matters due to prior LAC involvement.

Recommendation

5. The JIRT partner agencies should replace the 'Rejected' decision category with a new decision category of 'Referred for local response' for reports 'rejected' by the JRU, but referred to an agency/s for a local response.

PRACTICE SUGGESTIONS

- The JIRT partner agencies should explore, having regard to the observations in section 8.1, the most effective ways to communicate Helpline and JRU decisions to the relevant frontline 'responders' within each agency.
- The NSW Police Force and NSW Health should consider working with FACS to provide additional guidance to Helpline staff about factors to consider when determining the urgency of a report from a policing or health perspective, and whether to utilise the 'mandatory over-ride discretion' within the Structured Decision Making – Screening and Response Priority Tool.
- FACS should amend the 'mandatory over-ride discretion' within the Structured Decision Making – Screening and Response Priority Tool to clarify that it should be applied if a report raises ROSH concerns about a class of children that may warrant a prompt response by police.

204 For example, this may include taking action to ensure victim welfare, secure a crime scene, or interview adult witnesses. Generally speaking, it will not include conducting the forensic interview with the alleged child victim, as this should be undertaken by CAS officers who have specific training in interviewing children. Depending on the circumstances of the matter, these responsibilities may be executed independently or in collaboration with the CAS.

- The JIRT partner agencies should ensure the *JRU Process Guidelines* and *Local Planning and Response Procedures* clearly define each agency's (JIRT and non-JIRT) roles and related processes for activating a response to urgent matters during business hours when the Helpline/JRU assessment process is still underway, and urgent matters that require an 'after hours' response.
- The JIRT partner agencies should provide adequate guidance to their non-JIRT workforce, in the most appropriate policy document for each agency, about responding to urgent child abuse matters that meet the JIRT criteria while the Helpline/JRU assessment process is still underway.
- The JIRT partner agencies should regularly monitor the rejection rates against each 'JIRT reject' JRU decision category to enable trends to be detected and action to be taken where necessary.
- The JIRT partner agencies should streamline the current JRU decision categories, having regard to the observations in section 8.5 of this report, to better reflect the basis for certain referrals being rejected and to reduce inconsistent data recording.
- The JIRT partner agencies should review the reasons for the increase in the number of matters rejected for a JIRT response between 2015 and 2016 due to 'Prior LAC' investigation'. Depending on the outcome of the review, the JIRT partner agencies should consider whether further guidance should be provided in the *JRU Process Guidelines* about determining the appropriate use of this category.

Chapter 9. The JIRT referral criteria

A significant component of our inquiry has involved examining whether the JIRT referral criteria continue to be appropriate. This has been particularly critical in light of the consistently increasing number of child abuse reports referred to the JRU, and the importance of focusing the JIRT program's resources on the most vulnerable cohorts of children and young people.

9.1. Rationalising the current referral criteria and supporting policies

With the exception of the physical abuse criteria, which has been amended on a trial basis (most recently in July 2016), the core criteria have remained unchanged for many years.

The current JIRT referral criteria are as follows:

Sexual abuse reports:

- Disclosure and/or evidence of sexual assault.
- Any reports of sexual abuse of a child under the age of 18 years where the alleged offender is over the age of criminal responsibility i.e. 10 years.
- Presentation of physical indicators consistent with sexual abuse, for example, venereal diseases, pregnancy, unexplained bruising on or bleeding from genitals, presence of semen on child, unexplained bruises to breast, and
- The CSC will assess reports of sexualised behaviour and allegations where offenders are 10 years and under.

Neglect reports:

- Extreme neglect resulting in physical harm, for example, burns from nappy rash, and
- Malnutrition and/or dehydration from withholding of food and fluids.

Physical abuse reports:

Severe or serious physical injury (see JIRT Injury Guide Table) to a child or young person under the age of 16 years which is:

- Unexplained or inconsistent with the explanations provided, and/or
- Inflicted (non-accidental) or suspicious, and
- Caused by another person aged 10 years or over

Consideration should also be given to a history of recurrent bruising or injury. The presence of one or more injuries does not automatically denote a referral to the JRU. You must consider the above criteria and the level of severity of the injuries/indicators listed below.

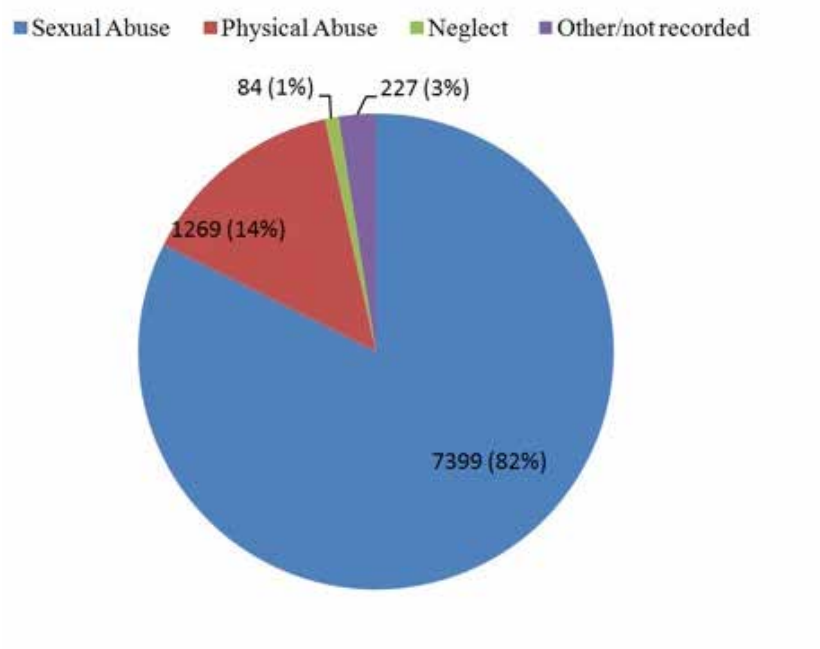
NB: The JRU retains discretion to accept cases raising child protection concerns for young persons 16-17 years of age.

JIRT Injury Guide table

Category of injury	Indicators or markers of severe and serious injury
SOFT TISSUE INJURY	• Serious bruising/Severe soft tissue injury in a child who is not independently mobile • Serious multiple bruises on any child (may appear with different colourings, from red to green) • Bruising or tiny multiple haemorrhages (petechiae) abrasions/lacerations/ incisions, particularly to a child's face, neck, ears or scalp, or any other body part, in a child not able to walk or pull themselves to standing position • Pattern bruising such as slap marks, belt marks, bite marks, marks made with a looped cord or other object marks on any child • Bruising in unusual locations, for example, the back, buttocks or genitals and the abdomen
HEAD INJURY	• Skull fracture • Intracranial injury: – Subdural haemorrhage – Subarachnoid haemorrhage – Brain injury including swelling or bleeding into the brain – Retinal haemorrhages (bleeding into the back of the eye)
FRACTURES	• Any fracture in a child who is not mobile • Any unexplained fracture • Multiple fractures of varying ages • Fractures accompanied by other injuries (brain, abdomen, lungs, heart)
BURNS	• Contact burns • Scalds, including immersion in hot liquid
INTERNAL ORGAN INJURY	• Any injury to the following organs: Liver, Pancreas, Spleen, Kidneys/ bladder, Adrenals, Bowel, Heart, Lungs
OTHER	• Immersion injuries, for example, near drowning in bath • Suffocation • Strangulation • Injury as a result of the fabricated illness • Ingestion of poisons/substances/medications • Female genital mutilation

Figure 2 shows the percentage of referrals to the JRU by primary abuse category for the 2015-2016 year. The distribution of referrals among these primary abuse types did not change significantly compared to the previous year. Referrals of sexual abuse allegations make up the bulk of referrals received by the JRU. A much higher proportion of sexual abuse matters are also accepted by the JRU compared with the other two primary abuse types. In 2015-2016, around 56% of sexual abuse referrals to the JRU were accepted compared with 22% of physical abuse and neglect referrals. Consequently, the primary abuse type of sexual abuse accounted for 92% (4,135) of all accepted JRU referrals in that year.

Figure 2: Referrals to the JRU by primary abuse type – 2015-16



Source: Derived by NSW Health from JIRTS data[205]

The JIRT Injury Guide Table was originally added to the physical abuse criteria in response to the 2006 JIRT review's recommendation about the need to provide guidance about the types of physical abuse injuries considered 'severe or serious'. We discuss the Injury Guide Table in further detail in section 9.6.

It is important to appreciate that a report will not be automatically accepted by the JIRT program simply because it meets one or more of the referral criteria. Although the core criteria have not changed significantly (with the exception of the amended physical abuse criteria), several policies, practices and guidelines governing its application have been developed over a number of years:

- NSW Police Force *Policy for the investigation and management of sexual assault victims aged 16-18 years* (August 2003)
- JRU *Adolescent Peer Sex Guidelines* (2008, amended August 2011)
- NSW Police Force *Adolescent Peer Sex Guidelines* (updated August 2014), and
- JIRT *Enhanced Aboriginal Services Protocol* (May 2010, updated January 2012).

We discuss the way these policies intersect with the JIRT referral criteria in the next section.

In practical terms, there is no one document which clearly outlines the factors that are taken into account as part of determining whether a report will be referred to the JRU or accepted for a JIRT response. Nor is there a single 'portal' where frontline staff can access the JIRT referral criteria and all of the related documents listed above. To make the JIRT referral criteria and assessment process more transparent and readily accessible for frontline staff, the partner agencies need to develop a single user-friendly resource. In this regard, we recommend that consideration be given to replacing the current JIRT referral criteria with a document which includes the criteria (taking into account our recommended amendments), together with sufficient detail about factors that can be considered by the JRU when applying the criteria to the individual circumstances of the children and young people the subject of referrals, and hyperlinks to other relevant documents that can be consulted for more detail.

205 We have used Health's aggregation of abuse types into the three core primary abuse type categories. Available JIRTS data is presented as multiple smaller abuse type categories.

Additionally, we suggest that the JIRT referral criteria be amended to include explicit advice about age thresholds as they apply to each of the three main types of abuse – the criteria are currently unclear on this issue. For example, although the criteria refer to the JIRT program accepting reports of sexual abuse for children and young people under 18 years, in practice, the JIRT program adheres to NSW Police Force policy that, except in limited circumstances, the investigation of sexual assault reports involving victims 16-18 years is the responsibility of LACs rather than the CAS. As well, there is no reference in the physical abuse criteria to the usual practice of the JIRT program only accepting reports of physical abuse that involve children under the age of 16, subject to the discretion of the JRU.

9.2. Guidance in relation to exercising 'professional judgement'

The JIRT referral criteria currently allow the Helpline and JRU limited discretion in relation to how certain elements of the criteria are interpreted, and whether individual referrals meet the criteria. For example, it is open to the Helpline (and the JRU) to decide in any given matter what may constitute 'evidence of sexual assault', 'sexual abuse of a child', or, to a lesser extent, 'severe or serious' injury. An example of where this discretion appears to be causing ongoing confusion is in relation to so called 'non-contact' or 'non-touching' sexual abuse referrals. At present, there is no clarity about whether such referrals meet the sexual abuse referral criteria, and both the Helpline and JRU have indicated that additional guidance in this area is required.[206]

While we support the need for the Helpline and JRU to exercise professional judgement in their application of the JIRT referral criteria, we believe they would benefit from having access to a clearer set of factors, documented in one location, to inform assessment decisions. For example, while guidance is dispersed across several separate documents,[207] and it is likely to be a consideration in practice, there is no specific reference in the JIRT referral criteria itself to the Helpline or JRU having regard to factors, in addition to criminality, such as:

- a child or young person's child protection and/or criminal history
- emerging patterns relating to disclosures or evidence of abuse (including 'non-contact' sexual abuse and behaviours indicative of grooming offences)
- victims who have been re-reported (involving the same or different persons of interest)
- reports involving concerning behaviour displayed, or comments made, by children and young people who are very young and/or 'pre-verbal'; or who for some other reason would be considered unable to make, or would face much greater difficulty in making, a disclosure of abuse
- reports about young people aged 16-18 years where the young person's particular circumstances (for example, a disability, including a cognitive and/or communication impairment,[208] their care situation or Aboriginality) make them particularly vulnerable,[209] or
- reports involving young people the subject of adolescent peer sex reports where it is known or reasonably believed that they have a cognitive and/or communication impairment making them particularly vulnerable.[210]

206 Advice provided by FACS, March 2017.
207 For example, in relation to the final dot point listed below, we note that the JRU *Adolescent Peer Sex Guidelines* require the JRU to accept referrals involving adolescent peer sex where a party has 'impaired intellectual functioning'.
208 We note that under Part 6 of the *Criminal Procedure Act 1986* a person who has a cognitive impairment is considered to be a 'vulnerable person' who is entitled to special provisions for the giving of evidence.
209 As discussed below in section 9.4.3, our view is that the JIRT criteria should be amended so that the Helpline will only refer sexual assault reports involving alleged victims 16-18 years to the JRU if they appear to be at further risk of ongoing harm and the alleged offender is a family member, close adult friend, neighbour or person in authority; or if available information indicates that the young person should receive a JIRT response, having regard to the 'factors to consider' that we have recommended should be developed.
210 See footnote 207.

The absence of a transparent (and documented) mandate for the Helpline and JRU to exercise professional judgement in applying the JIRT criteria, and the absence of associated guidance, is problematic for a range of reasons, including that it:

- creates a 'grey area' in relation to transparent decision-making
- increases potential for inefficiency (particularly once a report reaches the JRU, as there is likely to be more back and forth between the agencies in the absence of clear guidance)
- increases the risk that inconsistent decisions will be made (particularly if our recommendation to create a second JRU 'decision table' is accepted), and
- potentially leaves the Helpline and JRU open to criticism from frontline staff, other agencies and the public, who are more likely to be unaware of the factors the Helpline and JRU are able to take into account prior to making a decision.

The case study below is a good illustration of a decision to reject a matter for a JIRT response in the absence of a disclosure from the child, but where other risk factors were present (as well as evidence suggestive of sexual abuse).

Case study 2 – The need for clearer guidance when exercising professional judgement

We received a complaint from the father of a young girl who was concerned that there had not been a comprehensive response to reports he had made to the Helpline alleging that his daughter was being prostituted by her mother.

After reviewing the relevant FACS records, we identified that the most recent report by the girl's father had been assessed as risk of significant harm (ROSH) by the Helpline, with a recommended response timeframe of less than 24 hours. The report was referred by the Helpline to the JRU, where it was rejected for a JIRT response due to the absence of a disclosure of sexual abuse by the girl. It was then transferred to the relevant community service centre (CSC) for further assessment, but was closed due to competing priorities.

Our review of KiDS (the FACS database) identified that over the past eight years, there had been 16 previous reports about the young girl alleging risk of sexual harm, exposure to domestic violence and neglect. Eleven of these reports were classified as ROSH, and while the majority were made by the young girl's father, a number were also made by other government agencies. None of these reports led to a secondary assessment being undertaken at the CSC level.

Our check of Police information holdings also revealed that the mother had an extensive, 20 year history of prostitution, including a recent allegation that she was running an escort agency.

Against this background, we re-referred the matter to the relevant CSC and suggested they seek information from Police to inform their assessment of risk. We also sought advice from the FACS JIRT Director about the JRU's assessment decision. She agreed that, based on the available information – including the history of similar reports (particularly alleging sexual penetration); lack of evidence of prior investigation by JIRT or any other body; multiple reporters with presumably similar concerns; and relevant Police intelligence allegations – the JRU should have accepted the referral from the Helpline.

Both our office and the FACS JIRT Director share the view that, in the case outlined above, the referral should have been accepted based on the current referral criteria. However, in our view, if the JRU had access to a set of formalised factors to consider, it is much more likely that it would have had greater regard to the alleged victim's child protection history and other risk factors, and proceeded to accept the referral for a JIRT response. We recommend the development of a formal set of 'factors to consider' (ideally located in a revised JIRT referral criteria document) to inform professional judgement by the Helpline and JRU when applying particular elements of the JIRT referral criteria.

9.3. Grooming and the JIRT referral criteria

During Case Studies 37 and 57, the Royal Commission heard evidence from a number of witnesses about grooming in institutional settings.[211] The Commission has also examined the conceptual issues that arise in relation to defining and understanding grooming in its research paper, *Grooming and child sexual abuse in institutional contexts*.[212] In light of the attention given to this issue by the Royal Commission, we considered it important to examine whether there was scope to amend the JIRT referral criteria to better capture behaviour indicative of 'grooming offences'.[213]

The Commission's research paper identifies the difficulty in defining 'grooming', a term which encompasses a wide range of 'manipulative and controlling techniques' and behaviours that may not be 'explicitly sexual or directly abusive' in and of itself.[214] Many grooming techniques are difficult to distinguish from what could be considered regular behaviour in an otherwise normal relationship with a child.[215] The authors observe that these techniques often consist of multiple discrete acts, which may not appear unusual when considered in isolation. As a result, many perpetrators are only identified after subsequent abuse has been disclosed.[216]

This point was illustrated during Case Study 37, in which the Royal Commission considered how Grant Davies of RG Dance used social media to interact with his students and maintain 'almost constant contact with them at all hours of the day'.[217] It heard evidence from Mr Marcus Erooga, a United Kingdom expert in creating child-safe organisations and child grooming, who described Davies' behaviour as 'being on a spectrum from overt child abuse (physical, or emotional abuse and neglect) through to breaching appropriate boundaries and inappropriate use of power or authority'.[218] This 'spectrum', whereby the manipulative behaviour and abusive intent may materialise in a multitude of nuanced and overt forms, makes it difficult to establish criteria for definitively identifying grooming.

The Royal Commission found that Grant Davies was able to exploit his position within RG Dance to groom his students and their mother to enable him to commit child sexual abuse offences.[219] Detective Sergeant Kirsty Hales gave evidence that when the initial report was referred to the JRU, it did not meet the JIRT criteria because there was no allegation of a 'contact sexual offence or a serious physical or serious neglect element' at the time; as a result, the matter was referred to a Burwood LAC for investigation.[220]

The difficulty in conclusively defining grooming is compounded by the complexity that arises when attempting to categorise grooming techniques or the behaviours that typify a certain 'type' of perpetrator. The Royal Commission's research paper sets out the various typologies that researchers use to identify different types of perpetrators, for example, as predatory, opportunistic

211 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017.
212 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.
213 'Grooming offences' under the *Crimes Act 1900* (NSW) s.66EB 'Procuring or grooming child under 16 for unlawful sexual activity' include: s.66EB(2) Procuring children – an adult person who intentionally procures a child for unlawful sexual activity with that or any other person is guilty of an offence; s.66EB(2A) Meeting child following grooming – an adult person who intentionally meets a child, or travels with the intention of meeting a child, whom the adult person has groomed for sexual purposes, and who does so with the intention of procuring the child for unlawful sexual activity with that adult person or any other person, is guilty of an offence; s.66EB(2B) A child has been groomed for sexual purposes if – on one or more previous occasions, the adult person has exposed the child to indecent material; s.66EB(3) Grooming children – an adult person who engages in conduct that exposes a child to indecent material or provides a child with an intoxicating substance, and who does so with the intention of making it easier to procure the child for unlawful sexual activity with that or any other person is guilty of an offence.
214 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p.4.
215 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p.1.
216 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p.8.
217 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017, pp.17, 93.
218 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017, p.49.
219 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017, pp.24, 93.
220 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017, p.71.

or situational.[221] As evidenced in Case Study 37, different 'types' of perpetrator will use different grooming techniques on a child or on others (such as a parent) to gain access to a child.[222] However, as the authors of the paper point out, these typologies have significant limitations, including that perpetrators do not necessarily align with one 'type' and that typologies may overlap or change over time. In addition, the typologies cannot 'fully assess to what extent individuals who have perpetrated child sexual abuse sought out child-related employment and/or voluntary work with the specific intent of sexually abusing children'.[223]

Our office has provided the following guidance to agencies within our reportable conduct jurisdiction in relation to identifying and making a finding of sexual misconduct, including 'grooming behaviour':[224]

> *Grooming or procuring a child under the age of 16 years for unlawful sexual activity is a sexual offence. However, Schedule 1(2) of the Child Protection (Working With Children) Act also recognises grooming as a form of sexual misconduct. As grooming is a sexual offence if the alleged victim is under 16 years old, caution should be exercised before reaching a grooming finding (particularly in cases where the behaviour is directed towards a child under 16 years). As an alternative to grooming, in many cases it will be more appropriate to consider whether there has been a 'crossing of professional boundaries' and/or other more overt sexual behaviour.*
>
> *Furthermore, behaviour should only be seen as 'grooming' where there is evidence of a pattern of conduct that is consistent with grooming the alleged victim for sexual activity, and that there is no other reasonable explanation for it. The types of behaviours that may lead to such a conclusion include (but are not limited to) the following:*
>
> - *Persuading a child or group of children that they have a 'special' relationship, for example by:*
>   - *spending inappropriate special time with a child*
>   - *inappropriately giving gifts*
>   - *inappropriately showing special favours to them but not other children*
>   - *inappropriately allowing the child to overstep rules*
>   - *asking the child to keep this relationship to themselves.*
> - *Testing boundaries, for example by undressing in front of a child*
>   - *encouraging inappropriate physical contact (even where it is not overtly sexual)*
>   - *talking about sex*
>   - *'accidental' intimate touching.*
> - *Inappropriately extending a relationship outside of work (except where it may be appropriate – for example where there was a pre-existing friendship with the child's family or as part of normal social interactions in the community).*
> - *Inappropriate personal communication (including emails, telephone calls, text messaging, social media and web forums) that explores sexual feelings or intimate personal feelings with a child.*
>
> *An adult requesting that a child keep any aspect of their relationship secret or using tactics to keep any aspect of the relationship secret, would generally increase the likelihood that grooming is occurring.*

221 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, pp.14-16.
222 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse,* January 2017, p.93.
223 Patrick O'Leary, Emma Koh and Andrew Dare, 2017, *Grooming and child sexual abuse in institutional contexts*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p.14.
224 NSW Ombudsman Child Protection Fact Sheet – *Child Protection: Notifying and identifying reportable conduct,* updated 2017.

We developed this guidance to assist agencies to determine when to make a sexual misconduct finding in circumstances where there is insufficient evidence of a sexual offence, but where an employee has engaged in a pattern of conduct that could be regarded as sexual misconduct. A sustained sexual misconduct finding, if supported by evidence, can justify an employee's dismissal and/or other disciplinary action and, as such findings must be reported to the Office of the Children's Guardian, be taken into account in relation to the individual's ongoing suitability to hold a Working with Children Check.

While we believe that it is critical for reports involving an individual's behaviour to be closely scrutinised as part of assessing an overall pattern of behaviour, in our view, it is unrealistic to propose that the JIRT criteria be expanded to specifically incorporate behaviours indicative of grooming offences. The lack of clear categorisation of grooming techniques would make it nearly impossible for the JRU to assess whether certain behaviours, that in isolation may not appear unusual, convey intent to commit harmful sexual behaviour. In addition, if allegations relating to behaviours indicative of grooming offences were referred to the JRU, it would lead to an influx of referrals and create new capacity challenges.

However, our recommendation that the JIRT agencies should develop a set of 'factors to consider' for the JRU to utilise in applying the referral criteria, should, if implemented, go some way towards enabling the JRU to exercise its discretion to accept a report where there is evidence of a pattern of behaviour indicative of grooming offences.

9.4. Sexual abuse reports involving young people over 16, Aboriginal young people and adolescent peer sex

As noted in Chapter 7, our inquiry has identified that, to address the capacity issues currently facing the JRU and JIRT program more broadly, and to ensure that the JIRT is able to respond to the most vulnerable children and young people, aspects of existing policies, guidelines and practices governing the application of the JIRT referral criteria should be reviewed and amended. In particular, we are of the view that the JIRT agencies should reconsider how the JIRT program currently handles sexual abuse reports involving:

- young people over 16
- adolescent peer sex
- Aboriginal children and young people,[225] and
- 'prior LAC' involvement.

9.4.1. The NSW Police Force 16-18 years policy and its application to Aboriginal young people

Although the JIRT referral criteria includes sexual abuse reports about children and young people under 18 years, it is NSW Police Force policy that LACs have primary responsibility for the investigation and management of sexual assault reports involving victims over 16 years of age.

However, consistent with the JIRT criteria, the Helpline refers all reports of sexual assault involving victims aged 16-18 years to the JRU, which conducts a further assessment. Under the '16-18 policy' (as it is commonly referred to) the JRU refers all reports involving young people over 16 years to the relevant LAC for a local response unless:

- the young person is at further risk of ongoing harm and/or the alleged offender is a family member, close adult friend, neighbour or person in authority; and/or
- the young person is Aboriginal (consistent with the *Enhanced Aboriginal Services Protocol*).

225 We discuss the JIRT response to Aboriginal children in detail in Chapter 13.

9.4.2. Allowing greater flexibility in assessing sexual abuse reports involving Aboriginal young people

In May 2010, the *Enhanced Aboriginal Services Protocol* (EASP) was introduced to provide a more flexible assessment processes for sexual abuse reports involving Aboriginal children. It is intended to address the fact that, while Aboriginal children are significantly over-represented as victims of sexual abuse, a range of barriers to disclosure in Aboriginal communities may make it difficult for reports involving Aboriginal children and young people to meet the JIRT referral criteria.[226]

The EASP requires that when the JRU receives a sexual abuse report about an Aboriginal child or young person that does not meet current criteria for JIRT acceptance, it will undertake its standard information gathering processes but will also source (from the relevant JIRT agency staff) local knowledge about the child/young person's community to assist in determining whether the report can be accepted for a JIRT response. In addition, for reports involving Aboriginal children and young people from 20 specific communities (referred to in the document as 'Aboriginal engagement communities'), the JRU is required to source information from the local CSC and/or LAC and/or LHD.[227]

The JRU management team is required to review all available information and 'weight the allegation(s) and known vulnerabilities for the alleged victim within his/her family and community context about the source or chain of complaint'. The EASP also required that the 16-18 policy be suspended for Aboriginal young people.

In our 2012 report about responding to child sexual abuse in Aboriginal communities,[228] we recommended that, as part of a comprehensive review of the JIRT program, the partner agencies should focus on ensuring that there were adequate systems in place for assessing the ongoing impact of the EASP. The JIRT SMG subsequently commissioned an independent audit from the Internal Audit Bureau (IAB) in 2015 which found that, based on a sample of Aboriginal reports accepted/rejected by JIRT in 2013, compliance with the EASP was 'highly variable', but that the overall aims of the protocol were being achieved.

One of the IAB's recommendations was that the SMG consider amending the requirement to suspend the 16-18 policy for Aboriginal sexual assault reports, in favour of allowing the JRU to suspend the policy in relation to any sexual abuse report involving a young person over 16 (rather than on the automatic basis of Aboriginality) if the facts of the case indicate that acceptance by JIRT is warranted. In this regard, the audit noted that, while the suspension is intended to operate as a 'service enhancement' for Aboriginal young people, in practice, its blanket application may be discriminatory. This is because the 16-18 policy recognises that, in circumstances where there is no ongoing risk of harm or child protection concerns, young people aged 16-18 years should be allowed to participate fully in decisions affecting them and to have access to adult courses of action.

We support the IAB's recommendation. In our view, the JRU should retain discretion to accept a referral involving an Aboriginal young person over 16 years if there is available information to suggest that they would benefit from a JIRT response (see section 9.2 for our discussion about the need to develop a set of 'factors to consider' to guide the Helpline and JRU in exercising their professional judgement). In 2016, only 102 (36%) of JIRT accepted referrals for young people aged 16 years or older involved Aboriginal young people. Therefore, our suggested approach would not involve removing a large number of referrals involving Aboriginal young people from the JIRT program, but would provide greater flexibility to the JRU in determining whether a referral should be accepted and deliver a small reduction to the workload of local JIRT agencies.

226 The EASP was slightly modified in January 2012 by an SMG memo, *Maintaining enhanced access to the JIRT program for Aboriginal children and young people*.
227 Twelve of the 20 'Aboriginal engagement communities' fall within the Bourke JIRT's catchment area.
228 NSW Ombudsman, *Responding to Child Sexual Abuse in Aboriginal Communities*, December 2012.

9.4.3. Changing the JRU's assessment role for matters involving 16-18 year olds (including Aboriginal young people)

In 2016, the JRU assessed 1,120 reports involving an alleged victim 16 years or older (12% of all reports). Of these reports, only 25% (285) were accepted by the JIRT program. Of the reports that were not accepted for a JIRT response, just over half (53% or 446 reports) were referred to a LAC. Given that only one in four reports involving young people over 16 are accepted by the JIRT program, our view is that the JIRT criteria should be amended so that the Helpline will only refer sexual assault reports involving alleged victims 16-18 years to the JRU if:

- the young person appears to be at further risk of ongoing harm and the alleged offender is a family member, close adult friend, neighbour or person in authority, or
- available information indicates that the young person would benefit from receiving a JIRT response, having regard to the 'factors to consider' that we have recommended should be developed.

Currently, reports involving victims of sexual abuse aged between 16-18 years 'with impaired intellectual functioning'[229] are treated no differently to sexual abuse reports involving other young people in this age group.[230] With respect to the 'factors to consider', we recommend that reports involving young people known or reasonably believed to have a cognitive and/or communication impairment should be referred to the JRU for assessment, as the JRU is better placed than the Helpline to gather additional information to inform an assessment as to whether the young person would benefit from a JIRT response.

The Helpline must have regard to the young person's history as part of its own assessment and allocation of response priority, and while not as detailed (as it relies only on information known to FACS, not that held by Police or Health) as the assessment undertaken by the JRU, it should be able to identify whether the relevant factors apply.

The JRU would continue to assess any reports referred by the Helpline to determine if they should be accepted for a JIRT response. Otherwise, the Helpline would directly refer reports not falling into one of the two categories listed above to the relevant CSC or LAC for a local 'joined up' response. Local agencies would have the option to re-refer any matter to the JRU if evidence emerges that relevant risk factors are in play and that it would therefore benefit from a JIRT response.

Based on 2016 data, the approach we have outlined above could, if implemented, reduce the number of JRU assessments by around 600-700 hundred reports per year.[231]

If our recommendations are accepted, the NSW Police Force *Policy for Investigation and Management of sexual assault victims 16-18 years* will need to be amended accordingly.

9.4.4. Suspension of the 'Prior LAC' practice for reports involving Aboriginal children

The EASP also requires suspension of the 'Prior LAC' practice for reports involving Aboriginal children and young people.

When a LAC receives a report of sexual abuse, physical abuse or neglect of a child or young person, they remain responsible for its investigation unless and until it is accepted by the JIRT program. In practical terms, this involves attending to victim welfare, crime scene management and canvassing and interviewing adult witnesses. Where a LAC has commenced investigating a report that has been referred to the JRU and they consider that it is appropriate for the LAC to retain carriage of the investigation, the JRU may reject a report that meets the JIRT criteria. This determination is referred to as the 'Prior LAC' practice.

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229 NSW Police Force Policy and *Standard Operating Procedures for the Investigation and Management of Sexual Assault Victims* aged 16-18 years, August 2003, p.6.

230 By contrast, as we discuss in section 9.4.4, the *JRU Adolescent Peer Sex Guidelines* require reports involving adolescent peer sex (that is, 'consensual' sex where at least one party is under the age of consent) to be accepted if a party has 'impaired intellectual functioning'.

231 This estimate is based on 1,120 referrals involving a victim 16 years or older to the JRU, minus the number of those referrals that were JIRT accepted (285) – allowing for a certain number of additional referrals that would meet the two criteria for inclusion around additional risk.

Only a small proportion of reports – around 6% (516) in 2016 – are rejected by the JRU according to 'Prior LAC' practice. The independent IAB audit of the EASP found that suspension of the 'Prior LAC' practice for reports involving Aboriginal children and young people is an important provision because it ensures that as many of these children and young people as possible receive a jointly-planned response. While we agree that jointly planned responses are important, we do not accept that only JIRT agency staff can (or should) implement this principle, or that it should only apply to Aboriginal children.

As we discuss in Chapter 13 – and as the independent audit of the EASP acknowledges – in many cases, particularly in small remote communities, local police, health and community services staff may, as a result of their existing knowledge of the child/young person, their family and community and established rapport, be better placed than JIRT staff to respond to reports involving Aboriginal children and young people. Because JIRT staff are often removed from frontline service provision to communities (and the JIRT program is essentially a reactive entity and usually based in a metropolitan or regional centre), it is considerably more difficult for them to achieve this.

From our extensive auditing of police relationships with Aboriginal communities, we know that LACs in particular often have a strong and productive relationship with communities, including through programs they deliver for at-risk young people but also their broader community engagement via Police Aboriginal Consultative Committees and other local initiatives. Unless there is a compelling reason for the CAS to investigate a matter, it therefore makes good sense for LACs to maintain carriage of investigations where they have had prior involvement. However, it is important to reiterate that matters handled by a LAC should still be responded to in partnership with local CSCs and health services where necessary.

We recommend that the EASP be amended to remove the requirement for automatic suspension of the 'Prior LAC' practice for reports involving Aboriginal children and young people. As noted by the IAB audit, the JRU is already exercising professional judgement when determining whether to apply the suspension to these reports – JIRTS data indicates that in 2016, 3% of Aboriginal referrals were rejected citing 'Prior LAC investigation'.

9.4.5. 'Adolescent peer sex' reports

'Adolescent peer sex' (APS) is the term used to refer to 'consensual' sexual activity where at least one party is under the age of consent.

In our 2012 report about responding to sexual abuse in Aboriginal communities, we noted that legislation in some Australian jurisdictions allows, as a defence for engaging in consensual sexual activity with a person under the age of consent, that the two participants were of a similar age. The Victorian Director of Public Prosecutions has a guideline which specifically provides direction on decisions as to whether to prosecute sexual offences in 'boyfriend/girlfriend' cases.[232]

No such legal defence or guideline is available in NSW, with 'adolescent peer sex' involving young people over the age of 13 years and under 16 years being managed at the discretion of both police and prosecutors. According to the CAS, prosecutions are rare.[233] We discuss the need for law reform in this area in Chapter 19.

When the JRU receives an APS report from the Helpline, it conducts a further assessment (including consideration of relevant factors such as child protection history, criminal history, impaired cognitive functioning and power imbalances) to determine if the matter should be accepted or rejected for a JIRT response. The *JRU Adolescent Peer Sex Guidelines* require a report to be accepted 'where both parties have impaired intellectual functioning'; however, we understand that, in practice, a report is accepted if only one party falls within this category.

232 Director of Public Prosecutions Victoria, *Director's Policy: Prosecutorial Discretion*, updated 24 November 2014, p.4.
233 A CAS review over a six month period in 2011, for example, showed that of 141 APS reports, none were prosecuted.

Prior to the establishment of the JRU in 2008, local JIRT units decided how APS reports would be handled. Between December 2008 and December 2010, the JRU *Adolescent Peer Sex Guidelines* stipulated that, where there was no evidence of complaint, no relevant child protection history, and no relevant criminal history, an APS report would be rejected for a JIRT response and referred to the relevant CSC. Use of the guidelines was suspended in December 2010 due to concern by Police that because there is no legal defence in these matters, the guidelines were inconsistent with their obligations in administering the relevant age of consent legislation.

The guidelines were reinstated in 2011 with an amendment requiring the JRU to refer APS reports rejected for a JIRT response to the CAS for a 'police only' response. Although technically rejected by JIRT, we understand that, at the time, these matters were counted as 'accepted' referrals, leading to a spike in the JIRT acceptance rate.[234] This resulted in an increased workload against a background of significant resourcing constraints already facing the CAS at that time.

In August 2014, the NSW Police Force decided to transfer responsibility for investigating APS matters to LACs, and the NSW Police Force *Adolescent Peer Sex Guidelines* (a separate document to the JRU guidelines) were amended to reflect this. If, during the LAC investigation of an APS matter, it becomes apparent that there is a complaint or evidence of sexual assault, the report must be re-referred to the Helpline. When the JIRTS database was introduced in mid-2014, APS matters which were previously rejected for a JIRT response but referred for a 'police only' response and counted as 'accepted' referrals were now counted (appropriately in our view) as 'rejected' referrals.

Our consultations with the JRU revealed a significant degree of frustration about the extent to which the assessment of APS reports is consuming scarce resources. In a context where the partner agencies agree on the need to maximise access to JIRT for the most vulnerable children and young people, it is necessary to consider the continuing desirability of the current arrangements for the assessment of APS reports where there is no complaint or evidence of coercion. It appears that, at present, there is an unnecessary 'double handling' of APS reports by the Helpline and the JRU in circumstances where the JRU could be assessing reports in more detail for particularly vulnerable cohorts.

In our view, similarly to what we have recommended in relation to sexual abuse reports involving young people aged over 16, it would be appropriate to restrict the circumstances in which the Helpline refers APS reports that do not involve a complaint or evidence of coercion to the JRU to those where:

- the young person is at further risk on ongoing harm, or
- available information indicates that the young person would benefit from receiving a JIRT response, having regard to the 'factors to consider' that we have recommended should be developed.

In relation to the 'factors to consider', we recommend that APS reports continue to be referred to the JRU for a decision in circumstances where they involve a young person (or young people) with a cognitive and/or communication impairment – in recognition that, while this cohort of young people have the same rights to sexual expression as their peers, they may be at greater risk of coercion or exploitation. In our view, the JRU rather than the Helpline is best placed to determine, through the gathering of additional information, whether or not a report that initially appears to relate to consensual adolescent peer sex involving a young person with a cognitive and/or communication impairment does, in fact, require a JIRT response.

As it does currently, the JRU would continue to assess APS reports referred from the Helpline to determine if they should be accepted for a JIRT response or referred to the relevant LAC, LHD and/or CSC for a local response.

The Helpline would refer all APS reports falling outside the categories listed above to the relevant LAC for a local response in consultation with the relevant LHD and/or (if required) the relevant CSC. Consistent with current practice, if further information indicative of a complaint or evidence of sexual assault became available, the LAC would refer the matter back to the Helpline.

234 Advice provided by NSW Health, June 2017.

Regardless of whether the JIRT program accepts or rejects an APS report, there is scope for decisions to be made on a case-by-case basis about which agency is best placed to 'lead' the JIRT or local response. For example, in some adolescent peer sex or sibling abuse matters, it may be appropriate for Health or FACS, in consultation with Police, to initiate first contact with a young person to help inform the level of police involvement.

In relation to the above proposal, FACS has commented on the 'workload impact' for the Helpline.[235] In our view, given that the Helpline currently refers APS reports to the JRU, the impact associated with instead requiring them to refer reports to LACs would be negligible. In any case, it needs to be weighed against the current resource impact on the JRU.

Based on 2016 data, implementing the above recommendation could potentially remove approximately 680 reports each year from the JRU's workload.[236] This would be a relatively small but beneficial reduction in workload, particularly when combined with the additional reduction that could be achieved if our recommendation about reports involving young people aged 16 years and over is implemented. These combined changes could reduce the referral numbers to the JRU by more than 10%.

FACS has also suggested that families would be unlikely to contact the Helpline for support in relation to APS if they knew that reports of this type would 'automatically be shared' with police.[237] While we have again recommended consideration of law reform in relation to adolescent peer sex (see Chapter 19), as it currently stands, the *Crimes Act 1900* does not recognise persons under the age of 16 years as being able to consent to sexual activity. Therefore reports about consensual APS remain criminal allegations which the Helpline has an obligation to report to Police, and which Police have an obligation to investigate. The Helpline already 'reports' APS matters to police by referring them to the JRU. What we are proposing is simply that, except in certain circumstances, they should refer them to LACs directly.

Moreover, we have recommended that the JIRT agencies develop better guidance for their frontline staff about responding in a 'joined up' way to matters referred by the JRU for a local response. For LACs, this would mean liaising with Health and, where appropriate, CSCs, when responding to APS reports. As noted earlier, Police have acknowledged that, where they are obligated to respond, Health and/or FACS may, in certain cases, be the more appropriate agency to make initial contact. The JRU *Adolescent Peer Sex Guidelines* and NSW Police Force *Adolescent Peer Sex Guidelines* will need to be amended accordingly if our recommendation is accepted.

9.5. Enhancing access to the JIRT program for children and young people with cognitive and/or communication impairment, or living in residential out-of-home care

A strong theme emerging from our review was the pressing need to consider how access to the JIRT program can be enhanced for other groups of children and young people, besides Aboriginal children, who are also at increased risk of sexual abuse and face significant challenges associated with disclosing abuse and receiving an appropriate response. In Chapters 14 and 16, we detail the reasons for our view that, in particular, children and young people who have cognitive and/or communication impairment, or who live in residential out-of-home care (OOHC), should be provided with enhanced access to the JIRT program. However, it is also important to briefly canvass those reasons here in the context of examining the adequacy of the current JIRT referral criteria.

235 Advice provided by FACS, May 2017.
236 This estimate is based on the number of APS reports that were rejected for a police-only response in 2016.
237 Advice provided by FACS, May 2017.

Children with cognitive and/or communication impairment are at increased risk of experiencing abuse, whilst also facing particular difficulties associated with making a clear disclosure if abuse does occur. While the pilot of the witness intermediary scheme (see Chapter 18) is reported to be significantly improving the quality of police interviews (and therefore evidence in chief) of these children and young people when they have been able to make a disclosure (or other evidence exists), access to the scheme is currently restricted to referrals which are accepted for a JIRT response, and only for those referrals being investigated by the CAS in the two court pilot sites – Sydney and Newcastle (although more recently, referrals of children and young people with cognitive impairment outside of the trial have been able to access intermediaries).

Children and young people living in residential OOHC are another particularly vulnerable cohort at heightened risk of sexual abuse – they are believed to be similarly over-represented as victims of sexual abuse and, as a group, are considerably less likely to disclose for a range of reasons associated with their backgrounds and care situation.

Only a very small proportion of children and young people in OOHC are placed in residential care. At the end of June 2016, 4% of children in OOHC were in residential care placements.[238] As we discuss further in Chapter 16, children and young people in residential care usually have 'complex and extreme support needs, displaying highly challenging behaviours that are not well supported in home-based care'.[239] The majority have a background of experiencing severe abuse and trauma, and multiple OOHC placements prior to residential care. Some have also entered the juvenile justice system. In our view, the type of multi-disciplinary response provided by the JIRT program is necessary to deliver the specialised response needed by this extremely disadvantaged and vulnerable group of children and young people.

We recommend that the JIRT partner agencies should, on a trial basis, amend the JIRT referral criteria to allow referrals involving children and young people with cognitive and/or communication impairment, and children in residential care placements, to have the benefit of a specialist JIRT response in circumstances where there is no clear disclosure of sexual abuse but there is:

- reason to believe that there may be barriers to the child of young person making a disclosure, and/or
- information that suggests behavioural changes or other indicators of abuse.

Disability advocates we consulted during our inquiry indicated that for children with severe disability, abuse is often signalled by unusual or sudden behavioural changes which may be difficult for people who do not know the child or young person to identify. The JIRT agencies should determine, in appropriate consultation with peak disability advocates, what 'behavioural changes or other indicators of abuse' will be prescribed for the purpose of the trial.

The 'factors to consider' that we have recommended be developed to inform the exercise of professional judgement by the Helpline and JRU should help facilitate the approach suggested – for which, as noted above, there is already a precedent in the EASP.

If our recommendations to enhance access to JIRT for both of the above cohorts of vulnerable children and young people are implemented, the number of 'new' matters that would potentially meet the JIRT referral criteria is not expected to be significant. However, we acknowledge that it would be problematic to make the recommendations without also considering current capacity issues affecting the JIRT agencies. In this regard, the recommended approach should be subject to an initial trial period.

Effective implementation will depend on a range of factors, including the skill of Helpline and JRU staff in identifying cognitive and/or communication impairment from available records and how to readily source further information to inform assessments. In this regard, adequate training and guidance will be required to support staff.

238 According to FACS' *Quarterly statistical report on services for children and young people*, June (quarter 4) 2015-2016, there were 681 (3.6%) children and young people in residential OOHC at the end of June 2016 compared to 553 (3.1%) at the end of June 2015.

239 Tim Moore, Morag McArthur, Steven Roche, Jodi Death and Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, p.13.

9.6. Physical abuse criteria

The physical abuse criteria have been subject to review and amendment over time. Following the 2006 JIRT review, the criteria was expanded to include injuries which are 'suspicious' in addition to injuries which are 'non-accidental'. This change was made to address the under-representation of physical abuse referrals to JIRT and the need to rely, in all cases, on a medical opinion to determine whether an injury is 'non-accidental'.[240] At the same time, the JIRT Injury Guide Table was also added to the criteria to provide additional guidance to the JRU and Helpline about what injuries are 'severe or serious'.

However, in June 2013, an internal FACS review of a child death observed that there was still 'a level of ambiguity' in the physical abuse criteria, noting that the interpretation of 'severe or serious' may be subjective, even with the additional guidance provided in the JIRT Injury Guide Table. The review recommended that the JIRT SMG consider the case to determine whether changes to the JIRT physical abuse criteria should be made.

In March 2015, the SMG provided additional advice, developed by NSW Health, to the Helpline to inform its decisions about referring physical abuse reports to the JRU. The advice encourages consultation with Health's Child Protection Units, together with consideration of the JIRT Injury Guide Table and reviewing the child's family and child protection history. The advice also makes clear that, in the absence of parents/carers obtaining the required medical examination, pursuant to section 173 of the *Children and Young Persons (Care and Protection) Act 1998*, FACS or Police can serve a notice requiring a child to be medically examined if they believe on reasonable grounds that a child is in need of care and protection, and that a medical examination can be requested to determine whether or not an injury is severe or serious, suspicious, or inconsistent with the explanation provided. The advice cautions that inconclusive clinical findings do not prevent a referral to the JRU.

In December 2015, the SMG endorsed new trial physical abuse criteria. The criteria were refined a few months later, in March 2016,[241] on the basis of preliminary feedback from the implementation of the trial.[242]

Further amendments to the criteria were endorsed by the SMG in July 2016:

- the word 'attempt' was removed in relation to strangulation
- 'Recurrent apnoea' was removed from the Injury Guide Table, and
- the word 'or' was reinstated – 'Unexplained or inconsistent with the explanations provided and/or inflicted (non accidental) or suspicious and caused by another person aged 10 years or over'.[243]

In June 2016, Health also provided draft clinical advice about contact burns and strangulation to the SMG for use at the JRU and undertook to finalise this advice following further internal consultation with expert clinicians. As we discuss in the next section, Health has now finalised its clinical advice on contact burns and strangulation and has prepared suggested amendments to the physical abuse criteria to better explain 'strangulation' and reorganise the Injury Guide Table (including to better describe what injuries are 'severe or serious' and the indicators or markers that a particular type of injury is 'inflicted or suspicious'). We recommend that these amendments are tabled before the JIRT SMG for its consideration as soon as practicable.

In Chapter 10, we discuss the need for Local Area Commands to also have a solid understanding of responding to physical abuse matters, given that many of these matters at the time of initial report may fall outside of the JIRT referral criteria but subsequently meet it. While in many cases – consistent with their responsibility for responding to domestic and family violence more broadly – LACs are well-placed to respond to reports of physical abuse against children and young people, it is critical that they understand the JIRT physical abuse referral criteria and know when to seek the early advice of the CAS in relation to whether a JIRT response or advice may be required.

240 Advice provided by NSW Health, June 2017.
241 Email to the JRU from NSW Health, 24 March 2016.
242 Advice provided by NSW Health, 2 March 2017. The trial criteria had used the phrase 'current severe or serious injury'. The word 'current' was removed because it was found to be excluding referrals of children in a way that had not been intended by the SMG.
243 Email to the JRU from FACS, 8 July 2016.

9.6.1. Strangulation reports

The JIRT Injury Guide Table, which is used to inform decisions about the assessment of physical abuse, lists strangulation reports as an indicator or marker of severe and serious injury that would meet the JIRT referral criteria. According to advice provided by Health, attempted strangulation can lead to adverse long-term impacts, including brain damage, and there is a high probability that it will be repeated, sometimes with fatal consequences. There is an elevated risk of a subsequent homicidal event occurring in a child who has been the victim of strangulation.[244] Significantly, however, in half of all cases of attempted strangulation, there are no obvious injuries.[245] Victims can experience internal injuries with a delayed onset of symptoms which can be serious or fatal.[246]

Strangulation reports have been a contentious issue for the JIRT program in recent times. Since there may be no apparent injuries at the time of the report, and no other corroborating information, reports involving strangulation may be rejected for a JIRT response. According to recent analysis conducted by Health, between 1 July 2014 and 30 January 2017, 123 referrals were assessed at the JRU where the primary abuse type was 'physical strangle/suffocate'.[247]

Of the 123 referrals:

- 13 were accepted for a JIRT response (including 1 previously accepted) – 10 of these referrals were allocated less than 24 hour response timeframes, and
- 110 were rejected for a JIRT response – 87 of these had previously or were currently receiving a police only/LAC response.

The following response priorities had been allocated by the Helpline for the 123 referrals:

- 66 were < 24 hours (these were reports where forensic evidence and/or an injury may have been current)
- 42 were < 72 hours, and
- 15 were < 10 days.

Forty four of the 123 referrals concerned children under the age of 10 years, while the remaining 79 children were aged between 11 to 17 years.

During the JRU assessment phase, only 19 of the 123 referrals had been the subject of a medical assessment and/or other treatment (15%); for a further four referrals, police advised parents/carers to take the child for a medical assessment. For the remaining 100 referrals, there was no information available on the JIRTS database about whether or not a medical examination and/or some other form of treatment occurred, or was being planned, at the time of the report.

During the course of our inquiry, Health submitted that strangulation reports should be accepted for a JIRT response because of the serious clinical risks for the child and the need to arrange and coordinate urgent medical assessment and treatment. Health provided us with the following advice:

> *any history of strangulation for any period of time should be considered potentially serious and the child should immediately be referred for assessment by a medical practitioner (paediatrician), preferably in an Emergency Department where resuscitation equipment is readily available, if the incident is less than 48 hours old. The level of urgency should depend on the history. All cases where strangulation or suffocation has been alleged should receive a medical review.*

Health has suggested that there should be much greater use of 'section 173' medical examinations in these cases. Health's view is that the low level of acceptance of strangulation referrals into the JIRT program points to a need to better understand the type of information available to the JRU at the time of assessing strangulation reports (for example, verbal report by alleged victim only, their age,

244 NSW Health, *Overview of medical aspects of strangulation*, 9 March 2017.
245 Advice provided by NSW Health, November 2016.
246 *Strangulation Assessment Card*, Training Institute of Strangulation Prevention, Alliance for Hope International, San Diego, USA, accessed 27 March 2017, http://www.strangulationtraininginstitute.com/resources/library/strangulation-assessment-card/.
247 Advice provided by NSW Health, March 2017.

as well as the presence or absence of any physical injuries) and the impact of this information on decision-making, as well as the subsequent outcome of any action taken by the JIRT program (that is, investigation or referral to local agencies).

Our consultation with the JRU in November 2016 identified shared concern about attempted strangulation reports, but a reluctance to mandate that all such reports should be accepted for a JIRT response. After listening to the nature of the concerns from each agency's perspective, we suggested that, in matters where no injuries are apparent at the time of the report and there is no other corroborating information, an acceptable solution would appear to be for the JRU to urgently refer the report to the relevant CSC with a recommendation that it seek parent/carer cooperation to obtain a medical examination, or if this cooperation is not forthcoming, that the CSC seek a 'section 173' medical examination. If a medical examination reveals evidence consistent with abuse, the report should then be re-referred to the JRU.

Health agreed to undertake further work with its senior clinical advisors to develop advice and guidance for JIRT and line agency staff to assist their understanding of how best to respond to strangulation matters. We understand that Health is now preparing advice about strangulation, for inclusion in the JRU's decision reports, to guide CSC's in assessing and allocating strangulation matters.[248]

In December 2016, the JIRT SMG considered the option of removing 'strangulation' from the JIRT Injury Guide Table and replacing it with specific injuries (internal and external) which can result from strangulation. This would mean that prior medical assessment and identification of serious injury would be required for the JRU to be able to accept strangulation reports for a JIRT response. Health once again noted that its clinical advisors were developing guidance for use by frontline staff. Health's clinical advisors subsequently prepared this advice after attending specialist training on 'strangulation' in February this year. The training was organised by the Red Rose Foundation[249] and included keynote speakers from the United States-based Training Institute of Strangulation Prevention, a program arm of the Alliance for Hope International.[250]

In March 2017, Health provided us with a copy of its clinical advice – *Overview of medical aspects of strangulation* – as well as suggested edits to the JIRT Injury Guide Table. According to Health, the suggested amendments to the criteria will provide a better explanation of strangulation, including the internal injuries that can result from strangulation. Health's clinical advice indicated that:

> *Strangulation requires a medical response as children with no visible injuries may have injuries evident on MRI or CT scanning of the neck or head. Medical assessment immediately following a strangulation event should occur promptly as a victim's clinical state may deteriorate rapidly even when the victim has no visible markings. Conversely, injuries may fade over time and be undetectable if there have been delays in presentation.*[251]

Given the clinical advice that injuries will not be apparent in 50% of presenting cases, Health contends that the JRU should be able to accept a strangulation report for a JIRT response (at least until further examination is undertaken) on the basis of a child or young person's disclosure of strangulation, even if no injuries are apparent, in the same way that the JRU accepts sexual assault referrals on the basis of sexual assault disclosures.[252] In this regard, Health has also suggested that the JIRT physical abuse criteria should be expanded to allow strangulation reports involving disclosures and/or a history of relevant symptoms to be referred to the JRU. This referral would facilitate a coordinated tri-agency response, including a medical forensic examination (with FACS and Police invoking their statutory powers to support Heath in arranging the medical examination when necessary), to assess whether the child or young person has sustained a severe or serious injury.

248 Advice provided by FACS, July 2017.
249 The Red Rose Foundation is a Queensland-based NGO that works to end domestic and family violence related deaths in Australia.
250 Alliance for Hope International is an NGO focused on creating innovative, collaborative, trauma-informed approaches to meeting the needs of survivors of domestic violence and sexual assault and their children.
251 Advice provided by NSW Health, *Overview of medical aspects of strangulation,* 9 March 2017.
252 According to clinical advice from Health, in the absence of visible physical signs, reports of a history of difficulty breathing or swallowing, loss of consciousness, incontinence of urine or faeces, change in voice or visual disturbance, provide additional indications of a strangulation event.

Having considered the advice provided by its senior clinicians, and the recent advice from FACS about potential compliance issues at the CSC level, Health has now confirmed its view that all reports to the Helpline that involve the alleged strangulation of a child should be automatically referred to and monitored by the JRU until the results of a skilled forensically-oriented medical evaluation is known. We support Health's position based on our assessment of the clinical advice it has presented and the risks associated with the Helpline/JRU making determinations without the benefit of supporting medical evidence.

In practice, Health's proposal would involve the JRU, where necessary, to seek the assistance of a CSC to obtain forensic medical evidence to inform the JRU's assessment and decision. However, while FACS has indicated that it appreciates the need for JRU assessments of strangulation reports to be informed by expert medical opinion, it has identified that referrals of this kind to CSCs will need to be assessed against other ROSH reports referred to CSCs at the same time. In this regard, FACS has indicated that the advice being preparing by Health about strangulation will be critical in guiding the actions of CSCs in progressing these urgent matters.[253]

Recommendations

6. **The JIRT partner agencies should develop, having regard to the observations in section 9.2, a formal set of 'factors to consider' to assist the Helpline and JRU to exercise professional judgement when applying the JIRT referral criteria.**
7. **The JIRT partner agencies should amend the JIRT Referral Criteria (and related line agency policies) to reflect that the Helpline will only:**
    a) **refer sexual abuse reports involving alleged victims aged 16-18 years to the JRU if:**
        i **the young person is at further risk of ongoing harm and the alleged offender is a family member, close adult friend, neighbour or person in authority, OR**
        ii **having regard to the recommended 'factors to consider' (recommendation 6), available information indicates that the young person should receive a JIRT response.**
    b) **refer sexual abuse reports involving adolescent peer sex to the JRU if:**
        i **the young person is at further risk of ongoing harm, OR**
        ii **having regard to the recommended 'factors to consider' (recommendation 6), available information indicates that the young person should receive a JIRT response.**
8. **The JIRT partner agencies should:**
    a) **on a trial basis, amend the JIRT Referral Criteria to allow referrals involving children and young people with cognitive and/or other communication impairment, and children and young people in residential out-of-home care, to receive a JIRT response in circumstances where there is no clear disclosure of sexual abuse but where there is:**
        i **reason to believe that there may be barriers to the child or young person making a disclosure, and/or**
        ii **information that suggests behavioural changes or other indicators of abuse.**
    b) **consult with peak disability advocates to determine the 'behavioural changes or other indicators of abuse' that will be prescribed for the trial.**

253 Advice provided by FACS, July 2017.

9. **The JIRT partner agencies should, on a trial basis:**
    a) **amend the *Enhanced JIRT services to Aboriginal children and young people protocol* (EASP) to remove the requirement to automatically suspend the '16-18' policy for sexual abuse reports involving Aboriginal young people, and**
    b) **allow the JRU to suspend the '16-18' policy in relation to a sexual abuse report involving *any* young person over 16, if available information (rather than Aboriginality alone) indicates that the young person would benefit from a JIRT response.**
10. **The JIRT partner agencies should amend the *Enhanced JIRT services to Aboriginal children and young people protocol* (EASP) to remove the requirement for automatic suspension of the 'Prior LAC' practice for reports involving Aboriginal children and young people.**
11. **The JIRT partner agencies should amend the JIRT physical abuse criteria to allow:**
    a) **all reports to the Helpline involving the alleged strangulation of a child or young person to be automatically referred to the JRU**
    b) **where necessary, the JRU to seek the assistance of a CSC to obtain medical forensic evidence to inform the JRU's assessment and decision.**
12. **To support the implementation of recommendation 11 above, NSW Health and FACS should settle advice for CSCs to guide their actions in responding to strangulation reports referred by the JRU.**
13. **NSW Health should formally distribute its clinical advice and recommendations relating to the JIRT physical abuse criteria to FACS and the NSW Police Force to inform their consideration of Health's proposed strategies to improve the handling of strangulation reports, contact burn reports and other physical abuse matters as soon as practicable.**

PRACTICE SUGGESTIONS

- The JIRT partner agencies should replace the current JIRT Referral Criteria with a more 'user-friendly' resource which, having regard to our related observations and recommendations, includes the core referral criteria; a list of formal 'factors to consider' when applying the criteria to individual matters; and hyperlinks to relevant agency policies and procedures (such as those noted in section 9.1), which have direct relevance to the criteria.
- The JIRT partner agencies should amend the JIRT Referral Criteria to explicitly state the age thresholds that apply to each of the three categories of abuse (sexual, physical and neglect).
- The JIRT partner agencies should consider the benefits of conducting a review of the response to the 123 'strangulation' referrals assessed by the JRU between 1 July 2014 and 30 January 2017 to examine the policing, child protection and health outcomes for the children subject of these referrals.

PART 4

The performance of JIRT agencies

NSW Police Force | The Department of Family and Community Services | NSW Health

Contents

Chapter 10. NSW Police Force

This chapter examines the performance of the NSW Police Force in the context of its role as a JIRT partner agency. Under the JIRT MoU, the role of Police is to detect and investigate alleged child abuse and neglect and initiate criminal proceedings, where appropriate.

Our commentary focuses on the Child Abuse Squad (CAS), which is responsible for leading the organisation's response to criminal allegations of child abuse. However, we also examine issues relevant to Local Area Commands (LACs) in light of the role they play in providing the 'first' response to certain JIRT matters, as well as investigating reports of criminal child abuse which fall outside of the JIRT program.

In assessing the performance of Police, we had the benefit of having completed a comprehensive review of the CAS at the time of our 2010-2012 audit of the implementation of the NSW Government's *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities* (Interagency Plan). As a result of that audit, we recommended that CAS resourcing be enhanced to enable it to effectively respond to the increased number of matters that were being accepted by the JIRT program. However, we stressed that an injection of resources alone would not lift the performance of the CAS, and recommended that any additional resourcing be accompanied by strengthened accountability mechanisms to drive ongoing performance improvements. The former CAS Commander agreed with this view and put a number of strategies in place to improve the supervision and reporting processes for individual CAS teams. The current Commander has continued to build on these strategies to strong effect.

The results achieved by the CAS over the last five years are impressive. As a proportion of JIRT referrals, the number of arrests by the CAS was higher in 2016 than at any other time previously.[254] And, overall, the number of arrests almost doubled between 2010 and 2016. The CAS reports that conviction rates in relation to matters referred to the JIRT program are on the increase, as are the use of AVOs and covert investigative measures.

In stark contrast to four years ago, the CAS is now viewed by police officers as an attractive place to work – a high performing squad where officers can hone their investigation and interviewing skills under the tutelage of experienced senior detectives. The NSW Police Force has also introduced a successful wellbeing program for the CAS, which has been highly praised during our inquiry not only by frontline CAS officers, but also staff from Health and FACS.

At the same time that the CAS was reforming its internal operations, a suite of criminal justice reforms were also introduced in response to our 2012 audit report. The most noteworthy of these were the pre-recording of the child's cross-examination, and the use of witness intermediaries to enable children to give 'their best evidence', as part of the Child Sexual Offence Evidence Pilot. The CAS has been closely involved in working with the Department of Justice to roll out the pilot scheme.

The NSW Police Force also has a range of additional responsibilities in the context of responding to allegations of child abuse in an institutional context. In 2009, we brokered an agreement with Police to develop standard operating procedures (SOPS) which clearly outline the responsibilities of the CAS and LACs in providing practical support to agencies responding to allegations of reportable conduct. The CAS has played an important leadership role in promoting awareness of the SOPS among LACs, and the SOPS have proved invaluable in ensuring that agencies receive a consistent response when liaising with police about criminal child abuse allegations involving their employees.

Both the CAS and individual LACs have also worked closely with our office in responding to matters we have referred to Police when our intelligence holdings have indicated that criminal action may be warranted. At our February 2016 reportable conduct forum, which brought together over 800 participants from across the schools, out-of-home care, religious and sporting and recreational sectors, former Commissioner Andrew Scipione APM, highlighted the joint work of Police and the Ombudsman in tackling employment-related child abuse, and emphasised the ongoing commitment of his police officers to supporting agencies.

254 We discuss the data relating to arrests in further detail in section 10.4.

Notwithstanding the significant achievements of the CAS over the last five years, there is scope for its operations to be further refined.

Through its Criminal Justice Case Study, the Royal Commission has highlighted areas of practice – such as interviewing techniques and responding more effectively to particularly vulnerable cohorts of children (including those with a disability) – where the Police response to child abuse could be strengthened. In this regard, it is positive that the CAS has already taken steps to improve its child interviewing training course. More broadly, the NSW Police Force has worked closely with our office to develop better guidance for police in responding to children with disability and vulnerable adults, particularly those with cognitive impairment and other communication difficulties. Later in this chapter, we discuss whether there is scope for the specialist officers in the CAS to have broader responsibility for providing advice and investigative support to LACs to help improve the response to vulnerable adults who come in contact with the criminal justice system, particularly (given the CAS' experience working with witness intermediaries) in relation to interviewing.

In assessing the performance of Police, it is important to bear in mind that the majority of reports referred to the JIRT program do not result in criminal charges and that there are a variety of legitimate reasons for this. It is therefore critical to also look beyond criminal justice interventions to examine how Police are sharing information with their JIRT partner agency colleagues to inform the management of ongoing risks, particularly in circumstances where the protections offered by a criminal prosecution are not available; and in ensuring that recent changes to interviewing practice are well executed.[255] Elsewhere in this report, we discuss critical areas of the JIRT partnership where the CAS (and the other JIRT agencies) can strengthen their interagency performance.

From an accountability perspective, we believe there is potential for the CAS to enhance its reporting capabilities to allow it to more meaningfully report on the outcomes it is achieving for individual children accepted into the JIRT program. This is particularly important given the limitations of the publicly available criminal incident and court data for child abuse, which, in our view, does not adequately reflect CAS (or LAC) productivity in relation to its response to criminal child abuse allegations. We have also recommended that consideration be given to reviewing the current chain of command under which the CAS operates, given the significant growth of the squad over recent years and the expansive set of responsibilities falling on a single Commander. As well, we highlight the potential for further integration between the sex crimes and child abuse squads given the complementary nature of their respective functions.

An important issue to emerge from this inquiry is the extent to which LACs are involved in delivering the first response to reported child abuse and investigating allegations of criminal child abuse which fall outside of the JIRT program. As well as handling almost 2,000 reports in 2016 that were referred to the JIRT Referral Unit (JRU) but rejected for a JIRT response,[256] LACs handle a large number of other serious child abuse reports that, for various reasons, do not meet the JIRT referral criteria or which the JRU decides LACs should maintain due to their 'prior involvement'. LACs also investigate almost all historical child sexual abuse reports made by adults. We discuss the potential for LACs to play a greater role in relation to certain types of matters currently investigated by the CAS, and identify areas where LACs could be better supported.

Finally, we highlight the need for the NSW Police Force to examine how it can strengthen its operational crime reporting processes in relation to the organisation's overall response to child abuse, and in doing so, appropriately distinguish the work of the CAS from LACs. This recommendation is particularly timely against the background of the Royal Commission's observations in its 2016 Criminal Justice paper about the need to strengthen the response when victims first report abuse to police; that is, at their 'point of entry' to the criminal justice system.[257]

255 We discuss interviewing in detail in Chapter 22.
256 Data sourced from JIRTS database.
257 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.84,107-110.

10.1. The CAS role in the JIRT program

The CAS is a specialist team of detectives responsible for the criminal investigation of all reports that are accepted for a JIRT response and – where there is sufficient evidence that a criminal offence has been committed – for arresting and charging the suspect. As part of its investigation of referrals accepted for a JIRT response, the CAS is also responsible for applying for Apprehended Violence Orders (AVOs) for children.[258]

The CAS operates across 23 sites grouped within six zones, with each zone being led by a Zone Manager (at Inspector level) – see Table 1 in Chapter 4.

The CAS also includes the Child Abuse Response Team (CART), a unit which was established in 2012 to provide assistance on complex matters, for example, those involving multiple offenders and victims, serious injury, and/or the use of covert investigative strategies.[259] Generally, the CART only handles investigations that meet the threshold for a JIRT response; however, it also provides assistance to LACs when required.[260]

10.2. Our 2012 review of the Child Abuse Squad – what we found

As part of our 2012 audit of the Interagency Plan, we conducted a comprehensive review of the CAS' operations. This review was prompted by our office receiving a number of complaints about the CAS in 2011. Among other allegations, the complaints stated that child sexual abuse cases were being shut down too early. In support of their allegations, the complainants referred to a marked decrease in charge and arrest rates for JIRT cases, particularly in certain locations.

Our early inquiries into this issue revealed that the (then) recently appointed Commander of the CAS had already identified a number of problems relating to policing performance within particular CAS teams, and had taken steps to explore the causes and implement remedial action.

However, in light of the importance of the issues raised, we formally required the NSW Police Force to provide us with productivity and related outcome data for all CAS teams. In response, Police provided us with a CAS state-wide workload analysis report, covering a ten month period in 2011, which included information about:

- authorised staff allocated to each CAS team
- allocated jobs for each JIRT and average jobs per officer
- the number of child interviews conducted, average number of interviews conducted per officer, and the proportion of interviews conducted per allocated number of jobs, and
- the number of arrests/charges carried out, average arrests per officer, the proportion of arrests per allocated jobs, and the proportion of arrests per interviews conducted.

Upon analysing this information, we noted the following:

- Of the then 22 CAS sites, the average number of 'jobs per officer' ranged from about 11 jobs per officer in the lowest ranked team to 49 in the highest ranked team.[261] As the average number of jobs per officer does not reflect the work involved in each job, we also considered the proportion of jobs allocated where a child victim was interviewed. Once again, we detected significant

258 A police officer must apply for an AVO if they suspect that a child has been the victim of a recent child abuse, domestic violence, or intimidation or stalking offence (or if they suspect that such an offence is imminent or is likely to be committed); and they believe that an order needs to be made to ensure the safety and protection of the child. See sections 27 and 49 of the *Crimes (Domestic and Personal Violence) Act 2007.*

259 NSW Police Force, State Crime Command, Child Abuse Squad, *Child Abuse Response Team Investigation Criteria*, 1 August 2012.

260 The Manager of the CART considers all written requests for assistance and the nature of the response required by the CART. Urgent requests can be made by telephone via the on-call CAS Inspector.

261 It is important to take other factors into account in assessing this information. For example, teams operating in rural and remote locations with significant Aboriginal populations can spend a considerable amount of time travelling and engaging with community groups and carrying out information and awareness sessions in schools to increase reporting.

variation across teams in relation to their per officer interview rates. It was interesting to note that two of the teams with the highest work volume and number of 'allocated jobs per officer' were among the lowest for the number of child interviews conducted on a per officer basis.

- In addition to gauging the rate of child interviews, two other important measures relating to work performance are the numbers of arrests and charges per officer as a proportion of all jobs allocated.[262] Those teams with the highest volume of jobs would be expected to be among those with the highest number of arrests. However, the data showed otherwise.
- Given the connection between interviews and resulting arrests, we also looked at the proportion of arrests per the number of interviews conducted. We found evidence of CAS teams conducting relatively high numbers of interviews per officer, but with low resulting arrest rates.
- One high volume team stood out in relation to its performance against all the measures. This team had the second highest arrest rate and the second highest rate of jobs per officer. Although this team was managing a high volume of work, it also had the highest percentage of interviews against allocated jobs.

From our review of the data, it was apparent that the CAS workload analysis report was an excellent tool for assisting to identify relative productivity, and associated outcomes, across the various teams. In November 2012, we discussed the potential benefits of using this report as a performance measure with senior representatives from the CAS and the State Crime Command. We subsequently recommended that it should be used by CAS senior managers to regularly track the performance of each CAS team.

We also recommended that the NSW Police Force (along with FACS and NSW Health) review whether the resources available to deliver on the key components of the JIRT program were adequate, and that Police also consider the adequacy of the allocation of supervisory positions within the CAS. In making these recommendations, we noted that any increase in the resources allocated to the CAS should go hand-in-hand with related improvements in accountability mechanisms to monitor and report on the performance of the CAS.

10.3. The Police response to our 2012 audit report

In addition to confirming that it would use the state-wide workload analysis report to track the performance of CAS teams on an ongoing basis, Police introduced a number of additional positive initiatives following our review of the CAS:

- Four new Inspectors were allocated to support the Commander to implement a range of systems to address identified problems. These positions have been pivotal in lifting performance across individual teams and strengthening accountability and leadership.
- 30 new investigators were allocated to the CAS – 27 of these positions were filled between May and December 2013, and the remaining three were filled in January, February and August 2014.
- An annual team leaders development review process was introduced to review the performance of individual squads and promote best practice, with the workload analysis report forming the basis of this process. (The annual TDR is complemented by a six monthly team leaders' conference and quarterly reviews of performance data for each CAS team.)
- Inspectors were tasked with tracking the performance of the squads within their area of responsibility, increasing their mentoring of individual teams, and conducting more regular field visits for this purpose.
- The Child Abuse Response Team was established to provide support to teams in relation to complex and protracted investigations, and the State Crime Command committed to supply additional support when necessary.

262 As discussed below, while arrest rates are an important measure of performance, it is important to note that there are a range of reasons, many of which are outside of the control of police, why a matter may not proceed to charge.

As a result of these initiatives, including the significant staffing increases, the available data demonstrates that there was a marked improvement across all key performance measures for the CAS following our 2012 report and that this improvement, which we discuss in the following section, has been sustained since that time.

More recently, the CAS has implemented further initiatives aimed at improving the quality and consistency of its work. Recognising the need to strengthen the leadership of teams in regional areas, the current Commander established additional Zone Manager positions in Newcastle and Wagga Wagga and, more recently, in Western NSW. There are now six CAS zones across the state, each led by a Zone Manager. (These zones are now more closely aligned with the six NSW Police Force regions.)

In addition, in 2016 the CAS hosted the National Police Child Abuse Forum, bringing together child abuse squads from around the country to share best practice and discuss challenges.

At the time of our 2012 report, senior members of the CAS were open about the challenges in attracting sufficient numbers of high quality police to the squad, citing the emotionally confronting nature of the subject matter as one of the reasons many police choose to avoid child abuse related work. Since that time, the CAS has made considerable progress in attracting experienced criminal investigators, actively promoting their work both within the wider organisation and in the media, and emphasising the strong results achieved by the squad. Today, the CAS is viewed by frontline police as an elite squad:

> *Over the past few years the arrest rate has significantly improved, which is evidence that the CAS is focusing on its primary role and responsibility to investigate crimes against children* – Zone Manager.
>
> *The CAS is a high performing arm of the NSW Police Force – having a dedicated squad to investigate the most serious forms of child abuse enables a strong focus on this crime* – CAS Investigator.
>
> *The Child Abuse Squad has increased the arrest/charge rate considerably over the last five years. The quality of investigators accepted at CAS and investigative methods utilised have improved significantly* – Team Leader.

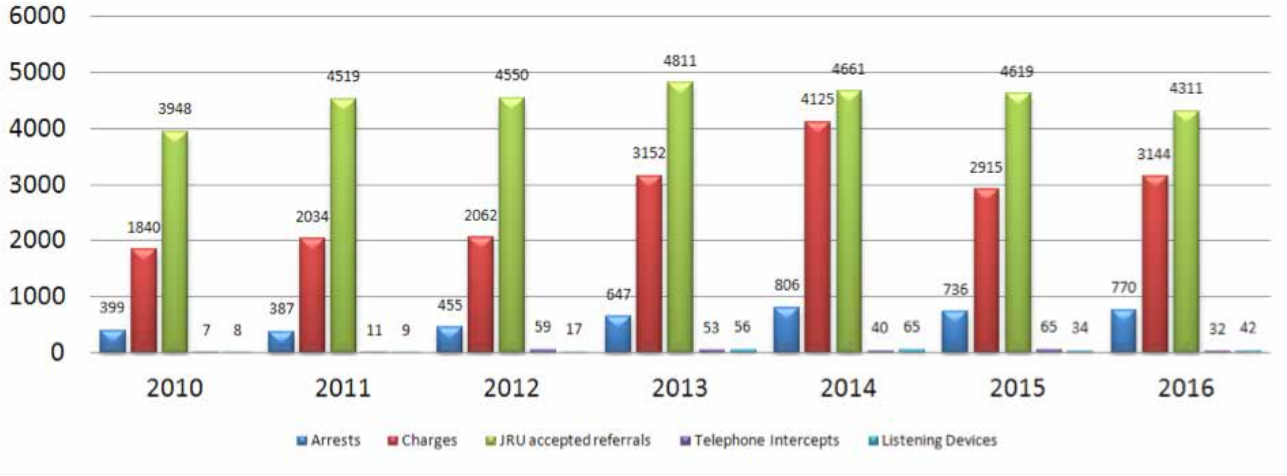
The CAS has also significantly strengthened its staff welfare and wellbeing program and related rotation policy, which we discuss further in section 10.7. As well as assisting the CAS to maintain the wellbeing of its staff, the rotation policy actively supports the training and development of officers from other commands by enabling them to use their time in the CAS to gain specialist skills to utilise when they return to LAC duties. In this way, it has helped to make the CAS a more attractive place to work.

In addition, an Inspector role was established and based at Police Headquarters to provide strategic and management support to the Commander. This role has relieved the Zone Managers from having to juggle these broader responsibilities, allowing them to focus on operational matters. In light of the significant challenges that the Zone Managers face in managing teams that have a very high rate of maternity leave and officers on part-time work arrangements, as well as frequent rotation of staff, this role has been a particularly valuable addition to the Squad.

10.4. Current CAS performance data

In response to our request for information for this inquiry, the CAS provided us with advice about its performance and staffing changes over the last five financial years, including detailed data disaggregated by the CAS team. In addition, in January this year, the Acting Commander provided us with the most recent 'performance snapshot' for the CAS at a state-wide level, which includes data up until the end of the 2016 calendar year (see Figure 3). While there is overlap in the data measures, given the more up-to-date nature of the performance snapshot, we have used both datasets as part of our consideration of CAS performance.

Figure 3: NSWPF Child Abuse Squad – Arrests, Charges and Accepted Referrals, Listening Devices and Telephone Intercepts 2010-2016[263]



As Figure 3 shows, in the three year period before the CAS was allocated additional resources, the number of arrests went from 399 in 2010 (with 1,840 related charges) down to 387 arrests (with 2,034 related charges) and then back up to 455 arrests in 2012 (with 2,062 related charges).[264] This represents an increase of 14% (with a dip in 2011) in the overall number of arrests between 2010 and 2012. The increase reflects work that was being done by the former Commander to improve interview rates and accountability more generally, as well as a 15% increase in the volume of reports accepted by the JRU during the same period.

Since then, the number of arrests has continued to increase – from 647 in 2013, when the additional resources started having an impact, to a peak of 806 in 2014. Notably, while the increase in arrests in the years prior to the additional CAS staffing was largely in line with the increase in referrals, the arrest numbers have remained high in 2015 and 2016 (736 and 770 respectively) despite a 7.5% decrease in the number of accepted referrals between 2014 and 2016. In fact, the number of arrests per accepted referrals[265] was higher in 2016 than in any previous year. Overall, the arrest numbers have almost doubled between 2010 and 2016. More recent data provided by the Acting CAS Commander in April 2017 suggests that the CAS is continuing to maintain similar arrest levels in 2017 – with 190 arrests (and 588 related charges) between 1 January and 31 March 2017.[266]

Also notable is the increased use of covert investigative techniques – an important measure of proactive policing – over the last seven years. In 2010, telephone intercepts were only used on seven occasions and listening devices on eight occasions. By 2012, a deliberate strategy by the then CAS Commander to lift the use of covert technologies resulted in intercepts being used on 59 occasions and listening devices on 17 occasions. Since that time, the use of both methods has remained around five times higher than it was in 2010. The use of these techniques is still minimal in the context of the volume of cases being investigated by the CAS – while they are an important tool for police, experienced detectives in the CAS acknowledge that a good quality recorded criminal interview of a child is still the most vital piece of evidence for a police investigation.

In addition to the positive trends in arrest figures and covert techniques, the more detailed CAS performance data provided for the past five financial years (summarised in table 2 below) also indicates improvement since 2012 – both in terms of performance against the additional measures that are captured, and improved consistency across different CAS teams.

263 Data provided by CAS, January 2017.

264 The number of arrests is generally a more accurate workload measure than the number of charges laid, as one offender may be subject to multiple charges (the data in Figure 2 illustrates that over the seven year period, on average each arrest resulted in 4.6 charges). However, the number of individual charges is still an important secondary measure, as processing and preparing briefs of evidence in relation to multiple charges impacts on police resourcing.

265 This measure is not an exact 'arrest rate' for the CAS, but it is a strong indicative measure of the proportion of matters that result in an arrest.

266 Data provided by CAS, April 2017.

Table 2: Child Abuse Squad – Data collection for JIRT review*

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Cases**					
Total cases	**3,926**	**4,257**	**4,538**	**4,089**	**4,112**
Interviews***					
Other	35	17	19	25	31
Suspect	1,006	659	907	845	825
Victim	2,658	2,709	3,421	3,168	3,153
Witness	658	645	827	835	727
Total Interviews	**4,357**	**4,030**	**5,174**	**4,873**	**4,736**
Warrants					
Search warrants	51	64	106	100	92
Crime scene warrants	47	85	88	40	36
Telephone intercept ^ warrants	20	56	35	74	65
Surveillance device ^^ warrants	35	58	71	68	46
Court/legal					
Court Attendance Notices (Arrests)	440	526	776	761	783
Offences with Court Attendance Notices	2,384	2,237	4,046	3,476	3,465
Court Notice Applications (AVOs)^^^	426	505	816	740	790
Staffing					
Superintendent	1	1	1	1	1
Inspector	4	4	5	5	7
Snr Sergeant	3	5	5	5	5
Team Leader	20	24	27	27	29
Investigator	110	136	144	146	145
Clerk 5/6	4	4	4	4	4
Total staff	**142**	**174**	**186**	**188**	**191**

Table notes:

* Source: Data provided by CAS on 4 November 2016.

** Data relating to cases was obtained through COPS downloads at a 'point in time' and captures all cases created, which at the time, were owned by the CAS. This figure is lower than the total number of matters accepted for a JIRT response, primarily due to the fact that the CAS may create one 'case' in COPS in circumstances where multiple reports are created at the Helpline and accepted at the JRU.

*** Figures for search and crime scene warrants relate only to those warrants which were executed. If permission was provided by the occupier (without warrant) or evidence was collected from a public place which does not require a crime scene warrant, this work is not represented in the table. It is likely the figures above under-represent the actual number of search and crime scene warrants executed by the CAS.

^ While every effort has been made to ensure all of the telephone interception warrants obtained by CAS were extracted from those formerly labelled Child Protection and Sex Crimes, it is possible that there are a small number which were not captured.

^^ While every effort has been made to ensure all surveillance device warrants obtained by CAS were extracted from those labelled Child Protection and Sex Crimes, it is possible that there are a small number which were therefore not captured.

^^^ The number of Court Notice Applications relating to AVOs is not a direct count of the number of AVOs issued or applied for by the CAS – it is a workload measurement that includes all AVO-related actions requiring work by the CAS. It includes: provisional orders granted; provisional orders with refusals outstanding; non-urgent applications; applications to vary; and applications to revoke that relate to AVOs that have been applied for or issued by the CAS.

The performance data confirms that there has been a net increase in the capacity of the CAS since 2012. The number of CAS staff has increased by 35%, from 142 in 2011-2012 to 191 as at 30 June 2016.[267] In addition to the enhanced resourcing following our 2012 report, five new positions were also allocated in December 2016, with a further five allocated in May this year, taking the total CAS staffing allocation to 201. Over the same five year period, the number of CAS cases has increased from 3,926 to 4,112 – peaking at 4,538 in 2013-2014 – an overall increase of 5% and an increase of 16% at its highest.

Our analysis of performance data at a team level shows that the additional resources were effectively distributed in order to address the problems we identified in 2012 relating to the varied performance of different CAS teams. For example, the results in the years from 2014-2015 to 2015-2016 show an increase in the consistency of average caseloads for each CAS team, taking into account differences for rural and remote locations that cover large geographical distances and with additional community engagement responsibilities in locations with significant Aboriginal populations.

The performance data also shows that CAS AVO-related actions increased from 426 in 2011-2012 to 790 in 2015-2016 (peaking at 816 in 2013-2014) – an increase of 85%. While the need for an AVO will obviously be dependent on the circumstances of an individual matter, it is an important measure as, aside from arrests and charges, AVOs are the primary intervention open to the CAS in seeking to protect individual victims.

Importantly, there has also been a 13% increase in the total number of victim interviews conducted by CAS officers – up from 2,658 in 2011-2012 to 3,153 in 2015-2016 (peaking at 3,168 in 2014-2015).[268] This represents a 9% increase in the proportion of victim interviews per case (up from 68% in 2011-2012 to 77% in 2014-2015, although there was a slight decrease in 2015-2016).

In interpreting this data, it is important to note that there can be more than one victim for each case. There are also a range of valid reasons for why an interview may not have been conducted (for example, unwillingness on the part of the victim to participate in a criminal process (this can often be the case where the matter has been reported by a third party, such as a mandatory reporter). However, interview/case ratio data is nonetheless an important indicator or 'flag' for managers to prompt them, where particular teams have lower than average ratios, to inquire further into the reasons why interviews have not been conducted.

We analysed the 2015-2016 interview data for each individual team to assess whether the results at any particular location may have accounted for the slight downward trend in that year. Unfortunately, while the state-wide counting rules for this measure have remained consistent, in 2015-2016 the CAS changed its processes for reporting on interviews conducted at the individual team level. In order to better reflect the workload impact of conducting interviews, the CAS introduced a new reporting process which included all interviews conducted – irrespective of whether they were with an alleged victim, witness, or the person of interest. While this type of broader reporting about interviews is valuable, the reporting was not broken down by child victim interviews. As a result, we were unable to calculate the proportion of victim interviews per cases allocated in 2015-2016 for each CAS team.

In looking at the data from the previous year (2014-2015), our analysis of victim interview and allocated case data shows that the proportion of victim interviews per case was 80% or more for 14 of the 22 teams. The ratio for the remaining eight teams ranged from 58% to 75%, with 70% being the median. While still indicating some variation between teams, this represents a significant improvement – both in terms of the overall interview/case ratio and the consistency between teams – when compared to data we previously reviewed in 2011.

267 The data is based on authorised positions and is not adjusted for part-time workers and/or periods of leave without pay or extended leave. A small number of positions, considered as 'over-strength – not to be deactivated' have been incorporated into the totals – these positions have been incorporated into the authorised strength positions during the 2015-2016 financial year. During the 2013-2014 and 2014-2015 financial years, CAS established a number of intelligence positions. A restructure of intelligence resources during the 2015-2016 financial year resulted in the creation of an Operational Intelligence Squad. The intelligence resources remain allocated to CAS; however, the positions are no longer captured under the authorised strength for the squad.

268 Each month, CAS enters the registered numbers of staff attached to authorised positions and provides them to INTRAK to extract a count of all interviews by CAS. As the data extracted from INTRAK is based entirely on the registered numbers of personnel in authorised positions, any interviews registered by secondees to the CAS are not captured. It is likely the total number of interviews is an undercount of the actual number of interviews conducted by police attached to the CAS.

There is value in the CAS reporting data on the total number of child interviews that each team conducts for productivity purposes. However, given the evidentiary importance of victim interviews, it is critical that the CAS is able to differentiate between child victim and other child interviews at a team level. During the course of our inquiry, the Acting CAS Commander agreed that the CAS will resume reporting to its senior management team on child victim interview data at the individual team level in future.

10.5. What BOCSAR data can tell us about Police performance

Data published by the NSW Bureau of Crime Statistics and Research (BOCSAR) provides useful information about Police performance in relation to its response to criminal child abuse but, as we discuss in section 10.5.3, it also has some limitations.

As noted earlier, LACs play an important role in responding to allegations of child abuse that may not meet the JIRT referral criteria but which nonetheless involve a potential criminal offence. For example, in 2016 almost 2,000 referrals were rejected by the JRU but were nonetheless sent to the relevant LAC for a response.[269] There are also additional referrals that are sent by the Helpline directly to LACs (or to other business units within the NSW Police Force, for example, Sex Crimes Squad) as well as matters that may be responded to by LACs or the Sex Crimes Squad but are outside the remit of FACS altogether (for example, historical reports of child abuse where the alleged victim is now an adult, and there are no related risks to other children).

While these matters constitute a significant proportion of all child abuse matters, they nonetheless account for a relatively small proportion of the total work load of LACs. As we discuss further in section 10.12.3, there is currently no mechanism for systematically recording the responses to, and outcomes resulting from, child abuse matters that are investigated by LACs. In this regard, the data published by the BOCSAR is useful in providing a more comprehensive picture of the overall response of the NSW Police Force to child abuse reports, above and beyond those reports investigated by the CAS.

As well as periodically publishing in-depth research on selected criminal justice issues, BOCSAR publishes quarterly and annual reports on trends in crime reported to or detected by police (based on data extracted from COPS) and annual statistics on the characteristics of defendants dealt with by NSW criminal courts.

While BOCSAR does not publish data on all child abuse offences, it does collect information about reports of child sexual abuse.[270] As matters of this type make up the bulk of the workload of the CAS and the child abuse reports that are handled by police more broadly, the data on child sexual abuse is a useful source for assessing results achieved by Police in this crime category.

10.5.1. Criminal Incident data

The crime data that is produced on a quarterly basis by BOCSAR includes reporting of all 'criminal Incidents'[271] disaggregated by various offence types. While data relating to child sex offence Incidents is not published by BOCSAR as part of its regular reporting, the data is considered public and is available on request.

269 Data extracted from JIRTS and provided by FACS on 6 March 2017 indicates that 1,987 matters were referred from the JRU to a LAC in 2016.

270 Criminal data is generally easier to collect in relation to child sexual abuse than physical abuse, as there are a discrete set of offences that cover child sexual abuse. While there are some specific offences in the *Crimes Act 1900* and *Children and Young Persons (Care and Protection) Act 1998* relating to the physical abuse of a child, there are also general offences under the *Crimes Act 1900* that may equally be used in circumstances where the victim is an adult or child. There are offences in the *Crimes Act 1900* relating to the neglect of a child; however, these are not prosecuted in very large numbers, making robust data analysis and reporting difficult.

271 A criminal incident is defined as an activity detected by or reported to police which: involved the same offender(s); involved the same victim(s); occurred at the one location; occurred during one uninterrupted period of time; falls into one offence category; and falls into one incident type (for example, 'actual', 'attempted', 'conspiracy').

The child sex offence incident data covers all reports made to the NSW Police Force, including historical reports of child sex abuse made by adults. BOCSAR calculates the proportion of matters that result in criminal proceedings by extracting COPS data on matters that are 'cleared up' within a certain timeframe, and then extracting COPS data on the number of those matters where criminal proceedings are commenced.[272]

Table 3 contains data for 2011-2015 about the number of child sexual offence Incidents reported to police, together with the 'clear up status' after 180 days and the number of matters where criminal proceedings were commenced.[273]

Table 3: Child sexual offence incidents involving a victim aged 0-15[274]

	Number of sexual offence incidents reported to police involving a victim aged 0-15	Number of incidents that were cleared up within 180 days of reporting	Number of incidents cleared up within 180 days where criminal proceedings were commenced
2011	5,636	1,743	648
2012	5,785	1,694	620
2013	6,260	1,916	911
2014	6,223	1,860	925
2015	6,571	2,304	938

Table 3 shows that there has been an overall increase of 17% in the number of child sex offence Incidents reported to police over the five year period from 2011-2015 – from 5,636 in 2011 to 6,571 in 2015 (with an 8% increase from 2012-2013 alone). The Royal Commission was established in late 2012, and it is likely that the increase is in part due to the resulting greater awareness of reporting obligations, and more individuals coming forward to report abuse.

While the number of reported incidents has increased by 17%, the number of incidents that were cleared up within 180 days where criminal proceedings were commenced has increased by 45% over the same period – indicating that reported child sex offence incidents are proportionally more likely to result in criminal proceedings now than they were in 2011.

There are some limitations to using the proportion of incidents resulting in criminal proceedings as a measure of police performance, primarily because 'incident data' creates a large base from which the relevant rate is calculated. Nonetheless, the upward trend in the number and proportion of matters where criminal proceedings are commenced is positive, and it suggests that the progress made by the CAS in recent years is also broadly reflected in the work of the NSW Police Force as a whole.

10.5.2. Criminal court data

The criminal court statistics produced annually by BOCSAR include data relating to the number of charges finalised (and the proportion proven) within the NSW Higher, Local and Children's Courts during each calendar year, and the number of defendants with a finalised charge (and the proportion with a proven charge).

These statistics are disaggregated by the type of offence category – including reporting on the number of child sexual assault and related offences (Table 4), as well as child pornography offences (Table 5).

As with the criminal Incident data, the data in the following tables (4 and 5) reflect all child sexual abuse cases finalised during the period for all NSW Police Force business units.

272 BOCSAR defines a 'cleared' criminal incident as one which, in the view of police, has been satisfactorily cleared by the commencement of legal proceedings or otherwise. A criminal incident is cleared, other than by commencement of legal proceedings, when under normal circumstances a charge or information would have been laid against at least one person, but, for a variety of reasons, police have been unable to make an arrest, despite knowing the identity of the offender and having sufficient evidence to support a charge (for example, where the offender has died or been committed to a psychiatric institution before a charge is laid).

273 This data does not reflect all incidents that result in criminal proceedings, as it is possible for criminal proceedings to be initiated at a point after 180 days from report, for example, if a victim initially indicates that they do not want to proceed and later changes their mind.

274 NSW Bureau of Crime Statistics and Research, *Progress of sexual offences through the NSW criminal justice system: 2011–2015.*

Table 4: New South Wales Criminal Court Statistics: Charge and Conviction data relating to Child Sex Offences

Child Sex Offences and related offences	Charges			Defendants charged		
	Charges finalised	Charges proven	% proven	Defendants with a finalised charge	Defendants with a proven charge	% proven
2011						
Sexual assault	2,186		40.8	524	304	58.0
Non-assaultive sexual offences	386	285	73.8	131	105	80.2
Total	**2,572**	**1,176**	**45.7**	**631**	**394**	**62.4**
2012						
Sexual assault	2,213	954	43.1	525	315	60.0
Non-assaultive sexual offences	552	364	65.9	189	156	82.5
Total	**2,765**	**1,318**	**47.7**	**683**	**452**	**66.2**
2013						
Sexual assault	2,209	1,150	52.1	567	366	64.6
Non-assaultive sexual offences	583	419	71.9	209	173	82.8
Total	**2,792**	**1,569**	**56.2**	**733**	**510**	**69.6**
2014						
Sexual assault	2,799	1,339	47.8	674	406	60.2
Non-assaultive sexual offences	598	404	67.6	212	173	81.6
Total	**3,397**	**1,743**	**51.3**	**851**	**554**	**65.1**
2015						
Sexual assault	2,992	1,342	44.9	748	425	56.8
Non-assaultive sexual offences	605	407	67.3	219	181	82.6
Total	**3,597**	**1,749**	**48.6**	**931**	**578**	**62.1**

Table notes:

1. Source: NSW Bureau of Crime Statistics and Research, *Criminal Court Statistics 2015* (Table 9 'Charges and defendants charged with domestic violence or child sex offences in finalised court appearances by type of offence'), http://www.bocsar.nsw.gov.au.
2. The statistics relate to defendants who had criminal cases finalised within the Higher, Local and Children's Courts during the reference period 1 January 2011 to 31 December 2015.
3. Data was sourced from the JusticeLink system and maintained by the NSW Bureau of Crime Statistics and Research.
4. Offence data is based on the ABS Australian and New Zealand Standard Offence Classification (ANZSOC), 2011 (Third edition) (cat. no. 1234.0).
5. The 'Sexual Assault' category includes offences in subdivision 031 of the ANZSOC, including sexual assault, aggravated sexual assault, and indecent assault offences.
6. The 'Non-assaultive sexual offences' category includes offences in category 0321 of the ANZSOC, including procure a child for prostitution/pornography; 'grooming' offences including those where a carriage service is used to groom; and force a minor to witness an act of sexual intercourse.
7. A defendant who is charged with both a sexual assault and a non-assaultive sexual offence will be counted once in each sub-category, but will only be counted once in the total row. Accordingly, the sum of the defendants charged with sexual assault and non-assaultive offences does not equal the total of defendants charged.

Table 4 shows that there has been an increase of around 3% in the proportion of charges proven over the five year period – up from 45.7% in 2011 to 48.6% in 2015. During the years 2013 and 2014, the percentage of charges proven peaked at 56.2% and 51.3% respectively. It is worth highlighting that the rate of charges proven for non-assaultive sexual offences (for example, procure a child for prostitution/pornography) and 'grooming' offences have remained relatively high throughout the period – the lowest rate was 65.9% in 2012 and the highest rate was 73.8% in 2011. The higher proven rates reflect that these types of offences may be more likely to involve evidence (for example, telephone and internet communications) beyond that provided by the alleged victim.

While the number of charges proven as a proportion of all charges laid is an important measure, as previously noted in relation to the CAS charge figures, it has limitations given the high variability in the number of charges that may arise from different reports. In this regard, the number of defendants with a finalised charge relating to a child sexual offence is the most comparable measure to the data provided by the CAS about the number of arrests made. Both indicators measure the number of individuals arrested for one or more child sexual offence(s), rather than the overall number of charges laid. Table 4 shows that in 2011, there were 631 defendants with a finalised child sexual offence charge and by 2015 this number had significantly increased by 48% to 931. The biggest jump of 16% occurred between 2013 and 2014. This aligns with both the increase in the number of reported incidents from 2012 to 2013,[275] and the injection of additional CAS resourcing.

BOCSAR compiles a separate report on charges relating to child pornography offences[276] – see Table 5 below.

Table 5: New South Wales Criminal Court Statistics: Charge and Conviction data relating to Child Pornography offences[277]

Child Pornography Offences	Charges			Defendants charged		
	Charges finalised	Charges proven	% proven	Defendants with a finalised charge	Defendants with a proven charge	% proven
2011	323	230	**71.2**	117	94	**80.3**
2012	451	326	**72.3**	168	138	**82.1**
2013	474	341	**71.9**	178	148	**83.1**
2014	520	341	**65.6**	189	154	**81.5**
2015	496	314	**63.3**	192	155	**80.7**

Although child pornography offences are generally investigated by the Sex Crimes Squad's Child Exploitation Internet Unit in collaboration with LACs, they are depicted here to provide a more complete picture of the NSW Police Force's performance in relation to its investigation of child abuse. Table 5 shows that there has been a 54% increase in the overall number of charges laid between 2011 and 2015, peaking at 520 charges in 2014. The table also shows that there has been a marked increase of 64% in the number of individual defendants with a finalised charge – rising from 117 in 2011 to 192 in 2015. The proportion of defendants with a proven child sexual offence charge has remained stable, ranging from 80-83% over the five years.

275 It is not possible to align the criminal incident data and the court data due to the time taken for matters to be finalised in court; however, it would be expected that there would be a lag of around one to two years for trends in reporting to be reflected in court data.

276 'Child Pornography' offences include offences in Category 0322 of the ANZSOC (for example, production, possession, distribution or display of pornographic or abusive material of a child).

277 NSW Bureau of Crime Statistics and Research, *Criminal Court Statistics 2015* (Table 2 'Charges and defendants charged in finalised court appearances by type of offence'), http://www.bocsar.nsw.gov.au/Pages/bocsar_court_stats/bocsar_court_stats.aspx.

10.5.3. Difficulties in aligning the BOCSAR data with related police data

As we outlined in our 2012 report, the available BOCSAR data is very useful in terms of providing broad indicative information about the volume of child sexual abuse reports to police, and the outcome of those reports. However, because it is not possible to track matters from report through to finalisation, it is limited in terms of its ability to inform a detailed analysis of police performance.

A recent report on the impact of delayed reporting on the outcomes of child sexual abuse cases commissioned by the Royal Commission summarised the limitations of the BOCSAR data:

> *Both the police and court data … are administrative datasets, and are not designed with research as their focus. For example, the primary purpose of the NSW Police Computerised Operational Policing System (COPS), as explained by the Australian Bureau of Statistics (ABS), is to record 'all police activities by NSW Police'; a 'secondary purpose' is to provide extracted data for BOCSAR and the ABS to produce crime statistics for New South Wales …*
>
> *Ideally it would be possible to track matters from reporting to police, through the investigation and prosecution process to court, and finalisation at court via conviction and sentencing. However, the nature of these administrative databases means it is not possible to map the police data directly onto the court data for several reasons, even where there is a common linking case number. In New South Wales, the link between police records and ODPP records is through the 'H number' but this link is lost if, as frequently happens, the charges, as eventually taken to trial or the subject of a guilty plea, are different from those laid by the police.*[278]

In seeking to utilise BOCSAR data to monitor the criminal justice outcomes for individual children reported to the JIRT program, a number of issues arise, including:

- The way that 'incidents' are defined means that the 'number of incidents' is likely to be much higher than the 'number of Helpline reports', 'JRU referrals', or 'individual CAS cases'. If a child discloses multiple incident types or offence categories, each will be considered a separate incident (for example, if a child discloses being indecently assaulted by someone who then attempts to sexually assault them, this will be counted as two incidents). Similarly, if a child discloses having been abused on multiple different occasions, each occasion will be counted as a separate Incident. If, in a matter involving two incidents, police lay charges in relation to one of those Incidents (that is, an arrest is made in connection with a matter), what would generally be considered a good outcome from a policing perspective would appear in the criminal Incident data as a '50% success rate' against the 'rate of Incidents leading to the commencement of proceedings' measure. The greater number of Incidents without corresponding charges, the lower the overall rate will be for 'commencement of proceedings' for any given year.
- The mandatory reporting system in NSW is broad,[279] and is the primary funnel through which criminal allegations of child abuse are reported. The system captures reports made by a vast array of government agencies and NGOs, as well members of the public, about individual children, or a class of children at risk of significant harm, which may not always have an identifiable person of interest, and/or where the victim may be unwilling to proceed or unable to provide sufficient evidence to support a charge. Most of these reports will be referred to the NSW Police Force – either via the JRU, or directly via the Helpline or a CSC where the JIRT threshold has not been met. This contributes to the overall volume of Incidents reported, that is, Incidents are not only recorded on the COPS system when a victim and/or their parent come forward directly to police but also when third parties make reports. Unlike other crime categories such as robbery, where victims are almost always the reporter and want to participate in a criminal proceedings, this is frequently not the case for child sexual abuse matters, which means that police often have to investigate matters that are unlikely to succeed from the outset. However, these less 'viable' criminal matters

278 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016, pp.48-49.

279 The *Children and Young Person (Care and Protection) Act 1998* sets out the current mandatory reporting framework and its broad range of reporting obligations. See section 27.

are included in the 'denominator' used to calculate the rate of criminal proceedings commenced. As different jurisdictions have different mandatory reporting thresholds, it is difficult to compare the number of Incidents and their outcome in NSW against those in other states and territories.

- The crime and court datasets are Incident and defendant-focused respectively, with neither being victim-focused – arguably the most important prism through which to view data about outcomes. Ideally, it would be possible to report on the number of children and young people who are reported to be victims of criminal child abuse in a given period; and an arrest rate and conviction rate as a proportion of those victims.
- The crime and court statistics are separate datasets and cannot be aligned. In addition to the fact that they do not correlate with one another (as one is based on Incidents and the other on charges and defendants), it is not otherwise possible to compare the datasets due to the time taken for matters to progress through the criminal justice system – an Incident that is reported in 2015 may be finalised in the same year, or it may not be finalised for 12 or more months.
- As noted previously, the available data reflects child sexual abuse only, excluding other allegations of criminal child abuse.
- It is not possible to differentiate between matters handled by the CAS and matters handled by other NSW Police Force business units – therefore the data cannot be solely relied on to measure aspects of CAS performance (or the performance of other specific business units such as LACs) in relation to charges and corresponding convictions.

Perhaps the most important consequence of the inability to track JIRT referrals and other criminal child abuse matters from 'end-to-end' is that it is very difficult to analyse reasons for attrition; in particular, how those reasons might differ depending on the circumstances of a victim, whether related to their individual characteristics (for example, placement in OOHC and/or Aboriginality) or the characteristics of the alleged abuse (for example, intra-familial or peer related).

The method we used to capture data on Aboriginal child sexual abuse victims during our three year audit between 2009-2012 is illustrated in the following case study, which highlights how an analysis of child sexual abuse matters from report through to completion can provide valuable insights into the reasons for attrition from the criminal justice system.

Case study 3 – Review of Aboriginal child sexual abuse victim cases

To inform our audit of Aboriginal child sexual assault, we identified a sample of cases for detailed review, drawing from Police data relating to 248 Aboriginal children who had been the subject of a reported Incident of child sexual abuse in 12 'target' communities[280] between 2006-2011 (the five year period of the Interagency Plan).

We interrogated the NSW Police Force COPS database to identify whether charges had been laid in relation to the reported Incidents, and the outcomes of those charges. Of the 248 Aboriginal children who had been the subject of a reported Incident of child sexual abuse, 38 cases resulted in a person being charged with at least one child sex offence. In one of these cases, the defendant was still awaiting trial at the time of our review; we reviewed the remaining 37 finalised cases involving a defendant charged with at least one child sex offence. Of the 37 finalised cases,[281] 11 were withdrawn prior to hearing or trial (30%). A conviction occurred in 23 of the remaining cases (62%). However, one third of these convictions were not in relation to sex offences, but were related to the same occasion.[282]

280 The 12 target communities for the purposes of our audit were the nine focus communities identified by Aboriginal Affairs through its Focus Communities program, as well as three additional communities that we selected to ensure our observations took geographic differences into account and positive initiatives being driven by communities in relation to child sexual assault.
281 We selected 27 of these 37 cases to review in closer detail.
282 The charges for which convictions were obtained included common assault; stalk and intimidate; recklessly wound; maliciously wound with intent to inflict grievous bodily harm; various firearms offences; and aggravated break, enter, and commit serious indictable offence.

When reviewing these 37 cases, we collected qualitative data relating to the reasons for attrition during the prosecution stage. The main reasons that we identified were:

- victims considered to be incapable of giving the required evidence in court
- victims not wanting to participate in the court process
- plea negotiations being reached which resulted in defendants entering a plea deal to other offences relating to the same Incident but which were not sex offences, and
- insufficient investigation by police, or notable errors or omissions in police investigations.

In cases where victims decided not to proceed, our case reviews and consultations highlighted a number of factors which impacted on victims' decisions. These included pressure from community or family members; parents' concerns about the impact of continuing on their child's wellbeing; fear or embarrassment; and not having an appropriately supportive living environment or other external supports available.

There are clearly a range of reasons why matters might be withdrawn during the prosecution stage. Similarly, there are many reasons why a matter that is reported to police may not result in an arrest. In the context of sexual abuse reports, the most common reasons for reports not proceeding to arrest are that:

- an alleged victim decides that they do not want to participate in a police interview; and/or they or their parents decide after an interview that they do not want to proceed[283]
- there is insufficient evidence to support a prosecution, and/or
- the alleged victim does not make a disclosure when interviewed, or is not able to sufficiently particularise the offence.

Other, less common reasons include a suspect not being identified; no offence being identified; or a child being too young or otherwise not considered credible.[284]

In matters involving reports of harmful sexual behaviour or sexual abuse by young people, there are additional factors that may reduce the likelihood of charges being laid – for example, the presumption of *doli incapax,* a proof that needs to be met before charges are laid which must be rebutted beyond reasonable doubt.[285] Research commissioned by the Royal Commission has also confirmed that reports relating to alleged sibling sexual abuse infrequently proceed to court.[286] In many such matters, a family may decide that it is not in the best interests of either child to proceed criminally.

Therefore, even if reliable victim-focused arrest and conviction rates were available, for this data to be meaningful and to properly inform policy and service responses, it would need to be supplemented with information about the reasons why matters that are reported to police do not proceed to charge, or do not result in a successful prosecution.

As we noted in our 2012 report, the collection of reliable qualitative information of this type is likely to require both a data collection solution, and an interrogation of individual case files. For example, while the shared JIRTS database or the COPS system could be enhanced to facilitate the accurate reporting on the proportion of attrition which is the result of a child deciding that they do not want to go to court, an interrogation of individual case files (such as the review we completed) allows for an

283 This includes matters which come to police attention via a mandatory report to the Helpline, but where the young person had no intention of reporting it to police and does not wish further action to be taken, for example in relation to adolescent peer sex reports.

284 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016.

285 Section 5 of the *Children (Criminal Proceedings) Act 1987* provides a conclusive presumption that no child under ten years of age can be guilty of an offence, while the common law provides for a presumption, rebuttable by the prosecution, that a child aged under 14 years of age is unable to understand that his or her actions are seriously wrong (known as *doli incapax*).

286 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016.

assessment as to the reasons why a child might make that decision. While the qualitative nature of this type of data may make it difficult to be the subject of detailed public reporting, it has the potential to be of significant value from a performance monitoring and service design perspective.

In our 2012 report, we recommended that the NSW Department of Justice, together with the Office of the Director of Public Prosecutions (ODPP) and NSW Police Force, identify the data required to adequately report on attrition of child sexual abuse cases. We also recommended that the JIRT partner agencies and the ODPP conduct periodic audits of a sample of child sexual abuse cases in order to identify and report on the reasons for attrition. We understand that, while these recommendations were supported by the relevant agencies, they have not been substantially progressed – due, in part, to a lack of available resources (particularly in the ODPP) to support their implementation.

We continue to hold the view that, while it may never offer a complete solution, there is significant scope at a systems level to improve the capacity for reliable and useful data collection relating to child sexual abuse matters – and that this is an area that requires investment at a whole-of-government level. Having said that, the work that has been done by the CAS to improve its processes for data collection and internal reporting demonstrates that, with some further enhancements, this type of reporting could be at least achieved within the CAS context (as we discuss below).

10.6. Scope for further improvements to CAS data collection and reporting

The efforts made by the CAS to implement, on an ongoing basis, the Quarterly statistical workload analysis report; and related annual team development review process, and to continue improving the efficiency and integrity of its reporting processes, are to be commended. The NSW Police Force processes for monitoring and reporting on its performance as part of the JIRT program are currently the most comprehensive of the three JIRT agencies.

Having said this, we believe that the CAS is now in a position to build on these processes to further enhance its reporting capabilities and – at least from the perspective of its own performance – to provide a clearer picture of arrest and conviction data as well as qualitative information about the reasons for attrition. This is particularly important given that the public reporting of child sexual abuse data does not, in our view, showcase the results being achieved by the CAS with respect to the individuals arrested in connection with each child victim accepted into the JIRT program.

As well as being valuable to the JIRT agencies more generally, evidence of this type will be essential to the evaluation of the witness intermediary program (see Chapter 18) given the role of intermediaries in supporting children and young people to give their best evidence.[287]

10.6.1. Arrest and conviction rates

As we have outlined, there is currently capacity to report on the number of referrals that are accepted for a JIRT response and the number of arrests made by the CAS. While a comparison of these figures provides an indication of the proportion of accepted JIRT referrals that result in an arrest, it does not translate to an exact 'arrest rate'. For example, if a referral is made alleging that one individual has abused multiple children, a referral report may be created for each child. However, from a CAS perspective, these matters may be merged into one 'Case' and, if the individual is arrested, this will only be recorded as one arrest – even if they are charged with offences against multiple children.

Estimating the proportion of JIRT referrals that result in a conviction is more difficult again. In supplying us with performance data, the Acting CAS Commander advised us that 'anecdotally, there is a conviction rate in excess of 80% for those offenders charged with one or more child abuse offences by the CAS'. However, the court data is not captured in a way that allows this estimate to be confirmed, or linked back to individual children accepted into the JIRT program.

287 A process evaluation is currently underway.

While there is capacity within COPS to record information about court outcomes, our own interrogation of the COPS system in reviewing individual cases during our 2012 audit identified that this information is not always accurate, and in matters which involve multiple victims, it is not always possible to determine to which victim the charges and subsequent court outcomes relate.

Whether it is achieved through the shared JIRTS database, enhancements to the use of the COPS system, or otherwise, we believe that the current CAS data collection processes could be relatively easily enhanced to allow for reliable reporting (at both a state-wide and individual team level) on a set of high level outcomes,[288] including the number of children accepted into the JIRT program where an arrest was made in connection with their matter and, of the involved defendants, how many were convicted of a child sexual offence. Ideally, this CAS arrest and conviction data could also be broken down by particular cohorts of victims (for example, Aboriginal children and children with disability) and types of matters (for example, juvenile defendants or sibling sexual abuse).

10.6.2. Information about the reasons for attrition

There are a number of reasons why matters investigated by the CAS may not result in an arrest and a successful prosecution. Systematically collecting this data would – if analysed together with information about certain characteristics of a matter (for example, whether a matter involves allegations against a sibling or another young person) – provide the JIRT agencies with valuable insights for the purposes of monitoring performance and identifying scope for practice improvement.

Currently, there is no capacity for reliable qualitative reporting of this type. While there is capacity via the JIRTS database to record information about how and why individual matters are 'completed' (including those that do not result in an arrest),[289] these data fields are not regularly filled in and allow only for recording reasons for matters not proceeding to charge – they do not capture any attrition that occurs at a later stage.

As with arrest and conviction rate data, we believe the CAS should develop a mechanism to enable the collection and internal reporting of information – at a state-wide and local CAS team level – about the reasons for attrition. This data needs to be victim-focused, and should include breakdowns against relevant contextual factors and characteristics such as the age of victims, the relationship between the offender and alleged perpetrator, and whether the victim has any particular vulnerability.

In relation to matters that proceed to arrest but not conviction, an assessment of the reasons for matters being withdrawn or acquitted will need to be informed by the professional judgement of the relevant ODPP solicitor. We understand that the ODPP currently provides certain information to police about failed prosecutions, as such, there would appear to be some scope to enhance and standardise the provision of high level feedback from the ODPP to police about the reasons for child sexual abuse matters not proceeding. If such a process is established, there would be merit in the CAS, together with the other JIRT agencies and the ODPP, revisiting the recommendation made in our 2012 report about conducting periodic joint audits of a sample of child sexual abuse cases.

As we discuss in the following chapters, if FACS and Health were to similarly improve their JIRT data collection processes, it would be possible to track the related child protection, health and criminal justice outcomes for each child accepted into the JIRT program. This would enable the agencies (independently and together) to conduct further targeted qualitative analysis, with the aim of informing improvements to service delivery, in areas where the data indicates particular trends.

288 Police and the other JIRT agencies separately record and store more finely grained information about individual children on their own data systems. We are not prosing that sensitive and detailed policing (or other agency) data about individual cases be stored into the shared JIRT database. Our recommendation is aimed at developing an efficient system for extracting agreed outcomes which reflect the tri-agency response to children who enter the JIRT program.

289 Reasons for completion might include: victim unwilling to give statement; no complaint from child; parents desired no action; and victim unwilling to go to court.

10.6.3. Better integration of the CAS within the COMPASS operational review process

As we discuss later in this chapter, performance for the NSW Police Force as a whole is primarily monitored through the use of a comprehensive results management framework and an intranet based corporate performance management system known as 'COMPASS'.

However, we understand that, in relation to the CAS, its corporate reporting occurs via the State Crime Command and is mostly limited to financial and human resource issues. The State Crime Command reports to COMPASS as a collective, focusing on key trends and related strategies to address them. The significantly increased arrests rates by the CAS following the injection of additional resources were a focus of a 'themed' COMPASS forum several years ago. However, the ongoing results achieved by the CAS over recent years have not been the subject of examination through COMPASS.

In our view, the COMPASS process should be utilised not only to promote best practice and share ideas between LACs, but also, where relevant, between specialist squads and LACs. With respect to maintaining the strong performance of the CAS into the future, we consider it important for some of the key measures the CAS has been tracking since 2012 to be reported through the corporate results management framework. In section 10.12, we also discuss the need for LACs to report against the same measures to give 'line of sight' at the executive level over criminal child abuse reports that is consistent with the treatment of other serious crime categories.

10.7. Managing staff welfare and wellbeing

At the time of our 2012 audit, the CAS acknowledged that the emotionally confronting nature of their work has an impact on officer welfare and wellbeing, and in turn, its ability to attract and retain high quality officers. The impact of vicarious trauma on staff is a concern for all of the JIRT agencies.

A literature review commissioned by the Royal Commission found that specialist policing units often experience a high turnover of staff due to the demands of a high volume workload and the high emotional toll of working solely on child abuse cases, which can result in burn-out and secondary trauma. The review cites the 2002 evaluation of the JIRT, which found that just over half of all police and child protection JIRT staff surveyed did not feel they were receiving the emotional support they needed to cope with their role.[290]

As we discuss earlier in this report, working in close proximity with staff from other agencies that have very different cultures can also exacerbate tension and make for a work environment that is, at times, experienced negatively.

Since 2012, the CAS has made considerable progress in addressing staff welfare concerns. In 2014, the State Crime Command implemented the 'CAS Welfare Framework' in recognition of the need to establish and maintain systems which identify and minimise work-related risks to the psychological health of employees.[291] The framework is multi-dimensional and includes a tailored recruitment and selection process, a structured induction process for all new CAS employees, and an early intervention and prevention program.

The recruitment and selection process requires that, in addition to evaluating the suitability of applicants based on core operational capabilities, applicants must undergo:

- initial screening to assess their potential suitability before a transfer is submitted to the CAS
- an interview by a panel which includes a psychologist, who is actively involved in tailoring questions to test the psychological suitability of applicants

290 Nina Westera, Elli Darwinkel and Martine Powell, *A systematic review of the efficacy of specialist police investigative units in responding to child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, March 2016, p.32.
291 NSW Police Force, *Child Abuse Squad Welfare Framework,* 2014.

- a State Crime Command risk assessment process
- background screening, and
- psychometric testing.

The wellbeing of officers once they join the CAS is monitored through the 'WellCheck' program.[292] The program, which is conducted by NSW Police Force psychologists, involves the use of assessment tools and a clinical interview aimed at the early identification of staff who have potential psychological trauma and/or staff who may benefit from additional counselling or support.

All officers attached to the CAS complete a WellCheck on a quarterly basis, and interim checks can be scheduled more regularly if deemed appropriate by the psychologist. CAS Zone Managers are required to provide the psychologist with information to inform the WellCheck process. Where relevant, self-care plans are developed and reports are provided back to the CAS.

The WellCheck process is supplemented by a range of other strategies, including:

- referrals to experienced psychologists, including external providers available through the NSW Police Force Employee Assistance Program
- referrals to the NSW Police Force peer support program
- ensuring that the CAS performance review process incorporates discussion about officers' general welfare, and
- staff training in resilience initiatives.

To complement the Welfare Framework, a NSW Police Force Rotation and Secondment Policy was developed to support the CAS in 2014. This followed agreement in late 2013 that LACs would provide replacements for CAS officers undergoing mandatory rotations.[293] The aim of the policy is to provide officers with a break from the CAS environment, and support them in furthering their career development.

The policy requires CAS officers to undertake a mandatory rotation after they have completed three years of active duty in the CAS and, if applicable, after subsequent three year periods. The CAS Commander may also determine that a CAS officer should be rotated out of the CAS sooner where required.

The period of mandatory rotation is a minimum of three months, but can be extended up to six months to meet the needs of the officer and the command. Suitably qualified 'replacement officers' are generally sourced from the CAS team's neighbouring LAC, with all LACs required to make every effort to provide a suitably qualified officer of similar rank and criminal investigative experience. This organisation-wide commitment is critical to the effective implementation of the Rotation and Secondment policy.

For LAC officers, part of the attraction of the policy is that a CAS placement may assist them to become eligible to undertake the 'Potential Detectives Recruitment Examination'. A secondment to the CAS can also assist officers to complete their pre-eligibility requirements and then be considered for their 'A-list placement' as part of completing the Criminal Investigation Recruitment Procedures. While the CAS prefers secondees to have completed the Investigator's Course, it will consider all expressions of interest.

The Welfare Framework and Rotation and Secondment Policy are both impressive initiatives and have been acknowledged as such by senior Health and FACS JIRT management. Police responses to the JIRT workforce survey also indicate that these initiatives have positively impacted on the wellbeing of CAS officers, with several commenting favourably on the culture within CAS.

However, around one in six CAS officers said their workload was too high and expressed concern about the impact on their capacity to respond to jobs thoroughly. Others noted the much higher ratio of cases held by CAS officers compared to other specialist squads, and raised concerns about staff 'burn-out'.

292 WellCheck is also used by other high risk specialist units within the NSW Police Force.
293 NSW Police Force, Deputy Commissioner, Field Operations, *Directive to all region commanders: CAS Mandatory Rotation Policy*, 24 February 2014.

Apart from these comments about high workload, CAS respondents did not raise any issues concerning welfare and wellbeing (apart from those relating to tensions in the relationship with JIRT partners, which are discussed in Chapter 25). By contrast, there were a number of comments by FACS and Health staff who responded to the survey about the need for their agencies to better manage staff welfare and wellbeing. Several of these respondents referred to the Police WellCheck program and Rotation and Secondment Policy and suggested these initiatives could be adapted for FACS and Health staff.

The NSW Police Force leadership team, and the CAS Commander in particular, should be commended for their efforts in relation to improving the management of staff work health and safety. As we discuss in the following chapter, there is merit in Police sharing their experience of implementing relevant initiatives with FACS and Health to assist these agencies to strengthen their own staff welfare and wellbeing programs.

10.8. Training and guidance for CAS staff

Given the specialist nature of the work of the CAS, it is critical that its officers are well trained and supported.

Most officers who join the CAS are already designated detectives – meaning that they have generally completed:

- at least five years service
- the Investigators Course, which is aimed at developing and enhancing basic criminal investigation skills and knowledge in general duties and plain clothes police, and
- the Detectives Education Program (DEP) – a program which provides specialist investigative training to police engaged in criminal investigation duties (including completion of the Advanced Diploma in Police Investigation)[294] to ensure they meet the standard required for designation as a detective.[295]

A one day workshop, 'Interviews by LAC Police', is now included in the DEP so that most staff have at least an introductory level of training in child interviews before joining the CAS. Upon joining the CAS, officers are then required to complete the JIRT Foundation Skills Program (discussed in Chapter 24) which includes a five day police-only Child Interviewing Course – run by the NSW Police Force Detectives Training Unit – focused solely on conducting a recorded criminal interview of a child. CAS officers are taught various techniques to assist them to communicate effectively with children while also complying with rules of evidence.

The Child Interviewing Course covers best practice techniques in areas such as building a rapport with children and young people, how to avoid leading questions and consolidating information through the use of tools such as body charts. It also promotes compliance with the NSW statutory child protection standards and various legal standards. Within three months of completing the course, officers must satisfactorily complete a workplace assessment in order to receive accreditation.

Once this training component is complete, CAS officers receive ongoing 'on the job' coaching and mentoring, for example, by working under the direct supervision of trained and experienced Team Leaders who monitor their interviews and other investigative work, and receiving direct feedback from the ODPP about the quality of their interviews and briefs of evidence.

From June this year, the CAS commenced implementing a mandatory annual review for all CAS staff, which will include a quality review of a sample of child interviews to ensure that interviews reflect best practice. The training and support provided to CAS staff in relation to conducting child interviews, and the scope for improvements in this area, is discussed further in Chapter 22.

294 Since 2016, it has been compulsory (as part of the DEP), for officers to complete the Child Interviewing Course.
295 Under some circumstances an officer may be accepted into the CAS prior to completion of the Detectives Education Program, on the expectation that they will complete the course as soon as practicable following recruitment.

In our view, there is scope for the NSW Police Force to consider the benefits of establishing a permanent education and training position within the CAS, staffed by an officer with solid operational experience, to provide regular, specialist 'refresher training' to CAS police. A position of this type would also be well-placed to provide support in developing the skills of Local Area Commands (we discuss the significant role played by LACs in responding to child abuse in section 10.10). As well, the position could have a key role in developing and implementing the training strategy for external stakeholders to the JIRT program that we have suggested in Chapter 24.

In addition to the direct support provided by their Team Leader, CAS officers also receive further instruction through directives issued by the CAS Commander and CAS Senior Management Team. Directives are used to reinforce procedures, provide updated advice on legislation/case law and changes to operational practice, and promote best practice.

Recent directives have covered best practice techniques in gathering admissible evidence from vulnerable victims and what to do if a child discloses abuse outside the context of a police interview. Advice was recently forwarded to all CAS officers about a recent High Court judgement, given its relevance to best practice in gathering evidence to rebut *doli incapax* in matters involving the charging of children aged 10-14 years.[296]

We cover the issue of police directives further, in the context of discussing strengthening the overall governance of the JIRT program, in Chapter 25.

10.9. Reviewing the structure and functions of the Child Abuse Squad

During our inquiry, we examined the different structures put in place by police forces around the country and overseas to respond to child abuse and child sexual exploitation, and compared these arrangements with the NSW Police Force model.

In addition to reviewing the available research and survey responses from CAS officers, we also requested that the CAS provide us with information about its operational structure, including its links with other 'companion' squads such as the Sex Crimes Squad, and data relating to human resource issues.

The CAS is one of 14 specialist squads which make up the NSW Police Force's State Crime Command (SCC). The SCC is headed by an Assistant Commissioner, who reports to a Deputy Commissioner, and is divided into four Directorates: Serious Crime, Organised Crime, Intelligence Coordination, and Business Services.

Six of the 14 squads – the CAS and Sex Crimes; Fraud and Cybercrime; Homicide; Property; and Robbery Squads – are located within the SCC's Serious Crime Directorate. Each of the six squads is headed by a Squad Commander (at the rank of Detective Superintendent) who in turn reports to a Director (at the rank of Detective Chief Superintendent).

The SCC has almost 1,000 authorised sworn officers – 533 of whom are located in the Serious Crime Directorate. With almost 200 officers, the CAS is now the largest of the NSW Police Force specialist squads, comprising 20% of the SCC's overall authorised strength.

The CAS has grown rapidly over recent years, and unlike other specialised squads in the SCC, it also has a large regional footprint – with offices stretching from Ballina and Inverell in the north, to Bourke and Broken Hill in the west, and Albury and Narooma in the south – which makes it a particularly challenging command to oversee. The Commander is required to remotely direct the activities of almost 200 officers across 23 sites throughout the state in addition to those of the CART and the Police arm of the tri-agency JRU.

296 *RP v The Queen* [2016] HCA 53.

In addition, the CAS faces other unique challenges, including:

- having to execute its core criminal investigative responsibilities in collaboration with two human service agencies, each of which have their own distinct cultures and responsibilities under the JIRT program
- managing 45% of all current maternity leave across the State Crime Command[297]
- ensuring no less than 25 staff, including one Detective Inspector, are rostered on-call and available to be recalled to duty at any given time
- managing a higher than average rate of part-time work agreements, and
- administering a complex rotation policy, which requires its nearly 200 staff to undertake a rotation of not less than three months, every three years (impacting up to 16 officers or approximately 8% of its authorised sworn strength), to ensure that the ongoing welfare of staff in light of the nature of the squad's work.

The CAS is also called upon regularly to deliver advice, guidance and training to partner agencies and other stakeholders operating in the child-related employment sphere. As discussed earlier, it plays a significant role in supporting both the reportable conduct and Working with Children Check schemes and, over the last four years, informing the work of the Royal Commission into Institutional Responses to Child Sexual Abuse.

We are of the view that, in recognition of the unique state-wide coverage of the CAS, and the significant suite of responsibilities that the CAS Commander is required to manage, it is timely for the NSW Police Force to consider the senior chain of command under which the CAS operates – and whether it is sufficient to support the Commander and the squad more broadly. In this regard, we note that FACS recently created a second FACS JIRT Director – with one Director now focusing on strategy and policy and the other on 'operations in the field' – in recognition of the need to share its JIRT leadership responsibilities among more than one individual.

As part of any review of the CAS operating structure, there would also appear to be merit in the NSW Police Force considering whether there should be a much closer alignment of the child abuse related functions currently sitting within the Sex Crimes Squad – which include the Child Exploitation Internet Unit (CEIU), the Child Protection Registry (CPR) and the Extended Supervision Order Investigation Team – with the responsibilities of the CAS given the obvious linkages.[298] For example, the same child sex offenders investigated by the CAS, if convicted, end up on the Child Protection Register with their activities monitored by the CPR centrally and by LACs in the field, and additional scrutiny provided (in relation to their internet usage) by the CEIU.

We understand that the original rationale for housing these units outside of the CAS was in part due to the already significant size of the CAS and the need to achieve a degree of balance in relation to staffing levels and caseloads across the Directorates within the SCC. It is unclear to what extent the right balance has been struck, but given the CAS is now responsible for 37% of staffing across all six squads in the Serious Crime Directorate and manages a complex caseload, it would appear timely to give consideration to whether a realignment has the capacity to deliver economies of scale and a closer integration of functions.

In addition, we note that separating the CPR and CEIU functions is inconsistent with approaches taken in certain other jurisdictions in Australia and the United Kingdom.

297 As at 13 March 2017, maternity leave impacted a further 16 officers or approximately another 8% of its authorised sworn strength, and accounted for 80% of all staff absent from the Serious Crime Directorate.

298 The Sex Crimes Squad also includes the Sex Crimes Teams, Royal Commission Referral Team, Intelligence Unit and Surveillance Unit.

Case study 4 – London Metropolitan Police Service

There are five main areas within the London Metropolitan Police Service that deal specifically with child abuse, all of which sit within the Sexual Offences, Exploitation and Child Abuse Command led by a Detective Chief Superintendent:

There are **18 child abuse investigation teams (CAITs)** covering all 32 London boroughs. The CAITs investigate allegations of intra-familial abuse (including when allegations are made about carers) involzzving all children under 18 years of age. Unlike the CAS, CAITs also investigate allegations of historical child abuse where the alleged victim is now an adult. Together, the CAITs employ of four Detective Chief Inspectors, 18 Detective Inspectors, 82 Sergeants and 299 Constables.

The **Serious and Complex Case Team (SCCT)** provides support to CAITs and investigates complex cases. It also takes on cases that are beyond the capacity of the regional areas. In addition, the SCCT investigates allegations of sexual assault where the investigation is older than five years ('cold cases'). The team is led by a Detective Inspector, and includes three Detective Sergeants and 24 Detective Constables working in a four-team structure.

The Proactive Taskforce is primarily responsible for risk managing, prioritising and locating the top 15 most 'high risk' and 'hard to find' suspects wanted for serious sexual assaults. The Taskforce also seeks to locate and arrest suspects in matters where limited intelligence exists. The team is managed by one Detective Chief Inspector, with one Detective Inspector, two Detective Sergeants and 12 Detective Constables.

The Paedophile Unit specialises in combating the activities of those who manufacture and distribute child pornography. Like the NSW Police Force Child Exploitation Internet Unit, they proactively target child abuse on the internet by targeting the activities of paedophiles.

The Sexual Exploitation Team (SET) is responsible for all child sexual exploitation investigations.

As is the case with the London Metropolitan Police, the CAS and the Sex Crimes Squad also report to a Director (at the rank of Detective Chief Superintendent). While in theory, housing the CAS and the Sex Crimes Squad in the same directorate should facilitate collaborative work in relation to child abuse related functions, in reality, effective joint strategic planning and operational tasking across two separate squads is challenging, and might be more easily achieved if the child-abuse related functions currently sitting within the Sex Crimes Squad were transferred to the CAS, along with the attendant resources. It could also provide more flexibility with respect to resourcing and allow officers from different child protection related business units to tap into each other's specialist expertise. While this issue is ultimately an operational matter for the NSW Police Force Executive, bringing all major crime investigations relating to child abuse under the one umbrella would appear to have a number of benefits.

In addition, there would also appear to be scope to capitalise on the combined expertise of the CAS (in light of their experience investigating abuse and working with intermediaries), by expanding its remit to include a specialist team of investigators tasked with providing investigative advice and assistance to LACs in conducting interviews with adults with cognitive impairment or other communication difficulties (including older people).

As we discuss in Chapter 18, in light of the disadvantage experienced by people with communication support or other complex support needs in accessing the criminal justice system,[299] we have been advocating for the extension of the intermediary scheme to include certain vulnerable adults with cognitive impairment or other communication difficulties. Again, the United Kingdom provides good

299 See, for example, the Australian Human Rights Commission's 2014 report '*Equal before the law: Towards disability justice strategies*', which found that people with disabilities who need communication supports or who have complex and multiple support needs are at increased risk in all Australian jurisdictions of being disrespected and disbelieved, and of not enjoying equality before the law – whether in the context of being the victim of a crime, accused of a crime, or a witness.

practice models in this area – as well as having an intermediary scheme that extends to vulnerable adults, the various territorial police forces have 'Public Protection Units' (PPUs) in most boroughs, which are responsible for leading the local police response to child abuse, domestic abuse and the protection of vulnerable adults. The London Metropolitan Police Service is also currently piloting 'Protecting Vulnerable People' units in three locations, which combine investigations for child abuse, rape and domestic abuse, and the safeguarding of vulnerable adults, into one team.

In our consultations with disability advocates for this inquiry, it was consistently stressed that it is critical to ensure that any centralisation of responsibility within the NSW Police Force for responding to adults with cognitive and/or communication impairment does not result in the 'quarantining' of good practice in this area. In this regard, we believe that there would be merit in considering whether the CAS should also have responsibility for providing training as well as investigative/interviewing support to LACs to help improve the response that is provided to vulnerable adults with cognitive impairment or other communication difficulties who are the subject of abuse. Irrespective of whether the intermediary scheme is expanded to include certain vulnerable adults, we believe a specialist team of this type is an important consideration.

Finally, in light of the general community view that all forms of abuse against children and vulnerable adults is abhorrent, and the public's legitimate expectation that the NSW Police Force should provide the best response possible, we believe it timely for the Police to consider whether there would be benefit in realigning the CAS's reporting structure within the State Crime Command, and extending the squad's specialist role to assisting LACs in responding to certain vulnerable adults.

10.10. The role of Local Area Commands in investigating child abuse

The majority of JIRT referrals that are rejected by the JRU are not regarded as criminal allegations and are therefore not referred to a LAC for a response. Where a referral does not constitute an alleged criminal offence, but raises concerns about ongoing risk to children or young people, the JRU will refer the matter to the relevant Community Services Centre (CSC) for action.

Where the matter is determined to require a police response but is rejected for a JIRT response, the JRU forwards it to the relevant LAC.

A significant proportion of the approximately 9,000 referrals sent to the JRU each year are referred on to LACs – in 2015, 35% of all JIRT rejected matters were referred by the JRU to a LAC,[300] with the proportion rising in 2016 to 47%, or around 2,000 matters.

In addition to matters referred by the JRU, LACs also receive reports assessed by the Helpline as not meeting the JIRT referral criteria, but which nonetheless contain an allegation or evidence of criminal conduct. CSCs will also refer matters to LACs in circumstances where there is no apparent criminal offence at the time of a Helpline report, but where a subsequent child protection assessment by the CSC reveals alleged criminal conduct. LACs also handle a large number of historical child sexual assault reports made by adults – this volume has increased significantly since the establishment of the Royal Commission.

While it is currently difficult to determine the total number of child abuse matters handled by the 76 LACs across the state, the available data indicates that, in recent years, LACs combined have managed anywhere from 1,500 to upwards of 3,000 child abuse reports each year.

What is clear is that LACs are increasingly playing a significant role in handling allegations of criminal child abuse. As part of assessing the performance of the NSW Police Force in the context of the JIRT program, we considered that it was also important to examine the role of LACs – in particular, where their responsibilities intersect with those of the CAS. In the sections below, we also make general observations aimed at strengthening the role of LACs in handling child abuse matters outside of the JIRT program.

300 JIRTS data provided by FACS, 6 March 2017.

10.10.1. Physical abuse

Handling allegations of physical abuse is 'bread and butter' work for LACs – a significant proportion of their work involves responding to domestic and family violence. To meet the JIRT referral criteria, the physical abuse of a child or young person must involve a 'severe or serious' physical injury/injuries that are caused by another person aged ten years or over, and suspicious and/or deliberate and/or inconsistent with the explanations provided.

Given this threshold, many physical abuse matters which come to police attention will fall outside of the JIRT program. It is essential that these matters nonetheless receive an appropriate police response. Some matters which do not initially meet the threshold may, on further investigation, do so. Like other types of child abuse, physical abuse may also be cumulative and/or escalate in severity. In this regard, an appropriate police response to all reports is vital in helping to establish a pattern of behaviour.

10.10.2. Adolescent peer sex

As discussed in Chapter 9, legislation in some Australian jurisdictions allows, as a defence for engaging in sexual activity with a person under the age of consent, that the two participants were of a 'similar age'.[301] There is no such legal defence available in NSW, with adolescent peer sex (APS) being managed through the operation of discretion on the part of both police and prosecutors.

In August 2014, the then Deputy Commissioner, Field Operations, endorsed a decision recommending transfer of responsibility for investigating APS matters from the CAS to LACs.

Currently, where the JRU receives a report concerning sexual activity between adolescents under the age of 16 years, it will conduct further inquiries to determine whether there is evidence of a complaint and/or any relevant child protection/criminal history that warrants a tri-agency JIRT response. Matters which are not accepted for a JIRT response will be referred to the relevant LAC for a local response. JIRTS data indicates that, in 2016, as many as 1,000 matters were referred to the JRU and subsequently forwarded to LACs. As discussed earlier, the volume of these reports has increased exponentially in recent years.

In our chapter on law reform, we once again recommend that the current legislation in NSW in relation to introducing a 'similar age' defence warrants review. If this recommendation is accepted, it will reduce the time that LACs are spending investigating APS reports where there is no evidence of coercion or other risk factors, and will allow them to redirect their resources towards matters more worthy of police attention.

10.10.3. Matters involving young people aged 16-18 years

Consistent with *NSW Police Force Policy and Standard Operating Procedures – Investigation and Management of Sexual Assault Victims 16-18 years*, reports alleging sexual abuse of a young person aged between 16 and 18 years are rejected by the JRU in circumstances where the alleged victim is reported to have been abused by a peer, stranger or acquaintance *and* there is no reported ongoing risk of harm from the alleged offender.[302] Where the JRU assesses a report as requiring a police response, it is referred to the relevant LAC for a response. In 2016, reports of this type accounted for 446 of the referrals made to the JRU (5% of all referrals).

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301 In the ACT, the child must be aged ten years or more, with no more than a two year age difference (*Crimes Act 1900* (ACT) s.55). In Victoria, the child must be aged 12 years or more, with no more than a two year age difference (*Crimes Act 1958* (Vic) s.45). In Tasmania, if the child is aged 15 years or more, there must be no more than a five year age difference; if the child is aged between 12 and 15, there must be no more than a three year age difference (*Criminal Code Act 1924* (Tas) Schedule 1 s.124). Legislation in Western Australia also allows a three year similar age defence for offences against children aged over 13; however, the accused must also prove that they believed on reasonable grounds that the child was of or over the age of 16 (*Criminal Code Act Compilation Act 1913* (WA) s.321). South Australia legislation (where the age of consent is 17 years) includes a similar age defence; however, it applies only where the accused is aged under 17 years and the other party is aged 16 years or more (*Criminal Law Consolidation Act 1935* (SA) s.49). Queensland and the Northern Territory do not have a similar age defence; however, they allow as a defence, where the child is above 12 years in Queensland and 14 in the NT, that the accused person believed, on reasonable grounds, that the child was of or above the age of 16 years (*Criminal Code 1899* (Qld) s.215; *Criminal Code Act 1983* (NT) s.127).

302 The current SOPS specify that, when the young person is at further risk of ongoing harm and/or the alleged offender is a family member, close adult friend, neighbour or person in authority (for example, school teacher, football coach, scout master), the matter will be handled by the JIRT program.

The policy position is based on the fact that specialised 'child interviewing training' is not required in order for LAC officers to interview young people aged over 16, and because they commonly interact with, and are required to interview, young people as part of their general policing work.

10.10.4. Delivering the NSW Police Force 'first response'

As discussed in section 8.3, LACs play a critical early role in investigating and taking appropriate action in response to criminal allegations of child abuse that are reported directly to local police (for example, by an alleged victim presenting at a local police station or where a call is made to the station or '000'). Their responsibilities include, but are not limited to, making a child at risk report to the Helpline if a child is identified as being at risk of significant harm (consistent with mandatory reporting obligations).[303] This reporting process is separate to the responsibility to record the reported crime on the COPS system.

Although the Helpline and the JRU (or, outside of business hours, the FACS Crisis Response Team in consultation with the on-call CAS Inspector) assess high priority matters quickly to ensure that the agencies are able to promptly respond, there can still be a delays from the time a report is first made to a LAC, until it is accepted for a JIRT response. For this reason, the reporting LAC is responsible for the initial police investigation until it has been accepted by the CAS (as well as the ongoing investigation of any matters that are not JIRT accepted).[304]

In these circumstances, the LAC's role includes ensuring victim welfare, crime scene management, canvassing possible witnesses, and interviewing adult witnesses and suspects in custody. (These responsibilities may be executed in collaboration with the CAS or alone depending on the particular circumstances.)[305]A LAC may also be responsible for removing a child or young person if they believe that the child or young person is at immediate risk of serious harm and for liaising as appropriate with FACS.[306]

LACs are not responsible for conducting the recorded criminal interview with the alleged child victim, or for otherwise obtaining a statement from the alleged victim – as this should be undertaken by investigators who are trained in interviewing children to ensure that the evidence is admissible in accordance with the *Criminal Procedure Act 1986* and the *Evidence Act 1995.* However, it is important for the attending police to obtain brief details of the alleged crime (so as not to contaminate the evidence later obtained during a formal recorded interview), to allow them to conduct an informed inspection of the home or other relevant locations, and provide relevant information to FACS for its home visit and safety assessment.

The CAS may also request assistance from a LAC in responding to a JIRT referral (irrespective of whether or not it was first reported to the LAC) in circumstances where the LAC is better placed to facilitate an urgent response – while CAS teams are located across the state, their geographic coverage is not as extensive as that of LACs in rural areas, and in some cases, the LAC will be able to respond more quickly than the CAS.

It is important to note that while the NSW Police Force requires LACs to support the 'first response' to criminal child abuse allegations, this early involvement on its own, should not be used by the JRU as the basis for determining that a matters should be rejected for a JIRT response due to 'prior LAC involvement'. As the CAS noted in their consultations with us, LACs 'should not be punished' by allocating them extra cases simply because they have acted quickly in meeting their first response obligations. As we discussed in section 8.5.2, the increased rate of JIRT rejected matters on the basis of prior LAC involvement warrants closer consideration.

303 Ordinarily, police fulfil their mandatory reporting responsibilities by creating a 'Child at Risk' report on the COPS system, which will automatically be referred to the Helpline. If a child or young person is at 'imminent risk of significant harm', police are also required to contact the Helpline – the police have access to a separate phone number for this purpose with a view to ensuring that these calls are answered immediately.

304 LACs are encouraged to contact the local CAS office, or the on-call CAS Inspector outside of the CAS' general business hours (7am to 5pm, Monday to Friday). Under some circumstances, the CAS may decide to take carriage of a matter immediately, prior to the JRU referral process being completed.

305 NSW Police Force intranet, CAS (JIRT) 'Response and Referral Process', accessed 1 February 2017; NSW Police Force, *Directive to all LAC personnel from Commander CAS*: *After Hours On Call Response by the Child Abuse Squad*, 11 March 2015.

306 Section 43 of the *Children and Young Persons (Care and Protection) Act 1998* provides that a police officer may remove a child or young person from a place of risk if they are satisfied, on reasonable grounds, that the child or young person is at immediate risk of serious harm; and that the making of an apprehended violence order would not be sufficient to protect them from that risk.

10.10.5. Matters where there has been 'Prior LAC' involvement

In certain circumstances, the JRU may assess a matter as meeting the JIRT criteria, but determine that a LAC is better placed to continue handling the report due to the nature of its prior involvement. These matters (known as 'Prior LAC' matters) are rejected for a JIRT response, and are referred to the relevant LAC and CSC. As discussed above, 'prior LAC involvement' rejection determinations should involve more than the LAC meeting its first response obligations.

In 2016, 452 matters (5% of all reports assessed by the JRU in that year) were referred to LACs in these circumstances – a 2% increase on the 209 reports assessed as 'Prior LAC' matters during the previous year.

In Chapter 21, we discuss the importance of Police, FACS, and Health working together effectively to respond to all reports of child abuse – irrespective of whether they are accepted for a JIRT response or not. This is particularly important for 'Prior LAC' matters, as they involve reports that are assessed by the JRU as otherwise meeting the JIRT referral criteria (and therefore as warranting a joint approach).

10.10.6. Matters referred directly by the Helpline

In circumstances where a report concerns a child or young person at risk of significant harm and relates to a criminal allegation, mandatory reporting bodies and members of the public are encouraged to report to both the Helpline and the Police. However, in the interests of ensuring that relevant criminal allegations are notified to Police outside of the JIRT partnership, FACS staff will also make a report to Police if it becomes aware of a possible criminal offence.

This may occur when a report is first made to the Helpline, if it assesses that a matter does not meet the JIRT referral criteria but nonetheless raises concerns of a criminal nature. It may also occur if a CSC subsequently identifies a possible criminal offence(s) in the course of conducting an assessment or other casework.

The volume of matters that FACS refers to LACs outside of the JRU process is not known. FACS advised us during the inquiry that it does not currently capture this data; however, it is intended that the new ChildStory database will enable this to be systematically monitored.

10.10.7. Historical allegations of child abuse

The Sex Crimes Squad directly manages historical child sexual assault matters where they are likely to be protracted or particularly complex; however, in most instances, historical reports are handled by LACs.

There has been a notable increase in the number of historical child sexual abuse Incidents reported to Police since the start of the Royal Commission. Research on the impact of delayed reporting on the prosecution of child sexual assault matters has found that the level of reporting of child sexual assault Incidents where the alleged victim was an adult at the time of the report 'remained relatively constant from 2000 to 2012 but increased by 55% between 2012 to 2014 (474 to 733). This coincides with the announcement of the Royal Commission. The number of reports of indecent assault declined from 2002 to 2007, but has almost tripled from 2007 to 2014 (130 to 363)'.[307]

The research also indicates that there was a similar (albeit more pronounced) increase in reports of this type in 1996-1997 and during the Wood Royal Commission into the NSW Police Service and that this spike continued for two years after that Commission ended.

307 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016, p.69.

10.11. Proactive policing of child sexual exploitation

There is no doubt that there are significant benefits in reports of criminal child abuse receiving an integrated response through the centralised JIRT program. From a policing perspective, there are clear benefits in these matters being handled by a specialist unit or identified staff with experience in working with children and their families as well as in working collaboratively with FACS and Health, and related support services.

Equally, however, there are matters where a local 'joined up' response, building on both the ability of LACs to form connections with high risk young people in their local area and the subject matter expertise of the CAS, is preferable. In this regard, we believe there is considerable scope for the NSW Police Force to consider the way in which LACs, in partnership with the CAS, can play an enhanced role in delivering proactive policing strategies targeted towards the sexual exploitation of children and young people – particularly those in out-of-home care (OOHC).

As we discuss in Part 5, children and young people in OOHC, and particularly those who are in residential care, are at heightened risk of child sexual abuse and sexual exploitation. In recognition of this, and in acknowledging the need to combine proactive interventions with high quality responses when reports of abuse are received, a number of other jurisdictions have implemented specific multi-agency responses to this cohort of high risk young people.

Case study 5 – Interagency responses to child sexual exploitation (Victoria Police)

During our inquiry, we met with representatives of Victoria Police to discuss their work with the Victorian Department of Health and Human Services (DHHS) to implement the 'Enhanced Response Model' pilot for children and young people in OOHC who are at risk of, or have been subject to, sexual exploitation.[308]

In recent years, the issue of sexual exploitation of children and young people in care has received significant attention in Victoria.[309] In response, the Victorian Government developed a framework in July 2015 – *Victoria's approach to protecting children: safe from abuse and exploitation wherever they are* – which has four priorities:

1. an enhanced and consolidated approach to child sexual exploitation
2. the development and implementation of a sexual exploitation education plan
3. the introduction of mandatory residential care staff qualifications, and
4. enhanced information and data analysis.

The Enhanced Response Model, which is being piloted by Victoria Police and the DHHS in five locations, is one of the key developments under the framework. As part of the model, the agencies have run a number of joint operations across the state targeting sexual exploitation of young people in care. They have also jointly conducted training with internal agency staff, as well as with OOHC providers.

The approach recognises that victims of child sexual exploitation are often disengaged from their families and communities, and are likely to have significant contact with police, the DHHS and other service providers. It also acknowledges that without a joined up approach, services to this very vulnerable cohort will be fragmented and unlikely to be effective.

While integrated case management and information sharing between agencies is not new in NSW, what stands out about the Victorian approach is the nature of the joint operations, and the lead role police are playing in relation to identifying and targeting suspects as well as young people in

308 DHHS defines sexual exploitation for the purpose of the pilot as 'children and young people under 18 being involved in exploitative situations, context and relationships where the young person (or third person or persons) receive "something" (for example, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities', http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/children,-youth-and-family-services/improving-responses-to-child-sexual-exploitation.

309 It has been referred to in the Victorian Parliamentary Inquiry into the Handling of Child Abuse by Religious and Other Organisations; the Royal Commission into Institutional Child Sexual Abuse; and in the 'As a good parent would' report into children in out-of-home care released by the Commission of Children and Young People in 2015.

residential or foster care who may be at risk of sexual exploitation, and providing the latter with joint casework and police support.

A key aspect of the policing approach involves using intelligence to inform suspect targeting, and adopting a variety of techniques to disrupt the suspect's activities and relationships. The work of police in this area is the subject of formal tasking, coordination and reporting – similar to the NSW Police Force's Suspect Targeting Management Program.

The pilot has two project managers, one each from the Victoria Police Family Violence Command and the DHHS, who meet monthly to coordinate joint activities and develop strategies. There is also a local area panel, which includes relevant senior police and DHHS staff, who meet monthly to exchange information about young people identified at risk and plan joint activities – including disruption strategies, collaborative investigation and child safety/protection planning.

Within Victoria Police, the model operates through the Sexual Offences and Child Abuse Investigation Teams (SOCIT), with SOCIT managers having responsibility for collecting and analysing intelligence holdings ahead of the monthly meetings, coordinating disruption strategies, and ensuring that each young person has an alert on the police database noting that they are subject to an enhanced response through the pilot.

A SOCIT officer is responsible for proactively building a relationship with the child (and their carer) and encouraging them to report any offences against them. Importantly, if the young person is being investigated for offences by another police unit, the SOCIT officer will also consult with that unit to help them understand the young person's vulnerability. The SOCIT officer also attends any DHHS care planning meetings for the young person.

The pilot commenced in early July 2016 and will be subject to an evaluation prior to a decision being made about state-wide rollout in 2017.

Case study 6 – London's Child Sexual Exploitation Operating Protocol

We also spoke to the Acting CAS Commander about a similar model operating in London – the Child Sexual Exploitation Operating Protocol – which he examined during a research trip in 2016 conducted in response to the Royal Commission highlighting the particular risks to children and young people in OOHC of sexual exploitation.

Implemented by the London Metropolitan Police in 2014, the Child Sexual Exploitation Operating Protocol involves regular meetings in each borough between local police, officers from the Child Sexual Exploitation team, police missing persons coordinators, child protection, health, education and youth offending authorities, and relevant non-government organisations. The meetings provide an opportunity for sharing and discussing intelligence, determining local profiles for child sexual exploitation, and agreeing on operational activities to tackle child sexual exploitation within the borough and across boundaries.

The type of activities that have been implemented under the protocol include the identification and investigation of potential offenders, the delivery of training to schools, and identifying exploitation 'hotspots' such as hostels and local food outlets. The Protocol also includes 'Operation Makesafe', which involves proactive work by police with businesses where child sexual exploitation may have historically taken place. Staff are provided with training about child sexual exploitation and have access to a dedicated police hotline that they can contact if they identify a potential victim or offender.

In relation to the Protocol's application to NSW, the A/Commander CAS concluded that a coordinated and local response is required when seeking to tackle child sexual exploitation. He emphasised the importance of having a thorough knowledge of OOHC residential facilities, staff and clients in order to be able to identify and address risks to vulnerable young people. In this regard, the A/Commander emphasised that the reactive nature and geographic spread of the CAS means that LACs, particularly those which house residential OOHC facilities within their boundaries, are generally better placed to develop the necessary local networks, cultivate intelligence and take part in 'disruption activities' with suspects.

We understand that the Director of FACS' five Intensive Support Services[310] has already initiated some good work with local police to target children and young people who are at risk of sexual exploitation. More recently, FACs has indicated that it is also in the process of establishing a 'virtual team' of specialist caseworkers located across FACS Districts and other business units, including the JIRT and the Intensive Support Services and coordinated by the Cross Cluster Operations and Business Support Directorate. The specialist caseworkers will provide a holistic assessment for children and young people in residential care where a ROSH report is received and the risk of harm is 'associated with the residential OOHC placement' (for example, an allegation against a staff member or another resident). This is a positive development which recognises the special vulnerability of children in residential OOHC.

In addition, given the need for wraparound responses to be provided to this particularly vulnerable cohort of children and young people, there would also be merit in the JIRT agencies together with agencies such as Education, Juvenile Justice and peak OOHC bodies/large providers, developing a state-wide framework or model for more effectively addressing child sexual exploitation informed by the Victorian and United Kingdom models outlined above.

There is already a strong precedent for this type of collaborative operational work by Police, FACS and the OOHC sector. As discussed in Chapter 16, under the leadership of Deputy Commissioner Jeff Loy as the NSW Police Force Corporate Sponsor for Youth, excellent progress has been made by local police in strengthening connections with residential care facilities in their area with the aim of reducing the contact of young people in care with the criminal justice system – this interagency work has been driven by a state-wide implementation committee chaired by FACs and ACWA.[311]

10.12. Enhancing the quality of the response by Local Area Commands

During our inquiry, the CAS issued a survey to all LAC Crime Managers to assess their knowledge of the role of the JIRT program, and their responsibilities in investigating child abuse allegations. Just under half of all LACs (47%) participated in the survey, and the responses were jointly analysed by the A/Commander CAS and the Assistant Ombudsman (Strategic Projects).

The surveys were a valuable tool for identifying gaps in JIRT systems/processes which need to be addressed, including processes for notifying LACs of assessment outcomes by the JRU and the Helpline and the need to clarify the role of LACs, particularly as 'first responders', in key documents such as the *JRU Process Guidelines* and the *NSW Police Force Operations Manual*.

The surveys also provided useful insights into the type of additional training, guidance and resources that LACs would benefit from accessing – these are discussed in the following sections.

10.12.1. Training for LACS on handling child abuse matters

Training in relation to investigating child abuse matters is currently provided to LAC staff through a number of avenues.

As noted earlier, the Detectives Education Program (DEP) includes a one day workshop – Interviews with children by LAC Police. While this workshop, targeted at police officers who deal with children who may be victims of crime and/or are witnesses to incidents, has only been included in the DEP program since 2016, it has been available as a separate workshop since 2003.[312] The course has been completed by 3,846 currently serving police officers. In 2016, it was delivered through separate workshops to 170 officers (from both LACs and specialist commands) as part of the DEP and a further 236 LAC officers.[313]

310 FACS' Intensive Support Services (ISS) provide case management for children and young people who have complex care and support needs. There are five ISS – three are based in the Greater Sydney area, one in the Hunter, and one in Wollongong.

311 In 2015, we brokered a 'joint protocol' between the NSW Police Force, FACS, the Association of Children's Welfare Agencies and the Aboriginal Child, Family and Community Care State Secretariat aimed at reducing the contact of young people in residential care with the criminal justice system. LACs have played a lead role in implementing the protocol at a local level, resulting in a number of positive outcomes in terms of the response to individual children, as well as the establishment of strong working relationships between local police and residential care services.

312 NSW Police Force, Education and Training intranet site, last updated 29 March 2016.

313 Advice provided by the NSW Police Force, February 2017.

The CAS also supports the participation of LAC staff in the JIRT Foundational Skills Program – including the week long child interviewing course. Currently, 12 of the approximately 48 positions on the course available each year are allocated to LAC investigators. The primary purpose of this is to ensure that there are sufficient numbers of suitably trained LAC staff available to fill CAS secondments as required. However, there are obvious benefits for LACs in having staff who are trained in child interviewing (and who have gained direct experience through secondments within the CAS) when responding to child abuse matters referred to LACs.

All sworn officers also receive mandatory training twice a year on particular aspects of police work. In 2010-2011, one of the mandatory training slots was used to provide child protection training which covered indicators and dynamics of child abuse, offender behaviours, child protection legislation and the initial police response to child abuse, including appropriate questioning techniques. The Acting CAS Commander recently advised us that he has been liaising with the Police Education and Training Unit with a view to obtaining approval for one of the two mandatory training slots in 2017-2018 to be used for delivering training to all sworn officers on responding to child abuse (including historical child abuse). The Acting Commander has also secured the Royal Commission's support to provide input into this training if approved.

LACs also receive training on responding to reports of historical child sexual abuse through the Investigation and Management of Adult Sexual Assault Course, which is delivered to around 100 investigators each year. The training is focused on developing awareness that victim care is paramount. It includes a presentation by a survivor of child sexual abuse who experienced a poor initial response when he presented to a LAC as an adult. The survivor tells his story to provide a victim's perspective of child sexual abuse and the difficulties that adult survivors face in reporting to police and in preparing for trial. A truncated version of the Adult Sexual Assault Course content, including content relating to victim care, is also covered in the Investigators Course.[314]

While the efforts by Police to provide victim-focused training are positive, the current courses do not cover all LAC officers who could be called upon at any point to provide an initial response to adults or children who report abuse to police. We therefore support the CAS' efforts to deliver a compulsory training session, covering the key principles of providing an appropriate initial response to victims who report child abuse, and the respective responsibilities of LACs, CAS and the Sex Crimes Squad, to all sworn officers.

On a separate but related note, after our participation in the Royal Commission's 2015 Criminal Justice Roundtable into Reporting Offences, we identified the need to improve the quality and consistency of information given to adult victims of alleged child sexual abuse – and other forms of serious abuse – about what will happen if they make a report to police.

Since the Roundtable, we have been working with key agencies to develop a 'guarantee of service'. The guarantee of service is aimed at providing victims and their supporters with information about how police will respond to reports of historical child sexual abuse, as well as a commitment to victims that they will be treated with courtesy, compassion, cultural sensitivity and respect. We prepared a draft guarantee of service and provided it to the NSW Police Force for its consideration last year. In preparing the document, we sought feedback from Health given their important role in working with victims and their families.

As well as being an important resource for Police, the document will assist other agencies that receive disclosures of historical child sexual abuse (such as religious bodies and educational institutions) to encourage victims to make a report to police. It will also help agencies, in circumstances where a victim has indicated that they do not want to pursue criminal action, to explain why the agency is obliged to report the disclosure to police, while giving certain assurances about the approach police will take if a victim does not want to be part of a police investigation.

We understand the Royal Commission has sought advice from the NSW Police Force about whether it intends to implement a guarantee of service of the type we have prepared.

314 Transcript of evidence provided by Detective Sergeant Matt Davey, NSW Police Force, Royal Commission into Institutional Responses to Child Sexual Abuse, Public Hearing – *Case Study 38* (Day 179), 24 March 2016.

10.12.2. Resources for LACs

In addition to the various training courses available, LACs can also access some information about responding to child abuse matters on the NSW Police Force intranet. The CAS intranet page provides clear and user-friendly information to assist LACs to understand their responsibilities, if a child abuse matter is reported directly to them, and to navigate the JIRT referral and response process. By accessing this resource, an officer with little knowledge of the JIRT process could acquire a basic understanding of the CAS, the process for referring matters to the Helpline, and the process for logging a request for CAS assistance.

During our inquiry, we were pleased to note that the CAS took steps to improve the information available on its intranet page, including by adding updated advice about the handling of adolescent peer sex matters and uploading a number of recently issued directives.

Having reviewed the available guidance on the CAS intranet page, we consider that there would also be benefit in creating a child abuse 'home page' on the broader NSW Police Force intranet which could include all relevant policies and procedures, as well as direct links to the CAS and Sex Crimes Squad pages. This would make it easier for frontline officers to quickly access all of the information that might be relevant to their handling of a matter. A similar approach is used for the external website of the NSW Police Force, which groups subject matter by key issues in a way that is both easy to navigate and informative.

The CAS also issues periodic reminders to LACs about how they should respond to reports in particular circumstances, for example, where a report is received outside of business hours.[315]

The LAC survey responses revealed a high level of general awareness about responding to initial reports of serious child abuse (that is, both their mandatory reporting obligations and requirement to record and respond to criminal allegations of child abuse); however, there were a number of LACs that were unaware of their responsibilities during the period before the JRU/Helpline assessment is completed. In this regard, a number of Crime Managers raised concerns in the LAC survey about the negative impact on victims arising from delays in matters being assessed and referred to the CAS (or back to the LAC) when a child or family attend a police station to report abuse. While these concerns are legitimate, the responses from some Crime Managers also indicated a lack of understanding about what steps the LAC can take to provide an immediate response in these circumstances. Responses to the JIRT workforce survey also indicate that some CAS staff are concerned that matters are not always being immediately acted on by LACs in circumstances where some response is required.

The CAS intranet page makes clear that, if a report is made directly to a LAC:

> *The investigation remains the responsibility of the Local Area Command up until the time it has been accepted by the Child Abuse Squad. The Local Area Command still continues to have obligations in ensuring appropriate resources are supplied to assist with victim welfare, crime scene management, canvassing, interviewing of adult witnesses and other investigative requirements during the on call response.*

However, it appears that there is an ongoing need for the CAS to ensure that certain LACs have a better understanding of their 'first response' obligations during the period prior to the JRU's assessment decision about a report. Any initial efforts to increase awareness should, in our view, be targeted towards those LACs which answered the relevant survey question poorly.

The survey responses also revealed that a number of LACs were unfamiliar with their role in handling adolescent peer sex matters and sexual assault matters involving 16-18 year olds. In light of the large volume of these matters – in 2016, 1,455 such reports were rejected by the JRU and forwarded to LACs for a response, accounting for 73% of all matters referred to LACs by the JRU – the CAS has acknowledged the importance of continuing to provide more comprehensive guidance to LACs about how to fulfil their obligations in practice.

315 A memo reminding LACs of their obligations in this area was issued by the A/Commander CAS in January 2017.

While there are specific Police policies covering the handling of adolescent peer sex matters and matters involving 16-18 year olds, there is no comprehensive document that covers the arrangements that relate to all matters where the role of LACs and the CAS intersect. Pleasingly, the CAS advised us during the inquiry that it intends to detail LAC responsibilities in the *NSW Police Force Operations Manual*, which is currently being updated.

10.12.3. Monitoring the performance of LACs in handling child abuse investigations

Currently, while the JIRTS database records information about the volume and type of reports that are referred by the JRU to LACs, it does not capture any information about the response that those referrals receive once referred to the LAC, or the resulting outcome. Furthermore, although the Police COPS database captures outcomes against individual Events/Cases, there is no systematic way to analyse the outcomes of all child abuse matters referred to Police broken down by those matters handled by LACs and the CAS.

Our analysis of JIRTS data from mid 2014 to the end of 2016 indicates that there is a high degree of variance in the volume of matters referred from the JRU to individual LACs. A total of 1,987 matters were referred by the JRU to LACs during the period – an apparent average of 48 matters per LAC. However, there were four LACs which each received more than 100 referrals, and another six LACs each received between 90 and 100 referrals. One LAC received 75 referrals in 2016 alone. Overall, we found that 28% of all matters referred by the JRU to LACs during the relevant period were handled by just 13% of LACs.

Given the usefulness of this analysis, we sought advice from the CAS about whether the data is periodically reviewed, either by the CAS and/or individual LACs or regions. We were advised that to-date, the LAC referral data has not been routinely provided to the NSW Police Force via the regular JIRTS agency report. The CAS agreed that there would benefit in this occurring to enable them to analyse trends and target certain LACs for developmental opportunities (for example, places in CAS-led training courses, if available). More broadly however, the analysis highlights the value in the NSW Police Force having a better understanding of the outcomes from child abuse matters handled by LACs.

As discussed earlier, the benefits of the enhanced accountability processes implemented by the CAS in recent years have been significant. Through our first hand experience of previously reviewing the performance of LACs in key policing areas (for example, work with young people, victims of domestic violence and Aboriginal communities), we know that having strong accountability and governance systems in place for specific areas of policing is crucial to lifting performance and raising awareness.

We believe that there is scope to enhance the existing reporting and accountability processes used by LACs in order to better capture information about the volume and outcomes of child abuse matters they handle. This data capture and reporting is also an important way for LACs to showcase their related work which, in many respects, is obscured by the current absence of performance monitoring and reporting in this area. It also allows the CAS to identify which LACs would benefit from undertaking the Interviewing Children by LAC Police Course.

Current reporting and accountability processes for Local Area Commands

As part of a comprehensive NSW Police Force results management framework (which governs the overall consistency of direction, accountability and performance across the organisation) each LAC is required to develop a business plan outlining how it will contribute to corporate priorities, and deliver responsive and effective policing services. These business plans identify community and stakeholder issues specific to the LAC and how they will be addressed; the plans include measurable targets that align with the priorities of the NSW Police Force as a whole.[316]

316 The overall NSW Police Force priorities are documented in the *NSW Police Force Corporate Plan 2016-2018*. The plan is organised around six key performance areas – crime, public safety, community and partners, our people, our systems and leadership.

Business plans are published in 'COMPASS' – an intranet-based corporate performance management system. LACS are required to report, to a set schedule, against particular indicators of performance, together with LAC-specific priorities, business plan strategies and risks. COMPASS also includes an assessment module that is used to formally review LAC performance each year.

In addition to the use of the assessment module, the Commissioner's Executive Team conducts periodic 'COMPASS forums', which involve reviewing performance in an area common to all or some commands. The purpose of the forums is to identify good practice and, where appropriate, consider how procedures might be improved.

Region commanders are also able to regularly review the information uploaded onto COMPASS by their LACs; as are the Corporate Spokespeople for particular areas, such as domestic and family violence, Aboriginal issues and youth.

During our inquiry, we reviewed the key indicators for three of the performance areas that are currently monitored via COMPASS – crime, public safety, and community and partners. The crime indicators include a number of categories covering sexual assault:

- sexual assault
- sexual assault (child, reported as a child)
- sexual assault (child, reported as an adult)
- sexual assault (adult), and
- indecent assault (not disaggregated by child/adult).

With the exception of 'sexual assault (adult)' each of the above categories is included in COMPASS for 'information purposes' only – meaning they are not included in the reporting schedule or considered as part of the assessment module. We understand that the original rationale for not including the child sexual assault categories in the reporting schedule was that the CAS handles the majority of these reports.

We understand that, more recently, LACs have been asked to report, through COMPASS, on their activities associated with managing individuals on the Child Protection Register (including monitoring the compliance of registrants). This is a positive development.

Scope for additional reporting on child abuse matters

In our view, there is value in the NSW Police Force being able to readily discern how many child abuse matters are handled by individual LACs, and the corresponding legal actions. While a majority of child abuse matters are handled by the CAS (and the matters handled by the CAS tend to be at the higher end of seriousness given that they are filtered by the JIRT referral criteria), there has been a significant spike in the number of historical matters being handled by LACs since the commencement of the Royal Commission – and a steady increase in the number of child abuse matters being handled by LACs. It is not clear whether the volume of child abuse matters now being handled by LACs has been the subject of detailed consideration in recent times.

For these reasons, there would be merit in LACs reporting on the number of referrals they receive from the JRU and the Helpline for a local response, as well as the number of child abuse matters they otherwise receive – with separate reporting of historical child sexual abuse reports made by adults. Reporting this type of data through COMPASS (rather than it only being collected for 'information purposes only') would enable child abuse reports and related trends in legal actions to be consistently captured and monitored. In our view, requiring reporting on the relevant sexual assault indicators (and disaggregating the 'indecent assault' category to distinguish between reports about children and historical reports involving children who are now adults) would significantly reinforce the importance of LACs responding effectively to child sexual abuse, including historical child abuse.

As LACs already do to positive effect in the domestic violence, youth and Aboriginal community domains, they could use the COMPASS process to report on their proactive strategies to target known or suspected predatory behaviour by individuals within their communities, such as the sexual exploitation of young people in local residential care placements. (Many LACS already effectively utilise COMPASS in this way to report on their activities targeting high-risk suspects in other crime areas, for example, domestic violence.) In this regard, we note that a significant proportion of residential care services are concentrated in certain metropolitan areas and parts of the Central Coast; in these locations, proactive work with partner agencies should already be a focus.

Our suggestions are consistent with the recognition given by the *NSW Police Force Corporate Plan* to the importance of improving criminal justice and interagency responses to vulnerable people as well as the plan's separate commitment to reduce serious crime.

Against the background of this inquiry and the release of the Royal Commission's final report, it would also appear timely for the NSW Police Force to give consideration to holding a 'COMPASS forum' focusing on the response to child abuse (by both the CAS and LACs). The last COMPASS forum on this theme was in September 2013 – however, we understand that on that occasion, the focus was on the work of the CAS to significantly improve its performance and related accountability and governance processes following our 2012 report (rather than the broader response by the NSW Police Force to child abuse).

Recommendations

14. The NSW Police Force should consider options for enhancing the data collection processes for the Child Abuse Squad to enable reliable reporting on:

- **a) the number (and proportion) of children accepted into the JIRT program where an arrest is made in connection with the JIRT report, and**
- **b) the number (and proportion) of matters involving arrests that result in a conviction.**

15. The NSW Police Force should collect the data detailed in recommendation 14 in such a way that it can be disaggregated by:

- **a) individual Child Abuse Squad teams, and**
- **b) particular cohorts of victims and types of matters (for example, matters involving juvenile defendants; allegations of abuse in an institutional context; and matters involving sibling sexual abuse).**

16. The NSW Police should, having regard to the observations in section 10.5 and 10.6 of this report, determine which criminal justice outcomes for children and young people referred to the JIRT program will be included in the overall JIRT performance monitoring framework and recorded in the shared JIRT database.

17. The NSW Police Force should implement COMPASS reporting on key performance measures already being collected by the Child Abuse Squad (and any future enhanced measures).

18. The NSW Police Force should work with FACS and the out-of-home care (OOHC) sector to consider options for developing and implementing an interagency model (informed by the Victorian and UK approaches discussed in section 10.11) for responding to the sexual exploitation of children and young people in residential OOHC.

19. The NSW Police Force should enhance the COMPASS reporting requirements of Local Area Commands in relation to the number of child sexual abuse matters they receive and investigate each year, and the related legal actions.

20. The NSW Police Force should consider the benefits of establishing a permanent training position within the CAS, staffed by an officer with solid operational experience, to provide regular, specialist 'refresher training' to CAS police; support the skill development of Local Area Commands; and inform the development and implementation of a JIRT program training strategy for external stakeholders.

PRACTICE SUGGESTIONS

- The NSW Police Force should consult with the Office of the Director of Public Prosecutions (ODPP) about whether there is scope to enhance and standardise the provision of high level feedback from the ODPP to police about the reasons for child sexual abuse matters not proceeding at court.
- The NSW Police Force should consider, together with the other JIRT agencies and the ODPP, revisiting recommendation 45 of the Ombudsman's 2012 report, *Responding to child sexual abuse in Aboriginal communities*, about conducting periodic audits of a sample of child sexual abuse cases.
- The NSW Police Force should consider reviewing the existing functions and reporting structures for the Child Abuse Squad and Sex Crimes Squad, having regard to our observations in section 10.9.
- The NSW Police Force should consider how specialised investigators from the State Crime Command (particularly the Child Abuse Squad given its experience working with witness intermediaries) could be utilised by Local Area Commands to obtain expert advice and assistance in responding to allegations of abuse against vulnerable adults with cognitive impairment or communication support needs (including older people).
- The NSW Police Force should consolidate and enhance the information and support provided to Local Area Commands in relation to responding to child abuse matters, including by:
  - Creating a child abuse 'home page' on its intranet which could include all relevant child abuse policies and procedures, as well as direct links to the CAS and Sex Crimes Squad intranet sites.
  - Documenting in the *NSW Police Force Operations Manual* the responsibilities of LACs in:
    - providing the 'first response' to child abuse matters during the period before the Helpline/JRU assessment
    - responding to referrals of child abuse matters from the Helpline or the JRU (where they have been rejected for a JIRT response)
    - investigating adolescent peer sex matters and matters alleging sexual abuse of young people aged 16 to 18 years.
  - Utilising the CAS to undertake periodic reviews of the volume of child abuse referrals made to individual LACs by the Helpline/JRU to ensure that any training and support is appropriately targeted.
- The NSW Police Force should consider holding a 'COMPASS forum' on the theme of responding to child abuse following the release of the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse.

Chapter 11. Department of Family and Community Services

This chapter examines the role and performance of the Department of Family and Community Services (FACS) in the context of the JIRT program.

The JIRT MoU states that the role of FACS is to receive and assess reports of risk of significant harm (ROSH) to children and young people, ensure the safety and ongoing care of children and young people, and initiate care and protection proceedings in the Children's Court.

FACS' contribution to the JIRT program is one of the stronger components of its overall statutory child protection response. The FACS arm of the JIRT program has attracted highly skilled and experienced staff, and has had greater success in retaining frontline staff than other parts of its organisation. Notwithstanding significant resource limitations, FACS JIRT has been able to maintain high face-to-face response rates to child protection reports, when compared to the child protection system more broadly.

The responses to the JIRT workforce survey indicate that staff from across all three JIRT agencies view the statutory child protection role played by FACS as essential to achieving quality safety and wellbeing outcomes for children and young people referred to the JIRT program. Irrespective of whether or not a referral to the JIRT program results in criminal charges being laid, FACS' broad mandate requires it to not only assess the allegations giving rise to the referral, but the overall circumstances of the child or young person the subject of the JIRT referral. This means that FACS is able to take a range of protective actions in circumstances where there is sufficient evidence of weight that abuse has occurred, even where police are unable to make an arrest.

FACS has taken a number of steps over recent years to strengthen the quality of its casework practice and training and mentoring of its FACS JIRT workforce. FACS' Office of the Senior Practitioner (OSP) is currently developing an assessment training package aimed at improving assessment quality with a tailored version to be developed for JIRT staff. Last year, FACS delivered a seminar to its JIRT and Community Services Centre (CSC) staff which covered current best practice in responding to child sexual abuse, including in relation to working with children, non-offending parents, suspected perpetrators, and children and young people with harmful sexual behaviour. To complement the seminar, this year FACS launched a comprehensive resource kit for staff, which includes advice and practical ideas aimed at improving the response to children who have been sexually abused.

It is also widely recognised that FACS holds critical information about children and their families, and the important role that this can play in informing the criminal justice and therapeutic responses delivered by Police and Health. Importantly, while there are a number of contentious issues in relation to the execution of the agencies' respective roles and responsibilities, FACS JIRT staff are generally viewed by their interagency colleagues as being highly collaborative and willing to openly share FACS' information holdings to ensure that children and young people reported to the JIRT program receive a comprehensive interagency response.

Since our 2012 report, FACS has also made significant contributions to the effective functioning of the JIRT partnership as a whole – most notably, the funding, development and ongoing management of the JIRTS database and, more recently, the development of the ChildStory database which, it is hoped, will provide a more efficient and seamless solution to the agencies' joint case management needs.

In this chapter, we outline the JIRT response currently delivered by FACS and how it could be further strengthened. In this regard, we examine the operation of FACS JIRT as well as the critical role played by CSCs in supporting the JIRT program, and how both can be enhanced.

In particular, we highlight the resourcing challenges that FACS JIRT has been facing for some time – challenges that have been exacerbated in recent years by the significant injection of additional resources for Police that has made it harder for FACS JIRT staff to 'keep up' with their police counterparts. While resourcing constraints are affecting the FACS JIRT response across the board, the impact appears to have been felt most acutely when there is a need for FACS JIRT to provide an urgent or after-hours joint response.

Towards the latter part of our inquiry, the NSW Budget for 2017-2018 was handed down and it was announced that FACS would receive a significant injection of funding, allowing it to increase its JIRT resourcing by 52% over the next two years.[317] We strongly welcome this enhanced resourcing, having highlighted the need for FACS to be better resourced for several years. It will be essential that these additional resources are accompanied by strong accountability mechanisms to drive the agency's JIRT performance. FACS also recognises this, and has advised us that it is in the process of strengthening its performance measures having regard to the observations in this report. FACS should also ensure that any injection of new resources delivers tangible results where they are most needed, including gaps in service provision which currently exist as a result of CSCs at times being unable, due to competing demands, to adequately respond to reports transferred by FACS JIRT.

11.1. FACS' broader child protection role

Under the *Children and Young Persons (Care and Protection) Act 1998* (Care Act), FACS is responsible for ensuring the care and protection of children and young people who are at ROSH. Through its Child Protection Helpline (the Helpline), FACS receives reports from mandatory reporters and other community members who hold concerns about the safety and wellbeing of children and young people.[318] For reports assessed by the Helpline as meeting the ROSH threshold, FACS is required to 'make such investigations and assessment as the Secretary considers necessary' to determine whether the child or young person is, in fact, at risk of significant harm.[319]

If, as a result of its investigations and assessment, FACS forms the opinion on reasonable grounds that a child is in need of care and protection, it must take 'whatever action is necessary to safeguard or promote the safety, welfare and wellbeing of the child or young person'.[320] This action may include providing or arranging for support services for the child and their family; developing a 'safety plan' (a parent responsibility contract) with the child's carers; developing a care plan (which may include allocation of parental responsibility – or aspects thereof – for a child to a person other than their parents, for example, a relative); and/or removing a child from the place of risk and, if necessary, making an application to the Children's Court for the child to be placed in out-of-home care (OOHC).[321]

Except in the case of referrals accepted for a JIRT response (and a small number of reports handled by other specialist FACS business units)[322] these functions are carried out predominantly by the 82 CSCs within the 15 FACS districts around the state. CSCs are responsible for assessing ROSH reports referred by the Helpline and, where required, taking appropriate child protection action or referring a child or family to another appropriate service (for example, an early intervention service).

In circumstances where a child or young person is placed in OOHC, the ongoing role played by FACS will depend on the nature of the placement. Previously, FACS managed the majority of OOHC placements; however, the 2008 Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry) resulted in a decision by the NSW Government to transfer this responsibility to the NGO sector. The transition commenced in early 2012, and it is intended that all statutory care placements will be managed by the NGO sector by mid-2022.

317 Advice provided by FACS, 23 June 2017.
318 See section 23 of the Care Act.
319 Care Act s.30.
320 Care Act s.34.
321 Care Act ss.34-36.
322 For example, a report about a child will be referred to the Intensive Support Services (ISS) (which provides case management for children and young people across NSW who have complex care and support needs) if the ISS is currently working with that child.

Currently, 57% of OOHC placements are managed by NGOs.[323] Where a child or young person's OOHC placement is being managed by an NGO, FACS may maintain case management responsibility, particularly if the child or young person's needs are highly complex. FACS also retains all residual aspects of parental responsibility[324] regardless of whether or not the child is case-managed by an NGO. In addition, FACS is responsible for responding to any ROSH reports involving children whose care is being case managed by an NGO, as this function cannot be delegated.

As the agency at the centre of the NSW child protection system, FACS also plays a pivotal role in ensuring that information about children and young people, and individuals who may pose a risk to them, is appropriately exchanged between human service and justice agencies, relevant NGOs and oversight and regulatory bodies. For example, FACS is an important source of information for the Office of the Children's Guardian (OCG) in administering the Working with Children Check (WWCC) scheme.

Our office also relies on FACS' information holdings in carrying out our reportable conduct function. We routinely undertake checks of the Community Services database (KiDS) to identify risk-related information about individuals who are the subject of reportable allegations. Where we identify that FACS holds records that may be relevant to the investigative or risk management activities of that person's employer, we will facilitate the exchange of that information to the relevant parties. In addition, if we identify information through our reportable conduct work that suggests urgent child protection action is required, we will send briefings to the FACS Deputy Secretary for review and action – the response provided by FACS on such occasions has been very positive.

As we discuss in Chapter 19, in the absence of robust inter-jurisdictional information exchange provisions similar to those in Chapter 16A of the Care Act, FACS also acts as the intermediary for information sharing between agencies in NSW and other states and territories, particularly when individuals identified as posing a risk to children move interstate.[325]

11.2. Role of FACS JIRT

Reports that are accepted for a JIRT response account for around only 3-4% of all ROSH reports received by the Helpline – in 2015-2016, just 4,500 of the 139,999 reports to the Helpline that were assessed as meeting the ROSH threshold[326] were accepted for a JIRT response.[327]

FACS JIRT is responsible for conducting the child protection 'investigation and assessment' component of FACS' response to ROSH reports which meet the JIRT referral criteria. This involves determining whether a child is at risk of significant harm, and if so, whether they are in need of care and protection.

Importantly, the threshold for FACS to substantiate that a child is at risk of significant harm and take protective action is different to the threshold for police to charge a person with a criminal offence. FACS must 'form an opinion on reasonable grounds' that a child or young person is in need of care and protection;[328] Police must know, or reasonably suspect, that a person has committed an offence to lay a charge. For the ODPP to prosecute a matter, they need to be satisfied that there is a reasonable prospect of a conviction (that is, a reasonable prospect that a matter will be proved beyond reasonable doubt).[329]

323 NSW Department of Family and Community Services, *Submission to the Legislative Council General Purpose Standing Committee No. 2 Inquiry into Child Protection*, July 2016.
324 The *Children and Young People (Care and Protection) Act 1998* enables the Children's Court to make an order allocating all or specific aspects of parental responsibility, for a child or young person in need of care and protection.
325 In our December 2012 report on responding to child sexual abuse in Aboriginal communities, we recommended that the NSW Government should actively pursue with the Federal Government and its state and territory counterparts, the need for legislative and related policy change that would address the current weaknesses in the regime for cross-border exchange of child protection-related information.
326 NSW Department of Family and Community Services, *Annual Report 2015-16, Volume 1: Performance and activities report,* p.21.
327 Advice provided by FACS, 12 January 2017.
328 *Children and Young Persons (Care and Protection) Act 1998* s.34.
329 NSW Office of the Director of Public Prosecutions, *Prosecution Guidelines*, 2007.

The different threshold for care and protection action means that FACS is often able to address safety and wellbeing concerns when police are unable to make an arrest, but where there is nonetheless sufficient evidence of weight that the alleged abuse occurred. In this regard, a wider range of protective interventions are available to FACS than through the criminal justice system. As noted earlier, FACS can develop a 'safety plan' with a child's carers; allocate parental responsibility (or aspects thereof) to someone other than a parent; and/or assume care of a child and make an application to the Court for the child to be placed in OOHC. The availability of these protective interventions is critical, particularly given the known difficulties in successfully prosecuting child abuse matters, particularly those involving sexual abuse.[330]

Irrespective of whether or not a referral to the JIRT program results in criminal charges being laid, FACS' broad mandate requires it to assess not only whether an alleged incident or incidents occurred, but also the overall circumstances of the child or young person the subject of the JIRT referral. In this way, a JIRT referral can act as a catalyst for FACS to identify and respond to other risks in a child or young person's household (for example, habitual non-attendance at school, parental/carer drug or alcohol use, domestic violence, supervisory or other neglect) which may or may not form part of the specific abuse alleged in the JIRT referral. We know from our many years of oversighting child protection matters that sexual and physical abuse often occurs in the context of other child protection concerns.

In practice, the actions that FACS will take in order to assess the safety of a child or young person will vary significantly depending on the circumstances of an individual matter. For example, while FACS will always need to consider a child's home environment, if the reported abuse involves a parent/carer, then it is much more likely that the child will be deemed in need of care and protection than in circumstances where the alleged abuse occurred in another setting.

In the first instance, FACS' assessment will be informed by the information holdings relating to the child and their family that are obtained as part of the initial JIRT referral and briefing processes, as well as information held by Police and Health.

In most circumstances, the next action is monitoring the recorded criminal interview with the alleged victim. As we discuss in Chapter 22, recorded criminal interviews are now conducted by police and monitored by FACS. During our inquiry, we recommended that police identify an appropriate point during the interview for a break to occur for the purpose of consulting FACS about any additional care and protection matters that have arisen – this step has now been included in current interviewing practice. However, where FACS has other questions relevant to the child or young person's safety that have not been canvassed, following the conclusion of the recorded criminal interview, they will seek additional information from the child or young person (known as a 'ROSH interview').

The subsequent actions of FACS may include:

- obtaining information from police about the outcome of any interviews with the person of interest and other witnesses (or speaking to these parties themselves in the event that a criminal investigation is not proceeding)
- conducting a home visit to speak with the child or young person and their family in the home environment, and
- speaking to other services or individuals who may be involved with the child or young person about their presentation and wellbeing.

The information obtained through these means is then used to inform a structured decision about whether the child or young person is in need of care and protection. Depending on the outcome of the assessment, FACS JIRT may immediately initiate relevant protective interventions (for example developing a safety plan with a non-offending parent/carer or removing a child and initiating care proceedings in the Children's Court). FACS JIRT may also take other steps during the assessment process aimed at mitigating risk, such as making referrals to other services.

330 See, for example, the Royal Commission into Institutional Responses to Child Sexual Abuse *Consultation Paper – Criminal Justice*, September 2016.

The FACS-wide benchmark for completing assessments is 60 days, although recent data suggests that the average timeframe for actual completion within the JIRT context is currently around 70 days.[331]

In circumstances where the assessment by FACS JIRT results in a determination that a child is at immediate risk of harm and cannot remain in their current home environment, FACS JIRT is also responsible for removing the child and taking appropriate action to find an emergency placement; lodging a care application with the Children's Court; and undertaking any interim work associated with the court proceedings. In these circumstances, FACS JIRT will retain case management of a matter until such time as the court determines whether or not the child is in need of care and protection.[332]

11.3. The intersection of the roles of FACS JIRT and CSCs

Once FACS JIRT has completed its role in a matter, if it determines there is an ongoing need for FACS involvement, it is responsible for developing a case plan and then transferring case management responsibility to the relevant CSC. The CSC is then responsible for undertaking ongoing casework with the child and their family. For example, in matters where a child has been assumed into care, the CSC will undertake any subsequent work associated with ongoing proceedings in the Children's Court, and permanency planning for the child if they remain in OOHC.

Additionally, if a ROSH report to the Helpline involves an allegation that a particular child has been sexually assaulted by a parent/carer for example, the Helpline will refer the report to the JRU for assessment but in addition, it will also generate a ROSH report about any *other* children who may be at risk (such as siblings of the reported child or other children living in the same household) and these related reports are sent to CSCs for a response. Depending on the circumstances of the matter, either FACS JIRT or the CSC will take the lead on working with the family. Similarly, if a report is received by the Helpline about an individual child, and there is sufficient reason to believe a 'class of children/young people' may also be at risk of significant harm, a separate report for the class of children will be created and sent to the CSC.[333]

Just as Police Local Area Commands are responsible for investigating allegations of criminal child abuse that do not meet the JIRT referral criteria, CSCs are responsible for handling risk of significant harm reports where there is no clear disclosure by the alleged victim or evidence of sexual abuse. However, it would not be uncommon during the assessment phase for the child to subsequently make a disclosure to a CSC caseworker. In these circumstances, the CSC re-refers the matter to the JRU for consideration of a JIRT response. It is expected that the JIRT agencies will then work collaboratively with the CSC to ensure seamless service delivery for the child/young person and their family.

It is clear, therefore, that CSCs have an integral role to play in delivering the broader FACS response to children referred to the JIRT program. However, as we discuss later, the capacity challenges facing CSCs across the state are such that a proportion of the cases transferred to them by FACS JIRT are closed due to competing priorities. In fact, CSCs may be less likely to prioritise transferred cases over non-JIRT matters that are yet to receive a face-to-face response, on the basis that the former have at least received some kind of response already.

While a comprehensive examination of the broader capacity of the child protection system is beyond the scope of this inquiry, our office has publicly reported our concerns about the ability of FACS to meet 'ROSH demand' in a series of reports to Parliament and most recently, in our August 2016 submission to the inquiry of the Legislative Council General Purpose Standing Committee No. 2 into child protection. In recent years, FACS has introduced a suite of reforms which have helped increase the number of children receiving a face-to-face response.[334]

331 Advice provided by FACS, February 2017. In providing this data, FACS noted that days taken to complete risk assessments are not a direct measure of how long FACS JIRT remains involved with the children referred to the program.

332 FACS advises that, historically, FACS JIRT initiates Children's Court action in approximately 5% of matters. (Advice provided by FACS, January 2017.) Data from the second half of 2016 indicates that its JIRT units initiated Children's Court action in 2% of matters, ranging from 0% in two units, to 6% in one unit. (Advice provided by FACS, 7 March 2017.)

333 A 'class of children' report is created where there are concerns about a group of children, but the names of the individual children are not known. If, for example, a report is made alleging that a teacher has sexually abused his child, a report will be created for the child who is the alleged victim, and a separate class of children report will be made for children at the teacher's school.

334 Our public reports and some of the recent reforms are discussed in section 11.6.

11.4. The FACS JIRT workforce

The FACS JIRT response is delivered by 17 JIRT units operating across 22 locations. These units include teams of between two and seven caseworkers reporting to a Manager Casework.[335] The units are grouped into four clusters, each managed by a Manager Client Services. Across the four clusters, there are currently four Managers Client Services, 19 Managers Casework, and 91 caseworkers.[336] Additionally, five FACS staff – four caseworkers and one Manager Client Services – are allocated to the JRU.[337]

Prior to the 2006 JIRT review, FACS JIRT staff reported up through the various Community Services directors in each FACS district. In 2010, FACS recognised the importance of a more streamlined reporting and accountability model, and a dedicated JIRT Assistant Director role (now a Director role) was created to support this model. The JIRT units now sit within FACS' State-wide Services arm, which also includes the Helpline, with a reporting line through to the Executive Director State-wide Services and up to a Deputy Secretary.

As part of a recent FACS-wide restructure, a second Director position was created to further strengthen the FACS JIRT model. Management responsibilities are now divided between a Director, Operations and a Director, Strategic Policy and Relationships. The additional Director role places FACS in a stronger position to respond to day-to-day operational issues, more closely track the performance of individual JIRT units, and focus on strengthening relationships with partner agencies to promote collaborative practice. The FACS JIRT senior management team is also supported by two project staff.[338]

11.4.1. The impact of the FACS and CAS staffing imbalance

In response to a recommendation in our 2012 report,[339] FACS commissioned Ernst & Young (EY) in 2014 to undertake a review of its JIRT resourcing.[340] At the time, 85 FACS caseworkers (including four assigned to the JRU) were allocated to the JIRT program.

The EY review – modelled on 2012-2013 caseload figures – found that FACS JIRT required an additional 9.5 caseworker positions in order to meet the demand of accepted JIRT reports. It was forecast that the number of caseworkers required would increase to between 108 and 123.5 by 2018. Based on this assessment, FACS increased its JIRT caseworker positions by ten in late 2014 – taking its caseworker allocation to the current 95. The extra caseworker positions were funded out of FACS' general caseworker budget rather than via any additional funding.

The JIRT program was initially established with an equal number of FACS and police officers. Since then, the CAS has increased its staffing substantially more than FACS JIRT. At the time of our inquiry FACS had around 60 fewer frontline officers allocated to the JIRT than the NSW Police Force's allocation to the CAS – 91 FACS caseworkers compared to 150 police investigators.[341] The extent of this staffing imbalance varies across locations – Bathurst has the most equivalent staffing numbers, with five caseworkers and six investigators, whereas Bourke, Broken Hill, Chatswood, Queanbeyan, and Wagga Wagga all have at least twice as many investigators as caseworkers.[342]

Our 2012 report focused on the urgent need to increase CAS resourcing as, at that time, there were clear quality and accountability issues that the CAS needed to address. As noted earlier, we also recommended that FACS and Health resourcing be reviewed in light of CAS resourcing enhancements – predicting that a staffing imbalance would compromise the overall JIRT program. While some enhancements have been made to FACS (and Health) staffing, our inquiry has revealed that the ongoing staffing imbalance has significantly impacted on FACS' ability to respond jointly to referrals accepted by the JIRT program.

335 The two largest JIRT units (Liverpool and Newcastle) include two teams.
336 Each FACS JIRT team also includes a Senior Administration Officer.
337 FACS also currently has a Senior Project Officer temporarily located at the JRU to meet demand for a FACS second in charge role.
338 One of these project staff is temporarily providing operational support to the JRU.
339 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.99 (Recommendation 20(a)).
340 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources: NSW Department of Family and Community Services*, 19 February 2014.
341 This figure excludes the JRU; and does not include officers allocated to the Child Abuse Response Team. Advice provided by FACS, February 2017 and advice provided by NSW Police Force, January 2017. The number of police investigators.
342 Advice provided by FACS February 2017.

JIRT Statewide Management Group (SMG) meeting records indicate that concerns have been raised since at least 2013 about FACS' inability to allocate cases at the same rate as the CAS.[343] The discrepancy between FACS and CAS staffing levels was also raised by staff from both agencies in responding to the JIRT workforce survey. Some CAS officers commented that there have been occasions where the efficiency or quality of the police response was adversely affected by waiting for FACS to have the capacity to allocate a caseworker to less urgent matters. Both FACS and CAS respondents commented that there have been differences of opinion between the agencies as to whether or not, and in what circumstances, it is in the best interests of a child for police to proceed with an interview in the absence of a caseworker being available to monitor it.

The staffing discrepancy was the most common resource issue raised by FACS staff who responded to the workforce survey – 24% of FACS respondents (including all of the Managers Client Services)[344] identified it as a factor limiting FACS' ability to effectively carry out its role in the JIRT program. One manager, for example, commented that:

> *I am concerned Police and Health are increasing their workforce (police significantly) … whereas FACS resourcing remains static. Sometimes I worry we have to pedal harder to get up the same hill with the police tapping their foot at the top of the hill wondering what's taking us so long.*

In addition to being a source of tension between FACS and Police, FACS advised us during the inquiry that their smaller JIRT workforce results in cumulative inefficiencies and duplication of effort as caseworkers attempt to 'catch-up' with police.[345] In this regard, the 2014 EY review found that, due to better synchronisation of police and caseworker responses,[346] caseworkers spent less time per case at units where the staffing levels of FACS and CAS were more evenly matched than at units where there was a greater discrepancy.

11.4.2. Recent enhancement to FACS JIRT staffing

Notwithstanding its 2014 resourcing enhancement, our inquiry found that FACS JIRT has continued to face challenges as a result of the staffing imbalance between FACS JIRT and the CAS and, more broadly, managing high caseloads within the JIRT units. In this regard, the recent Budget announcement about additional funding for FACS JIRT is positive. We have been advised by FACS that the funding will be used for ten new frontline JIRT caseworker positions this financial year; and a further 30 frontline JIRT positions with eight 'case work support' positions in the next year.[347] Outside of FACS JIRT, funding enhancements will also enable the creation of 42 additional caseworker positions and 66 extra 'case work support' positions within CSCs this year; and 23 additional caseworkers at the Helpline.[348]

This funding allocation will substantially address the CAS/FACS staffing imbalance. In addition, it will provide considerable scope for FACS to enhance its FACS JIRT response in a range of areas. In its submission to this inquiry, FACS stated that if it was successful in receiving additional funding, it would:

> *establish a JIRT after hour service, enhance JRU operations and quality uplift FACS response to cases … FACS will* [also] *be well positioned to respond to matters alongside Police and undertake work in high risk matters that it is not currently within the FACS JIRT role. Examples include but are not limited to managing the child protection component of high risk reports that are currently rejected at the JRU as per NSW Police' 'prior LAC' practice;*[349] *serious physical abuse allegations, involving children in the parental responsibility of the Minister … children with disabilities that may not meet the criminal*

343 For example, the minutes from the April 2013 SMG meeting indicate that concerns were raised by Police that their imminent staffing enhancement would likely result in an inability for FACS to allocate matters to a caseworker at the same time that they are allocated to an investigator, which may delay interviewing. Discussion occurred about negotiating a 'Police only' response in some such circumstances as well as processes for escalating concerns about FACS allocation.

344 We received a response from four of the five Managers Client Services.

345 Advice provided by FACS, February 2017.

346 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources: NSW Department of Family and Community Services*, 19 February 2014.

347 Advice provided by FACS, 23 June 2017. Case work support positions are intended to free up caseworkers from administrative duties to enable them to spend more time on active case work.

348 Department of Family and Community Services, *Media Release: NSW budget: increase in child protection caseworkers*, 13 June 2017, https://www.facs.nsw.gov.au/about_us/media_releases/nsw-budget-increase-in-child-protection-caseworkers.

349 Reports that meet the JIRT criteria but where the JRU determines it is appropriate, due to an investigation having already been commenced, for the LAC to retain carriage of the matter.

threshold for JIRT; and extending the Enhanced [Aboriginal] *Services protocol to physical abuse reports. FACS is open to considering other high risk areas that are known to the* [NSW Ombudsman] *and/or arise from the JIRT Review.*[350]

As we discuss in section 11.6.2, the substantial enhancement to FACS JIRT resourcing also provides an opportunity for FACS to explore how it can better support the work of CSCs in relation to JIRT matters.

11.4.3. The impact of, and likely reasons for, high staff vacancy rates

Caseworker vacancy rates and staff retention are important factors influencing FACS capacity to provide a quality child protection response. FACS has advised us that the JIRT program is seen to provide strong career development opportunities for FACS staff and has been fortunate in historically attracting high quality and experienced staff and having a higher retention rate than other areas of the organisation.[351] In 2016, 72% of JIRT caseworkers had been employed by FACS for five or more years, including 31% who had been employed for ten or more years. The rate of JIRT caseworker separation from FACS last year was just over half that of non-JIRT caseworkers.[352]

Although FACS has achieved significant improvements in its overall caseworker vacancy rates in recent years,[353] the vacancy rate for FACS JIRT remains relatively high – in the two years to December 2016, its average quarterly vacancy rate was 12.4% compared to 3% across FACS districts.[354] While this needs to be understood in the context of FACS JIRT employing comparatively fewer caseworkers (resulting in a higher percentage vacancy rate when a position is unfilled), it is still of concern. FACS has linked the high vacancy rate to the quality and experience of FACS JIRT caseworkers, stating that they are frequently targeted for secondments and more senior roles elsewhere in the organisation. Because the JIRT workforce is relatively small, vacancies are also much harder to absorb. In 2015-2016, FACS utilised approximately nine caseworkers from outside the JIRT to back-fill temporary JIRT vacancies; 12 other positions remained vacant.[355]

While we appreciate the complexities in balancing the operational needs of the JIRT with facilitating career development opportunities and maintaining wellbeing for staff, FACS should seek to confirm the main drivers behind FACS JIRT's higher than average caseworker vacancy rates.

FACS also advised us during our inquiry that 'cultural differences' between the JIRT partner agencies and tensions that have arisen in recent times in relation to issues such as changes to interview practice, have contributed to poor staff morale within FACS JIRT. The responses of FACS staff to the JIRT workforce survey support this view, with almost one third commenting on a decrease in staff morale and/or an increase in tensions across the JIRT partnership.

As we discuss in Part 7, the contentious issues we were asked to help address through this inquiry have been largely resolved at a leadership level in terms of settling a jointly agreed position; however, the execution of these new arrangements in the field will need to be closely monitored. In this regard, it will also be critical for the SMG and the agencies at a Deputy Secretary/Commissioner level to demonstrate a strong commitment to the changes and ensure that positive messages are communicated to staff about good collaborative practice. For example, FACS' annual *Shining a light on good practice* reports, prepared by the Office of the Senior Practitioner (or a similar standalone publication), could be utilised to promote positive examples of joint agency practice within the JIRT.

It is hoped that achieving clarity in relation to contentious issues in the JIRT partnership together with implementing stronger governance arrangements, will provide FACS staff with a greater level of satisfaction around their contribution to the JIRT program. FACS leadership also has a critical role to play in refocusing the way it messages the value of FACS' contribution to the JIRT program. Although

350 Advice provided by FACS, February 2017.
351 Advice provided by FACS, February 2017.
352 Advice provided by FACS, February 2017.
353 The overall FACS caseworker annual vacancy rate has decreased from 13% in 2009-2010 to 5% in 2015-2016. (*FACS caseworkers – annual data*, June 2016 quarter, http://www.community.nsw.gov.au/about-us/community-services-caseworker-dashboard, accessed 24 March 2017.)
354 *FACS caseworker dashboard – December 2016 quarter*, http://www.community.nsw.gov.au/about-us/community-services-caseworker-dashboard, accessed 24 March 2017.
355 Advice provided by FACS, March 2017.

the changes to interviewing practice have now been jointly endorsed and communicated by the SMG, it will be critical for the FACS JIRT leadership to demonstrate that it has embraced these changes by actively working alongside its local managers to ensure they are well executed into the future.

As well, the allocation of additional resources to FACS JIRT will enable FACS to enhance the overall quality of its 'end-to-end' response to children accepted into the JIRT program – this is also likely to lift morale.

11.4.4. Addressing broader staff wellbeing concerns

In conducting its 2014 review of FACS JIRT resourcing, EY found that, everything else being equal, JIRT caseworkers who were identified as having a poor or moderate level of wellbeing spent more time on each case than their colleagues who had a good or excellent level of wellbeing.[356]

The FACS JIRT Work Health and Safety Plan – *Strategies for the prevention of psychological illness and injury* – recognises that the cases handled by the JIRT involve the most extreme types of abuse and neglect and that JIRT staff are at greater risk of burnout and secondary traumatic stress. The plan envisages that the risk of secondary trauma will be minimised, as far as possible, through self-management by staff – in particular, by allowing enhanced access for JIRT staff to the Employee Assistance Program (EAP) and through providing resources for staff on the 'Safe & Well at Work' pages of the Community Services intranet. Other wellbeing measures include:

- providing staff with monthly one-on-one professional supervision and case review
- having an EAP representative and the FACS Work Health and Safety Unit attend at least one JIRT casework manager meeting a year to promote use of the EAP
- arranging for a psychologist to present annual sessions to each JIRT unit to discuss psychosocial self-care issues, and
- a job rotation policy which strongly encourages all JIRT staff to undertake a secondment of at least three months in another suitable area of FACS or the NSW public sector, after three years of continuous service in a JIRT unit.

While these are all very positive measures, 15% of FACS respondents to the JIRT workforce survey (excluding administration staff) said they are either not properly implemented, or are insufficient to deal with the risk of vicarious trauma.

As we discussed in the previous chapter, the NSW Police Force has successfully implemented the WellCheck program and CAS rotation policy – both of which are mandatory. To avoid implementation problems, the then Deputy Commissioner issued a directive to local area and specialist commands making it compulsory for them to immediately provide a replacement for the CAS when its officers are rotated out of the squad and into LAC positions.[357]

The responses to the workforce survey indicate that these measures are viewed positively by FACS (and Health) staff. A number of FACS managers and frontline caseworkers said that the FACS rotation policy should be enhanced – either by making it compulsory, or increasing the frequency of rotations. It was also suggested that rotating JIRT and CSC staff at least annually would help ensure JIRT staff stay abreast of FACS casework practices and conversely, expose CSC staff to working in a multi-disciplinary team model.

A significant number of FACS respondents also suggested that FACS should provide an external supervision mechanism, along similar lines to the Police WellCheck program, to monitor and respond to wellbeing issues for JIRT staff:

> *FACS JIRT need to provide a higher level of specialty supervision for staff due to the impact of vicarious trauma. Despite the fact Police and FACS JIRT are exposed to the same content, Police are provided with regular wellness checks by specialty psychologists, where FACS rely on staff to self identify their need to access EAPS. Many staff are not aware they require counselling until they are suffering significant negative effects* – FACS Casework Manager.

356 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources: NSW Department of Family and Community Services*, 19 February 2014.
357 Advice provided by NSW Police Force, March 2017.

Given the importance of staff welfare and wellbeing across all three JIRT agencies, and the views of FACS and Health staff, there would be merit in the SMG collaborating on the development of a FACS (and Health) wellbeing strategy that is modelled on the Police WellCheck program, and a related rotation policy. This approach would allow both FACS and Health to capitalise on any learnings from the implementation of the Police program.

11.5. Training and guidance

Notwithstanding that FACS JIRT attracts highly skilled and experienced caseworkers, it is critical for those staff to receive sufficient training and support to enable them to provide a high quality response to children and young people in the context of a multi-disciplinary program environment. It is equally important that CSC and Helpline staff are familiar with the operation of the JIRT program, and how it intersects with their roles and responsibilities.

This section outlines the current training provided by FACS to its staff and highlights aspects that could be enhanced. We recognise the challenges in delivering a quality training program and ensuring a high level of participation against a background of already stretched resourcing across FACS' workforce. A number of respondents to the JIRT workforce survey said their high caseloads prevented them from taking up training and development opportunities. While decisions to prioritise training need to be considered in the context of individual caseworker and JIRT unit demands, the long-term benefits of a establishing a well-trained and efficient JIRT workforce cannot be underestimated.

11.5.1. FACS JIRT training

All FACS caseworkers undertake a mandatory 16 week 'caseworker development program'. The program introduces the role of JIRT within the child protection context and the respective roles of FACS JIRT and CSCs. Specific training for FACS JIRT staff is provided through the JIRT Induction Course, including the JIRT Foundation Skills Program and other joint training modules. This training is discussed in detail in Chapter 24.

FACS JIRT staff also have access to an extensive range of training, including subject specific training workshops that are periodically delivered to both JIRT and CSC staff. For example, in 2012-2013, FACS developed and implemented a state-wide training program, *Working with Child Sexual Abuse*. The training focused on the prevalence of child sexual abuse, risk and protective factors, grooming tactics, working with non-offending partners, JIRT/CSC transfer procedures and the Child Protection Register. The training was provided to almost 1,000 staff across CSCs and JIRT units, including staff at seven of the 17 FACS JIRT units.

In 2013, FACS also contracted a 'subject matter expert' to develop and deliver training for CSC and JIRT caseworkers about safety planning for adolescents with sexually abusive behaviours. The training, which we also discuss in Chapter 17, was last rolled out to all JIRT units and CSCs in the first half of 2015.

Since 2002, FACS has also delivered a half-day cross-examination training workshop, delivered by a barrister and legal practitioner, to assist JIRT staff to prepare for and adequately conduct themselves when being cross examined in criminal proceedings. The workshop was last delivered to all JIRT units in the second half of 2015, with further sessions planned for 2017.

More recently, in November 2016, *See, Understand and Respond to Child Sexual Abuse* – a 'research in practice seminar' – was delivered to FACS staff as well as staff from NGO OOHC agencies. The seminar covered topics including:

- what caseworkers can do when they suspect a child has been sexually abused but they have not said anything directly
- how to effectively work with a parent who is struggling to understand what has happened to their child, and
- how to work with suspected offenders where there is insufficient evidence for them to leave the family home, but where there are nonetheless concerns about a child's safety.

To complement this seminar, a practical kit was developed by the Office of the Senior Practitioner and launched in May 2017. The comprehensive kit includes advice, practical ideas and resources aimed at improving the response to children at risk as well as those who have experienced child sexual abuse. While the resource was developed for child protection practitioners who are based in CSCs, with a view to supporting them to respond to matters that do not meet the JIRT criteria but nonetheless involve allegations of sexual abuse, it is also a valuable resource for JIRT staff. The resource will be supported by mandatory training of all CSC frontline staff, which has also been provided to FACS JIRT staff.

Most FACS respondents to the workforce survey indicated that, generally, they feel adequately trained to carry out their work. However, a high proportion of staff (40% of all FACS staff excluding administration staff) indicated that they require more training to specifically deal with matters involving allegations of harmful sexual behaviour or sexual abuse towards a sibling. As discussed in Chapter 17 this area of practice has been singled out by all three JIRT agencies as highly complex and there would be value in FACS and Health collaborating on the development of guidelines to help their staff better understand and respond to sibling sexual abuse.

11.5.2. FACS JIRT supervision

FACS advises that JIRT caseworkers regularly debrief with their manager at critical points in the assessment process and that staff have individual supervision at least once a month. FACS JIRT staff also have access to local Casework Specialists for advice on complex matters at the request of a JIRT Manager Casework. Casework Specialists also conduct 'drop-in' consultations on a fortnightly basis, providing casework staff with the opportunity to informally consult about particular matters or practice issues.[358]

Feedback from the JIRT workforce survey suggests that FACS staff generally feel well supported by their managers and the Casework Specialists. The fact that most FACS JIRT staff are fully trained and experienced at the time they commence work in a JIRT role may influence the volume of active supervision that is required on individual matters, although FACS has stressed that even the most experienced staff will require support on complex and very challenging matters.[359]

Some caseworkers suggested that it would be beneficial to have regular group supervision in place of, or in addition to, the current individual supervision arrangements. FACS has implemented group supervision in just under half of its CSCs through the rollout of its 'Practice First' model. The model, which was also trialled at Tamworth FACS JIRT, is based on greater collaboration, including through weekly group supervision sessions involving caseworkers, managers, psychologists, casework specialists and, where appropriate, staff from partner agencies.[360]

Given the collective experience of caseworkers and managers within the JIRT, there is significant scope for the quality of responses to be improved through the implementation of a group supervision model. FACS has advised us that a new Practice Framework, based on Practice First and including a group supervision model, will be launched in late 2017 and rolled out to all CSCs and JIRT units. In the interim, JIRT staff will continue participating in group supervision in their districts where matters involve collaboration between the CSCs and JIRT.[361]

358 Casework specialists are part of a FACS practice support team which reports through to the Office of the Senior Practitioner (OSP). The OSP was established in February 2013 with the purpose of promoting good practice and providing practice leadership and support to FACS staff. Three of the approximately 80 casework specialists within the practice support team have completed the JIRT Foundational Skills Course, with a view to ensuring that they can better support the JIRT units and CSC caseworkers in their handling of matters that have been referred from the JIRT, or may result in a referral to the JIRT.

359 Advice provided by FACS, May 2017.

360 Department of Family and Community Services, *Practice First: information for partner agencies*, http://www.facs.nsw.gov.au/__data/assets/pdf_file/0004/326281/Practice_first_info_for_partner_agencies.pdf.

361 Advice provided by FACS, May 2017.

11.5.3. Training and guidance for CSCs and the Helpline

Given the critical role that CSCs play in providing a response to children and young people who are the victims of serious child abuse and neglect, it is important that they have a good understanding of the JIRT program, and the responsibilities of CSCs to work collaboratively with their JIRT colleagues.

FACS advises that the 'caseworker development program' that caseworkers undertake when they first commence working with FACS, includes an introduction to the JIRT program that covers the respective roles of JIRT units and CSCs in circumstances where their work may intersect.

Several non-JIRT staff also participate each year in the JIRT Foundation Skills Program. Since 2014, 31 CSC caseworkers and one caseworker from the Mobile Child Protection Unit (Dubbo) have completed the course.[362] This contributes to the creation of a pool of trained staff available to take up positions in the JIRT units as required; for example, where temporary vacancies arise; and means that a proportion of staff rostered to provide an after-hours response in regional areas have received JIRT training.

For Helpline staff, the caseworker development program includes an additional one day workshop that covers the role of the JIRT program, with a focus on the JIRT referral criteria. As Helpline staff are responsible for initially assessing reports and determining whether or not they meet the JIRT referral criteria and should be forwarded to the JRU, this training is critical to the efficacy of the JIRT program.

As discussed in Chapter 7, the proportion of matters that are accepted for a JIRT response once they are referred from the Helpline to the JRU has decreased significantly over recent years. In 2010-2011, less than one third (31%) of reports that were referred to the JRU were rejected. This had increased to 47% by 2014-2015 and in 2015-2016, almost half (49.8%) of all reports that the Helpline forwarded to the JRU were rejected for a JIRT response.

It is preferable to have a situation where the Helpline is over-referring rather than under-referring matters to the JRU, as this provides the opportunity for the three agencies to jointly make a decision about whether or not a matter should be accepted for a JIRT response. However, this must be balanced with the need to ensure that the JRU is not unnecessarily completing assessments of matters that it will ultimately reject.

It is possible that further training and guidance for Helpline staff in assessing matters against the JIRT referral criteria would assist in reducing the volume of matters that are forwarded to the JRU and subsequently rejected for a JIRT response. In this regard, the development by FACS of a new neglect practice resource for the Helpline, due for release later in 2017, is a positive initiative.[363]

We have recommended that the JRU and SMG monitor patterns in the number of matters that are rejected – as part of this work consideration should be given to any specific areas where further training for Helpline staff is warranted.

11.6. Strengthening FACS JIRT practice

While the FACS JIRT workforce is largely comprised of skilled and experienced caseworkers, a number of policy and practice issues have been raised during this inquiry (and via our broader oversight role) which should be addressed. They include:

- exploring how FACS JIRT can better support the work of CSCs in connection with JIRT referrals
- improving the response to sibling reports and matters involving harmful sexual behaviours by one sibling towards another
- enhancing FACS JIRT assessment processes, and
- FACS' policies and procedures for identifying and recording persons of interest and persons causing harm.

362 Advice provided by FACS, February 2017.
363 Advice provided by FACS in June 2017 in response to NSW Ombudsman draft report, *Reviewable Deaths in 2014 and 2015, Vol.1: Child Deaths.*

In addition, FACS has recognised that its current processes for responding to reports that meet the JIRT referral criteria outside of business hours could be strengthened. The agencies' processes for responding to after-hours matters, and related capacity issues, are considered in Chapter 21.

We appreciate that the resolution of some of these issues – in particular, those relating to the after-hours response and the level of support provided by JIRT units to CSCs – have resource implications; however, the recent funding injection for FACS JIRT provides scope to address them. Regardless, if these practice and policy issues are addressed, this is likely to improve practice quality and should also deliver some gains in productivity.

The rollout of FACS' new database, ChildStory, is intended to be a more efficient and user-friendly system than KiDS and should also eliminate the duplication that currently exists across the JIRTS and KiDS databases and improve the productivity of FACS JIRT more generally.

In this section, we discuss relevant major reforms to the child protection system and related efforts by FACS to improve the proportion of matters that receive a face-to-face response. We also discuss some areas where there may be scope for FACS JIRT to work more flexibly with the CSCs, or provide CSCs with further support, in order to improve the overall FACS response to victims of serious abuse and neglect. In this regard, FACS has advised us that it is 'keen to further examine the intersection between JIRT and CSCs in order to make an informed decision about how to make sure that outcomes for children and young people are consistently positive'.[364]

11.6.1. The capacity of the child protection system

When a matter is referred to a CSC – either from a JIRT unit or directly from the Helpline – it is reviewed by the CSC together with any other new reports. If the CSC does not have capacity to allocate all incoming reports to a caseworker, it will triage the reports based on the urgency level assigned by the Helpline (where applicable) and any other relevant information (for example, the CSC's knowledge of the family). Priority will be given to allocating the most urgent matters for a response.

If a ROSH report is not allocated, it will be reconsidered at the next allocation meeting and, if it remains unallocated after a period of four weeks, it will be closed due to 'competing priorities'.[365] A significant number of reports are closed by CSCs under these circumstances, including matters referred by JIRT to a CSC after the JIRT response has been completed; related reports generated by the Helpline and referred to CSCs at the same time as the JIRT referral (for example, sibling reports and class of children reports); and reports that do not meet the JIRT referral criteria but that nonetheless involve allegations of child abuse and neglect. Therefore, the capacity challenges experienced by CSCs to meet ROSH demand impact directly on the FACS response to JIRT referrals.

Recent reforms and their impact

The child protection system has changed significantly since the JIRT was last reviewed in 2006. In particular, a range of legislative and structural reforms were introduced through *Keep Them Safe*[366] in 2010 following the Wood Inquiry. One of the primary objectives of the *Keep Them Safe* reforms was to allow FACS to concentrate its efforts on seeing children who were most at risk, by increasing the reporting threshold from 'risk of harm' to 'risk of significant harm'.

Since the commencement of the reforms, we have undertaken two comprehensive reviews (in 2011 and 2014) of their implementation and impact.[367] In 2011, we found that in the first 11 months of the new system, despite the raising of the threshold and significantly reduced demand (53% less reports were referred to CSCs for action than before the Wood Inquiry), FACS was conducting face-to-face assessments in relation to only one fifth (21%) of all children and young people assessed as being at ROSH.

364 Advice provided by FACS, February 2017.

365 Deidre Mulkerin, Deputy Secretary, NSW Family and Community Services, *Legislative Council General Purpose Standing Committee No.2 Inquiry into Child Protection*, transcript of hearing for 27 September 2016, p.60.

366 *Keep Them Safe* was introduced in 2010. It ran for five years and involved an investment of around $750 million in various reform initiatives. *Keep Them Safe* aimed to make child protection a shared responsibility of government and non-government agencies, to limit the statutory role of Community Services to children at risk of significant harm and to strengthen early intervention services, with the expectation that, over time, this would lead to a reduction in the number of children requiring statutory protection and out-of-home care services.

367 NSW Government, *Keep Them Safe: A shared approach to child wellbeing*, 2009-2012.

In addition, the data showed that although the number of reports which had been closed due to 'competing priorities' dropped by almost two thirds, the rate remained unacceptably high at 25% of all reports screened in at the Helpline.

Our 2011 report included a series of recommendations aimed at improving capacity and accountability, including:

- improved public reporting on responses to ROSH reports
- filling positions in rural and remote areas; setting average caseload and case completion targets; enhancing caseworkers supervision and support; and lifting staff morale
- developing more meaningful reporting on productivity and/or efficiency outcomes achieved, and staff vacancy and retention rates
- developing a reporting tool that could rapidly generate consolidated child protection history reports, and
- with key partners, adopting and implementing an intelligence driven child protection system.

By 2014, FACS had significantly progressed our recommendations, including making a range of improvements that better equipped it to assess, and accurately report on, its capacity to meet demand, including:

- enhancing IT systems to support more efficient risk identification and management
- improving its capacity to measure, monitor and report on issues which impact on the ability to respond appropriately to ROSH reports, and
- establishing the Office of the Senior Practitioner (OSP) to provide leadership in child protection practice by reforming and improving casework practice and systems; provide expert advice and training to practitioners; and support the implementation of 'Practice First'.

These improvements, together with a steady decline in the caseworker vacancy rate, contributed to an improvement in the ROSH response rate to 28%. While positive, this was still significantly short of an acceptable response rate. (At the time, FACS' best performing district was still only able to provide a face-to-face caseworker response to just under 40% of all ROSH reports it received.)

We also revisited the 'competing priorities' closure rate, which had increased from 25% (at the time of our last report) to 39%. We were advised by FACS that this increase was due to changes in the way that case closure decisions were recorded at CSCs since our last report and did not reflect a significant change in the way that these reports were being handled. FACS also advised that some of the 40,555 reports recorded as having been closed due to competing priorities may, in fact, have received another type of response from FACS or another agency.

In addition, FACS suggested that a Helpline screening of ROSH did not necessarily mean that the related ROSH report required a full safety and risk assessment. For example, additional screening and assessment at the local level might indicate that a full assessment was not required. Against this background, we recommended that FACS enhance its capacity to record, and report on, the actual nature of responses being provided to all children the subject of ROSH reports – not just those that result in a face-to-face response.

FACS indicated its support for our recommendations and agreed to report on its progress in implementing them. FACS published its first progress report on its website in April 2015.[368] The report addressed policy and practice concerns that we had identified, but also the changes introduced through the Safe Home for Life child protection reforms which were passed by the NSW Parliament in March 2014, just before our report was tabled.[369] FACS advised us last year that a tiered performance monitoring framework would be established to monitor and assess reform outcomes as part of the Safe Home for Life implementation Plan.[370]

368 http://www.community.nsw.gov.au/about-us/about-community-services/facs-2015-progress-report-in-response-to-the-nsw-ombudsmans-special-report-review-of-the-nsw-child-protection-system-are-things-improving.

369 *Safe Home for Life* is a four year program aimed at strengthening the child protection system through changes to legislation, better IT systems, and the implementation of new policies and practices. The reforms focus on building parenting capacity and increasing parental responsibility; providing support earlier to families to prevent their children entering care; and providing greater permanency for children and young people in care.

370 NSW Department of Family and Community Services, *Progress report in response to the Ombudsman's report – Review of the child protection system – Are things improving?*, 2015.

More recently, in May 2016, the NSW Legislative Council General Purpose Standing Committee No. 2 commenced an inquiry into child protection. Evidence provided during that inquiry by FACS indicates that, while the number of ROSH reports and the number of children receiving a face-to-face response have both substantially increased,[371] the proportion of ROSH matters receiving a face-to-face response, and the proportion of ROSH matters that are closed due to competing priorities, have remained largely unchanged since our 2014 report. In this regard, of the 76,574 children who were identified as being at ROSH in 2015-2016, 29% (22,462) received a face-to-face assessment and approximately 40%[372] of matters were closed due to competing priorities. The remainder received 'some response', such a direct referral to a support agency or an interagency case discussion.[373]

On 29 March 2017, the Premier and Minister for Family and Community Services announced additional reforms to build a 'better child protection system':

> *In the short term, FACS will be:*
>
> - *Changing the way we fund our service partners, starting with performance-based contracting to focus on finding children in care a permanent home within two years*
> - *Introducing a new service model based on child and family-centred tailored support packages*
> - *Introducing a new means-tested adoption allowance to help foster carers make their care arrangements permanent*
> - *Helping families stay together using new intensive home-based family preservation and restoration models that target the causes of harm and treat trauma.*
>
> *In the longer term, Their Futures Matter – a new approach to child protection and wellbeing in NSW – will bring together all government agencies, non-government organisations and the community to deliver the right supports to vulnerable children and families.*
>
> *Within the next three years, Their Futures Matter will deliver:*
>
> *(1) Needs-based supports: All children in, or at risk of entering out-of-home care (OOHC), and their families, will be receiving a coordinated package of supports based on their needs.*
>
> *(2) One connected response: A dedicated commissioning entity, independent of service delivery agencies, will be established to drive a single response for vulnerable children and families.*
>
> *(3) A smart system: An investment approach will be adopted across all services to ensure funding and evidence are aligned most effectively to wellbeing outcomes.*
>
> *Our new approach to child protection will ensure a coordinated response across government and the sector and will address the needs of children and families early to give them a strong foundation for a better life.*[374]

While these recent reforms are only just beginning, our consultations with FACS have been encouraging. FACS is placing strong emphasis on employing evidence based models that have achieved impressive results internationally, underpinned by strong governance and accountability arrangements. If the reforms achieve their intended purpose, they will no doubt lead to better outcomes for children who are accepted into the JIRT program and other vulnerable children.

371 The number of ROSH reports received by the Helpline has increased from 98,100 in 2010-2011 to 126,100 in 2014-2015. In 2014-2015 a total of 22,462 children received a face-to-face assessment compared with 19,826 children in the period 24 January-31 December 2010. (Sources: NSW Legislative Council, General Purpose Standing Committee No. 2, *Report no. 46: Child protection*, March 2017, p.49; NSW Ombudsman, *Keep Them Safe?,* August 2011, p.6.)

372 It is not possible to compare this figure directly with the proportion of matters closed due to competing priorities reported in our 2014 report, as the figure reported in 2014 related to the proportion of reports screened as ROSH at the Helpline that were subsequently closed due to competing priorities, whereas the figure provided in evidence at the 2016 inquiry related to the proportion of children who were reported to be at ROSH that were closed due to competing priorities. Historically, however, these figures have been similar.

373 NSW Legislative Council, General Purpose Standing Committee No. 2, *Report no. 46: Child protection*, March 2017, p.49.

374 NSW Department of Family and Community Services, 'Building a better child protection system' (media release), 29 March 2017, http://www.facs.nsw.gov.au/reforms/children,-young-people-and-families/building-a-better-child-protection-system.

11.6.2. Exploring how FACS JIRT can better support the work of CSCs

When a JIRT unit has completed its role in a matter, it will transfer case management responsibility to a CSC if it decides that further FACS involvement is required.

We asked FACS to provide us with data about the number of matters referred to CSCs from the JIRT. In response, FACS advised us that while matters 'referred for further child protection action are captured in KiDS, it is complex to extract the relevant data'. FACS attempted to extract data for 2015-2016, however it could not do so within the requisite timeframe. However more recently, FACS was able to provide us with an estimate (based on a manual review of JIRT matters), that around half of all matters are assessed by FACS JIRT as requiring transfer to a CSC for further action.[375]

The relevant FACS casework practice mandate, *Transfer of a child or family between teams, CSCs and JIRT*, states that 'the CSC must accept all cases transferred to them by JIRT and carry out a response that reflects the level of risk identified by JIRT'. However, in practice many matters referred to CSCs by JIRT units cannot be allocated due to competing demands. The proportion of these unallocated JIRT matters is also unknown – FACS advised us that it is currently unable to extract this information. FACS did note that a proportion of matters that are referred by JIRT to CSCs are matters where the CSC is already involved with the child's family, for example, the CSC may be concurrently responding to a sibling report; and that 'for these matters there is a guarantee that they will continue to receive a response'.[376]

Without data in relation to the number of JIRT matters referred to CSC for further action and the proportion of these that are allocated for a response, FACS is unable to provide meaningful outcome data for children accepted into the JIRT program. It is also unable to assess the true impact of CSC capacity constraints on the overall FACS JIRT response.

Our experience from reviewing child protection matters over many years suggests that the point of case transfer from FACS JIRT to the CSC is a weak point in the overall child protection response to JIRT matters that must be addressed. The responses to the JIRT workforce survey similarly suggest that this is an area of concern for FACS JIRT staff – one third of all FACS survey respondents raised concerns about CSCs not allocating cases referred by FACS JIRT. The same issue was also mentioned by a significant number of CAS and Health staff:

> *Where the JIRT response is completed and matters are transferred to CSCs for ongoing management, there is often an 'over-closure' of these matters where outstanding issues are still ongoing. This creates a significant anxiety in JIRT staff about transferring matters* – FACS Caseworker.
>
> *It has happened many times that JIRT has transferred a case to the CSC recommending allocation and it is closed due to competing priorities. This risks leaving children with no ongoing supports after experiencing severe physical or sexual abuse* – FACS Caseworker.
>
> *Police keep cases from beginning to end whereas FACS keep them for a short period of time and then send them to the local CSC. This results in many cases being closed by the CSC due to competing priorities* – CAS Team Leader.
>
> *CSCs may not keep cases transferred from JIRT open and allocated despite serious child protection concerns. This impacts on Health's capacity to work with families* – Senior Health Clinician.

A number of FACS respondents suggested that JIRT referrals should be given priority at the CSC over other cases. While the current casework practice mandate does state that all JIRT matters should be allocated, we appreciate the risks associated with mandating the allocation of JIRT matters at the expense of other reports from the Helpline that may also indicate a very high level of risk. Currently, CSCs only allocate around 60% of matters that are referred by the Helpline, and of these, only half receive a face-to-face response. Directing that CSCs must provide a response to all matters referred by JIRT units could have the effect of further reducing the CSC response rate, and may mean that higher risk CSC matters are not given a comprehensive response.

375 Advice provided by FACS, June 2017.
376 Advice provided by FACS, June 2017.

Other FACS respondents suggested that it would be beneficial for JIRT units to maintain carriage of higher risk matters for a longer period in circumstances where a CSC indicates that it cannot be immediately allocated. While we appreciate that it is not appropriate for FACS JIRT to provide long-term casework to families, there would appear to be merit in CSCs consulting with the referring JIRT unit if they are not immediately able to accept case management of a matter, with a view to supporting a more flexible approach to the timing of the transfer of cases from JIRT units – particularly once the additional FACS JIRT positions have been filled.

Improving sibling case coordination between the JIRT and CSCs

As part of its initial assessment of a report, the Helpline will consider whether the child named in the report has any siblings and, if so, whether the reported concerns indicate that those siblings may also be at risk of significant harm. For example, a child's siblings may be considered to be at risk if the report relates to harm that is alleged to have been caused by someone living in the home or if the reported concerns are otherwise related to the child's home environment (for example, if a child is alleged to have been abused elsewhere, but there are related concerns about supervisory neglect).

If a child's siblings are assessed as potentially being at risk of significant harm, a separate report will be generated by the Helpline for the siblings and sent to the local CSC. This is also the case in matters involving allegations of harmful sexual behaviour by one sibling towards another. Where such matters meet the JIRT referral criteria, a report for the alleged victim will be sent to the JRU, and a separate report for the child alleged to have engaged in harmful sexual behaviour will be sent to the CSC.

When 'related reports' are being managed by a JIRT unit and a CSC, close collaboration is essential to achieving a coordinated response and avoiding duplicated effort. To support such an approach, FACS has developed a casework practice mandate, *Sibling case coordination – JIRT and CSC*. The mandate directs that, where there is a both a JIRT referral and related sibling report, the JIRT unit and CSC should arrange a 'pre-assessment consultation' to clarify the roles and responsibilities of each worker and business unit. A further coordination meeting should occur following the JIRT interview to discuss the outcome and 'decide which unit should be responsible for coordinating and conducting the casework with the family unit'.

The mandate directs that the CSC will take the lead in matters where the family already has an allocated and active matter held at the CSC, or where there is a lengthy child protection history. The JIRT unit will take the lead if the report involves a person of interest who is not a family member, there are no ongoing risks to the child, and reports on the other siblings in the home relate exclusively to the relevant JIRT report. Beyond these circumstances, there is no further direction regarding which unit should take the lead, with the expectation that a decision will be made by the CSC and JIRT unit during the coordination meeting.

While one caseworker who responded to the JIRT workforce survey commented that FACS JIRT works well with CSCs in relation to sibling case coordination, 22 staff (including one Manager Client Services and seven Managers Casework) raised concerns about practice in this area.

A number of FACS, Police and Health survey respondents raised concerns about the high proportion of sibling reports that are either left unallocated or closed by CSCs due to competing priorities, in circumstances where JIRT staff have ongoing serious concerns about child safety. In some cases, closure is reportedly occurring at the CSC before the sibling the subject of the alleged harm has been interviewed as part of the JIRT response. FACS survey respondents expressed strong concern that the closure of a sibling sexual abuse report by a CSC will mean that the child/young person who allegedly engaged in the harmful sexual behaviour may not receive the support and treatment required to address their behaviours.[377]

377 Advice provided by Dale Tolliday, OAM, March 2017. For example, while New Street will work with a child or young person irrespective of whether FACS is actively involved in providing casework support, the New Street protocol for assessment requires the family and all relevant agencies to meet at the commencement of a New Street assessment and again at the conclusion of that assessment. NSW Health has advised us that the involvement of FACS is critical to this process, particularly in light of the fact that harmful sexual behaviour often occurs in the context of other child protection issues.

The Clinical Advisor for New Street Services (the main treatment service in NSW for children and young people aged 10–17 years who engage in harmful or abusive sexual behaviour) advised us that, as harmful sexual behaviour often occurs in the context of other child protection issues, it is preferable for the CSC to maintain an open case plan while New Street services are being provided; however, New Street will still provide therapeutic support where a case plan is closed.[378] Irrespective of whether a matter remains open at the CSC, New Street does require FACS, as well as other relevant agencies and the family of the siblings, to be engaged in the assessment of whether a child or young person is suitable for its services. We understand that FACS is not able to easily extract data on the number of sibling sexual abuse matters that are connected to a JIRT report, and are closed due to competing priorities, or otherwise not allocated by CSCs.

The sibling case coordination mandate does not provide specific guidance on how matters involving harmful sexual behaviour by a sibling should be managed. The comments by respondents to the JIRT workforce survey suggest that it is a common view that casework for the two siblings must be provided separately – a number of FACS staff suggested that the conflict of interest would be too great for these roles to be merged.

Sibling sexual abuse matters are among the most complex of those dealt with in the JIRT program. In many cases, it will be reasonable for FACS JIRT to seek support from the CSC to connect the child/young person who engaged in the harmful sexual behaviour with appropriate supports, while FACS JIRT provide supports to the victim. The case study below illustrates the importance of a coordinated approach.

Case study 7 – Responding to allegations of harmful sexual behaviour by a sibling

A matter was reported to the Helpline alleging that a 15-year-old boy had engaged in harmful sexual behaviour towards his younger sister. The matter was accepted for a JIRT response, and an interview was undertaken with the sister where she made disclosures of abuse. The police subsequently determined that it was not appropriate for the matter to proceed criminally.

The report for the brother was sent to the relevant CSC and allocated for a response. FACS JIRT worked with the CSC and Health to develop a safety plan. As the children's parents were separated, it was agreed that the brother would stay with their father, and the sister would remain with their mother while relevant health services arranged for the family to undertake further assessments and provide therapeutic services to both children.

The JIRT response to sibling sexual abuse matters is discussed further in Chapter 17 in the context of the capacity of the broader service system to deliver an adequate therapeutic response to this cohort of children and young people.

In non-sibling abuse matters that otherwise involve a sibling report – for example, where a disclosure has been made by one sibling of abuse by an adult family member, and it is unknown whether other siblings may also have been the victim of abuse; or where there are other child protection concerns that relate to the family as a whole – the potential for JIRT to provide a response to the siblings is greater, as it is unlikely that there will be a conflict in them doing so.

The responses to the workforce survey nonetheless suggest that there are still issues with the effective coordination of a response in these matters, due, at least in part, to the limited capacity of both CSCs and JIRT units and the ambiguity of the mandate regarding who should complete particular casework activities. A number of caseworkers raised concerns about the lack of support provided by CSCs in assessing siblings, with four caseworkers suggesting that the mandate be reviewed to make clear that CSCs should conduct assessments of all sibling reports that are related to JIRT matters.

378 New Street previously had a policy of only accepting cases with open case plans, but abandoned this position in 2006. However, *New Street Service Standards and Guidelines* have not been updated to reflect this change, which contributes to confusion about the scope of New Street services among JIRT staff. The need to update *New Street Service Standards and Guidelines* and other key policy documents addressing therapeutic services for children and young people with problematic or harmful sexual behaviours is addressed at section 17.3.2 of this report.

Notably though, one caseworker manager stated that:

> *JIRT caseworkers are very reluctant to complete assessments of siblings as they feel this should be the responsibility of the CSC … It can be difficult to address this issue with caseworkers as the policy itself is ambiguous [and] encourages JIRT caseworkers not to conduct assessments of siblings. What usually happens for these cases is the plan created for the CSC will remain unallocated awaiting the outcome of the JIRT assessment and the siblings will often not be assessed by anyone.*

While we can appreciate the benefits of building discretion into the policy, feedback from staff suggests that the level of flexibility might be too great. It would appear timely for FACS to work with its JIRT units, CSCs and casework specialists to review the mandate and include more specific guidance regarding the management of these very complex matters.

As FACS JIRT is responsible for conducting a comprehensive assessment of the child or young person who is the subject of the JIRT report, including their home circumstances (even if the abuse did not occur in that environment), simultaneously conducting an assessment of that child's siblings would be consistent with FACS JIRT's objective to provide a holistic response to the child and their family. It would also appear to be a more efficient use of FACS resourcing. In our view, there would be merit in considering reviewing the mandate to make explicit that sibling assessments should be completed by the JIRT unless there are compelling reasons for a CSC to conduct the assessment of a child's siblings (for example, if a sibling is the alleged offender, the CSC has a current open plan for the family, or has undertaken significant work with the family in the past).

The extent of CSC non-allocation or closure of sibling sexual abuse matters should also be assessed as part of any review, with consideration being given to requiring that CSCs keep case plans open until the child or young person who has caused sexual harm to a sibling has either been referred into therapeutic treatment or is being dealt with via the criminal justice process.

11.6.3. Assessment quality

It is FACS policy that matters referred to the JIRT program must not be closed due to competing priorities and must be assessed unless there are legitimate reasons why a face-to-face assessment is not required.[379]

Accordingly, the proportion of JIRT matters that receive a face-to-face assessment is comparatively high. In 2015-2016, 76% of JIRT matters (3,569 of the 4,710 accepted referrals) were recorded in KiDS as having received a face-to-face assessment – up from 71% in 2011-2012 and 73% in 2012-2013.

Our analysis of the 1,141 matters that were recorded as not proceeding to an assessment in 2015-2016 indicates that:

- 473 (41%) were matters where the child or young person was alleged to have been abused by a stranger, there were no other reported risk factors or child protection history, and the parents or young person refused FACS intervention
- 360 (32%) were matters where FACS determined, on the basis of a review of available information (including information provided by CAS and Health), that further risk assessment was not warranted
- 102 (9%) were matters that did in fact proceed to assessment, but the assessment was not linked in KiDS due to data entry issues
- 62 (5%) were matters where the report was referred interstate because the child or young person was living in another jurisdiction (including 30 that were closed and referred interstate by the JRU, and 32 that were closed and referred interstate by JIRT units).
- 50 (4%) were matters where the child or young person could not be located despite exhaustive attempts by staff to do so, and

379 A face-to-face assessment is defined by FACS for its reporting purposes as a matter where a safety and risk assessment (either a Safety, Risk and Risk Assessment Tool (SARA), or a Secondary Risk of Harm Assessment (SAS2)) has been completed. These assessment tools are discussed later in this section.

- the remaining 94 (8%) were matters where the reason for not proceeding to an assessment was incorrectly recorded and therefore unknown; an assessment was completed by a CSC rather than a JIRT unit; an assessment was incomplete at the time of data extraction; or a data entry error of some type was made.

It is positive that FACS JIRT has maintained such a high face-to-face response rate despite only receiving an additional ten casework staff since the time of our 2012 report. It is also positive that, while a small proportion of matters are subject to data entry errors or other data integrity issues, FACS is able to report clearly at a state-wide level on the reasons for matters not proceeding to assessment.

The fact that such a high proportion of JIRT reports require a face-to-face assessment, and the resulting high workload of the JIRT units, inevitably has consequences in terms of the ability of FACS JIRT teams to complete comprehensive assessments. In its 2014 review, EY found that 'the high volume of work and the inability to close matters due to "competing priorities" is resulting in caseworkers not spending the full time they need to perform a complete and high quality response on every case'.[380]

EY conducted an analysis, which was informed by a self-assessment by caseworkers and a review by FACS JIRT management of a small sample of cases that had recently been closed, of the extent of this shortfall. The analysis resulted in a preliminary assumption that caseworkers required around 27% more time on their cases in order to meet an appropriate level of quality and completeness. EY noted that this assumption was limited in terms of its robustness, and suggested that further work by FACS was required to refine it and establish clear consistent standards against which casework quality can be measured.[381]

The quality of FACS' child protection assessments goes to the very heart of its JIRT response. A comprehensive assessment is critical to ensuring that the allegations of serious abuse which led to the report are responded to (particularly in matters that do not result in criminal proceedings), and that the broader circumstances of a child or young person are considered.

While we are not aware of any steps taken by FACS to explore the accuracy of EY's assumption concerning the extra time required by caseworkers to complete matters to the requisite standard, this inquiry has provided some evidence of variability in the comprehensiveness of JIRT casework, which can be attributed, at least in part, to current staffing levels.

Conducting holistic assessments

In its submission to our inquiry, FACS advised that its JIRT senior management team has recently focused its attention on ensuring that its JIRT units are undertaking holistic assessments of referrals; that is, ensuring that they are not only comprehensively assessing the incident the subject of the JIRT referral, but also conducting a complete assessment of the circumstances of the child or young person. FACS also said that it has been encouraging its JIRT units to seek advice from local casework specialists on complex cases to ensure assessments are both comprehensive and holistic.[382] The focus on this critical area of practice is positive.

It is apparent from the workforce survey responses that the importance of conducting holistic assessments has been strongly communicated to the FACS JIRT units – 39% of FACS survey respondents mentioned that holistic assessments should be embedded in the FACS JIRT response. Most of these respondents said that this is an area where FACS is performing well, for example:

> [FACS JIRT] *ensures that more than just convictions are pursued.* [We give] *consideration to all aspects of the child's situation … Often there will be DV/drugs/mental health problems to address* – FACS Caseworker.
>
> *We conduct thorough assessments about the child and their families to ensure the best outcome during JIRT investigations and after investigation have ceased* – FACS Caseworker.
>
> *FACS is doing a good job of conducting comprehensive, holistic investigations and assessments to assess and ensure the safety of children* – FACS Manager Casework.

380 Ernst & Young, *Review of Joint Investigation Response Team (JIRT) Resources*, 19 February 2014.
381 While an additional ten staff have since been added to the JIRT, the caseloads have not changed significantly since the EY review.
382 Advice provided by FACS, March 2017.

However, a considerable number of FACS staff noted that improvements were still needed:

> *There is a tendency for FACS JIRT to focus on the incident, rather than conduct a holistic assessment* – Manager Casework.

> *FACS are involved during the interview, speaking with the family after the interview and then write a SAS 2 on the information obtained. This is not holistically assessing risk and safety for the child/ren in the household. In 6 months, I have completed 3 home visits on children in my caseload. I believe that this is not sufficient and that at least every child attached to a caseworker's caseload should be seen in their family home* – Caseworker.

> *The training offered by JIRT focuses heavily on the interview, and it appears that through evolution, JIRT caseworkers have interpreted this as their primary role. I think JIRT assessments are sometimes not holistic in nature … For example, in a matter where sexual abuse is alleged, a caseworker will often only address this concern and not assess other existing concerns such as drug and alcohol use, inadequate supervision etc which may in fact have contributed to the sexual abuse occurring. JIRT caseworkers rarely conduct home visits as there is a misconception … that home visits only need to occur when the abuse occurs within the household … Home visits should be compulsory for all children subject to a JIRT accepted report … Best practice and evidence supports children being observed in their own environment and this should be instilled in caseworkers in the JIRT program* – Manager Casework.

FACS advised us that its JIRT staff generally would conduct home visits, apart from the limited circumstances where sighting a child when they attend a JIRT unit (or other location) to participate in a recorded criminal interview is regarded as sufficient to assess safety and risk. For example, where the alleged abuse is not associated with the home environment and there are no other known risks. However, as illustrated by the comments above, a number of caseworkers and managers stated that they feel there is a need for JIRT staff to conduct home visits more routinely.

While we accept that home visits may not be necessary in all JIRT matters, as illustrated by case study 8 below, they provide a window into the family environment.

Case study 8 – Benefits of conducting home visits

A teenager disclosed that she had been sexually assaulted by her stepfather. The matter was accepted for an urgent after-hours response, and the girl was interviewed by officers from the CAS. A FACS caseworker from the Helpline's Crisis Response Team was also present. Following the interview, police successfully applied for a provisional AVO and, with the mother's agreement, the girl was temporarily placed in care.

FACS subsequently developed concerns about the extent to which the mother would be protective of her daughter if she were to return home. In consultation with police, FACS arranged to conduct a home visit. Their discussions with the girl's mother during that visit provided valuable insights into the family dynamics, the mother's understanding and knowledge of child sexual assault, and her protective ability. In conducting a 'walk through' of the home, FACS also identified a range of other child protection risks, including the discovery of child abuse material. Acting on the information provided by FACS, the police obtained a search warrant and seized a range of evidence. The stepfather was charged with a number of offences, and care proceedings were commenced. The girl is now living in OOHC.

To assess the extent to which FACS JIRT is conducting more holistic assessments, we asked FACS to provide us with advice about the JIRT casework performance data it currently collects. The information collected about casework activities is limited – for example, it does not include data relating to whether a home visit was carried out in the course of conducting an assessment, or whether any other parties (for example a child's school, other service providers, or non-offending family members) were consulted as part of an assessment.[383]

383 The casework activities that are reflected in the data that is currently collected include whether a forensic investigative interview was conducted (although FACS currently does not record whether or not the interview was monitored by FACS), and whether a FACS 'ROSH' interview was conducted.

As a result, it is not possible to know whether home visits are more routinely conducted by some units or clusters than by others.

We appreciate that collecting casework activity data alone will not provide a full picture of the quality of assessments; however, certain casework activity measures ('output' measures) will provide useful insights for FACS JIRT managers into the type of activities being carried out (or not) to inform assessments. In this regard, we have identified two outcome measures available to FACS that would also provide indicative data about the quality of the assessment process:

- the proportion of children and young people who receive a face-to-face assessment and who are re-reported to FACS within 12 months of JIRT plan closure, and
- the proportion of matters where harm is substantiated that relates to an issue other than an issue that was the subject of the JIRT referral.

As we discuss in section 11.7, the data that is available against these measures (although currently limited) indicates that there is a significant amount of variation between JIRT units.

FACS has advised us that the Office of the Senior Practitioner (OSP) is currently developing an assessment training package aimed at improving the quality of assessments, and that a version of this training will be tailored for the JIRT context and delivered to all JIRT staff. This is a positive development and one that will no doubt assist in improving the quality of assessments completed by JIRT units.

Given the various strategies being implemented to enhance the quality of assessments within the JIRT, there would appear to be benefit in the FACS JIRT leadership, together with the OSP, reviewing available casework activity and outcome data of the type we have proposed in order to monitor performance at a state-wide, cluster, and unit level against this critical area of JIRT practice.

Assessment tools

In response to recommendations made by the Wood inquiry, FACS rolled out a structured decision-making system, which includes a Safety, Risk and Risk Reassessment (SARA) tool, in 2011-2012. The SARA is an actuarial tool for assessing safety and risk within a household. It requires that certain information be entered into KiDS. SARA weights this information to provide an outcome as to:

- whether or not a child or young person is currently safe, safe with a plan,[384] or unsafe, and
- whether the risk that a child or young person will be abused or neglected in the future is low, moderate, high, or very high.

While the tool still allows for professional judgement (through a discretionary override of the risk outcome) it is intended to support increased consistency and validity in casework decisions.[385] In May 2017, FACS rolled out refresher training on the use of the SARA tool to its JIRT staff.[386]

As it is primarily designed to assess safety and risk in matters where all of the concerns relate to a child or young person's household environment, there are a number of circumstances where the SARA tool cannot be used to support valid outcomes.

These 'SARA exceptions' include matters where the alleged perpetrator is not a member of the household, and circumstances where the child or young person is in the care of the Minister.[387] Where a 'SARA exception' applies, FACS continues to make decisions based on a guided professional judgement model, using the Secondary Risk of Harm Assessment or 'SAS2' practice resource.[388]

384 A child or young person is considered safe with a plan if there are one or more dangers present in a household, but safety interventions have been initiated which mitigate the danger.
385 NSW Department of Family and Community Services, *Safety, Risk and Risk Reassessment: Policy and Procedures Manual*, updated August 2012.
386 Advice provided by FACS, May 2017.
387 NSW Department of Family and Community Services, *Safety, Risk and Risk Reassessment: Policy and Procedures Manual*, updated August 2012.
388 NSW Department of Family and Community Services, *Secondary Risk of Harm Practice Resource*, undated.

The assessment tools used by FACS were examined during the recent NSW Parliamentary Inquiry into child protection. In its final report, the committee questioned 'how effective these tools are given concerns they are not suited to a wide variety of factors and circumstances, for example, to assess risk in Aboriginal families and communities', and also raised concerns about their adequacy for assessing cumulative harm. The committee recommended that 'the NSW Government commission an independent review of [FACS'] screening and assessment tools and processes, to identify how they can be improved to enhance objectivity within child protection assessments'.[389]

While not an issue that was identified by a large number of FACS survey respondents, ten staff raised concerns about the application of both the SARA and SAS2 tools in the JIRT context. Most of these staff commented that the tools were often difficult to use in the JIRT context, particularly in sibling abuse matters, and suggested that a version of the assessment tool for JIRT staff should be developed. As part of conducting any review of its assessment tools, there would be merit in FACS specifically considering their application to the JIRT context, including whether the SARA tool accurately assesses risk in circumstances involving allegations against a household member who is not a parent or carer.

11.6.4. FACS policies and procedures for identifying and recording persons of interest and persons causing harm

There are a range of child protection actions that FACS can take to respond to immediate concerns about an alleged victim or other children, either whilst a police investigation is underway, or in circumstances where police determine that they will not proceed with criminal charges, but where there is nonetheless sufficient evidence of weight that the alleged abuse occurred.

In addition to its role in responding to immediate risk, FACS also has a responsibility to ensure that the information reported to it, and FACS' assessment of that information, is properly documented and readily available to assist in the identification and management of risk to other children in the future. For this purpose, FACS records certain individuals as a person of interest (POI) or a person causing harm (PCH) on its child protection database.[390]

The statutory threshold for taking child protection action (such as removing a child) is a belief on reasonable grounds that a child or young person is at risk of serious harm.[391] As such, FACS does not generally need to have finalised the related process of determining and recording an individual as a POI or PCH in order to initiate protective action. While, from an information gathering perspective, there is significant overlap for FACS caseworkers in assessing whether a child is at risk of significant harm, and making a subsequent determination about whether an individual has harmed them, the processes are distinct for valid reasons, as we discuss in the following sections.

Identifying and recording individuals as a POI or PCH is an important child protection safeguard; therefore, the processes for making such determinations need to be robust. In addition, as there is the potential for a POI or PCH record to have significant adverse consequences for the individual the subject of the record, caution must be exercised in making these determinations.

Given the importance of establishing good practice in this complex area, our office has been working with FACS for some time to refine its practices in relation to making POI and PCH determinations. In their submission to this inquiry, Police also identified the need for FACS' current processes for determining PCH to be reviewed, given that they can intersect with and impact on concurrent criminal investigations.

In this section we discuss the evolution of FACS' policy and practice in this area over recent years. We also discuss the suggestions we made to FACS during the course of this inquiry aimed at further refining the procedural guidance, and related operating frameworks for frontline staff and FACS' response.

389 NSW Legislative Council, General Purpose Standing Committee No. 2, *Report no. 46: Child protection*, March 2017 (Recommendation 4).

390 The relevant FACS casework practice mandate, *Identifying and recording POI and PCH*, states that the purpose of assessing and correctly recording a POI and PCH is to 'help to identify risk to children in the future'.

391 Section 30 of the Care Act provides that, on receipt of a report that a child or young person is suspected of being at risk of significant harm, FACS must make such investigations and assessment as is considered necessary to determine whether the child or young person is at risk of significant harm. Section 35 of the Act provides that, if FACS forms the opinion, on reasonable grounds, that a child or young person is in need of care and protection, they must take whatever action is necessary to safeguard or promote the safety, welfare and wellbeing of the child or young person.

How PCH and POI records are used

If FACS substantiates an allegation of abuse and determines that an individual is a PCH, this record is taken into account in assessing the risk posed by the individual in a range of contexts. For example, if a report is made to the Helpline about an individual that has been recorded as a PCH, the PCH record will be considered as part of FACS' assessment of, and response to, the report. It may result in a report being:

- screened in by the Helpline when it might not otherwise have met the ROSH threshold
- allocated a higher priority on referral to the JRU or a CSC, and/or
- allocated for a face-to-face response at a CSC in circumstances where it may otherwise have been closed due to competing priorities.[392]

Even in circumstances where there is insufficient evidence to determine that an individual is a PCH, reports alleging that a person has caused harm to a child or young person (that is, POI records) are critical child protection records. For example, multiple reports alleging that a person has abused different children, which individually cannot be substantiated may, over time, demonstrate a pattern of behaviour. While it may not be possible for police to lay charges in the absence of sufficient evidence about any individual allegation, repeated and unconnected allegations of similar behaviour would be highly relevant to a determination by FACS as to whether an individual is a PCH, and may be a critical factor in assessing that the strength or weight of the evidence is sufficient to determine (and record) that an individual is a PCH.[393]

In addition to the relevance of a PCH determination for FACS' internal processes, it also informs various probity checking processes for people who are engaged in, or seek to engage in, child-related employment. For authorised foster carers and other household members, an OOHC agency is required to conduct a 'Community Services check' in order to fulfil its probity checking obligations under the Carers Register.[394] This check is essentially a request under Chapter 16A of the Care Act to FACS, seeking any relevant information about the applicant, including any prior PCH determinations.

In the context of child-related employment more broadly (including certain volunteer roles), if a person is currently the holder of a Working with Children Check (WWCC) clearance, or if they apply for a WWCC, a PCH determination will be taken into account by the Office of the Children's Guardian (OCG) (if it is aware of that determination) in assessing the person's existing clearance, or future application. While a PCH determination will not automatically require the OCG to conduct a risk assessment of an individual, the OCG will consider it in the context of any other information that it holds about the person, and it may form part of their evidence in deciding that an individual poses a risk to children.[395]

Background – improving practice in identifying and recording persons of interest and persons causing harm

Throughout 2013 and 2014, we raised a number of concerns with FACS about their policies and procedures for identifying people as a POI and PCH, in particular:

- the ability to search for and locate records about adults on KiDS
- whether appropriate links were being made on KiDS to enable previous POI and PCH records to be readily identified as part of FACS' assessment processes

392 The respective screening and assessment tools used by FACS (including the Screening and Response Priority Tools; the Safety and Risk Assessment; and the triage assessment mandate) require FACS to take into account information about a child or young person's child protection history; as well as information about a relevant adult who has or may have previously ill-treated a child; in making decisions about current reports.

393 The FACS casework practice mandate for identifying and recording POI and PCH does not currently include any guidance about the consideration of prior POI records as relevant evidence in making a PCH finding. The relevance of prior POI reports is however referenced in the 'Person Causing Harm resource pack' (unpublished) which has been developed for FACS JIRT staff.

394 The NSW Carers Register came into operation in June 2015. It was set up to improve the process of authorising prospective carers and their household members, and to improve information sharing between OOHC providers. The register does not permit an OOHC agency to grant authorisation until it has confirmed that certain mandatory carer and household member checks, including a Community Services check, have been completed.

395 Advice provided by the Office of the Children's Guardian, March 2017.

- whether the Helpline was consistently recording individuals as a POI at the time it received a report
- PCH findings being made in circumstances where the evidence did not appear to reach an appropriate threshold, and
- PCH findings being made in the absence of the individual being provided with an opportunity to respond to the allegations (where there was no apparent reason for this opportunity not being afforded to them).

Since then, we have monitored FACS' progress in developing better guidance for its staff in this complex area of practice.[396] FACS has advised us that it has made a range of improvements to its practice and procedures, including:

- enhancements to KiDS in June 2014 to facilitate faster and more accurate identification of POI and PCH records
- reviewing and updating the relevant casework practice procedure in late 2014 to include improved guidance on the standard of proof required to determine that an individual is a PCH and emphasise the importance of affording individuals procedural fairness (except in particular circumstances)
- training and education delivered to Helpline staff in 2015 to improve awareness and use of the POI relationship in KiDS
- an audit of practice in 2015, and
- a further update of the relevant procedure (now termed a 'casework practice mandate') in 2016 to align it with FACS' new Casework Practice intranet site.

To accompany the casework practice mandate, during the course of this inquiry, FACS developed a 'Person Causing Harm resource pack', to support good practice within the JIRT program. The resource pack includes practical advice about the type of information that should be gathered in seeking to determine whether an individual is a PCH, and applying an appropriate standard of proof to PCH decisions. It also includes a number of scenarios to illustrate how to translate these concepts into practice. FACS intends to review the package following the recommendations from our inquiry and will distribute it to staff in the near future.

In addition to reviewing the resource pack, we also examined the current casework practice mandate. In doing so, we identified a number of areas where we believed additional guidance was needed for FACS caseworkers (in and outside of JIRT) and which should also address concerns raised by Police during this inquiry – these are discussed below.

Standard of proof required to identify an individual as a PCH

Over recent years we have been raising concerns associated with the standard of proof required for FACS to determine that an individual is a PCH – both in relation to individual cases and to the adequacy of guidance available to FACS staff in this very complex area.

In early 2015, we were pleased to receive advice from FACS that revisions to the case practice mandate had resulted in improved emphasis on and clarification of the degree of evidence required before determining that an individual is a PCH. The mandate directs that a decision to identify an individual as a PCH should be made by a caseworker, and approved by a Manager Casework. It includes the following guidance:

> *To identify an individual as a PCH apply the 'balance of probabilities'. This is where you test whether it is more probable than not that the person caused the harm. Consider the natural improbability of the harm, the gravity of the consequence as a result of identifying the person as PCH and unknown evidence or unintended admissions.*

396 In June 2015, we advised FACS that we intended to monitor its practice and procedures in this area via the Integrated Governance Framework (IGF) – a joint FACS and Ombudsman document aimed at improving how we monitor the progress made by FACS in implementing significant recommendations from our review and investigative work.

In oversighting the reportable conduct scheme, we support agencies on a daily basis to enable them to make findings about allegations that their employees have engaged in reportable conduct (including sexual misconduct/sexual offences and serious physical abuse).[397] These decisions are very similar, both in terms of the standard of proof required and the nature of the alleged conduct, to FACS PCH decisions and, in almost all cases, a sustained serious reportable conduct finding will also result in a FACS PCH record.

Our experience in the reportable conduct sphere has revealed how challenging it can be for even the most experienced agency staff to understand and apply civil standards of proof. In recognition of these difficulties, and in light of important recent developments in case law,[398] we have recently reviewed and updated our resources for agencies to provide them with updated guidance in relation to making sustained findings. Our fact sheets now include the following guidance in relation to making findings:

> *The decision-maker must assess the strength or weight of the evidence, when making a finding … The decision-maker should consider the reliability of the evidence; whether it is relevant to the alleged conduct; if accounts are consistent (over time, with other evidence, and more or less plausible); and whether there is any other evidence to corroborate or contradict an allegation*
>
> *… it is not necessary that reportable conduct be sustained to the criminal standard (i.e. beyond reasonable doubt). However, a sustained finding must be based on material that logically tends to show that all the facts necessary to establish the incident are made out to the reasonable satisfaction of the decision maker.*

We advise agencies in our reportable conduct jurisdiction to exercise caution when reaching a sustained finding in a matter that involves a criminal allegation (such as a sexual offence allegation or a physical assault allegation) in the absence of a criminal conviction. The decision-maker should base their decision on clear and cogent evidence, not guesswork, suspicion or rumour. The more serious the wrongdoing, the more care the decision-maker must exercise when deciding whether they are satisfied that the conduct is sustained.

Having reviewed FACS' guidance in the current casework mandate, we believe there is merit in updating it to also reflect recent case law, and to provide guidance similar to that contained in our fact sheets for agencies operating within our reportable conduct scheme. In addition, the mandate would benefit from the inclusion of guidance on the type of inculpatory and exculpatory evidence that should be considered when FACS staff are deciding whether or not to substantiate that a person has caused harm,[399] ideally supplemented with case studies illustrating how this evidence is relevant in practice to making decisions about a PCH finding. In this regard, the recent 'Person Causing Harm resource pack' developed by FACS contains some information that could be adapted and included in the mandate.

In addition to improving guidance – and in light of the difficulties associated with ensuring good and consistent decision-making in this area, combined with the adverse impact that a PCH determination can have on the rights and interests of the relevant individual – there would be merit in these decisions being approved at a more senior level. At a minimum, we believe the mandate should be amended to require that all decisions about whether or not to substantiate a PCH record be approved by a Manager Client Services rather than at Manager Casework level.

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397 Section 25A of the *Ombudsman Act 1974* defines 'reportable conduct' as any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence or an offence involving child abuse material), or any assault, ill-treatment or neglect of a child, or any behaviour that causes psychological harm to a child, whether or not, in any case, with the consent of the child.

398 Including *Sudath v Health Care Complaints Commission* [2012] NSWCA 171; *Sullivan v Civil Aviation Safety Authority* [2014] FCAFC 93; *Australian Communications and Media Authority v Today FM (Sydney) Pty Ltd* [2014] FCAFC 22; and *Minister for Immigration and Border Protection v SZSSJ* [2016] HCA 29.

399 Up until the most recent revision in 2016, the FACS procedure included some basic information about the type of evidence that should be reviewed in making a PCH decision. However, the current mandate does not include any reference to the need for FACS to consider relevant evidence in making a PCH decision; or any guidance about the type of evidence that might be considered for this purpose.

Intersection of POI/PCH processes with criminal investigations

While all referrals accepted by the JIRT program are assessed as involving criminal allegations of child abuse, in practice, around one fifth of these referrals will involve a criminal prosecution. The remaining matters will vary in terms of the degree of ongoing police involvement. This means that even within the JIRT context, FACS' processes for making PCH determinations will not necessarily 'intersect' with an active police investigation. However, where there is such an intersection, it is critical that FACS and Police liaise closely with each other about the nature of any contact with persons of interest to both agencies.[400]

The mandate currently states that if a report is allocated for a field response, FACS should 'tell the POI about the allegations and give them the opportunity to respond'. If FACS has identified a person as a PCH, the mandate directs staff to 'inform the person of the fact they have been identified and recorded as a person causing harm and the rationale for the decision'. In both cases, the mandate details exceptions to taking these actions, for example, where doing so 'may jeopardise a police investigation'. While the inclusion of this exception is positive, the mandate does not include any further details about the need for FACS officers to consult police about potential impacts on any police investigation.

We understand that the practice of FACS to date has been to make a PCH determination, where possible, prior to the criminal matter being finalised. Comments made by respondents to the JIRT workforce survey indicate that, in at least some units, it has been common practice for FACS to conduct detailed interviews with a POI for this purpose while criminal proceedings are on foot.[401]

During our inquiry, the CAS expressed concern about the potential for PCH interviews to jeopardise concurrent criminal investigations. For example, the CAS questioned the utility in FACS conducting 'PCH interviews' with individuals on remand for related criminal charges. In such circumstances, there is the potential for a POI to provide contrary information in an interview conducted by FACS to that given in a police interview, and the court could take this inconsistency into account when assessing the reliability of the police interview.[402]

We acknowledge the importance of FACS being able to clearly flag individuals of concern on its system to inform the Helpline's assessment of ROSH reports and other care and protection action it may need to take while a criminal investigation is underway. In this regard, during our inquiry we suggested to FACS that the relevant casework practice mandate should make clear that, rather than seeking to make a PCH determination while a criminal investigation is underway, a recent POI record should be sufficient to ensure that FACS will review the information associated with that record (including any concurrent criminal proceedings), in the event that any new reports are made to the Helpline while a matter is proceeding through the court. We suggested that as an additional safeguard, a 'POI pending criminal investigation' flag could be built into the FACS database to act as an interim risk label. In addition, we noted the importance of there being clear direction on the appropriate liaison mechanisms between FACS and Police.

In our view, there are a range of benefits for FACS in making PCH determinations after criminal proceedings have been finalised, both in terms of efficiency and the robustness of the determination. In this regard, any immediate risks posed by the individual can be managed through child protection and criminal interventions – either by virtue of the person being held on remand, or via bail conditions and/or an apprehended violence order. A relevant charge will also automatically trigger a referral to the OCG and, in almost all circumstances, a bar on an individual's WWCC pending determination of the proceedings for the offence.

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400 As well, while most of the time, Police and FACS will be examining very similar factual circumstances in making PCH determinations or charge decisions, there will be occasions where FACS could proceed to make a PCH determination when a police investigation is underway where FACS is satisfied for example, that there is sufficient evidence of other conduct involving an individual, over and above that being examined in a current police investigation. In such circumstances, FACS would be able to reach a PCH determination without traversing issues the subject of a related criminal investigation.

401 For example, one Manager Casework from the Metro 1 cluster commented that 'CAS are now telling us that we are not able to speak to offenders in custody at Police Stations … [or] with those in corrections awaiting prosecution. How do we assess safety to children, how do we meet our obligations around natural justice in recording individuals as Persons Causing Harm?'

402 This decision has similar and related implications for interviews with alleged victims or other potential witnesses, which are discussed in Chapter 22.

As a conviction for a child abuse offence requires a higher standard of proof than that required for a PCH record, a successful prosecution enables FACS to make a PCH determination without necessarily having to undertake an additional investigation for this purpose – thereby saving valuable caseworker time. Similarly, while the mandate directs that FACS must afford individuals procedural fairness by advising them of a decision to name them a PCH, this is also unnecessary in the event of a criminal conviction, as any negative impacts arising from a PCH record would not be different to or greater than those arising from the related conviction.

Where a matter does not result in a conviction, FACS will still need to determine whether an individual is a PCH. However, the benefit of seeking to make this determination after the criminal proceedings have been finalised is that FACS is able to obtain and rely on the evidence gathered by police and, where a matter has proceeded to trial, from the court process. As well as avoiding potential duplication by FACS in separately assessing a matter, this provides FACS with access to evidence that is comprehensive, and (in the case of matters that have proceeded to trial) has been thoroughly tested.

In response to our proposals, FACS indicated that it was concerned that introducing another POI category – POI pending criminal investigation – may result in its staff misunderstanding the level of potential risk involved, whereas, a PCH label is a well understood term among FACS staff. FACS also noted that there are implementation issues associated with creating an additional flag of the type we proposed at this point in time due to the imminent rollout of the ChildStory database. However, FACS did acknowledge the need for clear processes to be established for its liaison with Police where it is seeking to make a PCH determination while a criminal investigation is underway.

In this regard, FACS advised that it would now rely on the police decision to charge an individual with an offence, the nature of which means that the individual poses a significant risk of harm to children, as a sufficient basis for a PCH determination. In addition, FACS confirmed that (except for in certain circumstances discussed below) it will no longer inform relevant individuals that they have been labelled as a PCH, nor will it conduct interviews with them, in circumstances where there is a current police investigation and/or where the police have otherwise advised against such actions.

FACS acknowledges that its proposed approach raises procedural fairness issues; however, its view is that the risk associated with the consequences of a label other than PCH being misinterpreted is a greater concern. In this regard, FACS noted that, as is already the case, individuals have a right to complain about being ascribed a PCH label; and that a PCH record could be 'end dated where FACS receives evidence that the person did not cause harm to a child. In these cases, FACS would record why the determination was end dated'.

FACS also noted that there will be certain circumstances where it will need to conduct a PCH interview in order to fulfil its statutory child protection functions, for example, prior to charges being laid, where police have advised against such an interview. In such cases, FACS indicated that it would consult with police and attempt to reach agreement (which is consistent with the current LPR procedures). We recommended that, where there is still disagreement following field consultation between FACS and Police, matters should be escalated to the Director, Child Protection, Legal for review by the legal unit and further consultation with Police if deemed appropriate. If, following review, a decision is made by FACS that a PCH interview should proceed, then the Director, Child Protection, Legal will assist in formulating carefully framed questions to ensure that the interview does not traverse issues which go beyond what is necessary for FACS to assess safety.

While it is positive that FACS has acknowledged the need to change its practices in this area, we remain of the view that in the longer term, the better option is for FACS to introduce an additional POI pending criminal investigation category as part of future upgrades to its child protection database, and for this to be accompanied by appropriate guidance and training for its staff.

For the reasons outlined above, this approach ensures that individuals who pose a risk are appropriately flagged, the potential to jeopardise criminal investigations is minimised, and procedural fairness is afforded to affected individuals. In light of the commentary in this section, we recommend that, in consultation with Police and our office, FACS update the relevant mandate to reflect its decision to amend its practice in this area. In doing so, it will be critical in revising the mandate that clear advice is given to FACS staff about informing individuals of their PCH status once criminal proceedings have been finalised (particularly where the individual is not convicted), in order

to provide them with the opportunity to seek a review of the determination. As well, FACS will need to emphasise that its existing processes for affording procedural fairness continue to be applied in those matters where charges have not been laid nor is there an ongoing criminal investigation.

Naming children as a PCH

In May 2015, the then FACS JIRT Director issued a memorandum to all FACS JIRT staff, directing that any child or young person under the age of 16 years that had been assessed as responsible for causing harm should not be recorded in KiDS as a PCH without approval at Director level. FACS advised us that 'this recognised the significant implications a PCH recording had for young people while maintaining integrity to record those individuals accurately to inform future risk assessment and identification'.[403]

The FACS casework practice mandate is silent on the issue of recording children as a PCH, meaning that, outside of the JIRT context, a decision to record a child as a PCH currently only requires approval by a Manager Casework. The JIRT requirement for Director-level approval of child PCH records is a positive step, and one which logically, should be applied across FACS generally.

However, we also consider there would be value in complementing the elevated seniority in relation to decision-making in this area, with a set of 'factors to consider' to guide the decision-making of Directors about whether or not a child should be named as a PCH.

Despite the requirement for Director approval, the number of children who are labelled as a PCH by FACS JIRT remains significant – in the six months to 31 December 2016, 52 children under the age of 16 were recorded as a PCH across the JIRT units, accounting for 13% of the total number of people who were recorded as a PCH during the period.[404] While there are significant differences in the consequences of a PCH record and a criminal finding, the impact on a child of being told that they have been permanently labelled as a 'person causing harm' cannot be underestimated.

In this regard, the criminal justice system recognises, through a wide range of measures and procedures, that the actions of a child should be viewed and dealt with differently to those of an adult. For example:

- the statutory minimum age of criminal responsibility is set at 10 years old, and the additional common law presumption of *doli incapax* applies where a child is between 10 and 14 years old
- a court can only record a conviction against a child under the age of 16 in relation to indictable offences that have not been dealt with summarily (that is, a child can only be convicted in relation to a charge heard by the District Court)[405]
- the *Young Offenders Act 1997*[406] establishes procedures outside of formal court proceedings to deal with juvenile offenders, including issuing warnings that, while recorded, are expunged when the young person turns 21 years old,[407] and
- orders of the Children's Court are spent after a shorter crime-free period than convictions.[408]

In this context, there would also be merit in FACS giving consideration to amending its procedures to require that a PCH record against a child be reviewed after a period of time. This would allow FACS to consider new evidence relevant to any ongoing risk posed by the child, such as the child receiving appropriate therapeutic or other supports in addressing the relevant behaviour and whether any further concerns have been raised about the child's behaviours. Where appropriate, FACS could consider end-dating the PCH record. In this regard, it is important to stress that the record itself would still be exchanged as required under Chapter 16A with relevant bodies such as the OCG to inform the WWCC, and it would still be available for FACS to consider in the context of any future ROSH reports.

403 Advice provided by FACS, January 2017.
404 In one JIRT unit, 45% of all PCH records from the period were ascribed to children under 16; in another, children under 16 accounted for 36% of all PCH records. (Advice provided by FACS, 7 March 2017.)
405 See section 14 of the *Children (Criminal Proceedings) Act 1987*.
406 The principles of which include that the least restrictive form of sanction is to be applied against a child who is alleged to have committed an offence; and that criminal proceedings are not to be instituted against a child if there is an alternative and appropriate means of dealing with the matter.
407 See section 17 of the *Young Offenders Act 1997*.
408 Part 2 of the *Criminal Records Act 1991* provides that an order of the Children's Court is spent after a crime-free period of not less than three years; and that a conviction of a court (other than the Children's Court) is spent after a crime-free period of not less than ten years.

This proposal could help to minimise the potential for harm to a young person as a result of being advised that they are a PCH. Importantly, it would also serve as a safety net – both in terms of FACS' responsibility, as the statutory child protection authority, to provide a response to the child who has been named as a PCH; and also in ensuring that the child or young person receives appropriate support to minimise the potential for them to engage in similar behaviour in the future.[409]

Records relating to the rationale for a decision about whether PCH should or should not be substantiated

POI and PCH records are only valuable in the context of a future assessment of risk if the records contain clear information about the nature of the conduct or alleged conduct, the nature and weight of any relevant evidence, and the reasons for making a decision to substantiate the allegation or otherwise.

In the section on 'Recording a PCH', the casework practice mandate includes some related guidance for staff:

> *Important things to record are … the circumstances of the harm and any other relevant information regarding the individual's capacity to acknowledge and understand the impact of their behaviour, views of the individual regarding the allegations and rationale for not informing an individual of their PCH status … This information may need to be reviewed in the future if this individual has contact with other children and there needs to be a clear and concise record of the events.*

While the inclusion of this advice is positive, it does not provide a clear statement about the need to document the rationale for a decision to record an individual as a PCH, or to record an individual as a POI but not a PCH. Documenting the rationale for a decision not to name a person as a PCH is important, as these records may range from matters which are considered to be false or vexatious, through to matters where there is evidence which just falls short of that required to substantiate harm. We recommend that in revising its practice mandate, FACS includes clear advice about documenting PCH and POI decisions.

11.7. Monitoring and driving the performance of FACS JIRT

In addition to the need for the JIRT SMG to establish an overarching JIRT performance and monitoring framework, each JIRT agency should establish strong internal governance and accountability processes to drive and monitor the performance of individual JIRT units.

The data each agency collects must not only align with the outcome data identified to assess the overall performance of the JIRT program, but should be supplemented with a range of other measures that enable each agency to assess practice and productivity at an individual 'JIRT unit' level.

As discussed in the previous chapter, following our detailed review of the CAS' performance during our 2010-2012 audit of the Interagency Plan to tackle Aboriginal child sexual abuse, the CAS implemented a robust performance monitoring framework and related accountability process, as well as a range of changes to its investigative practices, recruitment and human resource management. As a result, the CAS has been able to significantly improve its performance over the last four years and importantly, clearly demonstrate this through the outcome and productivity data it now routinely collects and analyses.

While we did not conduct a similarly comprehensive review of FACS JIRT in 2012, our report did recommend that each of the JIRT partner agencies consider the evidence base available to support a performance framework for the JIRT.

As we discuss in this section, FACS has made a range of improvements to its governance and accountability processes since 2012. Many of these improvements were made during the last financial year, which means only limited performance data was available for this inquiry. However, we are confident that the measures FACS has recently implemented will address some of the gaps in performance monitoring that previously existed.

409 While there is no data available on the number or proportion of children named as a PCH who receive a child protection response, anecdotally we understand that many matters, particularly where there is no evidence that the child is themselves a victim of abuse, do not meet the ROSH threshold or are closed due to competing priorities, meaning that FACS will not have any ongoing engagement with the child or their family, unless the report relates to harm done to a sibling.

In the context of the additional resourcing, FACS will now have the capacity to significantly lift its performance in key JIRT program areas. However, just as we emphasised in relation to the CAS in 2012, this additional resourcing needs to be accompanied by a strong accountability framework to drive and monitor performance improvements.

If, in addition to the measures it has already taken, FACS further enhances its JIRT performance monitoring and accountability processes as we discuss in the following sections, it will be well placed to ensure that its new resources are well targeted as they come on line, and that any issues with productivity and quality can be readily identified and addressed.

11.7.1. Data requested from FACS

We asked FACS to provide us with a range of workforce, productivity and performance data for the past five years, disaggregated by JIRT unit. The data we requested included:

- number of referrals allocated to each JIRT unit and per caseworker
- number of matters where a face-to-face assessment was provided, and the reasons for matters not proceeding to assessment
- average time taken to complete an assessment
- number of matters that resulted in an application to the Children's Court
- number of child interviews where FACS participated
- number of matters where harm was substantiated and where a POI or PCH was identified, and
- number of matters that were referred to a CSC for further action, and the proportion of those matters that were closed due to competing priorities.

FACS was unable to provide us with the full set of data requested for a range of reasons. FACS did provide certain data covering the five year period, but it could only be aggregated at a state-wide level. Certain unit level data was provided but it was only for a six month period in 2016. Other data provided was merely an approximation, as complete records could not be relied on. Some data – for example, data relating to the closure of matters transferred from JIRT units to CSCs and data relating to the number of recorded criminal interviews where FACS participated – could not be provided at all.[410]

In the absence of much of the data we requested not being routinely collected and analysed by FACS, it would have been too time consuming, given the short timeframe for our inquiry, to extract it manually from the KiDS/JIRTS databases. Some of the difficulties in extracting data are due to the cumbersome nature of the KiDS platform, which will hopefully be resolved over time with the implementation of the more user-friendly ChildStory database.

11.7.2. What the data tells us – six month snapshot

At the start of the 2016-2017 financial year, FACS JIRT implemented a number of manual data capture processes which enabled it to provide us with data against certain measures for the period July to December 2016. Given the short period, it is difficult to draw too many conclusions regarding the productivity or performance of individual JIRT units; however, our analysis of the available information revealed the following:

- Across the 17 JIRT units, the average number of accepted cases per caseworker in 2015-16 ranged from 36 to 72. The average across all JIRT units was 49. FACS advised us that, in January 2017, it reallocated one caseworker position from the unit with the lowest number of accepted cases per caseworker to the unit with the second highest number.
- In 2015-2016, 76% of all JIRT matters were recorded in KiDS as having received a face-to-face assessment. The face-to-face response rate in individual units ranged from approximately 67% to 88%.

410 FACS provided us with some data relating to interviews; however, it only covered a six month period and detailed the total number of formal and informal interviews with alleged victims, including interviews conducted by police with no FACS involvement.

- Reliable data on the number of matters allocated for a face-to-face response per caseworker in individual units was not available; however, the data that was available for 2015-2016 indicates that the actual number of matters per caseworker that proceeded to assessment (the estimated actual caseload) ranged from around 30 in four of the JIRT units, to around 60 in one unit. On average, across all JIRT units, each caseworker was allocated approximately 40 matters in 2015-2016 that required a face-to-face response.
- Data on the reasons for matters not proceeding to a face-to-face assessment was not provided at a unit level; however, it was provided for 2015-2016 at a state-wide level. There are four 'reason categories' available to FACS JIRT in deciding not to proceed with an assessment.[411] In 2015-2016, in the vast majority of cases where a decision was made not to proceed, it was either because the matter involved a stranger and the child or family did not want FACS assistance (52%),[412] or FACS determined, on the basis of a review of available information, that further risk assessment was not warranted (39%).[413] Notably, the second of these two categories, which accounted for more than one third of all matters not proceeding, is the only category which requires the use of discretion by FACS JIRT in determining not to proceed. While the variation in reasons across units is not known, the overall number of matters that did not proceed to assessment varied from approximately 12% to 33%.
- The average time taken to complete a face-to-face assessment across all JIRT units in 2015-2016 was 73 days. The average time in individual units varied significantly – from 43 days to 109 days.
- The four units with the lowest estimated actual caseload all performed better than average in terms of time taken to complete assessments, and the two units with the highest estimated actual caseload all performed below average. However, there was no clear correlation across all units between the estimated actual caseload and the time taken to complete assessments.
- As we discuss in section 11.7.3, the Western cluster has been manually collecting a range of data since 2009 – a process which was rolled out to all units from 1 July 2016. FACS provided us with data for the full 2015-2016 financial year for the Western cluster units, and also provided data for all JIRT units for the period from 1 July to 31 December 2016. Based on the six month dataset, just over 40% of all matters were substantiated. However, when looking at the full 2015-2016 data for the four Western cluster units, the substantiation rate in each unit was above 70% (with an average of 75%). FACS advised us that it estimates the substantiation rate for JIRT matters to be anywhere between 60% and 80%. Therefore, the variance between the two data sets suggests there may be issues with the quality of the data in those units that have only been collecting it for six months, and that the overall substantiation rate may be underrepresented.
- FACS advises that, historically, FACS JIRT initiates Children's Court action in approximately 5% of matters. Data from the second half of 2016 indicates that its JIRT units initiated Children's Court action in 2% of matters, ranging from 0% in two units to 6% in one unit. However, FACS also indicated that it cannot extract reliable data from KiDS relating to applications that are lodged by CSCs following transfer of a matter from JIRT, which means the number of JIRT reports involving the initiation of proceedings is unknown.
- Across all units, 12% of matters where harm was substantiated involved substantiation of harm other than that identified in the original JIRT report ('other harm'). This proportion ranged in individual units from 0% to 31%. As we discuss earlier in this chapter, this is one indicator of the extent to which holistic assessments are being conducted. There was a strong correlation between the estimated actual caseload and the likelihood of 'other harm' being substantiated – indicating that high caseloads may negatively impact on the capacity of caseworkers to undertake holistic assessments.

411 FACS JIRT units can decide not to complete an assessment if:
- the child or young person is alleged to have been abused by a stranger, there are no other reported risk factors or child protection history, and the parents or young person refuse FACS intervention
- FACS determines, on the basis of a review of available information (including information provided by CAS and Health), that further risk assessment is not warranted
- the report is referred interstate as the child or young person was found to live in another jurisdiction, and
- the child or young person could not be located despite exhaustive attempts by staff to do so.

412 Percentage excludes matters where there were data entry errors in the recording of the reason for not proceeding.

413 Percentage excludes matters where there were data entry errors in the recording of the reason for not proceeding.

- Data relating to the 're-reporting rate' (the number of children and young people who are the subject of another ROSH report to FACS within 12 months of an assessment being completed) is not available by JIRT unit. For FACS JIRT as a whole, the most recent data indicates a re-reporting rate of 25%, which is significantly lower than the overall re-reporting rate for FACS.[414]
- Where harm was substantiated, a PCH was named in approximately 50% of all matters. This proportion varied significantly between JIRT units – from 79% at its highest to 19% at its lowest.[415] As discussed earlier, it is currently FACS policy to finalise a PCH determination, where possible, as part of a JIRT assessment. While there are some circumstances where harm is substantiated and it is not possible to name a PCH,[416] overall this proportion appears low. FACS advises that, as part of a quality assurance process, managers conduct 'dip samples' of matters where harm has been substantiated but no PCH named.
- While precise data is not available, FACS recently advised us that around half of all JIRT matters are assessed as requiring transfer to a CSC on the completion of FACS JIRT involvement and, of those, we are advised by FACS that many are allocated for a further response by a CSC – including all matters where the CSC is already working with the child's family.

Although there are undoubtedly some reliability issues with the data presented above and, as stated at the outset of this section, it is difficult to draw firm conclusions from such a brief period, it nonetheless illustrates how useful data of this type can be in assessing the performance of JIRT units and identifying trends. As we discuss in the remainder of this chapter, it is data that we believe FACS should consider monitoring as part of its overall governance and accountability processes for individual JIRT units, and that FACS should determine which of these indicators should form part of FACS' performance monitoring framework for the JIRT.

11.7.3. The FACS JIRT monitoring framework

The FACS JIRT units report to one of four Manager Client Services, who in turn report to the Director JIRT Operations. The FACS JRU Manager reports to the Director JIRT Strategy and Policy. The Directors are responsible for reviewing and assessing performance data from all JIRT units – which currently includes the regular review of some, but not all, of the data discussed above. Both Directors report to the Executive Director, Statewide Services.

The two 'headline indicators' FACS JIRT has used over the last five years to measure its performance are:

- the proportion of children and young people who receive a face-to-face assessment, and
- the proportion of assessments that are completed within 60 days of the date of report.

There are also two supplementary indicators:

- the number of children and young people in statutory OOHC case managed by FACS with a case plan, and
- the number of children and young people who are the subject of a ROSH report while in OOHC.

These four indicators are also used by the FACS districts as part of their reporting and accountability process – regular reporting occurs through to the FACS executive, and they are considered by the districts as part of a quarterly business review process.

The FACS JIRT leadership team recently approved a monitoring framework for the JIRT, including the four indicators listed above as well as the following two measures:

- the proportion of matters that are assessed as not requiring a face-to-face assessment, and
- the proportion of matters where a response occurs within the priority timeframe recommended by the Helpline/JRU.

414 In 2014-2015, the overall re-reporting rate for FACS was 40.5%. The lower re-reporting rate for FACS JIRT is likely to be at least in part due to the volume of reports that are accepted for a JIRT response that do not relate to allegations within the home.
415 There was no apparent reason for this variation.
416 For example, where it is substantiated that a child has been physically harmed by a parent or carer but it is not known which parent or carer caused the harm; or where it is substantiated that a child has been sexually abused but they are not able to identify the perpetrator.

We understand that reporting against these measures will occur on a quarterly basis.

The two measures relating to the timeliness of responses – the number of assessments completed within 60 days and the proportion of matters where there is compliance with the recommended response timeframe – provide important information about the capacity of JIRT units to respond to the volume of reports received in a timely fashion. When considered together with caseloads, they are likely to provide a good measure of which units may require more staff, or where there may be other performance and productivity issues that need to be addressed.

As discussed earlier in this chapter, FACS JIRT units operate on the premise that all accepted reports must proceed to a face-to-face assessment, unless one of the four 'reason categories' that are available to FACS JIRT in deciding not to proceed with an assessment apply. Decisions not to proceed with an assessment must be approved by a Manager Client Services.

Monitoring the face-to-face assessment rate is an important FACS-wide measure, and any significant variation in the proportion of matters receiving an assessment of this type would be indicative of practice and/or capacity issues. It is also pleasing that FACS has now included an additional measure – 'reason assessment did not proceed' – to complement the face-to-face rate.

During our inquiry, FACS acknowledged that there would be benefit in tracking assessment data at a JIRT unit and state-wide level. It will be important for any monitoring to be supplemented with a qualitative analysis of cases managed by units with relatively high proportions of matters that are not proceeding to assessment.

FACS has advised that the indicator relating to 'the number of children and young people in statutory OOHC case managed by FACS with a case plan' is triggered when FACS JIRT initiates action in the Children's Court, and that it therefore provides a measure of the number of matters where FACS JIRT takes child protection action at the highest possible level.

The other supplementary measure, relating to the number of children and young people who are the subject of a ROSH report while in OOHC, is not a performance measure of FACS JIRT per se. While the measure is useful for FACS generally – in that it reveals information about the volume of children who are alleged to be the victims of serious abuse while in the care of the Minister – it does not reveal anything about a JIRT unit's actual involvement in a matter, including what outcomes are achieved for the child or young person as a result of the JIRT report.

As we discuss in Part 5, knowing the OOHC status of a child is an important component of the JIRT program data for all agencies, as it is important that the agencies can track the outcomes that are achieved for children in OOHC who enter the JIRT program. However, this broad JIRT program data is separate from the need to measure the efforts of FACS JIRT units in relation to work associated with the care process, and outcomes for children as a result of entering the JIRT program.

While the indicators and measures contained in FACS' JIRT monitoring framework are valuable, they do not provide a complete picture of the performance of individual JIRT units, or of FACS JIRT as a whole. Last year, FACS decided to start collecting additional supporting data via a 'JIRT Register' which has been modelled on an initiative developed in 2009 by the Manager Client Services in the Western Cluster. The register involves the manual collection (via an Excel spreadsheet) of performance and productivity data at a unit and cluster level and has been primarily used as a local management tool. Information collected via the register includes for example, whether a report to JIRT results in FACS substantiating that a child or young person has been harmed; and whether a POI and/or PCH was identified.

The implementation of this register in the Western cluster and, more recently, across all clusters, is very positive. Much of the data that we analysed during this inquiry was sourced from the register rather than from KiDS, demonstrating its importance in filling information gaps.

11.7.4. Enhancing the FACS JIRT monitoring framework

We discuss the data that we believe should be collected and reported on across the JIRT program in the final chapter of this report. We also discuss the need for JIRT-wide data to include additional datasets relating to the particularly vulnerable groups of children and young people discussed in Part 5.

Beyond the need for JIRT-wide outcome data, it is important for the individual agencies to have additional and more detailed data about their own performance. Having regard to the recent enhancements to the JIRT monitoring framework, and advice from FACS that it is in the process of strengthening its JIRT key performance indicators, we have identified a number of additional measures which, in our view, are critical to a robust analysis of the performance of FACS JIRT.

In addition to the current six indicators noted above, the performance and outcome measures that we believe FACS should consider as part of its monitoring framework (for individual JIRT units/clusters and FACS JIRT as a whole) are:

- The number of JIRT accepted referrals which led to a substantiation that a child or young person was harmed. (As with charge rates, substantiation rates need to be viewed carefully and should not be the subject of a target.)
- Of the referrals where harm was substantiated, the proportion where the substantiated harm related to the reported concern; the proportion where it related to another issue; or both.
- The number of JIRT accepted referrals which led to the identification and recording of a Person of Interest (POI) in the FACS database and, of these POIs, how many were determined to be a Person Causing Harm. (Similar to substantiation rates, POI/PCH rates need to be viewed carefully and should not be the subject of a target.)
- The number of JIRT accepted referrals that were referred by FACS JIRT to a CSC for a further response.
- Of the referrals made to CSCs by FACS JIRT, the proportion that were allocated for a further response.
- The number of children the subject of an accepted referral who were re-reported to FACS within 12 months of the JIRT assessment being completed, and of these re-reports, the number that were accepted for a JIRT response.

As well as the performance and outcome measures suggested, there are a number of other data which would prove useful for FACS in assessing its JIRT practice. For example, important casework activities, such as whether a home visit was undertaken and/or whether any other relevant parties (for example, a child's school, other service providers, or non-offending family members) were consulted as part of an assessment; and outcome measures, such as whether a safety plan was implemented or whether a referral to another service (other than a health service) was made.

It would also be valuable for FACS to systemically collect and report on the relationship between the alleged victim and person of interest. This is important contextual information from a FACS productivity perspective – if the report relates to alleged abuse in the child's home, it is more likely that it will require FACS intervention. The proportion of matters in a unit or individual caseload relating to allegations against a parent or other household member is directly relevant to an assessment of productivity.

Relationship data of this type would also be valuable for external reporting purposes on trends in serious physical and sexual abuse.

While we recognise that adopting the performance and productivity measures suggested in this section will take time, in our view, it is critical as part of FACS' contribution to the broader JIRT performance and monitoring framework that it identifies the indicators it intends to adopt and the timeframe for being able to report against them.

In addition to improving data capture and reporting, we consider there would be value in FACS establishing a six monthly review process, similar to the CAS Team Development Review, involving all JIRT unit managers and led by the Executive Director, Statewide Services and the JIRT Directors. This would enable individual managers to benchmark their performance and best practice to be identified and shared.

While regular analysis of data will provide important insights, in order to assess the quality of casework practice in the JIRT, we believe there would be value in FACS' Office of the Senior Practitioner conducting periodic case reviews of JIRT matters. While we appreciate that casework reviews take place as part of everyday supervision, there are clear benefits in supplementing supervision with a review of a sample of cases undertaken by an expert external to the JIRT.

11.7.5. Enhancing governance and reporting to the FACS executive

The JIRT program is one of this state's most significant – if not the most significant – interagency initiatives. It is critical, particularly given the complexities involved in the ongoing implementation of a tri-agency partnership, that there is clear line of sight at the FACs executive level of FACS' contribution to the overall program – and that its JIRT arm is well supported.

In addition to recommending enhancements to the governance processes within FACS JIRT, our inquiry has shown that there would be benefit in strengthening the lines of reporting to the FACS executive. We have made similar recommendations in relation to each of the JIRT agencies to support an overall strengthening of the governance of the JIRT program by embedding the role of the relevant Deputy Secretaries/Commissioner into a twice yearly JIRT program review. In our view, this would not only improve the ability of each agency's executive to more closely track performance of its JIRT arm, but would also enable them to quickly identify and seek to resolve problems internally and across the partnership.

Over recent years, FACS has made a range of improvements to its accountability and governance processes across the organisation, including enhancing its public reporting of performance information (although this does not include a breakdown for JIRT); implementing a new performance reporting framework, which includes reporting against six Key Performance Indicators (KPIs) at a CSC and district level; and substantially enhancing its Quarterly Business Review (QBR) process.

An important feature of the QBR process is that it requires the district directors to come together with the FACS senior executives to report on progress. This process provides an opportunity for the executive to discuss comparative results with the districts, and for the districts to provide further data or other evidence that may provide critical context to their results against the KPIs. The process not only encourages improved performance by the districts, it also provides valuable information to inform policy development and reforms.

However, FACS JIRT does not participate in the QBR process as its own entity – although it does contribute to the overall performance monitoring framework by reporting against four of the six KPIs through to the Executive Director Statewide Services and the Deputy Secretary with responsibility for Statewide Services. While this contribution is positive, there is scope for FACS JIRT to be more closely integrated within the QBR process, but in a way that ensures its identity as a separate business unit is featured in discussions. We have made a similar recommendation to the NSW Police Force with respect to the status of the CAS within the broader State Crime Command and how its performance is tracked by the Police executive.

FACS has acknowledged that the 'buy in' to FACS JIRT at an executive level was previously an area of weakness in its JIRT governance processes; however, they consider that this has been addressed by the recent implementation of the reporting framework. While we agree that this layer of reporting is positive, as noted earlier, only a limited degree of information about the performance of FACS JIRT can be drawn from reporting against the four KPIs. In addition, the absence of FACS JIRT from the QBR process means that, unlike district directors, FACS JIRT leaders are unable to present and discuss their results with the FACS executive. In our view, it is critical that the executive has comparable accountability processes in place for its districts and FACS JIRT, particularly given that some of the most significant practice issues to emerge from this inquiry relate to the need for closer integration of JIRT and CSC functions.

Recommendations

21. **Having regard to the recently allocated funding for FACS JIRT, FACS should develop a proposal for determining the most effective way to deploy these resources with particular consideration being given to:**
    a) **Developing a FACS JIRT after-hours service.**
    b) **Supporting CSCs in responding to matters that meet the JIRT threshold but have been rejected for a JIRT response due to 'Prior LAC' involvement.**
    c) **Supporting CSCs in responding to matters involving serious physical abuse allegations which fall short of the JIRT criteria, but which involve a child with additional vulnerabilities, for example, a child with a disability or a child in out-of-home care.**
    d) **Developing a more flexible approach to the timing of the transfer of JIRT matters to CSCs for a further response, in circumstances where a CSC may not immediately be able to allocate the matter.**
22. **FACS, in consultation with Health and the NSW Police Force, should refine its JIRT Work Health and Safety Plan to include further measures aimed at addressing staff welfare issues, including consideration of a compulsory WellCheck program and rotation policy similar to that implemented by the NSW Police Force.**
23. **FACS, having regard to the issues raised in section 11.6.2 of this report, should review its casework practice mandate in relation to sibling coordination.**
24. **FACS should ensure that the assessment training package being developed by the Office of the Senior Practitioner and tailored for delivery to FACS JIRT staff, has regard to the analysis of available casework activity and outcome data discussed in section 11.7.**
25. **FACS should review, having regard to the observations in section 11.6.4, and in consultation with the NSW Police Force and the Ombudsman's office, the casework practice mandate for 'Identifying and recording POI and PCH' and the 'Person Causing Harm resource pack'. In doing so, FACS should update the guidance for staff on the:**
    a) **Standard of proof required to make a Person Causing Harm determination to reflect current case law and to include guidance on the type of evidence that should be considered by FACS staff in the context of making a Person Causing Harm determination.**
    b) **Processes for making a Person Causing Harm determination in circumstances where there is a concurrent criminal investigation, including the importance of informing individuals of a decision to record them as a Person Causing Harm once criminal proceedings have been finalised; and the importance of affording procedural fairness to individuals in matters where charges have not been laid and there is no ongoing criminal investigation.**
    c) **Importance of documenting the rationale for decisions that an individual is a Person of Interest or a Person Causing Harm.**
26. **FACS should, consistent with FACS JIRT practice, require Director level approval for all Person Causing Harm determinations involving a child under the age of 16 years, and if accepted, update the related casework practice mandate accordingly.**
27. **FACS should, having regard to the observations in section 11.7 of this report:**
    a) **Determine which FACS performance and productivity indicators will be included in the overall JIRT performance monitoring framework and develop a timeframe for reporting against these indicators.**
    b) **Finalise the additional FACS performance and productivity indicators that it intends to capture for internal FACS reporting purposes.**

c) Implement a business review process, on a six-monthly basis, for its JIRT managers, overseen by the Executive Director State-wide Services and the JIRT Directors, to enable comprehensive analysis in a group setting of the output and outcome measures captured via the JIRT register.

d) Utilise the office of the Senior Practitioner to conduct periodic case reviews of JIRT matters with a view to assessing the quality of casework practice.

e) Consider how to better integrate reporting of its role in the JIRT program with the existing FACS Quarterly Business Review process, or a separate robust process, to ensure sufficient accountability processes for FACS JIRT at a senior executive level.

PRACTICE SUGGESTIONS

- FACS, as part of any review of its assessment tools in response to the recent recommendations made by the Legislative Council General Purpose Standing Committee No. 2, should consider the appropriateness of these tools within the JIRT context, including whether the Safety, Risk and Risk Reassessment tool accurately assesses risk in circumstances involving allegations against a household member who is not a parent or carer.
- FACS should give consideration to increasing the level of approval required for all Person Causing Harm determinations involving people aged 16 years of age and over from Manager Casework to Manager Client Services level.
- FACS should develop a set of 'factors to consider' to guide the decision-making of FACS directors as to whether or not a child under the age of 16 should be named as a Person Causing Harm.
- FACS should consider requiring that Person Causing Harm records against a child under the age of 16 be reviewed after a period of time to allow FACS to consider new evidence relevant to any ongoing risk posed by the child (such as, whether the child has received appropriate therapeutic or other supports, and whether any further concerns have been raised about the child's behaviours). Where appropriate, following this review, FACS should consider end-dating the Person Causing Harm record.

Chapter 12. NSW Health

In this chapter we examine the role and performance of NSW Health in the JIRT program.

The JIRT MoU states that Health's role is to provide direct victim support and clinical advice on trauma during the JIRT process, conduct medical examinations and treatment, provide crisis and ongoing counselling for children and young people and their families, and refer children and young people and their families to other health services. Health has advised us, however, that it considers its responsibilities to children and families who have contact with the JIRT to be much broader, encompassing the provision of safe and appropriate healthcare that promotes trust in and engagement with the public health system; and assisting interagency partners to perform their core functions and achieve safety and justice outcomes, including through the provision of medical and forensic evidence, expert testimony in court and supporting client disclosure of abuse and engagement in the JIRT process.[417]

Health contributes to the JIRT program both through its JIRT health clinician workforce – who participate in assessment, planning and decision-making processes, and provide direct services (for example, crisis counselling) to clients in the period immediately after a JIRT referral – and through the work of its specialist health services, which may provide support, assessment, treatment and/or therapy to JIRT clients and their families past the crisis stage over a lengthy period of time. The role of JIRT health clinicians in coordinating access to ongoing health care is complex due to the variation of service delivery across the 15 LHDs, and the flexibility the health districts have in meeting local client and community need.

Health's positive contribution to the JIRT program has been reflected in comments in the JIRT workforce survey from all three JIRT agencies, many of whom commented that Health is performing well in advocating the health and wellbeing needs of children and families.

While Health has always played a pivotal role in providing initial and ongoing support to JIRT clients and their families, it has been more closely involved in the JIRT program since becoming a formal partner in 2006. Since then, Health has moved closer to the centre of JIRT operations with the introduction of three Health workers at the JRU in August 2008 and an initial JIRT health clinician workforce of 25 positions in 2010-2011, which has almost doubled to the current number of 48.5 positions. Despite the significant investment made by Health in expanding its JIRT workforce, JIRT health clinicians in the field are outflanked by the significantly greater numbers of police and FACS officers on the ground – in this, and other chapters, we discuss the practical impact of the disparity of JIRT resourcing across all three agencies.

As part of our three year audit of Aboriginal child sexual abuse, we closely examined the role and capacity of Health in delivering critical counselling and forensic services to children and young people who have been abused, and made a number of recommendations for improvement. During this inquiry we have had the benefit of being able to compare progress by Health five years on, and pleasingly, while further refinements are needed, the progress made has been substantial. This work has taken place under the former statutory health corporation, NSW Kids and Families, and during the past two years, the Ministry of Health through its Director, Prevention and Response to Violence, Abuse and Neglect (PARVAN), who is responsible for leading Health's strategic and policy direction for the JIRT program.

Health has acknowledged that challenges remain in relation to monitoring and meeting the demand for its counselling services. At the time of our 2012 audit, the capacity of sexual assault counselling services had been the subject of a number of comprehensive reviews, each of which found that the demand for services significantly outstripped supply. However, in an environment of significant demand across the health system as a whole, the available data was not sufficient to support a clear business case for an increase in the budget of the sexual assault services (SAS) – the primary provider of specialist counselling services in NSW. In this regard, Health should be commended for its significant investment in the development of a new shared data system linking sexual assault services and the JIRT Health program, which became operational on 1 July 2017. At this point in time, Health has advised that funding for frontline sexual assault counselling positions has still not been enhanced.

417 Advice provided by NSW Health, July 2017.

However, in saying this, Health's broader organisational involvement in responding to children and families who come into contact with the JIRT program needs to be acknowledged. In this regard, as part of the recent State Budget the NSW Government announced an additional $10 million in recurrent funding to improve Health services that respond to victims of violence, abuse and neglect. Health has advised that this funding will enable the Ministry of Health to work collectively and individually with Local Health Districts (LHDs) and the Sydney Children's Hospitals Network (SCHN) on clinical redesign and system reforms in relation to Health's specialist services which respond to child abuse and neglect, sexual assault, and domestic and family violence. It will also enable LHDs and SCHN to employ additional clinical staff to fill critical service gaps and enable SCHN to increase its state-wide clinical leadership of the New Street Services – Health's treatment program for children and young people with harmful sexual behaviour (discussed in Chapter 17). The funding boost is a significant and welcome development.

Since our 2012 report, Health has also shown strong leadership and injected additional funds to support better access to medical forensic examinations for sexual assault and physical abuse and neglect in rural and remote areas. Of note, Far West LHD has significantly increased the proportion of Aboriginal clients referred to its SAS for forensic examinations; and Hunter New England LHD has managed to double the proportion of clients receiving a forensic examination within four hours, at the same time as decreasing the proportion of clients waiting more than 72 hours. At the time of our 2012 report, we noted the lack of reliable data about the number of forensic examinations conducted on children each year, and the period of time between the alleged incident and the forensic examination given how far child victims often had to travel to undergo a forensic examination due to the unavailability of suitable practitioners near to where they live.

Our 2012 report was also critical of the large number of Health policies which applied to counselling, forensic procedures and medical examinations, and in particular, the fact that many of these policies were out of date and inconsistent. Since then, Health has made considerable progress in developing, revising and consolidating policies relevant to the work of the JIRT program, although a number remain in draft form. Health has advised us that finalising the consolidated policies is a high priority and that they expect to do so by July 2018.[418] It is essential that this occurs, and that Health develops specific guidance in relation to the provision of forensic services to children under 14 years – a key policy gap which remains unaddressed.

The Ministry also funds the NSW Health Education Centre Against Violence (ECAV) to produce a range of impressive resources and training courses to JIRT staff in the three partner agencies, other health practitioners, other government agencies, the NGO sector and the community. And as we outline in Chapter 13, ECAV has continued to demonstrate outstanding leadership in building workforce capacity in the Aboriginal Specialist Violence, Abuse and Neglect, Health and NGO sectors.

Finally, at the outset of this inquiry Health acknowledged that its devolved and complex organisational structure presents considerable internal governance challenges for the JIRT program. As a result, Health has proposed a number of initiatives, which we discuss in this chapter, to strengthen its internal governance and accountability arrangements. We also outline the data currently available within Health to enable performance monitoring of its obligations under the JIRT program, consider Health's proposals to strengthen its data collection, and discuss the need for key health outcome data to feed into the shared JIRT agency database. While the effectiveness of the proposed governance arrangements are yet to be seen, Health's efforts during this inquiry to examine how it can strengthen accountability across its organisation for delivering its JIRT response are commendable.

12.1. Health's role in the JIRT program

Health's role in the JIRT program recognises that access to medical forensic examinations (where required) and health care to address physical and psychological trauma resulting from abuse and neglect is of paramount importance to victims and non-offending family members. Health's role includes specific responsibility for the provision of integrated crisis counselling and medical and

418 Advice provided by NSW Health, June 2017.

forensic examinations, medical assessments and investigations, the provision of expert certificates, reports and witness statements for Police and FACS, and arranging services to respond to the medical and psycho-social support needs of children, young people and their families.[419] This role and responsibilities intersect closely with the work of Police and FACS.

Health's involvement with children and families is often long-term, including ongoing integrated healthcare (both physical and psychological) to promote a pathway to recovery for the child victim and their non-offending parents, or intervention around harmful behaviours where required.[420] Health service referrals may be made regardless of FACS or Police substantiation of abuse or neglect,[421] and Health's involvement with children and families who come into contact with the JIRT program may continue throughout childhood, adolescence and into adulthood after police and child protection investigations have concluded.

In light of the breadth and complexity of Health's responsibilities, the Ministry of Health has recently strengthened Health's clinical and policy leadership team by appointing a Clinical Associate Professor to the position of Senior Clinical Advisor for Sexual Assault, providing advice and expertise in the area of sexual assault and domestic and family violence medical and forensic services to the relevant policy teams.[422] A senior JIRT policy position is also located within the Child Protection and Violence Prevention Team at the Ministry of Health, and provides advice on policy and organisational issues relating to the JIRT health workforce.

Funded by the Ministry of Health, JIRT health clinicians[423] are a relatively new component of the Health workforce, with their role evolving over time to meet the needs of JIRT clients and partner agencies. JIRT health clinicians support engagement with the JIRT program by promoting a trauma informed process where victims and their families are encouraged to participate in the investigation. JIRT health clinicians facilitate the referral of children and young people to forensic medical examination and medical treatment services, and to the NSW Health SAS or other specialist Health services for counselling (such as New Street Services and Child Protection Counselling Services) and other health services (such as drug and alcohol, mental health, youth health, early childhood and domestic violence).[424] When required and if there is capacity, JIRT health clinicians provide crisis counselling to non-offending parents/carers and build rapport with children/young people and their families.

According to Health's Practice Framework for the JIRT:

> *The primary responsibility of the [health clinician] is to attend to and prioritise assessment and responses to the emotional, psychological and physical health and wellbeing of children and young people entering the JIRT system. This process must be undertaken whilst also preserving the legal integrity of the case being investigated.*[425]

JIRT health clinicians also participate in joint planning, provide health information and advice to JIRT partner agencies, assess health and wellbeing needs of children referred to the JIRT program, make appropriate referrals to specialist violence abuse and neglect services and other services, and directly support children, young people and their families before, during and after the interview process.[426] JIRT health clinicians work closely with the LHDs in various contexts as we discuss in the next section.

419 NSW Kids and Families, *JIRT Referral Unit (JRU) and Communication and Referral Processes*, October 2015, p.2.
420 Advice provided by NSW Health, March 2017, p.1.
421 Although, as we discuss later in this section, in most instances referrals to the main specialist services will only be accepted where abuse has been substantiated.
422 Advice provided by NSW Health, September 2016.
423 Throughout this report we refer to JIRT health clinicians to include both senior health clinicians and health clinicians.
424 This report distinguishes between a facilitated referral, where the referrer contacts the service provider and assists with making arrangements for the service, and recommended/suggested referrals, where the referrer suggests an appropriate service for the child or young person and/or their family to contact.
425 NSW Health Education Centre against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response*, 2013, p.8.
426 JIRT health clinicians may attend the interview in person as a support person for the child/young person but this rarely occurs in practice. They can observe and provide support if a child becomes distressed. They also provide information and support to family members during the interview.

Health also provides services to children and young people with harmful sexual behaviours, which we discuss in Chapter 17.

12.1.1. Structure of NSW Health

NSW Health comprises the Ministry of Health, LHDs, Speciality Health Networks, including the Sydney Children's Hospitals Network (SCHN),[427] and other statutory organisations which make up the NSW public health system.[428] Health's devolved governance structure means that operational management is provided by the LHDs and SCHN, with JIRT health clinicians, the specialist violence abuse and neglect services, and other health services reporting through their local management structures up to their respective Chief Executives.[429]

NSW Health includes 15 LHDs – eight[430] covering the Sydney metropolitan region and seven[431] covering rural and regional NSW. The SCHN includes the Children's Hospital at Westmead and Sydney Children's Hospital (Randwick) as well as a range of specialised services.[432] The two children's hospitals and child protection services at the John Hunter Children's Hospital are designated as Level 6 referral hospitals that provide state-wide support for medical and forensic assessment of children and young people. Each LHD and Specialty Network has a service agreement with NSW Health which sets out agreed service obligations, performance requirements and funding and other supports. LHDs and the SCHN employ JIRT health clinicians in the 22 JIRT sites across NSW.[433] Each JIRT health clinician is supported by at least one senior line manager – referred to as a JIRT Manager (there are 20 JIRT Managers in total)[434] – who is also responsible for managing other program areas within their LHD.

The Health Child Wellbeing Units (CWU) and CWU coordinators also play a necessary child protection role in the health system, enabling health workers to be more responsive to vulnerable children and families prior to or following a JIRT intervention.

The Ministry of Health has broad responsibility for achieving the NSW Health State Plan priorities, including supporting vulnerable families and young people in the community.

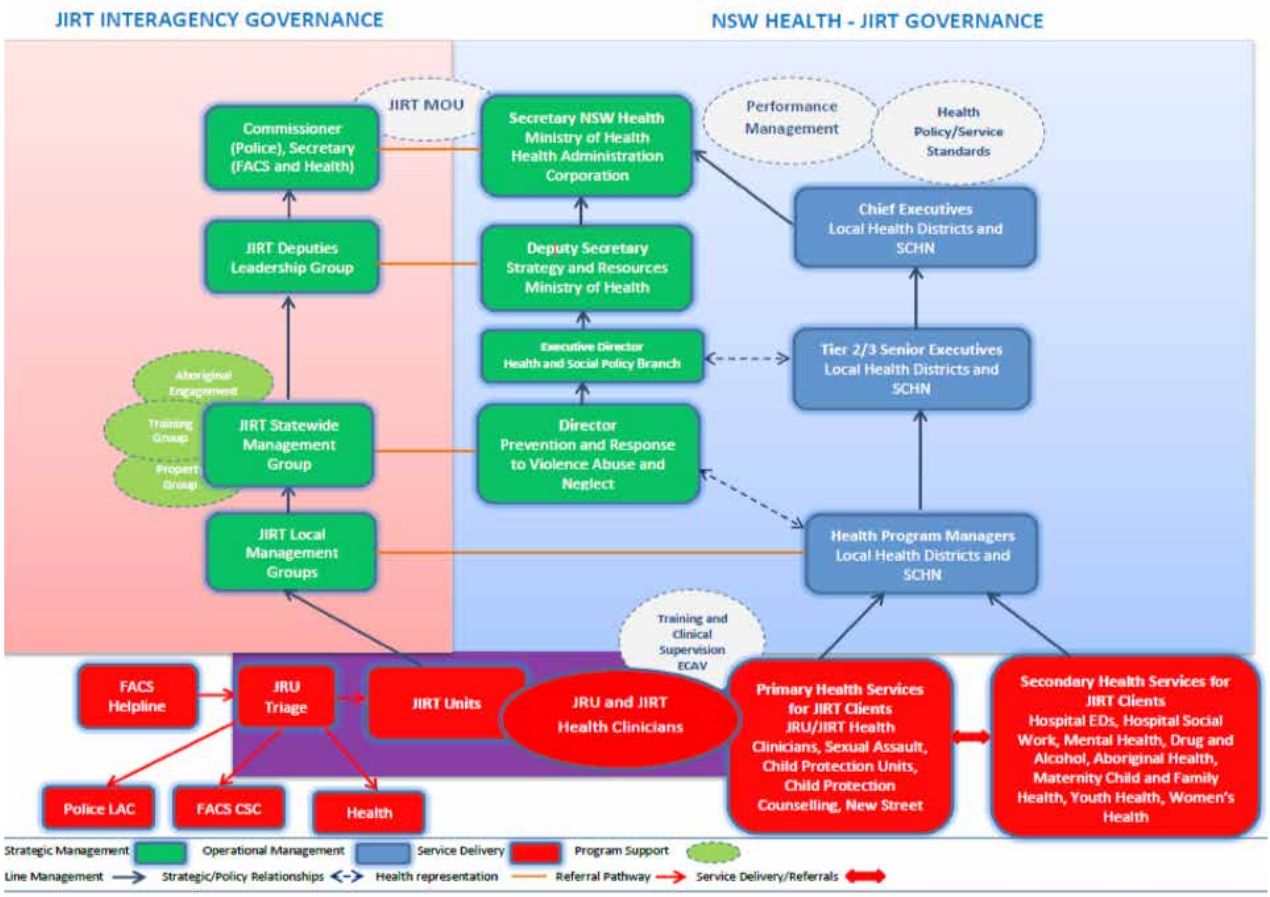
The Ministry of Health is responsible for 'system-wide' health responses and provides the strategic management of the JIRT Health response. The Ministry is represented on the JIRT Senior Management Group (SMG) by the Director, PARVAN Unit.[435] The Director, Child Wellbeing is also represented on the JIRT SMG, providing a direct link to the JRU Health team.[436]

The Ministry provides valuable support and leadership to the JIRT workforce through the development of guidance documents, training and other resources. It also drives the strategic management and policy direction of the JIRT Health response, issuing NSW Health policy directives, service standards and role delineation guidelines; monitoring service activity and performance; and representing Health on the key interagency JIRT governance groups.

427 In this chapter, when we refer to LHDs we are including the SCHN unless otherwise stated.
428 NSW Ministry of Health, *NSW Health Annual Report 2015–16*, October 2016, p.4.
429 Advice provided by NSW Health, March 2017.
430 Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney, Western Sydney.
431 Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW, Western NSW.
432 The SCHN holds the funding for two JIRT positions which deliver services to South Eastern Sydney LHD and the JRU Health positions. The Sydney Children's Hospitals Network also includes Bear Cottage, the Newborn and paediatric Emergency Transport Service, the Pregnancy and newborn Services Network (PSN), the Children's Court Clinic and other significant state-wide and national services. Health response to Ombudsman information request, 2 March 2017.
433 Local arrangements are in place whereby the Kogarah JIRT site is part of SCHN rather than Eastern Sydney LHD. (Advice provided by NSW Health, January 2017.)
434 The 20 positions include the Manager of the JRU and Director of NSW Child Wellbeing based in the SCHN. JIRT Managers are not necessarily located in a JIRT office. (Advice provided by NSW Health, February 2017.)
435 Health and Social Policy Branch, Ministry of Health.
436 Advice provided by NSW Health, December 2016.

Health's governance structure for the JIRT program is depicted below.

Figure 4: Health's JIRT governance structure



12.1.2. Health services within Local Health Districts and Speciality Health Networks

The JIRT Health response extends beyond the designated workforce of JIRT health clinicians. Immediate and ongoing Health responses for JIRT clients can be complex and involve a range of health specialties and service types. Non-offending family members may also need crisis and ongoing counselling, mental health and drug and alcohol services, domestic violence intervention, and broader health services in the longer term. Older children or young people referred through the JIRT program are likely to have additional needs specific to the impact of the abuse on their sense of self.[437]

JIRT clients may be referred to Violence and Neglect health services including Sexual Assault Services, Child Protection Units and Child Protection Counselling Services for medical or forensic examination, treatment, support or therapy.

Sexual Assault Services

The NSW Health SAS continues to be the most substantial service provider of specialised and targeted therapeutic care for victims of sexual assault in NSW, with greater coverage, and more capacity, than any other service. The SAS includes 58 dedicated service response sites for victims of sexual assault.[438]

Adults and children aged 14 and over can access SAS counselling through a number of different pathways; however, children under the age of 14 must be referred to the service as part of a formal investigation process. In most instances, a referral to the SAS will only be accepted for a

437 Advice provided by NSW Health, March 2017.
438 http://www.health.nsw.gov.au/sexualassault/pages/default.aspx.

child under 14 where the sexual assault has been substantiated.[439] However, support, advocacy and case management may be offered to non-offending family members/carers where there is no substantiation but concerns about the child's safety, health and/or wellbeing are present.

Child and Adolescent Sexual Assault Counselling Services (CASACs) are also embedded within SAS. In early 2013, there were 15 Child and Adolescent Sexual Assault Counselling Services (CASACs), comprising 12 services operated by NGOs and three services based in SASs in Gosford, Taree and Coffs Harbour. Up until this time, all CASACs had been funded by FACS.[440] CASACs were a critical component of the service landscape, but faced high demand, with some CASAC services reporting waiting lists of up to two years. Most CASAC services accepted referrals where there was no formal report of the sexual assault, or where the assault had not been substantiated.

Following a review by FACS in July 2013, funding and responsibility for the three SAS-based CASAC services was transferred to NSW Health in 2015-2016.[441] These three CASACs now have the same eligibility criteria and referral pathways as SASs. The transfer of funding responsibility for these services from FACS to Health is a small but positive step towards streamlining state-wide counselling arrangements – a recommendation we made in our 2012 report on Aboriginal child sexual abuse[442]

Child Protection Units

NSW Health has three specialist hospital-based Child Protection Units/Teams (CPUs).[443] The Sydney Children's Hospitals Network has a CPU at Westmead and at Randwick. The CPU in Newcastle has two separate locations – one (for sexual assault) based at Wallsend, and the other (for other forms of child maltreatment) at the John Hunter Children's Hospital.[444] Each of the three CPUs incorporates a SAS.

CPUs provide child protection services for children and young people who are victims of physical, sexual or emotional abuse (including domestic violence), or neglect. The services include a 24-hour crisis counselling, medical and forensic service, specialist psychosocial and medical assessment, forensic medical assessment, ongoing therapeutic and counselling services for victims of sexual assault and their non-offending family members, medical treatment, advocacy and case management, court support, and provision of expert certificates and reports and expert testimony in court. CPUs also provide state-wide 24-hour specialist consultation and support to community services and health workers.[445]

The CPUs at Randwick and Westmead also provide counselling services for children under ten years of age with sexualised behaviours. A specialised clinic for children under ten years with harmful sexualised behaviours also exists in Wallsend as part of the Hunter New England Local Health District.

Child Protection Counselling Services

NSW Health has funded a network of 16 Child Protection Counselling Services (CPCS) since 1997.[446] The CPCS provide specialist counselling and casework services to children and young people and their families to ameliorate the impact of abuse.[447] Clients are referred to CPCS by FACS, the JIRT program (via JIRT health clinicians), other Health specialist services, or where appropriate, the Children's Court. Services are provided where FACS has substantiated that the child or young person has been harmed physically, sexually, psychologically or through neglect. CPCS are located in each LHD and within the SCHN, and accept referrals for children 0-18 years and their parents/carers.

CPCS work usually involves a medium to long-term intervention (between three and 18 months).[448]

439 It appears that Health is considering a more flexible approach in relation to children under 14 years who have not made a formal disclosure of sexual assault. See discussion at section 12.3.5.
440 Advice provided by NSW Health, December 2016.
441 Advice provided by FACS, February 2017.
442 FACS has advised us that the remaining 12 CASAC services are now funded under the Child Youth and Family Services (CYFS) Program and service functions and funding is unchanged.
443 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.30.
444 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.30.
445 http://www.schn.health.nsw.gov.au/health-professionals/departments-clinics-and-units/child-protection-and-wellbeing.
446 Previously known as Physical Abuse and Neglect of Children (PANOC) services.
447 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.105.
448 http://www.health.nsw.gov.au/kidsfamilies/protection/Pages/CPU-counselling.aspx, accessed 18 January 2017.

Priority for CPCS is given to high-need families, such as those where there has been a previous child death in the family from suspicious injury, previous removal of the child or other siblings in the family, injury as a result of physical abuse or domestic violence, and other specific factors.[449] CPCS also provide counselling to children and young people in out-of-home care.

12.1.3. Health's JIRT resourcing

Health had mostly filled its initial JIRT workforce of 25 senior health clinician positions funded from 2010-2011 by the end of 2012.[450] Our 2012 report noted that while this was positive, it was important – against the background of significant capacity challenges in the counselling sector – for any broader review of the JIRT program to include an examination of Health's resourcing requirements to enable it to fulfil its JIRT responsibilities.[451]

In response, Health has made a considerable investment in increasing the size of its JIRT health clinician workforce, with the Ministry allocating recurrent funding for an additional 23.5 JIRT health clinician positions across the state.[452] The funding has been allocated to LHDs in two phases, with an additional 9.5 full-time equivalent (FTE) positions created in the 2015-2016 financial year and a further 14 FTE positions in 2016-2017.[453] This brings the total number of JIRT health clinician positions to 48.5 FTE.[454] Health also secured recurrent funding for its five FTE JRU Health positions.[455]According to Health, the funding agreement for these recurrent positions will, among other things, provide Health coverage in JIRT units during operating hours, and assist LHDs to implement the 'JIRT Health contact point'. The aim of the JIRT Health contact point is to ensure that LHDs provide a timely response to JIRT referrals – it is essentially an email address and phone number which is maintained during business hours by the JIRT health clinician or, if there is no health clinician on duty, another appropriate LHD representative.[456] Health had previously received feedback from LHDs that implementing the JIRT Health contact point had negatively impacted on service provision and that only limited support was being provided in the most urgent matters when the JIRT senior health clinician was unavailable.

The impact of the additional resources allocated by Health is yet to be fully realised as recruitment and induction of the new clinicians is still underway. There have also been some delays in recruiting to the new positions for various reasons, including challenges in attracting suitably qualified and experienced job applicants in regional and rural locations – in some locations vacancies have remained after two or three recruitment rounds.

A JIRT workforce snapshot in February 2017 shows that the total phase one (2015-2016) staffing allocation of ten clinician positions (9.5 FTE) had almost been filled, with two positions vacant but currently being recruited, and two full-time positions being filled on a part-time basis. Of the 17 allocated health clinician positions (14 FTE) in phase two (2016-2017), nine positions had been filled (8 FTE) and the remaining positions across five LHDs[457] were vacant – although some were in the process of recruitment and other LHDs showed evidence they were investigating strategies to fill the position. At the time of the snapshot, all allocated JIRT health clinician positions were filled in Far West LHD (Broken Hill) and Western NSW LHD (Bathurst, Dubbo and Bourke). Taree was the only JIRT site in NSW without a JIRT health clinician, although a funded position has been established there to help service the Port Macquarie JIRT.

The Ministry of Health has advised that it will undertake a more proactive recruitment campaign to urgently fill all JIRT health clinician roles.[458] The JIRT workforce snapshot indicates that LHDs are using a range of strategies to optimise their ability to fill allocated health clinician positions, such as job

449 These and other priority criteria are listed in the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.106.
450 Recent staffing information from Health confirms that this original workforce allocation currently has few vacancies. 2.5 full-time equivalent positions were vacant as of February 2017. One of these positions is likely to be re-filled in the near future and another has been temporarily filled pending recruitment finalisation.
451 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.96.
452 Advice provided by NSW Health, December 2016.
453 Advice provided by NSW Health, November 2016.
454 Advice provided by NSW Health, February 2017.
455 Advice provided by NSW Health, November 2016.
456 NSW Kids and Families, *JIRT Referral Unit (JRU) and Communication and Referral Processes*, October 2015, p.8.
457 Hunter New England, South West Sydney, Mid North Coast, Southern NSW, Northern NSW and Murrumbidgee.
458 Advice provided by NSW Health, December 2016.

sharing with nearby LHDs, and re-configuring part-time and full-time positions to make positions more attractive to applicants. Senior management group discussions have also touched on workforce coverage issues and Health has endeavoured to ensure that LHDs were still able to facilitate referrals through the JIRT Health contact point when particular health clinician positions were unfilled.[459]

Health has committed to encouraging Aboriginal applicants to apply in advertisements for JIRT workforce positions, where possible.[460] It is unclear to what extent this commitment has been implemented. The Aboriginal Senior Analyst position, formerly in NSW Kids and Families, has been transferred to the PARVAN team.[461] We discuss Health's Aboriginal workforce development in relation to JIRT and its specialist violence and neglect (VAN) services further in Chapter 13.

Despite Health's clinician recruitment drive, many respondents to our JIRT workforce survey commented that more positions are still needed and that vacancies lead to delays and increased pressure on other health clinicians, especially when existing staff take leave.[462] Some respondents also commented on the disparity between Health's JIRT workforce and that of the other JIRT partner agencies:

> *In my LHD, there are two part time Health Clinicians in a JIRT which has five full time Caseworker positions and seven full time Police positions (not including management positions). As a result, it is not possible for Health to provide the same coverage as the other partners and this can lead to a perception that the Health role is an 'add on' where possible, rather than an integral part of the tri-agency response* – Senior Health Clinician.
>
> *Difficult to be seen by partners as 'equal' partners when we have one or two staff compared to their bigger teams of staff* – Senior Health Clinician.

Health survey respondents said that the disparity in staffing between the agencies means that Police and FACS are able to schedule multiple interviews on the same day, but the JIRT health clinician cannot always attend to provide face-to-face support. One Health survey respondent commented that in a rural JIRT site, a health clinician position had been advertised four times over a period of more than 12 months before it was only recently filled.

The Ministry of Health has advised, however, that a disparity in staffing levels between the agencies does not in and of itself mean that more JIRT health staff are needed. Additional time is needed to assess the impact of Health's increased investment in its JIRT workforce and determine whether staffing levels are sufficient for Health to meet service demand and facilitate desired JIRT client outcomes. Recruitment and retention issues reflect and reinforce difficulties for some JIRT health clinicians who have reported feeling isolated and excluded from a team environment dominated by other agencies. A similar sense of isolation has also been reported in relation to forensic examiners.[463] Health is hopeful that its additional JIRT clinician positions will help to address this and, in turn, will encourage staff retention.[464]

The Ministry of Health currently funds ECAV[465] to deliver a JIRT health clinician workforce development strategy to strengthen the skill base, raise the profile of this work and support workers to manage vicarious trauma. The strategy comprises a specialised clinical individual and group supervision program to JIRT health clinicians to support them in facing the challenges presented by their role. It also provides regular strategic supervision to this group of clinical supervisors to ensure state-wide consistency. Twice a year, ECAV is also funded to deliver two JIRT Health Forums for health clinicians, their managers and supervisors. As well as providing up-to-date information and professional development, these forums encourage collaborative and reflective practice by health clinicians within the JIRT program and wider Health context.[466] ECAV also manages an intranet site which provides frontline staff with quick access to the most current policies and research.

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459 JIRT SMG minutes in December 2013 indicate that Health undertook to develop an alternative pathway in consultation with the relevant LHD. JIRT SMG minutes in March 2015 indicate that coverage of health clinician positions during periods of absence was discussed, and Health noted its work on strategies to increase the health clinician workforce.

460 Advice provided by NSW Health, November 2016.

461 Advice provided by NSW Health, September 2016.

462 In our survey, 29% of Health respondents commented on the need for more staff.

463 JIRT SMG meeting minutes, April 2013.

464 Advice provided by NSW Health, December 2016.

465 Funded until June 2018.

466 ECAV Courses List (as at 1 March 2016), NSW Health http://www.ecav.health.nsw.gov.au/uploads/60438/ufiles/pdf/ECAV_Courses_Master_List_1.3.16_VDv2.pdf.

The JIRT health clinician workforce development strategy delivered by ECAV has been a very valuable initiative. We understand that over the longer term, Health is keen to work in partnership with LHDs to ensure they play a stronger role in directly providing clinical supervision and other supports incorporated into the strategy to the JIRT health clinicians they employ.

A number of Health staff indicated that the reality of working within the JIRT program requires that additional steps be taken to proactively manage staff welfare issues:

> *I think there is value in the LHD looking at how the risk of vicarious trauma can be reduced for its JIRT Health employees, including the consideration of 'rotation' opportunities that enable staff to work temporarily in another work environment within their organisation. JIRT Police and FACS provide rotation opportunities for their staff and this is something I am hopeful Health could consider too* – Senior Health Clinician.

Similar issues were raised by FACS respondents to the workforce survey – and both FACS and Health staff pointed to the Police WellCheck program and related staff rotation policy as being a good model for identifying and managing the inherent workplace stress of interagency work and the risk of vicarious trauma for JIRT agency staff. As we noted in the previous chapter, there would be merit in the SMG collaborating on the development of wellbeing strategies for both FACS and Health, to enable them to capitalise on any lessons from the implementation of the Police program.

12.2. Health's JIRT activities

Health's involvement in JIRT decision-making commences at the JRU, where the three partner agencies collectively assess each referral against the JIRT referral criteria to determine whether a matter will be accepted for a joint response.[467] In certain circumstances, discussed further below, the JRU Health team can make a direct referral to a health service, regardless of whether or not a referral is accepted for a JIRT response.

Referrals accepted for a JIRT response are referred by the JRU Health team to the relevant JIRT health clinician,[468] who identifies the nature and availability of immediate services that could be offered.[469] Health clinicians record the number of referrals they receive, as well as other data, for reporting purposes. The data recorded by health clinicians is based on activities in relation to JIRT 'clients' – that is, children and young people referred to the JIRT program.

12.2.1. Limitations with Health data

In considering the data presented in the following sections about Health's activities – both in relation to the JIRT program and its broader role in providing counselling and medical forensic services and referring clients to other services for ongoing care – it is important to be mindful that it has a number of limitations, including:

- Incompleteness – for example, LHDs may not have collected data for certain periods because of staff shortages; data relating to medical forensic examinations of alleged physical abuse is not recorded for JIRT purposes;[470] there is under-reporting of JIRT health clinicians' work with children and young people with harmful sexual behaviour and families where there is sibling sexual abuse; and JIRT health clinicians also advise they do not always record their work in referring clients to health and other services.
- LHD 'cross-border' arrangements – some LHDs have entered into arrangements to share health clinician positions, which affects how they record the data across both LHDs.[471]
- The SCHN is unique in that it provides services to clients from across NSW and has also entered into local arrangements with some LHDs. For example, the Sydney Children's Hospital Randwick is

467 NSW Department of Family and Community Services, NSW Police Force, NSW Health, *Local Planning and Response Procedures*, 2013, p.2.
468 Or a suitable delegated staff member.
469 NSW Department of Family and Community Services, NSW Police Force, NSW Health, *Local Planning and Response Procedures*, 2013, pp.6-7.
470 Advice provided by NSW Health, March 2017.
471 Advice provided by NSW Health, March 2017.

the fund-holder for the provision of sexual assault services to children in part of South Eastern Sydney LHD, and this data is reported by the SCHN. The SCHN at Westmead reports data for the Parramatta JIRT site, which would otherwise be reported within Western Sydney LHD.

- The use of two different JIRT-related databases (JIRTS and the JIRT health clinician data) means some key data sets cannot be compared.
- The JIRTS database includes non-mandatory fields for recording direct referrals from the JRU to specialist and other health services. As the three partner agencies constituting the JRU management team take turns to complete the actions for each referral, these non-mandatory fields can be overlooked and remain unfilled (particularly by Police and FACS) providing an incomplete picture. The fields for recording referrals made by JIRT health clinicians are also non-mandatory.

Health has acknowledged these limitations and, as we discuss further in section 12.7, it has developed a strategy to improve its future data collection.

The available data in combination with a range of other information sources nonetheless provides a strong foundation from which to consider Health's JIRT referrals and related activities.

12.2.2. JIRT referrals processed by the JRU

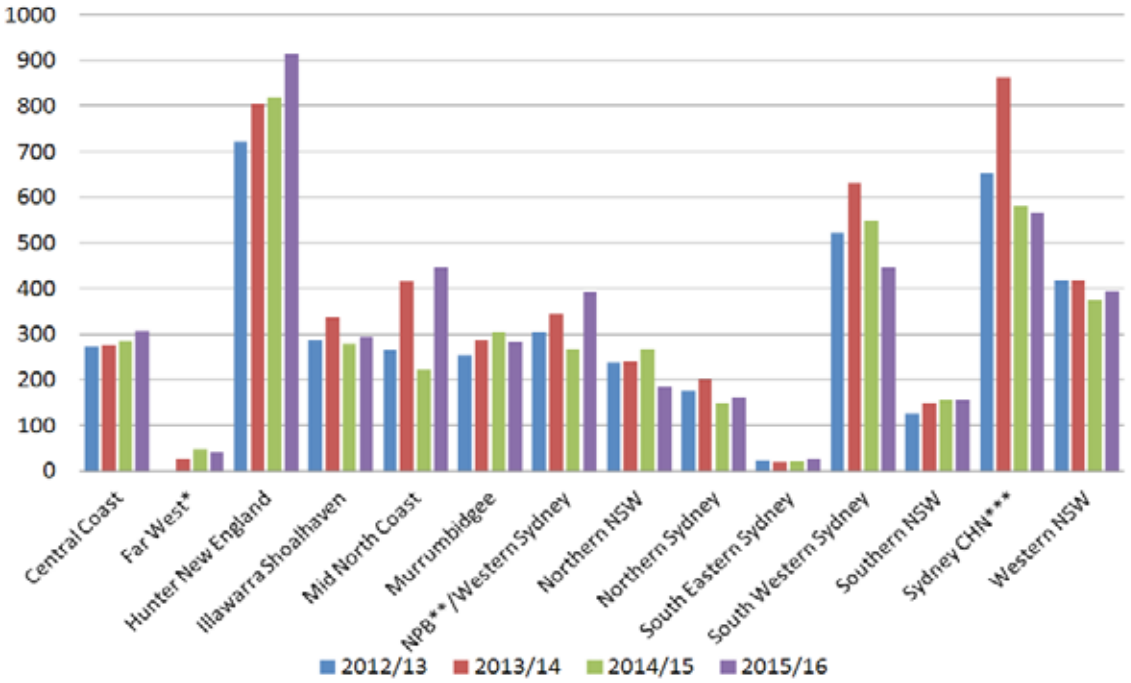
The total number of JIRT referrals processed, including accepted and rejected matters, where referrals were 'received, read and decisions made' by the JRU Health team, has increased significantly since the JRU's commencement (from 5,679 in 2007-2008 to 8,979 in 2015-2016).[472]

Figure 5 shows the number of referrals from the JRU received by health clinicians at each LHD between 2012-2013 and 2015-2016.

Referrals accepted for a JIRT response and forwarded to JIRT health clinicians

Figure 5 shows the numbers of accepted JIRT referrals received by JIRT health clinicians at each LHD between 2012-2013 and 2015-2016.

Figure 5: JIRT referrals received by JIRT health clinicians at Local Health Districts 2012-2013 to 2015-2016[473]



Notes: *There was no JIRT Senior Health Clinician for the Far West LHD until 2013-2014. 2013-2014 data is included from November only.
**Nepean Blue Mountains.
***Children's Hospital Network.

472 Data provided by NSW Health, February 2017.
473 Data provided by NSW Health, November 2016.

In 2015-2016 a total of 4,083 JIRT referrals were forwarded to JIRT health clinicians by the JRU. Health data also records a small number (approximately 1% of all referrals) of additional referrals to JIRT health clinicians from other referral sources. There are a number of reasons why a JIRT health clinician may receive a referral from a source other than the JRU. For example, in a situation where a child presents to a hospital emergency department, the hospital may refer the matter to the JIRT health clinician at the same time as making a report to the Helpline. Occasionally, a family who has previously been supported by a JIRT health clinician may re-refer themselves for additional assistance.

JRU direct referrals to health services

In some instances the JRU Health team refers clients directly to a range of health services – regardless of whether their matter has been accepted or rejected for a JIRT response. Health data shows that, of the 4,479 rejected matters in 2015-2016, 662 referrals[474] were made by the JRU to health services (15%). The vast majority of these referrals (13% or 593) were made to the SAS, with most of the remainder being referred to mental health services. For 17.5% (784) of referrals rejected for a JIRT response, the JRU Health team did not identify that a health service was required. JRU Health was unable to make direct health referrals for 3% (143) of rejected matters because relevant health services were not identified. The data that is currently available raises questions as to why the majority of referrals rejected by the JRU appear not to have been referred on to a health service.

As noted earlier, referral data is likely to be incomplete given that the fields in the JIRTS database for recording direct JRU referrals to health services are not mandatory. In our view, the fields should be mandatory and additionally, the reason for no Health referral being made by the JRU should also be recorded. Aside from data recording issues, Health advised us that there are various factors which limit the ability of the JRU Health team to make direct referrals for rejected matters.

In order to make a referral, the JRU health team needs to be able to identify, based on information available to JRU, what health service is needed – and this can, at times, be difficult to determine.

In 2014, Police and FACS also raised concerns with Health about the JRU making direct health referrals. The agencies were concerned that, as a result of receiving a JRU referral, health workers might pre-empt a planned response by a LAC and/or CSC by contacting a family to offer health services before the LAC or CSC had commenced their investigation. Police and FACS also expressed concern that a referral of a young person might be made by Health to a New Street Service prior to a Police investigation occurring.

As a result of the concerns expressed by Police and FACS, the JRU Health team now only makes direct referrals for rejected matters where a report indicates that the child/family will voluntarily present to a service (for example, supportive parents who will take a child victim of non-familial assault to a SAS), or where the child/family has a current or past engagement with the service they are being referred to (for example, young person who is a client of an adolescent mental health service). In other circumstances, the JRU Health team can make a direct referral after receiving clearance from Police and FACS. In our view, Health's JRU *Communication and Referral Processes* would benefit from greater clarity about the circumstances in which the JRU Health team can make a direct referral for a rejected matter.

In relation to the restrictions that apply to direct referrals from the JRU, Health advised us that they are particularly concerned to ensure that physical abuse and neglect matters, which are rejected by the JRU at a higher rate than sexual abuse matters, receive a Health response.

Of the 143 rejected referrals in 2015-2016 for which the JRU Health team did not make a referral because relevant health services were not identified as available, analysis by Health indicates that 140 involved physical abuse and neglect.[475] Health has advised us that in some instances, the JRU Health team is able to identify a health service which can respond straight away to a physical abuse matter that has been rejected for a JIRT response, including situations where a health service is involved with a family because the child has already presented to a hospital or health service. However, in some cases, health services are not available because referrals cannot be made unless there is evidence of physical abuse, which may require statutory intervention by FACS or Police through the issuing of a 's.173 order' to the parents/carers – which mandates that the child or young person undergo a medical examination.

The extent to which the above factors and others (such as service capacity) impact on JRU Health referral rates cannot presently be quantified. Making the JIRTS JRU Health referral fields (and the

474 Data provided by NSW Health, November 2016.
475 Advice provided by NSW Health, November 2016.

reason why no direct referral was made) mandatory will help to provide greater data accuracy and enable high-level analysis of why children and young people referred by the Helpline to the JRU, who have been assessed as being at risk of significant harm, have not been referred to a health service at the point of the JRU's decision.

12.2.3. Direct and indirect client activities performed by JIRT health clinicians

The JIRT health clinician role includes 'direct' and 'indirect' client activities. Direct activities involve contact with the child or young person or non-offending family members. This includes early psychosocial support – such as crisis counselling, rapport building and supporting the child/family during the JIRT interview as required – to assist the child's recovery from abuse and encourage them (and their family) to engage with the JIRT program and the health system.[476]

Indirect activities include:

- participation in joint planning of the JIRT response
- gathering and providing health information and specialist advice to JIRT partners to aid the joint investigation and response and ensure a trauma informed process
- case co-ordination
- 'warm referrals' to health and other services, and
- child protection advice within the health system.

Table 6 shows the overall proportion of clients receiving 'direct' or 'indirect' interventions from JIRT health clinicians in 2015-2016.[477]

Table 6: Proportion of JIRT clients receiving 'direct' or 'indirect' activities 2015-2016[478]

Clients		Direct activities		Indirect activities		Direct OR indirect activities	
All clients	**4,618**	2,034	44%	4,202	91%	4,224	92%
Aboriginal clients	**955**	440	46%	906	95%	909	95%

Direct client activity

An important part of the role of JIRT health clinicians is to work directly with a proportion of clients during the initial JIRT response to provide crisis counselling, support and other care depending on client needs. Case study 9 illustrates the value of this work.

Case study 9 – The value of support provided by JIRT health clinicians

JIRT accepted a second sexual abuse referral for a young child who had previously been interviewed, but had not made a disclosure. Following the second report, which related to the same allegations of abuse against the same person of interest, the child was again re-interviewed by Police. She did not make a direct disclosure during the interview, but made a partial disclosure afterward. The JIRT health clinician met with both the child and her mother after the interview. During the meeting, the child stated that she was too scared to tell Police what had happened because of threats made by the alleged perpetrator. The JIRT health clinician provided support, education and resources to the child's mother and referred the child and her mother to the local Sexual Assault Service (SAS). The referral provided to SAS was comprehensive, noting the possibility that counselling may assist the child to disclose more and confirming that any further disclosures would need to be reported. After accepting the referral, the SAS engaged with the mother's support worker to introduce her to the SAS worker and the service. An appointment was also made with the Child and Adolescent Mental Health Service for the child.

476 Advice provided by NSW Health, December 2016.
477 Data provided by NSW Health, June 2017.
478 Data provided by NSW Health, June 2017.

Table 7 summarises the direct client activity of JIRT health clinicians over a three year period. The data shows that the proportion of clients receiving therapeutic care and support from JIRT health clinicians has grown.

Table 7: Proportion of all JIRT clients receiving direct client activities 2013-2014 to 2015-2016[479]

Activity	2013-2014		2014-2015		2015-2016	
Crisis counselling	868	17%	712	16%	944	20%
Rapport building and support	718	14%	584	14%	1,027	22%
Support person for JIRT interview	50	1%	96	2%	105	2%
Other	305	6%	441	10%	416	9%

Note: Clients may have more than one related activity.

The number and proportion of clients receiving direct crisis counselling from JIRT health clinicians varied markedly among LHDs. In 2015-2016, less than 6% of clients received direct crisis counselling in Southern NSW, South Western Sydney and Illawarra Shoalhaven LHDs. In contrast, between 33% and 37% of clients received direct crisis counselling in Nepean Blue Mountains/Western Sydney, Murrumbidgee, Mid North Coast and Far West LHDs. The highest proportion of clients receiving crisis counselling (52%) was in Northern NSW LHD.[480] The highest *number* of clients receiving crisis counselling was in Mid North Coast LHD (162 clients) followed by Hunter New England LHD (145 clients).[481]

Health acknowledges that the state-wide figure for crisis counselling by JIRT health clinicians 'is slightly lower than might be expected'. However, Health's expectations about what would be an appropriate level have not been clearly established. According to Health, JIRT health clinician capacity could be impacting on the provision of crisis counselling and is 'known to be doing so in high referral volume offices', although this may improve with the expanded JIRT health clinician workforce.[482] As well, direct crisis counselling may instead be provided by other health professionals (for example, in SAS/CPUs or a hospital emergency department).

Health has also advised us that in some matters, other aspects of the JIRT response 'may take precedence' over the provision of crisis counselling and that improved policy guidance is needed in this area. Health intends to raise this issue at the SMG and will also address the provision of crisis counselling in the new JIRT health policy and procedures.[483] In light of the enhancements to the JIRT health clinician workforce, it will be important for Health to monitor the provision of direct client counselling across LHDs and to determine whether the rate of counselling has increased in accordance with improved staffing. Health will also need to collect data about the reasons why direct crisis counselling is not provided to ensure that counselling is available to all clients who would benefit from it, and that appropriate guidance is given to staff to inform their decisions.

Table 7 shows that, on average, 22% of cases referred to JIRT health clinicians involved the provision of rapport building and support. The proportion of clients for whom rapport building and support was provided also varied among LHDs. In 2015-2016, the SCHN, Hunter New England and Illawarra Shoalhaven LHDs each provided 6-7% of their clients with rapport building and support, compared with Far West (49%), Nepean Blue Mountains/Western Sydney (42%) Northern NSW (51%) and South Western Sydney (61%) LHDs.[484] The reasons for only around one fifth of JIRT clients receiving rapport building and support, and the variation among LHDs, are unknown and warrant further investigation by Health.

Table 7 also highlights that health clinicians rarely provide support to the child or young person during the JIRT interview – doing so in relation to only 2% of clients referred to the JIRT program. Two LHDs recorded no such instances over the three year period. Northern NSW LHD recorded the highest number and proportion (15%) of all LHDs. The low figures could reflect that a child or young person is unlikely to choose the JIRT health clinician as an interview support person if they have only just met

479 Data provided by NSW Health, November 2016.
480 Data provided by NSW Health, November 2016.
481 Data provided by NSW Health, November 2016.
482 Advice provided by NSW Health, December 2016.
483 Advice provided by NSW Health, June 2017.
484 Data provided by NSW Health, November 2016.

them. More recently, particularly since the establishment of the witness intermediary pilot scheme (discussed in Chapter 18), there has been a focus on limiting the number of additional persons present at interviews – although it is still Police policy to allow a child to have a support person present if one is requested and the person suggested is appropriate.

Indirect client activity

Table 8 below shows that participation in Local Planning and Response (LPR) meetings and information gathering activities occurred for a greater proportion of clients in 2015-2016 (67%) than for 2013-2014 (37%) and 2014-2015 (55%).

In 2015-2016, health clinicians attended LPR meetings in relation to 47% of clients in both South Western Sydney and Murrumbidgee LHDs, compared with over 90% of clients in Southern NSW, Northern NSW and Nepean Blue Mountains/Western Sydney LHDs. Health regards its participation in the LPR as an essential component of the JIRT health clinician role.[485] As discussed in Chapter 21, Health has concerns that the partner agencies may not always be including JIRT health clinicians (or the LHD JIRT contact person) in the LPR process. We understand that in future, JIRTS data will be able to show the extent to which health clinicians are included in LPR briefing and debriefing sessions.[486] In order to encourage Health's inclusion, Health has also proposed that LPR decisions should be 'signed off' by all three agencies in JIRTS (instead of the current practice of sign-off by two (or more) agencies).

It will be important for Health, in conjunction with the partner agencies, to more closely examine LPR participation rates given the degree of variation across LHDs. However, in saying this, in Chapter 21 we discuss the need for agencies to take a more pragmatic approach to what LPR 'participation' looks like – for example, phone contact may be sufficient rather than expecting clinicians (or other JIRT staff) to always attend LPR meetings in person. We have argued that the focus should be not on the mode of participation, but whether genuine tripartite consultation has occurred.

Table 8: Proportion (number) of all JIRT clients receiving indirect client activities 2013-2014 to 2015-2016[487]

All Clients	2013-2014		2014-2015		2015-2016	
Attend LPR meeting	1,845	37%	2,384	55%	3,080	67%
Information gathering	2,248	45%	1,885	44%	2,663	58%
Case co-ordination	736	15%	927	21%	814	18%
Referral to another agency	603	12%	589	14%	473	10%
Other	86	2%	28	1%	160	3%

State-wide, the provision of information gathering activities increased from 45% of clients in 2013-2014 to 58% in 2015-2016, but also varied among LHDs. In 2015-2016, information was gathered in relation to 93% of clients in Northern Sydney LHD compared to 16% of clients in Southern NSW LHD. A number of survey respondents raised concerns about the time-consuming nature of retrieving information from the many health databases – unlike Heath, Police and FACS both have centralised databases – and pointed out that this was negatively impacting the LPR. We discuss information gathering further in section 21.2.

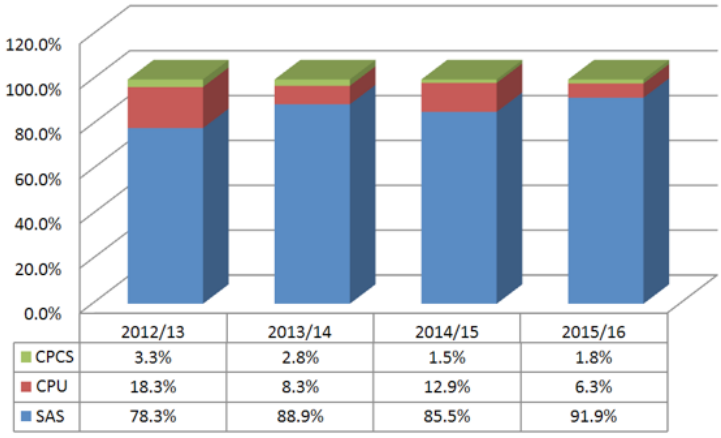
Referrals to violence and neglect health services

A key role of JIRT health clinicians is to identify 'the nature and availability of immediate services that may be offered to the child, young person and/or non-offending carer(s)'.[488] Like the fields in the JIRTS database for recording direct JRU referrals to health services, those for recording referrals to health and other services by JIRT health clinicians are not mandatory, and the reason for no referral being made also does not need to be recorded. This should be rectified to improve the accuracy of data collected.

485 Advice provided by NSW Health, December 2016.
486 Advice provided by NSW Health, December 2016.
487 Data provided by NSW Health, November 2016.
488 Advice provided by NSW Health, November 2016.

Notwithstanding the non-mandatory fields, JIRT heath clinicians are expected to collect referral data. Figure 6 shows the proportion of all referrals to violence and neglect (VAN) health services (SAS, CPU and CPCS) by each service type between 2012-2013 and 2015-2016.

Figure 6: Referrals to VAN health services by service type 2012-2013 to 2015-2016[489]



	2012/13	2013/14	2014/15	2015/16
CPCS	3.3%	2.8%	1.5%	1.8%
CPU	18.3%	8.3%	12.9%	6.3%
SAS	78.3%	88.9%	85.5%	91.9%

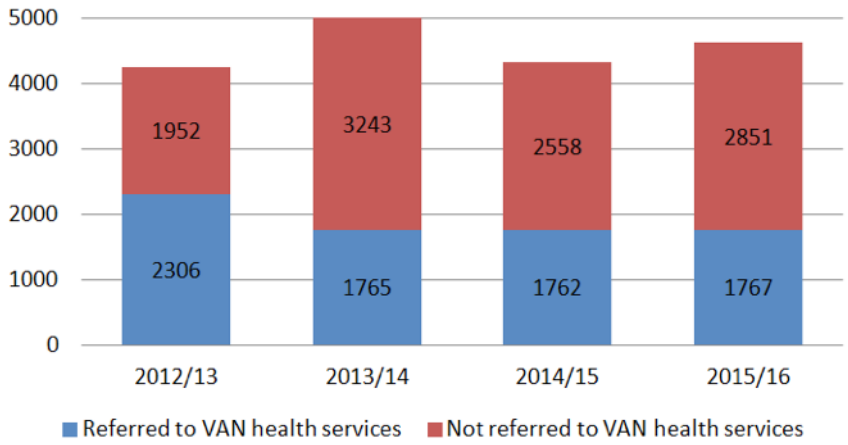
The vast majority of referrals to VAN health services are made to SAS. This is consistent both with the SAS having the greatest capacity of the three service types, and with the 'primary abuse type' of sexual assault comprising over 90% of JIRT referrals accepted by the JRU.[490] Referrals to the SAS have increased as a proportion of all referrals to VAN health services, from 78% in 2012-2013 to 92% in 2015-2016. Over the same period, referrals to CPCS and CPU have fallen.

As well as falling proportionally, the number of referrals to CPCS fell from 77 in 2012-2013 to 32 in 2015-2016. Health considers that these small numbers may be attributed to a range of factors that include service capacity, but also the lack of a direct referral pathway from JIRT to CPCS for unsubstantiated matters. Health's CPCS data shows that some 80% of referrals come from FACS, but it is not known how many of those referrals were originally JIRT matters.

Health has advised us that it is working to strengthen its response to serious physical abuse and neglect cases by building workforce capacity to provide '24/7' integrated crisis psychosocial medical forensic services, and strengthening pathways for ongoing healthcare and support for these children, young people and their families. As part of this work, Health is developing the *Child Protection Counselling Services – Standards and Guidelines*, which are close to completion. The new guidelines will promote broader access to CPCS and expand the range of referral sources, including via the JIRT program.

Figure 7 shows that in 2014-2015, health clinicians received 4,320 client referrals and that of these, 1,762 were referred on to a VAN health service. In 2015-2016, Health received 4,618 client referrals, and 1,767 were referred on to SHS.

Figure 7: JIRT clients referred to VAN health services 2012-2013 to 2015-2016[491]



489 Data provided by NSW Health, November 2016.
490 Data provided by NSW Health, November 2016.
491 Data provided by NSW Health, November 2016.

While figure 7 shows that the number of referrals to VAN health services has been consistent since 2013-2014, there has been significant variation over the same period in the proportion of all clients referred to these services. In 2015-16, 38% of clients were referred to a VAN health service compared to 41% in 2014-2015 and 35% in 2013-2014. In 2012-2013, 54% of clients were referred to a VAN health service.

According to Health, there are various reasons why not all accepted JIRT referrals are referred to a VAN health service:

> *There is a small window of time for medical forensic examinations after a sexual assault so a greater number of health and wellbeing medicals tend to be conducted than medical forensic examinations. A client may already be engaged with a health service, they may opt for other supports (such as victims of crime counselling or private health care), or a family may decline a health service referral in the immediate term wanting life to settle down for their child after the initial crisis of the abuse and stress of the JIRT process if their child is displaying no obvious symptomology. In some cases, for example, sibling abuse matters, families do not engage with health services due to arrests of family members and/or removals of children.*[492]

It is nonetheless unclear why the number of referrals to VAN health services has remained relatively stable, rather than reflecting fluctuations in the overall number of accepted JIRT referrals.

Almost all Health respondents to our JIRT workforce survey who mentioned referrals to VAN health services indicated that Health was performing well in this area, with many commenting positively about timely and/or high quality referrals of clients.

It will be important for the Ministry of Health to closely track service provision rates by VAN health services across the LHDs. When operational, the new SAS database will allow tracking of the number of referrals made to SAS (and, if the reported abuse type for a client is sexual abuse, any referrals made to CPUs and CPCS). It will also allow the reason for non-uptake of a referral to SAS to be recorded. However, Health will need to identify a method of obtaining data on service uptake (not just referral) for other VAN health services.

Referrals to other services

JIRT health clinicians also record data about client referrals to a range of other services both within and outside of NSW Health. Table 9 shows the number of these referrals by type in 2015-2016.

Table 9: JIRT clients referred to other NSW Health services 2015-2016[493]

Other NSW Health services	
Child and Family Counselling	55
Child and Young Person's Mental Health Service	74
Drug and Alcohol Service	7
Mental Health Service	85
New Street	27
Youth Health	39
Services outside of NSW Health	
Private Counsellor	130
School Counsellor	53
Victims Services	26

492 Advice provided by NSW Health, December 2016.
493 Data provided by NSW Health, June 2017.

12.3. Health's provision of counselling services

Sexual assault and other child protection counsellors play a critical role in coordinating responses for children and young people who are referred to the JIRT program.[494] It is well accepted that the long-term impact of trauma is reduced for those children and families who receive an immediate crisis response and counselling following a disclosure of abuse.[495]

For more than 14 years, evidence has been accumulating about the shortage of sexual assault counsellors in NSW. This issue has been highlighted in numerous reviews and inquiries. *Breaking the Silence*[496] and the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011* both acknowledged that there was a significant shortage in the availability of specialist child sexual assault counselling, particularly for Aboriginal victims. The review of NSW Health Counselling Services commissioned by NSW Health and published in 2011,[497] and our 2012 report about responding to Aboriginal child sexual assault, also confirmed the counselling shortage.

The budgetary and resourcing challenges faced by Health in 2012 have not abated, and the demands on the health system as a whole continue to dictate that any increase in the Sexual Assault Service (SAS) budget must be based on clear evidence of demand.[498] We asked Health to provide us with an update about enhancements to the SAS workforce for this inquiry. Health has advised that funding for frontline counselling positions has still not been enhanced:

> *It remains the situation that NSW Health Sexual Assault Services have not received supplementation from the Ministry of Health to expand their counselling capacity since initial program establishment except for the allocation of recurrent funding [for the] designated Aboriginal Child Sexual Assault counselling positions.*[499]

Health respondents to the JIRT workforce survey confirmed that counselling services, particularly in rural and remote LHDs, continue to struggle to match demand:

> *Quicker access to support services to assist the families [is needed]. It's too slow at the moment. Families are torn apart for periods of between 6-18 months. I know personally families become frustrated at the time it takes to access counselling* – CAS Investigator.
>
> *Services need to be available quickly such as medicals and counselling as the families are often left in limbo waiting for referrals to be accepted and actioned* – FACS Manager Casework.
>
> *Being a JIRT in a rural/regional area, there is limited therapeutic service provision for children, young people and adults to address the impact of domestic violence. CPCS are often at capacity or not able to prioritise a referral. Generalist Social Work and Psychology Services have been significantly reduced in some areas, and where these services do exist there can be very long wait times. Some rural areas often do not have a pool of private practitioners that clients can access via referrals from their GP or Victim's Services* – Senior Health Clinician.

12.3.1. The need for Health to monitor and respond to demand for counselling services

Available data at the time of our 2012 report indicated that the SAS appeared to be seeing an increasing number of children. LHDs told us that they were experiencing pressure to provide counselling to a growing number of children, but that this was occurring at the expense of providing a comprehensive service.[500] At the same time, the JIRT program was facing serious state-wide resourcing challenges.

494 NSW Government, *Keep Them Safe*: *A shared approach to child wellbeing*, 2009, p.13.
495 NSW Department of Community Services and NSW Police, *Joint Investigative Response Team, Policy and Procedures Manual, 2001*, p.19.
496 NSW Attorney General's Department, Aboriginal Child Sexual Assault Taskforce, *Breaking the Silence: Creating the Future – Addressing child sexual assault in Aboriginal Communities in NSW*, February 2006.
497 ARTD Consultants, *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence services mapping*. Final Report to NSW Department of Health, February 2011.
498 The 2008 Garling report, for example, notes in relation to the NSW Public Hospital system: 'Given the demographic changes and the rising costs, it is the case that we have entered into a period of crisis'. (Peter Garling SC, *Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals*, 2008 – Overview, p.3).
499 Advice provided by NSW Health, February 2017.
500 A detailed discussion of our findings in relation to the capacity of counselling services in NSW can be found in section 10.1 of NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.102-107.

We recommended that Health collect, as a priority, the necessary data to allow it to determine the demand for (and staffing of) the SAS in order to demonstrate its counselling capacity challenges and inform a review of the adequacy of the SAS budget, including consideration of allocating additional funds to the LHDs to better meet demand.[501]

It is positive that Health is now able to report on the number of referrals (both by JIRT health clinicians and the JRU Health team) to the SAS and other services. As noted above, the vast majority of referrals by JIRT health clinicians are made to SAS. The new SAS database should improve the availability of uptake data for that service – if a referral to SAS is not accepted, it will be compulsory for the referral to be 'discharged' once a client's matter is closed, and for the reason for discharge to be recorded.

However, Health is still unable to report on referral uptake for other VAN services.

Health has suggested that other measures, such as time on waiting lists, may provide an alternative measure of service capacity. However, as we discuss below at section 12.3.4, waiting lists are not uniformly used in LHDs and the Ministry of Health is not currently monitoring them.

Health has acknowledged that the uptake of referrals to VAN services is a critical measure which demonstrates a key aspect of the 'value added' by Health in the JIRT partnership. In relation to referrals made by the JRU Health team for matters that are rejected for a JIRT response, it may also provide insights into the functioning of the JIRT referral criteria. It is essential that outcomes are documented for all children, regardless of the reported abuse type, who are referred to a VAN service via the JIRT program – including those who are not accepted by a service because of insufficient capacity. Health should, in our view, systematically monitor service uptake and capacity, and have mechanisms in place to follow-up individual referrals.

12.3.2. Counsellor vacancy rates

Our 2012 report found that Health particularly struggled to fill counselling positions in regional and remote areas of NSW. As a result, many victims of child sexual assault in these areas simply did not have access to counselling. Information we reviewed in September 2012 showed there were approximately 145 FTE sexual assault counsellor positions within NSW Health, with a vacancy rate of 17%. Within the metropolitan LHDs, the vacancy rate was 13% and in rural and regional LHDs it was 22%.[502]

A Health survey in February 2017 provided an updated snapshot of the SAS workforce, showing that in rural and remote LHDs, the overall vacancy rate has fallen 8% (to 14%), whereas there has been a 2% increase (to 15%) in metropolitan LHDs. However, the proportion of vacancies reported within each LHD varies considerably, from 20% in Western Sydney to 29% in Western NSW, with other districts (Nepean Blue Mountains, Central Coast and Far West LHD) reporting no vacancies at the time of the snapshot. This explains why responses to our JIRT workforce survey indicated that vacancies in rural and remote areas continue to be problematic for Health.

12.3.3. Recruitment and retention strategies

Our 2012 report highlighted the need for a whole-of-government approach to recruiting staff in high-need areas in NSW. While we found that there were comprehensive incentive programs in place for doctors, the incentives for other health professionals appeared limited. In the absence of a whole-of-government structure for incentives, our view was that it was critical for Health to continually review the locations and positions with high vacancy rates and poor staff retention, and implement stronger incentive schemes for these areas.[503]

For the purposes of this inquiry, we asked Health to update us about its progress in implementing our recommendations concerning the recruitment and retention of counselling staff. In response, Health provided information about the use by LHDs of the *Guidelines for Implementation of the Rural and Remote Incentives Scheme*[504] (the 'Incentives Scheme') to address difficult to recruit positions; however, only one regional LHD appeared to be making use of this scheme.

501 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendation 24).
502 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.108.
503 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendation 26).
504 NSW Department of Premier and Cabinet, December 2010. This is a scheme which provides chief executives with discretion to offer incentives to attract and retain employees in 'hard-to-fill' positions in rural and remote locations. Funding for the incentives scheme must be met from existing budget allocations. See *NSW Health Information Bulletin* (IB2011_002), January 2011.

Health also commented that in the past, the former Department of Health had been able to closely monitor staffing allocation levels as a means of ensuring that LHDs and the SCHN continued to resource SAS at the level provided for in historical budget allocations for this service. However, due to Health's devolved governance arrangements, there has been a move away from providing funds explicitly for individual positions, with Districts and Networks expected to fund services (inclusive of workforce requirements) within their overall budget allocations. As the 'systems manager', the Ministry of Health has a role in setting performance expectations and the LHDs have flexibility in how they will allocate resources and deliver services locally in order to meet those expectations and satisfy local population need. The service targets and outputs for LHDs are set out in service agreements between the Secretary and each of the Chief Executives.[505] Additionally, the NSW Health Performance Framework outlines the Ministry's leading role in performance improvement approaches, responses to performance concerns and management processes that support the achievement of NSW Health and Government policy and priorities. We discuss the issue of Health's JIRT governance further at the end of this chapter.

12.3.4. Responding to demand – waiting lists

All clients referred to SAS are provided with an initial psychosocial and safety assessment to determine their current safety and immediate support needs.[506] Where capacity cannot meet demand for counselling, a prioritisation system determines which clients receive services. Following a review of its sexual assault policy, Health changed its approach to prioritisation of service provision from a more rigid application of a numbered list of categories with descending priority, to a method based on a case-by-case assessment of 'clinical need' to guide decision-making about service provision.[507] While the clinical need assessment still relies on similar categories, this approach gives SAS more flexibility in assessing individual client needs.

Clients who do not receive a counselling service may be placed on a waiting list; however, the use of waiting lists is a matter for individual LHDs and not all services have them.[508] In 2016, the Ministry of Health surveyed LHD SAS about their use of waiting lists for counselling services.[509] Survey responses indicated that of the nine metropolitan LHDs,[510] four had no waiting list.[511] Six of the seven rural LHDs reported that they had no waiting list.[512] It is important to note that the lack of a waiting list does not equate to a service being able to meet demand, but is a reflection of LHD administrative practices. In this regard, survey feedback from Health respondents to our JIRT workforce survey about the lack of availability and/or capacity of counselling services for victims of both sexual and physical abuse outside of the Sydney metropolitan area is illustrative.

Although Health has collected data about waiting times for services (that is, the time between a JIRT referral being made to a health service and client attendance at the service) since 2013-2014, this data is not considered reliable because waiting times for between 30% and 40% of JIRT referrals are recorded as 'unknown'. Health expects that data about waiting times and referral uptake for SAS will improve dramatically once the new SAS database is implemented state-wide. The SAS database will have more specific indicators of waiting times for services that maintain waitlists, as it will capture the date and time of allocation to wait list, allocation to counsellor, and initial physical presentation at SAS. It is essential that this information is accurately collected and analysed so that decisions about enhancements to the overall counselling workforce are based on the best available evidence.

Comments about long waiting lists for CPCS are also noted throughout this report. One respondent to the Health JIRT workforce survey commented that the CPCS in their area had 'an over 6 month waiting period for services'. As noted earlier, the SAS database will collect information about referrals to CPCS (and CPUs) if the abuse type is sexual assault; however, for referrals involving physical abuse or neglect, this information will not be captured.

505 Advice provided by NSW Health, February 2017.
506 This may be by telephone or face-to-face.
507 Advice provided by NSW Health, September 2016.
508 Advice provided by NSW Health, March 2017.
509 A similar survey was also conducted by the Ministry of Health in August 2016.
510 Including the SCHN.
511 Advice provided by NSW Health, February 2017.
512 One LHD indicated that private counsellors were engaged if the SAS was unable to provide a service, and another reported that if a service was not able to be offered immediately a 'soft referral' would be made to Victims Services or a private provider.

12.3.5. Gaps in counselling services

Counselling for children and young people with unsubstantiated sexual abuse

Our 2012 report also highlighted that inadequate counselling capacity challenges was disproportionately affecting a number of specific groups. For example, counselling services were not widely available to children suspected of being sexually abused. This was largely because the SAS only provides counselling to children under the age of 14 if they have been referred as part of a formal investigation process. At that time, most CASAC services were able to accept referrals where there had been no formal report of the sexual assault; however, these services also reported lengthy waiting lists.

As noted above, NSW Health has reviewed and changed its sexual assault policy to prioritise client allocation based on an assessment of 'clinical need, giving considerations to the range of client categories'.[513] This revised method of prioritisation is set out in new draft *Standards and Guidelines for NSW Health Sexual Assault Services* (SAS Standards) which confirm that 'counselling for sexual assault will usually only be offered to children under 16 years following disclosure during a JIRT interview'. However, the draft SAS Standards also recognise that 'some children who have been sexually abused may not disclose during the JIRT interview'. In these circumstances, the health clinician (in consultation with JIRT partner agency colleagues) may decide that 'a referral to a SAS is appropriate'.[514]

The draft SAS Standards will provide detailed advice about processes to follow and factors to consider when deciding whether and how to provide counselling to this cohort of children and young people, including referral pathways from FACS to SAS.[515]

It will be important for Health to monitor the impact of the changed eligibility criteria. For this to occur, specific data will need to be collected for children and young people who received counselling in the absence of a disclosure during a JIRT interview. Pleasingly, NSW Health has confirmed that data on counselling for this group will be collected as part of the new SAS data collection.[516]

Counselling for physical abuse and neglect

The 2011 *Review of NSW Health Counselling Services* (the Counselling Review) found that all surveyed CPCS reported that they were unable to meet current demand for their services.[517] This inquiry has also identified that service gaps continue to exist for children and young people who are victims of physical abuse and neglect.

Health has commented that while there is a 'pathway from JRU/JIRT to CPCS, anecdotal feedback from JIRT senior health clinicians suggests the waitlists in some services may not be suitable in responding to urgent JIRT cases'.[518]

Capacity issues are only part of the problem, with the lack of counselling referral pathways for unsubstantiated matters also being a concern. The Counselling Review identified that, where FACS had not substantiated abuse and neglect, counselling and support services were not available to children and families identified as being at risk of violence, abuse and neglect. At that time, many CPCS only worked with JIRT teams occasionally,[519] and the current data indicates that this continues to be the case. CPCS also reported that they were often unable to manage the referrals coming from FACS and therefore would not have the capacity to respond if referrals also came from other sources.[520]

Physical abuse and neglect matters are rejected by the JRU at a higher rate than sexual abuse matters. Data provided by Health indicates that in 2015-2016, 143 matters were rejected under the physical abuse or neglect criteria, and that health services were not identified as available for these children.[521] Health has advised us that in some instances, the JRU Health team is able to identify a

513 Advice provided by NSW Health, September 2016.
514 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.60.
515 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, pp.61-63.
516 These referrals will be known in the dataset as 'form a belief referrals'.
517 ARTD Consultants, *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence services mapping*. Final Report to NSW Department of Health, February 2011, p.89.
518 Advice provided by NSW Health, November 2016.
519 ARTD Consultants, *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence services mapping*. Final Report to NSW Department of Health, February 2011, p.98.
520 ARTD Consultants, *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence services mapping*. Final Report to NSW Department of Health, February 2011, pp.64-65.
521 Advice provided by NSW Health, November 2016.

health service which can respond straight away to a physical abuse matter that has been rejected for a JIRT response, including situations where a health service is involved with a family because the child has already presented to a hospital or health service. However, in some cases, health services are not available because referrals cannot be made unless there is evidence of physical abuse, which may require statutory intervention by FACS or Police through the issuing of an order to the parents/carers which mandates that the child or young person undergo a medical examination.[522]

Health noted that:

> *Agencies are agreed on the need to ensure that the large proportion of rejected matters (particularly in the area of physical abuse) receive appropriate follow-up and are re-reported if appropriate after further information is gathered in the field. … NSW Health believes there should be greater use of section 173 orders for medical examination in physical abuse matters in order to avoid under-estimating the seriousness of some of these cases where child deaths do occur.*

While Health currently collects data about JIRT referrals to CPCS and CPUs, as with SAS data, it cannot currently provide data about the number of clients who actually attend counselling for physical abuse and neglect. CPUs and CPCS are separate to the SAS and will not be incorporated into the new SAS database. Health indicated that for the time being, CPUs and CPCS will continue to use separate manual databases, while Health continues to scope options for extracting data and reports from its existing electronic medical record systems.

Health has advised that it will still be able to manually generate reports on counselling uptake for these services 'by looking at cases where JIRT is the referral source, and whether the client/family had any counselling sessions prior to discharge'.[523] However, the use of separate databases will mean JIRT data cannot easily be compared across service types. It is also unclear whether physical abuse and neglect referrals rejected due to a lack of service capacity will be reportable.

Data about counselling provided to JIRT clients by hospital social work departments is also not currently collected by Health, and we are unaware of any proposal to collect data about hospital-based crisis counselling. While we appreciate that it may be complex to obtain, Health should examine how this data can be extracted. Without data about hospital-based services, much of Health's work to support victims of physical abuse and neglect will go unrecognised.

Health has indicated that it will consider the benefits of ensuring that the collection of data about referrals for counselling is aligned across all service types, consistent with the minimum data set it has developed for the SAS. We welcome Health's commitment to improve its physical abuse and neglect data, and related systems to monitor referral uptake.

12.4. Medical and forensic examinations

Medical forensic examinations are critical to the crisis response provided by Health to children who may be victims of sexual assault, physical abuse or neglect. Medical and forensic examinations aim to review, assess and diagnose clinical findings and gather biological and toxicological evidence for use in court,[524] identify and respond to treatment needs, provide medical information, support and reassurance, and facilitate the coordination of appropriate referrals for ongoing physical and psychological wellbeing.[525] Forensic examinations are specifically for the purpose of gathering evidence for use in court.[526] Medical examiners often identify health issues other than those related to abuse during a medical and forensic examination and make appropriate health referrals.

A sexual assault medical and forensic examination is conducted when there is a likelihood of collecting forensic evidence which may support an investigation or prosecution. Whether or not the examination should be conducted is influenced by how recently the alleged incident of abuse occurred, the likely existence of bodily fluids, and the type of sexual assault.[527]

522 Pursuant to section 173 of the *Children and Young Persons (Care and Protection) Act 1998*.
523 Advice provided by NSW Health, March 2017.
524 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.80.
525 In 2015-2016, 238 medical examinations were conducted in the absence of a forensic examination. Data provided by NSW Health, November 2016.
526 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.80.
527 Advice provided by NSW Health, November 2016.

Forensic evidence related to a suspected sexual assault can be collected from a range of sources, including the victim's clothing and the scene of the assault. DNA evidence is a possible component of forensic evidence; however, it is often not present in cases of child sexual assault. In fact, many types of sexual abuse leave no physical evidence because of the way the abuse is perpetrated. In addition, injuries may heal rapidly, leaving little or no trace after 48 hours, and delays in disclosing abuse are common.[528] Despite these limitations, there is no question that forensic evidence can be highly valuable for investigators.

Medical forensic examinations are also performed in cases of suspected physical abuse to make determinations about the timing of injuries and whether or not an injury is severe or serious; and to assess the probability, that an injury was caused intentionally, or is inconsistent with the explanation provided.[529] Medical forensic examinations in cases of suspected neglect are performed not only to help substantiate neglect, but also to provide an opportunity for early intervention and prevention of further neglect. Medical forensic examinations in physical abuse and neglect matters also seek to identify familial, environmental and lack of safety factors that may have contributed to the abuse or neglect. During the consultations informing our 2012 report, the limited availability of suitably qualified medical practitioners to undertake medical forensic examinations of child sexual assault victims was repeatedly raised with us, particularly in rural and remote NSW, as a significant barrier to increasing the rate of reporting, especially by Aboriginal children who are over-represented in sexual assault statistics generally and in rural and remote locations in particular.

Both community members and agency staff, particularly police, also expressed concern about the distances that victims living in remote areas had to travel to be forensically examined. This issue had been known to agencies for many years and had also been the subject of a number of reviews and inquiries without evidence of significant progress to resolve it.[530]

Our 2012 report noted that there was a lack of reliable data about the number of forensic examinations conducted on children (particularly Aboriginal children) each year; how far child victims travelled to undergo a forensic examination, and the period of time between the alleged incident and the forensic examination. However, there was anecdotal evidence and broad agreement among agencies that the time taken to conduct examinations, and decision-making processes in relation to both provision of transport and whether an examination was required, were less than optimal.

In the period since our report, Health has made some significant improvements, including in relation to data collection, funding of regional and rural LHDs to increase the availability and quality of forensic services, and training and resources for health practitioners involved in conducting forensic examinations. However, the data available for our inquiry has a number of shortcomings and has limited our ability to confidently report on key outcomes for children accepted into the JIRT program, including the distance travelled and the time taken to receive a forensic examination. In addition, Health is unable to provide data about forensic examinations in relation to physical abuse and neglect.

Health has acknowledged these limitations and has commenced several positive initiatives – including the new SAS database, the Child Abuse and Sexual Assault Clinical Advice Line (CASACAL), and the revised draft SAS Standards – which it anticipates will lead to considerable improvements in medical forensic service provision and associated data collection. It will be important for Health to assess the impact of these initiatives when they have been fully rolled out.

It is also worth noting that, in contrast to the negative feedback we received from agencies (including Health staff and police) during our earlier audit, Health's role in coordinating and conducting forensic examinations did not emerge as the subject of strong criticism in responses to the JIRT workforce survey. Although good progress has been made, a number of the complex challenges outlined in our 2012 report have yet to be fully resolved. The section below describes the progress Health has made since 2012, and considers strategies in place to improve both data collection and the operational effectiveness of forensic examination services for children and young people accepted into the JIRT program.

528 Medical evaluations may fail to reveal specific findings even where penetration has been confirmed by the perpetrator, NSW FACS, NSW Ministry of Health, NSW Police Force, *JIRT Foundation Skills Course: Participant's Manual*, December 2014, p.96.
529 NSW Kids and Families, *Suspected Child Abuse and Neglect (SCAN) Medical Protocol*, July 2014.
530 These include the Aboriginal Child Sexual Assault Taskforce, the JIRT review and the Wood Special Commission of Inquiry.

12.4.1. Processes for the collection of forensic evidence

Sexual assault medical forensic examinations

When allegations of child sexual assault are made to the Helpline, it notifies the JRU (or, if the report is after-hours, the Helpline Crisis Response Team will contact the on-call CAS duty officer). If the alleged sexual assault is reported to have occurred within the relevant forensic collection timeframe, the JRU will treat the collection of any forensic evidence as a priority. In business hours, the JRU Health team contacts the relevant JIRT health clinician who is responsible for making a referral to a SAS or a forensic examiner. Once contacted, the SAS is responsible for the overall coordination of medical and forensic services and, in consultation with on-call medical staff, will decide whether a child should be forensically examined.

Health JIRT can recommend a medical forensic examination but the decision about whether and when to proceed is ultimately a matter for the examining doctor. Medical practitioners take account of the current recommended timeframes in their decisions about when to conduct examinations.[531] Depending on the type of sexual assault, the critical time period may be as brief as 12 hours from the time of assault, while in other circumstances, forensic evidence may still be obtained up to a week after the event.

The health and welfare of the child is also a key consideration for medical practitioners in determining whether and when to conduct a forensic examination. [532]

A medically qualified person can conduct the forensic examination to document injuries, collect forensic specimens via a Sexual Assault Investigation Kit (SAIK), and provide an expert opinion to be used as part of the prosecution of an alleged perpetrator. The SAIK includes the Child Sexual Assault Medical Protocol,[533] which is used to document the examination, as well as swabs, slides and other items to assist with evidence collection and preservation. Once the forensic examination is completed, police will arrange for the SAIK to be delivered to a forensic laboratory.[534]

The qualifications required for doctors and nurses to conduct acute sexual assault forensic examinations of children vary according to the age, psychosocial and physiological development of the child or young person, the competencies of the health professional and the policies of the LHD.

Medical and forensic examinations for children under the age of 16 are undertaken by a range of medical practitioners across NSW. Depending on training, experience and credentials, these practitioners include:

- paediatricians and paediatric registrars
- general practitioners (Visiting Medical Officers)
- other staff specialists such as sexual health physicians, and
- gynaecologists and gynaecology registrars.

Qualifications include courses offered by the Royal Australasian College of Physicians, training programs for paediatricians and Units of Study in Child Sexual Assault offered as part of the Monash University Master of Forensic Medicine. The NSW Health Education Centre Against Violence (ECAV) offers NSW examiners a nationally accredited qualification – the Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault – and online professional development courses, which cover delivering medical and forensic services to young people.

Sexual Assault Nurse Examiners (SANEs) may provide a sexual assault forensic medical examination to children or young people between 14 and 16 years of age who were not assaulted by a caregiver or a relative.[535]

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531 *Guidelines for the collection of forensic specimens from complainants and suspects*. These are updated every six months.

532 To inform our inquiry, Health provided us with a draft flowchart – *Determining the urgency of medical interventions: Suspected child or adolescent sexual abuse* – used by paediatricians and forensic physicians. The flowchart illustrates clinicians' considerations in determining whether to conduct an examination in 'child unfriendly hours' or wait until the next day. It also highlights that 'a decision to delay a high-priority medical forensic intervention is only made when it is unavoidable, or in the best interests of the child and their carers'.

533 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.92. The Adult Sexual Assault Protocol may be used where an eligible young person has attended an adult Sexual Assault Service (that is, a young person aged 14-16 years who was not assaulted by a caregiver or relative or aged 16 years and over).

534 *JIRT Foundation Skills Participant Manual*, NSW Family and Community Services, NSW Ministry of Health, NSW Police Force, December 2014, p.96.

535 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.81.

Early Evidence Kits (EEKs) allow doctors, nurses and police officers to guide a person through self-collection of forensic samples prior to a full medical and forensic examination. Where there is likely to be a delay before a forensic examination can be conducted by a qualified practitioner, the use of the EEK can allow the person to eat, drink and pass urine whilst minimising the possibility of losing forensic evidence.[536] In 2013, an interagency group led by the NSW Police Force considered the use of EEKs in NSW. EEKs were subsequently piloted in metropolitan Sydney but have not yet been endorsed by the Ministry of Health, nor formally rolled out across NSW. If available and effective for use by children or young people, these kits may provide a mechanism to collect some forensic specimens in cases where forensic examination by a qualified practitioner cannot occur due to practitioner availability, proximity or other factors.[537] We understand that Health is considering, in consultation with stakeholder agencies, the efficacy of EEKs in relation to children and young people.[538]

Physical abuse and neglect medical forensic examinations

There are significantly fewer referrals to the JRU for physical abuse and neglect than there are for sexual assault, with the former accounting for only 22% of accepted JIRT matters in 2015-2016.[539]

Medical forensic examinations in relation to suspected physical abuse and neglect occur in a very different context to examinations arising from sexual abuse allegations. While sexual assault forensic examinations usually follow a disclosure of sexual abuse, examinations in relation to physical abuse and neglect usually arise when a child or young person presents with an injury or illness at a hospital emergency department, is admitted to hospital, or presents to a GP, and the particular injury or the child's medical history raise suspicion that the harm may not have been accidental, or that neglect may have been a contributing or sole factor. In the first two scenarios, the child is already within the public health system and referrals from the JRU/JIRT for a medical forensic examination are generally unnecessary unless an inadequate medical forensic examination has been conducted.

Under section 173 of the *Children and Young Persons (Care and Protection Act) 1998*, Police or FACS may also refer a child for an examination. This provision allows FACS or Police to serve a notice on a parent or carer of a child requiring them to present the child for a medical examination. On completion of the medical examination, the doctor provides a written report to the Secretary of FACS.[540]

Our consultations during this inquiry indicated that the capacity of regional LHDs to conduct medical forensic examinations in relation to physical abuse and neglect is variable, depending on the attitudes, training and skills of paediatric consultants in child protection at Level 4 hospitals. Health has confirmed that it does not systemically collect data about forensic examinations for physical abuse and neglect.[541] In our view, it is critical that Health has a system in place to collect data about these examinations.

Further, only some LHDs have listed evidence of child protection expertise in the position descriptions of paediatric Visiting Medical Officers and staff specialists. In our view, it would be useful for the monitoring of the child protection skills of paediatric consultant appointments to be undertaken by LHDs and reported to the Ministry of Health.

Doctors working in emergency departments have various levels of knowledge, skill and experience. Some doctors in smaller hospitals may be primarily GPs who are also employed by the LHD. Some, but not all, have specialist qualifications in general practice but very few have training in child protection. In many cases, the identification of child abuse or neglect will be uncertain and warrant consultation with a paediatrician at a Level 4 hospital, or a paediatric child protection specialist at a Level 6 hospital.[542] We understand that LHDs are required to have pathways in place to facilitate access to such advice and, where required, the transfer of the patient.[543]

536 Women and Infants Research Foundation, *Early Evidence Kits in Recent Sexual Assault: Spermatozoa Detection in Urine And Other Forensic Specimens*, http://www.wirf.com.au/sites/default/files/binder2_0.pdf.
537 We are aware that some LMGs have discussed the use of EEKS and that a variety of views exist about the efficacy of their use in relation to younger children (LMG meeting minutes for Mid North Coast, July 2016; Newcastle, August 2016; The Entrance, August 2016).
538 Advice provided by NSW Health, March 2017.
539 Data provided by NSW Health, November 2016.
540 NSW Health, *Information sheet: physical abuse and neglect*, March 2015.
541 Advice provided by NSW Health, March 2017.
542 Major specialty areas are delineated using up to six levels of service – Level 1 (the lowest complexity of care) to Level 6 (the most complex care), which correspond to increasing complexity. A hospital or health care facility is considered to be at a particular level when the majority of clinical and support services provided are at that level.
543 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.13.

The Suspected Child Abuse and Neglect (SCAN) Medical Protocol provides medical officers with a standard template and clinical guidance to record a forensically oriented medical assessment of a child or young person. This enables 'an opinion to be formed as to the probability that injuries have been caused intentionally or that neglect is present'.[544] The JRU Health team may also consult with health reporters about use of the SCAN Protocol.

The SCAN Protocol, which was introduced in 2014, addresses the criticism made by the 2006 JIRT Review that the absence of such a protocol was contributing to inconsistent practices.[545] It is pleasing that Health has now addressed this issue. However, some concern was expressed by respondents to the JIRT workforce survey that medical practitioners may be unaware of the protocol. There would be merit in Health actively promoting the use of the SCAN Protocol to relevant hospital staff and other health clinicians. Health has also acknowledged that it needs to know more about how extensively, and in what circumstances, the SCAN Protocol is being used.

Health has indicated that, even where the protocol is used, the skill of the treating medical officer in detecting signs of physical abuse or neglect is crucial. In this regard, it is positive that the Royal Australasian College of Physicians will soon be enhancing specialist paediatric training to include a 'Vulnerable Child' module, which has increasing skills in detecting physical abuse as one of its aims.[546]

Where doctors suspect physical abuse and/or neglect, a child will generally remain in hospital to ensure their safety and until a specialist assessment or consultation has occurred. In circumstances where a report is referred to JIRT and the child is not already in hospital, the JIRT health clinician will contact their Level 4 or higher paediatric service if they need to refer a child for a forensic examination to obtain evidence in relation to suspected physical abuse or neglect. In areas where there is no local service, the clinician will contact the closest Level 4 service.[547]

In section 12.4.5, we outline Health's CASACAL initiative, which is aimed at improving the support and guidance provided to rural and remote forensic examiners. Once operational, CASACAL may provide useful insights into physical abuse and neglect forensic examinations. Health is also in the process of updating the physical abuse criteria and will settle the document in consultation with the JIRT SMG.

Given the progress Health has made in data collection, policy development and clinical guidance in relation to acute sexual assault forensic examinations, it is now timely for Health to renew its focus on physical abuse and neglect medical forensic service provision as part of the broader efforts to strengthen Health's response to serious physical abuse and neglect cases described in section 12.2.3 above.

12.4.2. What the available data tells us about sexual assault medical and forensic examinations

At the time of our 2012 report, Health was unable to quantify basic information such as the number of sexual assault forensic examinations on children in each LHD. The absence of quality data about forensic examinations complicated attempts to improve service provision. As noted earlier, Health's new SAS database will now capture this information.

Health's data collection practices have improved significantly since 2012. Currently, data about forensic examinations is recorded by JIRT health clinicians in each LHD.[548] Although there are still a number of quality and reliability issues and some significant data gaps, Health is now able to provide data about the number of JIRT clients assessed as requiring a forensic examination in each LHD.[549] Data can also be separately reported for Aboriginal clients.

544 NSW Kids and Families, *Suspected Child Abuse and Neglect (SCAN) Medical Protocol*, July 2014.
545 NSW Health, NSW Police, NSW Department of Community Services, *NSW Joint Investigation Response Team (JIRT) Review*, November 2006, p.44.
546 Advice provided by NSW Health, March 2017.
547 Advice provided by NSW Health, March 2017.
548 Data is subject to some variability because of differing LHD collection processes.
549 For the purposes of the current data collection, an examination is 'required' if the JIRT health clinician (or SAS counsellor) and the forensic examiner jointly decide that it should be conducted. Although the Helpline, JRU, Police or FACS may *request* a forensic examination, the term 'required' in the Health data denotes this joint examiner/health clinician decision.

In 2015-2016, the Health data indicates that 220 acute sexual assault forensic examinations of JIRT clients were required (4.8% of all JIRT clients).[550] In 2014-2015, 5.5% of JIRT clients required forensic examinations, and previous years recorded similarly small proportions.[551]

The small number of acute forensic examinations may reflect a number of factors, including that:

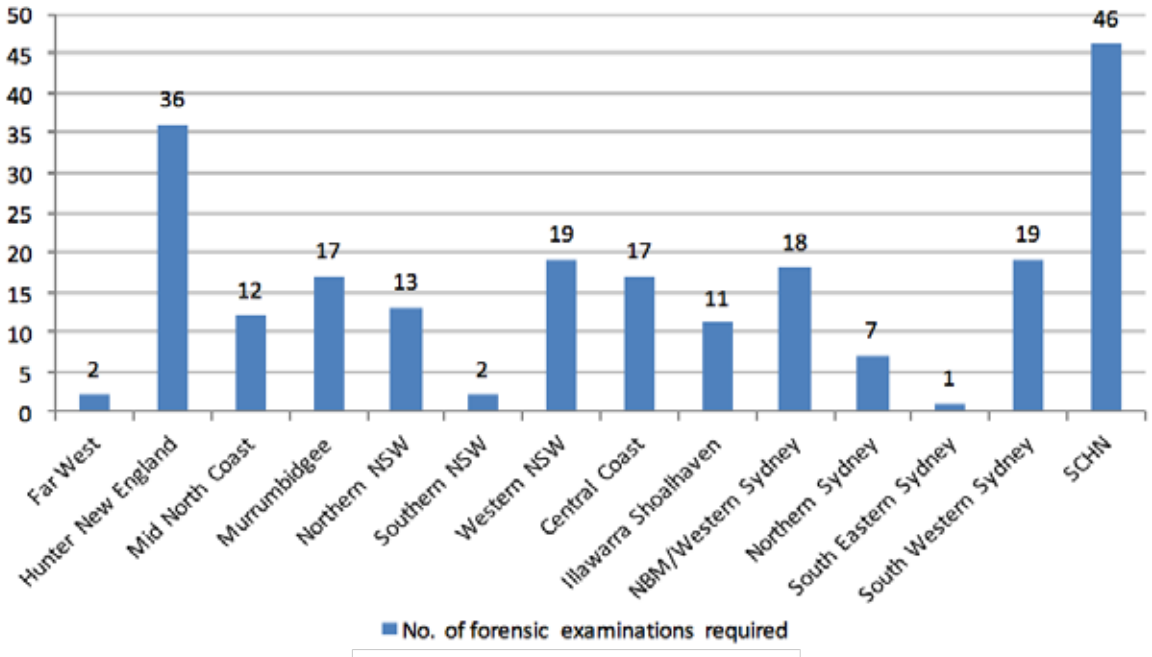
- physical abuse and neglect forensic examinations are not recorded (although these account for only a small proportion of all accepted JIRT matters)
- children frequently delay disclosing sexual abuse beyond the timeframes for collection of forensic samples
- forensic evidence is not available for some types of sexual abuse, nor in many instances of child sexual abuse because of forensic evidence collection timeframes, and
- in some instances, initial delays (for example, in JRU assessment or locating an examiner) may mean that by the time the medical examiner is notified, forensic evidence is no longer viable and consequently, the examination is not required.

Health has suggested that the reported numbers of required acute sexual assault forensic examinations may under-represent the extent of Health's work in medical forensic service provision. There are many non-acute medical forensic examinations (that is, examinations outside the timeframe for forensic evidence collection for the purpose of assessing what has happened to a child) which are not recorded in Health's JIRT program data. For example, a sexual assault medical forensic examiner in one LHD conducted 35 examinations in 2015-2016 but of these, only 11 were classed as 'acute'. The same examiner has advised NSW Health that in many sexual assault matters there are also indicators of low level neglect that result in referral for a full paediatric physical review, which again, is not reflected in Health's JIRT program data.[552]

Health has confirmed that the new SAS database will provide a more complete picture of this work in sexual abuse matters as data will be collected for all relevant variables (that is, acute medical/acute forensic, acute medical/non-acute forensic, non-acute medical/acute forensic, non-acute medical/non-acute forensic).

As illustrated in Figure 8, more than a third (37%) of all acute sexual assault forensic examinations for 2015-2016 were required within the SCHN or Hunter New England LHD, which likely reflects the '24/7' capacity of their CPUs.[553]

Figure 8: Acute Sexual Assault Medical and Forensic Examinations required 2015-2016[554]



550 16.8% (37) of these related to Aboriginal JIRT clients. (NSW Health, Joint Investigation Response Team State-wide Data 1 July 2015-30 June 2016).
551 Data provided by NSW Health, November 2016.
552 Advice provided by NSW Health, June 2017.
553 Slightly higher proportions were recorded in previous years, for example 46% of forensic examinations were conducted at Hunter New England/SCHN in 2014-2015 and 42% in 2013-2014.
554 Data provided by NSW Health, November 2016.

Currently, data is not specifically collected about the number of forensic examinations *actually* performed. This means that it is not possible to determine the number of occasions when a forensic examination was required, but did not occur.

The closest available indicator from which an inference can be drawn about the number of forensic examinations conducted is the data on the time taken to conduct an examination. However, this data should be interpreted with care because timeframes are 'unknown' for a proportion of clients. When the health clinician does not record any details about the time taken to conduct a forensic examination, the timeframe is reported as 'unknown'.[555] In 2015-2016 timeframe data was listed as 'unknown' for 15% of clients.

In addition, because forensic examinations are only said to be 'required' after a forensic examiner has been contacted, it is unclear from the measure whether any clients were assessed as not requiring an examination because of delays which occurred prior to contacting the forensic examiner, such as delays in making the Helpline referral, the JRU assessment, or in locating an available and qualified medical practitioner. Timeframes for collection of forensic evidence may have lapsed because of these kinds of delays.

The number of forensic examinations required and the proportion actually conducted are key measures for Health's performance in the JIRT program. Health needs to ensure that the new SAS database includes both of these measures.

12.4.3. Availability of suitably qualified practitioners

Sexual assault forensic examination access issues are compounded for children under the age of 14, because the range of forensic examiners qualified to perform examinations on younger children is restricted due to the specialised nature of this work. Our 2012 report found that access to qualified practitioners in rural and remote areas was particularly difficult – they were rarely locally available, tending instead to be attached to larger hospitals which may be located a considerable distance from the victim. In areas where there were suitably qualified GPs (who usually only examine children 14 years and older), they were often unavailable during daytime hours because of competing demands from their private practice, or were reluctant to take on the work because of the potential need to give evidence in court.[556]

In 2012, Health was unable to provide us with data about how many children under the age of 14 required and received forensic examinations, and it remained unable to do so for this inquiry. Health has confirmed that 'age related data' will be collected in the new SAS database, which is positive. It will be critical for the SAS database to have the capacity to report data separately against this age cohort.

Responsibility for transporting children for forensic examinations

Health previously acknowledged that the size of NSW, as well as the lack of services in some areas and limited service function in others, meant that while the central and northern coastal regions were relatively well served by existing 24-hour services, the western, southern and northern inland regions were not. As a result, access to a forensic medical examination in these areas often involved lengthy negotiations and inquiries by sexual assault workers and/or police trying to locate an available practitioner to conduct the examination, as well as appropriate transport to a suitable health facility. Organising long distance transport can be stressful, complex and time consuming – and while transport is being negotiated, victims must wait. Travel by road may then be required over long distances, taking many hours.

The distress and discomfort of potentially lengthy travel for forensic examination may be exacerbated by children being required not to wash or change their clothes before the examination. After-hours situations can be particularly difficult. The delays and difficulties associated with transporting children over long distances can compound their trauma, compromise the quality of physical evidence, and act as a significant disincentive to reporting assaults.

555 This could potentially be for a range of reasons such as the health clinician not following up regarding the referral, the information was known by the health clinician but was not entered in the spreadsheet, or the forensic examination did not occur.

556 LMG minutes noted that this continued to be a concern in one LHD in early 2013.

At the time of our 2012 report there was no policy directive relating to the transporting of child sexual assault victims for forensic examinations. As a result, the JIRT agencies expressed confusion about which agency was responsible for transporting victims to facilities able to provide a forensic examination.

It remains the case that transport for children to access medical forensic examinations may still be provided by Health, Police[557] or FACS.[558] If a child first presents to a hospital emergency department or another health service, Health is responsible for transporting them to a facility where a forensic examination is able to be conducted. Health may also provide transport where Police, FACS or private travel arrangements cannot be made.[559]

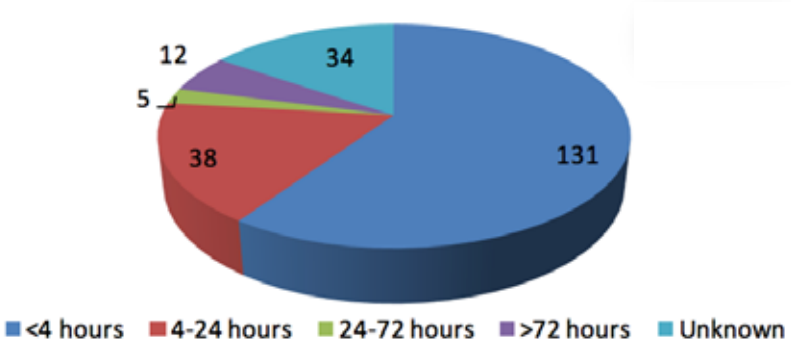
We previously recommended that Health develop a policy that provides for equal access to transport options regardless of which agency has first contact with the victim about the reported sexual assault. The main criticism in relation to forensic examinations from JIRT workforce survey respondents was the lack of clarity about transport options. In our view, this illustrates that there remains a need for such a policy to be developed.

12.4.4. The time taken to perform a forensic examination

The time taken to arrange a forensic examination is important not only because of evidentiary imperatives, but because of the impact on the child and family of lengthy delays or travel during a time of crisis. Delays were of significant concern to Health staff and police at the time of our 2012 report.

In 2015-2016, timeframes could be reported for 85% of matters in which a forensic examination was required[560] – an improvement on the situation in 2013-2014, when timeframe information was unknown for 20% of all clients requiring a forensic examination.[561] Of the 220 forensic examinations which were required in 2015-2016, 60% (131) were conducted within four hours of the medical examiner being notified of the need for the examination. There was no significant difference between rural and metropolitan LHDs. The proportion of clients receiving examinations within four hours has increased since 2013-2014, when only 43% of children were examined within four hours of notification of the examiner.[562]

Figure 9: Time taken to provide a forensic examination 2015-2016[563]



As Figure 9 shows, in 2015-2016, 38 children waited between four and 24 hours for a forensic examination. Overall, 60% of forensic examinations were conducted within 24 hours of the medical examiner being notified.

It is encouraging that the majority of children are seen within four hours of the examiner being notified. However, in 2015-2016, at least 12 children were kept waiting for periods in excess of three days before being examined. While this number has fallen from 29 children in 2013-2014,[564] waiting for more than

557 NSW Health, *Medical and Forensic Management of Adult Sexual Assault*, 2016, p.16.
558 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.46.
559 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.47.
560 Data provided by NSW Health, November 2016.
561 According to Health the 'unknown' category has been derived from the data where, 'Was an acute sexual assault medical/forensic examination required?' = 'Yes', and there is no information provided on 'Time between the request for sexual assault medical/forensic examination and when the examination was conducted'. There is no formal definition of 'unknown'.
562 Data provided by NSW Health, November 2016.
563 Data provided by NSW Health, November 2016.
564 Data provided by NSW Health, November 2016.

three days for a forensic examination following a recent sexual assault is clearly unsatisfactory. Given the small number of matters where this arises, it would be worth investigating the circumstances of each to determine what occurred and how such a lengthy delay could be avoided in future.

Health has also advised that, '[a] new standard is proposed as part of the draft SAS Standards which, if adopted, will require that the process of planning for an integrated sexual assault medical and forensic examination for all children, young people and adults following a recent sexual assault has started within two hours of the victim presenting to a NSW Health service'.[565]

Delays in providing forensic examinations

Although the available data shows an overall improvement in the timeliness of forensic examinations, responses to the JIRT workforce survey indicated that there are ongoing concerns about waiting times and distances travelled for forensic examinations in regional and remote areas:

> *Being a geographically large LHD … children and young people must travel long distances for sexual assault medical examinations* – Senior Health Clinician.

> *Dedicated paediatric forensic examiners [should be available] at all major hospitals. There have been times when children and their families have had to travel considerable distances due to no locally available forensic medical examiners* – Senior Health Clinician.

> *[Health should] provide easier access to forensic medicals in regional areas so that clients do not have to travel, or miss out on a SAIK because there is no doctor available* – Senior Health Clinician.

Delays may also be caused by a preference for interviewing the child before any medical or forensic examination occurs. While this issue has been the subject of some disquiet among health clinicians, and does not sit easily with certain Health policies, there may be a valid need to inquire into the nature of the assault to determine whether a forensic examination is warranted in appropriate cases.

According to the *JIRT Foundations Skills Course: Participants Manual*, 'ideally the child or young person is interviewed first by JIRT before any … medical or forensic examination and counselling'.[566] However, a different perspective is provided by Health's *Child Wellbeing and Child Protection Policies and Procedures for NSW Health:*

> *Health workers contribute to the JIRT response by sharing information obtained from the medical and psychosocial assessments to assist in the investigative process. Health workers are trained to conduct these assessments while maintaining the requirements of the criminal justice response. The Health response is not reliant on JIRT interview or substantiation as a criterion to proceed.* [567]

Consistent advice needs to be provided on this issue to JIRT health clinicians and other JIRT agency staff to avoid confusion and reduce the possibility of friction between agencies.

Our 2012 report recommended that data be collected about 'the time from the making of the child sexual assault report to the time of the forensic examination'.[568] For the collection of forensic specimens, the clock starts ticking from the time the sexual assault occurred, with some specimens ideally requiring collection within 12 hours of the sexual assault.[569] It is critical that delays at any point after a report of sexual assault is made (both prior to and following contact with a medical examiner) can be accounted for, understood and where possible, minimised. Determining the best approach to collecting this data is complex, but it is important that the design of the new SAS database improves accountability in relation to the provision of timely forensic examination.

565 Advice provided by NSW Health, March 2017.
566 NSW Family and Community Services, NSW Ministry of Health, NSW Police Force, *JIRT Foundation Skills Course: Participants Manual*, December 2014, p.90.
567 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health,* April 2013, p.80.
568 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendation 30(e)).
569 Advice provided by NSW Health, March 2017.

Reasons for delay

Health's 2015-2016 data indicates that reasons for delay were documented in relation to 58 clients who experienced delays of over four hours in being provided with a forensic examination. The most commonly cited reason for this delay was that the forensic examination was not considered to be in the child's best interests, for example, because the child was unwell, asleep or had other medical issues.[570] The next most common category, which was far more common for rural LHDs, was 'transport required'.

It is interesting to note that practitioner availability was only cited as a reason for delay on three occasions.[571] However, for an examination to be recorded as 'required', an examiner must first have been notified – conversely, if no examiner was available, then the forensic examination would not be listed as being 'required'.

With only around 220-250 forensic examinations required for JIRT clients each year, Health should be in a position to provide a detailed analysis of the reasons for any delays so that action can be taken to avoid them in future. Health has indicated that information about 'time-frames' and 'reasons why forensic examinations are not conducted' should improve once the new SAS database is implemented.[572] We understand that the database will require recording of the following information for sexual assault cases:

- date and time medical/forensic examination requested[573]
- date and time medical/forensic examination commenced
- transport required to a second health facility for the client to attend medical/forensic
- who provided the transport to attend the medical/forensic
- travel distance required for the client to attend medical/forensic
- travel time required for the client to attend medical/forensic, and
- reason for delay in providing an acute medical/forensic (if > 2hrs) – consent not given; delay not caused by Health; no forensic examiner available; mental health issues; transport required; was not in child's best interest; alcohol and/or drugs issues; physical injuries; medical assessment required; other and N/A.[574]

The new data collection has potential to provide valuable information about the provision of forensic services to JIRT clients. However, it will be important that 'reason for delay' data is as clear as possible to enable problem areas to be addressed. In this regard, categories such as 'delay not caused by Health' and 'other', without additional explanation, do little to enhance the understanding of the reasons for delay. With this in mind, we consider that Health should review the 'reason for delay' categories currently proposed for the new SAS database. Health has indicated that it will monitor the data on 'reason for delay in providing an acute medical/forensic (if > 2hrs)' and consider if further data categories are required.[575]

12.4.5. Health initiatives to improve quality and accessibility of medical forensic services for all forms of abuse

At the time of our 2012 report, Health was committed to the Child Abuse and Sexual Assault (adult and child) Forensic and Medical (CASAFAM) Project – a scheme to develop and enhance forensic medical services already in place for sexual assault victims, and to improve training and support for practitioners. Health allocated substantial funding to CASAFAM but no tenders were submitted to fully develop the model, and it ultimately did not progress. A number of valuable activities and sub-projects were nonetheless initiated under the CASAFAM umbrella and continue to operate.

570 Almost 30% (17/58) of the reasons recorded were for required examinations where no timeframe was recorded. It is possible that these instances included forensic examinations which were within the four hour period.
571 Advice provided by NSW Health, March 2017.
572 Advice provided by NSW Health, November 2016.
573 Health has advised that 'requested' will have the same definition as 'required'.
574 Advice provided by NSW Health, March 2017.
575 Advice provided by NSW Health, June 2017.

The Ministry of Health has continued to show leadership in seeking to improve the quality and accessibility of forensic service provision. Health's achievements and new initiatives in the provision of forensic examinations are detailed in this section.

Rural and remote LHD funding enhancements

In 2012 we identified that some services experienced difficulties in delivering a quality forensic service due to a lack of flexibility in managing their budget, and a lack of discretionary funds. We reported a range of difficulties encountered in arranging transport to forensic examinations, depending on the LHD, the resources available at the time the victim presents to a service, and the particular situation of the victim and their family. We found that no single transport solution would be appropriate in all circumstances, and therefore recommended that additional flexible funding be provided to rural LHDs to allow them to resolve individual circumstances as they arose. These funds were also necessary for expenses like emergency accommodation and other incidental costs. We also recommended that Health consider allocating additional funds to LHDs to provide SAS with access to a pool of flexible funds for transport, brokerage and other incidentals.[576]

In June 2015, the NSW Government responded to our recommendations, announcing that Health had decided to 'purchase service enhancements from all rural LHDs to ensure the availability of 24/7 integrated psychosocial, medical and forensic crisis responses for child and adult victims of recent sexual assault'.[577] These funds were to allow rural and remote LHDs to implement locally responsive service models involving a range of initiatives, including recruitment and training of counselling staff. Funding was also to provide for improved technology, transport, flights and other transport costs. The Government reported that:

> *Technology and equipment is being updated to … enable doctors to provide timely and quality care close to victims' homes. Access and transport is being improved, for example, with health staff in the Far West LHD, now being trained to provide a 'first-line' response to victims locally in a Sexual Assault Assessment Centre. Several rural LHDs have also received funds specifically for flights and vehicle costs to retrieve victims and transport medical and counselling staff.* [578]

The enhanced funding for these additional services was $334,603 in 2013–2014,[579] and $1,867,105 in 2014–2015, with provision made for recurrent funding of $1,789,605 from 2015–2016.[580] Health has advised that this targeted funding has assisted rural LHDs to resolve local challenges in providing 24/7 responses to child and adult victims of recent sexual assault, with a particular focus on Aboriginal communities. Health's considerable investment in responding to the concerns we raised in our 2012 report is very positive.

We also asked Health for details about the distribution and use of these funds among LHDs. A number of LHDs reported that they had purchased (or had received approval to purchase) one or more colposcopes[581] and were providing training and policy development to support use of this instrument.[582] Although it is not known whether the investment in colposcopes will impact access to forensic examinations, it is likely to improve the quality of forensic evidence available for prosecutions.

Some LHDs advised that they had used funds to recruit additional paediatric and other clinical and non-clinical positions. However, a number of these LHDs reported that they were experiencing difficulty recruiting to the funded positions. Far West LHD reported that it utilised funds to enable its

576 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendation 24(c)).
577 NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report*, June 2015, pp.13-14.
578 NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, June 2015, pp.13-14.
579 NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report*, June 2015, pp.13-14.
580 Advice provided by NSW Health, September 2016.
581 Colposcopes are used to facilitate ano-genital examination and provide lighting, magnification and capacity for still and video imaging. The decision to invest in colposcopes is in line with research commissioned by (then) NSW Kids and Families which found that 'photo-documentation of clinical findings … improves the likelihood of detecting ano-genital injury, improves the accuracy of diagnosis, and allows other experts to comment on the evidence without being present at the time of examination'. (See A. Cossins, A. Jayakody, C. Norrie and P. Parkinson, *Forensic and medical photography, video recording and video transmission for cases of suspected sexual abuse in children: An Evidence Check review brokered by the Sax Institute for NSW Kids and Families*, March 2015, p.6.
582 Advice provided by NSW Health, February 2017.

Integrated Violence Prevention Response Services (IVPRS) Team to provide 'first responders training' (specialist medical training in child sexual assault and child abuse medical forensic examinations) to Health staff and non-government agencies (including the Aboriginal Medical Service) in remote areas of Balranald, Wilcannia and Broken Hill. The LHD also committed additional fundng (beyond the Ministry of Health's enhancements) to support growth in its IVPRS team. Funds were also allocated to establish the Assessment Centre at Wilcannia (discussed below).[583]

Data for Hunter New England LHD is also promising, with that LHD managing to increase the proportion of clients receiving a forensic examination within four hours (from 38% in 2013-2014 to 75% in 2015-2016) and decrease the proportion of clients waiting more than 72 hours for an examination over the same period (from 47% in 2013-2014 to 6% in 2015-2016).[584]

Overall, the increased funding and the way it has been applied appear to have significantly enhanced the quality and timeliness of service provision in rural locations.

Child Abuse and Sexual Assault Clinical Advice Line (CASACAL)

The Ministry of Health is leading the development of the Child Abuse and Sexual Assault Clinical Advice Line (CASACAL) – a state-wide telephone advice line operating 24 hours a day and seven days a week.

CASACAL will give clinicians better access to clinical expertise, advice and support – particularly in those areas where there is no specialist CPU available. CASACAL will be available only to NSW Health staff, including GPs working as Visiting Medical Officers (VMO).[585] Health anticipates that most of the callers using CASACAL will work outside metropolitan areas. [586]

We understand that the CASACAL is anticipated to be implemented state-wide in August 2017. Health has also advised that quality assurance tools and data collection will be components of the initiative.[587] Health should be commended for developing the CASACAL initiative.

Assessment centres

During 2012, 'assessment centres' were being established in Walgett, Coonamble, Lightning Ridge, Nyngan, Cobar and Mudgee to provide victims of sexual assault with initial information and support, and to avoid any unnecessary long distance travel for a medical/forensic service. However, at the time of our report little information about the effectiveness of these services was available.

Western LHD recently advised us that the assessment services continue to operate and have access to a list of suitably trained staff who are available to be contacted when there is a presentation of sexual assault. Staff support the victim and collaborate with the on-call service to explain their rights, what a medical forensic examination entails and if necessary, provide transport to Dubbo or Bourke for an examination.[588]

Our 2012 report also noted that an assessment centre intended for Wilcannia (in the Far West LHD) had not been established because pilot initiatives had focused on the Western NSW LHD.[589] The Wilcannia SAS assessment centre is now funded through the Ministry of Health Medical and Forensic Services to provide both clinical and community engagement streams. The LHD reports that, although the assessment centre is not yet operational, there has been an increase of JIRT referrals of Aboriginal children to VAN health services, from 14 children in 2014-2015 to 26 children in 2015-16.[590]

583 Advice provided by NSW Health, February 2017.
584 Data provided by NSW Health, November 2016.
585 GP VMOs and VMO Paediatricians are often the clinicians who conduct child abuse and child sexual assault examinations in rural and remote areas.
586 Advice provided by NSW Health, February 2017.
587 Each of the three Child Protection Unit/Team sites has been allocated additional funding of $180,000 to support the implementation of CASACAL and recurrent funding of $180,000 per annum. Health estimates that design and development of the telephony will cost approximately $30,000. Health response to Ombudsman information request, 6 February 2017.
588 Advice provided by NSW Health, February 2017.
589 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.122-123.
590 Advice provided by NSW Health, November 2016.

Supplementary fees for medical practitioners

Another Health initiative examined in our 2012 report was the introduction of a new supplementary payment to encourage and attract additional clinicians to provide a medical and forensic sexual assault service for children on behalf of rural LHDs.[591] While the payment was largely welcomed by LHDs and appeared to lead to some improvement in service provision in a number of districts, we suggested that more evidence was needed to properly assess its impact.

Since then, ECAV has been funded to work with the Ministry of Health to review the effectiveness of the supplementary payment.[592]

Health has advised us that, at least until mid-2017, it will continue to fund LHDs to enable supplementary payments to VMOs who conduct sexual assault forensic medical and medical examinations for adult and child victims.

Sexual Assault Nurse Examiner program

The Sexual Assault Nurse Examiner (SANE) program was another strategy adopted by Health to address the shortage of medical practitioners able to conduct forensic examinations for victims of sexual assault. As noted earlier in this chapter, SANEs are nurses employed by Health who are qualified to undertake forensic examinations of adult victims of sexual assault – that is, a person 16 years or over who has experienced sexual assault and attends a SAS. SANEs may also examine adolescents 14 years or older, if they present to an adult SAS and were not assaulted by a caregiver or relative.

Only a small number of SANEs were employed by LHDs at the time of our 2012 report. Five LHDs – (Illawarra Shoalhaven, Western, Western Sydney, Nepean Blue Mountains and Hunter New England) indicated to us that they employed SANEs. At that time, Health had no plans to increase the number of SANEs providing forensic services to 14-16 year olds. However, we saw potential to improve access to examinations for these older children through expanding the number of filled SANE positions.

In October 2015, the NSW Government announced $1.3 million over four years to expand the number of qualified SANEs in high-risk rural communities. This funding is being used for ECAV to deliver training and support programs for SANEs. Health advises that there are now 17 SANEs working with SAS across NSW. The original five LHDs continue to employ SANEs and additional positions have now been created in Mid North Coast and Far West LHDs.[593]

ECAV is now a key partner in the SANE project, and offers a nationally accredited qualification, the Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault and other relevant professional development courses for nurses employed in SANE roles. At the time of our 2012 audit report, NSW nurses attended a pilot training course provided by the Victorian Institute of Forensic Medicine in order to be suitably qualified to be employed as a SANE. Since then, the Ministry of Health has funded ECAV to deliver a workforce development strategy to expand the number of nurses who are suitably qualified to be employed in SANE positions. We understand that ten nurses recently graduated from the 2016 Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault and are now suitably qualified to undertake the SANE role, and a further ten nurses are enrolled in the 2017 course. Health advises that the development of the SANE workforce will continue to be progressed in 2017.[594]

One difficulty for LHDs in employing SANEs is that as a consequence of the relatively small number of sexual assault examinations conducted in many LHDs,[595] there is insufficient workload to create designated positions and on-call arrangements are instead utilised. There are award and payment issues associated with the rostering of SANEs under such arrangements, and LHDs must ensure clinical supervision is provided to SANEs by a medical lead position.

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591 Known as Payment Determination 24, the fee was payable to any registered medical practitioner who conducted a physical examination of a sexual assault victim on behalf of the (then) Greater Southern, Greater Western, Hunter New England or North Coast Area Health Services (AHS) otherwise than as an employee of the applicable AHS.

592 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendation 40).

593 NSW Heath Education Centre Against Violence, List of SANEs by Local Health District, January 2017. SANEs working in the ACT also provide services to NSW residents in Southern NSW.

594 Advice provided by NSW Health, June 2017.

595 Our 2012 report found that the five LHDs employing SANEs performed a total of 22 examinations over three years. (NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.125-126).

We understand that Health is continuing to explore options to increase the range of health practitioners qualified to perform forensic examinations on children under 14 years of age.[596] Again, the efforts of Health in this complicated area are impressive.

Training and resources for examiners and JIRT agencies

As discussed above, an area where Health and ECAV in particular have excelled is workforce development of sexual assault medical forensic examiners. ECAV provides a suite of accessible, high quality and free education opportunities for doctors and nurses delivering medical forensic services. This includes introductory training (face-to-face and online live webinars), a nationally accredited qualification the Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault and online self-directed learning via the ECAV website for on the job training tools and accessible information. ECAV also runs a regular SANE Professional Support Network.

ECAV has established a Medical and Forensic Management of Adult Sexual Assault Training Standards Committee to oversee the development of all training and curriculum. ECAV has also employed a permanent staff specialist position in the role of Workforce Development Advisor to oversee all training activities.

In October 2016, Health launched the updated Medical and Forensic Examination Record (MFER) Adult Sexual Assault. The MFER is used by forensic examiners to document the sexual assault examination. According to Health, it will contribute to improved medical and forensic documentation, forensic evidence collection and toxicology collection. ECAV has developed online training to support clinicians in its use. In 2017, the Ministry of Health will commence work to develop a version of this document for use when conducting sexual assault examinations of children.

In addition, a 'Medical and Forensic Examination App' has been developed for use by doctors and nurses who examine children and adults following sexual assault, child sexual and physical abuse and neglect. The app is designed to inform clinicians' responses when examining patients, consulting about patient management, writing medico-legal reports and developing local procedures and guidelines.[597] It was scheduled for release in June 2017.

A revised edition of ECAV's *Medical and Forensic Management of Adult Sexual Assault* manual was released in 2016, incorporating up-to-date information and guidelines to support clinical practice. It includes specific guidance on sexual assault of young people aged 12-15 years, as well as adults and young people aged over 15 years. The manual is not designed to provide guidance about forensic examinations of children under 14 – we recommend that Health develops specific guidance for this age cohort.

ECAV has also developed an information card about the Medical and Forensic Management of Adult Sexual Assault[598] which provides a quick reference for Health and interagency partners about this process. Two separate online JIRT Health and Medical and Forensic 'SharePoint sites' for JIRT health clinicians, medical forensic examiners and SAS managers/clinicians have also been developed to allow easy access to information and resources to support their practice.[599]

Our 2012 report highlighted that the relevant policies and procedures of the JIRT agencies were inconsistent and unclear, at times resulting in friction between workers from different agencies when urgent decisions needed to be made about if, and when, a forensic examination should be performed – further complicating the situation for medical practitioners.

While the ultimate decision will be made by the forensic examiner, usually in consultation with a SAS counsellor or JIRT senior health clinician, the decision about whether or not to *request* the examination may be made by the JRU, Police, FACS or the Helpline, depending on the circumstances and timing of the report of sexual assault. This decision needs to be made quickly and on a sound basis so that potential evidence is not lost and unnecessary examinations are not arranged. It can take time to find a suitably qualified examiner and this process needs to commence without unnecessary delay. The timing of forensic examinations also takes into account the need for other

596 JIRT SMG minutes for March 2015 summarise a discussion, in the context of 'strategic priorities', which included Police suggesting that Health consider using paediatric nurses to conduct SAIKS for children under 14 years. Health advised that it was exploring options.
597 Advice provided by ECAV, January 2017.
598 Including young people.
599 Advice provided by NSW Health, September 2016.

urgent medical treatment and the needs of the child or young person, including their emotional and mental wellbeing. For these reasons, our 2012 report recommended that in consultation with JIRT agencies, Health develop procedures that outline the decision-making regime relating to forensic examinations.[600]

Current information guiding the JRU and JIRT units about the appropriate overall timeframes within which a forensic examination may provide useful evidence, remains somewhat ambiguous. The available guidelines have different maximum timeframes outside of which forensic evidence may not be available. The *JIRT Foundation Skills Course: Participant's Manual* sets out timeframes 'which have been determined by the Forensic laboratory', and these vary from 'up to 72 hours' to 'up to 12 hours', depending on the nature of the swabs being collected.[601]

The NSW Police Force *Guidelines for the collection of forensic specimens from complainants and suspects*[602] (Police Guidelines) included in ECAV's new *Medical and Forensic Management of Adult Sexual Assault* manual also set out timeframes for collection of samples. For some sample types, the timeframes vary according to the age of the person being examined – often with shorter timeframes for younger examinees. However, the Police Guidelines state that some forensic specimens may be obtained up to seven days after a sexual assault. The *Child Wellbeing and Child Protection Policies and Procedures for NSW* state that, 'an urgent sexual assault forensic medical examination may be required' when the 'child or young person was sexually assaulted within the previous 5 days'. [603]

More recently, Health has been developing 'Sexual Assault Client/Victim Service Pathway' that maps the referral and service response for children, young people or adults who have been sexually assaulted.[604] According to Health, these pathways will be embedded in the new SAS Standards when they are published. The draft SAS Standards suggest that, because timeframes for the collection of forensic evidence may change regularly, each SAS needs to have a system for ensuring that forensic examiners are kept abreast of the latest guidelines. The draft SAS Standards also endorse the Police Guidelines for use by medical practitioners[605] and indicate that if the alleged sexual assault occurred within the last five days, a referral for a forensic medical assessment should be made.[606]

Although the SAS Standards have not yet been released, the *JRU Communication and Referral Processes* and the *Local Planning & Response (LPR) Procedures* have improved the clarity of decision-making. However, some issues, such as the timeframe for forensic examinations and transportation responsibilities, would benefit from clearer guidance. In our view, the best location for this guidance is the *JRU Process Guidelines*[607] – given this document should essentially be a one-stop-shop for guidance and advice at the assessment stage – with a link to more detailed advice contained in the *JRU Communication and Referral Processes* document.

12.5. Policy and procedures to guide decision-making relating to the JIRT program

Our 2012 report was critical of the large number of Health policies which applied to counselling, forensic procedures and medical examinations, transportation of children and young people and other aspects of service provision relevant to the operation of the JIRT. In particular, we observed that many of the policies were out-of-date and inconsistent.[608]

Published in 2013, ECAV's *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response: A Resource Paper Outlining the Key Issues, Evidence and Practice Considerations for Senior Health Clinicians* provides valuable advice for new JIRT health clinicians. The practice

600 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.134 (Recommendation 35).
601 NSW Family and Community Services, NSW Ministry of Health, NSW Police Force, *JIRT Foundation Skills Course: Participants Manual*, December 2014, p.95.
602 NSW Police Force, Version 13 (February 2017).
603 NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW*, 2013, p.81.
604 Advice provided by NSW Health, September 2016.
605 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.91.
606 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.43.
607 The *JRU Process Guidelines* (at pp.6,13) currently include the need for a forensic examination as one of a number of reasons why the JRU response timeframe might be changed.
608 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.6.

framework addresses how a JIRT intervention differs from interventions delivered in more traditional health/therapeutic settings. It also provides detailed guidance about the health clinician role, and a range of practice approaches.

Policy guidance on JIRT for the broad health workforce is currently housed within the *Child Wellbeing and Child Protection Policy and Procedures for NSW Health*.[609] NSW Health Chief Executives are responsible and accountable for ensuring that this policy is understood and implemented by all Health workers. The policy and the *NSW Health Sexual Assault Services Policy and Procedures Manual (Adult)*[610] are the primary sources of guidance for SAS and JIRT health clinicians in relation to children and young people. However, many elements of these policies are out-of-date, and no new guidelines have filled the gap left by the *Child Sexual Assault Procedures Manual* (1997), which has not been in use for some time.

At the time of our 2012 report, Health advised that the key policies and procedures guiding its staff in responding to child sexual assault were being reviewed, with a view to developing a new Adult and Child Sexual Assault Policy and Procedures Manual.[611] We highlighted that it was critical for this review to be both comprehensive and expeditious.[612] While progress has not been swift, the SAS Standards are expected to provide detailed guidance for SAS, including specific guidance in relation to children and young people and working with JIRT. *Child Protection Counselling Services – Standards and Guidelines* are also being developed by Health's PARVAN team, and are close to finalisation.[613]

The Ministry of Health recognises the need for a consolidated set of JIRT Health policies and procedures to guide consistent practice in meeting Health's responsibilities under the JIRT program.[614] The Ministry is currently collaborating with LHDs and Specialty Health Networks to develop these consolidated policies. According to Health, they will 'set out the roles and responsibilities' of JIRT health clinicians and guide the 'health system response to the risks to the child or young person's health, safety and wellbeing in the immediate and longer term, and how it is governed'.[615] The Ministry of Health has also advised that it will consult with the Agency for Clinical Innovation[616] in the development of a 'model of care' to guide the health system in caring for JIRT clients.[617]

The new consolidated policies and procedures are a central feature of Health's strengthened JIRT governance arrangements:

> *The legal and policy obligations of NSW Health in relation to JIRT will be clearly identified in the proposed NSW Health JIRT policies and procedures which are due to be finalised following the JIRT review. These obligations will be described not only in terms of expert and timely health service delivery, but also in relation to information sharing and coordination of services around the child or young person. LHDs/SCHN Chief Executives will be required to ensure those obligations are understood across their health services and there is compliance with the policy.*[618]

A number of responses to our JIRT workforce survey emphasised the need for the consolidated policies and procedures to be made available without further delay:

> *The Health response would be improved by clear policies and procedures/standards and guidelines that would provide a framework for the health role and that are able to be communicated to the other agencies* – Senior Health Clinician.

> *JIRT Health Practice Standards and Guidelines, JIRT MoU, JIRT Policies and Procedures: There are too many different Memos, Guidelines, out-dated Policies and Procedures and MoU. This needs to be consolidated and updated as a priority* – Senior Health Clinician.

609 NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW*, 2013.
610 NSW Kids and Families, *NSW Health Sexual Assault Services Policy and Procedures Manual (Adult)*, July 2005.
611 According to the Ministry of Health, the new manual will also be consistent with the 2006 *Interagency Guidelines for responding to Adult Victims of Sexual Assault* which are also currently under review.
612 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (at 11.4.3, p.128).
613 Advice provided by NSW Health, February 2017.
614 Health advises that these consolidated policies and procedures will be completed following this inquiry.
615 Advice provided by NSW Health, December 2016.
616 The Agency for Clinical Innovation is a board-governed statutory health corporation which works with clinicians, consumers and managers to design and promote better healthcare for NSW, http://www.health.nsw.gov.au/about/nswhealth/pages/structure.aspx.
617 Advice provided by NSW Health, December 2016.
618 Advice provided by NSW Health, February 2017.

While Health has made good progress in producing and revising policies and procedures relevant to the work of the JIRT program, a number of gaps persist and many policies are still in draft form. Health has advised that the target date for completing its proposed consolidated JIRT Health procedures is July 2018. It is essential that Health finalise these policies and procedures as a matter of priority, and that specific guidance is developed in relation to the provision of forensic services to children.

12.6. Accountability and governance for the JIRT program

The successful implementation of the JIRT program requires robust structures to ensure both 'intra-Health' and 'interagency' accountability. Unlike FACS and the NSW Police Force, which have clear lineal reporting structures for the JIRT program, Health's devolved JIRT governance structure (made up of the Chief Executives of its 15 LHDs and the Sydney Children's Hospitals Network, and a Health Ministry responsible for strategic and policy direction) presents unique challenges for Health in ensuring it meets it responsibilities under the JIRT program.

While the LHDs/SCHN have primary responsibility for frontline service delivery, Health has a performance framework between the Ministry and Districts/Networks that can be leveraged by the PARVAN unit to manage performance issues.

In this section, we examine how accountability for the JIRT program across NSW Health could be embedded more firmly in the operational structures of the LHDs and SCHN. We also discuss the data currently available within Health to enable performance monitoring of its obligations under the JIRT program. In doing so, we consider Health's proposals to strengthen its data collection, primarily through the development of a new SAS database, and the need for key health outcome data to feed into the shared agency database for the JIRT program.

12.6.1. Health's current systems for collecting and analysing data

Reliable data about key health outcomes for children and young people accepted into the JIRT program is critical to measuring results, continual performance improvement for Health, and the JIRT partnership more generally. Health, along with its partner agencies, needs to settle the key health outcomes for the JIRT program, and ensure it has adequate systems in place to collect reliable outcome data and related processes for its ongoing analysis.

To date, health clinicians have manually collected a range of data relating to the JIRT program from across the various LHD databases. We understand this manual exercise can be both time-consuming and present challenges in terms of consistency. The PARVAN Unit currently analyses all JIRT performance data and where data gaps or inconsistencies are identified, proactively liaises with LHDs to seek to remedy these. In future, Health will collect relevant JIRT data via its new SAS database, which is expected to significantly improve data reliability and the efficiency of data collection and analysis processes.

Because the SAS network provides most of the counselling services for JIRT clients and coordinates the provision of forensic services, certain SAS outcome measures are integral to assessing the performance of the JIRT program.

Our 2012 report found that, due to the significant shortcomings in its existing data collection processes, the SAS had a very limited capacity to monitor basic indicators. For example, the SAS could not measure the number of children and their non-offending parents/carers referred to counselling services and the uptake rate.[619] We also found that data was not collected about the number of children requiring forensic examinations, and how many of these children were actually examined. We recommended the minimum data which, in our view, needed to be collected and analysed for Health to assess its performance, and to inform related service planning.

Although the data collection processes implemented by Health since 2012 in relation to forensic examinations and counselling have not fully resolved our concerns, the available data has improved considerably. Earlier in this chapter, we noted that Health is now able to collect a range of data

619 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.2-3.

relevant to its performance under the JIRT program, including data about:

- the number of JIRT referrals received by JIRT health clinicians in each LHD
- referrals (by the JRU Health team and/or by JIRT health clinicians) to the SAS and other services
- the number of sexual assault medical forensic examinations required
- direct and indirect supports provided to clients by JIRT health clinicians, and
- other data about health service provision.[620]

Significantly, all Health data can now be disaggregated by Aboriginal status and by LHD (although data is not currently reported for individual JIRT sites within LHDs). Other critical demographic data, such as age and disability, is not currently available, but the new SAS database will capture age and 'special care requirements' of referred clients. We have recommended that all JIRT agencies consistently collect demographic data in the shared JIRT database which is informed by data held on the primary agency databases.

Despite the JIRT CEO Report Card (and associated annual meeting of JIRT agency CEOs) being abandoned by the JIRT agencies several years ago, it is positive that Health has continued to provide some performance data about its role in the JIRT program to its Secretary in an annual 'Health CEO JIRT Report Card'.

We examined several of Health's Report Cards for this inquiry and found that, while they provide some useful summary and descriptive information, there is little analysis or explanation of trends or other findings. Instead, they mainly focus on process, compliance and activity reporting.

Health has advised us that it agrees more in-depth analysis of JIRT Health data trends is needed, and that the Ministry intends to undertake this in consultation with LHDs. Health also advised that data analysis will inform the new JIRT Health policy and procedures and ongoing performance monitoring of the JIRT health response.[621]

12.6.2. Health's plans to build a stronger data platform

At the time of our 2012 report, the Ministry of Health advised us that it was working with the SAS to 'refine and develop' key performance indicators (KPIs) for its new SAS database, which is the main component of Health's strategy to improve its data collection. A major strength of this new database will be its accessibility to both JIRT health clinicians and SAS staff. The database will also capture the source of referrals to the SAS, enabling data capture against the cohort of SAS clients referred via the JIRT program.

Health commenced piloting the SAS database in June 2016; however, state-wide implementation was delayed because of several system enhancements and changes which flowed from initial feedback. State-wide training on the implementation of the database was expected to commence by the end of the 2016-2017 financial year.[622]

The development of the new SAS database addresses many of our 2012 recommendations.[623] For example, the database will now capture details about clients with particular 'special care' requirements, including a range of disability types and other indicators of vulnerability (Aboriginality is already being captured).[624] As well, it will capture data about the time taken to conduct or commence planning for a forensic examination, and the time from referral to first physical presentation at the SAS. The database will also enable reporting of aggregated data about service provision for children under 14 years of age.

These are positive enhancements. However, there are a number of refinements that we believe Health could make to its data collection and reporting to more comprehensively cover key service areas related to the JIRT program, and improve its capacity for reporting on a 'per client' and 'per LHD' basis. These refinements include:

- **Data about the uptake of referrals to all VAN health services:** Health has made a commitment that, when available, referral uptake data will be incorporated into Health's JIRT performance data.[625]

620 Advice provided by NSW Health, December 2016.
621 Advice provided by NSW Health, March 2017.
622 Advice provided by NSW Health, December 2016.
623 Advice provided by NSW Health, December 2016.
624 Including: self harm tendencies; chronic illness; psychiatric condition; client displays harmful sexual behaviour (child under ten).
625 Advice provided by NSW Health, January 2017.

This information is crucial to monitoring and understanding service demand and capacity, and outcomes for JIRT clients. Health has advised us that the new SAS database will allow referrals rejected by SAS, and the reason, to be captured. However, data about the uptake of referrals to other services will not be captured by the SAS database as these services (such as hospital social work departments, CPUs, emergency, outpatient and inpatient paediatric services and CPCS) sit outside the SAS. This information is crucial to understanding outcomes for all JIRT clients.

- **Data about the reasons why referrals to VAN health services do not result in service provision:** As noted above, Health has advised us that there will be capacity within the SAS database to identify the reason for a referral to a SAS service not resulting in a SAS intervention; however, this information needs to be captured for all service types.
- **Data to measure both the number of forensic examinations initially sought through the JIRT program and the number actually conducted:** Current data only relates to forensic examinations which a forensic examiner has determined are required and does not account for any 'drop-off' related to reasons to such as delays in contacting a forensic examiner. Health has advised that the SAS database will be able to capture if an examination was not conducted/completed.
- **Data about forensic examinations conducted in relation to physical abuse and neglect:** This data is not currently captured by Health, but in our view should be.
- **Data about the reasons why a forensic examination may not have been conducted:** Health has committed to providing this data for sexual assault forensic examinations and has advised that the SAS database will capture the reason why an examination was not conducted/completed, including 'medical practitioner not available'. However, Health must ensure that the data categories are meaningful and specific. Health has advised us that it will monitor the data on 'Reason for delay in providing an acute medical/forensic (if>2hrs)' and consider if further data categories are required.

Finally, together with Police and FACS, Health should settle which health outcomes for children and young people referred to the JIRT program should be included in the overall JIRT performance monitoring framework and recorded in the shared JIRT database. Health has made clear that it has embraced the opportunity that an enhanced shared JIRTS database could provide for monitoring and assessing a child's 'therapeutic journey' through the JIRT program, noting that:

> *With the state-wide rollout of JIRTS completed late last year, and the development of FACS' ChildStory system and the Government's Data Analytics Centre, there should be increased opportunities to measure victims' progress through and beyond the initial JIRT process.*[626]

Health has also recognised the need to enhance its performance monitoring measures to enable a better understanding of the outcomes achieved for clients referred to Health via the JIRT program.[627] Health has advised us that it will develop a new set of measurable performance criteria focussing on outcomes for clients.

At a minimum, we have suggested that Health should collect data related to the following key outcomes:

- direct JRU Health referrals to all health services for accepted and rejected JIRT matters and referral uptake
- referrals made by the JRU to JIRT health clinicians in each LHD
- individual direct and indirect client activity performed by JIRT health clinicians
- counselling referrals by JIRT health clinicians to key specialist health services (and hospital social work departments) for all abuse and service types, and referral uptake for each abuse and service type, and
- decisions within the JIRT program (by the JRU Health team and JIRT health clinicians) to seek a forensic examination, and the number of forensic examinations actually conducted for all abuse types.

This data also needs to be linked to individual JIRT clients and should be reported by each LHD (broken down by JIRT site).

Health has advised us that it will be consulting internally and with partner agencies about future JIRT Health data requirements, but that it is likely to collect data on broader outcomes than those

626 Advice provided by NSW Health, December 2016.
627 Advice provided by NSW Health, December 2016.

identified above; for example, data about the outcome of forensic examinations both in terms of their findings and what interventions (for example, substantiation of abuse, criminal charges) they supported.

Health has indicated that in settling future data collection and reporting needs, it will take into account both the 'program logic' we discuss in Chapter 25 and the domains of health performance (which relate to equity, effectiveness and efficiency) set out in the National Health Reform Performance and Accountability Framework.

Until a new JIRT performance and monitoring framework (with associated data collection processes) is developed and implemented, we recommend that Health continues to utilise its existing mechanisms to report on relevant data and trends.

12.7. Health's governance structures

In advice provided to inform our inquiry, Health described the governance structures in place to drive JIRT performance in the following terms:[628]

> *The Ministry of Health provides strategic management of the JIRT Health response, issuing NSW Health policy directives, service standards and role delineation guidelines, monitoring service activity and performance, and representing Health on the key interagency JIRT governance groups.*
>
> *Operational management is provided by the LHDs (including SCHN) with JIRT health clinicians, the specialist violence abuse and neglect services, and other health services reporting through their local management structures up to their respective Chief Executives.*
>
> *The Ministry of Health receives information on operational issues which need to be escalated to the JIRT SMG. This usually takes the form of feedback via the JIRT managers, although some LHDs require this escalation to occur via the Chief Executive. There is also a direct link between JRU operational management and strategic management through the inclusion of Health's Director, Child Wellbeing (SCHN) on the JIRT SMG. Strategic policy and operational issues are also discussed at the quarterly state-wide network meetings of JIRT health clinicians and managers, Sexual Assault Services, Child Protection Counselling Services and district/specialty network representatives for domestic and family violence health responses, which the Ministry of Health attends for part of the time.*
>
> *The interagency Local Management Group meetings also provide a direct link between JIRT operations and the JIRT SMG.*

Health has acknowledged that the split between operational and performance responsibility for the JIRT program means that:

> *the Ministry of Health, as systems manager has a role in setting performance expectations and the LHDs/SCHN have flexibility in how they will allocate resources and deliver services locally in order to meet those expectations and satisfy local population need. The Service Agreements between the Secretary and the LHDs/ Specialist Health Networks underpin a system of purchasing health services to achieve particular outputs and outcomes, and NSW Health has a performance management system*[629] *for determining whether performance expectations are being met by the LHDs.*[630]

Unlike the Director, PARVAN, the Commander of the CAS and the two Directors of FACS JIRT, have direct operational responsibility for JIRT staff in the field and can generally act immediately within their scope of authority to address practice concerns, or escalate issues quickly through to their respective executive tiers. The impact of the devolved JIRT governance structures on frontline workers was a common concern raised by Health staff who responded to the JIRT workforce survey:

> *JIRT Police and FACS have a centralised governance structure while Health is de-centralised. This is challenging, particularly in relation to how matters should be escalated or addressed at higher levels as the organisational structures of each agency don't neatly align* – Senior Health Clinician.

628 Advice provided by NSW Health, March 2017.
629 Set out in *A Healthcare System to meet our needs Health Reform Improving Patient Care: Performance Framework,* http://www.health.nsw.gov.au/Performance/Documents/performance-framework.pdf.
630 Advice provided by NSW Health, February 2017.

The governance structure of health (compared to Police and FACS) constantly impacts the day to day relationships, dynamics and practicalities of the JIRT partnership, as both other agencies have very operationally direct lines of communication with their staff, which Health does not. Basic things like getting a desk and an operating phone in a JIRT office for a health worker is incredibly problematic and time consuming, and creates an environment where health staff can easily start to see themselves as 'less than' or devalued, which impacts work – Health Manager.

JIRT partners, Police and FACS, have state-wide departments enabling decisions/processes to be secured quickly and efficiently. This is not the same in Health as it is made up of Local Health Districts that have various layers of governance structure that encumbers timely responses – Health Manager.

At the outset of this inquiry, Health acknowledged that its devolved JIRT governance structure presents challenges in relation to implementing the JIRT program, and it has proposed a number of initiatives which it intends to implement following our inquiry, to strengthen its governance arrangements. These initiatives include:[631]

- Reinforcing NSW Health's role and responsibilities under the JIRT program across the health system (taking into account the findings and recommendations from this inquiry).
- Formalising communication channels between LHD/SCHN senior management and the Ministry of Health with respect to the JIRT program, to enable internal or interagency issues to be quickly escalated and resolved via the JIRT SMG.
- Promoting integrated care pathways for JIRT clients from the initial crisis response and through their long-term recovery from trauma.[632]
- Seeking to include the LHD/SCHN Chief Executives as signatories to the updated JIRT MoU, which the agencies have committed to preparing following this inquiry.
- Outlining NSW Health's legal and policy obligations in relation to the JIRT program in relevant Health policies and procedures (which are due to be finalised following this inquiry), including obligations regarding the provision of expert and timely health services, as well as information sharing and the coordination of services for children and young people.
- Refining the existing JIRT CEO Report Card measures into a new set of measurable performance criteria which focus on outcomes for clients.
- Compiling quarterly aggregated LHD and state-wide reports for LHDs to feedback to SAS.[633]
- Linking the annual Health CEO JIRT Report Card with enhanced performance monitoring of health services delivered via the JIRT program.

Health has also commented that our inquiry 'has been an opportunity for the Ministry of Health to have more regular communication with JIRT Health management about issues affecting Health's performance in JIRT, authorised by Chief Executives who have nominated JIRT review contact officers for their districts/networks'.

Both the Ministry of Health and LHDs have indicated they are 'keen to keep these lines of communication open beyond the JIRT review'.[634] It is positive that Health has proposed to formalise these enhanced communication arrangements to ensure they are maintained. Health has also advised us that JIRT and SAS program managers have been informed that the reporting requirements for JIRT will be reviewed with a view to developing a new performance management framework for the JIRT Health response in the near future.

631 Advice provided by NSW Health, March 2017.
632 Approaches will be considered to promote the integration of care for JIRT clients across different health services. For example, a number of LHDs, including Southern NSW, Murrumbidgee, Illawarra Shoalhaven and Western Sydney LHDs, have integrated violence abuse and neglect services in their management structures. The Southern NSW LHD has worked with NSW Health's Agency for Clinical Innovation on a clinical redesign project to improve and broaden access to after-hours crisis responses to sexual assault, child abuse and neglect, and domestic and family violence presentations. The Southern NSW LHD project also seeks to ensure an integrated patient journey beyond the initial crisis presentation with the aim of reducing the long-term impacts of untreated trauma.
633 Advice provided by NSW Health, December 2016.
634 Advice provided by NSW Health, December 2016.

Health's efforts during this inquiry to examine how it can strengthen its JIRT governance arrangements are commendable. However, to further enhance the proposed arrangements, and in light of the significance of the JIRT program in NSW, there would appear to be sufficient justification for specifically mentioning the SAS and JIRT programs in the service agreements between the Secretary and LHDs/SCHNs.[635]

Finally, while the current annual reporting by LHD chief executives to the Ministry of Health is positive, more frequent reporting would enable a prompt response to indications that performance may not be on track in certain locations – and help identify good practices to be shared. In our view, the preparation and timing of the Report Card should be linked with the bi-annual meetings we have recommended take place at the Deputy Secretary/Commissioner level for the JIRT program. (We discuss JIRT program governance further in the final chapter.)

Recommendations

28. NSW Health should:

- **a) Ensure that the core elements of its JIRT workforce development strategy continue to be delivered in a way that is consistent with Health's broader workforce development and governance priorities.**
- **b) Consider further enhancing the support provided to its JIRT workforce, having regard to the staff welfare and wellbeing model developed by the NSW Police Force.**

29. NSW Health should take steps to ensure that the fields in the shared JIRT database for recording referrals by the JRU Health team and JIRT health clinicians are made mandatory, and require the reason for no referral to be recorded.

30. NSW Health should closely track, for each LHD/SCHN, the rate of referral of JIRT clients (broken down by Aboriginality) to other services, and take action to address low referral rates in identified LHDs.

31. NSW Health should ensure that the new Sexual Assault Service database collects robust data about:

- **a) The age of JIRT clients, ensuring that children under 14 years of age are captured as a discrete cohort, to allow monitoring of counselling service uptake and provision of forensic examinations.**
- **b) The number of children and young people referred to counselling where the alleged abuse had not been substantiated by a FACS (care and protection) and/or Police (criminal) investigation.**
- **c) The number of forensic examinations assessed as 'required' by a qualified forensic examiner and the number of required examinations actually conducted.**
- **d) Delays impacting on the viability of forensic evidence and/or waiting times for forensic examinations of children and young people referred via the JIRT program, including delays which occur prior to notifying a forensic examiner, and the reasons for delays.**
- **e) Indicators of service capacity, such as counselling position numbers, vacancy rates and waiting lists for relevant counselling services.**

32. NSW Health should review the capacity of the Sexual Assault Service to provide counselling services to JIRT clients.

635 Health's advice indicates that its implementation of both the SAS and JIRT programs is 'aligned with the strategic priorities of the Government and service expectations are included in current NSW Health policy directives and role delineation guidelines relating to these programs'. (Advice provided by NSW Health, February 2017).

33. **In relation to physical abuse and neglect referrals to the JIRT program, NSW Health should:**
    a) **Assess the adequacy of existing counselling referral pathways available to JIRT clients, to determine whether an expansion or realignment of services may be required to meet demand.**
    b) **Ensure a process is developed with FACS and the NSW Police Force to record the use of 's.173 notices' in connection with physical abuse referrals made to the JRU.**
    c) **Review the use of its SCAN Protocol.**
34. **NSW Health should consider including specific performance indicators for the JIRT program in the Service Agreements between the Secretary and the LHDs/ Specialist Health Networks.**
35. **NSW Health should, having regard to the observations in section 12.6.2 of this report:**
    a) **Determine which health outcomes for children and young people referred to the JIRT program will be included in the overall JIRT performance monitoring framework and recorded in the shared JIRT database.**
    b) **Finalise the health outcomes for children and young people referred to the JIRT program that it intends to capture for internal Health reporting purposes, and adjust its reporting process accordingly.**

PRACTICE SUGGESTIONS

- In relation to reports rejected for a JIRT response, NSW Health should collect and analyse data about the outcome of direct JRU referrals to specialist health services and the reasons for non referral.
- NSW Health should monitor the proportion of JIRT clients in each Local Health District/ Sydney Children's Hospitals Network (LHD/SCHN) who receive direct client activities from JIRT health clinicians, to understand the reasons for variation among LHDs/SCHN and to determine whether they are suitably resourced to provide such activities to all clients who would benefit from receiving them.
- NSW Health should ensure that data collected about counselling referrals for JIRT clients is consistent with the Sexual Assault Service minimum data set across all service and abuse types (including physical abuse and neglect) and across all Health entities (for example, hospital social work departments).
- NSW Health, in consultation with Police and FACS, should settle guidance about the relative timing of the recorded criminal interview and medical forensic examination (when required) which clarifies how these urgent activities should generally be prioritised.
- NSW Health should review the circumstances of all medical forensic examinations in the 2015-2016 period that were delayed by more than 72 hours, to determine the cause of the delay and to address any systemic problems in collaboration with the other JIRT partner agencies.
- NSW Health should consider requiring Local Health Districts to monitor and report to the Health Ministry, about the child protection expertise of paediatric consultant appointments within each LHD/SCHN.
- NSW Health should update the guidance contained within the *JRU Process Guidelines* about determining the maximum period from an alleged sexual assault which may still allow for the collection of viable forensic evidence, and include a link to the more detailed advice available in Health's *JRU Communication and Referral Processes*.
- NSW Health should consider implementing recommendation 35(a) of the Ombudsman's 2012 report, *Responding to Child Sexual Assault in Aboriginal Communities*, to ensure equal access for all JIRT clients to transport to a forensic examination.
- NSW Health should consider reviewing the impact of its proposed new governance arrangements for the Health JIRT response, having regard to feedback from JIRT Health staff and partner agencies, after the arrangements have been in place for a suitable period.

Part 5

Responding more effectively to vulnerable cohorts of children and young people

Aboriginal children and young people | Children and young people with disability | Children and young people from culturally and linguistically diverse communities | Children and young people in out-of-home care | Children and young people with harmful sexual behaviours

Contents

Chapter 13. Aboriginal children and young people

Given that Aboriginal[636] children and young people are disproportionately represented as victims of sexual abuse and in the child protection and criminal justice system more broadly,[637] it has been important for our inquiry to assess how well the JIRT program is responding to their needs. In doing so, we have had regard to a range of sources.

In addition to the JIRT workforce survey, requesting advice from the JIRT partner agencies and reviewing key JIRT documents and data, we have consulted with the Chairperson and key staff of AbSec (the peak body providing child protection and out-of-home care policy advice in NSW); ECAV's[638] Aboriginal Communities Matter Advisory Group (ACMAG);[639] and Aboriginal health workers employed by ECAV. We also travelled to Bourke, which has a significant Aboriginal population and a high rate of child sexual abuse, to meet with JIRT staff servicing the area. Finally, our inquiry has been informed by our many years of work oversighting service delivery in Aboriginal communities, including our audits of the *NSW Interagency Plan to Tackle Child Sexual Abuse in Aboriginal Communities* (Interagency Plan) and the NSW Police Force *Aboriginal Strategic Direction*, and our ongoing responsibility to monitor the implementation of OCHRE – the NSW Government's plan for Aboriginal affairs.

A range of factors associated with the 'intergenerational transmission of trauma'[640] and socio-economic disadvantage make Aboriginal children and young people, as a cohort, more vulnerable than their non-Aboriginal peers to being abused. While limited disclosure and under-reporting to police obscures prevalence data, the Australian Institute of Health and Welfare found that, in 2012, there were (depending on the jurisdiction) two to four times more sexual assaults on Aboriginal children aged 0-9 than on non-Aboriginal children of the same age and two to three times more assaults on Aboriginal children aged 10-14.[641] Our own analysis in 2012 of police data relating to 12 communities in NSW found that, while Aboriginal children made up just 12% of all children living in these communities, they comprised 23% of reported victims of sexual abuse under the age of 15.[642]

The barriers to Aboriginal children and young people disclosing and receiving an appropriate response to child sexual abuse are well known. They include:

- Fear of violence, intimidation or ostracism by other community members if a disclosure or report is made.
- Mistrust of authorities and 'the system', due to past experiences of forced removal of children and other historical injustices.
- A sense of betrayal of the kinship group.
- Fear of bringing shame on the extended family and the community.
- Normalisation of violence in some communities, making it unlikely that child sexual abuse would be reported.
- Concern to protect the perpetrator, arising from the high rate of Aboriginal deaths in custody.
- Geographic isolation and lack of infrastructure or support services, lack of information about child sexual abuse and how to respond to it, and having no one to whom to report the abuse.[643]

636 Use of the term Aboriginal in this chapter, including in relation to data, is inclusive of Aboriginal, Torres Strait Islander and Aboriginal and Torres Strait Islander children and young people.
637 See Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, July 2016. According to FACS data, the rate of Aboriginal children and young people at ROSH in NSW is 174 per 1,000 compared to 36.2 per 1,000 for non-Aboriginal children and young people (FACS Statistics, Objective 1: Dashboard 3).
638 Education Centre Against Violence, a unit of NSW Health.
639 The ACMAG's membership includes ECAV's Aboriginal senior educators and Aboriginal counsellors employed by New Street (NSW Health's main service for children and young people who engage in harmful sexual behaviour). It is chaired by the Director of ECAV.
640 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.151.
641 Data cited by Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, July 2016, p.32.
642 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012, p.84.
643 See Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, July 2016, pp.32-34.

Over the past decade, in recognition of the particular vulnerability of Aboriginal children and young people, JIRT has had a considerable focus on improving the way it engages with Aboriginal communities and responds to reports about Aboriginal children. We noted the positive impact of this focus in our 2012 report on responding to Aboriginal child sexual abuse, and recommended that it continue.

Given the focus, it is unsurprising that more than 80% of respondents to the JIRT workforce survey rated JIRT's response to Aboriginal children as being either satisfactory, above satisfactory or good. However, it is worth noting that Health staff were generally less likely to respond favourably, with more than two-thirds of respondents to the survey providing suggestions about how the JIRT program could further improve its response to the needs of Aboriginal children and young people. In particular, the Health feedback reflects a strong desire to see greater numbers of Aboriginal Health workers employed to encourage and support children and their family members to speak up about abuse.

Consistent with this feedback, our review has confirmed that the JIRT program has achieved considerable success in engaging with Aboriginal communities and improving access to JIRT for Aboriginal children. However, these must be ongoing processes that are continuously reviewed – particularly against a background where the number of reports referred to the JRU is increasing each year, and there has been a recent decline in the proportion of reports about Aboriginal children and young people accepted by the JIRT program.

For more than a decade, our systemic work with Aboriginal communities – which has involved consulting thousands of Aboriginal people as well as many hundreds of agencies and organisations responsible for providing services to them – has enabled us to identify, at a very practical level, what is needed to improve service delivery to vulnerable Aboriginal children and their families.

In this regard, we have identified some additional opportunities to strengthen JIRT's response to the needs of this cohort. As outlined in Chapter 9, we believe it is also timely to make some changes to the way that Aboriginal sexual abuse reports are handled in the JIRT referral process. It is important to also recognise that our broader recommendations aimed at strengthening JIRT will benefit Aboriginal children and young people given that they are the subject of roughly one in five reports referred to the JIRT program.

13.1. JIRT program initiatives to improve service delivery to Aboriginal children

Aboriginal children and families' experiences of the JIRT was a key theme of the JIRT review in 2006, which resulted in recommendations aimed at achieving more proactive engagement with Aboriginal communities; increased employment of Aboriginal staff in areas with many Aboriginal communities; provision for culturally appropriate support people for interviews; and increased cultural competence training for staff. The review also commented on the importance of pre-interview rapport building, observing that Aboriginal children (and children from diverse cultural backgrounds) may be more responsive to interviewers where they can develop a degree of trust in the interviewer beforehand. These recommendations were subsequently reflected in the Interagency Plan, which identified 'improved communication and operational protocols for JIRTs' as one of five immediate state-wide actions.

In 2008, the Wood Inquiry found that 'Aboriginal communities remain over represented in the child protection system and culturally appropriate interventions for Aboriginal children, young people and their families are not widespread in any of the agencies that are expected to work with them'.[644]

Among a range of broader observations and recommendations, Justice Wood emphasised that the JIRT program should be made more accessible to Aboriginal communities and more effective in responding to reports involving Aboriginal children and young people. Justice Wood also recommended that the NSW Ombudsman be tasked with auditing the Interagency Plan; this recommendation was accepted and we reported the findings and recommendations arising from our three year audit in December 2012.

644 Hon James Wood AO QC, *Report of Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, Volume 1, p.iv.

13.1.1. JIRT Aboriginal Consultation Protocol and Community Engagement Guidelines

Justice Wood acknowledged as a positive initiative the development of the *JIRT Aboriginal Consultation Protocol,* which was introduced in 2009 in response to a recommendation of the 2006 JIRT review and consistent with a key action contained within the Interagency Plan. Underpinning the protocol is a requirement for JIRT agency staff to consult with Aboriginal staff from within their own agencies to obtain advice that may assist with case allocation, planning and decision-making.

The introduction of the protocol was supplemented by the state-wide implementation of the *JIRT Aboriginal Community Engagement Guidelines* in April 2010. The guidelines require each JIRT unit to develop a practical plan for engaging with the Aboriginal communities in their local area. Following the initial implementation of the guidelines, there was an increase in requests from Aboriginal communities for more information about how JIRT operates, and how to respond to disclosures of child sexual abuse in a community setting. As a result, a pilot community workshop was developed and delivered by the JIRT State-wide Training Sub Committee in August 2011 to the Taree/Purfleet communities, with ECAV playing a critical role in ensuring an Aboriginal facilitator was part of the tri-agency training team. We discuss this workshop and the value of ECAV's community engagement role more broadly in section 13.6.2.

13.1.2. Establishment of the Bourke JIRT

As outlined in our 2012 report, the temporary establishment of the Bourke JIRT in July 2009 was a significant initiative aimed at providing a better JIRT response to vulnerable children and young people in one of the most disadvantaged parts of the state – Far West NSW – which has a significant Aboriginal population. Our report highlighted the Bourke JIRT's efforts in engaging a broad range of community groups and service providers, including those in small remote communities, with a particularly strong focus on educating health workers and schools about child sexual abuse and the JIRT's role. The Bourke JIRT was subsequently permanently established in response to our recommendation that this should occur.

13.1.3. Enhanced Aboriginal Services Protocol

In May 2010, the *Enhanced JIRT services to Aboriginal children and young people protocol* (EASP) introduced more flexible assessment processes for sexual abuse reports involving Aboriginal children. It recognised that while Aboriginal children are significantly over-represented as victims of sexual abuse, a range of barriers to disclosure in Aboriginal communities may make it difficult for these reports to meet the JIRT referral criteria.

The way in which the EASP affects decision-making at the JIRT Referral Unit (JRU) is discussed in detail in section 9.4. Central to the protocol's operation is the requirement that, if the JRU receives a sexual abuse report about an Aboriginal child or young person that does not meet the JIRT referral criteria, staff must seek additional local information about the child and their community to assist in deciding whether the report should nonetheless be accepted into the JIRT program.

In our 2012 report, we noted that the introduction of the EASP led to a significant increase in the proportion of Aboriginal sexual abuse reports accepted by the JIRT program. While the acceptance rate has since declined (both overall and for Aboriginal children and young people), sexual abuse reports involving Aboriginal children and young people are still proportionately more likely to be accepted by the JIRT program compared to sexual abuse reports overall.

13.2. Reports to the JRU involving Aboriginal children and young people

In this section we discuss the available data relating to referrals to the JRU for Aboriginal children and young people, the proportion that are accepted for a JIRT response, and some of the factors relevant to the acceptance rate. It is important to acknowledge that when the JRU receives a child abuse report from the Helpline, the child or young person's Aboriginality may be unknown or unclear – particularly if the child has not previously been reported to the Helpline or received services from FACS. It is important that, where a child is suspected by the JRU to be Aboriginal but confirmation of this is not clear in the referral, the JRU takes proactive steps (for example, seeking information from Personal Health Records or school enrolment records) to obtain clarity. There would be benefit in amending the *JRU Process Guidelines* to emphasise this responsibility.

We understand that Aboriginality data entered into JIRTS by the JRU is not necessarily 'remediated' if a child or young person's Aboriginal status is later confirmed/clarified.[645] It is therefore likely that there are more, rather than less, reports about Aboriginal children and young people than is reflected in the official JIRTS data. Analysis of data about reports to the JRU which involve Aboriginal children is subject to this caveat.

13.2.1. Referral and acceptance rate

In 2015-2016, 17% of reports referred to the JRU involved children or young people known to be Aboriginal. Since 2010-2011, this figure has remained relatively stable, with only slight fluctuations of 1-2%.

The data indicates that there has been a significant decline in the proportion of reports about Aboriginal children and young people that are accepted for a JIRT response – down from 76% in 2010-2011 to 56% in 2015-2016.

The decrease in the acceptance rate for reports involving Aboriginal children is consistent with the decline in the acceptance rate for reports overall (down from 69% in 2010-2011 to 50% in 2015-2016). This decline has occurred against a background where the number of reports referred to the JRU over the same period has increased by 44%.

We understand that the JIRT partner agencies have not examined the decline in the acceptance rate (either generally or in relation to Aboriginal children and young people). However, as discussed in Chapter 9, we understand that the decline in accepted referrals for Aboriginal children and young people may be due to changes to how the JIRT program is now handling adolescent peer sex referrals.

Table 10: Referrals to JRU by Aboriginality of alleged victim[646]

	2010-11		2011-12		2012-13		2013-14		2014-15		2015-16	
	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known
Accepted	4,261	740	4,070	759	4,536	908	4,928	909	4,463	869	4,500	852
Rejected	1,948	240	2,166	326	2,317	343	3,037	432	3,918	600	4,471	662
Total	**6,209**	**980**	**6,236**	**1,085**	**6,853**	**1,251**	**7,965**	**1,341**	**8,381**	**1,469**	**8,971**	**1,514**

645 As discussed in section 25.3, we believe that the JIRT agencies should improve their data collection and reporting both overall and in relation to particularly vulnerable cohorts such as Aboriginal children and young people.

646 Data provided by FACS (sourced from JRU access database and JIRTS), 13 January 2017.

Table 11: Sexual abuse referrals to JRU by Aboriginality of alleged victim[647]

	2010-11		2011-12		2012-13		2013-14		2014-15		2015-16	
	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known	All Referrals	Aboriginal known
Accepted	4,007	692	3,846	726	4,258	849	4,539	841	4,062	800	4,135	785
Rejected	1,609	189	1,806	247	1,959	289	2,469	343	2,902	430	3,256	408
Total	**5,616**	**881**	**5,652**	**973**	**6,217**	**1,138**	**7,008**	**1,184**	**6,964**	**1,230**	**7,391**	**1,193**

13.2.2. Sexual abuse referrals

Because the vast majority of reports referred to the JRU involve sexual abuse, we asked FACS to provide us with a breakdown of this data by Aboriginality so that we could identify any significant trends.

In 2010-2011, 90% of reports about Aboriginal children and young people involved sexual abuse. This had decreased to 79% by 2015-2016. There has also been a decrease in the annual proportion of overall reports involving sexual abuse – down from 90% in 2010-2011 to 82% in 2015-2016.[648]

There has not been any significant change since 2010-2011 in the proportion of sexual abuse reports that involve Aboriginal children and young people. The annual figure has consistently ranged between 16-18%. However, in 2015-2016 the proportion was at its lowest (16%) since 2010-2011 (when the proportion was also 16%).

13.2.3. JRU assessment and decision-making

With the exception of sexual abuse reports (which are governed by the EASP), reports about Aboriginal children and young people are assessed by the JRU in the same way as any other report.

In Chapter 9 we outlined the impact of the EASP on particular categories of reports (matters involving Aboriginal young people aged 16-18 years and matters where there has been prior investigation by a Local Area Command), and recommended that the EASP and other relevant policies and procedures be reviewed to allow the JRU more discretion in its assessment of these reports.

In 2015, the JIRT agencies commissioned the Internal Audit Bureau (IAB) to conduct an audit of the implementation of the EASP. The IAB found that:

- JRU staff demonstrate a highly appreciative awareness of the need for enhanced access to the program
- the JRU consistently considers the child or young person's community context in the assessment of Aboriginal child sexual assault reports, and
- JRU referrals of reports involving Aboriginal children to JIRT and other services generally meet demanding timeframes.[649]

The main challenge identified by the audit was the requirement to gather additional information to inform the JRU's decision about whether JIRT should accept a report. In this regard, the audit recommended that the EASP should more clearly explain what is meant by the statement that the JRU 'reviews all available information and weights the allegation(s) and knows vulnerabilities for the alleged victim within the family and community above the source or chain of complaint'. It also identified that the EASP should be amended to further clarify procedures for sourcing, utilising and documenting information about the child or young person's community.

647 Data provided by FACS (sourced from JRU access database and JIRTS), 13 January 2017.
648 Analysis of data supplied by FACS, 13 January 2017.
649 Internal Audit Bureau, *Audit of January 2012 Memorandum: Maintaining Enhanced Access to the JIRT Program for Aboriginal Children and Young People*, June 2015, p.3.

We support this recommendation. Our related recommendation that the JIRT partner agencies should develop a set of 'factors to consider' to guide the JRU's professional judgement should assist in this regard.

Other recommendations made by the independent audit included:

- Providing annual training about the EASP to all relevant JRU and JIRT staff and line managers.
- Integrating the EASP into other relevant JRU and JIRT process and procedure documents.[650]
- Undertaking an internal audit of electronic data to identify areas of consistent and inconsistent record keeping and how the data collection process in relation to Aboriginal sexual abuse reports and the application of the EASP can be improved.[651]
- Developing a monitoring and evaluation framework to set out the measures that will be used to track and assess performance against the intended aims of the EASP.[652]

Although the SMG noted the findings and recommendations of the independent audit in September 2015, the JIRT partner agencies' position on the recommendations remains unclear and the EASP has not been amended since the audit. We recommend that the partner agencies finalise their position and amend the EASP accordingly as a priority, having regard to the additional observations and recommendations arising from our inquiry.

13.3. Reports about Aboriginal children and young people accepted by JIRT

Compared to data about the number of reports involving Aboriginal children referred to the JRU and the rate at which these reports are accepted, there is limited available information about the outcome of reports involving Aboriginal children that are accepted into the JIRT program and how this compares to the outcome of accepted reports for all children. The independent audit of the EASP also recognised this, concluding that while the EASP is an effective tool for enhancing access to JIRT, there is a need to assess the referral pathways, experiences and outcomes of Aboriginal children once reports are accepted.

13.3.1. Aboriginal consultation

As noted earlier, the *JIRT Aboriginal Consultation Protocol* identifies consultation by JIRT with an Aboriginal staff consultant (for example, child protection case workers, health workers and police Aboriginal Community Liaison Officers) from within the three partner agencies as a key strategy for better informing casework planning and decisions in relation to accepted reports involving Aboriginal children and young people. The protocol provides specific guidance about the type of matters that Aboriginal staff consultants (ASCs) from each agency may be requested to provide advice on. These include knowledge of kinship, community, culture and heritage that may be relevant to a JIRT investigation; and information about culturally appropriate supports that may assist children and their families through the JIRT process.

The protocol states that JIRT managers will determine the most appropriate ASC to be utilised. Further, when selecting an ASC, the following issues must be considered to avoid conflict of interest:

- kinship relationship to the child or young person, and/or alleged perpetrator
- relationship with the community in which the child or young person belongs, and
- personal experiences of the ASC that relate to the matter being investigated.[653]

650 EASP has since been incorporated into the JRU Process Guidelines.
651 In light of data reliability issues identified, any such audit should be future focused.
652 This recommendation is consistent with our 2012 recommendation that the JIRT agencies ensure there are adequate systems in place for assessing the ongoing impact of the EASP.
653 NSW Department of Community Services, NSW Police Force, NSW Health, *JIRT Aboriginal Consultation Protocol,* 2010.

The protocol also states that 'each agency is responsible for documenting its own record to identify that consultation with an ASC has occurred during the JIRT process. This includes recording the Consultation Plan and record of the consultation'. An Aboriginal consultation plan template is included in the protocol for this purpose.

The *Local Planning and Response Procedures* do not contain any reference to the consultation template or any guidance about Aboriginal consultation more broadly. The 'LPR fact sheet' included in the JIRT Foundation Skills Course (which has now been replaced by the JIRT Foundation Skills Program) states that the need for Aboriginal consultation should be discussed in the LPR briefing meeting, the minutes of LPR meetings are to be recorded using the appropriate template form, and each agency should include a copy of the minutes on the relevant case file.

The program also includes a useful example of a completed Aboriginal consultation plan for a fictitious child, which clearly shows the investigative value of the information obtained from the consultation. Also contained in the training program are examples of completed briefing and debriefing meeting templates, and an interview plan, detailing the information obtained from the Aboriginal consultation and how it will be used. It would be useful for this more detailed guidance to be incorporated into the *Aboriginal Consultation Protocol* itself. However, it is important to note that a protocol without individual agencies also having a good relationship with their local Aboriginal communities and knowledge of key community networks will be of limited use. (As the JIRTS database now incorporates LPR screens 'online', there would be benefit in embedding the templates into these screens.)

The protocol states that JIRT staff and managers are responsible for ensuring that it is complied with. However, it appears that there is no systematic monitoring of compliance with the protocol by the JIRT partner agencies, either individually or collectively. The LPR screens within the JIRTS database include 'JIRT Aboriginal Consultation Plan required' as a task within the 'Safety, Welfare and Wellbeing Summary'; however, we understand that no LPR report exists to measure quantitative completion of this task (or any other task required as part of the LPR). And, while each agency is expected to keep records of Aboriginal consultation, there appears to be no facility within JIRTS to upload LPR records.

In recording data about consultation, it is also important to recognise that there will be times when consultation is not always possible when there are risks associated with child safety (including gathering evidence for the criminal investigation) that must urgently be attended to, where this is the case, the decision not to conduct a consultation should be documented.

For the reasons outlined above, we were not able to measure the extent to which JIRT is routinely or appropriately consulting with Aboriginal staff in relation to the handling of reports involving Aboriginal children. However, the adequacy of Aboriginal consultation was a strong theme emerging from the JIRT workforce survey, particularly among FACS respondents. Overall, one third of all respondents highlighted cultural consultation when asked how JIRT could strengthen its response to Aboriginal children and young people. Inconsistent use of consultation was mentioned by more than 40% of these respondents:

> *JIRT have made several attempts to have cultural consultations with identified caseworkers and people within the community however there is limited people available to attend such meetings* – FACS Caseworker.
>
> *Currently, Aboriginal consultations rarely occur* – FACS Manager Casework.
>
> *The JIRT Consultation policy is not used or even known by some Police staff within the unit, this needs to be better incorporated into the LPR process* – FACS Manager Casework.
>
> *[There needs to be] more consistent use of Aboriginal cultural consultants and … clearer policies with monitoring of compliance* – Health Manager.

Concern about superficial or 'tokenistic' consultation was raised by some respondents, with several emphasising that cultural consultation is only useful when it is meaningful; that is, when the consultant has specific knowledge about the community and/or family – these views were also echoed by AbSec. Survey feedback on this issue included:

> *The presenting issues for Aboriginal children and young people can vary dramatically depending [on] their community and locality … only local knowledge … can be utilised in guiding any response and long term planning* – FACS Manager Casework.

> *Consultations need to involve people who are knowledgeable of the child's Aboriginal nation/family etc. [They are] useless [if the consultants] … don't know their area, community or supports* – FACS Caseworker.

In contrast, a few respondents highlighted difficulties associated with using local cultural consultants:

> *Aboriginal consults cause big issues in small communities because usually people are related and that information is fed back to the offender before police investigate* – CAS Investigator.

> *Effective Aboriginal consultation within FACS is not … always appropriate given potential local conflicts of interest and privacy for families* – FACS Manager Casework.

A small number of FACS respondents indicated that current consultation processes are incompatible with often urgent timeframes required by the JIRT process.

About one-third of FACS staff who commented raised the need for Police and/or Health, but particularly the former, to be more involved in Aboriginal consultation. This issue appears to be linked to concern on the part of FACS and Health about the adequacy of compliance with the LPR, including an alleged failure to conduct briefing meetings and Police not having sufficient regard to relevant information provided by their partner agencies to inform the recorded criminal interview. For their part, several CAS respondents to the workforce survey commented on the need for more, and closer, liaison with Aboriginal Community Liaison Officers attached to Local Area Commands (LACs), suggesting an awareness of the value of Aboriginal consultation.

It is our view that local JIRT managers, both individually and within Local Management Groups (LMGs), are best placed to monitor, in a way that extends beyond quantitative measurement, whether appropriate Aboriginal consultation is occurring within their JIRT unit. The JIRTS database or any new shared database needs to be configured in such a way as to promote this data being accurately and efficiently recorded. Embedding the Aboriginal consultation process into the LPR is essential to ensure that, as with any other child or young person, good quality planning around an interview and identifying the most appropriate supports, or any specific vulnerabilities takes place, and in a way that does not have the potential to prejudice the criminal investigation. This should take place as part of monitoring implementation of the LPR more broadly, which we have discussed in more detail in Chapter 21.

13.3.2. Interviews of Aboriginal children and young people

The JIRT Training Course (part of the JIRT Foundation Skills Program) includes a 90 minute session about interviewing children and young people from Aboriginal communities. The training is aimed at equipping participants to:

- identify issues relevant to interviewing Aboriginal children
- understand the Aboriginal consultation process and identify and utilise resources to 'facilitate effective service delivery in a cross cultural context'
- apply a flexible interview approach when interviewing Aboriginal children and young people
- develop a rapport and assessment of the child
- explain the routines and ground rules of the interview, and
- develop techniques for eliciting a free narrative and specific detail of an offence from Aboriginal children and young people.

The training emphasises that, although the same investigative interview framework is used when interviewing Aboriginal children, 'in preparing for the interview and during an interview, different factors must be taken into consideration in terms of the engagement process, language and communication barriers, and the child and family's history and past experiences that may impact on a JIRT interview and intervention'.[654]

We were unable to obtain data from JIRTS or from the agencies about the number of interviews conducted with Aboriginal children and young people. While the CAS holds information about interview numbers separately on its INTRAK database, it does not break this information down by Aboriginality of child victim interviewed. Within the LPR screens, the JIRTS database has the capacity to record information, including Aboriginality, about the interview with the child subject of the JIRT report. However, there is no JIRTS report for extracting relevant metadata about interviews. In addition, there does not appear to be any capacity to record information about child protection interviews separately carried out by FACS (although as discussed in Chapter 11, FACS has now started recording this manually in its JIRT Register). There would appear to be merit in capturing Aboriginality against child interviews (either via the Police INTRAK system or the shared JIRTS database)[655] for recorded criminal interviews conducted by CAS, and using ChildStory to capture additional care and protection interviews conducted by FACS.

About a quarter of respondents to the JIRT workforce survey – including almost one third of FACS participants – identified a need for 'the JIRT process' to be more flexible in order to better meet the needs of Aboriginal children and young people. Insufficient flexibility was also raised by Health staff. Respondents suggested that more time needs to be taken to build rapport with Aboriginal children and young people and/or engage with the child and their non-offending family members prior to undertaking an interview:

> *My experience is that a meet and greet first is beneficial to building rapport for interview to take place on second appointment* – FACS Caseworker.
>
> *I believe that children and young people who are Aboriginal are not given enough time to build rapport and break down their barriers of speaking with authorities and hence the cases often don't proceed criminally* – FACS Manager Casework.
>
> *Providing the opportunity for a rapport building session prior to having to come into the CAS to do an interview [is beneficial]* – Health Clinician.

Senior officers from the CAS have indicated that, while rapport building with Aboriginal children in particular can be valuable before an interview, this must be weighed against the urgency of the matter. And while multiple interviews are generally not desirable, with Aboriginal children this may, at times, be necessary. In this regard, the CAS commented that there can also be value in Health conducting counselling with an alleged child victim after an interview has occurred where no disclosure was made to help support them in feeling ready to undergo another interview.

FACs and Health respondents also identified a need for Police to have stronger regard to relevant information from other sources to inform their interviews of Aboriginal children and young people, and greater flexibility in relation to where interviews are held. Some respondents suggested that, because of historical relations between police and Aboriginal people, and because families of children reported to JIRT have often had interactions with police, requiring Aboriginal children to attend a CAS office for an interview could act as a barrier to their participation in the investigative process. In response to this concern, the CAS noted that CAS offices are not located in police stations and half of them are co-located, integrated spaces shared with FACS and Health, so the associations with any past negative experiences of police are less likely to be an issue in the context of attending a JIRT suite or CAS office. However, the CAS also indicated that they are open to conducting interviews in locations other than JIRT/CAS offices, such as the offices of Aboriginal OOHC agencies, where appropriate,[656] and noted that they regularly conduct interviews at schools and other suitable settings where the child victim is likely to feel more comfortable.

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654 NSW Department of Family Services, NSW Police Force, NSW Health, *JIRT Foundational Skills Course Participants Manual*, p.174.
655 The JIRTS database will be transitioned across to FACS' new database – ChildStory – late this year.
656 For example, the child is OOHC but the alleged abuse occurred prior to them entering care, or where the abuse has no connection to the care placement.

Other respondents commented that because recorded criminal interviews of children are now led by the CAS, it can be culturally inappropriate in circumstances where only a male officer is available to interview Aboriginal girls and young women. The CAS have indicated that they source a female officer whenever a need has been identified and noted that two thirds of its workforce is female. In addition, the CAS advised that in their experience, many female children and young people are comfortable with male interviewers; what matters most in the view of the CAS is developing a rapport and showing sensitivity.

Our wider consultations also identified concern that Aboriginal boys and young men may be unwilling to disclose abuse in a police-led interview due to having a negative perception/previous experience of police. Some respondents indicated that the use of support people during interviews with Aboriginal children is particularly beneficial to ensure cultural safety, but is not always encouraged. The CAS have indicated that while the use of appropriate support persons is not discouraged as a general approach for any child victim, it can be difficult early on in the investigative process to be clear about who potential witnesses and offenders may in fact be, which means the use of certain individuals as support people can be risky, and this needs to be taken into account. While we agree with the challenges around identifying suitable support people early on in an investigation, when a child or young person requests a particular support person, and there is no valid reason to reject the request, police should facilitate it.

Further issues related to JIRT interviews are discussed in Chapter 22.

Witness intermediaries

In Chapter 18, we discuss the witness intermediary pilot scheme currently operating in two sites (covering four JIRT units). The scheme is aimed at enabling children and young people who have been sexually abused to give their best evidence by utilising appropriately qualified and trained intermediaries to conduct an assessment of the child and make recommendations to police and the court about strategies for maximising effective communication with them.

Our consultations identified strong support for designated Aboriginal witness intermediaries. We agree that there is value in this proposal. It is well established that culturally responsive service provision includes giving Aboriginal people the choice to access Aboriginal (as well as mainstream) services and that there are unique cultural factors that may impact on some Aboriginal people's communication in institutional settings.

While some strategies for recruiting Aboriginal intermediaries have already been explored in the pilot locations (including amending the legislation to enable people with teaching qualifications to be appointed as intermediaries),[657] we believe that there is scope to further consider this issue as part of the evaluation of the scheme. In this respect, it will be important to explore the type of appropriate qualification pathways that could be put in place for Aboriginal applicants. In light of ECAV's successful Aboriginal Qualification Pathway in building a workforce of Aboriginal Specialist workers in the Violence, Abuse and Neglect sector, it would be worthwhile exploring the development of a suitable qualification and training course for Aboriginal intermediaries.

13.4. Recording and monitoring outcomes for Aboriginal children and young people

As noted earlier in the chapter, there is limited available information about outcomes facilitated by JIRT for Aboriginal children and young people, and how they compare to the outcomes facilitated by their non-Aboriginal peers. The reason for this is that, with the exception of Health, the JIRT partner agencies do not collect JIRT program outcome data in a way that can be systematically disaggregated by Aboriginality.[658]

657 The scheme previously included people with tertiary qualifications in psychology, social work, speech pathology or occupational therapy.
658 The introduction by FACS of manual data collection processes through its JIRT Register (discussed in Chapter 11) should, in time, enable it to report on certain outcome data disaggregated by Aboriginality.

13.4.1. NSW Police Force

As we discussed in Chapter 10, there are challenges associated with obtaining more refined data about the number of matters handled through the JIRT program that result in criminal charges and/or convictions. We have recommended that the CAS should start collecting charge and conviction data in the shared JIRT database (rather than just in COPS) against individual children the subject of accepted JIRT referrals (rather than incidents), and data about individuals arrested in connection with the children reported, to provide more meaningful information about criminal justice outcomes for children and young people who enter the JIRT program. We also recommend that this data should be broken down against the various cohorts of particularly vulnerable children discussed throughout this Part of the report.

13.4.2. Health

As discussed in Chapter 12, Health collects data about referrals to specialist health services and other direct and indirect activities performed by JIRT health clinicians to support children and young people in the course of responding to referrals to the JIRT program.[659] JIRT health clinicians are required to collect data in such a way that it can be disaggregated by Aboriginality.

Referrals to health services from the JRU

While noting that JIRTS fields for Health referral actions are not-mandatory, JIRTS data indicates that for the 9,059 referrals received by the JRU in 2016, the JRU Health team made a direct referral to a health service in 11% of matters (993). Of the direct referrals to a health service, 7% (66) were for Aboriginal children or young people. This indicates that the JRU Health team were less likely to make a referral to a health service for Aboriginal children when compared to all children reported to the JRU (Aboriginal children accounted for 17% of reports referred to the JRU in 2016, and 7% of referrals to specialist services). However, as the JRU generally only makes direct referrals to a health service if a matter is rejected for a JIRT response, it is likely that this discrepancy is due to the higher acceptance rate for Aboriginal children.

Activities undertaken by JIRT health clinicians

The available data for the period 2012-2013 to 2015-2016 indicates that:

- The proportion of Aboriginal clients referred to a Violence and Neglect (VAN) health service by a JIRT health clinician has fallen in recent years – from 46% in 2012-2013, to 37% in 2015-2016. The overall proportion of referrals for all children has also fallen over this period – from 54% in 2012-2013, to 38% in 2015-2016.
- There was variance in this change across different local health districts (LHDs) – in Southern NSW LHD the proportion of Aboriginal children referred to an SHS fell from 100% to 45%, whereas in Western NSW LHD it increased from 5% to 32%. The Far West LHD SAS had a substantial increase in the proportion of Aboriginal clients referred: from 13% of total clients in 2014-2015 to 50% in 2015-2016.
- Most Aboriginal clients who received a referral to a VAN health service were referred to a Sexual Assault Service (90%). Six per cent were referred to a Child Protection Unit and 3% were referred to a Child Protection Counselling Service.
- On average, fewer than 5% of Aboriginal clients each year were identified as requiring an acute sexual assault forensic examination. This is consistent with the proportion of all children requiring a forensic examination.

We discussed the decline in referrals for all children to health services in Chapter 12. As we noted in that chapter, it will be important, once the new Sexual Assault Service database is operational, for Health to track the proportion of matters that are referred, including a focus on referrals for Aboriginal children.

659 Data is collected through the JIRTS database and a manual data collection process completed by health clinicians.

In addition to referring clients to a VAN health service, the data relating to direct and indirect support provided to Aboriginal children and young people by JIRT health clinicians indicates that in 2015-2016:

- 21% of Aboriginal clients received crisis counselling (compared to 20% of all clients), and
- 24% of Aboriginal clients received rapport building and support (compared to 22% of all clients).

It is positive that Health collects data about outcomes facilitated by Health JIRT for Aboriginal children and young people. As well, it is positive to note that all of the available measures indicate that Aboriginal children and young people are receiving comparable support to their non-Aboriginal peers. However, the state-wide JIRT data summaries that Health produces on an annual basis do not currently contain any systematic reporting of outcomes facilitated by JIRT Health for Aboriginal children and young people. In this regard, there would be merit in the Ministry of Health considering how it can improve its processes for analysing and reporting on this data in order to better monitor trends and performance with respect to Aboriginal children and young people.

13.4.3. FACS

At an organisational level, FACS captures Aboriginality in its KiDS database and publically reports a range of measures that are disaggregated by Aboriginality. For example, statistics for 2014-2015 indicate that:

- the rate of Aboriginal children in 'risk of significant harm' (ROSH) reports was 174 per 1,000 (compared to 36.2 per 1,000 for non-Aboriginal children)
- there were 4,691 Aboriginal children and young people in ROSH reports where secondary assessment determined actual harm or risk of harm – an increase of 2.2% since 2011-2012, and
- 5,610 (32.8%) Aboriginal families received an intensive family support service – an increase of 4.4% since 2011-2012.

FACS' policy commitment to protecting vulnerable Aboriginal children and their families is embedded in its overarching *Aboriginal Cultural Inclusion Framework 2015-2018* (ACIF). The headline indicators that FACS is using to measure the success of the ACIF include decreasing the over representation of Aboriginal children and young people who are at risk of significant harm and decreasing the over-representation of Aboriginal children and young people in OOHC.[660]

More recently, in partnership with AbSec, FACS has developed a 'co-design plan for Aboriginal children and young people 2015–2021', which aims to achieve a number of outcomes, including: 'Aboriginal children in the child protection and out-of-home care systems are connected to family, community, culture and country, and are safely supported in environments that are suited to their best interests' and 'Tailored, child and family-centred, holistic supports that are delivered as needed, not just at crisis, as a package of supports across the continuum, rather than through a programmatic design creating inflexible practice'. These outcomes are directly relevant to FACS JIRT's business.

While the KiDS database does capture Aboriginality, FACS advised us that disaggregating relevant data to enable reporting of productivity or outcomes within its JIRT units is 'enormously resource intensive', and that the data could not be produced for this inquiry.[661] And, while data that is collected on the JIRT Register can be disaggregated by Aboriginality, there is not yet sufficient data to enable any analysis in relation to Aboriginal children and young people.[662]

660 The ACIF requires FACS Districts to establish local engagement arrangements with their Aboriginal communities to inform priorities and strategic actions, and to develop Aboriginal Cultural Inclusion Plans. At a central level, the framework commits FACS to implement Aboriginal Impact Statements to ensure the effect of any changes to policies, programs and services on Aboriginal people is properly considered.

661 Advice provided by FACS, 21 March 2017.

662 The 'JIRT Register' is discussed in Chapter 11. It was rolled out to all FACS JIRT units at the start of this financial year. While we have included some indicative data in Chapter 11 for the first half of 2016-2017, it is not yet possible to conduct any valid analysis for subsets of this data, for example that relating to Aboriginal children.

FACS has acknowledged that it would be appropriate for its JIRT units to be able to report by Aboriginality, to align with the broader FACS child protection data. As we discussed in Chapter 11, the transition to the new ChildStory database, which will incorporate both KiDS and the shared JIRTS database, provides an important opportunity for FACS JIRT to significantly improve its ability to collect and monitor a range of data, including measures relating to its response to Aboriginal children and young people. In the interim, the JIRT Register provides an opportunity for FACS to start tracking its performance in working with Aboriginal people and other vulnerable cohorts.

13.5. The value of a Child and Family Advocate role

Our recommendation to establish a Child and Family Advocate role within the JIRT program is expected to significantly enhance JIRT's capacity to facilitate positive outcomes for Aboriginal children, young people and their families. The role, which is outlined in Chapter 6, was strongly supported by the Aboriginal advisors we consulted for this inquiry. The advocate's core role would be to work with children and their families to enhance their understanding of the JIRT process, act as a conduit (where appropriate) for passing on information (approved by the relevant agency) about the status of their respective responses, and ensure they are linked with and receive appropriate supports and follow up.

As we noted earlier, Child and Family Advocates will need to be used judiciously and we would envisage them playing a minor role in many cases where there are no ongoing support needs, other than health needs, or where children and young people and their families do not want ongoing advocacy support.

We know from our many years of work with Aboriginal communities that one of the most powerful 'community engagement' strategies for maximising Aboriginal people's access to services is ensuring that individual matters are well handled. When one family has a positive experience, this produces a significant positive flow on effect, with other families being more willing to engage with the service. The Child and Family Advocate could play a significant role in helping to ensure a well coordinated JIRT response that is tailored to the needs of Aboriginal children and their families.

We also believe that there would be merit in designating a certain number of the child and family advocate positions as 'Aboriginal'. However, in doing so, it will be critical that a common set of core requirements for the advocate role are identified (for both Aboriginal identified and mainstream roles) to ensure that all advocates have the requisite technical skills. If, following a trial of the child and family advocate role it is expanded across the state, it will be important that cultural competency is a core capability for the role and for managers supervising these positions, particularly as it would not be feasible to have Aboriginal designated roles in each location. If a select number of roles are designated as Aboriginal, careful consideration will need to be given to identifying additional capabilities for these designated roles to expand the pool from which suitably qualified Aboriginal applicants can be drawn.

13.6. Engagement with Aboriginal communities

As noted earlier, the *Aboriginal Community Engagement Guidelines* were implemented state-wide in April 2010 in response to an action contained within the Interagency Plan. The guidelines envisaged that each JIRT would develop a practical plan for engaging with the Aboriginal communities in its local area.

In our 2012 report about responding to sexual abuse in Aboriginal communities, we noted advice we had received from the JIRT SMG that a review by Community Services of the effectiveness of the guidelines was underway, and had so far identified that the guidelines had led to a greater level of engagement with Aboriginal communities by JIRT staff – including participation in Aboriginal community events and stronger links with Aboriginal service providers. We were told that the JIRT

agencies had also been approached by several Aboriginal women's groups, service providers and other community leaders during the previous year for information about how to handle disclosures and support victims without compromising investigations. We recommended that targeted community education work, particularly with Aboriginal women's groups, should remain a focus for the JIRT agencies.

While the JIRT partner agencies continue to acknowledge the importance of effective engagement with Aboriginal communities, the extent to which this has been driven and monitored by the SMG appears to have been limited since the review by FACS of the *Aboriginal Community Engagement Guidelines* in 2012. We were told that the SMG requested that JIRT units 'prioritise' engagement with Aboriginal communities in 2015,[663] but apart from the delivery of the JIRT Aboriginal community engagement workshop, it is difficult to identify specific initiatives or outcomes resulting from this request in the majority of locations.

It was not practical within the inquiry timeframe to assess the extent to which each JIRT is consistently and effectively engaging with its local Aboriginal communities as envisaged by the *Aboriginal Community Engagement Guidelines*. However, it was apparent from our consultations with key Aboriginal advisors, and with frontline JIRT staff, that much good work continues to take place 'on the ground' – albeit with scope for further improvement. Of respondents to the workforce survey who made suggestions about how JIRT could strengthen its response to Aboriginal children and young people, CAS staff were more likely to raise the need for more or better engagement with local Aboriginal communities, drawing a strong connection with levels of reporting and successful investigations. This feedback reflects what we know from our extensive work in auditing police engagement with Aboriginal communities.

Overall, around 20% of respondents from across the three partner agencies commented on the need for more, or for more meaningful Aboriginal community engagement by JIRT. However, many noted that the JIRT program is limited in the resources it has to achieve this.

It is important to acknowledge that, of necessity, the JIRT program is mainly a reactive entity and will always be limited in its capacity to undertake intensive community engagement. It is certainly important for JIRT agency staff to have a solid understanding of the communities they service, and to interact appropriately and respectfully when they come into contact with community members. It is particularly important for those staff to have knowledge of, and good relationships with, other local service providers in their communities – such as schools, OOHC providers, health services, CSCs and Local Area Commands – which are likely to have close and continuous contact with Aboriginal children and young people (and their families). These service providers can provide them with important information about children and young people who are referred to the JIRT program, as well as access to Aboriginal staff who may be well placed to provide cultural advice of the type envisaged by the *JIRT Aboriginal Consultation Protocol*.

The JIRT Facilitating the Disclosure (Aboriginal community engagement) workshop delivered under the auspice of the JIRT State-wide Training Subcommittee by ECAV, Police and FACS (discussed in the next section) provides a valuable opportunity for local JIRT units to interact with community members and other local service providers. However, current funding limits the number of these workshops that can be delivered each year. There is scope for the JIRT program to utilise existing consultation mechanisms in Aboriginal communities to carry out targeted community education activities to build awareness about child abuse, the systems in place for reporting abuse, and how it will be responded to. For example, during our inquiry, an Aboriginal community member told us that her local Police Aboriginal Consultative Committee (PACC) had invited representatives from the JIRT agencies to attend a meeting for an open discussion. This was reported to have been highly successful. Another positive event was the delivery of the Weaving the Net program in 2017 to the community members in Northern Rivers region which also included participation by JIRT agency staff.

663 Advice provided by NSW Health, December 2016.

The Bourke JIRT

The Bourke JIRT was established with temporary funding in July 2009 to complement the Safe Families program which had been operating in five Western NSW sites at the time. The four year program was the single largest investment made under the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*.[664]

In our 2012 audit report, we highlighted that the Bourke JIRT should be commended for its efforts to engage a broad range of community groups and service providers, including those in smaller remote communities. The feedback that we received about the team during our community visits was very positive, and we detected a high level of awareness about the existence of the Bourke JIRT. The team appeared to have fulfilled its brief to raise community awareness of the issue of child sexual abuse, as well as the role of the JIRT program.

Police and other agency representatives were strongly of the view that the Bourke JIRT should be maintained, and that its future should not be tied to the Safe Families program. We argued that the existence of the Bourke JIRT in the Orana Far West region was an important symbol of a commitment by government to providing support for child sexual assault victims in remote parts of the state. The NSW Government accepted our recommendation that the Bourke JIRT be permanently funded.

As part of this inquiry, we visited Bourke to meet with the current JIRT team. While it was apparent that resourcing means the team is limited in the amount of targeted community engagement work it is able to undertake, it was clear that it remains an important focus. For example, at the time of our visit, the team had recently met with the local school in Brewarrina, with plans to link in with staff training sessions at all schools in Bourke JIRT's catchment area – which includes Broken Hill and Wilcannia – in 2017. Staff identified their immersion in local communities as a benefit, enabling familiarity and trust to be developed. Feedback received from community bodies in Bourke about the JIRT continues to be overwhelmingly positive.

The appointment of a Director and Coordinator position at the Maranguka multiagency service hub in Bourke provides excellent conduits to the community that can be utilised by the JIRT agencies and help them to build a strong partnership with that service, which also houses the Western NSW Family Referral Service.[665]

Perhaps most critically, however, the JIRT program needs to ensure that it provides timely and sensitively conveyed information to non-offending family members and, where appropriate, other service providers. This information should explain the process, progress and outcome of individual investigations resulting from reports involving Aboriginal children and young people. The Aboriginal advisors we consulted told us that this communication is critical to ensuring that Aboriginal communities do not lose faith 'in the process' and to the willingness of families to continue to engage with not only the criminal investigation, but also critical therapeutic services provided by Health. As one Aboriginal health worker we consulted during the inquiry put it:

> *There needs to more transparency so that the non-offending family member and child understand why the process takes so long, what the procedures are and why they are important. If the parent doesn't know the process they lose trust in it – they don't see it as helping their child and may withdraw.*

664 Safe Families was a $22.9 million program – the single biggest investment made under the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities – aimed at reducing child sexual assault in targeted Aboriginal communities in Western NSW. The four year program, which commenced in 2009, failed to achieve its intended outcomes for a range of reasons, which we detailed in our 2011 report, *Addressing Aboriginal Disadvantage: the need to do things differently.*

665 Family Referral Services aim to connect vulnerable children, young people and their families with appropriate local services.

13.6.1. The importance of community engagement by partner agencies at the local level

> *Community engagement is an ongoing process that actively involves people in decision making on issues that impact on their safety and wellbeing. The aim of engagement is to identify issues that may impact on delivery of services and jointly develop strategies to address these. Establishing and maintaining local partnerships is critical in effective engagement and contributes to community capacity building.*[666]

As we noted in our 2012 report, the JIRT program's effectiveness in responding to sexual assault, serious physical abuse and neglect of Aboriginal children is heavily reliant on community members coming forward to report allegations. In turn, this depends on communities being encouraged to report, and feeling confident about doing so.

Aboriginal people are much more likely to come forward about child abuse and domestic violence if solid relationships are formed with local service providers and they can be confident that action will be taken to secure their safety. One CAS investigator who responded to the JIRT workforce survey expressed this very simply: 'Community engagement increases reporting.'

Therefore, while the JIRT program has an important contribution to make to community engagement, it is the local service arms (CSCs, LACs and local health districts) of each JIRT agency, which are ideally positioned to build strong, consistent relationships with the local communities they service, and to work in partnership with those communities to build an efficient and responsive service sector that encourages people to feel safe in coming forward to report abuse. We discuss in the sections that follow how each of the three JIRT agencies have sought to strengthen their relationship at the local level with Aboriginal communities.

The NSW Police Force Aboriginal Strategic Direction

The *Aboriginal Strategic Direction* (ASD) governs the NSW Police Force's approach to working with Aboriginal communities to deliver meaningful outcomes for Aboriginal people. It involves a three-tiered consultative process.

The first tier requires Local Area Commands (LACs) within communities with a high Aboriginal population, to establish local Police Aboriginal Consultative Committees and, in consultation with them develop a LAC Aboriginal Action Plan that focuses on achieving 'local solutions for local issues'. The Aboriginal Issues Officer at each LAC, who is a senior officer, is responsible for ensuring that the priorities contained in the action plan are addressed. The second tier is the Aboriginal Strategic Direction Steering Committee which is responsible for driving and monitoring the implementation of the ASD across the organisation. It is chaired by the Corporate Sponsor for Aboriginal Issues, who is an Assistant Commissioner. The Police Aboriginal Strategic Advisory Committee (PASAC), chaired by the Police Commissioner, is the final tier in the governance structure. It considers issues of state-wide relevance and concern to Aboriginal communities across NSW.

Over the course of our four year program of auditing the implementation of the ASD and our ongoing involvement in the PASAC, we have identified significant improvements in the relationships between police and Aboriginal communities. The strong governance framework underpinning the ASD and ongoing leadership by the Commissioner, Corporate Spokesperson, and Commanders has been critical to facilitating and maintaining strong relationships between police and many Aboriginal communities. There is also scope for CAS Zone managers to attend local consultative committee meetings to discuss the role of the JIRT program and encourage community members to come forward about abuse.

666 NSW Health, draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.152.

The delivery of the Love Bites program by the NSW Police Force

Love Bites is a domestic/family violence and sexual assault prevention program for students aged between 12 and 17 years who have disengaged from the school system. The program and the facilitator training has been developed by the National Association for Prevention of Child Abuse and Neglect (NAPCAN), a non-government organisation whose aim is to raise public awareness of child abuse and neglect and the effect of its impacts by developing and promoting effective prevention strategies and programs. The Love Bites program opens up discussions around family violence with children in a safe and supportive environment. Love Bites helps children to decide right from wrong, and what healthy and unhealthy relationships look like.

The NSW Police Force has been delivering the Love Bites program successfully for some years via its School Liaison Police Officers and Youth Command. The program initially targeted high school students in years 10 to12 but a version has now been developed for students in years 7 to 9. 'Love Bites Junior', the recent addition to the program, covers themes such as:

Year 7 – Friends

Communicating mindfully, warning signs of abusive behaviour, power in relationships, responding to concerns as bystanders, seeking help, rights and responsibilities in relation to sharing sexualised images.

Year 8 – Respectful Relationships, Bullying and Gender

Respect in relationships, gender roles and stereotypes, jealousy, sexual harassment and homophobia, challenging harassment, discrimination and gender stereotypes, seeking help.

Year 9 – Relationships, Love and Control

Gender expectations and relationships, responding to jealous feelings, love and control, warning signs of a controlling/abusive relationship

Using funding from the ASD's crime prevention grants fund, the NSW Police Force's Aboriginal Coordination Team ran a series of facilitator training sessions for Aboriginal Community Liaison Officers (ACLOs) to enable them to deliver the program to their local Aboriginal communities. The Commander, Operational Programs, suggested that rather than restrict the train-the-trainer sessions to ACLOs, it should be extended to interested police officers – additional funding was sourced for this purpose. The train-the-trainer session was delivered to 15 participants, comprising ACLOs, Domestic Violence Liaison, School Liaison and Youth Liaison officers.

A second round of Love Bites facilitator training is planned for officers from the Child Abuse Squad, as well as other officers. The sessions are likely to take place in Kempsey, Dubbo and Guildford. Officers from the Ballina, Port Macquarie and Coffs Harbour areas also attended the training in June this year.

In addition, this year CAS officers from Bourke and Broken Hill delivered the Love Bites training to Broken Hill and Willyama High Schools.

FACS Guiding Principles for strengthening the participation of local Aboriginal communities in child protection decision-making

The Grandmothers Against Removals (GMAR) group was formed in Gunnedah in 2014 to provide an avenue for concerned community members to have a say about the implementation of child protection practices and the relationship between Aboriginal families and FACS. In 2014, our office established a working group with GMAR and FACS to inform the development of a set of Guiding Principles for improving Aboriginal participation in child protection decisions as envisaged by the Aboriginal Child Placement Principles and FACS's *Aboriginal Cultural Inclusion Framework* (ACIF).[667]

667 Under the ACIF, FACS and Aboriginal communities have developed cultural inclusion plans for all FACS districts which identify local priorities and strategic actions to break the cycle of disadvantage and improve outcomes for Aboriginal people, families and communities.

It was intended initially that these Guiding Principles would operate locally, but we recommended to GMAR and FACS that a document be developed for state-wide implementation – and they agreed. We prepared the document in close collaboration with GMAR, and it was ultimately endorsed by FACS and AbSec. The then Minister for Family and Community Services officially launched the Guiding Principles in Tamworth on 9 November 2015. Since then, governance arrangements for implementing the Guiding Principles have been settled, and FACS has worked closely with GMAR to plan and deliver initiatives to promote and implement the Guiding Principles in local communities across the state.

Since then, we have continued to support and monitor the implementation of the principles. After GMAR members raised concerns with us in March 2016 about the progress of implementation, we asked FACS for advice about establishing governance arrangements and promoting the principles. We also convened meetings with FACS, GMAR and AbSec to discuss the next steps. FACS subsequently invited GMAR to give a presentation about the principles to delegates at the Ministerial Roundtable on Aboriginal children and young people in OOHC in May 2016.

Governance arrangements for implementing the Guiding Principles have now been settled, and a dedicated implementation working group known as the Guiding Principles Yarning Circle (GPYC) has been established to serve as the 'state wide advisory group' envisaged in the principles. It comprises representatives from GMAR, FACS, AbSec, the Aboriginal Legal Service, and an Aboriginal child and family service, with our office holding observer status; and has met regularly since September 2016. FACS newly established Aboriginal Child and Family Reform Group also includes two GMAR representatives.

FACS has also worked with GMAR to plan and deliver initiatives to promote and implement the Guiding Principles in local communities across the state. For example:

- conducting joint visits to a number of communities across NSW[668] to raise awareness about the Guiding Principles and encourage the establishment of Local Advisory Groups (LAGs) amongst community members, local community service centres (CSCs) and relevant service providers
- trialling a joint 'road show' for FACS caseworkers in the Hunter New England district on the Guiding Principles and how practices need to change to give effect to them, and
- holding a two-day LAG Development Workshop with around 80 community representatives from across the state to equip them to set up LAGs by providing information about the principles, relevant templates in toolkits, and advice from GMAR, FACS and other GPYC members.

FACS have also taken steps to elevate the delegation at which decisions are made in relation to proposed removals of Aboriginal children to Director level, and are looking at additional strategies to ensure FACS complaints policy and processes are culturally responsive.

The FACS Minister and Secretary both attended the December 2016 GPYC meeting, which provided an opportunity to showcase the good work carried out by the GMAR with support from FACS to promote awareness of the Guiding Principles in communities and developing related resources. The meeting also considered proposed data indicators by which the impact of the Guiding Principles will be tracked – it is intended that these be made public once settled.

In our view, successful implementation of the Guiding Principles will require:

- local CSCs knowing who their communities are and building strong relationships with the Aboriginal leaders in those communities
- effective communications and training to raise awareness with both local communities and FACS staff about the principles, and
- strong governance and processes for translating the state-wide Guiding Principles and ACIF into practice locally – making sure individual cases are responded to effectively.

If the principles are well implemented across communities, we consider that they have the potential to make a significant difference to the cultural appropriateness and quality of care and protection decisions involving Aboriginal children in this state.

668 Including Dubbo (Western NSW district), Ballina (Northern NSW district), Macksville/Kempsey (Mid North Coast district), Wyong (Central Coast district), Mount Druitt (Western Sydney district), Nowra (Illawarra Shoalhaven district) and Moree (Hunter New-England district).

13.6.2. The role of the NSW Health Education Centre Against Violence

We profiled the excellent community development and education work undertaken by the Education Centre Against Violence (ECAV) in our 2012 report about responding to child sexual abuse in Aboriginal communities.

ECAV is a state-wide unit within NSW Health which is responsible for workforce development and training programs in the specialised areas of adult and child sexual assault, domestic and Aboriginal family violence and physical and emotional abuse and neglect of children. It provides the mandated training for NSW Health JIRT health clinicians, specialist child protection, sexual assault and Aboriginal family health workers, as well as targeted training to mental health and drug and alcohol workers. ECAV provides face-to-face and online training, learning and resource development services, clinical and policy consultation, mentoring and supervision, and community development programs. It also provides training to other government and non-government agencies, and communities.

JIRT Facilitating the Disclosure Workshop

As noted earlier, after the introduction of the JIRT *Aboriginal Community Engagement Guidelines*, ECAV as part of the JIRT Training Sub-committee helped to develop and deliver a pilot community workshop about the role of JIRT, and handling disclosures of child sexual abuse in a community setting, to the Taree/Purfleet communities in August 2011. Following the success of this workshop and a number of requests from other Aboriginal communities for similar training, the JIRT Training Sub-committee developed a flexible two-day JIRT Aboriginal community engagement workshop, 'What to do if a child discloses child sexual assault?', able to be tailored to the needs of individual communities. The workshop is designed to equip participants with knowledge about child sexual abuse as well as a broad understanding of how the JIRT model works. It is jointly delivered by ECAV, Police and FACS staff.

Since February 2013, the workshop has been delivered on nine occasions to more than 400 participants in Lismore/Ballina, Wellington, Bourke, Coolangatta, Narrandera, Grafton, Casino, Taree, and Raymond Terrace. From 2015-2016, ECAV has been provided with recurrent funding to provide a specialist trained Aboriginal facilitator to join part of the tri-agency training team to deliver four of the workshops each year.[669]

We reviewed the participant evaluations for six workshops delivered between May 2015 and September 2016. The evaluations clearly demonstrated the workshop's value, with the vast majority of participants (including a mix of Aboriginal community members and local service providers) agreeing that the training had 'definitely' increased their knowledge of the JIRT program; made them more confident about talking to other Aboriginal community members about child sexual assault and the role of the JIRT program; and equipped them to support a child who discloses sexual abuse.

Weaving the Net

Weaving the Net (WTN) is an intensive program spanning six to eight months which aims to provide community members with accurate information about child sexual abuse, child abuse and family violence. ECAV receives recurrent funding from the Centre of Aboriginal Health to deliver the program in one community per year.

Between 2013 and 2016, WTN was delivered in Taree, Bowraville, Kempsey and Wellington, with 113 Aboriginal and non-Aboriginal community members and service providers in regular attendance. Subject to support from the community to proceed, it is due to be delivered in Coraki in 2017.

Strong Aboriginal Women and Strong Aboriginal Men

Strong Aboriginal Women (SAW) and Strong Aboriginal Men (SAM), is a program consisting of three workshops (and prior consultation) aimed at raising awareness of child abuse and neglect, child and adult sexual assault, and domestic and family violence. It includes a healing component, with participants assisted to address their own histories of trauma and abuse while strengthening their capacity as parents, partners and leaders to ensure safety and healing for themselves, their families and community.

669 The workshops in Orange have recently been conducted and Dareton will be delivered next.

The SAM program, in connection with SAW and ECAV's Aboriginal Qualification Pathway (see below), was identified in 2014 as a best practice model for addressing family and sexual violence in Aboriginal communities.[670]

Between 2013 and 2016, SAW was delivered to 162 Aboriginal women in Taree, Wilcannia, Toomelah, Narranderah, Yamba, Bowraville, Murrin Bridge, Tweed Heads, Ballina, Forster, Boggabilla, Brewarrina, Evans Heads and Macquarie Fields.[671] SAM was delivered to 231 Aboriginal men in Taree, Emerton, Dubbo, Moree, Yamba, Murrin Bridge, Griffith, Inverell, Casino, Tweed Heads, Ballina, Forster, Glebe, Mt Druitt, Gunnedah, Brewarrina, Boggabilla, Macquarie Fields, Walgett, Coraki and Gilgandra.[672]

ECAV received funding from the former federal Department of Families, Housing, Community Services and Indigenous Affairs Housing to deliver SAW for the first two years, while initial funding for SAM was provided by Aboriginal Affairs and the Centre for Aboriginal Health. Although all funding has ceased, ECAV has continued to deliver the programs, absorbing costs, due to community demand. However, additional funding is needed to meet this demand on an ongoing basis, and to develop a more strategic approach to targeting communities.

In 2015-2016, the Ministry of Health provided ECAV with a one off payment of $30,000 to allow the delivery of regional forums for the SAW and SAM programs. The regional forums are aimed at enabling further mentoring of Aboriginal leaders who have participated in the programs, and increasing networking and support both within and across communities to address family and sexual violence.

In our 2012 report, we recommended that the government give consideration to designating a lead agency with responsibility for pulling together a state-wide strategy for the development and distribution of resources aimed at raising awareness about Aboriginal child sexual assault, and the delivery of relevant community development programs such as WTN, SAW and SAM. We also recommended that additional funding be provided to enable ECAV to extend the delivery of these programs.

As the programs are critical to building community capacity to identify, report and respond to child abuse – and this, in turn, is fundamental to strengthening the JIRT program's ability to effectively meet the needs of Aboriginal children and young people – we reiterate our recommendation. In our view, rather than dedicate additional resources to the JIRT program (or redirect existing resources) for Aboriginal community engagement, it makes sense to provide ECAV with the additional funding it requires in order to expand the delivery of existing (and well regarded), community engagement and development programs.

13.6.3. Making local communities safer

Building a strong sense of community safety requires all components of the service system to be in place and operating effectively at a community level, including prompt policing and child protection responses, access to counselling services and safe and secure accommodation.

In turn, this requires a coordinated effort by government to move past a 'crisis response' towards developing a combination of short and longer-term measures to properly address the immediate safety issues in communities, and to build an efficient and responsive service sector that reaches those most in need. To achieve this, agencies need to know who their communities are and build strong relationships with the Aboriginal leaders in those communities. Weak relationships with local Aboriginal communities substantially undermine the ability of agencies to discharge their responsibilities, particularly in locations with significant Aboriginal populations.

In our 2012 report we recommended that the government should provide better support to Aboriginal (and other community) leaders – particularly those in high need communities – by funding NGOs with significant community development expertise, to work for and in accordance with the instructions of, Aboriginal and other community leaders. We also recommended that lead human service and justice agencies be tasked with developing a cross-agency framework for community safety planning to guide the development and implementation of local community safety plans in high-need Aboriginal communities.

670 Carmody, Salter & Presterudstuen, *Less to Lose & More to Gain?,* 2014.
671 Prior to this, SAW was also delivered in Tabulam, Cranebrook, Maclean, Wallhollow, Condobolin, Tweed Heads, Albury, Redfern and Walgett.
672 Prior to this, SAM was delivered in Toomelah, Wallaga Lake, Walhollow, Redfern, Wilcannia, Tamworth and Menindee.

As well, we recommended:

- Developing a state-wide strategy for the development and distribution of resources aimed at raising awareness about Aboriginal child sexual assault, and the delivery of relevant community development programs delivered by ECAV (and increased funding for ECAV to support this).
- Supporting the creation of a state-wide network of Aboriginal women's groups focused on preventing Aboriginal child sexual assault, and the establishment of an annual state conference for the network.
- Identifying successful personal safety/protective behaviours training courses for delivery within schools with significant Aboriginal population.
- The development and implementation of a child safe house trial in a select number of high-need Aboriginal communities in Western NSW.[673]

Our recommendation about supporting community leadership has been reflected in the Local Decision Making (LDM) initiative as part of OCHRE, the NSW Government's plan for Aboriginal affairs. The initiative includes provision for an independent broker to work closely with community to support leadership and capability building. And, in March 2015, the government announced that, to further strengthen existing child protection measures in NSW schools, it would provide $4 million over four years to deliver a specialised program to children and young people. However, actions taken to implement the other recommendations outlined above remains unclear. More than four years on, our consultations with Aboriginal advisors have confirmed that they remain relevant to improving the response to Aboriginal child sexual assault, and supporting a key commitment of the JIRT program, to improve its response to Aboriginal children and young people.

13.7. Aboriginal workforce development

It is well established that an important strategy for improving the cultural responsiveness of mainstream agencies is building a strong Aboriginal workforce. The 2006 JIRT review recommended increased employment of more Aboriginal staff at all levels and regular rotation of Aboriginal staff into the JIRT program.

About 7% of respondents to the JIRT workforce survey, from across the three agencies, commented on the need to increase the number of appropriately trained Aboriginal staff. Our consultations also supported employing more Aboriginal staff, not only within the JIRT program, but in the broader workforce that supports it. In this regard, there was particularly strong support for increasing the number of Aboriginal health workers employed by LHDs, building their capacity to support the work of the JIRT program, and ensuring they are paid the appropriate award.

As part of our inquiry we asked each partner agency to provide us with Aboriginal workforce data.

13.7.1. NSW Police Force

The CAS advised us that the NSW Police Force does not routinely record information about the number of CAS employees who identify as Aboriginal. However, we were advised that the CAS does currently employ some investigators who identify as Aboriginal. There are no identified Aboriginal positions within CAS, and very few identified Aboriginal sworn positions across the broader organisation.

However, it is important to recognise that the NSW Police Force has made a strong commitment to increasing its overall numbers of Aboriginal police officers, and has made significant in-roads in this area. The successful iPROWD program is a unique partnership between the NSW Police Force, TAFE NSW, NSW Aboriginal Housing Office, Charles Sturt University, NSW Aboriginal Education Consultative Group and the Federal Government. It delivers a customised training program to assist Aboriginal people to gain entry to the NSW Police Academy at Goulburn.

673 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012, pp.52-64.

Originally established in the Western region, the program was rolled out across the state in 2010. It utilises strong community partnerships to assist students with accommodation and support needs, and includes a significant mentoring component, with participants supported from the time they start the program until their confirmation as a Constable. As at May 2016, 80 participants had joined Police as either sworn or unsworn officers; a further 15 were due to attest before December 2016 and another 50 were in the process of being recruited. As the number of sworn Aboriginal police officers continues to increase, the capacity for specialist squads, including the CAS, to recruit them will expand.

The NSW Police Force also employs 56 ACLOs across 32 LACs with significant Aboriginal populations. ACLOs are members of their LAC's crime management team and are responsible for providing advice and support to police in the management of Aboriginal issues across the command. To perform this role, they require strong knowledge of their local communities.

As noted earlier, some CAS respondents to the workforce survey thought there was greater scope for the JIRT program to utilise ACLOs for the purpose of obtaining information and advice about engaging with Aboriginal children and young people.

13.7.2. FACS

There are no identified Aboriginal positions within FACS JIRT. However, there are seven caseworkers who identify as Aboriginal (Dubbo, Mid North Coast, Penrith and Parramatta JIRT teams each have one Aboriginal caseworker while The Entrance JIRT has three Aboriginal caseworkers).[674]

More broadly, FACS has a strong commitment to enhancing its Aboriginal workforce. The *FACS Aboriginal Employment Strategy 2016–18* aims to attract and recruit more Aboriginal staff to FACS, build capabilities and promote Aboriginal cultural understanding. FACS is working towards achieving a target of 7.5% of staff who identify as Aboriginal by June 2018. As part of a suite of strategies to meet this goal, FACS is currently planning to establish targeted traineeship and graduate programs for Aboriginal people, building on its successful Aboriginal cadetship program which has recruited 27 individuals since 2014. FACS is also in the process of designing an Aboriginal Leadership Development Program for high potential employees.[675]

13.7.3. Health

NSW Health is committed to growing an Aboriginal workforce consistent with the priorities and key actions set out in the *Good Health – Great Jobs Aboriginal Workforce Strategic Framework 2016 – 2020*.[676]

Aboriginal people are employed across NSW Health in a range of occupations and can apply for any position in NSW Health where the role requirements are met. In addition, Aboriginal identified positions exist where Aboriginal identity, cultural knowledge or connections are a genuine aspect of the role. These targeted positions aim to improve employment opportunities and outcomes for Aboriginal people. A variety of training programs and scholarships have been specifically developed to support Aboriginal people to become a part of the NSW Health workforce.

Stepping Up[677] is NSW Health's recruitment resource. It aims to assist Aboriginal job applicants understand how to apply for roles in NSW Health, and hiring managers to more effectively structure the recruitment to roles within NSW Health. In addition, the Aboriginal Health Worker Guidelines for NSW Health[678] provide the scope of practice for NSW Health Aboriginal Health Workers and education and training pathways, including traineeships and supervision and support for these workers. This document describes how best to recruit Aboriginal Health Workers to match the health needs of their Aboriginal clients.

674 Advice provided by FACS, February 2017.
675 NSW Department of Family and Community Services, *Annual Report 2015-16*, p.43.
676 http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2016_053.
677 http://www.steppingup.health.nsw.gov.au/.
678 http://www.health.nsw.gov.au/workforce/aboriginal/Publications/aboriginal-health-worker-guidelines.pdf.

Health informed us that while there are currently no Aboriginal JIRT health clinicians, it is committed to recruiting an Aboriginal workforce within JIRT Health and is developing a strategy to support this. The Ministry of Health presented to the JIRT Managers State-wide Network on this issue in May 2017, and used this opportunity to promote the use of the above resources, particularly *Stepping Up*.

In response to our 2012 report, Health established a new Aboriginal Senior Policy Analyst position with functions including the promotion of health equity for Aboriginal people and championing Aboriginal health in government initiatives addressing sexual assault, in collaboration with ECAV.[679] Previously located in the former Office of Kids and Families, the position has since been transferred to the Prevention and Response to Violence Abuse and Neglect team within the Ministry of Health. Health has advised us that the position works in collaboration with prevention and response services, including JIRT health clinicians, to ensure that NSW Health works from a 'culturally competent and trauma-informed framework considering the individual and collective experiences of current and historical harm'.[680]

Health's Sexual Assault Services (SAS) are the single largest provider of sexual assault counselling services and receive a large number of reports referred by JIRT (or the JRU). As at December 2016, SAS had a total of 5.6 (FTE) designated Aboriginal counsellor positions. However, only 2.5 (FTE) positions were filled (one in Hunter New England LHD and 1.5 in Illawarra Shoalhaven LHD). Hunter New England LHD had an additional 1.1 unfilled designated FTE Aboriginal positions, and Western Sydney LHD had 2. We were advised that Hunter New England LHD was 'exploring recruitment options' for filling its vacant position. It is not clear why the positions in Western Sydney LHD are unfilled or what recruitment strategies have been utilised.[681]

The scarce Aboriginal workforce within SAS is a concern given the high demand for culturally safe, trauma-informed sexual assault counselling by Aboriginal workers. In this regard, it is disappointing that the situation is now worse than in 2012 when we reported that Health had recently established seven designated Aboriginal child sexual assault counselling positions, bringing the total number of FTE Aboriginal sexual assault counsellor positions across NSW Health to 8.5. We noted that the positions had facilitated a two and a half fold increase in the number of Aboriginal children receiving counselling from the Hunter New England SAS (where four of the seven positions were based) – a clear demonstration of the value of identified positions.

To date, it is not clear whether the Ministry has raised concerns formally with the LHDs/SCHN about the almost complete lack of Aboriginal counsellors employed by SAS.

In contrast to SAS, which provide counselling services for sexual assault victims, Health's New Street Service, which works with children and young people aged 10-17 years who have engaged in harmful sexual behaviour, employs seven Aboriginal counsellors across its four services in Dubbo, Sydney, Tamworth and Newcastle. Two of the counsellors are male. These positions are located at Sydney New Street, but provide a state-wide service. A recent evaluation found that 27% of clients accessing New Street Sydney services were Aboriginal, a significant increase from the 5% during 1998–2006, prior to the employment of the Aboriginal workers.[682] It would appear that there is scope for SAS to consider the recruitment and retention strategies adopted by New Street, in addition to the observations about training and career progression for Aboriginal health workers outlined below.

Notwithstanding the very small number of Aboriginal counsellors employed by SAS, we have been told during our consultations that Certificate IV qualified Aboriginal family health workers are frequently expected by community to provide counselling in the course of undertaking their duties. Because they are not qualified or employed as counsellors, however, they are unable to provide counselling and are therefore not paid at the same level as counsellors employed by SAS. We discuss this issue further in the next section.

679 Advice provided by NSW Health, 2014.
680 Advice provided by NSW Health**,** December 2016.
681 Advice provided by NSW Health, February 2017.
682 The evaluation recommended that designated positions for Aboriginal male and female counsellors be funded for each New Street Service, and that tri-annual funding be provided for the two male Aboriginal counsellor positions to enable them to maintain a state-wide focus. (NGO Consulting Group, NSW Health, ECAV Aboriginal Qualification Pathway and New Street Services Statewide Aboriginal Counsellors: Evaluation report, September 2016.) NSW Health has advised us that the two identified male Aboriginal positions have now been permanently established (Advice provided by NSW Health, 20 June 2017).

Health has recognised that to significantly improve the health status of Aboriginal people there is an immediate need for organisations to provide more respectful, responsive and culturally sensitive services. A culturally competent organisation can also better support an Aboriginal workforce. NSW Health is committed to mandatory Aboriginal Cultural Training for all health staff. *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (2011)[683] has been implemented across Health to assist in increasing cultural competencies and therefore promoting greater understanding of the processes and protocols for delivering health services to Aboriginal people.

13.8. Access to sexual assault counselling

As noted earlier, an important way to encourage reporting of child abuse is for Aboriginal communities to see that children and their families are being actively supported when they come forward. Counselling is a crucial component of this support. During our 2010-2012 audit we were told that insufficient counselling services can have a negative impact on the willingness of victims to come forward to report abuse.

In 2006, the Aboriginal Child Sexual Assault Taskforce identified a chronic shortage across agencies of counsellors and support staff able to respond to sexual assault in Aboriginal communities, including a shortage of Aboriginal staff. The Interagency Plan recognised this shortage and committed NSW Health to 'provid[ing] additional Aboriginal specialist child sexual assault counsellors' to help address the gap.[684]

Our audit found that apart from the establishment by Health of seven designated Aboriginal child sexual assault counselling positions,[685] there had been little improvement to the significant shortage in the availability of specialist sexual assault counselling, particularly for Aboriginal victims. As we discussed in Chapter 12, the issues we identified in 2012 in relation to the capacity of the service system remain relevant.

In 2012 we recommended that NSW Health designate responsibility to ECAV[686] for developing an Aboriginal recruitment and staff development plan with the specific aim of increasing the number of Aboriginal sexual assault counsellors across NSW. Significant progress has been achieved since then to develop an 'Aboriginal qualification pathway'. In addition to the Certificate IV Aboriginal family health worker course jointly developed by ECAV and the Centre for Aboriginal Health in 2001, ECAV has developed Graduate Certificate and Advanced Diploma qualifications. The Advanced Diploma of Aboriginal Specialist Trauma Counselling was introduced in 2011, and in 2015 it was accredited by the Australian Counselling Association (ACA). This enables graduates to register as professional counsellors. In 2013, ECAV also entered into an agreement with Sydney University to develop the Graduate Certificate in Human Services (Trauma Stream), which provides a pathway to the Masters in Social Work.[687]

A recent evaluation of ECAV's Aboriginal qualification pathway identified a need to increase both the number of students undertaking the Certificate IV, and the number progressing to the Advanced Diploma and Graduate Certificate. To date, just over 20% of Certificate IV qualified Aboriginal family health workers have progressed to the Advanced Diploma. We support the evaluation's recommendations aimed at enhancing awareness of, and addressing current barriers to entry to, the Aboriginal qualification pathway.[688]

683 http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_069.pdf.
684 NSW Government, *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006–2011*, January 2007, p.20.
685 The Aboriginal positions included two FTE each in Hunter New England and Illawarra Shoalhaven, funded recurrently from 2007-2008, and two FTE in Western Sydney (in the NGO, Rosie's Place initially) from 2008-2009.
686 In consultation with the Ministerial Advisory Body on Aboriginal Child Sexual Assault and the Aboriginal Communities Matter Advisory Group established by ECAV.
687 NGO Consulting Group, NSW Health, ECAV Aboriginal Qualification Pathway and New Street Adolescent Service's Statewide Aboriginal Counsellors: Evaluation report, September 2016 (unpublished). We understand that ECAV's training program is subject to a current evaluation by the Centre for Aboriginal Health.
688 For example, the evaluation recommended that, to reduce individual and workplace costs associated with entry to the Aboriginal qualification pathway, ECAV should become a registered provider of ABSTUDY and seek additional funding to administer the provider role. It also recommended that ECAV be provided with an increase in funding to enable ECAV to run the Certificate IV course twice annually, and continued funding to deliver the Advanced Diploma and Graduate Certificate once a year.

As well, we agree that leadership is required from the Ministry of Health to encourage LHDs to support more Aboriginal family health workers to undertake the Advanced Diploma in order to meet the demand for trauma informed counselling for Aboriginal people. It is also essential that LHDs have the willingness, capacity and funding to implement flexible solutions, including mentoring Aboriginal staff into positions over a period of time, where other attempts to recruit appropriately trained and qualified Aboriginal sexual assault counsellors are unsuccessful. We suggest that the Ministry of Health raise these issues with LHDs in the context of seeking advice from them about the existing inadequacy of Aboriginal counsellor positions within SAS.

Finally, we support the evaluation's recommendation that, in light of the recent accreditation by the ACA of the Advanced Diploma, consideration should be given to appointing graduates of the Diploma to the NSW Health counselling positions covered by the NSW Health Services, Health Professional (State) Award, which provides for a wider range of pay levels and career progression than the NSW Health Services Aboriginal Health Services (State) Award under which most Aboriginal health workers are currently paid.

Improving the availability of culturally safe, trauma informed sexual assault counselling for Aboriginal children and young people; and increasing the number of skilled Aboriginal workers who can provide advice about engaging with Aboriginal children, young people and their families, are critical to strengthening the JIRT program's overall response to their needs. However, the JIRT program alone cannot achieve this. It is now more than four years since we highlighted the critical shortfall in sexual assault counselling capacity, particularly for Aboriginal children and young people, in NSW. A stated commitment by government to improving the response to Aboriginal children and young people who are sexually abused is not enough – tangible actions are needed.

Recommendations

36. The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 13.4, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by Aboriginality and monitored.

37. The JIRT partner agencies should, having regard to the observations and recommendations contained in Chapters 9 and 13, finalise their position on the recommendations made by the 2015 IAB audit of the implementation of the *Enhanced Aboriginal Services Protocol*.

PRACTICE SUGGESTIONS

- The JIRT partner agencies should consider examining the reasons for the recent decline in the rate of reports involving Aboriginal children and young people accepted by the JIRT program, and if any related JRU practice issues are identified, implement appropriate strategies to address these issues.
- The JIRT partner agencies should:
  - Amend the *JRU Process Guidelines* to emphasise that where the JRU suspects a child or young person is Aboriginal, but the referral has not clarified this, staff should make appropriate enquiries to confirm their Aboriginality.
  - Amend the *Aboriginal Consultation Protocol* to include more detailed guidance, similar to that contained in Module 3 of the previous JIRT Foundation Skills Training Course, about the Aboriginal consultation process.
  - Embed the *Aboriginal Consultation Protocol* within the Local Planning and Response Procedures.
- The NSW Police Force should ensure that:
  - Aboriginal Community Liaison Officers (ACLOs) receive adequate guidance about the JIRT program and the role of the Child Abuse Squad.

- ACLOs are appropriately consulted by the Child Abuse Squad about reports involving Aboriginal children and young people from communities within the Local Area Commands they service.

- NSW Health should raise with Local Health Districts/Sydney Children's Hospital Network (LHDs/SCHN) the observations and recommendations in Chapter 13 about:
  - The low number of Aboriginal counsellors employed by the Sexual Assault Service.
  - The need for LHDs/SCHN to support more Aboriginal family health workers to obtain a counselling qualification.
  - The benefits of implementing flexible solutions where other attempts to recruit appropriately trained and qualified Aboriginal sexual assault counsellors are unsuccessful.
- NSW Health should consider:
  - Supporting the recommendations made by the independent evaluation of ECAV's Aboriginal qualification pathway and, in seeking to address current barriers for Aboriginal people entering the dedicated qualification pathway, the successful recruitment of Aboriginal counsellors by New Street Services.
  - Appointing graduates of the Advanced Diploma to the NSW Health counselling positions covered by the NSW Health Services, Health Professional (State) Award.
- The JIRT partner agencies should:
  - Examine the scope for ECAV to be provided with additional funding to support the expanded delivery of the 'Facilitating the disclosure' Aboriginal community engagement workshop and other positively evaluated community engagement and development programs run by ECAV.
  - Subject to the availability of additional resourcing, expand the delivery of the 'Facilitating the disclosure' Aboriginal community engagement workshop across NSW.
- The JIRT partner agencies should provide advice to the Ombudsman's office about the steps taken by relevant agencies to implement recommendations 5-11 of the Ombudsman's 2012 report, *Responding to child sexual abuse in Aboriginal communities*.

Chapter 14. Children and young people with disability

Disability is caused by a range of conditions, including intellectual, physical, cognitive, sensory, neurological impairments or mental illness. It is widely understood that children with disability, particularly children with cognitive and/or communication impairment,[689] are at significantly increased risk of all forms of abuse, including sexual abuse.

Research commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse cites international data (no Australian figures are available) which estimates the risk of abuse for children with disability as approximately 3.5 times higher than for children without disability – children with disability are also around three times more likely to experience sexual violence.[690] There is also some evidence that a greater proportion of sexually abused children with disability experience serious sexual abuse (involving penetration) compared to sexually abused children without a disability.[691] Our own data from the reportable conduct scheme indicates that 29% of all notifications of reportable conduct closed in 2013-2014 and 2014-2015 involved a child with disability or child with additional support needs.[692]

Providing more equitable access to mainstream services for people with disability, through better systems and processes, is a key focus area of the *NSW Disability Inclusion Plan*[693] mandated by the *Disability Inclusion Act 2014*. Consistent with this, and with what is known about the heightened vulnerability of children and young people with disability, the JIRT partner agencies recognised at the outset of our inquiry the importance of examining whether the JIRT program is adequately responding to the needs of this cohort.

Our inquiry has identified that there is significant scope for the JIRT program to improve the way it is responding to children and young people with disability. This is starkly reflected in the results of the JIRT workforce survey – despite what is known about the vulnerability of children and young people with disability to serious abuse, almost one quarter (23%) of respondents indicated that the JIRT program's response to this cohort is less than satisfactory or poor, and only 12% stated that it is good. Respondents made a range of suggestions about how to strengthen the JIRT program's response in this area. These, and other strategies we have identified, are discussed in this chapter.

In addition to obtaining advice from the partner agencies and eliciting feedback from frontline JIRT staff through the workforce survey, we consulted key disability advocates including Children and Young People with Disability Australia (CYDA), People with Disability Australia (PWDA), the Disability Council of NSW and the Intellectual Disability Rights Service. We also had regard to relevant research commissioned, evidence heard and observations made by, the Royal Commission.

689 Cognitive impairment refers to a broad range of disorders that affect cognitive functioning, including intellectual disability, acquired brain injury and foetal alcohol spectrum disorders. Communication impairment refers to difficulty with any aspect of communication, including speech, language, voice, fluency or social communication. Communication impairment may or may not coexist with cognitive impairment. Children with neuro-developmental disorders such as autism, Down Syndrome and cerebral palsy often have some type of communication impairment. Brain injury, hearing impairment and cleft palate may also cause communication impairment. (NSW Health, NDIS and Cognitive Impairment Factsheet, January 2015, http://www.schn.health.nsw.gov.au/; Speech Pathology Australia, Communication impairment in Australia Factsheet, http://www.speechpathologyaustralia.org.au/)

690 Sally Robinson, *Feeling safe, Being safe: What is important to children and young people with disability and high support needs about safety in institutional settings?* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Centre for Children and Young People, Southern Cross University, February 2016, pp.28-29.

691 Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of New South Wales, July 2016, p.47.

692 Section 25A(1) of the Ombudsman Act defines reportable conduct as:
- any sexual offence or sexual misconduct committed against, with or in the presence of a child – including a child pornography offence
- any assault, ill-treatment or neglect of a child
- any behaviour that causes psychological harm to a child – even if the child consented to the behaviour

In presenting this data, it is important for us to acknowledge its limitations. Until recently, we could not be confident that agencies were using a consistent approach to determining whether or not an alleged victim had a disability, and if so, the nature of the disability. Recent enhancements to our data collection processes are discussed later in this chapter.

693 February 2015.

Finally, we have been informed by the exercise of our employment related child protection and disability reportable incidents functions as well as our oversight of the delivery of community and disability services.[694] These combined functions provide us with unique insights into a range of relevant systems issues, many of which relate to criminal justice system responses to the abuse of people with disability (including children and young people).

14.1. Disclosure and reporting of abuse by children and young people with disability

Children and young people with disability face particular barriers to disclosing and reporting abuse, and to receiving timely and appropriate justice and support when they do:

> *They may find it difficult to recognise and disclose abuse, and they may not have language to use to describe what happened. They may be unable to disclose abuse to people they do not know or in unfamiliar settings or circumstances. Many victims of child sexual abuse find it difficult to provide sufficient particularity in disclosing the abuse, but this may be an even greater problem for young children and people with disability. Young children and people with disability may face particular difficulties in understanding and responding to questions they are asked in language which may be beyond their current linguistic and cognitive abilities. They may also face prejudicial assessments of their competence, reliability and credibility throughout the criminal justice system.*[695]

Other barriers to the disclosure of abuse may include heightened dependency on personal care supports; difficulty in distinguishing non-abusive touch from abusive touch; fear that disability support services will be interrupted or removed; a lack of opportunity to report abuse to authorities, due to the ongoing presence of, and dependence on, caregivers;[696] limited understanding of abuse associated with a failure to educate children with disability on protective behaviours and sexuality; and a greater likelihood that 'physical and behavioural indicators of abuse by children with disability may be misinterpreted as bad behaviour or as part of the child's disability and so may be overlooked or dismissed'.[697]

In this context, it is not surprising that the evidence indicates that rates of non-disclosure of child abuse by children with disability are high.[698] In this regard, research commissioned by the Royal Commission has observed that 'children and young people who use non-standard methods of communication have been found to lack the language to describe their experiences in their preferred communication form (for example, sign language or communication devices)'.[699]

The disability advocates we consulted stressed that, at least initially, the most compelling 'evidence' that children with a severe disability have been abused – particularly those with communication impairment – may be significant behavioural changes. In turn, these changes may only be discernible to care givers who have existing knowledge of the child or young person. Frequently, others may attribute the behaviours to the child or young person's disability.

694 The Disability Reportable Incidents scheme in NSW commenced on 3 December 2014 and is the first – and only – legislated scheme in Australia for the reporting and independent oversight of serious incidents involving people with disability living in supported accommodation. The scheme is modelled on the reportable conduct scheme. Under Part 3C of the *Ombudsman Act 1974*, the Ombudsman oversees the actions and systems of FACS and certain funded providers to prevent, handle and respond to serious reportable incidents relating to people with disability living in supported accommodation. The Ombudsman's employment related child protection functions are contained in Part 3A of the Ombudsman Act and require us to keep under scrutiny the systems that government and certain non-government agencies in NSW have for preventing reportable conduct and handling reportable allegations and convictions involving their employees. The *Community Services (Complaints, Reviews and Monitoring) Act 1993* sets out the Ombudsman's various functions to review and monitor the delivery of community and disability services.

695 Royal Commission into Institutional Responses to Child Sexual Abuse, *Case Study 38*, Opening address by Counsel Assisting – Week 2, p.17846.

696 Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of New South Wales, July 2016, p.40.

697 Royal Commission into Institutional Responses to Child Sexual Abuse, *Case Study 38*, Opening address by Counsel Assisting – Week 2, pp.17849-50.

698 Associate Professor Jan Breckenridge and Gabrielle Flax, *Service and support needs of specific population groups that have experienced child sexual abuse*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of New South Wales, July 2016, p.39.

699 Sally Robinson, *Feeling safe, Being safe: What is important to children and young people with disability and high support needs about safety in institutional settings?* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Centre for Children and Young People, Southern Cross University, February 2016, p.33.

Unsurprisingly, respondents to the workforce survey identified challenges associated with interviewing children and obtaining a disclosure, particularly from children with communication impairment, as a key barrier to the JIRT program's capacity to respond effectively to children and young people with disability.

As outlined in Chapter 9, except for reports involving Aboriginal children (which are subject to the *Enhanced Aboriginal Services Protocol*), the JIRT program can only accept a report of sexual abuse if there is a 'disclosure and/or evidence of sexual assault'. For the reasons discussed above, reports about children and young people with cognitive and/or communication impairment are less likely to meet this threshold at the outset of the JIRT referral process. However, while some children and young people may never, due to the nature/severity of their disability, have the capacity to disclose their abuse in a way that will meet evidentiary standards, others may be able to do so if provided with access to appropriate supports, including assistance with communication. Many children and young people with cognitive and/or communication impairment will not be afforded this opportunity if there is an over-reliance on disclosure during the initial assessment of a JIRT referral.

We recommended in Chapter 9 that the JIRT criteria be extended, on a trial basis, to provide better access to the JIRT program for children and young people with cognitive and/or communication impairment, by allowing reports to be accepted for a JIRT response if there is no clear disclosure, but there are 'behavioural changes or other indicators of abuse' present.[700] The disability advocates we consulted were strongly supportive of the proposal.

14.2. JIRT data about disability

Despite what is known about the heightened vulnerability of children and young people with disability to abuse, it is difficult to objectively determine the extent to which the JIRT program is adequately responding to this cohort. Currently, the partner agencies do not systematically collect or disaggregate data, either individually or collectively, about JIRT reports involving children or young people with disability. As a result, it is not possible to determine how many reports referred to the JRU involve children with disability, or the proportion of these reports that are accepted for a JIRT response. It is also not possible to examine the child protection, criminal justice or clinical/therapeutic outcomes facilitated by the JIRT program for this cohort, or how these compare with outcomes for children and young people without disability.

Through its various forums, the Royal Commission has made clear that it considers the systematic capture and related analysis of data about the incidence of abuse of children with disability – in both disability specific and mainstream service settings – to be essential. The need for 'routine and reliable identification of disability in administrative data sets' has also been emphasised in a recent research report commissioned by the Royal Commission, and was strongly endorsed by the disability advocates we consulted for this inquiry.[701] In addition, enhanced data collection is consistent with the NSW Government's commitment to measure and report on the progress of actions under the NSW Disability Inclusion Plan.

As a first step towards measuring the JIRT program's performance in relation to responding to children and young people with disability, we recommend that the SMG immediately take steps to ensure the collection and monitoring of data about disability at all stages of the JIRT process, beginning with referrals by the Helpline to the JRU.

700 As discussed in Chapter 9, it is a matter for the agencies to determine, in consultation with the disability sector, what 'indicators of abuse' will be prescribed for the purpose of the trial.

701 Professor Gwynnyth Llewellyn, Dr Sarah Wayland and Ms Gabrielle Hindmarsh, *Disability and child sexual abuse in institutional contexts*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney, November 2016, p.71.

We appreciate that the Helpline may only have limited information about a child or young person's disability status at the time of receiving a 'risk of significant harm' report. However, in our view, where it is known, or reasonably believed at the time of receiving a report, that a child or young person has a disability, this should be systematically flagged by the Helpline and contained in the referral to the JRU. There should also be capacity through the shared JIRT database for a record to be amended to include a disability flag that must be mandatorily selected by the JRU or, if a child or young person's disability becomes known at a later stage, by the relevant JIRT agencies locally.[702] The flag would not only help to inform the JIRT agencies' response to individual matters by acting as a trigger to consider relevant issues, it should enable the partner agencies to regularly monitor trends in relation to reports involving children or young people with disability.

Currently, our office records the disability status of alleged victims the subject of reportable conduct notifications[703] using the four categories contained in the Nationally Consistent Collection of Data on School Students with Disability (NCCD):

- Physical: The total or partial loss of part of the body; the presence in the body of organisms causing disease or illness; the presence in the body of organisms capable of causing disease or illness; the malfunction, malformation or disfigurement of a part of the person's body.
- Cognitive: The total or partial loss of the person's bodily or mental functions; or a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction.
- Sensory: The total or partial loss of the person's bodily or mental functions; or the malfunction, malformation or disfigurement of a part of the person's body.
- Social/Emotional: A disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement or that results in disturbed behaviour.

The NCCD categories, which are used by schools, are based on the disability definitions contained in the *Disability Discrimination Act 1992* (Cth). Our office adopted the categories as the schools sector argued that it made sense for them to use a common process for classifying disability across various business areas, including the provision of funding and related supports to students. The categories provide a simple and consistent way for us to capture data from across the various sectors within our jurisdiction. In this regard, FACS has also indicated that it is prepared to start collecting disability data about children in out-of-home care in ChildStory, in accordance with the categories above, regardless of whether these children are the subject of a reportable conduct notification.

While the NCCD categories are one option, and are broadly recognised, both PWDA and CYDA support the use of the International Classification of Functioning, Disability and Health (ICFDH), which adopts a more functional approach to disability. We note that the Australian Institute of Health and Welfare has developed a 'standardised disability flag' consistent with the ICFDH for use by services. The flag focuses on identifying whether an individual has a health condition or disability that restricts their everyday activities and participation, and the extent of the restriction.

We recommend that the partner agencies consult further with the disability sector to determine the most appropriate model of disability data collection. In relation to using the NCCD categories, we note that an important consideration will be the benefits of maintaining consistency of classification for both reportable conduct notifications and allegations of abuse that occur in other contexts and do not constitute reportable conduct. Whatever system is adopted, it is essential that it be both meaningful and user-friendly, and supported by adequate guidelines for staff.

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702 FACS advised us on 21 March 2017 that 'the issue of reporting by disability is complex, and is the focus of current work for data collection in ChildStory'.

703 We began collecting enhanced data about the disability status of alleged victims of reportable conduct in December 2015 after identifying the need to improve the quality and consistency of our data collection in this area.

14.3. Training about communicating with and interviewing children and young people with cognitive impairment and/or other disability

One fifth of respondents to the JIRT workforce survey commented on the need for better training in responding to matters involving children with a disability, particularly in relation to the interview process. For example, one CAS investigator noted that:

> *It would be beneficial for CAS staff to undergo training on ways in which to better interview children and young people with disabilities. The general JIRT training does not cover this and seeing as though children and young persons with disabilities are vulnerable and often taken advantage of in relation to sexual abuse, staff need to be trained according[ly] to elicit the best, most accurate information from these complainants so that offenders can be prosecuted. It is frightening how much investigators are not confident in interviewing this social group and as such these matters are not prosecuted successfully or at all, through no fault of the complainant but the investigators due to their lack of ability.*

Currently, in addition to any disability awareness training provided by the partner agencies to their own workforce,[704] the JIRT Foundation Skills training for JIRT staff contains a 90 minute module on working with children and young people with disability. The module is presented by a Health JIRT facilitator and is aimed at equipping participants to:

- identify and define disabilities that affect communication
- understand the historical, social and political context of disability and its impact on the processes of interviewing children and investigation
- outline the benefits of planning for an interview with a child or young person with a disability, the challenges that this may involve and resources to assist the interview, and
- identify appropriate support services to support children and young people with disabilities who have experienced abuse.

The training includes a discussion of 'myths' about the capacity of children with intellectual disability to provide accurate and detailed information during an interview and to be competent witnesses in criminal justice proceedings. It also covers the importance of non-criminal justice safety and support interventions.

The need for police nationally to gain expertise in interviewing people with disability, particularly those with communication needs and intellectual disability, and inadequate training and education in this area, have been brought to the attention of the Royal Commission via submissions and hearings.[705]

During the Royal Commission's Case Study 41 – which inquired into the responses of three disability service providers to allegations of child sexual abuse – evidence was provided to the Commission's public hearing about the JIRT response to a 2012 report of abuse involving a child with disability. The Commission heard that in March and April of that year, CIE, a child with moderate autism, was interviewed by JIRT and disclosed sexual abuse. CIF, the mother of CIE, gave evidence that the JIRT officers interviewed CIE by asking questions that only required yes or no answers. CIE communicated his answers with his mother's assistance by using a computer or a QWERTY board.[706] According to CIF, the JIRT officers commented that 'this was the first case that they had had with a child that can communicate like this'.

704 For example, all FACS caseworkers receive guidance about disability as part of their initial compulsory training, while disability awareness is included in the Mandatory Police Continuing Education Scheme.

705 For example, see the submissions of People with Disability Australia to the Royal Commission's *Issues paper 8* on police and prosecution responses (May 2016) and *Consultation Paper – Criminal Justice* (September 2016).

706 A QWERTY board is a piece of laminated paper with a standard computer keyboard printed on it.

CIF told the Commission:

> *I felt that JIRT officers were not patient, they ran the interview how they wanted and never took [CIE] or his needs into consideration …[CIE] was not given enough time to provide JIRT with enough details about the abuse. The interviews went for one hour each, but I believed that [CIE] needed more than two interviews. I tried to explain to the JIRT officers that my son would need multiple interviews, but I was ignored … We were later informed by the JIRT officers that they had substantiated the allegations [but] could not proceed to prosecute because my son was not a competent witness and they did not have enough evidence.*[707]

At the time of writing, the Commission has not made findings in relation to the JIRT agencies' response to the allegations involving CIE.[708]

The disability advocates we consulted also identified a need for enhanced training about disability and trauma for police in particular, given their role in leading recorded criminal interviews of children, including a strong focus on identifying disability and facilitating flexible communication methods.

In this regard, as part of a broader Disability Rights Project we have been funded to implement,[709] our office has engaged UK Professor Penny Cooper to develop a guide and training package for the NSW Police Force (and disability service providers) to improve their communication with people with cognitive impairment, and to provide advice on obtaining best evidence from people with cognitive impairment who are the subject of, or witnesses to, alleged abuse. Professor Cooper devised and delivers the national training and procedural guidance for registered intermediaries in the United Kingdom, and also trained the first cohort of intermediaries employed by the witness intermediary pilot scheme in NSW. The Acting CAS Commander, and senior officers from the NSW Police Force Training and Education Unit, are among our expert police advisors on the project.

The guide and training package, which separately considers the particular needs of children, provides advice about types of disability; assessing an interviewee's competence and capacity; removing barriers to the interviewee's participation in the interview, including by making reasonable adjustments; and utilising witness intermediaries. It will be used to adapt both the Detectives Education Program, and the Child Interviewing Course (discussed in Chapter 10), and will serve to significantly improve the training that is provided to the CAS and other detectives about investigating matters that involve a person with cognitive impairment.

In Chapter 10 we also suggested that the NSW Police Force consider having dedicated specialist investigators within the State Crime Command (largely drawn from the CAS given their experience in working with intermediaries and investigating abuse), who can be called on by Local Area Commands for investigative advice and assistance in interviewing vulnerable adults, particularly those with cognitive impairment or communication support needs (including older people).

In addition to the specific measures we have discussed aimed at improving the police response, we also believe that, as part of its broader JIRT training review, there is merit in the SMG considering whether the guidance currently provided to JIRT agency staff about best practice in responding to reports involving children and young people with disability is adequate. In doing so, it should seek advice from the peak disability advocates consulted for this review and other appropriate bodies, such as Speech Pathology Australia and Communication Rights Australia.

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707 Royal Commission into Institutional Responses to Child Sexual Abuse, Public Hearing – *Case Study 41* (Day 199), Transcript, 12 July 2016, p.20193.

708 The Royal Commission released its final report about Case Study 41 on 14 June 2017 but noted that it is considering the role of JIRT in its broader work in relation to criminal justice.

709 The project aims to develop a practical and lasting framework that enables people with disability and their supporters to better understand and exercise their rights. Our focus is particularly on building the capacity of people with disability to understand and exercise their rights as NSW moves towards the National Disability Insurance Scheme, including by strengthening systems to prevent, identify and respond to abuse, neglect and/or exploitation of people with disability.

14.4. Witness intermediaries

> *There would seem to be potential for comprehensive and professional intermediary schemes to make a significant difference in reducing the problems that children and people with disability face in being heard by the criminal justice system.*[710]

In Chapter 18, we discuss the witness intermediary pilot scheme currently operating in two sites (covering four JIRT units). The scheme is aimed at enhancing the quality of the evidence provided by children and young people who have been sexually abused by utilising appropriately qualified and trained 'intermediaries' to conduct an assessment of the child and make recommendations to police and the court about strategies for maximising effective communication with them.

The intermediary scheme is a significant development in terms of improving the response provided through the JIRT program to children and young people with disability. The early feedback from the pilot sites has been extremely positive, and the responses to the JIRT workforce survey suggest that it is impacting positively on the quality of the JIRT program's response to this cohort. As we discuss in Chapter 18, children with disability from outside of the pilot sites have also been given access to a witness intermediary.

Notwithstanding the benefits of the intermediary scheme, it is important to recognise that there is no single 'solution' to the complex barriers impacting on access to justice for children and young people with disability who have been abused.

In this regard, while witness intermediaries have the potential to greatly enhance communication with children and therefore, the quality of children's evidence, the service they provide does not negate the need for adequate information sharing between the JIRT partner agencies, and other relevant service providers, about the individual child and their disability.[711] For example, services that have previously worked closely with a child may be able to suggest effective strategies for engaging them, as well as provide other information useful to the investigation. To this end, respondents to the JIRT workforce survey emphasised the importance of a consultative, planned approach by the JIRT program – particularly in relation to the interview process. We suggest that the *Local Planning and Response Procedures* be amended to include specific factors and actions to be considered when responding to reports that involve children and young people with disability.

14.5. Clinical and therapeutic responses to children and young people with disability

As JIRT Health data is not disaggregated by disability, it is not possible to comment on whether children and young people with disability who are the subject of reports accepted by JIRT are being provided with access to appropriate specialist health services. However, it is appropriate to note that as part of a comprehensive policy review, NSW Health has developed new draft standards and guidelines for its Sexual Assault Services (SAS) which incorporate detailed advice about responding to children, young people and adults with disability.

The draft standards and guidelines currently require that all sexual assault workers have an understanding of indicators of sexual abuse for people with a disability, including responding to disclosures and/or behavioural or physical indicators of sexual assault, and that SAS have the capacity to assess communication needs and access tools to assist in communicating with clients with intellectual and/or sensory impairments. The significance, in the absence of a disclosure, of behavioural changes (for example, fear of being alone, nightmares and or sleep disturbances, regression, avoidance behaviour, emotional distress related to particular events) as well as physical indicators (for example, presence of bruising, ano-genital injuries, STIs, pregnancy) are emphasised.

710 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.382.
711 One quarter of respondents to the JIRT workforce survey – mostly FACS and Health staff – identified a need to improve the JIRT interview process, and in particular, interview planning, for children with disability.

In preparing to provide a SAS response, sexual assault workers are required, with the consent of the victim or parent/caregiver, to gather specific information about the person's disability and how it impacts on their communication patterns, as well as their current level of functioning and wellbeing. The use of trusted support persons to assist with communication is encouraged. If a medical or forensic examination is required, the practitioner is expected to learn the names the person uses for body parts and provide developmentally appropriate explanations of each stage of the examination.

The role of sexual assault workers in providing support and advocacy to encourage victims to report sexual assault, participate in the criminal justice system and access their rights and entitlements as victims of crime, is also emphasised. The standards and guidelines also contain useful advice about planning the provision of counselling for people with intellectual, cognitive and sensory impairment and communication difficulties, including links to appropriate resources.

14.6. Child protection interventions for children with disability

FACS was unable to provide us with data about child protection interventions facilitated by FACS JIRT and/or CSCs for children and young people with disability referred to the JIRT program.

As well as ensuring that children and young people with disability (and their families) who are referred to the JIRT program receive appropriate child protection interventions where this is warranted, FACS JIRT and CSCs can play an important role in identifying the need for other disability and related services and supports, including those provided under the NDIS, and making appropriate referrals. However, we acknowledge that resourcing and capacity issues may limit the extent to which FACS staff are able to consistently perform this function in practice. This is a further area where the establishment of a Child and Family Advocate role for the JIRT program can provide an important 'safety net' – albeit only in relation to reports accepted by JIRT.

14.7. Benefits of establishing a Child and Family Advocate role within JIRT

As discussed in Chapter 6, feedback from our consultations has strongly endorsed the establishment of a trial of a Child and Family Advocate role within the JIRT program.

Together with other particularly vulnerable groups of children and young people who come into contact with JIRT, children with disability (and their families) are especially likely to benefit from the provision of the more seamless and individualised support that a position of this type can offer. A formalised advocacy approach within JIRT is strongly supported by the disability advocates we consulted.

It is also important to point out that the Child and Family Advocate's role would not be to replace the specialist advocacy and support services that are already provided by advocates in the disability sector, or other advocacy services that may already be engaged with children and their families. Rather, the creation of an advocate position would provide a more formalised pathway for JIRT to ensure that children and young people with disability receive appropriate referrals, including to disability services that provide specialised advocacy and supports. In this regard, there is considerable scope for JIRT to make better use of existing resources in the disability sector.

Recommendations

38. The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 14.2 and in consultation with peak disability advocates, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by disability status and monitored.

39. The JIRT partner agencies should, in consultation with peak disability advocates and other appropriate bodies (such as Speech Pathology Australia and Communication Rights Australia), review and enhance the training and guidance provided to Helpline and JIRT agency staff (including the JRU) about identifying and responding to reports involving children and young people with disability, including appropriate consultation with disability experts and accessing specialist clinical and community resources.

PRACTICE SUGGESTION

- The JIRT partner agencies should amend the *Local Planning and Response Procedures*, having regard to the observations in Chapter 14, to include specific factors and actions that should be considered when responding to reports that involve children and young people with disability.

Chapter 15. Children and young people from culturally and linguistically diverse backgrounds

As part of our inquiry, the JIRT partner agencies identified a need to consider whether the JIRT program is meeting the needs of children and young people from culturally and linguistically diverse (CALD) backgrounds.

An individual is generally described as being from a 'CALD' background if they, or at least one parent, were born in a non-English speaking country and/or their cultural norms and values differ from those of the mainstream community.[712] In a service delivery context, 'CALD' is often used as shorthand for people not of Anglo-Saxon heritage and for whom English is not the language primarily spoken at home. CALD communities account for a significant proportion of the population in NSW.

In any discussion about people from CALD backgrounds, it is important to emphasise their individuality, and that:

> *their specific issues and challenges may differ depending on the particular cultural group with which they identify; the number of years they have been in Australia; their pathways both to Australia and once residing in Australia, and the level of community and family support they receive once they are living in Australia.*[713]

Against this background, it is generally acknowledged in both the research and by practitioners that children and young people from CALD backgrounds may face a number of issues that make them a vulnerable social group[714] and that, while risk factors common to all families are also prevalent in CALD families, there are additional risk factors which may lead to CALD families having contact with the child protection system.[715]

Because of the diversity of CALD communities, assessing the extent to which the JIRT program is meeting the needs of children and young people from CALD backgrounds is not a straightforward exercise. A lack of data about the CALD status of children and young people referred to JIRT means it is also not possible to identify related trends, or to measure whether JIRT's response to these children differs significantly from its response to other children and young people.

In forming the observations outlined in this chapter, we have primarily drawn on responses to the JIRT workforce survey and available research, in addition to our consultations with the JIRT partner agencies and external stakeholders. It should also be acknowledged that as children with disability, and those who reside in out-of-home care (OOHC) may also come from CALD backgrounds, the observations and recommendations contained in other chapters in this Part are also relevant to this cohort.

15.1. Data about CALD children and young people

Individuals born overseas and/or speaking a language other than English at home comprise a significant proportion of the NSW population. According to the 2011 Census, 25.7% of people living in NSW were born overseas, 22.5% speak a language other than English at home and 17% of people who speak languages other than English do not speak English at all, or do not speak it well.[716] Australian population trends indicate that, increasingly, families and children coming to the attention of the child protection system will be from culturally, linguistically and religiously diverse backgrounds.[717]

712 Australian Institute of Family Studies, *Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia*, AFRC Issues No. 3, June 2008.
713 Professor Graeme Hugo, Dr Kelly McDougall, Dr George Tan and Dr Helen Feist, on behalf of the Multicultural Youth Advocacy Network (MYAN) Australia, *CALD Youth Census Report 2014*, p.16.
714 Professor Graeme Hugo, Dr Kelly McDougall, Dr George Tan and Dr Helen Feist, on behalf of the Multicultural Youth Advocacy Network (MYAN) Australia, *CALD Youth Census Report 2014*, p.16.
715 Diversity Consultants, *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families*, July 2012, p.12.
716 NSW Government, Multicultural NSW website, accessed 2 March 2017. Multicultural NSW is the lead agency for implementing the policy and legislative framework to support multi-cultural principles in NSW. http://multicultural.nsw.gov.au/.
717 Diversity Consultants, *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families*, July 2012, p.9.

There is, however, very little available information about the prevalence in NSW (and across Australia) of child abuse and neglect among CALD communities, and the number of CALD children and young people having contact with the child protection system. This lack of data has been identified by Multicultural NSW as a significant gap and an impediment to providing culturally responsive services to vulnerable children, young people and their families.[718]

Consistent with this situation, at present there is no systematically available data concerning reports about CALD children and young people that are referred to the JRU or accepted by JIRT. Therefore, as is also the case for children with a disability and those in OOHC, it is not possible to compare trends or outcomes in relation to this cohort, as compared to children and young people from non-CALD backgrounds.

Just as we have recommended that the JIRT partner agencies prioritise the collection of data about other vulnerable groups, we recommend that they also take steps to collect data that can be disaggregated by CALD status, so that the JIRT program's response to this cohort can be better monitored and measured. We note that this recommendation is consistent with commitments by FACS and NSW Health in their respective policies relating to cultural diversity to improve the collection, analysis and use of cultural diversity data.[719]

For example, the *NSW Health Policy and Implementation Plan for Culturally Diverse Communities 2012-2016* aims to provide direction to the NSW health system in building capacity to identify health needs and deliver health care to CALD communities across NSW. Priority 1.1 commits NSW Health to improve the collection, analysis and dissemination of data and evidence about the health of culturally, religiously and linguistically diverse groups. While their implementation status is unclear, strategies under the plan include introducing a mandatory field and flag in all electronic health records to indicate when an interpreter is required, improved recording of country or birth and audits of the Health Care Interpreter Service utilisation against records that an interpreter is needed.[720]

FACS' *Cultural Diversity Framework (2014-2017)* commits FACS to the integration of cultural and linguistic diversity with planning, monitoring, reporting and evaluation – supported by enhanced collection and analysis of cultural diversity client data; improving data consistency; integrity and utilisation. [721]

15.2. Training for JIRT staff about working with CALD children and young people

It is well recognised that, for a variety of reasons, individuals from CALD backgrounds may face linguistic, cultural and other barriers to accessing 'mainstream' services. For these reasons, the development of 'culturally responsive' service models has been advocated for many years as an important access and inclusion strategy. This is reflected in FACS' *Cultural Diversity Framework*; the NSW Police Force's *Priorities for Working in a Culturally, Linguistically and Religiously Diverse Society*;[722] and NSW Health's *Policy and Implementation Plan for Healthy Culturally Diverse Communities*. The *Children and Young Persons (Care and Protection) Act 1998* also requires consideration of the appropriateness of each child protection response in light of the child or young person's (and where relevant, their family's) language, religion and cultural background.[723]

The JIRT Foundational Skills course includes a 105 minute session, facilitated by staff from FACS' Multicultural Services Unit, about working with CALD clients. It is aimed at equipping participants to engage in 'culturally reflective practice' through:

718 Diversity Consultants, *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families*, July 2012, pp.12, 26.
719 NSW Department of Family and Community Services, *Cultural Diversity Framework*, 2014-2017, p.8; NSW Health, *Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012–2016*, p.15.
720 NSW Health, *Policy and Implementation Plan for Healthy Culturally Diverse Communities* (2012-2016) http://www.mhcs.health.nsw.gov.au/policiesandguidelines/pdf/policy-and-implementation-plan-for-healthyculturallydiverse2012-2016.pdf.
721 FACS, *Cultural Diversity Framework*, http://www.facs.nsw.gov.au/__data/assets/file/0020/303914/FACS-_Cultural_Diversity_Framework.pdf.
722 NSW Police Force, *Priorities for Working in a Culturally, Linguistically and Religiously Diverse Society* (2011-2014) http://www.police.nsw.gov.au/__data/assets/pdf_file/0004/73156/Internet_-_MPSP_Plan_2011-14.pdf.
723 *Children and Young Persons (Care and Protection) Act 1998* s.9.

- developing an understanding of the impact of culture on human behaviour and how this may influence an investigative interview with a child or young person, and
- identifying the process and procedures when using an interpreter for an investigative interview.

There is a strong emphasis on participants developing awareness of their assumptions and prejudices about particular cultures and religions, and suspending these assumptions in order to approach an investigation in an unbiased way. The training also focuses on the significant effect that migration and refugee trauma can have on the investigative interview, both in relation to how the interview is conducted and how information and behaviour is interpreted. It is explained that cultural norms, rules and historical treatment, for example, can shape the child or family's perceptions of authority and impact on rapport building – and that these issues should be considered prior to an interview.

JIRT agency staff are also taught that they must proactively identify where an individual lacks the language skills to communicate effectively in English and in these circumstances, engage a professional interpreter. A practical exercise involving an interpreter is incorporated into the session.

The training encourages JIRT agency staff to develop an awareness of, and familiarity with, the predominant CALD communities in their local area. While it is important not to homogenise particular communities, knowledge of some general characteristics of cultural groups can help to inform effective and culturally appropriate service delivery. Participants could be provided with links to appropriate resources to facilitate this learning. NSW Health's Multicultural Health Communication website also includes valuable community information summaries about specific CALD populations.[724] It would be useful to include the link to this website and the Secondary Risk of Harm (SROH) CALD Assessment in the *JRU Process Guidelines* and *Local Planning and Response Procedures*.

The JIRT Foundation Skills *Participants' Manual* includes the following, comprehensive checklist to use when responding to a 'risk of significant harm' (ROSH) report about a CALD child or young person. The checklist helps users to identify possible linguistic, cultural, migration and settlement issues that may affect a child from a CALD background, such as refugee trauma and migration pressures. The checklist should inform the provision of appropriate supports having regard to the issues that are identified.[725]

SROH CALD ASSESSMENT CHECKLIST

This checklist can be used as a *planning* tool in Pre Assessment Consultations to identify for possible linguistic, cultural, migration, and settlement issues that may need to be explored during assessments, and/or as a *review* tool in Assessment Consultations to check if critical issues have been accurately identified and addressed.

Language Needs

- Have we checked if family members require a professional interpreter?
- Have we checked if family members require written notifications, correspondence and/or information in their first language?
- Have we accurately identified the relevant language and dialect?
- Have we arranged for an interpreter and/or written translations?
- Have we considered using Community Language Allowance (CLAS) Officers for simple enquiries?
- Have we considered involving Multicultural Caseworkers as primary or secondary caseworkers?
- Have we assessed the impact of language barriers on parental and family functioning?

724 http://www.mhcs.health.nsw.gov.au/services/community-profiles-1.

725 A further useful resource is the 'Cross-Cultural Assessment' checklist, developed by Jatinda Kaur, to assist practitioners when working with CALD families in child protection settings. (See JK Diversity Consultants, *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families*, July 2012, p.35.)

Issues relating to harm

- Have we identified any culturally based differences in the family's understanding and approach to issues such as: gender and child-parent relationships, appropriate child discipline, and attitudes on what constitutes abuse and neglect?
- Have we checked the parents/carers' level of understanding of what constitutes abuse and neglect under NSW child protection laws?
- Have we checked cultural meanings ascribed by parents/carers, children and family members with multiple secondary sources?
- Have we sought to identify and build on aspects of traditional parenting practices that will contribute to the care and protection of children?
- Have we identified migration and settlement pressures that are having adverse effects on family and parental functioning?
- For refugee families, have we ascertained if parents/carers are experiencing the effects of refugee related trauma?
- Have we ascertained if there are direct and ongoing effects of refugee and trauma experiences on the health and development of refugee children and young people?
- Have we worked to identify skills, abilities, and strengths that they have gained as a result of their unique pre-migration and migration experience?

Informal and formal supports

- Have we explored culturally and linguistically appropriate supports that can strengthen parenting capacity, family relationships, and social connectedness?
- Have we assisted the family to meet basic settlement needs through referrals to Migrant Resource
- Centres, ethno specific organisations, and Commonwealth funded settlement services?
- For refugee children and adults with trauma symptoms, have we explored referrals to appropriate therapeutic services such as STARTTS, to specialist health services such as NSW Refugee Health Services?

Significantly, almost one quarter of respondents to our JIRT workforce survey commented on the need for more or better training about responding to children and young people from CALD backgrounds – particularly in relation to CALD demographics, cultural and religious customs, complex trauma experienced by migrants and refugees and available services. While the majority of respondents were FACS staff, CAS and Health staff were also well represented in this feedback.

The survey feedback suggests that there would be value in the JIRT partner agencies reviewing – individually, together and in consultation with appropriate expert advisors (such as the specialist cultural diversity resources existing within each partner agency, Multicultural NSW, and the Ethnic Community Services Cooperative) – the adequacy of the training that is provided to frontline JIRT staff about working with CALD children, young people and families. As part of this review, there would also be merit in considering the benefits of targeted training for JIRT staff working in areas with high concentrations of particular CALD groups – particularly new and emerging communities. In this regard, consideration should be given to utilising Education Centre Against Violence's existing cultural equity training.

15.3. Practice issues for JIRT in responding to children and young people from CALD backgrounds

> *Negative experiences such as cultural insensitivity or a failure for CALD young people to find an appropriate service for their needs may result in some young people deciding not to seek help in the future.*[726]

The JIRT workforce survey asked respondents about how well the JIRT program is meeting the needs of children and young people from CALD backgrounds, and how its response to this cohort could be improved. Overall, the majority (82%) of respondents thought that the JIRT program is providing a satisfactory, above satisfactory or good response. Health staff were generally less likely to respond positively.

15.3.1. Guidance for staff

The development of practice guidelines for working with CALD individuals, families and communities has been identified in the research as an important strategy for developing 'culturally responsive' service models.[727]

While there are a suite of documents that staff should have regard to in handling reports about Aboriginal children and young people, very little guidance – apart from that contained in the JIRT Foundation Skills training – appears to be provided to JIRT staff to assist them to respond effectively to reports involving children and young people from CALD backgrounds. Existing procedures (including the *JRU Process Guidelines* and *Local Planning and Response Procedures*) are notably silent on practical considerations, such as cultural consultation and the use of interpreters.

Being identified as a child from a CALD background should not automatically lead to that child receiving a different type of response to other children. As the definition of CALD is very broad, it is important for staff to understand what might make one child who is from a CALD background more vulnerable than another. The SROH CALD assessment checklist directs staff to consider factors such as language needs, migration pressures and ongoing refugee or other trauma when assessing the risks to the child, which provides some guidance as to what may increase their vulnerability.

We do not consider that there is a need for an additional policy or procedure governing the JIRT program's response to CALD children and young people. However, more needs to be done to ensure the specific obligations on JIRT agency staff to appropriately respond to this cohort are made explicit. In our view, and having regard to the observations in the remainder of this chapter, both the *JRU Process Guidelines* and *Local Planning and Response Procedures* should be amended to provide practical guidance about responding to reports involving children and young people from CALD backgrounds.

15.3.2. Cultural consultation

Along with training, cultural consultation – that is, consulting with a person likely to have knowledge of a child or young person's cultural, linguistic or religious background in order to inform case planning – was the most frequently raised issue by respondents to the JIRT workforce survey in relation to responding to CALD children. One quarter – mainly FACS staff – commented on this area of practice. FACS staff were particularly likely to say that cultural consultations should be undertaken by JIRT agencies more frequently as part of the LPR process:

> *We have mandatory processes in place for ATSI children to conduct a consult prior to interviewing the child to discuss terminologies they may use and how they may react to certain questions and body language. This does not exist for children from CALD backgrounds even though the relevance is exactly the same* – CAS Investigator.

726 Professor Graeme Hugo, Dr Kelly McDougall, Dr George Tan and Dr Helen Feist, on behalf of the Multicultural Youth Advocacy Network (MYAN) Australia, *CALD Youth Census Report 2014*, p.17.

727 JK Diversity Consultants, *Cultural diversity and child protection: A review of the Australian research on the needs of culturally and linguistically diverse (CALD) and refugee children and families*, July 2012, p.8.

Police and FACS should participate in multicultural consultations to determine strategies for engagement with children and families – FACS Caseworker.

Cultural consultation needs to be done more consistently – Health Manager.

Only a small number of respondents provided reasons as to why cultural consultation does not occur as frequently as they believe it should. A few commented on lack of access to appropriate people or resources to consult. In this context, while we did not seek CALD workforce data from the partner agencies, a small number of respondents indicated that a more culturally diverse JIRT workforce would also assist to improve the response to CALD children and young people. The witness intermediary pilot was also identified by a small number of respondents – mainly CAS staff – as being beneficial for this cohort.

Limited resources and time constraints associated with the JIRT interview process were also mentioned as factors inhibiting cultural consultation. If adequate information gathering and consultation is not taking place as it should, then cultural competency is one aspect of practice that is likely to suffer. The role we envisage for a child advocate could assist in bridging some of these gaps, for example, by helping to source relevant information to inform a response to CALD children, and liaising with relevant local services. In addition, people with local knowledge of a child's particular community could inform the work of an intermediary in conducting their assessment of a child or young person's communication needs prior to an investigative interview.

15.3.3. Use of interpreters

Just over 20% of survey respondents commented on issues relating to the use of interpreters. Half of these respondents indicated that there is a need for JIRT to have better access to interpreters, particularly in rural and remote parts of the state. Challenges associated with relying on telephone interpreters were noted, as was the need for better and faster availability of specialist interpreters who are familiar with the investigative process and competent and confident in translating discussions that relate to the sexual and physical abuse of children:

Greater access to facilitate interviews with non English speaking children [is] needed, as there is virtually no access to local interpreters in rural areas – CAS Investigator.

In regional and remote NSW access is limited to telephone interpreters and cannot [be] organised when Level 1 responses are required – FACS Caseworker.

We need more timely access to interpreters to improve response times – FACS Manager.

We note that issues relating to the use of interpreters, particularly in rural and remote areas, are not unique to the JIRT program. However, we recommend that the JIRT partner agencies further examine the concerns raised by respondents to the workforce survey about access to interpreters, and if founded, take steps to address these with the appropriate agencies.

15.3.4. Tapping into the broader CALD community engagement activities of each partner agency

Equal numbers of respondents to the JIRT workforce survey from each partner agency – 14% overall – commented on the need for better engagement with/education of CALD communities:

In the same way that community engagement has worked to increase disclosures in Aboriginal communities we should be doing it in CALD communities but the JIRT arrangement is limited in its resourcing to support this – CAS Team Leader.

JIRT needs to engage more with local community so that there is support for what we are doing and children can go to people in the community for support during the JIRT process if required – FACS Manager.

Many of the observations about community engagement in our chapter on Aboriginal children are also relevant to a discussion about how the JIRT program can improve the way it responds to children and young people from CALD backgrounds. To that end, JIRT agency staff need to have a good awareness of what culturally responsive service provision involves and knowledge of the communities they service, including resources they can access for advice and assistance. Enhanced training and procedures, as discussed above, are required to support this.

However, JIRT units' ability to engage with communities in an intensive, ongoing way is limited by the reactive, crisis-driven nature of their work and by their already very full workloads. The JIRT program's effectiveness in responding to children and young people from CALD backgrounds substantially relies on the local service arms (community service centres, Local Area Commands, and local health districts) of each JIRT agency building strong relationships with the local communities they service. In this regard, it is essential for each agency to support the JIRT program through its broader engagement activities.

Hunter New England CALD child protection forum

FACS presents the Mary Dimech Multicultural Awards each year, to recognise FACS staff who do outstanding work with multicultural clients and communities. In 2016 the team award was won by FACS Hunter New England district, for organising a CALD Child Protection Forum on collaboration and practice. With the help of the District's Multicultural Advisory Committee, over ninety people attended from a range of non-government and government services. People at the forum said that it provided them with a much better understanding of what child protection caseworkers do, and how to work with FACS and migrant and mainstream services, to support multicultural families.[728]

Working with African communities in Coffs Clarence Local Area Command (LAC)

Coffs Clarence LAC has been working over many years to build communication and cooperation with newly arriving communities from Sudan and other African nations. The LAC's engagement process includes:

- Increasing what newly arrived communities know about police and the law through communication strategies including information sessions delivered by local officers in collaboration with English learning centres and settlement service providers. Police have also been trained in relation to some of the issues that impede communication and trust between them and newly arrived communities.
- Identifying what police and communities need through consultation including research, meetings and interviews with officers, community members and local service providers. Consultations identified the development of a support persons register as a means of improving interaction and partnership between police and newly arrived communities.
- Training and engaging community members as support persons to work actively with police, offenders, victims, witnesses and the wider community to foster trust, good working relationships and positive outcomes for police and community members. The community actively works with the LAC to recruit, train and mentor support persons as well as engage communities as needs arise.[729]

728 Multicultural NSW, http://www.multicultural.nsw.gov.au/.
729 NSW Police Force, *NSW Police Force Priorities for Working in a Culturally, Linguistically and Religiously Diverse Society and Multicultural Policies and Services Forward Plan 2011- 2014*, p.14.

However, there is also scope for the JIRT program, at both a state-wide and local level, to leverage off the substantial existing capacity within each JIRT agency for driving improved engagement with and service delivery to CALD communities:

- NSW Health is guided by the *Policy and Implementation Plan for Healthy Culturally Diverse Communities*. Its resources include the NSW Multicultural Health Communication Service, Health Care Interpreter Services, Multicultural Health Units in LHDs, the NSW Refugee Health Service and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors.
- FACS is guided by *Diversity Matters: Cultural Diversity Framework*. Its resources include a Multicultural Services Unit, a Multicultural Advisory Group, District Multicultural Advisory Committees and child protection multicultural caseworkers.
- The NSW Police Force is guided by *Priorities for Working in a Culturally, Linguistically and Religiously Diverse Society*. Its resources include a Corporate Sponsor for Cultural Diversity; the Cultural Diversity Team, Operational Programs and a network of LAC based Multicultural Community Liaison Officers.

In this regard, we suggest that the JIRT SMG gives consideration to how the JIRT program could more strategically and systematically utilise existing resources within the three partner agencies to strengthen the JIRT program's response to children and young people from CALD backgrounds, for example by:

- Developing a 'JIRT community engagement workshop' that can be tailored to the needs of particular CALD communities – similar to the Aboriginal community engagement workshop that is currently delivered, but drawing on the broader engagement activities of each 'line agency'.
- Delivering targeted training to JIRT agency staff about issues specific to particular CALD communities that are significantly represented in their location.
- Developing a referral and resources pathway for JIRT agency staff to access cultural and linguistic advice and support as they require it, including tapping into existing knowledge of and contacts held by local arms of each partner agency.

Recommendations

40. The JIRT partner agencies should individually and collectively ensure, having regard to the observations in section 15.1, that data about outcomes facilitated by the JIRT program for children and young people is disaggregated by CALD status and monitored.

41. The JIRT partner agencies should, in consultation with relevant expert advisors (such as the specialist cultural diversity resources existing within each partner agency, Multicultural NSW and Ethnic Community Services Cooperative), review the adequacy of the training that is provided to frontline JIRT staff about working with CALD children, young people and families.

PRACTICE SUGGESTIONS

- The JIRT partner agencies should, having regard to the observations in section 15.3, amend the *JRU Process Guidelines* and *Local Planning and Response Procedures* to provide practical guidance about responding to reports involving children and young people from culturally and linguistically diverse backgrounds.
- The JIRT partner agencies should consider how the JIRT program can more effectively utilise specialist cultural diversity resources within the three partner agencies to strengthen JIRT's response to children and young people from culturally and linguistically diverse backgrounds, for example, by:
  - Developing a JIRT community engagement workshop that can be tailored to the needs of particular CALD communities – similar to the Aboriginal community engagement workshop that is currently delivered, but drawing on the broader engagement activities of each 'line agency'.

- Delivering targeted training to JIRT staff about issues specific to particular CALD communities that are significantly represented in their location (such training should focus on the specific communities, or backgrounds, which have particular vulnerabilities – such as children and young people who came to Australia as refugees; have limited English; have experienced trauma or are from particular cultures where speaking out to authorities is not the norm).
- Developing a referral and resources pathway for JIRT staff to access cultural and linguistic advice and support as they require it, including tapping into existing knowledge of and contacts held by local arms of each partner agency.

- The JIRT partner agencies should formalise a position on the type of circumstances where 'cultural consultation' should be routinely sought by JIRT staff in responding to reports about children and young people from culturally and linguistically diverse backgrounds; and if so, ensure that adequate guidance is provided in the *JRU Process Guidelines* and *Local Planning and Response Procedures* about where such advice can be accessed.
- The JIRT partner agencies should further examine the concerns raised by respondents to the workforce survey about access to interpreters and if founded, take appropriate steps to address these concerns with the relevant agencies.

Chapter 16. Children and young people in out-of-home care

As the work of the Royal Commission into Institutional Responses to Child Sexual Abuse has demonstrated, children and young people living in out-of-home care (OOHC) are at heightened risk of abuse, particularly sexual abuse. The Commission's March 2016 consultation paper about the sexual abuse of children in OOHC reported that just over 40% of all allegations of abuse recounted during its 4,700 private sessions held to that point were reported to have occurred in OOHC. The Commission held a public hearing focusing on the OOHC system in March and June 2015, and several of its public hearings have examined both historical and contemporary cases of abuse in OOHC.[730]

As the Royal Commission has observed:

> *Children in OOHC are particularly vulnerable to sexual abuse due to previous sexual harm and other victimisation, social or economic deprivation, family trauma and dislocation from family... Unlike children who are victimised in other institutional settings, many children in OOHC face additional disadvantage because they have lost their connection to family, community and culture (noting that this may not always be the case for children in kinship/relative care). The cumulative harm that many children experience prior to entering care can adversely affect their development. It can also affect their capacity to form trusting relationships conducive to disclosing abuse and promoting their safety.*[731]

While all children and young people in OOHC are vulnerable by virtue of their circumstances, this vulnerability is heightened for the small number living in residential care placements – the majority of whom have experienced severe abuse and/or neglect.[732] These children and young people often have very high support needs, displaying challenging behaviours that cannot be adequately accommodated in home-based care. Challenging behaviours can involve risk taking, poor impulse control, and resistance to boundaries, and in some situations, can escalate into violent and/or criminal behaviour.[733] Typically, young people in residential care have experienced numerous prior placement breakdowns.

The incidence of child sexual abuse is believed to be higher for young people in residential care settings than in other forms of OOHC and the broader general population. While the Royal Commission has commented on 'the poor state of knowledge nationally in relation to the current incidence of child sexual abuse in OOHC', its analysis of available data indicated that '33% of sexual abuse reports over the period 2012-13 and 2013-14 we received from government and non-government organisations were about children in residential care.'[734] Research conducted in the Netherlands and cited by a recent research paper commissioned by the Royal Commission estimated that 28% of young people in residential care had self-reported that they had been sexually abused whilst in care.[735] The Commission has also observed evidence that many survivors of child sexual abuse in residential institutions also experienced physical abuse, psychological maltreatment and neglect while in OOHC as children.[736]

730 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.13.

731 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.16. (i).See, for example: L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Family Matters,* No 70*,* 2005, pp.38–45; D Finkelhor & J Dzuiba-Leatherman, 'Victimization of Children', *American Psychologist*, vol 49(3), 1994, pp 173–183; D. Finkelhor, *Child Sexual Abuse: New Theory and Research*, The Free Press, New York, 1984, pp.56–57).

732 Tim Moore, Morag McArthur, Steven Roche, Jodi Death, Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, p.13.

733 Other examples of challenging behaviour include stress intolerance; alcohol and other substance abuse; self-harming; behaviours; social isolation and limited capacity to form relationships with peers and/or adults; sexually inappropriate behaviour; anti-social behaviours, including aggression and or violence towards people, and in some instances, criminal behaviour. (See NSW Department of Community Services, *Out-of-home Care Service Model – Residential Care*, April 2007.)

734 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.5.

735 Tim Moore, Morag McArthur, Steven Roche, Jodi Death, Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, p.16.

736 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.80.

Our own data from the reportable conduct scheme indicates that over half of the 1,169 reportable conduct matters that we finalised in 2016 related to the OOHC sector. One quarter of the 427 matters relating to sexual abuse and misconduct related to the OOHC sector. Allegations relating to OOHC were more likely than allegations relating to other sectors to relate to physical abuse (41% of OOHC notifications compared to 33% of all notifications) or neglect (28% compared to 18%);[737] and less likely to relate to sexual abuse or misconduct (17% compared to 37%). Of the sexual abuse and misconduct matters that we finalised in 2016, 21% were sustained. By way of comparison, the sustained rate for sexual abuse and sexual misconduct for the schools sector is generally 5-10% higher than it is for the OOHC sector.

The lower notification rate for sexual abuse and misconduct in the OOHC sector is consistent with evidence to the Royal Commission that children and young people who are abused in OOHC face barriers to disclosure that are often connected to their heightened lack of power and authority as a result of their care circumstances.[738] Our consultations suggest that other factors creating barriers to disclosure include the 'culture' of a child or young person's care placement (whether the care environment is experienced as safe and supportive); impacts arising from complex trauma; and normalisation of abuse arising from the child's previous experiences and the experiences of their peers in care.

Through our monitoring of the delivery of community services, including OOHC, and our role in oversighting allegations of reportable conduct arising in OOHC, we have made a range of observations about the systemic response to sexual abuse against children in OOHC which we have brought to the Royal Commission's attention.[739] These observations, together with the Royal Commission's work on this subject, have informed our assessment of the extent to which the JIRT program is adequately responding to children and young people in OOHC. We have also relied on information provided by the JIRT partner agencies, the JIRT workforce survey, and our consultations with a range of external stakeholders, including the Association of Children's Welfare Agencies (ACWA – the peak body for OOHC agencies in NSW) and AbSec (the peak body providing OOHC policy advice on issues affecting Aboriginal children and young people).

16.1. The out-of-home care system in NSW

As at 30 June 2016, there were 18,659 children living in out-of-home care (OOHC) in NSW.[740] The number of children and young people in OOHC has doubled over the past ten years, increasing by more than 1,000 in the year to 30 June 2016 alone.[741]

Aboriginal children are substantially over-represented in the OOHC system – they comprise 37% of children in OOHC[742] and are around ten times more likely to be in OOHC when compared to their non-Aboriginal peers.[743] The OOHC population also includes a large number of children with disability – in February 2016 FACS advised us that recent sampling work indicated that a sizeable number (12%) of children in OOHC have a disability.

Of the children and young people in OOHC at 30 June 2016:

- 48% were in relative/kinship care placements
- 43% were in foster care placements, and
- 4% were in residential care.[744]

737 Allegations of physical abuse and neglect that constitute reportable conduct may not meet the threshold for a referral to the JIRT program.
738 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.27.
739 NSW Ombudsman, *Submission to Royal Commission's Consultation paper on institutional responses to child sexual abuse in OOHC*, April 2016; *Submission to Royal Commission's Issues paper on preventing sexual abuse of children in OOHC*, January 2014.
740 NSW Department of Family and Community Services, *Quarterly report on services for children and young people*, Quarter 4, 2015-2016.
741 NSW Department of Family and Community Services, *Quarterly report on services for children and young people*, Quarter 4, 2015-2016.
742 NSW Department of Family and Community Services, *Quarterly report on services for children and young people*, Quarter 4, 2015-2016.
743 NSW Department of Family and Community Services, *Annual Statistics* (dashboard 8), 2014-2015.
744 The remaining 5% were in supported accommodation, independent living placements, or placements with parents. (*Quarterly report on services for children and young people*, Quarter 4, 2015-2016).

While the number of children and young people in residential care is small, this cohort includes some of the most disadvantaged, vulnerable and challenging young people in the OOHC system. The placement of these young people in residential care – which is generally considered to be the placement of 'last resort' – aims to provide a safe and supportive environment in which to address the combined impacts of abuse, neglect and separation from family. In NSW, residential care is primarily provided by accredited non-government OOHC agencies funded by FACS.

16.1.1. Current OOHC reforms

In November 2015, the NSW Government commissioned an independent review of the OOHC system ('Tune review') in response to the continuing increase in the number of children and young people placed in care. The review found that the growth in the OOHC population is unsustainable, and that the current OOHC system is failing to improve long-term outcomes for children and to arrest intergenerational abuse and neglect. Among the systemic issues identified by the review was a failure to respond to the needs of very vulnerable children, young people and their families using a 'client centred' (as opposed to a 'program-centred') model of service delivery.

Their Futures Matter – the government's reform agenda in response to the findings and recommendations of the Tune review – was announced in November 2016. The reform introduces tailored support packages for children and families to ensure that families receive appropriate and evidence-based services; enhanced monitoring of the effectiveness of these services; and a single 'commissioning entity' in FACS with influence over all cross-government funding for vulnerable children and families, so that commissioned services are coordinated and holistic. The reforms will initially be targeted at children under 12 in residential care – we had previously raised concerns with FACS about the recent growth in this cohort.[745]

In November 2016, FACS and ACWA also released a draft *Therapeutic care framework for NSW*, a set of principles to guide the consistent delivery of 'therapeutic care' across the OOHC sector. Therapeutic care for a child or a young person in OOHC is:

> *An holistic, individualised, team-based approach to the complex impacts of trauma, abuse, neglect and separation from families and significant others; and other forms of severe adversity. This is achieved through the provision of a care environment that is evidence driven, culturally responsive and provides positive, safe and healing relationships and experiences to address the complexities of trauma, adversity, attachment and developmental needs.*[746]

The final framework was released in April 2017.

The NSW Government is currently redesigning the residential care system, with a focus on the provision of Intensive Therapeutic Care (ITC) through individualised packages for children and young people. The ITC model is intended to support children and young people over 12 with high and complex needs that cannot be met in a family-based or foster care placement by:

- Addressing individual needs through the provision of therapeutic care with a strong focus on healing from trauma.
- Doing more to keep children and young people safe.
- Providing clear pathways to less intensive service types and permanency.
- Providing a broader range of options for children and young people to achieve outcomes, particularly around health and education.

Therapeutic Specialists will be introduced to act as practice experts and be responsible for oversighting and coordinating therapeutic case plans for children and young people.

While FACS previously advised that new service provider contracts were due to commence in July 2017,[747] at the time of writing we understand that the timeframe is unclear.

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745 NSW Ombudsman, *Submission to NSW Legislative Council Purpose Standing Committee No. 2 Inquiry into Child Protection*, August 2016.
746 NSW Department of Family and Community Services and Association of Children's Welfare Agencies, *Draft NSW Framework for Therapeutic Out of Home Care*, October 2016.
747 http://www.community.nsw.gov.au, accessed 3 April 2017.

FACS is also investing in a new Trauma Treatment Service for children in OOHC. The service will employ a multidisciplinary team to work with children suffering trauma from exposure to abuse and neglect by applying evidence-based interventions selected through a comprehensive assessment of the child. Finally, FACS is establishing an 'intermediary organisation' to act as a subject matter expert on trauma informed therapeutic care for children and young people in statutory OOHC. Among other things, it will be responsible for the workforce development of ITC service providers.[748]

16.2. How JIRT responds to reports about children and young people in OOHC

Although they are among the most disadvantaged and vulnerable children and young people in the state, and at significantly increased risk of sexual abuse, there are no special provisions governing the way that reports of serious child abuse involving children in OOHC are assessed by the JRU when considering whether a referral should be accepted for a JIRT response.

The JIRT partner agencies do not record or monitor disaggregated data about interventions or outcomes in relation to referrals to the JRU, and referrals accepted into the JIRT program, that involve children and young people in OOHC. This means it is not possible to systematically assess how the JIRT program is responding to this cohort of children and young people compared to others referred to the program.

As we have also recommended in relation to data about Aboriginality and disability, it is important that the JIRT partner agencies are able to more effectively report on and monitor their work with children in OOHC (including being able to disaggregate any data for children in OOHC by those who are Aboriginal or have a disability).

We understand that the agencies have already taken some steps to improve their data in this area. In March 2016, the Royal Commission drew attention to inadequacies in the collection of data about the sexual abuse of children and young people in OOHC. It released a six point data collection model which provides for the collection of data relating to incidents of alleged sexual abuse in OOHC, as well as the therapeutic and criminal justice responses to those reports.[749]

At a public hearing held by the Royal Commission in March this year, which examined the response of Commonwealth, State and Territory governments to allegations of sexual abuse, the FACS Secretary, Mr Michael Coutts-Trotter, gave evidence that FACS has made significant changes to its data collection processes, with a view to ensuring that it can comply with the requirements of the six point model. While Mr Coutts-Trotter noted that there were some issues with the data capture to date, he indicated that these should be resolved by the ChildStory database rollout later this year.[750] This is clearly a very positive development. Once any current data integrity issues are resolved, the JIRT agencies will be well placed to report on the outcomes for children and young people in OOHC who have been referred to the JIRT program.

Our office has agreed to work closely with FACS as it refines its processes for collecting data about the alleged abuse of children in OOHC (including allegations of abuse by a carer or OOHC agency employee; and allegations of abuse or harm by another child or young person). The FACS Secretary recently indicated his support for monitoring the issue of 'OOHC data enhancements' via the 'FACS/ Ombudsman Integrated Governance Framework', the process we use to monitor FACS' progress in responding to systemic issues identified in the course of our oversight.

748 Advice provided by FACS in June 2017 in response to NSW Ombudsman draft report, *Reviewable Deaths in 2014 and 2015, Vol.1: Child Deaths*.

749 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in OOHC*, March 2016.

750 Transcript of Mr Michael Coutts-Trotter, Secretary of NSW Family and Community Services, Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 51 (Day 257)*, Transcript 7 March 2017.

About one in five respondents to the JIRT workforce survey expressed the view that the JIRT program's response to children and young people in OOHC is unsatisfactory or poor. As discussed below, our consultations also identified a number of areas where the response by the JIRT program to reports involving children in OOHC could be improved.

Interestingly, many survey respondents took the opportunity to comment not only on how the JIRT program is responding to this cohort of children and young people, but on the OOHC system more broadly. In this regard, several respondents observed perceived inadequacies in relation to the availability of appropriate placements, assessment of placement suitability and carer screening – issues we have raised for a number of years through our monitoring of the delivery of community services and oversight of reportable conduct matters. The CAS indicated that it was not uncommon for children and young people in OOHC to be the subject of multiple JIRT referrals; however, the challenge for the JIRT agencies is getting these children and young people to disclose abuse in circumstances where there are issues in play with the security and suitability of their placement.

The frustration expressed by JIRT agency staff, whose contact with children and young people in OOHC takes place at the 'pointy end' of the child protection system, is understandable. While it is not their role to resolve the challenges confronting the OOHC system, many of which are being addressed by FACS through its various reforms, these staff have a critical responsibility to ensure that vulnerable children and young people in care are not further traumatised, stigmatised or placed at additional risk through their interactions with the JIRT agencies. In turn, this depends on all JIRT staff having a clear appreciation of the vulnerability of these children and the impact of complex trauma, and on the capacity and responsiveness of FACS and Health more generally, in providing quality services and supports to children and young people in care who are accepted into the JIRT program. A number of JIRT agency staff we consulted noted that the JIRT program will have limited impact if broader service system challenges are not addressed.

16.3. Engagement and communication between JIRT and OOHC agencies

The most common issue raised in the JIRT workforce survey about reports involving children and young people in care was the need for better engagement, communication and/or coordination between JIRT agencies at the local level and the Community Services Centre or OOHC agency responsible for managing the care arrangements of the child the subject of a 'JIRT accepted' report. This issue was mainly raised by FACS staff. We also received similar feedback from representatives of NGO OOHC agencies, who are keen to work more closely with the JIRT agencies to support the child/carer and, where relevant, manage risks where the alleged perpetrator is a carer or staff member.

A key theme arising from both the workforce survey and our OOHC sector consultations was the importance of the JIRT partner agencies and the OOHC sector having a clear understanding of one another's roles and responsibilities when a report about a child in OOHC is accepted for a JIRT response. In oversighting the reportable conduct scheme, we have long recognised that this can be a difficult space for agencies (in the OOHC sector and for child-related sectors generally) to work in. The training our office delivers to agencies within the reportable conduct scheme (including OOHC agencies) is designed to provide general advice about the role of key agencies in responding to allegations of serious child abuse, including in circumstances where an agency may be needed to respond concurrently to a criminal investigation.

Conversely, the NGO OOHC agencies we consulted suggested that it would be beneficial to improve the JIRT agencies' understanding (particularly that of Police) of their role and obligations – not only in the context of providing effective support to the alleged victim and their carer during a JIRT investigation, but also in taking appropriate risk management action in circumstances where a report relates to an allegation against a carer, an employee or another child in care. For example, they noted the importance of the JIRT agencies promptly sharing information with them about the status of a criminal investigation, or substantiation (or otherwise) that abuse had occurred.

The responses to the workforce survey also indicate there is scope for frontline JIRT agency staff to better understand the role and obligations of OOHC agencies if a child in their care has disclosed abuse – for example, a small number of respondents expressed frustration that they cannot deal directly with a child or young person's foster carers without first liaising with the OOHC agency. While there is clearly a need for OOHC agencies to facilitate prompt contact between the JIRT agencies and carers when required to inform investigations, it is equally important that OOHC agencies are informed as soon as possible that a child being managed by their agency has been referred to the JIRT program, to enable them to access any necessary services for the child, and help the carer in supporting the child.

Police already have Standard Operating Procedures (SOPS) that give guidance to police officers about responding to employment-related criminal child abuse allegations against employees of agencies responsible for the provision of services to children and young people. The SOPS are essentially a guarantee of service from Police to agencies within our reportable conduct jurisdiction about how they will support their investigations and related risk management. However, it is important for frontline JIRT agency staff to be cognisant of the role that agencies play above and beyond the need to manage risks associated with allegations against carers or staff.

In this regard, in December 2014 we hosted a forum, in partnership with AbSec and the NSW Police Force, aimed at strengthening the understanding of the respective responsibilities of Aboriginal OOHC agencies and Police in responding to allegations against carers, and building closer relationships between Police and local Aboriginal communities. The forum was attended by 160 participants from Aboriginal OOHC agencies, Police, FACS, the OCG and ACWA.

To keep the momentum generated by the forum going, we recommended that a number of the outcomes and commitments should be built into the ongoing monitoring and accountability framework for the NSW Police Force's *Aboriginal Strategic Direction* (ASD). The NSW Police Force Corporate Spokesperson for Aboriginal issues agreed with this approach. Police agreed to invite their local Aboriginal OOHC agencies to participate in their Police Aboriginal Consultative Committees across the state. In addition, 'strengthening the relationship between Aboriginal OOHC agencies and police commands' was made a standing agenda item for the Police Aboriginal Strategic Advisory Committee forum for 12 months, so that good practice and systemic concerns could continue to be identified and acted upon. While the forum and the related outcomes were positive, we recommend that the ongoing implementation of these commitments should be closely monitored.

More generally, there would also be benefit in the JIRT training sub-committee seeking to work with ACWA and AbSec to develop a factsheet outlining the JIRT process, and the obligations on JIRT and OOHC agencies to work cooperatively in responding to reports of serious child abuse about children and young people in OOHC. Our office would be more than happy to work with the JIRT agencies and peak bodies to assist in preparing guidance, as we did with the Police employment-related child protection SOPS. As we discuss in Chapter 24, there is also scope for specific information about working with OOHC agencies (as well as other key stakeholders such as schools and early childhood services) to be incorporated in the JIRT Foundation Skills Program, and in the updated *Local Planning and Response Procedures*.

16.4. Better guidance for carers in handling disclosures

As well as identifying the need for better liaison between the JIRT agencies and OOHC providers, AbSec and a number of Aboriginal OOHC agencies have previously raised concerns with our office about the importance of foster carers being adequately equipped to respond appropriately when a child first makes a disclosure. For example, we have been told that carers are often uncertain about how they should go about questioning a child so as not to prejudice a potential criminal inquiry, while at the same time, avoiding the child 'shutting down' completely.

We understand that following our December 2014 Aboriginal OOHC agency forum, work was progressed by the JIRT agencies to develop a course for foster carers on what to do when a child in care discloses abuse. A session on this topic was delivered by the JIRT agencies at the 'OOHC Critical

Incidents' forum convened by FACS in 2015 and was well received. There would appear to be merit in the JIRT training sub-committee working with ACWA and AbSec to adapt the 'Facilitating Disclosures Workshop' developed by NSW Health for the OOHC context with the aim of open sessions being offered – ideally, a few times a year. In suggesting that the JIRT training sub-committee have input into the development of such a course, it is important to note that we are not advocating that such it be delivered by the JIRT agency staff given the already significant demands on their time. In addition, our office would also be prepared to assist in the broader delivery of such a course through our community and education training arm.

16.5. Understanding the vulnerability of children and young people in OOHC and the impact of trauma

Another theme arising from the workforce survey was the need for JIRT staff to have a better understanding of the situation of children and young people in OOHC – particularly the impact of trauma – and enhanced training about working effectively with them:

> *Children in OOHC are the most vulnerable group and an awareness of this vulnerability needs to be instilled through training* – FACS Caseworker.

> *Additional training and incorporation of knowledge around complex trauma into the planning for interviews etc, and more training on understanding the difficulties these children have in disclosing when they don't feel safe [is required]* – Health Clinician.

> *More training and information [should be made] available to staff about working with this group* – CAS Investigator.

Some comments from survey respondents appeared to suggest a limited understanding of the link between complex trauma and challenging behaviours (particularly risk taking and resistance to boundaries) exhibited by some children and young people in OOHC.

A related theme arising from the workforce survey, particularly in responses from Health staff, was the need for the JIRT program to take a more flexible approach to interviewing children and young people in OOHC. In particular, respondents stressed that children in OOHC are more likely to have complex attachment issues resulting from their histories of trauma, and that many do not like engaging with police. It was noted that these factors need to be taken into account as part of planning for the forensic interview. A number of Health staff suggested that the JIRT agencies need to be prepared to engage in more extensive rapport building with this cohort (particularly children and young people living in residential care settings); take a 'long range' view to achieving a positive outcome; and be flexible about where interviews take place. The CAS acknowledge that 'diving in too early in relation to conducting a police interview with this cohort' can lead to non-disclosure and the need for additional interviews, which increases the likelihood of conflicting statements being given which can compromise the criminal investigation, and add further trauma to the child or young person involved. For these reasons, the CAS supports carefully executed rapport building leading up to the police interview for children in OOHC provided the delayed interview does not put the particular child's safety at risk.

Related to this, a small number of respondents commented on the need for the LPR process to be more effectively utilised for reports about children and young people in care so as to ensure that their child protection history, possible impacts of trauma in the interview context and suitable techniques for addressing these are identified and discussed. For example, young people in residential care placements should have Individual Behaviour Support Plans, which outline positive strategies to assist carers and young people to manage challenging behaviour and could also help to inform the recorded criminal interview and other components of the JIRT response.

Based on feedback to this inquiry, we suggest that the *Local Planning and Response Procedures* are amended to provide specific guidance about factors that should be considered in responding to reports that involve children and young people in care – including the need for interviews to be informed by appropriate information, and more communication with OOHC agencies and (where appropriate) carers.

The JIRT Foundations Skills Program does not provide any specific guidance about the vulnerabilities of children and young people in OOHC; the challenging behaviours that some such children may exhibit and the link between these behaviours and complex trauma; or useful strategies for JIRT staff to use when engaging with this cohort. In light of their particular vulnerability and significant over-representation as victims of sexual abuse, this gap should be rectified. In this regard, it is worth noting the excellent work of Police, FACS and ACWA in implementing a joint protocol which we brokered in 2015, aimed at reducing the contact of young people in residential OOHC with the criminal justice system in August 2015 (see case study below). The training that has been developed to support frontline police and residential care workers to understand and implement the protocol provides a good template for training JIRT agency staff on engaging young people in residential care – for example, it includes a number of training scenarios that demonstrate the particular vulnerabilities and barriers to disclose that may exist for children in residential care.

Case study 10 – Joint Protocol to reduce the contact of young people in residential OOHC with the criminal justice system

The challenging behaviours exhibited by many young people in residential care can lead them to come into contact with police at a greater frequency than other young people.[751] The Protocol is underpinned by a shared acknowledgement that challenging behaviours are best managed using trauma-informed approaches, consistent with principles of therapeutic care, that support the young person while also ensuring the safety of others. It aims to:

- Reduce the frequency of police involvement in responding to behaviour by young people living in residential services, which would be better managed solely within the service.
- Promote the principle that criminal charges will not be pursued against a young person if there is an alternative and appropriate means of dealing with the matter.
- Promote the safety, welfare and wellbeing of young people living in residential services, by improving relationships, communication and information sharing both at a corporate level and between local police and residential services.
- Facilitate a shared commitment by police and residential services to a collaborative early intervention approach.
- Enhance police efforts to divert young people from the criminal justice system by improving the information residential services provide police about the circumstances of the young person to inform the exercise of their discretion.
- Ensure that appropriate responses are provided to young people living in residential services who are victims.

The Police and FACS (together with ACWA and AbSec) are signatories to the Protocol and have been actively promoting it to their workforce. A range of communication strategies have been used by Police to promote the Protocol and the obligations on police to adhere to it. The FACS Minister has also written to all residential OOHC services to inform them of the Protocol and the need to implement it. Information about the Protocol has been circulated to FACS staff and OOHC agencies through existing governance structures in each of the FACS districts, and resources have been produced for frontline service staff. AbSec's two accredited OOHC agencies are actively developing

751 Legal Aid NSW, *The Drift from Care to Crime: A Legal Aid NSW Issues Paper*, October 2011. According to the Children's Legal Service, a large number of their 'high service user' clients have a history of being in OOHC, with a significant proportion of these having lived in residential care services.

the local relationships necessary to put the Protocol into practice. ACWA is informing residential services about the protocol and developing online training to provide further support. Police are also delivering training with FACS/ACWA to residential care staff, and have rolled out training to police commands on the Protocol.

Consistent implementation of the Protocol by local police and residential OOHC services is an important way of encouraging young people in residential care to feel confident about disclosing abuse, and engaging with police when they do so.

16.6. Enhancing access to JIRT for children and young people in residential care

The size of the OOHC population in NSW means it would be unviable to mandate that *all* serious child abuse reports about children and young people in care must receive a JIRT response regardless of whether or not the report meets the JIRT referral criteria. (In NSW, if a child in care is the subject of a JIRT referral, it will only be accepted for a JIRT response if the referral meets the JIRT Referral Criteria.) While Western Australia and Queensland take a different approach to responding to reports of serious child abuse involving children and young people in care, the OOHC population in NSW is substantially larger (more than five times that in Western Australia and double that in Queensland).[752]

However, as set out in Chapter 9, we are of the view that there is a strong case for providing enhanced access to JIRT for the comparatively small number of children and young people living in residential care (681 at the end of June 2016), because the evidence indicates that they are among the most vulnerable children and young people in the state.

Research for the Royal Commission has identified a range of individual, systemic and structural factors that increase the vulnerability of young people in residential OOHC to sexual abuse, including:

- the institutionalised and hierarchical nature of many residential care settings
- high turnover of staff and young people
- the mix of young people in care, including co-placement of young people who have displayed problematic sexual behaviours with young people who have been sexually abused
- a hypersexual peer culture resulting from a high rate of previous experience of sexual abuse among young people in care, and
- a prevailing attitude that young people placed in residential OOHC are 'problem' children.[753]

In interviews with children and young people in residential care conducted as part of this research, many of the interviewees reported that they did not feel safe in residential care due to the threat of physical violence and sexual assault from their peers and outsiders. Many were ambivalent about the capacity of residential care staff to protect and support them and most had limited connections to other trustworthy adults.[754]

752 In Western Australia, the CAS (which operates in the Perth metropolitan area) investigates the sexual and physical abuse of children within the care of the Department for Child Protection and Family Support when the offender is 'linked' to the Department. In Queensland, SCAN teams, comprising representatives of Child Safety Services, Queensland Police, and health and education agencies, are involved in responding to certain cases, including those where Child Safety Services is responsible for ongoing intervention with the child (that is, if there is abuse within a family – including foster care – setting), where coordination of multi-agency actions is required to effectively assess and respond to the protection needs of the child. Unlike JIRT, the focus of SCAN teams is not joint investigation of child abuse, rather information sharing and discussion to support each agency to fulfil its own responsibilities.

753 Tim Moore, Morag McArthur, Steven Roche, Jodi Death and Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, p.17.

754 Tim Moore, Morag McArthur, Steven Roche, Jodi Death and Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, pp.7-8.

In addition to being more vulnerable to abuse, children and young people in residential OOHC also face unique barriers to disclosing sexual abuse. These barriers are associated with:

- previous negative experiences of contact with police
- fear of removal from the placement, compounded by limited alternative placement options, if the abuse has occurred in the current placement, and
- complex trauma histories that may impact on an individual's capacity to articulate a single, clear disclosure.

For these reasons, reports about the sexual abuse of children and young people in residential care may be less likely to be accepted for a JIRT response, as the JIRT referral criteria requires a 'disclosure and/or evidence of sexual assault'. We have recommended in Chapter 9 that the JIRT criteria be extended to provide better access to the JIRT program for children and young people in residential care, by allowing reports to be accepted for a JIRT response where there is no clear disclosure, but there are indicators of abuse present.

FACS has recently advised us that it is in the process of establishing a 'virtual team' of specialist caseworkers, located across FACS Districts and coordinated by the Cross Cluster Operations and Business Support Directorate, who will provide a holistic assessment for children and young people in residential care where a ROSH report is received and the risk of harm is 'associated with the placement' (for example, an allegation against a staff member or another resident). The specialist caseworkers will work together with caseworkers from both CSCs and JIRT units (where applicable) to ensure that a comprehensive and coordinated response is provided. This is a positive development which recognises the special vulnerability of children in residential OOHC.

In our view (as discussed in Chapter 10), given the need to provide wraparound responses to this particularly vulnerable cohort of children and young people, we believe there would be merit in the JIRT agencies (together with agencies, such as Education, Juvenile Justice and peak OOHC bodies/large providers), developing a state-wide framework or model to more effectively address child sexual exploitation informed by the Victorian and UK models outlined above.

Finally, like the other particularly vulnerable groups of children and young people we have discussed in this Part, the establishment of a trial of the Child and Family Advocate role within the JIRT program will significantly benefit children and young people in residential care placements – particularly given the complexity of their support needs and in many cases, the absence of other trusted adults in their lives who can act as advocates. In this regard, it will be critical for Child and Family Advocates to work closely with OOHC agencies managing the placements of young people in residential care (and OOHC more broadly) to ensure a coordinated, planned approach is taken to addressing their identified needs.

16.7. Young people who engage in harmful sexual behaviour towards other young people

As well as children in OOHC being at heightened risk of sexual abuse by adult perpetrators, research suggests that children in residential OOHC are particularly likely to be exposed to 'problematic peer sexual behaviour'.[755]

As we discuss in the following chapter, as well as ensuring that there is comprehensive collection and monitoring of data relating to allegations of abuse perpetrated against children in OOHC, it is equally important for this to occur with respect to children and young people in OOHC (and other institutions) who are alleged to have harmed their peers. It is also important that improved data collection and analysis is accompanied by robust monitoring or oversight of the response to allegations of serious 'child-to-child' incidents in institutional settings, to ensure that both victims and those children and young people who have caused sexual harm receive an appropriate service response.

755 Tim Moore, Morag McArthur, Steven Roche, Jodi Death and Claire Tilbury, Institute of Child Protection Studies, Australian Catholic University, *Safe and sound: Exploring the safety of young people in residential out of home care*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016, p.8.

Recommendations

42. The JIRT partner agencies should, having regard to the observations in sections 16.3 and 16.4, and in consultation with ACWA and AbSec, consider how best to improve engagement and communication with the OOHC sector and expand the reach of JIRT (endorsed) training for foster carers about responding to disclosures of serious abuse.

43. The JIRT partner agencies should ensure, having regard to the successful training program rolled out by FACS, Police and ACWA to support the implementation of the *Joint Protocol to reduce the contact of young people in residential care with the criminal justice system,* that training and induction for JIRT staff includes relevant information about:

- **a) The heightened vulnerability of children and young people in OOHC, particularly residential care, to sexual abuse.**
- **b) The impacts of trauma on children and young people in OOHC; the link between trauma and challenging behaviours; the principles underlying therapeutic care; and strategies for engaging effectively with these children and young people.**
- **c) The role of OOHC providers and how JIRT should engage them when responding to reports involving children or young people in OOHC.**

PRACTICE SUGGESTION

- The JIRT partner agencies should amend the *Local Planning and Response Procedures* to specify, having regard to the observations in Chapter 16, the specific factors and actions that should be considered when responding to reports about children and young people in out-of-home care.

Chapter 17. Children and young people with harmful sexual behaviours

While the primary focus of the JIRT program is, appropriately, the child victim, each of the JIRT agencies also has a strong mandate to work with children and young people (aged ten years and over) who come to their attention through the JIRT program due to their harmful sexual behaviours towards other children.[756] Harmful sexual behaviour occurs on a spectrum, but 'typically includes concerning, coercive, violent and/or controlling behaviour patterns'.[757]

Health's role, as the main provider of therapeutic treatment services available for young people and their families in this area, is pivotal. Through its statutory child protection role, FACS is often required to play a role in securing therapeutic treatment and support for this cohort where they are in OOHC or where the child or young person is otherwise at risk of significant harm.[758] Police, through their commitment to diverting young people from crime, also have a role in working with partner agencies to direct young people who come to their attention due to harmful sexual behaviours towards treatment. As well, the exercise of police discretion to charge is inextricably linked to the early treatment options that are available for this cohort.

There are a number of practice areas where the views of JIRT agencies have differed during this inquiry; however, the need for a well coordinated therapeutic response for children and young people with harmful sexual behaviours is not one of them. At the outset of our inquiry, the JIRT agencies asked us to once again consider[759] this important area of service delivery. In doing so, they emphasised the need to highlight what is required to better respond to this vulnerable and high risk cohort while, at the same time, protecting others who could be harmed in future if problematic behaviours are not addressed as early as possible.

All of the JIRT partner agencies identified the limited availability of therapeutic services for children and young people with harmful sexual behaviours as one of their biggest concerns. Over 100 JIRT staff who responded to the JIRT workforce survey expressed concern about the absence of Health's New Street program (which provides coordinated, specialist treatment to young people who have engaged in harmful sexual behaviour) or other therapeutic services in some areas, and/or existing services being full and unable to accept new referrals. JIRT staff were concerned this increased the risk of continued harmful sexual behaviours and further contact with the JIRT program and/or adult criminal justice system.

Our 2012 report about responding to child sexual abuse in Aboriginal communities identified an urgent need for NSW to review its arrangements for providing therapeutic treatment for children and young people with harmful sexual behaviours. In particular, we highlighted the uncertainty about the extent to which Health's already stretched sexual assault services were able to provide specialist help to the families of children aged under ten.

Despite the (then) recent expansion of the New Street program, we also highlighted that the program was unlikely to provide the help needed to young people living outside the Sydney, Newcastle, Tamworth and Dubbo areas where these specialist programs were based at that time.

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756 In its *Consultation Paper: Institutional Responses to Child Sexual Abuse in Out-of-Home Care,* the Royal Commission identified the most common descriptors used by service providers, government departments and schools as being 'problem sexual behaviours' for children under 10, and 'sexually abusive behaviours' for children aged 10 to 18. More recently, in her opening statement to the Royal Commission's Case Study 57, Senior Counsel Assisting noted that the Royal Commission favours the term 'children with harmful sexual behaviours'. (Royal Commission into Institutional Responses to Child Sexual Abuse, March 2016). While recognising that some stakeholders prefer to retain the distinction of 'problem sexual behaviours' for children under 10, we have chosen to use the term 'harmful sexual behaviours' in this report, consistent with the Royal Commission's position.

757 Professor Aron Shlonsky, B. Albers, D. Tolliday, Dr S. Wilson, J. Norvell and L. Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended,* Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, May 2017, p.13.

758 FACS is also required to provide a statutory child protection response to children and young people who exhibit 'extremely sexualised behaviour' – this cohort of children are considered to be at risk of significant harm, as the behaviour is considered an indicator of possible sexual abuse. These reports will be 'screened in' at the Helpline and sent to the relevant community services centre for an assessment. (FACS, *Screening and Response Priority Policy and Procedures Manual*, November 2013.)

759 We had previously considered this aspect of service delivery, and made related recommendations, in our 2012 report about responding to Aboriginal child sexual abuse.

And, while Juvenile Justice (JJ) at that time offered important specialist programs and interventions – including a revamped Sex Offender Program – there were numerous impediments to helping young people with multiple and complex needs within the relatively brief time allowed by a control order or a community supervision plan.

We acknowledged that, with New Street and other small but effective specialist services, Health had demonstrated a significant commitment to establishing and extending effective therapeutic services. However, the piecemeal evolution of treatment services in NSW had left important gaps in the service system. In particular, we stressed that there was a real danger that a small but potentially high-risk group of young people were falling through these gaps, and receiving no effective agency response to their harmful sexual behaviours.

We recommended that all agencies and services with responsibilities in this area come together to consider creating a cohesive legislative and policy framework that explicitly sets out the respective roles of police, child protection, accommodation providers, and support agencies and treatment services, in supporting effective treatment strategies – including the use of treatment orders. While we noted this scheme should give priority to therapeutic treatment and emphasise the value of early intervention, parental and family involvement and voluntary participation, we also emphasised that it should also provide effective sanctions for high-risk individuals and families who do not comply with their treatment plans. In making this recommendation, we profiled the therapeutic treatment scheme in Victoria.

As we discuss in this chapter, while there have been some changes since our 2012 report, including an extension of New Street to six sites with two new services recently established at Wollongong and Nowra in March 2017, and a new treatment service by JJ based on a multi-systemic therapy, the same gaps and risks essentially remain.

The work of the Royal Commission has put the spotlight back on the issue of young people who engage in harmful sexual behaviours, particularly in the context of residential OOHC and other institutional settings. The Commission has identified the New Street Service and Victoria's Therapeutic Treatment Orders (TTOs) as innovative approaches to addressing problem or harmful sexual behaviour (PHSB).[760] It has noted:

> *Treatment is likely to be a significant priority for many children with harmful sexual behaviour. This may be particularly the case for children who are below the age at which they will be held criminally responsible for their actions. It might also be a consideration for some children who are dealt with in the criminal justice system.*[761]

Research commissioned by the Royal Commission in relation to current best evidence in the therapeutic treatment of children with harmful sexual behaviours has recently been published,[762] and the Commission is expected to report on this issue later in 2017.

The NSW Government has advised the Royal Commission that it supports consideration of rehabilitative sentencing options for children who sexually harm their peers, and will further consider this issue in the context of the Royal Commission's work in this area.[763] The government has also advised that its new Sexual Assault Strategy, which is due to be released at the end of 2017, will include a focus on responding to children and young people (10-17 years) who have engaged in harmful sexual behaviour.[764]

In this chapter, we examine the currently available therapeutic treatment options for children and young people, and how they could be more effective. We also discuss how the JIRT program responds to referrals of reports involving allegations of harmful sexual behaviour by children and young people, and changes that can be made to improve collaboration between JIRT partners in this complex area.

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760 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper: Institutional Responses to Child Sexual Abuse in Out-of-Home Care*, March 2016, p.40.
761 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.548.
762 Professor Aron Shlonsky, B. Albers, D. Tolliday, Dr S. Wilson, J. Norvell and L. Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended,* Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, May 2017.
763 NSW Government, NSW Government Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse *Consultation Paper – Criminal Justice*, October 2016, p.22.
764 Women NSW, NSW Sexual Assault Strategy: The NSW Government invites you to Have Your Say, 10 July 2017.

17.1. Prevalence of children and young people with harmful sexual behaviours

The prevalence of harmful sexual behaviour by children and young people is difficult to establish, but it is believed to be 'a significant problem that represents a substantial proportion of sexual harm to children'.[765]

In our 2012 report on responding to child sexual abuse in Aboriginal communities, we examined BOCSAR data on all NSW sexual abuse incidents reported to police in 2011. The data showed that there were 4,876 suspects of all ages identified in connection with these incidents, and of these suspects, 1,021 (20.9%) were juveniles aged 17 years or younger. Of all the sexual abuse incidents attributable to juvenile suspects, 84.5% of their alleged victims were children 15 years and younger.[766]

While this data is now five years old, it provides a picture as to the extent to which juvenile suspects are the subject of sexual abuse incident reports involving children and young people.

We also considered Police data on all reported sexual abuse offences for a five year period covering 2007-2011, which showed that only 16% of sex offences that juveniles were suspected of committing led to charge.[767]

The Royal Commission recently considered the rate of sexual offending by children and young people in its *Consultation Paper – Criminal Justice*. While the data includes juvenile offending against adults, it still provides a strong picture as to prevalence, given that available research shows that most juveniles sexually offend against their peers:

> *Despite making up a very small proportion of matters finalised in the courts, recorded crime statistics show that juvenile offenders are responsible for a significant proportion of sexual offences, and they offend at a much higher rate than the general offender population. In 2014-15, for matters where the principal offence was sexual assault, the overall offender rate in Australia for people proceeded against by police was 36.6 per 100,000. The offender rate for juveniles was significantly higher than the overall rate, at 54.5 for 10 to 14 year-olds and 83.3 for 15 to 19 year-olds*
>
> *The data shows that children between the ages of 10 and 14*[768] *commit sex offences at 1.5 times the rate of the general population and that those between the ages of 15 and 19 commit sex offences at more than twice the general population rate.*[769]

The above data does not include children and young people who have not been charged by police. There are a range of reasons why a matter involving harmful sexual behaviour by a child will not receive a criminal justice response.

NSW Health's Education Centre Against Violence (ECAV) states that it 'appears sibling sexual abuse accounts for 50% of sexual abuse of children and young people by other children and young people',[770] with 'it estimated as being five times more prevalent than parent-child sexual abuse'.[771] Despite being considered the most common type of intra-familial abuse, sibling abuse is the least reported, and the least analysed and discussed.[772] The secrecy that often surrounds sibling abuse makes it particularly difficult to determine its prevalence.

765 Professor Aron Shlonsky, B. Albers, D. Tolliday, Dr S. Wilson, J. Norvell and L. Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended,* Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, May 2017. p.6.
766 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012, p.85.
767 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012, p.201.
768 That is, children aged above 10 years and below the age of 14 years.
769 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, October 2016, p.550.
770 NSW Health Education Centre Against Violence, *ECAV Courses Available for Request List as at 1 March 2016: Working therapeutically with children & young people who have experienced sibling sexual assault*, March 2016.
771 NSW Health Education Centre Against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response: A Resource Paper Outlining the Key Issues, Evidence and Practice Considerations for Senior Health Clinicians*, 2013, pp.41-43.
772 Dale Tolliday, *Reintroducing young people to their family where there has been sibling sexual abuse*, Child and Family Welfare Association of Australia Inc. and Centre for Excellence in Child and Family Welfare 2005 National Symposium.

Reports related to the alleged sexual abuse of a sibling rarely proceed to court.[773] The victim and victim's family are less likely to support a criminal justice response in sibling abuse matters. Evidence suggests that victims struggle with concern for their offending sibling and experience guilt that their disclosure may harm their family.[774] Parents, while wanting to protect their child from further abuse, may not wish to assist in the criminal prosecution of their other child, which may result not only in a conviction and custodial sentence, but restrictions on the child's schooling; the child being subject to the *Child Protection (Offenders Registration) Act 2000*; and the child's offending subsequently being considered in Working with Children Check risk assessments. On some occasions, family members simply do not acknowledge the abuse has occurred.

In addition, the common law provides for a presumption (known as *doli incapax*), rebuttable by the prosecution, that a child under 14 years of age is unable to understand that his or her actions are seriously wrong. Section 5 of the *Children (Criminal Proceedings) Act 1987* provides that no child under ten years of age can be guilty of an offence.

The scale of the problem of children and young people who engage in harmful sexual behaviour becomes more apparent once matters that do not result in reports or criminal proceedings are considered. The Mental Health Coordinating Council and NSW Sentencing Council cite research that estimates that children and young people are responsible for about a third of all child sexual harm.[775] Other researchers estimate that children and young people are responsible for at least half of all child sexual harm.[776]

While it is well known that the problem of children and young people with harmful sexual behaviour is significant, as we discuss later in this chapter, improved data is needed in this area to inform service planning and to identify age-related factors in criminal justice system attrition and the provision of therapeutic services.

17.2. The current therapeutic framework for responding to children and young people with harmful sexual behaviour

In order to understand the JIRT response to referrals where it is alleged that the sexual harm was caused by another child or young person, it is necessary to first understand the framework in NSW for providing therapeutic support to this cohort.

Early therapeutic intervention can help prevent children and young people from engaging in continuing and/or escalating harmful sexual behaviour. Therapeutic intervention is of particular importance in sibling abuse matters, as it is likely there will be some form of ongoing family relationship where the risk of further harm will need to be managed.

Treatment strategies have moved away from those used for adult sex offenders and now emphasise more holistic, child centred, family focused interventions which recognise that the harmful sexual behaviours must be addressed in conjunction with other concerns. This means that the effects of issues such as family violence, exposure to pornography, mental health and multiple placements in care may need to be tackled along with the harmful sexual behaviours. Some children who engage in harmful sexual behaviour are also victims of abuse – both need to be addressed as part of a holistic treatment plan.

Police decisions (generally made by CAS officers participating in the JIRT response) about whether or not to charge a child or young person with a sexual offence – are highly relevant to the type and timing of any therapeutic response for the child or young person. As noted previously, the common

773 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse*, University of Sydney Law School, August 2016.

774 NSW Health Education Centre Against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response: A Resource Paper Outlining the Key Issues, Evidence and Practice Considerations for Senior Health Clinicians*, 2013, pp.41-43.

775 Mental Health Coordinating Council, *Reframing Responses, Stage Two: Supporting women survivors of child abuse —– an information resource guide and workbook for community managed organisations*, 2010, p.11; NSW Sentencing Council, Penalties relating to sexual assault offences in New South Wales, Volume 3, May 2009, p.109.

776 C. Boyd and L. Bromfield, *Young people who sexually abuse: Key issues*, ACSA No.3, Australian Institute of Family Studies, 2006.

law presumption of *doli incapax* must be rebutted by the prosecution, which means that the threshold for police in determining whether or not to charge a child (between the age of 10 and under 14 years of age) is high, and provides an important safeguard.

Where a decision is made not to charge, a child or young person who has sexually harmed a peer may receive therapeutic services provided or arranged by Health, with JIRT health clinicians largely responsible for service referrals. The care and protection system also provides a limited therapeutic response to persons who have not been charged, as outlined at section 17.2.3 below.

Where a child or young person is charged, they may receive a therapeutic response from JJ, but not unless a finding of guilt has been made. As the court process may take over two years, the laying of charges may effectively deny a child or young person therapeutic support for a considerable period of time, increasing the risk of further harmful sexual behaviour.[777]

Children and young people who are charged, but whose charges are withdrawn, dismissed or are subject to a not guilty finding, do not receive therapeutic services from JJ. They are likely to have had little ongoing contact with the health system, with Health less likely to arrange therapeutic support than at the time of the child or young person's original contact with the JIRT response. Given the high rate of attrition in matters where children and young people are charged with sexual offences, there is therefore a group of higher-risk children and young people who may receive no treatment for their harmful sexual behaviours.

17.2.1. Services provided through the criminal justice system

Until 1998, all therapeutic services for children and young people who sexually harmed their peers were provided through the criminal justice system. The criminal justice system continues to provide some therapeutic services.

The Children's Court, upon finding a child or young person guilty of a sexual offence, may make custodial or community-based orders that require or enable JJ to provide therapeutic services to address harmful sexual behaviour.[778] Similar sentencing options are available in the higher courts.

JJ's Sex Offender Program ceased in June 2014. JJ psychologists, in collaboration with caseworkers, are now responsible for the assessment and treatment of children and young people who sexually offend. JJ psychologists identify and build on strengths with the offender, their family and community in a multi-systemic approach. JJ recognises the importance of working with the offender's family, wherever possible, as the majority of offenders are related to those they harm. JJ psychologists are provided with specialist training and mentoring via clinical supervision, and Therapeutic Guidelines are being developed for both custodial and community-based settings.[779]

JJ can only work with offenders for the term of their orders, which are generally short. There are no specific referral pathways between JJ therapeutic services and services that may be provided in the community after a court order has expired, although children and young people who have ceased to be engaged with the justice system are eligible for services provided or arranged by Health.[780] These factors limit the effectiveness of the therapeutic response provided through the criminal justice system.

We also note that the Court may make an order adjourning sentencing for a period of up to 12 months, for the purposes of assessing an offender's capacity and prospects for rehabilitation, or allowing the offender to demonstrate that rehabilitation has taken place.[781] There is the potential for children and young people to access JJ or privately provided therapeutic services during this period and for an assessment of their participation to inform the Court's final sentencing decision.

777 Parents may seek private therapy for their child at any time, but this would be unusual while charges remain outstanding or may still be laid, as this may allow an inference to be drawn at trial that the offending behaviour is acknowledged.
778 See s.33 of the *Children (Criminal Proceedings) Act 1987* and cl.7 of the *Children (Criminal Proceedings) Regulation 2016*.
779 Advice provided by Juvenile Justice, 16 March 2017.
780 KPMG, *Evaluation of New Street Services, NSW Kids and Families, Final Report*, March 2014, p.29. Confirmed by New Street Clinical Advisor on 24 April 2017.
781 *Children (Criminal Proceedings) Act 1987* s.33(1)(c2).

This approach is similar to aspects of the TTO legislation which exists in Victoria; however, as we discuss later in this chapter, there are a number of significant differences between the NSW response and that of Victoria.

17.2.2. Services provided through the health system

The majority of children and young people who sexually harm their peers are not the subject of criminal charges and are eligible for therapeutic services provided through the health system.

Children and young people aged 10-17 years

Health's New Street Services, which opened its first site at Parramatta in 1998, provides an early intervention and prevention focused therapeutic service for children and young people with harmful sexual behaviours who are 10 to 17 years of age.

New Street aims to get its clients to build self-insight and take responsibility for their actions and for the harm that they have caused the victim and the victim's family (generally their own family, as over half of New Street's clients have engaged in sibling sexual abuse).[782] It conducts individualised counselling sessions with the child or young person and works with their family and other agencies providing services to them (for example, Education, FACS, OOHC agencies). Clients stay involved with the program for an average of two years.[783]

New Street operates from six sites – Parramatta (servicing the five Sydney LHDs and the Central Coast and Nepean Blue Mountains LHDs), Tamworth and Newcastle (servicing the Hunter New England LHD) and Dubbo (servicing the Western NSW and Far West LHDs). The fifth and sixth sites at Wollongong and Nowra, established in March 2017, service the Illawarra Shoalhaven LHD. All New Streets provide outreach services from additional sites within their LHDs.[784]

A Clinical Advisor working from the Sydney Children's Hospitals Network provides clinical supervision and consultation support to New Street teams. New Street also provides a secondary consultation service for other professionals who work with children and young people with harmful sexual behaviours.

Any person connected with a child or young person's care, including a family member, GP, school counsellor, Police, FACS, Health or another government or non-government service provider, can make a referral to New Street.[785] (JIRT referrals are detailed at section 17.3.1.)

New Street only accepts referrals where harmful sexual behaviour has been substantiated by Police or FACS, generally through the JIRT process, and where criminal proceedings do not proceed or the child or young person's contact with the criminal justice system has concluded. The child or young person's family must acknowledge the harmful sexual behaviour during intake assessment, on the basis that a family-focused therapeutic response cannot be provided when the family is 'in denial'.[786]

New Street gives priority to children and young people in OOHC, children with high and complex needs, and Aboriginal children and families, having regard to its assessment of the level of risk of harm and the need for early intervention. Over half of New Street's clients are in OOHC,[787] with Parramatta New Street having been funded by FACS since 2007 to work with children and young people in OOHC who are aged 8-17 years and who have high and complex needs.[788]

782 KPMG, *Evaluation of New Street Services, NSW Kids and Families, Final Report*, March 2014, p.1.
783 KPMG, *Evaluation of New Street Services, NSW Kids and Families, Final Report*, March 2014, p.39.
784 The Hunter New England New Street provides outreach services at Moree, Inverell, Armidale, the Upper Hunter Valley and Taree. New Street Western provides outreach at 12 locations. NSW Health has advised us that the number and location of outreach services varies dependent upon service demand, that is, only the service commitment to deliver by outreach is fixed, not the number and location of outreach sites. (Advice provided by NSW Health, 20 June 2017.)
785 NSW Health, *JIRT Referral Unit (JRU): Communication and Referral Processes*, October 2015, p.21.
786 A number of respondents to the JIRT workforce survey raised concerns about New Street intake criteria. Some concerns related to intake criteria that have been superseded. Others related to the need for the family to acknowledge PHSB and services not being available where a child or young person is charged.
787 KPMG, *Evaluation of New Street Services, NSW Kids and Families*, Final Report, March 2014, p.1.
788 These are the only services New Street provides to children under ten years of age.

Our 2012 report identified an acute shortage of treatment places for 10-17 year olds and recommended that Health review New Street services to assess:

- their capacity to meet demand across NSW
- the adequacy of funding for New Street Western
- the viability of creating additional service hubs in certain locations
- the adequacy of funds to evaluate the program's impact in rural and remote settings (including its reach and outcomes for Aboriginal people), and
- the adequacy of funds allocated to research projects.[789]

In response, Health commissioned KPMG to evaluate New Street and conducted separate demand modelling. Additional funding was provided to New Street Western and funds were allocated for research in New Street's budget.[790] Additional outreach services have also been provided.

KPMG's 2014 evaluation found that 42% and 26% of new clients were Aboriginal in 2011 and 2012 respectively, compared with 15% and 14% in 2009 and 2010. Aboriginal children, young people and communities remain a New Street priority, with Aboriginal Counsellor positions established at every service.[791] New Street services operating in LHDs with a rural component have a service mandate to dedicate at least 50% of activities to Aboriginal families and communities.[792]

KPMG's evaluation found the New Street model was considered effective by all stakeholders. Significant findings included:

- 78% of clients who completed the program had taken responsibility for their behaviour
- 89% of clients who completed the program had ceased their behaviour by case closure, with a 3% rate of recurrence at the three month post-closure follow up (outcomes not known for the remainder)
- New Street contributed to overall safety outcomes for children and young people
- New Street proved effective in rural settings, due to its outreach component
- children and young people showed greater understanding of their behaviour and how it affects other people, leading to better relationships and behaviour change, and
- parents reported that New Street had helped them cope better personally and with their children, and they could see a clear difference for their family.[793]

Health is currently finalising *New Street Service Standards and Guidelines* to reflect the post-evaluation New Street model.

Health has advised that demand modelling undertaken in 2014 identified 830 potential New Street clients state-wide and that service demand is likely to have increased since that time. The demand modelling identified Northern NSW, Mid-North Coast and the Murrumbidgee as the next priority areas for a New Street service (in addition to the recently established Illawarra Shoalhaven service).

Currently, the full functioning capacity of New Street is approximately 130-140 clients, a significant increase on the 60-70 clients at the time of our 2012 report. However, New Street still falls well short of meeting demand for services in the LHDs in which it operates, and it does not provide a service in five others.

789 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012 (Recommendation 66).
790 Advice provided by FACS, December 2014.
791 http://www.health.nsw.gov.au/kidsfamilies/protection/Pages/New-Street-Services.aspx, accessed 23 April 2017.
792 NSW Health, *NSW Health response to the 2014 KPMG New Street Evaluation Report*, November 2016.
793 KPMG, *Evaluation of New Street Services, NSW Kids and Families, Final Report,* March 2014, pp.2, 39: NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the NSW Ombudsman's Report,* June 2015, p.16. A separate 2014 study found New Street was able to demonstrate a number of positive treatment effects among treatment completers, when compared to their matched controls, but was unable to demonstrate effectiveness in specifically decreasing problem sexual behaviours. (L. Laing, D. Tolliday, N. Kelk and B. Law, *Recidivism following community based treatment for non-adjudicated children and young people with harmful sexual behaviours*, Sexual Abuse in Australia and New Zealand, 6(1), 2014, pp.38-47). New Street advises this is attributable to the small sample size, the use of data used in a 2006 evaluation, and the study not adjusting for New Street prioritisation of services, with the treatment group likely to hold a bias towards greater risk of sexual and other offending. The non-completion rate of 32% in the 2014 study is now under 10% (even though completion is not legally mandated), highlighting the significant changes that have taken place since the data used for the 2014 study.

Health has advised that there are no new resources available within its existing budget allocation for further service expansion at this time, but LHDs are undertaking planning work to be ready in the event that new resources are identified.[794]

JIRT health clinicians are encouraged to refer children and young people who cannot access New Street services to private providers.[795] Another LHD service, such as a Child and Adolescent Mental Health Services (CAMHS), might also be engaged.[796] Private provider services vary in terms of both therapeutic approach and quality.

Children under ten years of age

While children under ten years of age are not referred for a JIRT response because (sexual allegations are not regarded as criminal offences), a number of staff from the JIRT partner agencies noted in the workforce survey the importance of younger children with harmful sexual behaviours receiving therapeutic support to reduce the risk that they may cause further harm (which could later bring them into the JIRT program).

Our 2012 report identified that:

- there was no consistent response across LHDs to these younger children, with the only specialist program for this group provided by the Hunter New England LHD's Sparks Clinic
- most LHDs only provided services to younger children who had themselves been abused, with uncertainty among LHDs as to Health's policy position on service eligibility
- data was generally unavailable on demand for therapeutic services for this group, with the limited available data suggesting demand was not being met, and
- Health was developing a *Responding to Children under Ten who Display Problematic or Harmful Sexual Behaviour* policy.[797]

We made recommendations for Health to:

- clarify its policy for service eligibility of clients who are not victims of abuse
- review the capacity of LHDs to meet clients' demand for services
- ensure that its new Sexual Assault Services (SAS) database includes common data requirements for the client group, with data to include the number of referrals, reasons for each referral, service take-up and service outcomes, and
- develop clear policy on the nature and level of services that each LHD should provide to the client group and review the need for additional specialist services.[798]

Health has progressed the first of these recommendations, with the *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, published in April 2013, making it clear that SAS will only provide services to children and young people with harmful sexual behaviours who are themselves victims of sexual assault, and that LHDs are responsible for providing a therapeutic response to other children through their broader therapeutic services.[799]

The draft *Standards and Guidelines for NSW Health Sexual Assault Services* reiterate that universal service commitment, and make it clear that younger children who are not sexual assault victims may receive services through CAMHS, Child Protection Counselling Services, Child Protection Units or Child and Family Services. Children who receive counselling before they are ten years old will be able to continue receiving the service after they turn ten.[800]

ECAV provides training and practice forums for counsellors from the above services that emphasises the importance of a therapeutic model that engages families and other service providers.[801]

794 Advice provided by NSW Health, December 2016.
795 The Office of the Children's Guardian (OCG) administers a voluntary accreditation scheme for those working with people who have committed sexual offences against children. OCG maintains a list of accredited providers.
796 NSW Health, *JIRT Referral Unit (JRU): Communication and Referral Processes*, October 2015, p.21.
797 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012, pp.203-206.
798 NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, December 2012 (Recommendations 68-72).
799 NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*, April 2013, p.107.
800 NSW Health, Draft *Standards and Guidelines for NSW Health Sexual Assault Services*(unpublished), 2016, Standard 1g and pp.110-111.
801 NSW Health Education Centre Against Violence, *ECAV Courses Available for Request* (List As at 1 March 2016): 'Working with families around sexualised behaviours of their children (aged under ten)' – 3 day workshop: and 'Practice forum: Working with children under 10 with sexually harmful behaviours'.

Health is in the process of finalising a state-wide service model for children under ten, which will be reflected in new *Standards and Guidelines for NSW Health Services providing a response to children under 10 years old with problematic or harmful sexual behaviour and their non-offending families/caregivers*.

Data on service need and demand, and services provided, is still unavailable. While the new SAS database should capture services provided by a SAS, it will not capture services provided by other health services. Health is considering the most appropriate system to collate the recommended data.

17.2.3. Services provided through the care and protection system

Section 75 of the *Children and Young Persons (Care and Protection) Act 1998* enables the Children's Court, in its care and protection jurisdiction, to order a child under 14 years of age to attend a therapeutic program relating to 'sexually abusive behaviours' and to order the child's parents to take necessary steps for the child to participate in the program. An order cannot be made if the evidence of sexual abuse upon which the application is based is, or has been, the subject of criminal proceedings, and unless the court had considered a treatment plan that outlines the therapeutic program proposed.[802]

Section 75 was developed when therapeutic services were generally provided through the criminal justice system. As services are now able to be arranged through the health system before a treatment plan is developed, and without a court order being made, section 75 is very rarely used. It bears some resemblance to the Victorian TTO legislative framework (discussed in the next section) but lacks the linkages between criminal and care and protection jurisdictions, and clear reporting and referral pathways. Victorian legislation also does not require a treatment plan before an order is made.

Until recently, FACS had funded Youth off the Streets to provide the New Pathways program in the Illawarra. New Pathways was NSW's only OOHC residential program designed to support young people who have complex needs and harmful sexual behaviours. Being a residential-based program for children and young people in OOHC, FACS recently reviewed its funding arrangements for New Pathways as part of its broader reforms to improve the quality of residential care services in NSW – the outcome of which was that the funding for New Pathways was not renewed.[803]

FACS is transitioning its OOHC arrangements to an Intensive Therapeutic Care (ITC) model which will focus on children and young people recovering from the trauma caused by abuse, and will seek to provide them with clear pathways to less intensive care placements. The ITC model is specifically aimed at accommodating and supporting children and young people aged 12 years and above with identified high and complex needs (including sexualised behaviours).

FACS has been working with residential care providers over the last two years to examine the best way to deliver a high performing system for supporting vulnerable children and young people in care in NSW. A key component of the new model is a rigorous recommissioning process aimed at ensuring that government funding is awarded to providers that are most capable of meeting the requirements of the new ITC model.[804]

The new ITC contracts will commence on 1 October 2017, and the new model will be implemented in two phases with the full service model operational by December 2018. FACS has advised us that it is consulting organisations about how the therapeutic needs of New Pathways' clients may best be met.[805]

802 Local Courts, *Local Court Bench Book: Children's Court: Care and Protection Jurisdiction* – s.75 only excludes orders where a child is convicted of the relevant offence, but the Court has excluded orders where proceedings have commenced.
803 Residential OOHC care services have not been subject to open tender since 2005.
804 The recommissioning of ITC is a two stage open tender process: an Expression of Interest (EOI) stage and Request for Tender (RFT) for applicants who are successful at EOI. The EOI stage closed on 23 December 2016. 52 EOI applications were received and evaluated by a panel consisting of FACS and Treasury staff, supported by specialist advisory teams which included subject matter specialists. The evaluation panel recommended that 26 applicants be shortlisted (18 existing providers and eight new providers) to progress to the RFT stage. An RFT was issued to the successful EOI applicants on 20 March 2017. Eight existing residential care providers were not successful in the EOI stage.
805 Advice provided by FACS on 26 April 2017.

17.2.4. The need for an integrated service response framework

Our 2012 report observed that specialised therapeutic services for children and young people who sexually harm their peers have evolved in a piecemeal fashion, without any overarching policy or legislative framework to guide overall service planning. We identified the following service gaps, which appear to still exist:[806]

- Children and young people have no access to therapeutic services before police decide whether or not to charge.
- Children and young people have no access to therapeutic services between the time of charge and the time of a finding of guilt or the withdrawal or dismissal of charges, which may be for over two years.
- Children and young people who have their charges withdrawn or dismissed, or who are found not guilty, do not receive therapeutic services from JJ. They are likely to have had little ongoing contact with the health system post-charge and Health is unlikely to facilitate a therapeutic response at this time. Given the high rate of attrition in matters where children and young people are charged with sex offences, there is a group of higher-risk children and young people (that is, those whom police had sufficient evidence to charge) who receive no treatment for their harmful sexual behaviour.
- There is no referral pathway between JJ and Health therapeutic services after a court order has expired.

Our report recommended that:

- JJ work with Health to establish formal links between JJ and New Street programs to provide a pathway for young offenders to receive ongoing support following their release from juvenile justice detention (recommendation 73).[807]
- Health, together with the then Department of Attorney General and Justice, FACS and Police, develop and implement an integrated service response framework for children and young people who sexually harm their peers, with consideration given to adopting elements of the Victorian scheme (described below) for identifying and diverting children and young people with harmful sexual behaviours into treatment (recommendation 65).

The Victorian Therapeutic Treatment Order Scheme

The Victorian TTO scheme was established under the *Children, Youth and Families Act 2005* (Vic),[808] and commenced on 1 October 2007. It provides for police, the Criminal Division of the Children's Court or any member of the community to report concerns about children who are 10-14 years of age, and who exhibit harmful sexual behaviours, to Child Protection Services (CPS). Most requests for CPS to assess a child's suitability for a TTO are made by the Criminal Division of the Children's Court after the child has been charged with a sexual offence.

When either police or the Court makes a report, CPS must refer the matter to the Therapeutic Treatment Board (TTB) for advice about whether there is a need for a TTO. It may also refer other reports to the TTB for advice. The TTB comprises police, Office of Public Prosecutions and Human Services representatives.

The scheme was introduced in response to the low number of sexual assault prosecutions of children under 15 years old, and the lack of incentives for high-risk abusers to seek voluntary treatment. There was a concern that children with some of the riskiest harmful sexual behaviours were among the least motivated to seek voluntary treatment, and that the criminal justice system

806 The assessment of gaps was based on 2017 advice provided by Health and Juvenile Justice in responding to information requests for this inquiry.
807 The same applies to children and young people who have completed community based orders.
808 See ss.185, 248-258, 339 and 349 of the Act.

did not provide a reliable pathway into treatment for this group. A related concern was the reluctance or inability of dysfunctional families, or families in crisis, to provide the support needed for successful treatment.

CPS applications for TTOs are made to the Family Division of the Children's Court. Although TTOs are in addition to, not instead of, any criminal charges, a TTO suspends criminal proceedings while treatment is provided (TTOs may be for up to 12 months, with applications able to be made for a 12 month extension). If the child cannot live at home, the Court may also make a therapeutic treatment placement order (TTPO) requiring the child to live in accommodation that supports the treatment.

If, at the end of the TTO, the Court is satisfied that the child has satisfactorily participated in the program, it must discharge the child without any further hearing of the sexual offence proceedings. The Court must have regard to the therapeutic service provider's satisfaction as to the child's participation and opinion on the effectiveness of the treatment.

Between 2014-2015 and 2016-2017, the Children's Court made 56 TTOs; 18 extensions of TTOs; no TTPOs; and 1 extension of a TPPO.[809] In 2016-2017, 1,325 children and their families accessed the SABTS, either voluntarily or as a result of receiving a TTO.[810] While most children voluntarily seek treatment (referrals can be initiated by the child's family, the CPS, or other organisations), the TTOs provide an alternative pathway into treatment when a child and/or family are reluctant to seek help.[811]

All therapeutic services are provided by one of Victoria's 13 Sexually Abusive Behaviour Treatment Services (SABTS), a network of government funded NGOs that provide treatment for children and young people across Victoria. SABTS were established in 2007 in response to the growing awareness of children engaging in sexually abusive behaviour and recognition that a child developmental approach, using an attachment and trauma framework, will assist children and their families to understand and stop the behaviours.[812]

In addition to providing court ordered treatment, SABTS provide voluntary treatment services to children and young people. Previously, while there were 40 funded treatment places in three locations for young people aged 15-17, most SABTS only provided treatment to children under 15 years of age.[813] However, in March 2016, the Victorian Royal Commission into Family Violence recommended legislative change to enable the Court to make TTOs for young people aged 15-17 years. We understand that the recommendation has been accepted and that a legislative amendment is being prepared. In 2016-2017 the Department of Health and Human Services provided extra funding to all SABTS providers to enable them to prepare and receive referrals for 15-17 year olds. In the same year, 87 young people in this age group accessed a SABTS program.[814]

One of the strengths of the Victorian scheme is that it has created a legislative and policy framework that explicitly sets out the respective roles of police, child protection, accommodation and support agencies and treatment services, in supporting effective treatment strategies – including the use of treatment orders. While the scheme gives priority to therapeutic treatment and emphasises the value of early intervention, parental and family involvement and voluntary participation, it also provides effective sanctions for high-risk individuals and families who do not comply with their treatment plans.

The adoption of a similar scheme in NSW, integrating criminal justice and therapeutic service systems within a diversionary framework, would allow therapeutic support to be provided, irrespective of any criminal charge, and to continue after the expiry of any sentencing. It would also be more likely than a formal order to encourage children and families to engage with voluntary treatment, and significantly address the service gaps we have identified earlier in this chapter – leading to earlier access to treatment.

809 Children's Court of Victoria, *Annual Report 2014-2015*, 10 December 2015; data for 2015-2016 and 2016-2017 provided by request (data for 2016-2017 as at 23 June 2017).
810 Data provided by Victorian Department of Health and Human Services (data as at 30 April 2017).
811 Victorian Department of Human Services, 'Children in need of therapeutic treatment' (information brochure), 2007.
812 Advice provided by Victorian Department of Health and Human Services, 29 June 2017.
813 Victorian Department of Human Services, *Problem Sexual Behaviour or Sexually Abusive Behaviour*, May 2012, p.9.
814 Advice provided by Victorian Department of Health and Human Services (data as at 30 April 2017).

NSW, which has a larger population than Victoria, has far fewer treatment services and these are only available in a handful of locations across the state. The marked difference between the number of children and young people in each state who have received treatment indicates that there is significant scope for NSW to expand its treatment places. If investments are made at the right points in time for these high-risk young people, and their behaviours are turned around before they reach adulthood, the benefits will flow to the wider community.

During both our 2012 audit and this inquiry, clinicians from the New Street network and Juvenile Justice expressed interest in the Victorian scheme, and a view that there is merit in consideration being given to developing a similar framework in NSW. We understand that the relevant agencies supported recommendation 65 of our 2012 audit, subject to resourcing, and Health proposed that it be considered through an interagency review; however, it is unclear whether it has been progressed.[815] In the meantime, both New Street and JJ have committed to improve interagency information sharing, coordination and referral pathways from custody to community.[816]

In our view, any framework developed for NSW should also provide for data collection and reporting on each referral of a child or young person with harmful sexual behaviours to a therapeutic service; the persons or bodies making and receiving those referrals; refusals to accept referrals; the reasons for each referral and refusal; service take-up and service outcomes.

We note that recent research commissioned by the Royal Commission has suggested that the Victorian framework 'may warrant consideration as part of a national commitment to addressing this issue'.[817] In light of the close consideration the Royal Commission will give to the adequacy of treatment services for children and young people with harmful sexual behaviours, and our previous recommendations on this issue, we will provide a copy of this chapter to the Royal Commission to inform its findings.

17.3. The JIRT response to referrals involving children and young people with harmful sexual behaviours

Reports of child sexual abuse meeting the JIRT referral criteria, where the person who allegedly caused sexual harm was 10-17 years of age at the time of the alleged harm, are referred to the JRU to assess whether they should be accepted for a JIRT response.

CAS officers are experienced in interviewing child complainants and witnesses which means that they are well placed to interview children and young people suspected of offences. CAS officers may also apply to the Children's Court for an Apprehended Violence Order (AVO) against a child or young person who has sexually harmed a peer, in order to protect the complainant and other relevant persons.

FACS JIRT officers assess whether children and young people who sexually harm their peers pose an ongoing risk of significant harm to particular children and, in conjunction with the relevant CSC, take any necessary protective action – this will commonly involve separating the child or young person from those they have sexually harmed. The FACS response more broadly should involve an assessment of whether children who have sexually harmed a peer are themselves at risk of significant harm. Research has shown that harmful sexual behaviour, particularly involving siblings, is more prevalent where there is parental neglect or where families are struggling with other problems such as domestic violence, drug and alcohol misuse, or mental health issues.

JIRT health clinicians refer some children and young people with harmful sexual behaviour, but who have not been charged with sexual offences, to therapeutic services.[818] FACS staff and, to a lesser degree, CAS officers, also sometimes make referrals to therapeutic services.[819]

815 Advice provided by FACS, December 2014.
816 Advice provided by Juvenile Justice, 16 March 2017; Meeting with Dale Tolliday, New Street Clinical Advisor, 7 December 2016.
817 Professor Aron Shlonsky, B. Albers, D. Tolliday, Dr S. Wilson, J. Norvell and L. Kissinger, *Rapid evidence assessment: Current best evidence in the therapeutic treatment of children with problem or harmful sexual behaviours, and children who have sexually offended,* Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, May 2017. p.72.
818 NSW Health, *JIRT Referral Unit (JRU): Communication and Referral Processes*, October 2015, p.21.
819 FACS generally makes referrals for children and young people in OOHC. The 2014 KPMG evaluation found that FACS made the most New Street referrals, with the JIRT response providing the second most referrals.

17.3.1. JIRT referrals to the New Street Service

Table 12 below shows the number of referrals made by the JIRT program to New Street Services over the last four financial years.

Table 12: JIRT Program Referrals to New Street Services[820]

Referrals from JIRT to New Street Services				
JIRT	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**
Ballina	-	-	-	1
Bankstown	1	1	2	7
Bathurst	8	-	3	6
Bourke	5	-	-	-
Chatswood	-	5	3	3
Coffs Harbour	1	-	-	-
Dubbo	1	2	3	3
Inverell	1	-	-	3
Kogarah	2	-	4	-
Liverpool	1	7	5	6
Newcastle	3	5	2	1
Parramatta	4	3	2	4
Penrith	4	2	2	2
Port Macquarie	1	1	1	1
Tamworth	3	6	1	2
The Entrance	3	6	3	2
Wagga Wagga	-	-	-	1
Wollongong	-	-	4	
Total	**38**	**38**	**35**	**42**

Some of the above referrals were made from JIRT sites within LHDs that do not have a New Street Service (some children may abuse a peer while on family visits or holidays, or families may move between the time of the offence and disclosure). There also appear to be relatively low referral rates from some JIRT sites with high caseloads where there is a New Street service in the area (for example, Newcastle), suggesting either that referrals are not being made, or that they are being made to other services.

The 2014 KPMG evaluation found that some organisations did not make referrals to New Street due to a perception that New Street was at capacity and would be unable to accept new referrals.[821] New Street's Clinical Advisor, Dale Tolliday, advised us of anecdotal evidence that this view was also held in certain JIRT sites.

The JIRT referral data depicted in Table 12 was provided directly by New Street. Health was unable to provide data on JIRT referrals of children and young people with harmful sexual behaviour to other therapeutic services. Ideally, the shared JIRTS database should capture referrals made to New Street and other therapeutic services, given the importance to mapping service demand.

820 Compiled by Dale Tolliday, New Street Clinical Advisor, 19 April 2017. Health JIRT locations that have not made referrals are not included in the table.

821 KPMG, *Evaluation of New Street Services, NSW Kids and Families, Final Report*, March 2014, p.39.

17.3.2. The views of JIRT staff about the program's response to children and young people with harmful sexual behaviour

In responding to the workforce survey, 31% of JIRT agency staff indicated that the JIRT program's response to children and young people with harmful sexual behaviour is less than satisfactory – the rating for this cohort was lower than the response given to all other vulnerable groups identified in the survey:[822]

- 38% of CAS respondents rated it 'more than satisfactory'; 36% rated it 'satisfactory', and 26% rated it 'less than satisfactory'
- 39% of FACS respondents rated it 'more than satisfactory'; 36% rated it 'satisfactory', and 25% rated it 'less than satisfactory', and
- 61% of Health respondents rated it 'less than satisfactory', 28% rated it 'satisfactory', and 11% rated it 'more than satisfactory'.

The marked difference in Health satisfaction is unsurprising given that Health staff are the most likely to be mindful of this issue. However, when asked how the JIRT arrangement could better meet the needs of these children with harmful sexual behaviour, over 100 JIRT staff from across the three agencies raised concerns about the limited availability of therapeutic services – clearly demonstrating a widespread view across the JIRT program that increasing the availability of therapeutic services would improve its overall contribution to this high risk cohort.

Many of the respondents to the JIRT workforce survey called for the expansion – both in terms of capacity and geographical distribution – of New Street services.

Several respondents to the JIRT workforce survey raised concerns about the current system delaying access to therapeutic services. One CAS officer noted:

> *There are no immediate supports available for child offenders. If these offenders are to face any prospect of rehabilitation they should be engaged with offender programs at the earliest opportunity. A lot of these offenders can only access programs well after the initial disclosures or arrest and even after court proceedings even if the child has indicated their guilt.*

The responses to the workforce survey, as well as information provided during consultations for this inquiry, have also identified other improvements that could be made to the JIRT response to children and young people who sexually harm their peers – these are discussed in the following sections.

Police decisions to charge

A number of FACS and Health respondents to the workforce survey suggested that more effective sharing and consideration of information provided to their agencies by the CAS, when they are determining whether to proceed with charges, might lead to additional children and young people receiving earlier treatment (in appropriate cases) rather than being charged.

While charging decisions are clearly a police responsibility, the current arrangements in NSW mean that a decision to charge a child has a direct impact on whether they can receive early therapeutic intervention. In circumstances where charges have been laid, and therapeutic support is not being provided, this may also impact on the ability of FACS to carry out safety planning for families dealing with sibling sexual abuse.

In our view, if the Local Planning and Response (LPR) process is executed effectively, it should facilitate the sharing and proper consideration of relevant information to inform charge decisions, and assist the JIRT agencies to identify related impacts for the young person in terms of therapeutic treatment options and broader safety planning undertaken by FACS.

822 Asking separate workforce survey questions on victims of intrafamilial abuse has resulted in some data integrity issues, as a respondent may have noted concerns about sibling sexual abuse in responding to questions about children and young people who abuse their peers, children and young people who are victims of intrafamilial abuse, or both.

Consideration of 'doli incapax' in charging a child

Where a child who is alleged to have sexually harmed another child is aged between 10 and under 14 years of age, police are required to gather evidence that the child knew that he or she had acted in a seriously wrong manner before proceeding to charge.

In its *Consultation Paper – Criminal Justice*, the Royal Commission noted that in NSW between 1994 and 2014, 27.4% of sex offence matters heard in the Children's Court had all charges dismissed without hearing, most commonly where no evidence was offered by the prosecution. Fewer than half of the children and young people prosecuted for sex offences in the Children's Court were convicted (47.9%, compared with 62.3% in the higher courts).[823] As attrition data is currently not captured by the JIRT program (see Chapter 11), we are unable to determine whether adequate consideration being given to *doli incapax* is a contributing factor.

In December 2016 the High Court, in the case of *RP v The Queen*, considered the necessary evidentiary threshold to rebut *doli incapax* in a NSW case where the District Court, in a judge only trial, convicted a child (aged 11 and 12 years at the time of the relevant acts) of the aggravated indecent assault of, and sexual intercourse with, his brother (aged 6 and 7 years at the time of the relevant acts).[824] Gaegler J. noted:

> *Both the trial judge and the Court of Criminal Appeal placed considerable weight on the fact that the transcript of a police interview with the brother allowed inferences to be drawn from the circumstances of the first act of sexual intercourse in which RP engaged with his brother at their home.*
>
> *They were that RP: knew that his brother did not want to engage in intercourse, used force on his brother, was aware that his brother was crying and in pain, put his hand over his brother's mouth to stop him calling out so as to avoid detection, persisted knowing that he was causing great distress to his brother, stopped only when an adult returned to the home, and afterwards told his brother not to say anything.*[825]

However, all High Court Justices concluded that the evidence presented was insufficient to rebut the presumption of *doli incapax*. The only additional evidence provided was two reports, made when RP was 17 and 18 years of age, that showed he had intellectual functioning at the top of the borderline range for intellectual disability. In the absence of any further evidence as to RP's intellectual and moral development and home background at the time of the sexual acts, the inferences that could be drawn from the police interview were held to be insufficient to rebut the presumption.

The CAS informed us that it has circulated the High Court's decision among its officers, advising that 'the judgment reaffirms what is considered best practice in gathering evidence to rebut the presumption'.[826] Nevertheless, the decision is likely to require more detailed investigations as to the intellectual and moral development and home background of children aged between 10 and under 14 years – this may include additional interviews with family members and members of the child's school community, and collaboration between FACS and Police on such matters where relevant. We note that CAS also advised us that it will provide this section of our report to the legal section of the Detectives Training Unit to consider whether there is adequate coverage of the issues raised in *RP v The Queen* and related evidence gathering.

Given the decision of the High Court on the evidence required to rebut the presumption of *doli incapax*, there would appear to be merit in the ODPP and Police jointly assessing in what circumstances police would benefit from seeking a sufficiency advising from the ODPP before charging children who were aged between 10 and under 14 years at the time they allegedly committed a sexual offence.[827]

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823 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.549.
824 *RP v The Queen* [2016] HCA 53 (21 December 2016).
825 *RP v The Queen* [2016] HCA 53 (21 December 2016), para.41.
826 Advice provided by the CAS, 27 March 2017.
827 ODPP Guideline 14 notes ODPP will, where a relevant matter is referred by Police for advice, advise Police as to the sufficiency of evidence. Allegations of child sexual assault are relevant matters for the purposes of Guideline 14. The ODPP, in its submission in response to the Royal Commission's *Criminal Justice Consultation Paper*, stated its preference to have more control over the decision to charge in respect of child sexual abuse offending and the identification of the correct charges before those charges were laid (although it did not raise *doli incapax* issues in making this submission). The ODPP stated it encourages police to seek pre-charge advice because of the complexity of charging in this area. (See NSW Office of the Director of Public Prosecutions, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse: Consultation Paper - Criminal Justice*, October 2016, p.14.)

Police applications for a final AVO

New Street's Clinical Advisor has raised concerns about some AVO applications being made to the Children's Court without health clinicians or FACS workers being consulted. In particular, he has noted that the terms of some AVOs restrict a child or young person from having any contact with the victim and/or members of the victim's family (a particular issue in sibling sexual assault matters). This may prevent the child or young person discussing the harm they have caused, in controlled circumstances where the victim/family members are present, which may be an integral part of the therapeutic response.

A FACS respondent to the JIRT workforce survey also raised concerns about the lack of consultation with FACS JIRT staff in applying for AVOs in intra-familial abuse matters, as AVOs may affect FACS casework with the family.

While police may need to urgently make a provisional AVO, or apply for an interim AVO, generally speaking, there should be time for information sharing with JIRT Health and FACS staff about the need for, and the appropriate conditions of, a final AVO. It would make sense for this exchange of information to occur through the usual LPR process.

In addition, consideration could be given to Police and Health, in consultation with the Children's Court, developing a draft standard condition for an AVO imposed on a child or young person who has allegedly sexually harmed a peer, which would permit contact with a person that would otherwise be prohibited by the AVO, with that person's consent, as part of a clinically approved therapeutic plan for the child or young person. Clearly, it would be a matter for the Court to determine whether such an order was appropriate in each individual case.

Improving the JIRT response to sibling sexual abuse

All JIRT partner agencies identified the need for improved guidance in responding to sibling sexual abuse, in the context of dealing with children and young people as both victims and perpetrators, and with families that may have conflicted loyalties.

The need for an improved response to sibling sexual abuse was also the strongest theme in responses to JIRT workforce survey questions concerning children and young people who abuse other children/young people and children and young people who are victims of intra-familial abuse. The Practice Framework for the JIRT Health response notes:

> *There will be a need to balance the concerns for both the victim, the sibling who has abused and the parents and carers who are confronted with the story that one of their children has seriously harmed another*
>
> *It is now known that intervention must consider the wellbeing of both siblings and prioritise protective strategies and therapeutic opportunities for both. The context for this cannot occur in isolation from the parents and solid work needs to be undertaken with them to enlighten them as to what has happened, what needs to now happen and what that future path may involve.*[828]

FACS commonly takes action to protect the harmed sibling from ongoing risk of significant harm. This generally involves requiring the siblings to live in separate locations, although there has been a shift towards establishing a safety framework that allows the siblings to remain in the same home after a period of separation and assessment, in appropriate cases.[829] Decisions in relation to changing the living arrangements of a child or young person with harmful sexual behaviours are generally carried out in consultation with the JIRT senior health clinician and, where they are or are likely to be involved in the case, a SAS, CAMHS and/or New Street.[830]

828 NSW Health Education Centre Against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response: A Resource Paper Outlining the Key Issues, Evidence and Practice Considerations for Senior Health Clinicians*, 2013, pp.41-43.
829 NSW Health Education Centre Against Violence, *A Practice Framework for the Joint Investigative Response Team (JIRT) NSW Health Response: A Resource Paper Outlining the Key Issues, Evidence and Practice Considerations for Senior Health Clinicians*, 2013, pp.41-43.
830 NSW Health, Draft *Standards and Guidelines for NSW Health Sexual Assault Services* (unpublished), 2016, p.111. The SAS assesses whether there is sufficient safety for the victim to commence sexual assault counselling and has ongoing involvement in determining safety strategies for sibling interaction.

JIRT health clinicians may refer a child who has sexually harmed a sibling to New Street or other therapeutic services. This is done in consultation with staff from other JIRT partner agencies and any SAS or other health service that is providing counselling or other support to the sibling.

Some CAS and FACS respondents to the JIRT workforce survey have suggested that the JRU should be able to allocate reports about sibling sexual abuse perpetrated by children who are aged between 10 and under 14 years for a 'FACS/Health JIRT only' response, where it is assessed there is 'no prospect of a criminal prosecution being commenced'.[831] However, in this regard the CAS noted that there can still be value in them speaking with the young person about their behaviour so that they have a better understanding of its impact and seriousness.

A number of CAS, FACS and Health respondents also suggested that police should have limited involvement in matters of younger children who have engaged in sexual harm that are referred for a JIRT response, particularly those involving sibling sexual abuse, given the inability of police to charge on *doli incapax* grounds and the difficulties associated with a criminal justice response to sibling abuse.

Due to the complexity of sibling sexual abuse matters, the JRU is not well placed to make decisions about which agency/s should lead the response. These types of matters need to be the subject of discussion between all three agencies during the LPR process. As with other alleged offences, it is not possible or appropriate to exclude police from the early stages of the assessment and response as they need be able to make an informed decision about the viability and appropriateness of criminal proceedings. However, there is considerable scope for FACS, Health and Police to closely plan and jointly execute the initial engagement with the family in sibling sexual abuse matters, subject to contamination of evidence issues being managed (for example, Health could identify the wishes of the alleged victim/willingness of family to participate in a prosecution).

While police may be satisfied that sibling abuse has occurred, a criminal justice response may not always be possible or in the best interests of the sibling who has been harmed. During our consultations with the CAS for this inquiry, the senior management team indicated that they were keen to explore how FACS and Health could take a stronger role in these matters. For example, it is well understood by the partner agencies that sibling sexual abuse referrals are complex and sensitive, and that Health is well placed to inform the initial engagement with the victim and their family. Health can provide a 'softer' point of entry for children and families reluctant to engage with Police or FACS. To maximise the effectiveness of its resources, we recommend that further consideration be given by the SMG to better articulating the role that Health can play in relation to sibling sexual abuse matters.

On a related note, the CAS also supported our view that data captured about JIRT referrals should include the number of matters involving children and young people alleged to have sexually harmed, and of these, the number of referrals involving sibling sexual abuse. This data is not only critical to obtaining a clearer picture of prevalence, but also of the type of responses these matters receive when they are handled by the JIRT program. As well as providing insights into attrition, better data capture in this area would provide further context to police charge/arrest data (including relevant trends), as there are valid reasons why such matters do not proceed by way of charge. In our view, it is problematic that police charge/arrest data does not currently distinguish between matters involving adult offenders and those involving children and young people as suspects (with a breakdown for sibling sexual abuse).

In responding to the JIRT workforce survey, 40% of FACS respondents indicated that they require more training in dealing with sibling sexual abuse matters. FACS staff also commented on the need for further training about the circumstances in which families should be required to separate siblings as part of a safety plan. In this regard, the responses provided by FACS staff to the workforce survey indicate a lack of clarity concerning the management of sibling separation – some caseworkers commented that it is FACS policy that siblings must always be separated where there has been

831 There were two cases in 2014-2015 where the JRU rejected matters for JIRT referral and directly referred clients to New Street.

substantiated harm; others stated that it is dependent on the circumstances of the case; and one caseworker said that separation should occur in circumstances where it is a condition of therapeutic services working with a family.

FACS has advised that it offers a workshop on 'safety planning for adolescents with sexually abusive behaviours' to CSC and JIRT staff. This training, developed in 2013 and last delivered to all JIRT units and CSCs in the first half of 2015, focuses on the initial safety assessment and issues including placement, contact and daily activities. While this is positive, it is not clear how comprehensively the training covers safety planning for sibling abuse matters. Thirty-two percent of the survey respondents who indicated that further training was required in this area were staff who have worked within the JIRT program for three years or more, and therefore should have participated in this training. A number of CAS and Health JIRT staff also identified the need for additional training in responding to sibling sexual abuse.

More recently, FACS has developed a resource kit for its child protection practitioners on responding to child sexual abuse.[832] As discussed in Chapter 11, while the kit is aimed at CSC staff, it also includes a range of information that is relevant to the delivery of a collaborative response to reports of sibling sexual abuse matters by CSCs and FACS JIRT – including important guidance on safety planning and decisions about separation or reunification. ECAV also delivers a course for health clinicians on 'Working therapeutically with children and young people who have experienced sibling sexual assault'.

While the recent work by FACS to improve the resources available for its staff is positive, given the prevalence and complexity of sibling sexual abuse, and the concerns expressed by all JIRT partner agencies in this area, in our view there is a need for JIRT interagency training that has a specific focus on responding to sibling sexual abuse. We also recommend that the JIRT SMG, in consultation with experts on sibling sexual abuse, develop joint guidelines for addressing sibling sexual abuse reports through the LPR. As CSCs also have a role in responding to sibling matters, it will be important that any training on responding to sibling sexual abuse and managing sibling separation is also provided to CSC staff.

Some JIRT staff also suggested that CSCs appear unwilling to provide financial support to separate siblings in sibling sexual abuse cases, with this largely left to families to manage – this may place disadvantaged families or families with few other supports in a difficult position and increase the risk of one or more of their children being taken into OOHC. We also suggest that FACS review its policies and procedures for supporting sibling separation in sibling sexual abuse matters (where separation is assessed as appropriate), with a view to ensuring child and family safety, and to reduce the risks of family breakdown and children being placed in OOHC.

Need for improved JIRT collaboration with schools

A number of respondents to the JIRT workforce survey identified the need for additional JIRT collaboration with schools to better manage harmful sexual behaviour that presents in the school environment.

We note that the Department of Education has established an interagency working party, including senior representatives of CAS, FACS, Health and New Street, to improve the whole of government response to children with 'offending, problem or harmful sexual behaviour' in schools. The Royal Commission has also considered that response in its 2016 public hearings for Case Study 45.[833]

We welcome the attention of the Royal Commission and the Department of Education on this important issue and are satisfied that any improvements to the JIRT-school relationship can be progressed through the interagency working party. We discuss the scope for schools and the JIRT agencies to collaborate more closely in the chapters on JIRT training and the *Local Contact Point Protocol*.

832 Department of Family and Community Services, *See, understand and respond to child sexual abuse – a practical kit*, November 2016 (launched 31 May 2017).

833 Royal Commission into Institutional Responses to Child Sexual Abuse, *Case Study 45, Response to children with problematic or harmful sexual behaviour in schools*, public hearings held between 20 October and 4 November 2016.

17.4. Independent oversight of the response to children and young people who sexually harm their peers in OOHC and other institutional settings

As we discussed in the previous chapter, the Royal Commission has heard evidence that children and young people sexually harming their peers is 'a serious and common problem in contemporary OOHC',[834] with a significant proportion of sexual abuse of children and young people in OOHC believed to be perpetrated by peers.[835]

While FACS is currently unable to provide accurate data on incidents of peer abuse in OOHC, it is committed to improving reporting in this area.

Currently, the appropriateness of OOHC agency responses to children and young people who sexually harm their peers, including whether matters have been duly reported to Police and the Helpline (and then referred for a JIRT response) cannot be meaningfully assessed, as incidents of sexual harm perpetrated by children in OOHC and other institutional settings are not covered by the reportable conduct scheme or any other formal reporting scheme. There is no comprehensive mechanism to scrutinise the adequacy of service responses to these matters in order to inform and drive practice, important at both individual case and broader systems levels.

Under Part 3A of the *Ombudsman Act 1974*, the Ombudsman is only notified of a subset of alleged incidents – that is, any incident where neglect on the part of a carer or worker is alleged to have contributed to the abuse or harmful sexual behaviour.

In contrast, Part 3C of the Ombudsman Act requires certain disability accommodation providers to notify us of allegations of 'client-on-client' abuse, breaches of AVOs, and unexplained serious injuries. This enables us to monitor the adequacy of the accommodation provider's response, including any referral to Police. The disability reportable incidents scheme was introduced in December 2014, with peer-to-peer conduct included in recognition of the special vulnerability of persons with disability.

Given that children and young people are also a vulnerable group, our view is that a similarly centralised approach should be introduced within NSW, to provide oversight of the identification, reporting and response to alleged serious 'child-to-child' incidents (including those involving harmful sexual behaviour and physical abuse) in OOHC and other appropriate institutional settings. To ensure that only more serious incidents are reported, the threshold could be, for example, all reports that meet the criteria for a report to the JIRT program.

We also consider it important that, whatever body might be responsible for receiving such notifications, it should have the requisite investigative powers to examine how all relevant agencies are responding to reports of such incidents. As we have raised this issue in recent submissions to the Legislative Council General Purpose Standing Committee No. 2 Inquiry into Child Protection and the Royal Commission, we have not made any further recommendations on this issue in this report.

Recommendations

44. The JIRT partner agencies should consider, together with other key stakeholders (such as the departments of Justice and Education) and having regard to the observations in Chapter 17 and relevant recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse, implementing recommendation 65 of the Ombudsman's 2012 report to Parliament, *Responding to child sexual assault in Aboriginal communities*, in relation to the development of an integrated service response framework for children and young people with harmful sexual behaviours.

834 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper: Institutional responses to child sexual abuse in OOHC*, March 2016, p.37.

835 Gail Furness SC, Royal Commission into Institutional Responses to Child Sexual Abuse, *Opening address, Case study 24: Preventing child sexual abuse on out of home care*, 10 March 2015.

45. The JIRT partner agencies should develop, in consultation with relevant experts, guidance about responding to reports involving sibling sexual abuse building on FACS' *See, Understand and Respond to Child Sexual Abuse – A practical kit*. This guidance should be referenced in, and linked to, both the *Local Planning and Response Procedures* and JIRT interagency training materials (with training and resources being made available to Community Services Centre staff).

PRACTICE SUGGESTIONS

- The JIRT partner agencies should collect data about the age of each child or young person (the subject of a JIRT referral) who has been identified as causing sexual harm, to inform any assessment of therapeutic treatment needs and related service capacity.
- The JIRT partner agencies should include guidance in the *Local Planning Response Procedures* about the need for sharing and proper consideration of information from all three agencies to:
  - inform charge decisions relating to a child or young person with a sexual offence given the impact of charges on access to early therapeutic intervention, and the broader safety planning and care/protection work undertaken by FACS.
  - inform Police decisions when applying for an AVO against a child or young person, and if so, the appropriate conditions that should be sought given the impact on broader safety planning and care/protection work undertaken by FACS.
- The JIRT partner agencies, in consultation with the Children's Court, should consider developing a draft standard condition for an AVO, to be issued in appropriate circumstances and where consent is provided, that would permit a child or young person who has caused sexual harm to have contact with an individual (which would otherwise be prohibited by the AVO) in order to facilitate the implementation an approved therapeutic treatment plan.
- The NSW Police Force should consider whether there is merit in working with the Office of the Director of Public Prosecutions (ODPP) to identify the types of matters where police officers would benefit from seeking a sufficiency advising from the ODPP, before charging a child or young person who was aged between 10 and under 14 at the time they allegedly committed a sexual offence.
- The NSW Police Force should consider including in its collection of 'reasons for attrition data', any matters involving dismissal of charges on *doli incapax* grounds.
- FACS should consider reviewing its policy on how it supports sibling separation in sibling sexual abuse matters (where separation is assessed as appropriate), including in relation to financial support.

Part 6

The impact of legislation

The Child Sexual Offence Evidence Pilot | Potential Law Reform

Contents

Chapter 18. The Child Sexual Offence Evidence Pilot

Only around 19% of child sexual assault incidents and 35% of child indecent assault incidents reported to the NSW Police Force in 2014 proceeded to court,[836] with the high rate of attrition partially attributed to the negative impact of the court process on the wellbeing of child victims.[837]

All Australian states and territories recognise that children, as well as adults with cognitive impairment and communication support needs, may require additional support when giving evidence in criminal proceedings; and that all complainants in sexual offence proceedings may require support.

A range of special measures have been introduced by Australian jurisdictions to assist such persons in giving evidence and reduce the stress of doing so. In NSW, a number of special measures have been in place for some time to support children and other vulnerable witnesses, including the pre-recording of evidence, the ability to give evidence by way of closed circuit television, and the ability to have a support person when giving evidence in chief.

A clear intention behind these special measures is to reduce attrition from the criminal justice system – as such, they are directly relevant to the aims of the JIRT program and many of the agency's functions.

At the time of our 2012 audit of the NSW Government's implementation of the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*, we noted that, while the measures that were already in place were positive, there were additional facilities which would, if available, further improve the court process for victims.

We recommended that the (then) Department of Attorney General and Justice (DAGJ) consider providing an option to allow for a child's entire evidence to be pre-recorded in certain sexual assault proceedings.

We also recommended that DAGJ consider the viability of amending the *Criminal Procedure Act 1986* to establish a registered intermediary scheme for the purpose of facilitating enhanced communication between vulnerable witnesses and police or the court. We identified the Registered Intermediary Scheme of England and Wales, which has operated across those jurisdictions since the conclusion of a four-year trial in 2008, as a potential model for a NSW scheme. As we reported, a 2007 evaluation of the trial found that witness intermediaries have a clear capacity to reduce the attrition of matters involving vulnerable witnesses, including children, from the criminal justice system.

In October 2015, the NSW Government announced that it would pilot a three year Child Sexual Offence Evidence Pilot to commence on 31 March 2016. The pilot, administered by Victims Services within the Department of Justice, involves the use of witness intermediaries as well as an expansion of the use of pre-recorded child evidence in court proceedings for prescribed sex offences. It operates in the Downing Centre (Sydney) and Newcastle District Courts and includes proceedings commenced by the CAS in the Bankstown, Kogarah, Chatswood and Newcastle JIRT locations. The pilot has already reportedly had a significant positive impact in these locations.

We understand that Victims Services has commissioned an independent process evaluation which is currently underway; and that a full evaluation will be conducted at the completion of the pilot in early 2019.

836 Judy Cashmore, Alan Taylor, Rita Shackel and Patrick Parkinson, *The impact of delayed reporting on the prosecution and outcomes of child sexual abuse cases*, Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, University of Sydney Law School, August 2016. As discussed in Chapter 10, there are a range of other reasons why sexual abuse incidents reported to police may not result in criminal proceedings – including the victim and/or their family not wishing to criminally proceed.

837 Department of Justice, Victims Services, Children's *Champion (Witness Intermediary) Procedural Guidance Manual* (2016), November 2016, p.11.

18.1. The witness intermediary scheme

The Criminal Procedure Act provides for Victims Services to appoint individuals with tertiary qualifications in psychology, social work, speech pathology, teaching or occupational therapy as witness intermediaries.[838] Intermediaries must successfully complete a witness intermediary training course and complete 14 hours of professional development per year.[839] The first group of witness intermediaries received training from Professor Penny Cooper, an expert on the Registered Intermediary Scheme in the United Kingdom.

The Act provides that:

> *(3) For the purposes of proceedings to which this Part applies, the Court:*
>
> *(a) must (except as provided by subclause (4)) appoint a children's champion for a witness who is less than 16 years of age, and*
>
> *(b) may, on its own motion or the application of a party to the proceedings, appoint a children's champion for a witness who is 16 or more years of age if satisfied that the witness has difficulty communicating.*
>
> *(4) The Court is not required to appoint a children's champion if it considers:*
>
> *(a) there is no person on the panel established under this clause available to meet the needs of the witness, or*
>
> *(b) it is otherwise not practical to appoint a children's champion, or*
>
> *(c) it is unnecessary or inappropriate to appoint a children's champion, or*
>
> *(d) it is not otherwise in the interests of justice to appoint a children's champion.*[840]

Police use of witness intermediaries for the purpose of assisting relevant children and young people in the pilot areas to give their best evidence during the recorded criminal interview is not legislated by the Act. Instead, administrative arrangements in place between the NSW Police Force and the Department of Justice enable the CAS to request an intermediary from Victims Services. Police seek consent to use an intermediary from children and young people who have the capacity to give it. Otherwise, consent is sought from a suitable adult (but not if the adult is a person of interest or is considered non-protective). Where a suitable adult is not available to give consent, a 'commissioned officer'[841] may approve the use of an intermediary.

There is no provision for appointing intermediaries for the accused or defence witnesses, or for adults who have cognitive impairment or communication support needs. There is also no provision for appointing witness intermediaries in Children's Court proceedings for prescribed sexual offences (we discuss coverage of the scheme further in section 18.2).

As far as possible, the use of witness intermediaries to assess children for the purpose of recorded criminal interviews is a 'fluid' rather than highly structured process. Witness intermediary assessments for police are generally brief[842] and are not recorded. The venues for assessments vary; they commonly take place in a JIRT interview suite but may take place in a school, hospital or other suitable place for the child or young person. There must be a responsible third party present to ensure the assessment is conducted impartially and to ensure that the intermediary does not become a witness if an admission is made during the assessment. The interviewing officer is the preferred third party; this enables the officer to gain an understanding of the child's communication needs before the interview and helps them to build a rapport.

838 Clause 89(1)-(2) of Schedule 2.
839 Clause 100A of the *Criminal Procedure Regulation 2010* and Victims Services, Department of Justice, *Children's Champion (Witness Intermediary) Procedural Guidance Manual (2016)*, November 2016, p.7. Disability advocates have emphasised that in addition to having relevant qualifications, witness intermediaries for children with disability should have specific training in communicating with people with disability and understanding the impacts of trauma.
840 Clause 89, Schedule 2.
841 A sworn police officer holding the rank of Inspector or above.
842 The CAS has advised us that the assessment usually takes about 15 minutes; longer if required.

The witness intermediary then briefs the interviewer about the assessment, and the interviewer and intermediary discuss how the police interviewer can elicit the child's best evidence during the interview. Issues discussed may include the use of developmentally appropriate vocabulary and sentences, cultural considerations that may affect communication, the frequency of breaks and the use of communication aids.[843]

The witness intermediary then attends the recorded criminal interview, which the CAS generally prefer to hold on the same day as the assessment. The intermediary sits in the interview room, away from the child, and is visible on the audio-visual recording,[844] so it can be seen that they have not inappropriately communicated with the child. The witness intermediary and police officer agree beforehand on how the intermediary will intervene during the interview if it becomes necessary. If required, feedback is generally provided during interview breaks, unless it can be provided without interrupting the flow of the interview.[845] However, to avoid conjecture at court about what the interviewer and witness intermediary may have discussed, breaks for this purpose are avoided.

In England and Wales, the intermediary ideally participates in a 'ground rules' hearing before the witness' evidence is taken in court. In the hearing, the intermediary can report to the court on the witness' requirements and the judge can give guidance to counsel as to which recommendations of the intermediary are to be adopted in questioning the witness.[846] The NSW Act, Regulations and District Court Rules and Practice Notes make no provision for ground rules hearings and although they were not permitted by the court in the early stages of the trial, we understand they now regularly occur at the discretion of the court. In her evidence to the Royal Commission during its Public Hearing into Case Study 46, Ms Gina O'Rourke SC of the NSW ODPP expressed the view that the requirement for ground rules hearings in criminal proceedings involving the use of witness intermediaries in NSW should be formalised.[847] The Department of Justice has also advised us that 'Witness Intermediaries value the ground rules hearing and see these as instrumental to facilitation of an effective pre-recorded hearing'.[848]

18.1.1. Use of witness intermediaries

Between the start of the pilot and 31 January 2017, 601 children and young people were referred to the intermediary scheme in the pilot locations – the majority (531) by the CAS and the remainder by the court. Of these, 90% (540) were matched to an intermediary.

Victims Services has noted the following conditions giving rise to communication difficulties for the children and young people referred through the pilot:

- trauma (118 cases)
- mild, moderate or severe learning disability (92 cases)
- language delay/disorder, dysarthria, elective /selective mutism, voice disorder, dyspraxia or stammering/stuttering (87 cases)
- mental health issues (79 cases)
- Attention Deficit Hyperactivity Disorder (48 cases)
- Autism Spectrum Disorder (23 cases)
- hearing impairment (13 cases)
- neurological and progressive disorders (4 cases)
- cerebral palsy (4 cases)

843 We note that s.275B of the Criminal Procedure Act provides that a witness with communication difficulty is entitled to assistance from a person or communication aid; however, we understand the provision is infrequently utilised.
844 The witness intermediary is not visible in the 'main' frame but in a smaller 'PIP frame'.
845 Department of Justice, Victims Services, *Children's Champion (Witness Intermediary) Procedural Guidance Manual (2016)*, November 2016, pp.15-16.
846 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.377.
847 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 46*, evidence of Ms Gina O'Rourke SC of the NSW ODPP, transcript of 29 November 2016.
848 Advice provided by Department of Justice, Victims Services, June 2017.

- brain or head injury (4 cases) , and
- physical disability (3 cases).[849]

Of those referred to the scheme, 11% of the children and young people were Aboriginal (in 2015-2016, 19% of accepted JIRT referrals involved Aboriginal children and young people); and 8% were from culturally and linguistically diverse backgrounds.[850]

To date, witness intermediaries have been used to assess children and young people prior to a recorded criminal interview, but also to review recorded criminal interviews conducted by police prior to the start of the pilot, for the purpose of making an assessment of the child for court.[851] Not all interviews progress to criminal proceedings, and children and young people interviewed in the four participating JIRT areas may have their matters listed in courts not covered by the pilot. Also, delay between interview and the commencement of criminal proceedings means that some matters, where intermediaries have been used for the recorded criminal interview, have not yet proceeded to court.

The case studies which follow illustrate the positive impact that an intermediary can have in assisting a child to give their best evidence.

Case study 11

T gave evidence at a pre-recorded hearing with the assistance of an intermediary. The intermediary's report indicated T was able to understand short statements and questions. The intermediary's recommendations provided guidance for the defence counsel to frame questions in a way that T would understand.

T demonstrated severe anxiety, with the intermediary recommending that T be able to use a stress management tool like a stress ball or play-doh during questioning. T used play-doh during cross-examination.

T was able to answer all questions during cross-examination, with the intermediary intervening on two occasions to suggest less complex language be used. Towards the end of the cross-examination, the defence counsel was asked, when putting the defendant's case directly to T, to do so in short statements without the use of tagged questions.[852] The defence obliged and a number of statements were put to T, who was able to answer accordingly and without confusion.[853]

Case study 12

S was interviewed by police with the assistance of a witness intermediary, having previously been interviewed by police in relation to other sexual assault matters. Despite S's previous contact with the JIRT program, very little information was held about her communication needs.

The intermediary identified that S had an extreme anxiety disorder that had impacted on her social networks and ability to leave home and that as a result, S had not attended school for almost three years. S was also found to have very poor reading and communication skills – equivalent to those of a much younger child.

Police were unaware of this information during S's previous contact with the JIRT program, and believe they would not have been able to conduct a detailed interview with S had the intermediary not been involved. As a result of the information obtained through the witness intermediary's assessment, the JIRT agencies were able to put in place strategies to better support S.[854]

849 Information about the communication needs of some children and young people was not recorded. (Advice provided by Department of Justice, Victims Services, February 2017.)
850 Advice provided by Department of Justice, Victims Services, February 2017.
851 Where the court proceedings have commenced since the pilot commenced.
852 A tagged question is a grammatical structure in which a declarative statement is turned into a question by adding an interrogative fragment (for example, 'You're T, aren't you?'). Tagged questions can be confusing for children and other vulnerable witnesses.
853 Case study provided by the CAS.
854 Case study provided by the CAS.

In addition, between the start of the pilot and 31 January 2017, a witness intermediary was used to support 11 children and young people with disabilities interviewed by the CAS in non-pilot locations.[855]

Case study 13

The CAS was concerned that C, who has cerebral palsy and epilepsy, would not engage with police during an interview, due to her communication difficulties. Although C resided in a non-pilot location, the CAS requested a witness intermediary

C was interviewed by police with the assistance of the intermediary – who has a professional background in occupational therapy and experience working with people with cerebral palsy – and the use of a communication aid. C made clear disclosures about criminal offences committed by the offender.

After the interview, further corroborative evidence was obtained and the offender was arrested and charged. The offender admitted the offences prior to the matter going to hearing and pleaded guilty.[856]

As at 31 January 2017, the ODPP had also utilised sections 26 and 41 of the *Evidence Act 1995* on seven occasions to seek the court's permission to use witness intermediaries in non-pilot locations, notably for children under ten years of age and children and young people under 18 years of age with cognitive impairment.[857]

18.1.2. Feedback about the witness intermediary scheme

During our inquiry we received overwhelmingly positive feedback about the witness intermediary scheme from a diverse range of stakeholders.

Of the one quarter of respondents to the JIRT workforce survey who discussed witness intermediaries, more than 60% (including staff from all three agencies) commented favourably. Most of the positive responses noted that intermediaries had improved communication, police evidence gathering, and the ability of the JIRT response to better meet the needs of children. Most of the positive comments were made in response to survey questions about the JIRT response to children and young people with disabilities.

One-third of those who commented positively stated that the witness intermediary scheme should be expanded across the state.

A number of submissions[858] to the Royal Commission's *Consultation Paper – Criminal Justice* also include favourable comments about the impact of witness intermediaries. The NSW Government's submission stated:

> *Anecdotal feedback from District Court Judges involved with the Pilot, the ODPP and the Child Abuse Squad Pilot sites has indicated that the Pilot is achieving its intended aims, particularly in relation to reducing the stress and duration of court proceedings and improved evidence collection due to the assistance of the [intermediaries] at police interviews.*[859]

During our inquiry, the CAS also observed that the scheme is beneficial because it compresses the timeframe from the initial report, through to the recorded criminal interview and then any court proceedings that ensue.

855 We support the involvement of witness intermediaries in police interviews continuing to be managed administratively, with legislation in this area being unnecessary and likely to reduce responsiveness in intermediary use. The CAS has been able to use intermediaries outside the pilot arrangements without the risk of challenge that exists under the criminal proceedings legislative framework.
856 Case study provided by the CAS.
857 Advice provided by Department of Justice, Victims Services, February 2017.
858 Including submissions by the NSW Government, Office of the Director of Public Prosecutions, Aboriginal Legal Service, and Women's Legal Service.
859 NSW Government, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.16.

The ODPP's submission also noted that 'Feedback in relation to the relatively small number of matters that have progressed as part of the Child Sexual Offences Evidence Pilot suggests that the use of a witness intermediary has significantly improved the court process for child victims and the quality of the evidence they have given'.[860]

On 29 November 2016, Ms Mahashini Krishna, the Commissioner of Victims Rights in the Department of Justice; Detective Chief Inspector Peter Yeomans of the CAS; Ms Gina O'Rourke SC of the ODPP; and Ms Sharyn Hall of the private bar (who has been defence counsel in hearings involving witness intermediaries) all gave evidence to the Royal Commission, in which they indicated their support for the use of witness intermediaries. Ms Krishna noted that the use of intermediaries has been embraced by both prosecution and defence counsel.[861] Detective Chief Inspector Peter Yeomans indicated that Police strongly support the use of intermediaries.

Health and FACS have also advised us that they consider the witness intermediary pilot to be a positive step towards better engaging children with disability in the JIRT response.[862]

The Royal Commission has considered witness intermediary schemes in its *Consultation Paper – Criminal Justice*, as a number of parents have given evidence that their children's abusers had escaped justice because their children had either been too young to give evidence in court, or had cognitive problems that prevented them from doing so. The Royal Commission heard evidence from witnesses involved in the design and administration of the UK's Registered Intermediary Scheme that:

> *the introduction of the Registered Intermediary Scheme in England and Wales has not only allowed many people to give evidence who otherwise might have been deemed unable to do so but also, over time and with support from senior members of the judiciary, it has encouraged a cultural change at the bar, recognising that examining evidence from vulnerable witnesses requires skill and planning and that traditional approaches have prevented these witnesses from providing evidence at all.*[863]

The Royal Commission concluded:

> *there would seem to be potential for comprehensive and professional intermediary schemes to make a significant difference in reducing the problems that children and people with disability face in being heard by the criminal justice system.*
>
> *Improving the quality of evidence provided – and, in some cases, providing reliable evidence where at present none can be given – would appear to be consistent with the aims of making the criminal justice system accessible and increasing its capacity to produce safe convictions for institutional child sexual abuse.*[864]

During this inquiry, FACS indicated support for the reforms, commenting that they have 'the potential to immediately add enormous value' in the criminal jurisdiction. However, FACS also expressed some concern about the way the witness intermediary pilot has been implemented so far.[865] For example, there were suggestions by some FACS staff in their survey responses that intermediaries have been 'replaced' in the interview room.

It is worth noting that the Child Sexual Offence Evidence Pilot commenced two months after the CAS directive about recorded criminal interviews, which stated that police, from January 2016, would conduct all recorded criminal interviews without FACS being present in the interview room. Therefore the intermediary pilot was being rolled out during a period of significant change for the program.

860 NSW Office of the Director of Public Prosecutions, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse: Consultation Paper – Criminal Justice, October 2016, p.26.
861 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 46*, transcript of 29 November 2016.
862 Advice provided by NSW Health, December 2016; Advice provided by FACS, May 2017.
863 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.381.
864 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.382.
865 FACS also indicated that in three of the four pilot locations, settling the administrative arrangements between Victims Services and the CAS has caused certain inefficiencies and delay to the care and protection investigation. We were advised that implementation at the fourth site was 'negotiated in a collegial and child focused manner'. Advice provided by FACS, May 2017.

Police explained that one of the practical reasons for the change relating to FACS' presence in the interview room, is that it can be difficult for the police interviewer to establish a rapport with a child or young person when a number of people are present in the interview room – and that it is essential for the intermediary to be present. In addition, the intermediary's presence in the interview can usefully inform any further assessment of the child requested by the court. In this regard, Professor Penny Cooper, who has assisted in the development of both the England and Wales and NSW witness intermediary schemes, has reported that:

> *Having the intermediary visible and audible in the interview recording ensures that their role is transparent*[866] *… all witness intermediaries in NSW have been trained to facilitate communication while seated beside the child in an interview suite and later beside the child in the TV link room at court.*[867]

Our recent discussions with FACS have clarified that going forward, its primary concern is ensuring that its staff are not under-utilised because of the role now being played by the intermediary during the police interview. While FACS is not suggesting that its staff should perform the actual role of a witness intermediary[868] – acknowledging that as an officer of the court, an intermediary must be impartial – but rather that 'they have the skills to continue to add value to police communication with certain children and young people'.[869]

Consistent with the aims of the JIRT program, the CAS should share with and seek information from FACS and Health before lodging a request for an intermediary with Victims Services. Both agencies may have useful information about the child that, if passed on by the CAS to Victims Services, may allow better matching of witness intermediaries to particular communication needs. FACS and Health staff may also have useful information or insights into a child or young person's communication support needs, particularly where the child has a disability, or where the impact of trauma may be impeding the child's capacity to communicate effectively. (As discussed in Chapter 14, non-offending family members (and services already in contact with a child) are also well placed to provide to critical sources of information in relation to the child's communication needs.)

Similarly, proceeding to interview without sufficient time to engage a witness intermediary, as has occurred during the pilot in a number of cases, will likely disadvantage some children. In our view, Police should defer interviewing a child until a witness intermediary is available, unless the relevant CAS Team Leader, having requested any relevant information from FACS and Health, is satisfied that the child or young person has no communication needs that would warrant the use of an intermediary, or that there are exceptional reasons why deferring the interview is not appropriate.

In relation to the current 'target group' for the witness intermediary scheme, FACS has suggested that a better approach, within the existing funding arrangements, would be redirecting the use of intermediaries towards 'the most vulnerable children, including those with disabilities (cognitive impairment or with known communication difficulties), instead of applying the arrangements 'to all children who receive a JIRT intervention via the pilot sites'. While this suggestion makes sense, we understand that, at this stage of the pilot, a deliberate decision has been made to utilise witness intermediaries as frequently as possible in order to build their experience and develop a solid evidence base. We have been advised that even where a child does not initially present as having any particular communication needs apart from those associated with their age, it is not uncommon for the intermediary's assessment to reveal further issues that may impact on the child's ability to give their best evidence. We further note that the pilot has already included children with disability from non-pilot locations, due to their particular vulnerability.

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866 If the intermediary is not visible, the defence may raise doubts as to whether he or she was coaching or otherwise acting inappropriately with the witness during the interview.

867 P. Cooper, *'Children's Champions: Getting the Best Evidence from Child Complainants in Sex Abuse Cases: The First Witness Intermediaries in Australia'*, *Australian Police Journal*, Dec 2016, Vol. 70, No. 4, p.201.

868 While FACS and Health staff may be eligible for appointment to the witness intermediary scheme on the basis of their qualifications, skills and experience, they could clearly not perform the role of a witness intermediary as employees attached to the JIRT program. As an officer of the court, a witness intermediary must be impartial. A FACS or Health officer might have their impartiality questioned in subsequent proceedings on the basis of a conflict of interest.

869 Advice provided by FACS, May 2017.

As we discuss below, we support state-wide implementation of the current witness intermediary scheme to all children and young people who are complainants in child sexual offence matters. In this regard, we agree with the view expressed by the Department of Justice that 'the age of the child is an inherent vulnerability'.[870] However, we are also of the view that there is a strong case for making witness intermediaries available, at a minimum, to assist children and young people with cognitive and/or communication impairment involved in JIRT matters across the state.

During our consultation last year with the Commissioner of Victims Rights, she acknowledged that there had been some communication issues with FACS and Health around implementation that had, in her view, largely been addressed – however, she was keen to ensure any outstanding concerns would continue to be worked through collectively with all three JIRT agencies. FACS has since advised us that it has met with the Commissioner and has also provided feedback to the pilot's Implementation Management Group (which meets monthly and at which all JIRT partner agencies are represented) to inform the first stage of the evaluation.[871]

In light of the submissions made during this inquiry by FACS, there would clearly be benefit in the JIRT SMG further discussing practical implementation issues directly with the Commissioner, to ensure any ongoing concerns do not impede the effective use of what is widely regarded as a valuable resource for vulnerable children in this state. In this regard, the Department of Justice has indicated that Victims Services would welcome a further meeting with the JIRT partner agencies to discuss the implementation of the pilot.[872]

18.1.3. Possible enhancements to the witness intermediary scheme

As well as being provided with evidence about the implementation of the intermediary scheme so far, our consultations and research have identified three key areas we believe are worthy of consideration during the evaluation; these are discussed below.

Expansion of the witness intermediary scheme

We support state-wide implementation of the current witness intermediary scheme (that is, a scheme that is available, as required, to all children and young people who are complainants in child sexual offence matters). In saying this, for the reasons discussed in Chapter 14, we believe there is a strong case for making witness intermediaries available, at a minimum, to assist in all such matters across the state in involving children and young people with cognitive and/or communication impairment.

We also support the expansion of the scheme to matters involving a child or relevant young person complainant in Children's Court prescribed sexual offence proceedings (currently the scheme applies only to matters heard in the District Court). In this regard, we do not believe that the age of the alleged perpetrator should be a relevant factor in determining the communication needs of the complainant or prosecution witnesses.

In addition, we support an expansion of the use of witness intermediaries beyond children and young people in prescribed sexual offence proceedings. In our view, a witness intermediary should be available as part of the police interview process where the relevant person is a child, or Police are satisfied that the person has a disability or other condition resulting in a difficulty communicating, and that the facts of the case may be better ascertained if the person is assisted by a witness intermediary. However, we acknowledge that any expansion of the witness intermediary scheme will need to be phased, to enable the development of a sufficient intermediary workforce and to allow other resourcing issues to be identified and addressed.[873]

870 Advice provided by Victims Services, Department of Justice, June 2017. We also note the Department's further advice concerning a recent study – reportedly the first empirical evidence of its type – which found that typically developing children recalled significantly more people, actions, objects and general details when assisted by a registered intermediary for a mock interview. (Lucy A. Henry, Laura Crane, Gilly Nash, Zoe Hobson, Mimi Kirke-Smith and Rachel Wilcock, *'Verbal, Visual and Intermediary Support for Child Witnesses with Autism During Investigative Interviews'*, *Journal of Autism and Developmental Disorders*, Springer, 13 May 2017.)

871 Advice provided by FACS, May 2017.

872 Advice provided by Victims Services, Department of Justice, June 2017.

873 In its submission to the Royal Commission's criminal justice issues paper, the NSW Government stated that 'Continuation or expansion of the Pilot will be considered after evaluation of the Pilot. If special measures are to be expanded, consideration must be given to sufficient resourcing for the relevant agencies particularly Legal Aid NSW, the NSWPF Child Abuse Squad, the Court, the ODPP and Victims Services'. (NSW Government, *NSW Government Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.16.)

This will require the NSW Government to identify priority areas for expansion.[874]

If expansion is to be phased by offence type, it is our view that complainants in child sexual abuse, serious physical abuse and neglect matters should be prioritised, given the trauma associated with giving evidence in such proceedings and that such trauma may contribute to a complainant's ability to communicate effectively when giving evidence. We understand that, given the need to deliver broader police training on working with intermediaries, Police support extending the scheme to all CAS locations before any further extension to encompass child abuse matters handled by LACs or offences involving other complainants. In saying this, Police have also indicated that there should be scope for LACs to liaise with the CAS, on a case-by-case basis if, in exceptional circumstances, a strong need for an intermediary is identified. In such circumstances, the CAS could negotiate with Victims Services on behalf of the LAC.

If expansion is to be phased by location, we support the position taken by the Aboriginal Legal Service (NSW/ACT) in its submission to the Royal Commission's *Consultation Paper – Criminal Justice*,[875] that a regional or remote location with a significant Aboriginal population be prioritised for implementation. In this regard, it may be possible for audio-visual equipment to be utilised to facilitate witness intermediary assessments.

Finally, we note that communication during criminal proceedings is more challenging than at interview, and that in England and Wales intermediaries are not involved in all child interviews.[876] If there is a significant expansion of intermediary use following the pilot, then intermediary availability is likely to demand a more targeted approach to using intermediaries in investigative interviews.

Aboriginal witness intermediaries

In Chapter 13 we noted that Aboriginal children, who are at significantly increased risk of sexual abuse, may face particular difficulties interacting with the criminal justice system, especially in relation to communication.[877]

Our 2012 review of 27 cases of Aboriginal child sexual assault prosecuted by the ODPP identified several matters where prosecutors reached a decision to withdraw charges against the defendant because they had formed a view that the complainant would be incapable of providing the testimony that would be required in court. While it is not possible to conclude whether an intermediary would have resulted in a different outcome in these matters, it is clear, both from overseas evidence and our consultations for this inquiry, that intermediaries can play a very valuable role in supporting vulnerable children to give evidence.

Our consultations with ECAV's 'Aboriginal Communities Matters Advisory Group'[878] and AbSec revealed strong support for designated Aboriginal witness intermediaries. Based on our many years working directly with Aboriginal communities, we agree that there is value in this proposal. Culturally responsive service provision includes giving Aboriginal people the choice to access Aboriginal (as well as mainstream) services. We note that both the Aboriginal Legal Service NSW and the Victorian Law Reform Commission also support the availability of Aboriginal intermediaries for Aboriginal witnesses.[879]

874 The Department of Justice has advised us that it supports a phased approach to any potential further roll out of the pilot measures, and that the funding implications for the agencies involved will need to be carefully considered and additional funding allocated accordingly (Advice provided 1 June 2017).

875 Aboriginal Legal Service (NSW ACT) Ltd, *Criminal Justice Consultation Paper: Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse*, October 2016, p.12.

876 See the England and Wales Court of Appeal case of *R v Boxer* [2015] ECWA Crim 1684.

877 See the *Children's Champion (Witness Intermediary) Procedural Guidance Manual (2016),* November 2016, p.19. See also Aboriginal Legal Service (NSW ACT) Ltd, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.11.

878 ACMAG was established in 2003 and its members provide leadership and mentoring for new Aboriginal trainers and workers; and to ensure that there is an Aboriginal voice in ECAV's training, resource development and policy initiatives.

879 Aboriginal Legal Service (NSW ACT) Ltd, *Criminal Justice Consultation Paper: Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse*, October 2016, p.11; Victorian Law Reform Commission, *The Role of Victims of Crime in the Criminal Trial Process*, August 2016, p.171.

In October 2016, the Criminal Procedure Act was amended to allow teachers to be appointed witness intermediaries. This change was made due to concern that the previous qualifications required for appointment did not enable sufficient numbers of Aboriginal people to apply to work as witness intermediaries. The effectiveness of this strategy is not yet known, and will no doubt be considered during the evaluation of the Child Sexual Offences Evidence Pilot. The Department of Justice recently advised us that a targeted round of witness intermediary recruitment, aiming to increase the number of Aboriginal applicants, will be conducted.[880]

Regardless of the impact of this strategy, Aboriginal experts in the child health and wellbeing area have strongly advocated, given the over-representation of Aboriginal children as victims of abuse, for a suitable qualification pathway to be recognised specifically for Aboriginal people who apply to become intermediaries. In light of its successful track record in training and mentoring Aboriginal people, there may be value in Health seeking funding for ECAV to develop, in conjunction with Victims Services, such a training course to complement the establishment of dedicated Aboriginal witness intermediaries (if this approach is adopted), and in any event, to increase the number of Aboriginal people eligible to apply for 'mainstream' intermediary roles.[881]

Provision of witness intermediaries for vulnerable adults with cognitive impairment or communication support needs (including older people)

Although not directly related to the subject of our inquiry (and outside the scope of the Child Sexual Offence Evidence Pilot), it is important to note for contextual reasons that we have previously urged that the use of witness intermediaries should not be restricted to children and young people, but should be expanded to accommodate vulnerable adults with cognitive impairment and other communication support needs.

The general vulnerable person special measure provisions that exist under Part 6 of Chapter 6 of the Criminal Procedure Act extend to relevant persons with cognitive impairment, and there is no sound policy reason in our view for excluding such persons from access to communication assistance in giving evidence or in being interviewed by police. Ideally, a witness intermediary should be available to a witness in criminal proceedings if the witness is a child, or the court is satisfied that the witness has a disability or other condition resulting in a difficulty communicating, and the facts of the case may be better ascertained if the witness' evidence is given with the assistance of a witness intermediary.[882]

The Human Rights Commission has recently called on all Australian jurisdictions to enact legislation to facilitate the provision of communication assistance to people with an intellectual disability who come into contact with the criminal justice system.[883]

In 2016, South Australia introduced the 'communication partner scheme', which largely focuses on people with intellectual disability. The scheme was introduced as part of South Australia's Disability Justice Plan, to tackle the notion that disability denotes 'unreliability' in court proceedings.[884] It is largely based on the Registered Intermediary Scheme in England and Wales, but has some differences, including that it applies to defendants, and that communication partners are volunteers. The scheme, which commenced on 1 July 2016, largely focuses on persons with intellectual disability. It will be evaluated at the end of 2017.[885]

In Victoria, the Office of the Public Advocate (OPA) coordinates a volunteer independent service that provides support and communication assistance to people with cognitive impairment and mental illness in police investigative interviews.[886] However, in May this year, the Victorian Government

880 Advice provided by Department of Justice, Victims Services, June 2017.
881 The Department of Justice has advised us that while the Implementation and Monitoring Group (IMG) overseeing the pilot scheme is not in support of further altering the qualification criteria for witness intermediaries at this stage, an ECAV accredited course could be considered in the future if the IMG supports this. (Advice provided June 2017.)
882 Clause 89(3)(b) of Schedule 2 of the Criminal Procedure Act focuses on a witness over 16 years of age having difficulty communicating, not on the cause of that difficulty. However, making specific reference to disability may encourage the issue to be better considered in cases where the witness has a disability, given the high correlation between disability and communication issues.
883 Nance Haxton, *National approach crucial to make Australians with disability equal before the law*, ABC News, 20 March 2017. http://www.abc.net.au/news/2017-03-20/australians-with-a-disability-are-not-equal-before-the-law/8370482.
884 Nance Haxton, *National approach crucial to make Australians with disability equal before the law*, ABC News, 20 March 2017, http://www.abc.net.au/news/2017-03-20/australians-with-a-disability-are-not-equal-before-the-law/8370482.
885 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.380.
886 Victorian Law Reform Commission, *The Role of Victims of Crime in the Criminal Trial Process*, August 2016, p.171.

announced that it will fund a state-wide intermediary scheme for children and adults who are vulnerable witnesses. *The announcement implements the* Victorian Law Reform Commission's (VLRC) August 2016 recommendation that an intermediary scheme should be established, modelled on the existing scheme in England and Wales, for child victims and for victims who have a disability which is likely to diminish the quality of their evidence. The VLRC contemplated that intermediaries' functions may include assistance during police interviews, and that the proposed scheme would therefore replace the OPA volunteers.[887]

The Tasmanian Law Reform Institute is currently investigating the feasibility of introducing an intermediary scheme in Tasmania to facilitate equal access to justice for victims, witnesses and accused persons with complex communication needs.[888]

Our extensive work, both with Police and people with disability, in exercising our functions to monitor and review the delivery of disability services, and oversighting the handling of reportable disability incidents, has identified a clear need in NSW for vulnerable witnesses (not only children), to have a greater level of support when they are participating in interviews with police and giving evidence in criminal proceedings. We first raised this issue publicly in our 2012 audit report into Aboriginal child sexual abuse, when we recommended that the then DAGJ consider introducing a registered intermediary scheme.

At our November 2016 forum – *Addressing the abuse, neglect and exploitation of people with disability* – senior NSW Police Force representatives addressed participants about the results achieved from the Child Sexual Offence Evidence Pilot and the benefits of broadening the scheme to vulnerable adults with cognitive impairment and older people in need of communication support. There was overwhelming support for the proposed approach from the more than 500 forum participants.

In our March 2017 submission to the Australian Law Reform Commission's (ALRC) *Discussion Paper on Elder Abuse*, we submitted that there would be merit in considering the inclusion of communication intermediaries (witness intermediaries) as a key element of the proposed National Plan to address elder abuse.[889]

The disability advocates we consulted during this inquiry all support the use of witness intermediaries for people with disabilities, with a focus on communication needs rather than a particular type of disability that may impact on communication.[890] While the expansion of witness intermediaries to vulnerable adults with cognitive impairment or communication support needs (including older people) is out of scope of the provisions available under the current Child Sexual Assault Evidence Pilot, the Department of Justice has advised us that it nevertheless supports such expansion in principle.[891] In our view, an intermediary scheme for vulnerable adults with cognitive impairment or other difficulties in communicating (including older people with communication support needs) is a critical component of a robust safeguarding framework aimed at preventing and responding effectively to the abuse and neglect of people with disability, and other vulnerable members of the community.

In making the above observations, we note evidence given to the Royal Commission by Professor Penny Cooper, who observed that the primary justification for the provision of intermediaries is that all people have a right to participate in the justice system, and that if a person requires an intermediary to provide accurate and reliable evidence then it should be provided.[892] As previously noted, in its submission to the Royal Commission's 2016 *Consultation Paper – Criminal Justice*, the ODPP also supported the use of witness intermediaries in all matters involving child victims and for any court participant who requires assistance.[893]

887 Victorian Law Reform Commission, *The Role of Victims of Crime in the Criminal Trial Process*, August 2016, p.129.
888 Tasmania Law Reform Institute, *Facilitating Equal Access to Justice: An Intermediary/Communication Assistant Scheme for Tasmania?* Issues Paper No 22, May 2016.
889 NSW Ombudsman, *Submission in response to Australian Law Reform Commission Discussion Paper on Elder Abuse*, 1 March 2017.
890 See also evidence of Dr Jessica Cadwallader, People with Disability Australia, Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 46*, Transcript, 29 November 2016. Women's Legal Services NSW also supports making witness intermediaries available to witnesses who have a disability that affects communication (see Women's Legal Service NSW, *Response to Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, 31 October 2016, p.2).
891 Advice provided by Department of Justice, Victims Services, June 2017.
892 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 38*, Transcript, 24 March 2016.
893 NSW Office of the Director of Public Prosecutions, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse: Consultation Paper – Criminal Justice*, October 2016, p.26. The Victorian Law Reform Commission has also stated that restricting the availability of intermediaries to children, or certain groups of children or offences, is not justified. (Victorian Law Reform Commission, *The Role of Victims of Crime in the Criminal Trial Process*, August 2016, p.172.)

In our view, consideration should also be given to the merits of expanding the scope of the witness intermediary scheme to include defendants and defendant witnesses in those proceedings where intermediaries are available to the complainant and prosecution witnesses. If a complainant with communication needs has access to an intermediary, while a defendant with communication needs in the same proceedings does not, questions will inevitably be raised about the fairness of the trial.

Finally, the experience in NSW has shown that introducing an oversight scheme to prevent and improve the response to serious incidents of abuse of people with disability has, unsurprisingly, increased the number of matters being referred to police for investigation involving adults with cognitive impairment or communication support needs who would benefit from the assistance of an intermediary during their police interview.[894]

The Council of Australian Government's Disability Reform Council recently released the *NDIS Quality and Safeguarding Framework*,[895] which commits to establishing a national scheme for oversighting serious disability incidents. The ALRC's recent discussion paper on elder abuse has also proposed a similar national reporting scheme for elder abuse, overseen by the Aged Care Complaints Commissioner. We are encouraged by the accord between the recommended safeguards for people with disability and older people, and are keen to ensure that, where practicable and appropriate, this translates to a consistent approach to vulnerable adults more broadly.

We would therefore argue that the introduction of intermediary schemes for vulnerable adults with cognitive impairment or others in need of communication support (and the related infrastructure), should be considered at both a NSW and national level.

18.2. Expansion of pre-recorded evidence

In NSW, 'vulnerable persons' (children who are under the age of 16 and people who have a cognitive impairment) are able to have the audio-video recording of their investigative interview admitted as their evidence in chief in court. Research commissioned by the Royal Commission found that this is one of the most effective and frequently used special measures for child sexual abuse complainants[896] – it minimises the number of times the child will be required to answer questions about their abuse, and may also improve the quality of evidence because the interview is conducted closer to the time of the abuse.[897]

The Child Sexual Offence Evidence Pilot extends the existing special measures for using a pre-recorded interview as evidence in chief by providing that a complainant or prosecution witness who is under 16 years of age will give evidence at a pre-recorded evidence hearing before a judge, subject to any contrary order of the court.[898] For a complainant, their pre recorded interview will generally still be used as their evidence in chief, and will be heard during the pre-recorded evidence hearing, with the Crown and defence represented to conduct cross-examination and re-examination as required.

This aspect of the pilot also extends to a complainant or prosecution witness who is 16 or 17 years of age if the court is satisfied that hearing their evidence at a pre-trial hearing is in the interests of justice.[899] We understand that this is occurring in practice as part of the pilot.[900]

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894 On 3 December 2014, the disability reportable incidents scheme was established under Part 3C of the Ombudsman Act. This means FACS and funded disability services are required to notify our office of allegations of serious incidents involving people with disability living in supported group accommodation. NDIS-funded providers must also notify us of such allegations under the NSW transitional safeguards working arrangements.

895 Australian Government, Department of Social Services, *NDIS Quality and Safeguarding Framework*, December 2016.

896 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, *An evaluation of how evidence is elicited from complainants of child sexual abuse,* Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, August 2016, pp.55, 60, 82.

897 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.128.

898 It is noted that District Court Criminal Practice Note 11, *Child Sexual Offence Evidence Pilot – Downing Centre*, provides that all evidence of a witness under 16 years of age must be pre-recorded – court orders to the contrary are not contemplated, although cl 84(5) of Schedule 1 provides that the wishes and circumstances of the complainant and the availability of court and other facilities necessary for a pre-recorded evidence hearing are factors to be considered in making such an order. A child may continue to give evidence in this manner even if they become an adult during the course of the proceedings.

899 The framework for the giving of evidence in pre-recorded evidence hearings is provided for in clauses 81-87 of Schedule 2 of the Criminal Procedure Act and District Court Criminal Practice Note 11.

900 Advice provided by Department of Justice, Victims Services, June 2017.

The legislation supporting the pilot provides that:

> *A witness whose evidence is pre-recorded at a pre-recorded evidence hearing cannot give further evidence without the leave of the court, which the court must not give unless it is satisfied:*
>
> *(d) that the witness or other party is seeking leave because of becoming aware of a matter of which the party could not reasonably have been aware at the time of the recording, or*
>
> *(e) it is otherwise in the interests of justice to give leave.*
>
> *The further evidence is, so far as practicable, to be given by pre-recording at a hearing in the same way as the original pre-recorded evidence unless the Court otherwise directs.*[901]

As with the witness intermediary scheme, feedback on the implementation of this aspect of the pilot has been positive. In their submission to the Royal Commission's consultation paper on criminal justice issues, the NSW Government noted that:

> *Preliminary analysis of administrative data collected by Victims Services indicates that pre-recorded hearings are being held, on average, six months prior to the trial listing date. This allows the child complainant's cross examination to occur much closer to the date of the report to police than was previously possible.*[902]

In his evidence to the Royal Commission on 29 November 2016, Detective Chief Inspector Peter Yeomans of the CAS indicated his support for pre-recorded evidence hearings, noting that giving evidence earlier in the criminal justice process significantly reduces trauma for children and their families, and may increase the reliability of that evidence. He indicated that all of the families he had dealt with since the start of the pilot supported the process.[903] Police have particularly highlighted as beneficial that there must be a compelling reason for the court to recall a child to give further evidence.

During our inquiry, the CAS brought to our attention a matter involving a 16-year-old victim of sexual abuse, with a cognitive impairment, who was electronically interviewed by police in accordance with the existing special measures under the Criminal Procedure Act. While the existing measures for vulnerable persons would have enabled a recording of her police interview to be used as her evidence in chief, the additional measures provided for by the pilot – the ability to have all evidence heard at a pre-trial hearing including cross-examination and re-examination – were not available to her as she had turned 18 by the time the accused was committed for trial. The CAS was of the view that she would have benefited from giving evidence at a pre-recorded hearing, and it has suggested that this measure should be extended to people with a cognitive impairment, in the same way that the various special measures for vulnerable persons in the Criminal Procedure Act apply to both children under 16 and people with a cognitive impairment.

While we appreciate the practical reasons for the narrow focus of this aspect of the pilot (as with the witness intermediary component discussed previously), we agree that in the long-term, there would be value in people with a cognitive impairment or other difficulty in communicating having access to pre-recorded hearings. From our consultations during this inquiry, it would appear that there is also merit in considering, as part of the pilot's evaluation, whether the use of pre-recorded hearings should be broadened (consistent with their use in other Australian jurisdictions) to be available to:

- Young people aged 17 and 18 years.[904]
- People who are likely to suffer severe emotional trauma or be so intimidated or distressed that they cannot give evidence satisfactorily in normal court proceedings (including older people with communication support needs).[905]

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901 Clause 87, Schedule 2, Criminal Procedure Act.
902 NSW Government, *NSW Government Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.16.
903 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 46*, transcript of 29 November 2016.
904 Victoria, Western Australia, the ACT and the Northern Territory have pre-recorded hearings available to young people up to the age of 18 years.
905 This may be of particular assistance in intrafamilial matters, or matters involving a person in a position of authority. Similar provisions operate in Western Australia, Queensland, Tasmania and the ACT.

- People with a disability other than a cognitive impairment. (While recognising that there are many people with a disability who will be able to give evidence in the traditional manner, we note that all other Australian jurisdictions, except for Victoria and the ACT, have 'vulnerable persons' provisions that apply to a broader range of people with disability than those in NSW.)[906]

The Department of Justice has noted that any expansion to pre-recorded hearing provisions will require funding to facilitate technological upgrades to Courts as required, and that this may include the requirement for more remote witness rooms to be constructed.[907]

By the time the Child Sexual Offence Evidence Pilot is evaluated, the Royal Commission will have released its findings. The question of what special measures are, and should be, available to various cohorts of people in the context of sexual offence proceedings has been closely considered by the Commission. This has included a detailed review of the use of both intermediaries and pre-recorded evidence and a review of the other special measures that are in place in NSW and elsewhere.

As well as informing the evaluation of the pilot, we expect that the Royal Commission's findings will inform the NSW Government's consideration of other improvements that can be made to the criminal justice response to child sexual abuse (and the abuse of vulnerable adults, as discussed above).

We note, for example, that in its submission to the Royal Commission's *Consultation Paper – Criminal Justice*, the ODPP identified what it believes to be a range of inconsistencies or gaps in the operation of special measures in NSW (that fall outside of the pilot)[908] – these include:

- 'Child' is not uniformly defined across all applicable Acts, with a child being defined as under 18 years of age in some circumstances, and under 16 years in other circumstances. This means for example that 'children' aged 16 and 17 years do not currently have access to all of the benefits of their younger peers – for example, a child aged 16 or 17 years is not automatically entitled to have their investigative interview used as evidence in chief, and therefore police do not routinely conduct recorded interviews for this cohort.
- There are different provisions relating to how a support person may assist a 'vulnerable person' in prescribed sexual offence proceedings[909] when compared to other criminal proceedings. In general, a support person may assist a vulnerable person with 'any difficulty in giving evidence associated with an impairment or disability'.[910] However, this section does not apply to victims of prescribed sexual offence proceedings; and the alternative provisions are narrower in terms of how a support person can assist a victim.[911]
- Where a sexual abuse matter commences in the Local Court and is committed for trial in the District Court, a victim is prohibited from having to give evidence twice. However, for matters that commence in the Children's Court (because the alleged offender is a juvenile), the same protection does not apply.

While these other measures are directly relevant to the operation of the JIRT program, we do not consider it necessary – given the evaluation of the Child Sexual Offence Evidence Pilot and the Royal Commission's examination of these issues – to make further recommendations in this report. The Department of Justice has indicated that it will provide a copy of the report to the pilot evaluation team for its consideration.[912] We have been advised by the Royal Commission that it will similarly consider our commentary within this chapter as part of making its findings in relation to criminal justice issues.

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906 The Royal Commission has noted that people with disability may face significant challenges as complainants of sexual abuse. (See Royal Commission into Institutional Response to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, p.356.)
907 Advice provided by Department of Justice, Victims Services, June 2017.
908 NSW Office of the Director of Public Prosecutions, *Submission to the Royal Commission into Institutional Response to Child Sexual Abuse Consultation Paper – Criminal Justice*, November 2016, p.25.
909 Prescribed sexual offences are defined in section 3 of the Criminal Procedure Act, and include sexual offences against children and adults.
910 Section 306ZK of the Criminal Procedure Act.
911 The alternative provisions in 294C and 275B of the Criminal Procedure Act enable a support person to assist a witness who has difficulty communicating in giving evidence – but only if the witness ordinarily receives similar assistance in communicating on a daily basis. A complainant is otherwise able to have a support person present and within sight while they are giving evidence, but the support person is not able to assist the complainant. The intermediary scheme in effect addresses this discrepancy to the extent that it affects children within the pilot locations; however, even if the intermediary scheme in its current form were rolled out on a state-wide basis, there would still be an inconsistency for vulnerable adults who are the victims of prescribed sexual offences when compared to other offences.
912 Advice provided by Department of Justice, Victims Services, 1 June 2017.

Recommendation

46. The NSW Police Force should ensure that, in relation to the witness intermediary scheme, the Child Abuse Squad:

a) Shares information with and considers information from FACS and NSW Health JIRT staff before requesting a witness intermediary from Victims Services.

b) Defers interviewing a child until a witness intermediary is available, unless the relevant CAS Team Leader (having requested any relevant information from FACS and Health) is satisfied that the child or young person has no communication needs that would warrant the use of an intermediary, or that there are exceptional reasons why deferring the interview is not appropriate.

Chapter 19. Potential law reform

The 1997 report of the Wood Royal Commission into the NSW Police Service[913] highlighted the detrimental impact of disjointed agency responses to child victims of sexual abuse. It led to the establishment of Joint Investigation Teams (JITs), the precursor to the JIRT program, and a wide range of legislative reforms.

The introduction of the *Evidence (Children) Act 1997* resulted in significant improvements to the joint investigation, assessment and prosecution of child abuse matters.[914] Along with amendments to the *Criminal Procedure Act 1986*, this provided the legislative foundation for the JIRT response, including the dual purpose audio-visual recorded interview, the admissibility of the recorded interview as a child complainant's evidence in chief, and the installation of monitoring suites at JIRT sites – as well as making other child-focused improvements to the criminal justice system.

The *Children and Young Persons (Care and Protection) Act 1998* (Care Act) reformed the care and protection system and required the then Director-General of DoCS (now the Secretary of FACS) to encourage the development of procedures and protocols to promote a coordinated interagency and inter-sector approach to the care and protection of children and young people. Child protection legislative reform has continued ever since, with the 2008 *Special Commission of Inquiry into Child Protection Services in NSW* (Wood Inquiry) accelerating the pace of change, leading to the introduction of the information exchange provisions of Chapter 16A of the Care Act – which have been of particular benefit to JIRT operations.

While the JIRT program is essentially an administrative arrangement between the three partner agencies, a range of legislation impacts on its operation. In setting our inquiry's terms of reference, the JIRT agencies requested that consideration be given to any legislative issues impacting on the operational response of the JIRT program. The Child Sexual Offence Evidence Pilot, discussed in the previous chapter, is one area where legislative reform has impacted significantly on the operation of the JIRT. In this chapter, we discuss a number of other issues that were raised during the course of our inquiry – including issues relating to the operation of Chapter 16A, as well as a number of issues (which were identified primarily by Police) that impact on the criminal justice response to children and young people who are referred to the JIRT program.

As noted previously, the Royal Commission into Institutional Responses to Child Sexual Abuse is currently considering a wide range of criminal justice and child protection reforms that will impact on the operation of the JIRT program. It is likely that legislative reforms will be made following government consideration of the Commission's final reports. We have provided the Commission with a copy of this report to inform its final recommendations.

In addition, the NSW Department of Justice is currently undertaking a comprehensive review of child sexual offences. This review is in response to recommendations made in late 2014 by the Parliamentary Joint Select Committee on Sentencing Child Sexual Assault Offenders. The Committee recommended that the NSW Government should carry out a review of child sexual assault offences, with a view to consolidating and simplifying the current framework, and identifying whether new offences should be created to fill any existing gaps. The NSW Child Sexual Offences Review will take into account the final recommendations of the Royal Commission in formulating its position. As we discuss a number of child sexual offences in this chapter, we recommend that the NSW Police Force provide a copy of this report to the Department of Justice to inform its review.

913 His Hon James Wood, *Final Report* of the *Royal Commission into the New South Wales Police Service*, May 1997.
914 This Act was later incorporated into Part 6 of Chapter 6 of the Criminal Procedure Act.

19.1. Issues relating to information exchange

Since the JIRT program was last reviewed in 2006, there have been a number of significant legislative reforms that have impacted on its operation – most notably the introduction of the information exchange provisions contained in Chapter 16A of the Care Act.

This section outlines the general operation of Chapter 16A within the JIRT context and its positive impact, as well as a number of areas where information exchange arrangements could be further strengthened both within NSW and across borders.

We discuss concerns raised by Police during this inquiry about the practical impact of Chapter 16A on some aspects of police investigations in Chapter 21, in the context of discussing the information sharing aspect of the LPR process.

19.1.1. Exchange of information that promotes the safety, welfare and wellbeing of children and young people

In our submission to the 2008 Wood Inquiry, we argued for the introduction of legislation allowing relevant agencies to be able to share information that promotes the safety, welfare and wellbeing of children.

In particular, we suggested that certain agencies with significant responsibilities in this area (such as police, schools, health services and relevant early intervention and out-of-home care non-government service providers) should be able to communicate directly with each other, without having to rely on FACS to pass on critical information, and without being restricted by privacy concerns.

Justice Wood's final report emphasised the need to prioritise child safety above privacy concerns and recommended that agencies, including relevant non-government organisations, should be free to exchange information for the purpose of the safety, welfare and wellbeing of a child or young person. In response, the Care Act was amended in 2009 to introduce Chapter 16A, which permits information that promotes the safety, welfare or wellbeing of children or young people to be exchanged between prescribed bodies, despite other laws that prohibit or restrict the disclosure of personal information, and whether or not the child or young person consents to the information exchange. Chapter 16A also requires prescribed bodies to take reasonable steps to coordinate decision making and the delivery of services in relating to children and young people.

Section 245D(4) of the Care Act provides that:

> *a prescribed body is not required to provide any information that it has been requested to provide if it reasonably believes that to do so would:*
>
> *(a) prejudice the investigation of a contravention (or possible contravention) of a law in any particular case, or*
>
> *(b) prejudice a coronial inquest or inquiry, or*
>
> *(c) prejudice any care proceedings, or*
>
> *(d) contravene any legal professional or client legal privilege, or*
>
> *(e) enable the existence or identity of a confidential source of information in relation to the enforcement or administration of a law to be ascertained, or*
>
> *(f) endanger a person's life or physical safety, or*
>
> *(g) prejudice the effectiveness of a lawful method or procedure for preventing, detecting, investigating or dealing with a contravention (or possible contravention) of a law, or*
>
> *(h) not be in the public interest.*

Since Chapter 16A commenced, we have consistently worked to raise agencies' awareness of its availability and to ensure that they have appropriate policies and procedures in place to facilitate its use. The provisions have had a significant impact – enabling information from a variety of sources to be easily gathered to better inform assessments of children who may be at risk, and better tailor appropriate responses.

The multi-disciplinary nature of the JIRT model exemplifies the value of the Chapter 16A provisions. The ability for the JIRT agencies to freely share their respective information holdings, and to easily obtain information from other agencies that may be involved with families, is critical to the initial JRU assessment and the LPR process.

In comparing the JIRT program with other multi-disciplinary models, the Australian Centre for Child Protection (ACCP) noted:

> *The JIRT (NSW) have a comprehensive process for information exchange and case discussion in their local area response protocol; this includes planning initial contact with children and families, collecting and exchanging information available about the family, planning the interview, and coordinating the response following the interview. The process is supported by [the] wide information sharing provisions in [NSW] in place since 2009.*[915]

FACS has noted that 'the processes at the JRU and JIRT units for sharing information are excellent, [however] field compliance is subject to individual interpretation and often reflects broader tri-agency dynamics at any point in time'. While information sharing between Police, FACS and Health staff can be improved, as further outlined in Chapter 21, the comments made to this inquiry generally reflect practice rather than legislative issues. All of the agencies commented positively during the inquiry on the impact of Chapter 16A and the way in which these provisions are used in practice.

Notwithstanding the immense benefits of the Chapter 16A provisions, the Royal Commission has observed that there still appears to be anxiety and reluctance about information sharing in some quarters, suggesting 'that more needs to be done in [NSW] to promote understanding and confidence in sharing information to protect children in OOHC contexts'.[916] As noted by the recent NSW Parliamentary inquiry into child protection, anxiety and reluctance about information sharing is not confined to the OOHC sector. The inquiry expressed concern that there may be a lack of knowledge in the child protection sector about information sharing laws for child protection concerns.[917]

We agree with these concerns about the general operation of Chapter 16A which, from our experience, are most apparent in the failure by agencies to disclose relevant information under section 245C of the Act (that is, where the information has not been requested by another prescribed body). In our view, prescribed bodies should be proactively disclosing information in accordance with Chapter 16A, as other prescribed bodies who have a clear interest in receiving such information may not know of its existence. As noted by the Royal Commission, 'there does not appear to be any statement of policy that actively encourages proactive sharing where appropriate'.[918] While this would appear to be less of an issue for the JIRT program than for agencies working outside it, we believe that additional policy guidance should be given in this area.

We also believe that there would be benefit in considering how the information exchange provisions could be strengthened in two particular areas – interstate information exchange and the definition of prescribed bodies.

Interstate exchange of information related to child safety, welfare or wellbeing

We have advocated for many years for a nationally consistent approach to information sharing provisions.[919] It is essential that relevant bodies within each state and territory have the power to exchange information relating to the safety, welfare and wellbeing of children with like bodies in other jurisdictions.

While Police and FACS have both established systems for sharing certain information with their interstate counterparts, the type of information and the context in which it can be shared is limited when compared to Chapter 16A. In addition, there is limited scope for information sharing with and between other agencies.

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915 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 5.5.

916 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Institutional Responses to Child Sexual Abuse in Out-Of-Home Care*, March 2016, p.76.

917 Legislative Council General Purpose Standing Committee No. 2, *Report 46 – Inquiry into Child Protection*, March 2017, pp.168-169.

918 Royal Commission into Institutional Responses to Child Sexual Abuse, *Strengthening information sharing arrangements*, Discussion Paper, December 2016, p.23.

919 See, for example, *NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.174-176.

In the JIRT context, interstate information exchange is a heightened concern in 'border towns' – particularly in the state's north, north-west and far south, and areas bordering the ACT. For example, during this inquiry, NSW Health cited a recent case in which Canberra Hospital was unable to discharge a NSW child who had suffered alleged physical abuse, because it could not gain timely access to NSW information as to whether it was safe for the child to return home.[920] We have also been told by Police that the increase in grooming allegations involving the use of social media has highlighted current impediments to the interstate exchange of information.

Currently, FACS relies primarily on the *Protocol for the Transfer of Care and Protection Orders and Proceedings and Interstate Assistance* (the Protocol) as its vehicle for obtaining information from other jurisdictions. Among its purposes, the Protocol is intended to 'provide for cooperation between jurisdictions to facilitate the care and protection of children and young people'. To this end, the Protocol provides for (among other things), 'information sharing' between state child protection authorities. However, the provisions in the Protocol specifically related to 'information sharing' only refer to relevant child protection agencies providing to their interstate counterparts information that they 'hold' (clause 25).

Our 2012 report about Aboriginal child sexual abuse highlighted that there are a number of problems with the still current arrangements. Firstly, consistent with the Protocol, FACS has taken the view that it should not make a request to its counterpart in another state unless it is acting pursuant to its own legislative responsibilities (this requires it to first form an opinion that the relevant issue has already met, or may meet, the risk of significant harm threshold).

Secondly, facilitating cross-border exchange of information via statutory child protection authorities may not be effective in cases where the critical information being sought is not actually 'held' by the statutory child protection authority in the state where the information is located. (For example, it may be held by a health service.) We are aware that particular interstate child protection authorities believe that they do not have the legal authority to even request critical information from a third party agency within their jurisdiction, in circumstances where they themselves do not 'hold' the information being sought, and where the seeking of such information would not be for the purpose of protecting a child from within their own state.

These limitations create a situation where a child reported to the JIRT program who has either moved or lived interstate (or where the alleged offender either has or now lives interstate) may receive a different service response, compared with a child reported to the JIRT where there has been no involvement of interstate agencies with either the child or the alleged offender.

We have repeatedly raised our concerns about interstate information exchange arrangements in public reports and submissions over the past five years, including in various submissions to the Royal Commission. The Department of Premier and Cabinet has indicated that the impediments to interstate information exchange are a priority in the context of its work in connection with issues arising from the Royal Commission, and we look forward to seeing significant reform in this area in the near future.

Including organisations with management responsibility for prescribed bodies within the Chapter 16A framework

Based on data from the reportable conduct scheme, together with research undertaken by the Royal Commission, it is estimated that around 20% of all matters that are referred to the JIRT program relate to allegations of abuse in an institutional context.[921] In these matters, it is critical that there is scope not only for the easy exchange of information between the JIRT agencies, but also for the agencies to exchange information with the relevant institution, assist them in managing any risk that the individual may pose, and otherwise provide an appropriate response where possible.

920 Advice provided by NSW Health, March 2017.

921 In 2015, the Royal Commission asked FACS to analyse a random sample of 100 accepted JIRT referrals, resulting in a finding that 19 of the 100 cases involved allegations of institutional child sexual abuse. Factoring in error margins, the Commission's researchers estimated that somewhere between 13% and 28% of accepted referrals relate to institutional abuse. Our own data on the number of reportable notifications in 2015-2016 that related to sexual abuse, sexual misconduct, physical abuse and neglect indicates that the mid-point of the Commission's estimate is likely to be accurate.

For the purposes of Chapter 16A, prescribed bodies include the NSW Police Force; NSW government departments; schools; health services and practitioners; out-of-home care providers; children's services;[922] and 'any other organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children'.[923]

We have previously suggested – including in submissions to the Royal Commission – that consideration be given to broadening the definition of 'prescribed body' to include organisations exercising management responsibilities in respect of prescribed bodies.[924] This issue arises in the context of some religious organisations – for example, while Catholic schools or Catholic community services would fall within the definition of 'prescribed body', the Catholic Diocese responsible for those bodies might not. Management bodies of this kind possess, and should be able to readily receive and disclose, child protection-related information.

Section 245B(2A) of the Care Act states that a reference to a prescribed body is a reference to all the parts of that body (however described). However, that may not be sufficient to extend the Chapter 16A framework to a related entity that has separate legal identity.

The Royal Commission has also identified the need to consider how legislative frameworks for information exchange might apply to 'institutions with complex or federated structures'.[925] We believe that there is merit in this issue being considered as part of any review of Chapter 16A in NSW in response to the Royal Commission's final report.

19.2. Broader issues that impact on the effective criminal justice response to child abuse

The extent to which victims have confidence in the criminal justice system impacts directly on their willingness to participate in that process. The effectiveness of the criminal justice system as a whole therefore impacts directly on the ability of Police to carry out their responsibilities under the JIRT program.

In their submission to this inquiry, Police raised a number of legislative issues that they believe impact significantly on the criminal justice response to child abuse matters. Most of these issues – tendency and coincidence evidence, persistent sexual abuse offences, and grooming offences – have been examined at length by the Royal Commission (through their public and private hearings, research, and public consultation) and are matters that the NSW Government has already committed to consider through its Child Sexual Offence Review.

In light of the Commission's detailed consideration of these issues, we have focused on documenting the impact of the issues as they relate to the JIRT program, to inform the Commission's deliberations. In our view, the issues raised by Police are important – many of them were examined by our office during our three year audit of Aboriginal child sexual abuse but are yet to be addressed.

19.2.1. Tendency and coincidence evidence and joint trials

In our 2012 report, we recommended that the then Department of Attorney General and Justice consider creating a presumption in favour of joining trials for sexual assault prosecutions.

Child sexual assault cases often involve multiple incidents and multiple victims of a single offender. For example, a parent may abuse a number of siblings, an uncle may abuse a number of cousins, or a person in authority may abuse a number of children within the scope of that authority. When matters with more than one child complainant proceed to court, they can either be tried jointly or as separate matters. The primary reason for the separation of court proceedings is to protect a defendant's right to a fair trial.

922 See section 248(6) of the Care Act.
923 Clause 8(1)(j) of the Children and Young Persons (Care and Protection) Regulation 2012.
924 See also NSW Ombudsman, *General Purpose Standing Committee No. 2 Inquiry into child protection – Response to supplementary questions*, 4 November 2016.
925 Royal Commission into Institutional Responses to Child Sexual Abuse, *Strengthening information sharing arrangements – Discussion Paper*, December 2016, p.15.

Evidence from a complainant or witness about an accused may be admissible as 'tendency or coincidence evidence' in other proceedings against that accused, where prior allegations, offences or behaviour could be used to determine whether the accused committed particular offences.[926] In deciding whether or not to allow joint trials (or to otherwise allow tendency or coincidence evidence to be admitted), a judge must determine whether the probative value of tendency or coincidence evidence substantially outweighs the danger of unfair prejudice to the defendant.[927] However, the Royal Commission has noted that 'a rational argument can be made that the courts' concerns about unfair prejudice are misplaced'.[928]

Separate trials will often mean that a child victim will have to testify more than once in these circumstances. (While the Child Sexual Offence Evidence Pilot provides additional protections for children in this regard, the pilot's geographical scope is currently limited.) As a result, court processes may be drawn out substantially for victims, and may be complicated by the fact that a witness must give evidence in a trial relating to a different complainant without making reference to the offences against them. For example, if offences by a parent against two siblings are tried separately, a child might be required to give evidence that relates to their sibling, without making any mention of the fact that they were also abused by the parent.

Our 2012 report noted the ODPP's advice that this often has the impact of weakening a case to the point where there is no prospect of conviction, and also increases the likelihood that a trial will have to be aborted due to a witness accidentally giving evidence which is inadmissible.

Evidence given to the Royal Commission in Case Study 38 also highlights how providing separate trials for multiple complainants alleging abuse in the same setting can undermine the confidence of victims and their families in the criminal justice system, including with the JIRT response. The common use of separate trials may discourage some reporting of abuse, or willingness to give evidence, particularly as a child witness may need to give evidence in multiple trials and so relive their own abuse.[929]

During this inquiry, Police noted that England and Wales have had more liberal laws for the admission of tendency and coincidence evidence than any Australian jurisdiction for more than a decade. The Royal Commission has also closely considered the experience of England and Wales, and has noted that those laws do not appear to have given rise to injustices for defendants.[930]

The Royal Commission is reasonably satisfied that the law should change to facilitate greater admissibility of tendency and coincidence evidence, although it has not yet identified a preferred model. However, it has released *Evidence (Tendency and Coincidence) Model Provisions*, which provide two alternatives for consideration, both broadly modelled on the provisions of England and Wales.[931] The first retains concepts of tendency and coincidence evidence, while the second replaces them with the single concept of propensity.

19.2.2. Persistent sexual abuse of a child

In our 2012 audit report, we raised concerns about the operation of section 66EA of the *Crimes Act 1900*, which establishes the offence of persistent sexual abuse of a child.

The offence, which was enacted in 1999, recognised the difficulties for children and young people in particularising individual incidents of child sexual abuse to a sufficient level for the purposes of prosecution, particularly if abuse has been ongoing over a lengthy period of time. It sought to

926 Tendency evidence (also known as propensity evidence) could be used, for example, in institutional abuse matters where offences against a child may go towards proving alleged offences against other children. Coincidence (similar fact) evidence looks at the similarities in two or more events or circumstances to determine whether it is improbable that the incidents occurred coincidentally. (See Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.387-391.)

927 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.169-170 and p.173.

928 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.446.

929 Royal Commission into Institutional Responses to Child Sexual Abuse, *Public Hearing – Case Study 38*, evidence of Mr Peter Henry and Mr John Dunn, Transcript of 16 March 2017, pp.17474-17492.

930 Hon Justice Peter McClellan AM, Chair, Royal Commission into Institutional Responses to Child Sexual Abuse, *Seeking 'justice for victims'– Part I*, speech at the Australian Lawyers Alliance NSW Annual State Conference, 17 March 2017.

931 Available at http://www.childabuseroyalcommission.gov.au/policy-and-research/our-policy-work/criminal-justice.

address these barriers by requiring a lower level of particularisation in relation to individual incidents, but requiring the victim to identify three or more incidents ('a course of conduct'). It is a requirement of the offence that proceedings are instituted by, or with the approval of, the ODPP.[932]

In light of the high proportion of sexual offences against children that are perpetrated over a period of time by someone known to the victim, it was anticipated that the introduction of section 66EA would significantly increase prosecutions for child sexual offences. However, the NSW Bureau of Crime Statistics and Research has reported that the offence was charged on only 42 occasions between April 2006 and March 2016.[933]

The ODPP has repeatedly made it clear that prosecutions for the offence have not met expectations because of the manner in which the offence is constructed,[934] with the offence being interpreted by the NSW Court of Appeal as a procedural provision, rather than an offence in its own right.[935]

The Royal Commission has noted that other Australian jurisdictions have experienced similar issues with the practical effect of persistent sexual abuse offences, with the exception of Queensland, where the relevant offence – which focuses on an unlawful relationship rather than particular unlawful acts – is regularly charged.

At the time of our 2012 report, we were advised that consultation on the intent and operation of section 66EA would be undertaken in 2013, and that amendments, if required, would be introduced.

While this has not yet occurred, we note that this issue has since been considered closely by the Royal Commission, and that it is also being considered as part of the NSW Child Sexual Offence Review. Justice McClellan has noted that 'it is unacceptable, in [the Commission's] view, that the criminal justice system should accept a situation in which children who have suffered the most extensive abuse may be those who are less able to receive justice in the criminal courts'.[936] We anticipate that the Commission will make recommendations in this area that will lead to positive amendments to the NSW offence.

Police indicated during our inquiry that the ODPP has been reluctant to prosecute section 66EA, and submitted that consideration should be given to removing the requirement that proceedings be approved by the ODPP. We understand from our earlier consultations with the ODPP, and their ongoing representations regarding the offence, that their reluctance to approve proceedings under section 66EA has been largely due to the difficulties arising from the construction of the offence. While we therefore anticipate that the substance of the Police concerns would be largely addressed if the offence were amended, we note that the ODPP has previously agreed that the 'resources involved in sanctioning the charge are prohibitive to the proper application of the section'.[937] Accordingly, we believe that there is merit in consideration being given to removing this requirement, as part of any review of the section.

19.2.3. Grooming offences

The case studies that have been examined by the Royal Commission demonstrate that grooming is a precursor to, or a component of, a significant proportion of child sexual abuse offending.[938]

As we discussed in Chapter 9, in practice grooming can involve a very broad range of behaviours – many of which, in the absence of any unlawful intent, are common and appropriate in adult-child relationships. As a result, the criminal law response to grooming must strike a balance between covering a sufficiently broad range of behaviours, whilst not discouraging adults from developing appropriate supportive relationships with a child.

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932 See section 66EA(11) of the Crimes Act.
933 NSW Government, *NSW Government Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.11.
934 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.166.
935 *R v Fitzgerald* (2004) 59 NSWLR 493; *R v Manners* [2004] NSWCCA 181.
936 Hon Justice Peter McClellan AM, Chair, Royal Commission into Institutional Responses to Child Sexual Abuse, Seeking 'justice for victims'– Part I, speech at the Australian Lawyers Alliance NSW Annual State Conference, 17 March 2017.
937 Office of the Director of Public Prosecutions NSW, *Submission to the Inquiry into family violence by the Australian Law Reform Commission (ALRC) and the New South Wales Law Reform Commissio*n, 25 June 2010.
938 See, for example, the Royal Commission's Case Studies 6, 12, 32 and 38.

Offences relating to grooming have been in place in NSW since 2008. The current provisions make it an offence for an adult to intentionally procure a child for unlawful sexual activity; and to engage in behaviour that grooms a child for the purpose of making it easier to procure that child for unlawful sexual behaviour. NSW limits the application of the relevant offence by defining specific conduct that constitutes 'grooming' – namely, an adult engaging in conduct that exposes a child to indecent material, or provides a child with an intoxicating substance with the intent to procure them for sexual activity.[939]

By contrast, the Victorian offence, introduced in 2014, covers any words or conduct used with the intention of facilitating a child's involvement in a sexual offence. The offence extends to grooming a person who has care, supervision or authority of the child (for example, a parent).[940] Police submitted during this inquiry that the JIRT response to grooming offences might be enhanced if NSW were to adopt a broader grooming offence of the kind that exists in Victoria, while retaining the current elements of the NSW grooming offence.

The Royal Commission closely examined grooming offences in different jurisdictions as part of its criminal justice consultation process, and we expect that it will make recommendations regarding grooming offences in its forthcoming criminal justice report. The NSW Government has also confirmed that grooming offences are being reviewed as part of the current Child Sexual Offences Review, and that this will include consideration of the benefits and risks of adopting broader provisions similar to those in Victoria, taking into account any recommendations of the Royal Commission.[941]

19.2.4. Criminal offences for serious neglect

Police also raised concerns during this inquiry about the adequacy of the existing offences for dealing with matters involving the serious criminal neglect of children; in particular, noting that the available offences are not appropriate in all circumstances and that it can be difficult to prove each element of the offences beyond reasonable doubt.

The key relevant offences in the Crimes Act are contained in sections 43 and 43A. Section 43 makes it an offence for a person to, without reasonable excuse, intentionally abandon or expose a child under seven years of age if it causes a danger of death or serious injury to the child; and section 43A makes it an offence for a person who has parental responsibility for a child to, without reasonable excuse, intentionally or recklessly fail to provide the child with the necessities of life, if that failure causes a danger of death or serious injury. Both offences are punishable by five years imprisonment.[942]

Police have suggested that an additional offence, similar to section 101 of the *Children and Community Services Act 2004* (WA) should be enacted in NSW. That section provides:

> *A person who has the care or control of a child and who engages in conduct* [943] *—*
>
> *(a) knowing that the conduct may result in the child suffering harm as a result of any one or more of the following —*
>
> *(i) physical abuse; or*
>
> *(ii) sexual abuse; or*
>
> *(iii)emotional abuse as defined in section 28(1); or*
>
> *(v) neglect as defined in section 28(1);*[944]*or*
>
> *(b) reckless as to whether the conduct may have that result,*
>
> *is guilty of a crime, and is liable to imprisonment for 10 years.*

939 See section 66EB of the Crimes Act.
940 Section 49B of the *Crimes Act 1958* (Vic).
941 NSW Government, *NSW Government Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016.
942 Police indicated that they may also seek to use other offences in the Crimes Act in responding to some specific examples of serious neglect, for example, the offence relating to endangerment of life through the use of poison contained in section 39. There are also relevant child abuse and neglect offences contained in sections 227 and 228 of the Care Act, which are punishable by fine.
943 'Engage in conduct' means to do an act or to omit to do an act.
944 'Neglect' includes failure by a child's parents to provide, arrange, or allow the provision of adequate care for the child; or effective medical, therapeutic or remedial treatment for the child. (Subsection (a)(iv) was removed from the Act.)

There are a number of important differences between the Western Australian provision and section 43A of the Crimes Act, including that it operates on a different threshold relating to the potential for a child to suffer 'harm' rather than 'serious injury'; it does not have an inherent 'reasonable excuse' defence; and it has a longer term of imprisonment.

As these offences are outside of the remit of both the Royal Commission and the current Child Sexual Offences Review, Police provided a comprehensive submission to the relevant Ministers in 2016, outlining their concerns and proposing that an offence similar to that in Western Australia be enacted. We understand that the submission is currently being considered by the Department of Justice. We welcome consideration of the offence of criminal neglect. While neglect matters make up only a small proportion of referrals to the JIRT program, to provide better protection for very vulnerable children, it is important that there are appropriate criminal justice avenues for dealing with individuals alleged to have engaged in serious criminal neglect (as opposed to neglect that is more appropriately dealt with under the Care Act).

19.2.5. Similar age defence in adolescent peer sex matters

As we discussed in Chapters 9 and 10, all reports of adolescent sexual activity involving children under 16 years of age are currently referred to the JRU in the first instance. Following this, reports are either accepted for a JIRT response where particular risk factors exist or, more often, referred to a Local Area Command (LAC) and/or Community Service Centre (CSC).

Research indicates that a significant proportion of adolescents engage in sexual activity prior to the age of consent.[945] As the Crimes Act does not recognise persons under the age of 16 years as being able to consent to sexual activity, police have an obligation to investigate all reports, irrespective of the circumstances. The consequences for a young person if they are convicted of adolescent peer sex are significant – including that they become a registrable person, and as a result, are subject to reporting requirements for between four and seven and a half years.[946]

In practice, prosecutions in adolescent peer sex matters are rare, with police and prosecutors generally exercising discretion not to pursue the matter through the Courts. Nonetheless, the effect of police investigating such matters can have negative consequences for the young people involved. The JIRT partner agencies have raised concerns with us about the impact of the current arrangements for responding to reports of adolescent peer sex where there is no evidence at the outset of coercion – including that:

- police involvement can cause trauma for the adolescents involved
- it impacts on police workloads and diverts resources from the investigation of more serious incidents
- adolescents may be deterred from seeking treatment for sexual health concerns, and
- it may damage the relationship between the adolescents involved and police, as well as any current or potential engagement with other agencies who could provide valuable supports.

In Chapter 9, we recommended that the JIRT referral criteria be amended so that the Helpline is only required to refer adolescent peer sex matters that do not involve a complaint or any evidence of coercion to the JRU in particular circumstances.[947] While this recommendation, if accepted, will reduce the number of matters handled by the JRU, it will not remove the workload at LAC level, nor will it address the particular concerns raised by the agencies about the broader impact on young people.

945 See, for example, A. Smith, P. Agius, A. Mitchell, C. Barrett and M. Pitts, *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University, 2009.

946 *Child Protection (Offenders Registration) Act 2000* ss.14A and 14B.

947 We recommend that matters still be referred to the JRU for further assessment if one of the children involved is at ongoing risk of harm; or if available information indicates that the young person would benefit from receiving a JIRT response, having regard to the 'factors to consider' that we have recommended should be developed.

In our 2012 audit report, we noted that legislation in some Australian jurisdictions allows, as a defence for engaging in sexual activity with a person under the age of consent, that the two participants were of a similar age.[948] In all relevant jurisdictions, the defence does not cover non-consensual sex (that is, it only applies in circumstances where there is no evidence of a complaint or of coercion).

Currently, four Australian jurisdictions provide for a defence of similar age in the following circumstances:

- In the ACT, the child must be aged 10 years or more, with no more than a two year age difference.[949]
- In Victoria, the child must be aged 12 years or more, with no more than a two year age difference[950] – the Victorian Director of Public Prosecutions has also issued a guideline on decisions to prosecute in other 'boyfriend/girlfriend' cases.
- In Tasmania, if the child is aged 15 years or more, there must be no more than a five year age difference – if the child is aged between 12 and 15 years of age, there must be no more than a three year age difference.[951]
- In South Australia, where the age of consent is 17 years, the child must be 16 years of age, with no more than a year age difference.[952]

Canada also has a defence similar to that in Tasmania – if a child is aged 14 years or more, there must be no more than a five year age difference; and if a child is aged 12 or 13 years of age, there must be no more than a two year age difference.

We recommended in 2012 that the (then) Department of Attorney General and Justice review consent provisions with the introduction of a similar age defence in mind.[953] We also recommended that a proposed review of the Prosecution Guidelines by the Director of Public Prosecutions should consider the processes for managing adolescent peer sex matters.[954]

In October 2013, as part of a statutory review of the consent provisions for sexual offences in the Crimes Act, the then Department of Attorney General and Justice recommended that consultation should be undertaken on whether a 'similar age' defence should be introduced in NSW. While we understand that this consultation has not yet occurred, the NSW Government has indicated that the Department of Justice will be considering whether a similar age defence for sexual offences should be enacted in NSW and how it should be framed, as part of its current NSW Child Sexual Offences Review.[955]

While we appreciate that reform in this area is controversial, we share the concerns of the JIRT agencies regarding the potential for the current legislative situation in NSW to impact negatively on the wellbeing of children and young people. As such, we continue to be of the view that an appropriately constructed 'similar age' defence would be of benefit.

948 There is a separate statutory defence of honest and reasonable mistake of age in a number of other Australian jurisdictions, where a person may rely on a child's consent to sexual activity if they honestly and reasonably believed the child to be at least 16 years of age. The defence is available at common law in NSW.
949 Section 55(3) of the *Crimes Act* (ACT).
950 Section 45(4) of the *Crimes Act 1958* (Vic).
951 Section 124(3) of the *Criminal Code Act 1924* (Tas).
952 Section 49(4) of the *Criminal Law Consolidation Act 1935* (SA).
953 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, pp.164-165, 173.
954 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012 (Recommendations 59(b) and 61).
955 NSW Government, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Criminal Justice*, October 2016, p.21.

Part 7

Operational issues across the JIRT partnership

Co-location of Police, FACS and Health Staff in JIRTs | Local Planning and Response | Interviewing | The JIRT Local Contact Point Protocol | The JIRT Training Program

Contents

Chapter 20. Co-location of Police, FACS and Health staff in JIRTs

At the outset of our inquiry, FACS and Health made clear that the accommodation of JIRT staff was one of a number of contentious issues requiring resolution. The responses to the JIRT workforce survey confirmed that uncertainty about whether Police intended to move away from the preferred 'co-location' model was causing considerable concern for FACS and Health staff, with the model widely regarded by many JIRT agency staff as being central to the success of the JIRT program (although, as noted in Chapter 4, only half of the 22 JIRT units are fully 'co-located').

Following our visit (outlined in Chapter 6) with members of the SMG and other senior JIRT agency representatives to Western Australia to examine the MIST model, and specifically the George Jones Centre facilities, we were able to reach agreement with the SMG about a mode of co-location that would better meet the needs of each partner agency. In this regard, it was particularly useful for the JIRT SMG to hear directly from police based at the George Jones Centre about their desire to continue working in the same building as their child protection and NGO MIST colleagues, but their need to also have a separate, dedicated space for police to discuss sensitive operational issues. This need was supported by the non-police members of the MIST but they (and police) also emphasised the benefits of having shared work spaces – such as interview, meeting and family rooms.[956]

During our visit to Western Australia, we were able to facilitate discussions with the SMG which resulted in a common position being reached on issues relating to co-location. This position was subsequently reflected in a joint SMG communication in December 2016.

In this chapter, we discuss the benefits of co-location in its various forms, as well as what the JIRT workforce had to say about the strengths and weaknesses of the current accommodation arrangements and how they could be improved.

20.1. The benefits and limitations of co-location in Multi-Disciplinary Team responses to child abuse

Co-location involves workers from different agencies being located in the same building or complex. Those workers may share an integrated workspace, or work in separate areas near to each other. Whether or not workers share their regular workspace, it is common for parts of the building or complex to be set aside for joint work or common use (for example, conducting interviews, interview monitoring, family and meeting rooms, welcome area).

In 2008, the Wood Inquiry supported, 'as a general principle … the concept of locating [JIRT] staff from DoCS and from other relevant human service agencies within the same general location, for example in a state government office centre, so as to facilitate cross agency client access to services'. Justice Wood clarified further that 'the Inquiry believes that co-location is preferable for those JIRTs that have a consistently heavy workload', noting that co-location is 'likely to be more necessary in rural and remote areas of the State than it is in the larger metropolitan centres'.[957]

Many Australian and international multi-disciplinary teams (MDTs), having regard to operational considerations, accommodate different agencies in separate sections or floors of the same building. While the Australian Centre for Child Protection's (ACCP) research (discussed in Chapter 5) notes that this approach may impact the degree to which these teams are actually integrated, it makes clear that co-location (whether involving integrated workspaces or not) is not essential to an effective interagency response to child abuse. Shared goals; regular communication and information sharing; clear interagency policies and procedures; effective dispute resolution mechanisms and strong governance all help to support an effective response, irrespective of co-location.

956 When the MIST trial commenced, WA Police were not initially operating out of the George Jones Centre which meant that their needs were not factored into the original design/layout of the building. After operating jointly for a period, the agencies now have a better idea of what type of shared and separate spaces are needed to execute their functions effectively.

957 Hon James Wood AO QC, *Final report of the Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, Vol.1, p.310.

Internationally, few MDTs co-locate police and child protection authorities, despite police and child protection workers commonly participating in MDT response reviews (police and child protection worker co-location is more common in Canada and Australia). Where police co-location occurs, it is highly unusual for police investigators to share an integrated workspace with staff from other agencies. It is more common for specialist police interviewers, who are not responsible for the investigation, to share integrated workspaces.

Research highlights that co-located MDTs are beneficial (although individual MDTs do not necessarily realise all of these benefits or may realise them to varying degrees) in that they:

- Support children and families attending a single location to have multiple needs considered and addressed. Research commissioned by the Royal Commission concluded that police responsiveness to child sexual abuse complainants was improved by the establishment of specialist units, particularly units where police and at least two other agencies are co-located to perform the primary role of providing a coordinated response.[958]
- Enable a more coordinated response and simplify the process of collaborating on cases.
- Build connection and professional relationships between team members.
- Provide higher levels of role clarity in the joint response
- Improve the connection between the statutory and service response to cases, and simplify the process of referral and follow-up on cases, and
- Reduce agency travel time for face-to-face interagency work.

However, co-location is not appropriate or possible in all areas. The ACCP states:

> *While at least theoretically co-location enhances the degree to which a cross-agency team can be built, in some contexts the value of this may be outweighed by costs and the logistical difficulties of operating in a co-located space. Co-location may be a desirable component of a response, but its feasibility may depend on the scale of the cases responded to from the centre.* [959]

The ACCP notes that some smaller jurisdictions which provide a state-wide response to child abuse locate their resources (for example, co-located facilities, medical examination sites) in capital cities.[960] Similarly, research on US Child Advocacy Centres (CACs) found that regional CACs 'were not significantly different from metro or suburban CACs on many variables, only in terms of mental health and medical services on site, and in the number of agencies co-located'.[961]

Full co-location may also be impossible when staff from at least one MDT agency service multiple sites through satellite or outreach arrangements – as occurs with some of the remote and rural JIRTs.

Scale and demand for services; service area size and population; workforce issues and the availability of suitable accommodation, are relevant factors in determining whether co-location of MDT agencies is appropriate in a particular area.

20.2. JIRT workforce views on co-location

Research commissioned by the Royal Commission noted that professional stakeholders supported the need to co-locate agencies in responding to child sexual abuse.[962]

Rather than diverting respondents towards issues that were reported as 'contentious', our JIRT workforce survey deliberately asked open questions about strengths and challenges. While the survey did not explicitly seek JIRT staff views on co-location, about 20% of respondents[963] commented

958 Other research cited in this section is drawn from the two ACCP reports and reviews of the JIRT and MASH responses, discussed earlier in Chapters 3 and 5.
959 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.
960 J. Herbert and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 5.2.
961 J. Herbert and L. Bromfield, *Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, August 2017, section 6.
962 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.95-96.
963 38 CAS, 16 FACS and 14 Health respondents.

on this issue. Most respondents (59%)[964] – primarily CAS staff – discussed negative aspects of co-location, while about one-third[965] discussed positive aspects of co-location (some comments were neither positive nor negative).

Responses that were supportive of co-location commented that it:

- creates a safe and supportive environment for children and families[966]
- reduces child and young person travel time in attending interviews
- supports an integrated interagency response to cases
- builds working relationships and respect between staff from different agencies
- makes information exchange quick and easy,[967] and
- makes it easier to organise joint briefings and debriefings on cases.

It was clear from the survey responses that the concept of co-location appears to be viewed very differently by individual workers. In this regard, it needs to be stressed that many of the respondents who expressed negative views about 'co-location' clearly considered it to involve staff sharing an integrated workspace (that is, work stations side-by-side). Some of the same respondents who said they were against co-location indicated that they would be happy to work from the same building or complex, but in separate areas. The relatively high level of concern expressed by CAS respondents, compared to child protection and health workers, is a reflection of police investigators, historically, not being used to being housed in an integrated interagency workspace – an unusual, if not unique, feature of the JIRT model, compared with other MDT models.

The greatest concern expressed about 'co-location' came from police respondents, who said it made it difficult to comply with legal and operational requirements when using covert methods of investigation (for example, the use of surveillance devices or telecommunications interception) and to maintain confidentiality within an integrated workspace. These concerns have sometimes resulted in CAS officers having to work from nearby LAC offices to conduct or discuss covert operations – a situation that is far from ideal.

Other concerns reported by CAS respondents included:

- feeling limited in being able to openly discuss criminal investigation strategies and 'soak up' discussions taking place between other police colleagues, as would occur in a police station environment, because they are less keen to do so in front of staff from other agencies
- staff from other agencies providing their views on operational policing issues, and
- co-location leading to a 'blurring' of roles.[968]

Significantly, a number of the CAS respondents made it clear that working in a separate space in the same building (as occurs in other MDTs) would address these concerns.

Other concerns about co-location expressed by FACS and Health staff included:

- working in a space with people with different roles can contribute to and exacerbate tension between agency staff
- insufficient private space for crisis counselling or sensitive phone conversations with clients, and
- access to work amenities for Health staff being more difficult, given the larger number of workers from Police and FACS, which can slow down the flow of work, and result in health staff feeling 'devalued'.

Similarly to their police colleagues, Health staff also expressed concern about being isolated from supportive networks of health colleagues and missing out on 'incidental learning'.

964 31 CAS, 2 FACS and 7 Health respondents.
965 5 CAS, 12 FACS, and 6 Health respondents.
966 One JIRT Health worker said, 'The saturation of services at the point of entry appears to provide a good level of support and reassurance to families. I believe having health present signifies to the families that the process is one of inclusion and promotes engagement not only with criminal investigation & child protection points of view but also promotes engagement from a holistic health perspective'.
967 Although two FACS workers commented that information exchange can be slow, despite co-location.
968 Role confusion concerns can be addressed through quality interagency policies and procedures and effective governance.

20.3. JIRT SMG – December 2016 Joint Communication

As noted at the outset of this chapter, the JIRT SMG were able to broker a co-location arrangement that was more suitable to the current (and future needs) of the JIRT agencies. The December 2016 SMG Joint Communication informed all JIRT agency staff of the agreed position reached around co-location arrangements, and reaffirmed the commitment of the three agencies to the JIRT program and the interagency collaboration necessary to support it.

In relation to JIRT property and accommodation issues, the Joint Communication stated that:

> *For operational reasons and in compliance with broader corporate directives, the NSW Police Force is consolidating its offices in the Sydney Metropolitan Area at Liverpool, Penrith and Strawberry Hills.*
>
> *The first of these locations will be a newly created CAS office in the Australia Post Building at Strawberry Hills, absorbing those currently at Chatswood and Kogarah, which will commence operations towards the end of the first quarter of 2017. FACS and Health are considering how best to manage this change in order to meet our respective obligations under the JIRT arrangement.*
>
> *The NSW Police Force is also intending to progressively transition away from* integrated *(our emphasis) co-located offices at Newcastle, the Entrance, Tamworth and, in the longer term, Wollongong; however it is unlikely that this process will be completed prior to the 2018-2019 financial year.*
>
> *It is the collective view of the SMG that future accommodation should preferably be located in the same building, ideally on the same floor, or at least within close proximity.*
>
> *The SMG recognises the need for appropriate governance to ensure overall service delivery and joint practice is not adversely impacted.*
>
> *The SMG is committed to interview, monitor, family and meeting rooms remaining available for use by each agency at relevant points of the JIRT process.*
>
> *The SMG will continue to engage with impacted staff to minimise disruption to core business activities, and ensure that agencies continue to engage with each other in a manner that builds upon already strong local working relationships.*[969]

The ACCP has noted that most of the JIRT sites are at least partly co-located, certainly to a greater extent than in any other Australian jurisdiction. We consider this an important characteristic of the JIRT model and the clear preference for co-location of JIRT agency staff in the same building is welcome, as is the commitment to interview, monitor, family and meeting rooms remaining available for use by each agency.

We agree with the partner agencies' assessment that all agencies need secure areas in order to appropriately perform their roles and functions under the JIRT MoU. While FACS and Health staff may benefit from working together in an integrated workspace (subject to space being available for each agency's use), locating police investigators in such a workspace is problematic, and has clearly contributed to tensions between agency staff.

Comparable Australian and international MDT models provide separate work spaces for police investigators. Police need a secure space to discuss covert and other sensitive manners, store sensitive material and freely discuss investigative techniques. The increased use of telecommunications interception and surveillance devices in CAS investigations since our 2012 report has made it increasingly necessary for CAS officers to have their own secure accommodation.

Providing separate and secure accommodation in a single building or complex, with areas for common use, will enable the benefits of co-location to be realised – provided they are supported by sound governance arrangements for making, and communicating to staff, decisions about changes to accommodation. If executed well, such an approach has the potential to address many of the concerns raised by JIRT agency staff. It is essential for any consideration of changes to accommodation to be discussed with the SMG at the earliest possible stage, to allow each agency to concurrently plan for and address any impacts on their agency.

969 JIRT SMG, *Joint Communication,* 21 December 2016, p.4.

Health has also suggested that the JIRT agencies review the impact of changed accommodation arrangements on service delivery after a reasonable period, and if necessary, jointly devise strategies for minimising any adverse impacts identified.

The consolidation of police offices in the Sydney metropolitan area is ultimately an operational and budgetary issue that has been determined, informed by a human resources review, by the NSW Police Force Commissioner's Executive Team. In this regard, the Police have advised that consolidation creates economies of scale which enable it to more effectively cover vacant positions or temporary staff absences across the CAS – a particular necessity given the significant amount of maternity leave in the squad, and shared resources such as police vehicles.

The co-location of JRU staff was not raised as an issue by JIRT staff or agencies, as it was accepted that continued 'integrated' co-location was necessary to support the effective discharge of JRU functions. However, our visit to the JRU highlighted the need for further consideration to be given to providing the JRU staff with additional work space which facilitates tri-agency decision-making, but which also provides the management team with adequate space of their own. If our recommendation to create an additional JRU 'decision-making table' is accepted, then future planning will need to factor this in. We understand that the joint agencies are currently exploring options for re-locating the JRU.

Recommendations

47. The JIRT partner agencies should review the accommodation needs of the JRU, taking into account any planned expansion of JRU resourcing as a result of the recommendations in this report.

48. The JIRT partner agencies should, as far as possible, co-locate JIRT agency staff in the same building, ideally on the same floor, or at least within close proximity to each other, with CAS officers having their own dedicated work area in accordance with the December 2016 SMG Joint Communication. Relevant future considerations relating to accommodation arrangements might include the following for specific JIRT sites:

- **a) The scale and demand for services; service area size and population; workforce issues; the availability of suitable accommodation; and the delivery of satellite or outreach services.**
- **b) FACS and NSW Health staff at co-located JIRT sites also having separate and secure workplaces, where considered desirable and appropriate, but in any event, they should have access to separate and secure areas to appropriately perform their roles and functions.**
- **c) Ensuring that interview, monitoring, family and meeting rooms are available for use by each agency at relevant points of the JIRT process.**

49. The JIRT partner agencies should ensure that:

- **a) Each agency discusses with the other partner agencies, at the earliest possible stage, any proposed changes to JIRT accommodation arrangements to allow the other agencies to concurrently plan for any impact on its own accommodation needs.**
- **b) JIRT agency staff are consulted about, and kept informed of, proposed changes to accommodation arrangements that affect them.**

50. The JIRT partner agencies should put in place appropriate governance arrangements to ensure joint practice is not adversely impacted by accommodation changes, and that decisions are jointly communicated to JIRT agency staff.

PRACTICE SUGGESTION

- The JIRT partner agencies should review the impact of changed accommodation arrangements on service delivery after a reasonable period, and if necessary, jointly devise strategies for minimising any adverse impacts identified.

Chapter 21. JIRT Local Planning and Response

> *The critical aspect of the LPR process is its timeliness, ensuring that appropriate information is shared, ensuring that each agency attends to their own roles and responsibilities and that, as far as possible, joint planning allows for the best outcome for the victim and non offending family/carers* – CAS investigator.
>
> *When working well, the LPR process is able to provide a comprehensive and holistic* [JIRT] *response* – JIRT Senior Health Clinician.

The JIRT partnership recognises that no one agency is able to address the multiple and interrelated needs of children, young people and their families who come to the attention of the program. The Local Planning and Response (LPR), which we described in Chapter 4, is the structured process used by the JIRT partner agencies to facilitate a coordinated, tri-agency response to referrals that have been accepted by the JRU. Once the JRU has forwarded a referral to the local JIRT unit, they each collect and share relevant information and then hold a briefing to plan the field response. After the initial field response, which includes the recorded criminal interview, staff 'debrief' about the outcome and plan any additional action required. The agencies should then continue to liaise as needed to ensure the child or young person's safety, welfare and wellbeing needs are met.

In our 2012 report on Aboriginal child sexual abuse, we noted that the LPR was a key component of the JIRT program and that compliance with it should be closely monitored.[970]

Compliance with the LPR and the extent to which the procedures reflect the current operating environment were both identified as issues of concern at the outset of our inquiry. In particular, the CAS have highlighted that the urgent evidence-gathering requirements associated with some JIRT referrals, combined with the difficulty for the JIRT arms of FACS and Health to 'match' the after-hours workforce capacity of Police, mean it is not always appropriate or possible to implement the LPR as prescribed. In this regard, the CAS pointed to the 'key principle', included in the *Local Planning and Response Procedures*, which states that 'An agency's responsibility to provide a service is not negated by another agency's decision or inability (supported by internal policies and procedures) not to provide a service.'

Conversely, FACS and Health have argued that while they appreciate the need for the Police to take a range of urgent criminal investigative actions when a report of serious child abuse is made (such as crime scene evidence collection, taking out AVOs etc), there are certain aspects of the investigation, particularly the child's recorded criminal interview, that are now occurring too quickly to enable them to participate in the process or provide input into the approach. Health has also expressed concern about the extent to which appropriate tri-agency liaison is occurring beyond the initial LPR briefing and debriefing meetings. Both FACS and Health are concerned about the potential for the safety, welfare and wellbeing of children (and their families) to be compromised if the LPR is not faithfully implemented. One of the key objectives of joint planning is to provide the child or young person with the best opportunity to 'tell their story'. Failure by the agencies to elicit sufficient information from the child can result in none of the partner agencies being able to pursue appropriate care, health or criminal action. A challenge for the JIRT agencies is to balance responsiveness to the individual needs and situation of the child with the requirement to execute a timely response.

There is no question that, at a conceptual and practical level, the LPR lies at the heart of the JIRT program. Without it, the JIRT program would cease to embody the model of 'shared responsibility' for the safety, welfare and wellbeing of children and young people that was envisaged by the Wood Inquiry and has been endorsed by successive NSW governments since and is enshrined in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (Care Act). Our consultations with the JIRT SMG have also confirmed their commitment to the LPR process, which was reflected in the statement in the December 2016 SMG Joint Communication that: 'the LPR is the basis for a quality, coordinated and planned response to allegations of child abuse.'

970 See recommendation 20(b)(vii).

The JIRT workforce survey revealed that, somewhat at odds with the degree of concern expressed by the JIRT agencies at the outset of our inquiry, the LPR appears to be adequately functioning in most areas, most of the time. However, it is clear that there are also several issues that need to be promptly addressed by the partner agencies to ensure that the LPR has sufficient structure as well as flexibility to operate with maximum effectiveness to achieve the intended purpose – that is, to develop a coordinated JIRT response – and that effective escalation processes are in place. Together with implementing the changes we have recommended to the JIRT referral criteria and the capacity of the JRU, strengthening the LPR should be a key priority for the partner agencies.

21.1. The LPR process

Following the 2006 JIRT review, *Local Planning and Response Procedures* were developed, trialled and amended over a three year period. After being finalised in late 2009, the procedures were implemented state-wide by April 2010, with varying degrees of participation by all three agencies in different locations.[971]

The LPR Procedures are designed to assist staff in jointly planning the local response for each accepted JIRT referral, consistent with the following principles underlying Chapter 16A (which was introduced in 2009 following the Wood Inquiry):

- agencies that have responsibilities relating to the safety, welfare or wellbeing of children or young people should be able to provide and receive information that promotes the safety, welfare or wellbeing of children or young people
- agencies should work collaboratively in a way that respects each other's functions and expertise, and
- each such agency should be able to communicate with each other agency so as to facilitate the provision of services to children and young persons and their families.[972]

Between December 2010 and January 2011, the JIRT partner agencies undertook an internal audit of compliance with the LPR. Although the audit was compromised by significant data limitations due to inconsistent and incomplete manual record keeping, it found that compliance with many aspects of the LPR was poor. The audit's recommendations informed a subsequent review of the *Local Planning and Response Procedures*, which were further amended in 2013.

The *Local Planning and Response Procedures* have not been updated since that time. Although the basic structure of the LPR process remains unchanged, the procedures no longer reflect various aspects of operational practice. In particular, the procedures pre-date the CAS directive in January 2016 about recorded criminal interviews of children being conducted by the CAS (rather than jointly with FACS) and do not refer to JIRTS, the joint database which is now used to document the LPR process outcomes.[973] The current LPR process, consistent with advice provided by the JIRT agencies in relation to current operational practice, is described in section 4.2.

21.2. Implementation of the LPR

Although the partner agencies provided us with some case studies to illustrate particular issues and more general anecdotal information, they were unable to supply us with any data by which the implementation of the LPR could be assessed. While LPR records are now entered into JIRTS, the state-wide rollout of the LPR component of JIRTS was only finalised in September 2016, and as discussed in Chapter 25, there is presently no way of systematically extracting LPR data for monitoring and reporting purposes.

971 FACS, NSW Police Force, NSW Health, *Inaugural KTS JIRT Audit: Compliance with Local Planning and Response Procedures*, March 2012, p.6.
972 Section 245A(2)(a)-(c) of the Children and Young Persons (Care and Protection) Act.
973 The JIRTS database will be integrated with FACS' new ChildStory database later this year.

The timeframe for our inquiry meant it was not possible to conduct a manual audit of records that would be statistically significant. In this regard, it should be noted that the partner agencies' own audit of LPR compliance in 2012 recommended that 'further collections of this type of data should only be considered if a technical solution [is] identified that allows data to be extracted from all participating agencies electronically. The manual collection of LPR data is not sustainable'.[974]

In addition to our consultations with the partner agencies, and with key external stakeholders in the schools, out-of-home care, disability and Aboriginal service sectors, we primarily relied on feedback from the JIRT workforce survey to assess the implementation of the LPR. The survey asked multiple choice questions about the LPR and also invited open comments, a large number of which were received from respondents across all agencies.

Notably, the majority of survey respondents rated the performance of all agencies in relation to the LPR as either 'adequate' or 'good'. This is an important finding, suggesting that the LPR is functioning reasonably well:

> *The LPR process ensures that as a JIRT unit all three agencies meet each week for the purpose of the briefings and debriefings; this is what makes our unit work so well. The commitment by all three agencies to this process does ensure that information is gathered and shared accordingly and allows an open forum to address the ongoing child protection and safety issues* – Health Clinician.
>
> *I think the process* [here] *runs efficiently and that all agencies work well together* – CAS Investigator.
>
> *The LPR process works well most of the time* – Senior Health Clinician.
>
> *The LPR process works well in our office, especially when it comes to incoming* [urgent] *jobs* – CAS Investigator.
>
> *At [our] JIRT we have standardised LPR procedures in place for a regular LPR meeting … all tri-agency partners attend. We use an agenda and have* [an administrative officer] *present to minute issues discussed on the day as well as the completion of electronic forms on JIRTS system* – FACS Caseworker.

Further, some respondents indicated that while the LPR is not always implemented in strict accordance with the documented procedures, the underlying principles of information sharing and joint planning are adhered to:

> *Although weekly meetings do not always occur due to operational commitments, each agency maintains good communication with each other to plan a response. FACS and Health in our area are always accommodating in relation to the wishes of police and how police want to conduct investigations/responses. We have a good working relationship with FACS and Health and each agency all prioritise the safety, welfare and well-being of children* – CAS Team Leader.
>
> *When* [LPRs] *occur consistently they work really well and each agency's input is respected and considered. They can be inconsistent and ad-hoc when issues of resources, demands on time, and location impact. However, despite LPRs not always being consistent, communication still occurs between agencies in my JIRT* – Senior Health Clinician.

Despite the majority of survey feedback suggesting that the LPR is functioning reasonably well, it is clear from both our consultations with the partner agencies, and a significant number of survey comments, that there is a considerable degree of concern within the JIRT workforce – particularly FACS JIRT – about a number of discrete issues which we discussed below. In our view, unless these issues are adequately resolved by the partner agencies, they have the potential to become entrenched and undermine the success of the overall JIRT program.

21.2.1. Limitations to implementation 'after-hours'

The extent to which the LPR can be effectively implemented 'after-hours' (that is, outside of standard business hours) was one of the most significant issues to emerge during our inquiry. The *Local Planning and Response Procedures* provide limited guidance, stating that if a child has been

974 FACS, NSW Police Force, NSW Health, *Inaugural KTS JIRT Audit: Compliance with Local Planning and Response Procedures*, March 2012, p.4.

interviewed as part of an 'after-hours' response, only a debriefing meeting is required. They are silent on what information should be shared by the agencies, or how, prior to responding. On this point, in reaffirming the importance of 'up front joint planning and consultation', the December 2016 SMG Joint Communication stated that '…there may be occasions where this cannot occur, for example, outside of business hours or where an agency needs to respond in exigent circumstances, noting that other agencies should still be consulted wherever possible prior to any field response'.[975]

The CAS stated that the full LPR process, as documented, cannot be implemented when matters requiring an urgent response are received after-hours, as the JIRT arms of FACS and Health are not available during these hours. Several CAS respondents to the workforce survey commented on this:

> *Police at CAS offices are either present or on call to ensure a 24/7 coverage and response. Any after-hours response is maintained by police from CAS. The LPR process is in my opinion non-existent between 5pm and 9am as FACS and Health JIRT are not working in the office* – CAS Team Leader**.**
>
> *The LPR process as documented only works in practice 'during ordinary business hours'. Outside of these hours, NSW Police carry full responsibility for all engagement as there is no after hours service provided by the attached JIRT agencies. Any engagement between NSW Police and other agencies outside working hours is 'ad hoc' through the* [child protection] *Helpline or local health avenues and is managed accordingly* – CAS Investigator.
>
> *FACS JIRT staff work during business hours and thus are only available on less than 50% of the potential occasions where an LPR process may need to take place* – CAS Investigator.

Health respondents to the survey also expressed concern about FACS JIRT's lack of after-hours capacity.

The CAS also pointed out that, regardless of whether a referral is received during or outside business hours, certain urgent actions – whether they relate to the police investigation, care and protection issues, forensic evidence collection or any other aspect of the JIRT response – may be required and implementing these actions should not be deferred in order to follow the documented LPR process to the letter as long as the spirit of the LPR is applied. In this regard, the CAS commented that experienced frontline JIRT agency staff are well placed to identify what is required and make decisions about how to respond quickly when needed.

FACS and Health acknowledged these views, but emphasised that where consultation with FACS and Health is required – particularly prior to police conducting the recorded criminal interview – this does not always occur:

> *The Police will adhere rigidly to their after-hours processes of managing the matter as a Police only. This has resulted in children and families not being supported after-hours by Health as the Police will not contact the after-hours crisis service to offer families support as they wait for an interview* – Senior Health Clinician.
>
> *The* [Sexual Assault Service] *offer 24hr coverage for medical and crisis assessment. The difficulty is that health is not always consulted in relation to an after-hours response leading to inconsistencies across NSW* – Senior Health Clinician.

FACS and Health also expressed concern about the CAS taking action to respond to after-hours referrals in the absence of having an urgent need to do so, and pointed to examples of police conducting a non-urgent interview of a child during business hours, without first conducting an LPR, on the basis of having initially received and taken 'police only' action in response to the referral after-hours.

While FACS and Health do not have an 'after-hours' JIRT-specific workforce, FACS' Critical Response Team (CRT) and Local Health Districts (LHDs) respond to urgent JIRT referrals after-hours with the latter required to maintain a 'JIRT contact point' when the JIRT health clinician is unavailable. The CAS advised that they routinely engage the CRT and LHDs after-hours, but expressed some concerns about the adequacy of the CRT model and the ease with which the 'after-hours LHD JIRT contact points can be navigated. These concerns included inconsistent decision-making, delays in responding, and rostered staff who are often unfamiliar with the JIRT process.

975 JIRT SMG, *Joint Communication*, December 2016, p.2.

A number of FACS staff indicated that, rather than relying on the CRT, it would be preferable for FACS JIRT to have on-call/flexible work arrangements:

> *I think JIRT FACS should be included in the on call roster … different working hours across all three agencies causes difficulties and provides scope for agencies to act alone* – FACS Manager Casework.

> *JIRT FACS should have allocated* [caseworkers] *to be able to respond to after-hours JIRT matters as they are often not conducted adequately* – FACS caseworker.

> *I think it would improve service delivery if FACS caseworkers and Police worked in teams on the same timetable, this would make scheduling briefings, interviews and de-briefings more efficient* – FACS Caseworker.

As discussed in Chapter 11, FACS has indicated that it will consider using a proportion of the additional frontline resources to be allocated to its JIRT units over the next two years to establish an after-hours service. FACS advised us during the inquiry that this would likely involve a JIRT team attached to the CRT, and an on-call roster for non-metropolitan areas.[976] While the enhancements to Health's JIRT workforce have strengthened its participation in the JIRT program, it will be important for Health to review the best way of ensuring that it has appropriate input into the LPR, while also ensuring that JIRT health clinicians have the capacity to meet their 'frontline' responsibilities.

Regardless, the *Local Planning and Response Procedures* should be amended to provide clearer guidance about what is expected of each agency, including the type of consultation that should occur, what information should be shared, and how, when an urgent JIRT response is required after-hours. In this regard, what is critically important in our view is that there is a clearly documented expectation that agencies will inform each other of how they plan to respond, prior to doing so.

21.2.2. Clarifying roles and responsibilities during the Helpline/JRU assessment stage

It became apparent during our inquiry that a lack of clarity about the roles and responsibilities of each JIRT partner agency (and their non-JIRT arms) in the period during the Helpline/JRU assessment of a report requiring an urgent response, has contributed to uncertainty about whether the LPR applies during this phase.

As described previously, when serious child abuse is directly reported to a police Local Area Command (LAC), they are required, in addition to making a mandatory report to the Helpline, to take a range of investigative actions while a decision is being made about whether the matter should be handled by a LAC, or accepted for a JIRT response. We highlighted that the roles and responsibilities of agencies in the Helpline/JRU assessment stage are not adequately documented in any JIRT or individual agency policies or procedures.

In our view, this lack of advice is highly problematic during a critical stage of the response to serious child abuse. The CAS have informed us that, in some circumstances, police taking urgent action in response to a referral prior to its acceptance by the JIRT program has been challenged by FACS and Health staff who say that this does not comply with LPR procedures. FACS and Health disagree, reporting that they acknowledge the appropriateness of 'police only' responses in certain circumstances, but stating that in other cases – particularly where police decide to interview a child – consultation with FACS and Health does not always occur when it should. FACS and Health have also highlighted that legitimate 'police-only' action during the pre-Helpline/JRU assessment period does not negate the need for the *Local Planning and Response Procedures* to be followed once the referral has been accepted.

So that respective agency obligations (including those of the non-JIRT workforce) are clear, and the process of mobilising a tri-agency response during the Helpline/JRU assessment phase is consistent, we have recommended that the *JRU Process Guidelines* (and relevant LAC, FACS and Health policies/directives) be amended accordingly. As we discuss later in this chapter, the *Local Planning and Response Procedures* should be similarly amended.

976 FACS response to information requirement, 27 February 2017.

21.2.3. Ensuring the LPR does not cause undue delay to the criminal investigation

A large number of CAS survey respondents commented that the LPR delays the police investigation and the response to victims in a way that does not occur for other types of crime. It is clear that this is a source of frustration for many investigators, including those who (from their survey responses) demonstrated an appreciation of the importance and value of a coordinated interagency response to child abuse:

> *Police like to respond ASAP to jobs however they are delayed due to* [the LPR] *process* – CAS Investigator.

> [The LPR] *delays the response time … Police are waiting for other agencies to be available to have briefings, conduct interviews etc* – CAS Investigator.

CAS respondents suggested that logistical difficulties and/or limited availability of staff from the other partner agencies are the primary reasons for the delay caused by the LPR:

> *Having everyone in place at the right time is difficult … to brief or debrief jobs requires multiple teleconference hook ups, sometimes involving people on route in country areas with poor mobile coverage* – CAS Team Leader.

> *The general availability of the* [Manager Casework] *has made it difficult to progress investigations from the police perspective. The* [Manager Casework] *has been unavailable due to court attendances, and home visits conducted with* [caseworkers]*. Briefings have been delayed, and debriefs significantly delayed, which has delayed the completion of the LPR* – CAS Team Leader.

> *FACS are too understaffed to execute this part of the process efficiently. This is resulting in FACS not allocating staff to jobs and Police doing the job alone and then reporting back on the outcome. In addition, when non-urgent jobs come in, I've been advised by FACS that they are saving their staff that week for* [urgent] *jobs. Therefore the Team Leader has to approach FACS and discuss* [the] *job in an attempt to have FACS allocate the job and/or proceed* [as a] *'Police only' so that the child and family are not waiting longer than necessary* – CAS Team Leader.

FACS staffing shortages, and the impact of these shortages on the JIRT response more broadly, were repeatedly cited by survey respondents from all three agencies. Because police are trained to respond urgently to reports of serious crime in a way that maximises the integrity of the investigation and aligns with the expectations of victims and the broader public , it is understandably frustrating for them to have to adjust their response timeframes to accommodate the availability of other agencies (when appropriate). The concept of planning a response collectively is a far more intuitive way of working for human service agencies such as FACS and Health, whose staff have greater familiarity with case management and case conferencing response models, whereas police generally operate in accordance with an emergency response model.

In the absence of information about the timeframes involved in completing the initial LPR, it is difficult to accurately assess the extent to which the availability of FACS and Health staff is contributing to delay to police investigations. For example, it is unclear whether the 'delay' is implicit to the LPR process, or to inefficient business practices. We know that in some areas, the partner agencies have identified creative ways of ensuring that they discharge their LPR obligations in the most efficient way possible – such as consulting by phone for urgent matters and scheduling regular, recurring meetings to conduct multiple LPRs for less urgent referrals. We support flexible approaches of this type occurring given the considerable workloads of staff from all three agencies.

However, even where local JIRT staff are coming up with pragmatic ways to at least meet the objectives of the LPR without strictly complying with the documented procedure, as we outlined in Chapter 11, frontline caseworkers are struggling to keep pace with the CAS, and this has become increasingly difficult since the CAS resourcing was enhanced several years ago. In our view, if this is not addressed, it will continue to create tension between the agencies. As noted in section 21.2.1, the recent budget announcement to increase FACS' resourcing will ideally enhance the capacity of FACS to respond to matters quickly during and outside of business hours.

It would clearly be unacceptable for the LPR to be operating in such a way that it impacts negatively on any one of the JIRT agencies' ability to discharge their core responsibilities. Therefore, it is critical that any examination of the adequacy of FACS and Health resourcing considers the capacity of these agencies to meet their LPR responsibilities. It is also critical that the JIRT SMG seeks to identify those locations where the LPR is working effectively and why. We intend to share our observations about trends in specific locations with the SMG to help inform such an exercise.

From our review of the *Local Planning and Response Procedures* and the feedback from frontline staff, the key to compliance appears to be ensuring each agency is properly resourced so that all three can respond jointly as intended; and secondly, where resourcing is a significant problem, that a clear expectation is placed on local managers to build strong working relationships with their JIRT partners to overcome any obstacles to joint collaboration. For this to work, frontline managers also need to be pragmatic about what the LPR should look like in practice, having regard to workloads and local conditions. The test, regardless of whether the process always 'ticks' every procedural box, should be whether the approach used is one of 'genuine partnership' and promotes overall child safety and wellbeing from the perspective of all three partner agencies. In suggesting more flexibility, it is also important for us to stress that this should not be seen as a green light for agencies to depart from the procedures. Sufficient numbers of survey respondents made it clear that the LPR process can and does work if executed well by local managers, with backing from the JIRT leadership.

21.2.4. Unequal 'ownership' and 'valuing' of the LPR

Concern was expressed at the outset of our inquiry about the extent to which the *Local Planning and Response Procedures* are being consistently implemented by all partner agencies. In particular, FACS and Health indicated that their frontline staff were reporting a perception that in recent times, the CAS has 'pulled back' from the LPR, prioritising police autonomy over the components of the JIRT response not directly related to the police-led criminal investigation.

While most agency staff commented that the LPR is generally working well, some FACS and Health respondents to the workforce survey made reference to the CAS not valuing the LPR process. In some locations, this has reportedly led to the CAS rarely attending briefing meetings. Health and FACS staff expressed concern that the CAS are acting without the benefit of the information held by their agencies, and instead, are often solely reliant on information provided by the JRU at the time of referral:

> *It has become evident over time that some offices within Police do not value the input of FACS or Health in the LPR process* – FACS Caseworker.

> *With the new practices of CAS Police, a lot of procedural issues are not being discussed in briefings and plans are changed on FACS after a briefing.* – FACS Manager Casework

> *Prior to the recent changes made by police, I believe the LPR process had been running quite well. In recent months there has been a shift, for example, police making initial phone calls to families without the briefing occurring. This has at times been detrimental to engaging with families as the process has not been explained well* – FACS Caseworker.

> [LPRs] *work well when all three agencies participate from the start – often the Police seem to have a head start and make decisions prior to any briefing with agency partners and, on occasion, have commenced their process without any reference to information they hold in their own system or information about other risk or concerns held by agency partners* – Health Manager.

While not dismissing the role of FACS and Health in responding to child abuse and neglect, some CAS respondents expressed a view that the LPR has limited utility for police:

> *The LPR seems to be a FACS based system, and it mostly doesn't have much impact on the response by CAS, apart from taking time away from completing the investigation* – CAS Team Leader.

> *The information provided during the LPR process is not overly important in relation to the CAS investigation* – CAS Investigator.

Among those CAS respondents who questioned the value of the LPR, a common theme was that the 'value' of the process was seen through the lens of what police need in order to investigate a crime – rather than from the perspective of what is needed to deliver a holistic and coordinated JIRT response. Although it is important to stress that comments of this type were in the minority, they give weight to the concerns expressed by FACS and Health staff about the level of commitment to the LPR by CAS in certain locations.

Some respondents suggested that if the SMG could reinforce the requirement for all three agencies to participate in the LPR (even if only by phone discussions for urgent matters), rather than merely 'encouraging' them to participate, this would go a long way towards improving their engagement with the process. Currently, closing a matter off on the JIRTS database requires only two agencies to 'sign-off'. Health has proposed that LPR decisions should be 'signed off' by all three agencies to encourage equal involvement and participation and therefore, a holistic JIRT response. The CAS has also suggested that the inability to identify the 'author' of LPR records entered into the shared JIRTS database is a weakness that should be addressed. We consider both proposals worthy.

The most recent SMG Joint Communication explicitly reaffirmed its 'continuing endorsement and support for' the LPR.[977] However, it is essential that this message is reinforced by each partner agency at a local management level, and that implementation is more closely monitored by the SMG.

21.2.5. Information sharing

The SMG's December 2016 Joint Communication emphasised that 'the timely and consistent exchange of information' relevant to the safety, welfare and wellbeing of a child or young person 'is critical to the field response and overall success of the JIRT arrangement'.[978] It also highlighted the importance of 'up front joint planning and consultation'.

In Chapter 19 we noted the significant legislative reform enacted with the introduction in 2009 of the information exchange provisions contained in Chapter 16A of the Care Act. The provisions have strengthened the operation of the JIRT program and child protection practice more generally. Despite this, during our inquiry some concerns were raised about the practical implementation of Chapter 16A within the LPR context. In this regard, poor quality information sharing by agencies was noted by numerous survey respondents as a factor undermining the value of the LPR.

Although the *Local Planning and Response Procedures* provide specific guidance about the type of relevant information that agencies should collect and share, it is apparent from some of the survey feedback that either this type of information is not being regularly exchanged, or that some JIRT staff do not consider the information 'relevant' to the safety, welfare and wellbeing of a child and/or to planning a coordinated JIRT response.

Health information

Medical, nursing and clinical staff have an obligation to obtain sufficient information to enable them to provide safe and appropriate care and treatment for patients (including children) who present at public hospitals and other health services. Health staff also have a statutory obligation to report suspected child abuse, and make reasonable inquiries to assist them in determining if they have 'reasonable grounds to suspect' a child is at risk of significant harm. Health's information holdings about an individual child and/or their family can therefore be considerable, and may be directly relevant to FACS and Police inquiries or investigations. It is therefore critical that relevant information is appropriately shared.

However, there was consensus among several Health and CAS respondents that Health faces particular challenges in the information-gathering phase of the LPR process because of the agency's separate LHD/Sydney Children's Hospital Network databases:

> *Health is also in a difficult position in relation to sharing information due to the LHD structures and this does make it hard to obtain and share information when a client has come from another area, particularly when it is not known if the child has resided elsewhere* – Senior Health Clinician.

977 JIRT SMG, *Joint Communication,* December 2016, p.2.
978 JIRT SMG, *Joint Communication*, December 2016, p.2.

Unlike police and FACS, the health system is not linked as a central database and thus health takes considerable time to conduct their background checks and often miss important information as it is simply unavailable to them – CAS Investigator.

It is difficult for Health to participate as fully as our information systems are so decentralised and cumbersome to extract information from – sometimes we do not have the relevant information in time – Senior Health Clinician.

Health would benefit from a single state-wide database similar to FACS & CAS so full health history can be accessed – Senior Health Clinician.

Health has multiple systems to record clinical records. Paper record files located at different towns are difficult to access in time for JIRT responses – Senior Health Clinician.

My experience with information from Health has been that unless the child has presented at the [local] *Children's Hospital, there is no history. At times, this has been a source of intense frustration because investigators have had to make additional inquiries with Medicare to determine any medical history or issues* – CAS Investigator.

We asked Health about how its JIRT health clinicians ensure that critical health holdings outside the LHD are shared with partner agencies during the LPR process. Health advised that JIRT health clinicians 'do not as a matter of course seek records from all other LHDs' but 'where additional information is indicated as being needed to complete an assessment or conduct an investigation this is sought on a case by case basis'.[979] Where a JIRT health clinician knows that a child has resided in another LHD, additional records may be sought from that LHD. We understand that paper-based records are being phased out, and in future, more e-records across Health will be linked and easier to access across LHDs.[980]

The challenges for Health associated with their devolved governance, including its data collection systems, are discussed in Chapter 12.

Disclosure of information relevant to police investigations

Some FACS and Health respondents expressed concern about the willingness of the CAS to share relevant information:

Police's ability to recognise the importance of information sharing and initiating the sharing of information with FACS/Health is an area of concern – FACS Caseworker.

In my experience Police are quite minimal in the information they provide, and if it's information post briefing or debriefing you have to hassle them – FACS Caseworker.

The information provided [by CAS] *is not comprehensive and it is reluctantly completed* – FACS Caseworker.

Very little information is ever shared with FACS during briefings and debriefings. 'Investigation ongoing' is a frequent response with nothing further provided. FACS' role is to assess the safety and welfare of children and information obtained by Police is crucial to this assessment – FACS Manager Casework.

The Police investigation is kept so confidential, even to JIRT agency partners … this perpetuates the culture that Police are the primary agency and that FACS and Health are secondary – FACS Manager Casework.

During the inquiry, FACS advised us that, 'The processes at the JRU and JIRT Units for sharing information in JIRT are excellent, however field compliance is subject to individual interpretation and often reflects broader tri-agency dynamics at any point in time'. FACS also noted that, on occasion, its JIRT staff have been advised during the LPR that Police do not hold any relevant information about a child or their family; however, when FACS has subsequently made a formal Chapter 16A request (through the centralised NSW Police Force 'iASK' application), they have received information that they believe to be pertinent to a child protection assessment.

979 Advice received NSW Health, March 2017.
980 Advice provided by NSW Health, March 2017.

A few CAS respondents openly acknowledged that they provide limited information to the other partner agencies due to concern about the extent to which, on some occasions, other agencies fail to appreciate the 'boundaries' of their respective roles:

> *It has become evident that other agencies at times are more interested in how police are planning to run an investigation rather than focus on their core responsibility. The LPR was meant for each agency to inform their actions however, this is not the case when FACS has an opinion and comment on how police conduct criminal investigations* – CAS Investigator.

> *FACS JIRT staff, at times, frustrate the purpose/intent of the LPR process by seeking to utilise it to involve themselves in the activities of other agencies over and above their own responsibilities with respect to care and protection issues. A consequence of this, is that other agencies are at times reluctant to fully engage in such processes for fear that FACS staff will utilise this as a basis to interfere and more importantly, it could compromise a criminal investigation* – CAS Investigator.

During our consultations the CAS also pointed to other reasons that police may need to withhold certain information from the other partner agencies. For example, the NSW Police Force has a strict policy about releasing information concerning covert investigations, including how this evidence is obtained and what equipment is utilised. However, the most frequently mentioned reason concerned the potential for the disclosure of information to prejudice a criminal investigation.

There is an exemption included in the Chapter 16A provisions which enables Police to decline to release information to another agency if they reasonably believe that doing so would prejudice a criminal investigation. While this is generally sufficient to ensure that other agencies are not placed in a position where they may compromise a police investigation, it does not mitigate this risk entirely – particularly in the context of the JIRT program, where information sharing is a pivotal component of the LPR process.

The effective operation of the Chapter 16A provisions in the JIRT context, including the use of the centralised JIRTS database which contains information from all three agencies, increases the amount of police information that FACS and Health are able to directly access.[981] All LPR documents created in JIRTS contain an automated caveat about disclosure. However, the effectiveness of the caveat depends on compliance.

In addition, because all matters accepted for a JIRT response involve criminal allegations, certain documents generated by FACS and Health (for example, a record or synopsis of a care and protection child interview, or a medical review) are likely to be integral to a criminal investigation. This means that, even if information that is 'owned' by the NSW Police Force is not released externally, there is still, theoretically, a greater risk in the JIRT context than otherwise for FACS or Health to disclose information that may compromise a police investigation.

Disclosure of information in the context of care proceedings

The CAS also flagged concerns they have held for some time about the potential for information to be released to a person of interest through care proceedings in the Children's Court.

If FACS is satisfied that a child is at immediate risk of serious harm, they can remove them without court orders.[982] In most circumstances, FACS must then lodge a care application with the Children's Court within three business days of the removal[983] – a process which involves providing the Court with a range of documents in their possession that are relevant to FACS' decision to assume care of the child.[984] Unless the Court determines that doing so would be detrimental to a child or young person's safety, FACS is also required to serve a copy of these documents on parties to the proceedings (including the parent(s) or guardian(s)).

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981 We have not been made aware during this inquiry of any instances of inappropriate disclosure of JIRTS database information, and note that FACS has mitigated against this risk by including a warning message when the database is opened that emphasises the confidentiality of JIRTS data, and reminds users of the importance of only disclosing JIRTS information in accordance with agency and interagency information security and privacy policies.

982 See s.43 of the Care Act.

983 See s.45(1A) of the Care Act.

984 FACS can apply for an emergency care and protection order if the issues that required removal of the child or young person are likely to be resolved quickly. The order places the child or young person in the care of the Secretary (or other person specified in the order) for a period of 14 days, and it may be extended for a further 14 days if required. In these circumstances, FACS is not required to provide the relevant documents to the Court.

Police have suggested that this requirement, including the short timeframe within which FACS is required to provide information to the Court, creates the potential for information that is critical to an active police investigation to become known to a person of interest. They raised the example of serious non-accidental injuries to infants where it is not immediately apparent whether or which parent or carer may have been responsible for the injuries. In such matters, FACS may immediately assume care of a child; however, police may need a period of time to pursue various investigative avenues before they can consider laying charges (for example, they may need to prepare an affidavit for covert warrants). This may mean that information such as medical reports will be served on a person of interest before police have sufficient evidence to charge.

In July 2016, as a result of a joint submission by Police and FACS, the President of the Children's Court, His Honour Judge Peter Johnstone, amended *Practice Note No.2 of the Children's Court of New South Wales* to exempt material that is received from Police, health service providers, or mandatory reporters (whether in the context of the JIRT program or otherwise) from being served in the initial bundle of materials, if doing so might prejudice an ongoing criminal investigation.[985] This provides time for the agencies to liaise and plan ahead. We understand that the Practice Note has gone a considerable way towards addressing the concerns of Police in terms of the immediate risk to a criminal investigation following a decision to remove a child.

However, there may still be a small number of matters (for example, where a police investigation requires the use of covert investigative techniques over a lengthier period before determining whether to charge) where there is scope for diverging views about the best way to execute care and protection action without comprising the police investigation. In these circumstances, FACS and Police need to effectively communicate and work collaboratively to achieve an outcome that is in the best interests of the child. While this issue relates to the intersection of care and protection and criminal justice processes, the solution lies with effective execution of the LPR.

Consideration of relevant information prior to the recorded criminal interview

As discussed previously, the CAS has conducted all recorded criminal interviews of children since January 2016. Before then, the LPR involved making a decision about who would lead and participate in the interview, and joint interview planning. The current *Local Planning and Response Procedures* reflect the previous practice and 'highly recommend' (but do not require) that an interview plan be prepared in certain circumstances.

Some survey respondents raised concerns about whether, or the extent to which, Police are now having regard to information held by FACS and Health prior to conducting recorded criminal interviews. This concern was expressed in the context of broader concern about compliance with the LPR, with many respondents noting that because police now solely conduct the recorded criminal interview, they often do not seek information from FACS and Health beforehand, or that LPR briefings occur while the victim is 'in the waiting area and this does not allow time for adequate planning for interviews or support for victims and their families'.

In light of the changes last year to the recorded criminal interview process, the *Local Planning and Response Procedures* should be updated to reflect the role of each agency in sharing, and considering, relevant information prior to the recorded criminal interview. The most recent SMG Joint Communication outlines the new interviewing process, but it does not explicitly address the role of FACS and Health in sharing relevant information to inform recorded criminal interviews, or the responsibility of CAS to have regard to such information. The partner agencies need to clarify and agree on a position and ensure that it is clearly communicated to the JIRT workforce and reflected in the amended procedures.

We discuss interviewing practice in detail in the next chapter.

Guidance about information sharing

In our view, the guidance in the *Local Planning and Response Procedures* about the type of relevant information that should be shared is sound. However, there would be value in enhancing the guidance – and related training for JIRT agency staff – by providing examples of how various types

985 Children's Court of NSW, *Practice Note No. 2 – Initiating Report and Service of the relevant portion of the Community Services file in Care Proceedings*, Amended 1 July 2016, p.2.

of information might be used to inform the JIRT response. For example, information about a Health service having prior engagement and rapport with a young person may warrant consideration of whether Health is best placed to initiate contact on behalf of the other JIRT agencies. The refreshed JIRT Foundation Skills Program, discussed in Chapter 24, provides an opportunity to provide this enhanced guidance, which should emphasise that any ambiguity about information exchange can pose a serious risk to children. Requests need to be clear, but in responding, agencies also need to be mindful that the requestor 'doesn't know what they don't know' – therefore, erring on the side of more rather than less information is more likely to promote the safety and welfare of children.

21.2.6. Limited Health participation

In addition to commenting on the challenges facing JIRT health clinicians in obtaining information to inform the LPR, several respondents to the workforce survey indicated that the participation of Health in the LPR is limited more generally, and that Health staff are often absent from briefings and debriefings, which can lead to children not being referred promptly to counselling.

Some Health staff commented that JIRT health clinicians are not always identified 'as an important part of the process' and that at times, there is a 'lack of professional respect for health expertise'. However, the comparatively smaller workforce of JIRT health clinicians was the most frequently identified obstacle to the consistent participation of Health in the LPR:

> *Our health clinicians struggle to meet operational needs. In my view they appear over worked and require more positions to assist with their caseload* – CAS Investigator.
>
> *I cannot understand how Health can be part of the process when there is only one person in that position for each office. If that person is absent from work the LPR process fails as there is no health involvement* – CAS Team Leader.
>
> *In terms of staffing,* [our] *JIRT is well staffed by FACS and Police however there is only one Senior Health Clinician and this is not enough for an office of this size and for the amount of work. As a result, every matter does not receive Health LPR information* – FACS Caseworker.
>
> *If the* [Senior Health Clinician] *position is vacant, there is not always a person managing their workload, or reviewing the cases referred to JIRT. There is no direction (policy) to state when the health service gap falls to FACS to fill or when it is the responsibility of the SHC's manager* – FACS caseworker.
>
> *We don't have a health worker at present … I feel that it is a big disadvantage not having a health worker on site* – CAS Investigator.

In our 2012 report about Aboriginal child sexual abuse we noted the results of an LPR audit conducted by the JIRT SMG, which found that Health's participation at that time was very limited.[986] However, this was prior to Health rolling out its initial workforce of 25 senior health clinicians (which has since grown to 48.5 positions). Despite the additional staffing, the workforce survey suggests that Health is still struggling to participate fully in the LPR.

As discussed in Chapter 12, the Ministry of Health has advised that all LHDs should maintain a 'JIRT contact point' in the absence of a JIRT health clinician. They have indicated that if agencies experience problems accessing the contact point or receiving appropriate assistance, this should be escalated to the Ministry. It is not clear whether, at a local level, agencies have sufficient knowledge of the 'back-up' arrangement, or are simply not utilising it. This should be clarified by the SMG and promoted with LHDs by the Health Executive.

We understand that in future, JIRTS data will be able to show the extent to which health clinicians are included in LPR briefing and debriefing sessions.[987] This will provide a stronger evidence base for Health to monitor and address concerns about the extent of their participation in the LPR.

986 NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012.
987 Advice provided by NSW Health, December 2016.

21.2.7. Providing better guidance on critical areas of JIRT practice in the LPR Procedures

During our inquiry, all three agencies provided us with advice about a number of critical practice areas where they believe closer collaboration and/or a better understanding of the impact on each other's roles is required:

- conducting care and protection interviews during the course of a criminal investigation
- conducting Person Causing Harm interviews during the course of a criminal investigation, and
- the timing of crisis interventions by Health during the course of a criminal investigation.

While each of these practice areas focus on different aspects of the JIRT response, to be well executed, they require genuine collaboration; an understanding of the core functions of each agency; and an understanding of how these intersecting functions should inform each agency's actions. This type of coordinated, multi-disciplinary response is at the heart of the JIRT program.

We know from our many years of reviewing child abuse investigations how complex it can be for agencies to navigate their way through the myriad of issues that can arise when taking action to protect children from imminent harm and provide them with much needed therapeutic supports, at the same time as a criminal investigation is being progressed

While it would be dangerous to seek to prescribe how practice in these areas should be executed on each occasion, the *Local Planning and Response Procedures* would benefit from the inclusion of some high level principles to underpin the response by agencies at these key stages in the JIRT response, including the risk involved in failing to collaborate, and the escalation process for efficiently resolving disagreements about how to proceed – given that time is always of the essence.

Conducting care and protection interviews during the course of a criminal investigation

As we discuss in the next chapter on interviewing, there will often be overlap between issues that are relevant to establishing the proofs of an offence during the recorded criminal interview and the information required to make an informed child protection assessment. However, there will be occasions where, to inform their safety and risk assessment, FACS workers will need to ask additional questions of a child victim which would not be appropriate to canvass during the recorded forensic interview. In practice, these questions should ideally be asked immediately following the recorded criminal interview, but there will be occasions where FACS is unable to be present to monitor the interview, or new information may come to light after a home visit by FACS, requiring further questioning of the child victim at a later stage. FACS might also need to interview a child victim's siblings or other individuals who police may have identified as potential witnesses for a criminal prosecution.

In their submission to this inquiry, Police highlighted advice they received from the ODPP about the relevance of a recent High Court decision, *Sio v The Queen* [2016] HCA 32, in relation to assessing the reliability of police interviews, which noted that courts are permitted to take into account any other representations made outside the context of the police interview and the entirety of the circumstances in which the representations are made. In the JIRT context, this would mean that an interview with an alleged victim, a suspect, or a witness (such as a sibling or non-offending parent) conducted by FACS for the purposes of a safety and risk assessment *may* cause a prior (or subsequent) police interview to be deemed unreliable if the reported information differs.

While acknowledging the importance of not prejudicing a criminal investigation, FACS has raised concerns about Police not giving due weight to the urgency of certain care and protection actions in some matters where consultation with the CAS has occurred. In response, the CAS has indicated that while it acknowledges the critical importance of undertaking home visits and other care and protection actions which may involve speaking with the child victim and other potential witnesses while a criminal investigation is underway, they have emphasised the importance of any interviews of this nature not traversing the same ground as the recorded criminal interview; that is, not focusing on establishing the offence to avoid potential inconsistencies arising.

Having said this, it will not be uncommon for a further disclosure of criminal abuse (or additional information relevant to an existing offence being investigated) to be made to a FACS or Health worker in the context of them performing their role. When this occurs, best practices would ordinarily involve the practitioner not 'shutting down the conversation' and focusing on basic details such as 'who, what, when, where' without getting into the specifics of the offence, and as soon as possible, reporting the offence to the relevant CAS team. In our view, there would be value in documenting the expectations on agencies when disclosures are made during the course of criminal investigations in the JIRT context in the *Local Planning and Response Procedures*.

In light of the legitimate issues raised by both agencies, it is therefore critical that FACS JIRT and the CAS liaise with one another about the steps that they intend to take in carrying out their statutory functions, including who they intend to speak to, and the broad nature of the discussions that they intend to have. It is equally important that information is readily exchanged about the outcome of these actions. As well as the obvious efficiency benefits, this minimises the potential for a FACS assessment to compromise a police investigation, and provides FACS with the opportunity to obtain critical information from police to inform its safety and risk assessment.

While it is critical for these discussions to occur at a local level, it is also necessary for robust and efficient escalation processes to be in place across the JIRT partnership to ensure that any issues which cannot be agreed upon can be resolved quickly.

Conducting Person Causing Harm interviews during the course of a criminal investigation

As we discussed in Chapter 11, similar issues can arise in the context of FACS conducting interviews to determine an individual's 'Person Causing Harm' (PCH) status (or advise them of that status). We have recommended that FACS should update its processes for determining when individuals should be identified as PCH, to address the concerns raised by Police about the timing (and in certain cases, necessity) of these interviews. While FACS' practice mandate on PCH is applicable to FACS generally and not only to the role of FACS JIRT, there would be value in the sections relating to liaison with police while criminal investigations are underway (which we outlined in section 11.6.4), being briefly referenced in the *Local Planning and Response Procedures* given the particular relevance to investigations conducted through the JIRT program.

The timing of crisis interventions by Health during the course of a criminal investigation

Health has advised us that, in certain matters, the CAS have directed JIRT health clinicians to delay contact with a victim and members of their family until police have determined whether family members are persons of interest or potential witnesses, taken statements and conducted further enquiries. According to Health, these directions have been made because of police concerns about the potential for contamination of evidence.

Health has argued that, while acknowledging the importance of its staff being mindful of contamination issues, police concerns about this issue have in some matters prevented JIRT health clinicians from providing crisis intervention and support to victims, and delayed referrals to counselling and other health services, in circumstances where a more collaborative approach would have led to a better outcome.[988] Health also argued that distressed parents are more likely to act in a manner that contaminates evidence than parents who do not receive crisis counselling and other appropriate health support.[989]

Health is also concerned that the 'fear of contamination' can cause Health staff and other mandatory reporters to shy away from conversations with children which could lead to disclosures being made. In this regard, the ODPP, in a recent resource it prepared for FACS, stressed the importance of not letting fear of contaminating evidence cause its workers to shy away from having important conversations with children that may elicit disclosures of abuse.[990]

988 Advice provided by NSW Health, December 2016.
989 Advice provided by NSW Health, March 2017.
990 Kara Shead (then) Deputy Director, Office of the Director of Public Prosecutions, 'De-mystifying contaminating evidence' (presentation to FACS caseworkers), 29 November 2016.

After raising Health's concerns with the CAS management team during this inquiry, they acknowledged that if Health intervenes at an early stage, this can help victims and families manage trauma and provide police with information that supports, rather than impedes, their criminal investigation. The CAS stressed that there are risks associated with early contact by Health with victims and their families if it is not well executed, just as there are risks where there is no support or delayed support. However, it agreed that these risks can be managed through effective collaboration. The CAS emphasised that workers who have early contact with victims and families need to ensure that information relevant to a criminal offence is not inadvertently passed on to potential suspects or witnesses; information from one witness is not shared with another, resulting in cross-contamination; and that the integrity of evidence is preserved. They also acknowledged that the risks are reduced if Health (and FACS) staff focus on providing victims and their families with information about the response that their own agency can provide.

21.2.8. Liaison by JIRT agencies with key external stakeholders – the special care role of schools and OOHC providers

A strong theme to emerge from our consultations with representatives of the schools and out-of-home care (OOHC) sectors, was that the JIRT agencies – particularly the CAS – were generally proactive in consulting them when their own employees were the subject of the allegations, but that they were less likely to be contacted in relation to managing the ongoing wellbeing of the child victim (which for these agencies, is relevant regardless of whether or not their own employees or other students/young people in care allegedly caused the harm).

In this regard, schools and agencies managing OOHC placements have rightly identified that the JIRT program – particularly FACS and Health – should be working closely with them to ensure a holistic response is provided in the interests of the child victim's care and therapeutic needs. Both schools and OOHC agencies also raised the need for the JIRT agencies to work closely with them when they are managing situations where a student or child/young person in their care has sexually harmed another child or young person. These types of matters were singled out by schools and OOHC agencies as the most challenging, and where they need to be working closely with the JIRT agencies to secure therapeutic supports as early as possible. The CAS agreed, adding that it is critical that agencies report criminal allegations at the earliest stage (in Chapter 24 we discuss the need for training which reinforces the responsibilities of agencies in relation to this and related practice areas).

As discussed in Chapter 6, the child and family advocate role we have recommended be established will be critical to creating and maintaining better linkages between the JIRT agencies and key stakeholders with a direct care and supervision role for children and young people referred to the JIRT program.

It is also critical that the CAS, in particular, maintains close contact with schools and OOHC agencies to help inform their related reportable conduct investigations when their employees/carers are the subject of allegation, and to provide them with advice on risk management strategies to avoid compromising any police investigation.

While the OOHC and schools sectors are two key external stakeholders for the JIRT program, the same need for effective liaison and information exchange applies to a range of other institutions that provide a care and supervision role to children, for example preschools and childcare centres.

It is essential that during the LPR, the JIRT agencies identify the need to liaise with these key external stakeholders and the nature of the information that should be exchanged, not only to inform the JIRT response, but also to promote broader child wellbeing. The *Local Planning and Response Procedures* lack any guidance on this critical area and this should be addressed.

21.3. Strengthening the *Local Planning and Response Procedures*

Although the SMG's December 2016 Joint Communication reaffirmed its endorsement of and support for the LPR, it is apparent from the JIRT workforce survey responses and other feedback provided to us during this inquiry that, in at least some areas, there are cultural issues that are undermining confidence in, and the implementation of, the LPR.

In our view, an important way for the SMG to reinforce the value of the LPR process is to update and refresh the document based on feedback we have presented in this report. Demonstrating that the SMG has taken on board this feedback will be critical to JIRT agency staff taking ownership of the process.

Based on our review of evidence made available during this inquiry, a number of actions should be taken by JIRT SMG to enhance and refresh the LPR process:

- Clarify and communicate the purpose of the LPR to JIRT agency staff – emphasising the importance of achieving 'purpose over process' and the risk to children when effective collaboration does not occur.
- Update the *Local Planning and Response Procedures* to reflect necessary practice changes and critical areas of the JIRT response where no guidance currently exists (as identified in this and other chapters, throughout this report).
- Establish operationally sensible escalation processes and related accountability mechanisms for driving effective local collaboration.

The *Local Planning and Response Procedures* are a sequence of highly structured and defined processes. The benefits of this prescriptive approach are procedural clarity, transparency and accountability. However, a considerable downside is that the strong emphasis on the process can have the effect of obscuring the purpose. Much of the workforce survey feedback about the LPR demonstrated a preoccupation with issues of process and it was not always clear whether, or how, these issues actually impacted on achieving the purpose of the LPR:

> *As a manager who has not participated in the LPR, what I hear from my staff is that the actual process as specified in documentation is probably sound. The reality of putting that into practice in an incredibly busy JIRT unit, with case volume and staff on and off duty, crisis happening, and minimal health staffing compared to the other FACS and Police teams, is constantly challenging, and in fact, rarely happens in the full correct manner* – Health Manager.

At its core, the purpose of the LPR is the sharing of relevant information to inform the delivery of a timely, comprehensive and coordinated safety, criminal justice and health response to child abuse and neglect. Rather than focusing too heavily on compliance with processes, the partner agencies should encourage a focus on achieving the purpose of the LPR – recognising that it needs to provide a level of flexibility that is responsive to the circumstances of each matter, the needs of victims and the operational requirements of the JIRT agencies.

As noted earlier, the *Local Planning and Response Procedures* should document a clear resolution and escalation process together with the process for initiating 'root cause analysis' reviews of individual cases by the Local Management Group (LMG) where concerns about non-compliance with the LPR have been raised.

In light of the concerns raised during this inquiry about compliance with the LPR process in certain locations, the shared JIRTS database needs to include a field to allow 'escalated concerns' relating to the implementation of the LPR in individual matters to be recorded. In our view, the SMG has a critical role to play in regularly reviewing this data to assess the frequency and nature of concerns relating to LPR compliance, and any trends regarding location. As it is a key indicator of the 'health' of the JIRT partnership, data about LPR compliance should also be reported in the JIRT Performance and Monitoring Framework, which we discuss in Chapter 25.

21.4. Providing guidance and support for agencies when child abuse reports are referred for a local response outside of the JIRT program

Finally, in discussing how the LPR should be strengthened, it is important not to lose sight of the need to ensure that all child abuse reports – irrespective of whether they are accepted for a JIRT response or not – are appropriately and effectively handled.

A significant number of child abuse reports are now responded to at a local agency level rather than through the JIRT program. This includes referrals that are screened by the Helpline as not meeting the JIRT criteria but which still require a Police and/or FACS response, as well as reports 'rejected' by the JRU and referred for a local response to Police/FACS. In practice, when a report is referred for a local response, a joined up approach should involve LACs, CSCs and LHDs consulting each other as needed about proposed initial and ongoing actions. As previously discussed in Chapter 9, there is scope for decisions to be made on a case-by-case basis about which agency is best placed to 'lead' the JIRT or local response. For example, in some cases, it may be appropriate for Health or FACS, in consultation with Police, to initiate first contact with a young person to help inform the level of police involvement in responding to an adolescent peer sex or sibling abuse matter.

The final report of the Wood Inquiry into Child Protection Services in NSW expressed concern about 'the experience of rejected referrals being sent back to a CSC without any ongoing case plan, and then closed without a secondary assessment or other action'. It further noted that 'cases rejected by JIRTs by reason of insufficient disclosure, where suspicion remains as to the occurrence of sexual assault, should not be closed without attention being given to referral for counselling and a therapeutic response'.[991]

At present, there are no clear guidelines for agencies in relation to providing effective, joined up responses to reports of sexual abuse, physical abuse or neglect that are not accepted by the JIRT program. Although the absence of such guidelines is not strictly a gap in accountability for the JIRT program, ensuring that these reports are appropriately handled is integral to improving the overall response by all three JIRT partner agencies to child abuse. For this reason, the JIRT SMG, in consultation with their line agencies, should take a lead role in ensuring the development of guidelines for staff that clearly outline their obligations to not only support the JIRT response, but also clarify what a joined up approach to child abuse reports should involve when matters are referred for a local agency response.

Recommendation

51. The JIRT partner agencies should amend the *Local Planning and Response Procedures* to ensure they reflect current operational practice, provide clarity about the purpose of the LPR and give practical guidance to JIRT agency staff in relation to the following critical areas:

- **a) The purpose of the LPR; the SMG's endorsement of the LPR and expectations about its implementation; and the risks to children when effective collaboration does not occur.**
- **b) That there will be a range of circumstances where the partner agencies agree a more flexible approach to implementing the LPR will be collectively required by local teams. (However, allowing for greater flexibility should not lead to routine departures from the LPR).**
- **c) The roles and responsibilities of each partner agency (and their non-JIRT arms) that apply to mobilising a tri-agency response to urgent referrals during the Helpline/ JRU assessment phase, and/or referrals which arise after-hours.**
- **d) The role of the NSW Health 'JIRT contact point' and the escalation process to the Health Ministry if agencies experience problems accessing the contact point or receiving appropriate assistance in the absence of a JIRT health clinician.**

991 Hon James Wood AO QC, *Final Report of the Special Commission of Inquiry into Child Protection Services in NSW*, November 2008, Vol. 1, p.309.

e) The purpose of information sharing, including examples of scenarios where the exchange of certain types of information has been critical in informing the JIRT response.

f) Current agreed processes for conducting recorded criminal interviews as set out in the December 2016 SMG Joint Communication, and the role each agency should play in having input to recorded criminal interviews. (See also related recommendation 52).

g) The high level principles (having regard to the observations in section 21.2.7) document that agencies should be guided by when executing their responsibilities during the following key stages of the JIRT response:

- **i conducting care and protection interviews during the course of a criminal investigation**
- **ii conducting Person Causing Harm interviews during the course of a criminal investigation, and**
- **iii the timing of crisis interventions by Health during the course of a criminal investigation**

h) The need to identify, liaise and exchange information with relevant external stakeholders (including but not limited to schools, out-of-home care agencies, and early childhood services) during the LPR to inform child protection and criminal investigations, and promote a holistic approach to addressing the wellbeing of children and young people accepted into the JIRT program.

i) The role and responsibilities of the Child and Family Advocate (if recommendation 2 is accepted) during the LPR.

j) The role and responsibilities of each agency in informing the work of witness intermediaries.

k) The process for recording and escalating concerns about the implementation of the LPR in individual matters.

PRACTICE SUGGESTIONS

- The JIRT partner agencies should consider developing separate guidelines (modelled on the updated *Local Planning and Response Procedures*) for frontline agency staff which clarify their roles and responsibilities in relation to responding in a 'joined up' way to child abuse reports that are referred by the Helpline or JRU for a local response. The guidance should include when it may be appropriate for Health or FACS, in consultation with Police, to initiate first contact with a young person to help inform the level of police involvement.
- The JIRT partner agencies should identify a solution that enables the 'author' of LPR records entered in the shared JIRTS database to be recorded.

Chapter 22. Interviewing

When the JIRT program was established in 1997, interviews of children and young people were generally conducted jointly by Police and Community Services. The local managers of each agency jointly determined who would lead each interview, having regard to the circumstances of the individual matter.[992] In addition to providing the child with the best opportunity to 'tell their story', the rationale for this practice was aimed at reducing the number of investigative interviews conducted with the child to determine whether criminal offences may have occurred and if care and protection concerns exist, so as to minimise the potential for further trauma to the child.[993]

In December 2015 the Commander of the Child Abuse Squad (CAS) issued a directive to the CAS indicating that police would solely conduct all recorded criminal interviews with children and/or young people in matters accepted by the JIRT program from 11 January 2016 onward. The directive referred to an earlier memorandum issued in June 2015, which indicated that the CAS had received feedback from the Office of the Director of Prosecutions (ODPP) and members of the judiciary, questioning why recorded criminal interviews were not necessarily being led by police officers.[994]

The December 2015 directive stated that in relation to recorded interviews admitted as evidence in chief:

> *It is crucial this evidence be obtained to its full potential including ensuring its admissibility under the Evidence Act to lessen the impact of any cross examination and further trauma to the victim (this includes obtaining proof/s of the offence/s, negating possible defences, identifying crime scenes and corroborative evidence – in addition, reducing leading questions and the possibility of contamination. As custodians of the criminal brief of evidence Police are in the best position to obtain this evidence … due to the training they receive in criminal investigations over many years.*
>
> *Police are also trained in the admissibility of evidence in criminal proceedings through giving evidence and through working closely with Crown Prosecutors/Solicitors from the ODPP in presenting criminal trials at the District and Supreme Courts and Police Prosecutors at the Local Court.*
>
> *As stated, it should be clearly understood that this in no way diminishes the role of other agencies within the JIRT model. It is clear, however, that the Police primary role (unlike any other organisation) is the investigation and prosecution of criminal offences.*[995]

As we discussed in Chapter 18, the introduction of witness intermediaries as part of the Child Sexual Assault Evidence Pilot also influenced the decision by Police to no longer permit FACS staff to be physically present in the interview room.

During this inquiry, the CAS has also submitted that:

> *On advice from the Office of the Director of Public Prosecutions, it is best practice for Police interviews to be conducted with only the Police interviewer and child/vulnerable person in the room. Additional persons may inhibit, distract and/or influence the child/vulnerable person from giving 'best evidence' during the interview process.*[996]

At the outset of our inquiry, there was considerable tension between the partner agencies about this significant change in JIRT practice and how it was executed. While this tension centred on the issue of interviewing, our consultations with the partner agencies, and feedback from the JIRT workforce survey, clarified that it also stemmed from a perception by FACS and Health that the CAS memorandum was indicative of a broader 'shift' in relation to the overall aims of the JIRT program.

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992 Transcript of Detective Chief Inspector Peter Yeomans, CAS, Royal Commission into Institutional Responses to Child Sexual Abuse, Public Hearing – Case Study 46 (Day 234), 29 November 2016, pp.23911-2330.

993 See NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding* (incorporating February 2013 interim changes), August 2006, p.1.

994 NSW Police Force Memorandum, *Interviewing Child Victims*, 4 June 2015.

995 NSW Police Force Memorandum, *Interviewing Child Victims*, 21 December 2015.

996 The memorandum goes on to note that 'If the child/vulnerable person wishes a support person to be present they should have one, however consideration must be given as to who is most appropriate to perform this role (including whether they are a witness or not protective/supportive of the child); bearing in mind that this may also increase trauma and stress during the interview process)'. (NSW Police Force Memorandum, *Police interviews – including the use of blue tooth kits*, 13 March 2017.)

In this regard, they were concerned that the criminal investigation was being prioritised over, or without sufficient regard to, other fundamental components of the JIRT response and the overall safety, welfare and wellbeing of the child.

Underlining its operational significance, interviewing was the most commonly raised issue in the JIRT workforce survey, particularly for FACS respondents – 75% of whom made related comments. Some FACS respondents commented that they felt 'devalued' and/or 'deskilled' as a result of no longer having direct involvement in interviewing children and expressed concern that the change would make FACS JIRT a less attractive place to work. Concern was also expressed by FACS staff that the new arrangements would lead to children being re-interviewed by FACS.

During the course of the inquiry and following conciliation by our office, the SMG sought to resolve the concerns in relation to interviewing practice. In their December 2016 Joint Communication, the SMG advised the JIRT workforce that:

> *The NSW Police Force is responsible for conducting electronically recorded police interviews (interviews) with victims and witnesses. This is essential for police to properly discharge their functions under the JIRT MoU, and ensure the integrity of any related criminal investigations or prosecutions; however this should in no way detract from the equally important, albeit separate functions, that FACS and Health perform in relation to assessing and investigating issues of safety, risk, health and wellbeing.*[997]

In this context, the SMG recognised:

- The value of the information obtained via recorded police interviews in achieving positive care and protection outcomes for children.
- The need for interviews to be conducted in a manner that reduces the risk of further trauma to the child.[998]
- The important support provided by FACS and Health to non-offending parents and family members during this stage of the JIRT process.

The SMG also collectively reminded staff of the importance of:

- FACS and Health being able to electronically monitor interviews for the purposes of listening to and observing children to inform assessments and investigations as to whether a child or young person is at risk of significant harm, as well as other issues concerning safety, risk, health and wellbeing.
- Police, as a matter of best practice and in the interests of the child, identifying an appropriate point during interviews for a break to occur,[999] for purposes including consultation with FACS and Health about any additional care or protection matters, or clinical issues that may have arisen.
- FACS and Health being able to ask further questions of children immediately following the conclusion of the recorded criminal interview to clarify any care, protection or clinical issues not already canvassed by police.
- FACS and Health being able to retrospectively review interviews via electronic media, request written or verbal summaries of relevant aspects, or arrange transcripts where required for use in care proceedings.

The changes to interviewing practice represent a significant shift in the role played by FACS staff over a lengthy period, and understandably, required careful communication to the field. It would have been preferable for the changes to interviewing practice to have been announced via a Joint Communication from the SMG (of the type sent in December 2016). It is nonetheless positive that following our conciliation the agencies were able to come to document how the interview process should be executed. (We discuss the issue of JIRT agency directives further in Chapter 25 in the context of JIRT governance.)

997 JIRT SMG, *Joint Communication*, 21 December 2016.
998 Including by reducing the need for interviews to occur on multiple occasions.
999 Unless there are valid reasons not to do so, such as where the child is very young or it would interrupt the free flow of the interview.

While the recorded criminal interview is one of a number of critical components of the overall JIRT response, it has, for understandable reasons, become the barometer for assessing the degree of cooperation and collaboration between the JIRT agencies. However, the change in interviewing practice should not be seen as a move away from the partnership or a 'green light' to work in silos. Rather, it presents JIRT practitioners with a new challenge, requiring them to execute their respective roles in an integrated way, while also focusing on making a difference in those areas where their agency is best placed to take the lead. If this does not occur, the agencies risk fracturing their relationship into the future and weakening the quality and reputation of the JIRT program.

Having considered the available evidence, including directly consulting members of the judiciary, the Office of the Director of Public Prosecutions (ODPP) and the Royal Commission, we believe the reasons for Police solely conducting the criminal interview are sound. The current approach is designed to strengthen the quality of evidence gathered to support the commencement and outcomes of criminal proceedings. The additional assistance of witness intermediaries in the pilot locations will further strengthen the quality of evidence. If, in executing these new arrangements, Police work effectively with FACS to support its child safety and broader care and protection assessment, then the arrangements have the potential to deliver improved outcomes for children and young people, and continue to 'reduce the number of investigative interviews required' as articulated in the JIRT MoU.

While the December 2016 Joint Communication from the SMG was an important way for the three agencies to both explain, and show their support for, the changes to interviewing practice, it will also be critical for the SMG to communicate to the field that they are monitoring the implementation of the changed arrangements. In this regard, our recommendation in the previous chapter that local JIRT managers should escalate concerns to the SMG when practice is not being adhered to, and our related recommendation that interview participation data should be collected, analysed, and reported on, will allow the SMG to identify those sites where the new interview arrangements are being well implemented, and where prompt action needs to be taken to address any problematic practice in this area.

22.1. The rationale for police conducting the recorded criminal interview of the child victim

In NSW, the *Criminal Procedure Act 1986* provides the legislative basis for a recorded interview of a child under 16 to be admitted to court as their 'evidence in chief'.[1000] The recording takes place in advance of any trial, at a time when the events in question are often fresh in the child's memory, and in a way that avoids additional stress to the child associated with testifying in court.[1001] Preparation for the recording and the evidence that is elicited may also clarify key issues in the trial for both the prosecution and the defence, prompting earlier resolution. The use of pre-recorded evidence in court is controlled by the judge and, where required, objections and inappropriate questions can be edited out of the final recording to be shown to the jury.[1002]

However, with these considerable benefits come increased evidentiary risks.[1003] As the Royal Commission has observed, 'because the pre-recorded interview is likely to be used as the complainant's evidence in chief, the quality of the interview is crucial. It is likely to constitute most, if not all, of the prosecution's direct evidence about the alleged abuse'.[1004]

1000 If a statement made by a vulnerable person to an investigating official regarding a criminal offence is recorded, the vulnerable person is entitled to give evidence in chief in the form of the recording: Criminal Procedure Act, s.306U(1). This entitlement applies to a child who was under 16 years at the time the recording was made, regardless of his or her age at the time of giving evidence (s.306U(2)).
1001 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.380.
1002 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.380.
1003 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.380.
1004 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.127.

The Royal Commission's Complainants' Evidence Research report emphasised that considerable skill is needed to ensure that the interviewing methods used do not reduce the reliability and credibility of a child's evidence at trial.[1005] In particular, the canvassing of details not central to proving the criminal offence, or 'over particularisation' in relation to establishing the offence, can create inconsistencies in the child's evidence that may lead to extensive cross-examination and 'adversely affect the jury's view of the complainant's reliability and credibility'.[1006] It is for this reason that child interviewing in relation to criminal matters is a highly specialised skill. Professional stakeholders consulted for the research commented that interviewing sexual abuse complainants is a difficult skill to learn, especially when there is a need to balance investigative and evidentiary requirements.[1007] Ensuring skilled police interviewing capability was therefore considered to be a high priority.[1008]

As discussed in Chapter 5, police officers conduct the forensic child interview in the majority of jurisdictions in Australia. Our consultations with ODPP Crown Prosecutor, Ms Gina O'Rourke SC, and two of the Specialist District Court Judges[1009] in November 2016 confirmed they support specialist police undertaking interviews of children. However, each also emphasised the importance of interviews being informed by appropriate information, with input from all three JIRT agencies, and the use of skilled interviewing techniques by police.

During our inquiry, Police provided us with examples of cases where they had received feedback from the ODPP and individual judges about why particular matters were no-billed by the ODPP or where prosecutions failed which supported their position. In essence, the view put forward by Police is that the risks associated with traversing care and protection issues in the pre-recorded evidence of a child about a criminal matter are appreciable; that police are best placed to ensure the integrity of a child's evidence in chief by controlling the way in which the interview is conducted; and that police have an implicit duty to do so as a result of their primary role to detect and investigate crime. The CAS also put forward the view that a police-led criminal interview monitored and reviewed by FACS is an effective way of striking a balance between safeguarding the integrity of a child's evidence in chief and ensuring care and protection issues are also addressed.

However, as we discuss throughout this and other chapters in the report, there are a range of practical issues that need to be effectively dealt with in order to ensure that the overall child interview process is managed in a collaborative manner.

In the context of the changes to interview practice, it is important to note that Police have recognised that there is scope for them to improve how they conduct recorded criminal interviews of children, and they have taken a range of steps to strengthen practice and training in this area which we outline in section 22.3.

22.2. Ensuring police interviews are conducted collaboratively

During our inquiry, the CAS confirmed that, while they are responsible for conducting the recorded criminal interview with the child victim, they are committed to ensuring that the interview process is conducted in a way that promotes the identification of child protection and wellbeing concerns, and reduces further trauma to the child. (This commitment has also been reflected in the December 2016 Joint SMG Communication.)

In this section we discuss a number of practical issues identified by the agencies during our inquiry, which need to be addressed in order to facilitate the effective implementation of the new interviewing arrangements.

1005 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, Royal Commission into Institutional Responses to Child Sexual abuse, *An evaluation of how evidence is elicited from complainants of child sexual abuse,* August 2016, p.45.
1006 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.128.
1007 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, Royal Commission into Institutional Responses to Child Sexual abuse, *An evaluation of how evidence is elicited from complainants of child sexual abuse*, August 2016, pp.25-26.
1008 Martine Powell, Nina Westera, Jane Goodman-Delahunty and Anne Sophie Pichler, Royal Commission into Institutional Responses to Child Sexual abuse, *An evaluation of how evidence is elicited from complainants of child sexual abuse*, August 2016, p.45.
1009 Hon Judge Jennie Girdham SC and Hon Judge Catherine Traill.

22.2.1. The intersection of care and protection and criminal issues in the interview process

The CAS memorandum of December 2015 directed that:

> *All matters that deal with the care and protection of the victim that impact on the criminal investigation will be asked by Police during the course of the electronically recorded interview. FACS will have the option of monitoring or reviewing the interview and, when appropriate, discussing with Police questions that deal with the care and protection of the victim that need to be asked. Further care and protection questions may be asked after the criminal interview has been completed* [but these] *do not need to be electronically recorded.*[1010]

The majority of FACS respondents to our workforce survey were concerned that, as a result of the new interviewing arrangements, FACS is now required to undertake more 'secondary child interviews' and that this is not best practice because of the potential for additional interviews to negatively impact on the child's wellbeing. In response to these concerns, Police noted that a fundamental element of the FACS JIRT response is conducting a home visit. In this regard, there will be occasions where FACS needs to put additional questions to a child; however, this form of follow up questioning should not be viewed in negative terms, as the issues are unlikely to have been known at the time of the initial child interview. For this reason, it is important to distinguish between what could be reasonably be regarded as a missed opportunity to canvass issues during or immediately following on from the recorded criminal interview and occasions where additional questioning at a later stage is both appropriate and necessary.

In their view, FACS's role in asking additional care and protection questions immediately after the criminal interview, should not be regarded as a 'secondary interview' but rather, an integral part of the one 'interview process', of which the recorded criminal interview is one component.[1011] Police also noted that a fundamental element of the FACS JIRT response is conducting a home visit. In this regard, there will be occasions where FACS needs to put additional questions to a child; however, this form of follow up questioning should not be viewed in negative terms, as the issues are unlikely to have been known at the time of the initial child interview.

The changes to interviewing practice have been designed to obtain information relevant to the commission of any criminal offences on the electronic record, as well as to inform the care and protection assessment. In our view, for the new interviewing arrangements to work they need to be viewed as a 'process', with each stage being carefully executed, rather than the focus being on the need to encapsulate the JIRT response through a single event, that is, the recorded criminal interview.

The JIRT MOU is a formal agreement to:

> *foster cooperation between departments for the mutual benefit of working effectively on creating relationships that provide the best outcomes for children, young people and their families.*

A constructive discussion between the FACS caseworker and the police interviewer needs to take place prior to and/or during the interview break to avoid any unnecessary separation of the interview process or certain questions being asked during the recorded criminal interview that are best asked separately by FACS.

If, after consultation with the police interviewer before or during the interview break, it is considered best for FACS to ask particular care and protection questions after the completion of the police interview (that is, questions deemed to be extraneous to establishing the necessary proofs for the alleged offence(s)), then Police and FACS need to work cooperatively to ensure the 'handover' to FACS is managed as seamlessly as possible in the interests of the child's wellbeing.

In addition, the police officer briefly introducing the FACS caseworker before the interview, and indicating that the FACS caseworker may need to talk to them later, is more likely to encourage the child to view any questioning by FACS after the police interview as part of the one process.

1010 NSW Police Force Memorandum, *Interviewing Child Victims*, 21 December 2015.

1011 In Western Australia as part of the MIST response – where specialised child interviewers are used – care and protection issues are generally not canvassed until the recorded part of the criminal interview has been completed.

As we have discussed elsewhere, it is critical that the police interviewer is able to establish a rapport with the child and this requires any contact with other individuals prior to the start of the interview to be carefully managed on a case-by-case basis. However, it is more likely that a child or young person understanding how the interview process may unfold, and perceiving that Police and FACS are part of the one team, will support them to 'tell their story' during the recorded criminal interview and during any subsequent questioning by FACS.

Without a collaborative approach, the capacity of the new interviewing arrangements to facilitate the identification of child safety, care and protection, therapeutic and criminal justice needs of the child will be undermined.

22.2.2. Timing of recorded criminal interviews of children

During the inquiry, concerns were raised by both FACS and Health staff about not being given sufficient notice of Police plans to conduct an interview. In this regard, FACS told us that, at times, their staff had been given as little as 30 minutes prior notice of a recorded criminal interview by the CAS.

Health shared similar concerns about JIRT health clinicians receiving inadequate notice of interviews, and observed a perceived reluctance by police to utilise after-hours arrangements for obtaining Health assistance. They emphasised the importance of non-offending family members having the option of being supported by a health worker around the interview process, both to reduce their distress and improve their understanding of the investigation process – factors which, as Health has stressed, promote engagement with counselling and other support services as well as ongoing cooperation with the investigation.

Where there are compelling reasons, such as the need to quickly apprehend an offender to prevent further harm to a child, it may be necessary for police to conduct an urgent interview of a child (during or after business hours). In such circumstances, FACS and Health should be contacted by Police, and if they are unable to provide staff to attend the interview, Police may determine that they need to proceed. However, in most circumstances, there will generally be sufficient time for interview arrangements to be planned in consultation with FACS and Health. (As we discuss in Chapter 11, the recent injection of funding to enhance FACS resources will ideally go some way towards addressing current capacity issues to support its after-hours response (currently performed by the Crisis Response Team). In relation to Health, it has made arrangements for the LHDs to be the point of contact for Police and FACS after-hours.)

As a child is unlikely to give their best evidence when tired or hungry, it is good practice to interview them in the morning, when they have had sufficient sleep and food.[1012] The CAS has advised that, they would rarely interview a child late in the day, and in practice, it is more likely that interviews conducted 'after-hours' have taken place during the day but on a weekend, rather than after 5pm. Police also noted that the urgency of conducting the recorded criminal interview is often driven (appropriately in their view) by FACS' imperative to establish care and protection issues not only by a desire by police to immediately interview a child.

Regardless, where there is no compelling reason to carry out an urgent interview, it is not in the best interests of the child – nor is it in the spirit of the multiagency response to child abuse which the JIRT program is designed to provide – for interviews to proceed without each agency being given the opportunity to attend and provide relevant information to inform the interview process. Proceeding with recorded criminal interviews when they are not urgent, and in the absence of FACS and Health, also increases the likelihood that FACS will need to conduct a separate interview at a later time, and potentially leaves the child and family unsupported during the interview process.

Where a child is in a health facility, such as a hospital, it is also imperative that the CAS liaises with the management of that facility before entering the premises to conduct an interview, so that child protection staff can be involved in ensuring the interview process is coordinated with the health care of the child.

1012 CAS record of meeting with Crown Prosecutor, Gina O'Rourke SC, 6 December 2016, p.1.

The CAS leadership team has confirmed that any instances of interviews being conducted without FACS and Health having been contacted should be escalated to the relevant CAS Team Leaders and Zone Managers as appropriate. Similarly, Health has indicated that the Director, PARVAN should be advised whenever FACS or Police have difficulties in securing a response from an LHD outside of normal business hours. It will be important that compliance in this area is tracked closely by the SMG over the next 6-12 months. We discuss interview participation and related data collection further in the next section.

Presently, JIRT procedures do not contain any specific guidance about the factors that will be considered by the CAS in determining the need for an urgent interview of a child, or the process they will follow to negotiate the timing of the interview with FACS and Health. The absence of this guidance appears to have led, on occasions, to unilateral decision-making by the CAS which, while possibly in the interests of the criminal investigation, has undermined the tri-agency nature of the JIRT arrangement and its capacity to provide children and their families with a holistic response. As noted in Chapter 21, this gap in accountability should be addressed through appropriate amendments to the *Local Planning and Response Procedures* along with other amendments we have recommended aimed at strengthening the LPR, including ensuring compliance with the pre-interview information sharing and briefing requirements.

CAS survey of FACS interview involvement

To better inform its understanding of how CAS teams have been engaging FACS staff in the interview process, the CAS asked its Team Leaders to collect interview data over a two month period in November and December 2016.

In discussing the survey data collected by CAS, we recognise that it is indicative only, having been collected by the CAS to inform its understanding of its own officers' practice, and that its accuracy has not been verified by FACS.[1013] Having said this, the data collected by the CAS has provided some valuable insights into the type of data that could be collected in future.

During November to December 2016, a total of 556 recorded criminal interviews of children were conducted. The survey indicated that 17 out of 22[1014] CAS locations contacted FACS JIRT (or the FACS CRT after-hours) prior to an interview, on average, at least 80% of the time. Of these locations, 12 recorded that they contacted FACS on more than 90% of occasions (including six that indicated they made contact on 100% of occasions).

The survey did not collect information about the reasons why FACS was not contacted prior to the interview; or the amount of notice provided to FACS prior to the planned commencement of the interview.[1015]

Of the occasions where FACS was notified, FACS staff were present to monitor the interview 86% of the time.[1016] The reasons provided for FACS not being present to monitor an interview (as recorded by CAS) included:

- CAS provided an immediate response to a request for assistance by a LAC
- the interview was conducted in another state
- a child witness was interviewed
- the response was after-hours
- FACS staff were not available to attend
- the matter had not yet been accepted by the JRU
- the interview was a 'follow up' interview for the purpose of clarifying evidence

1013 We also note that the data collected was not done so via a retrospective audit, with Team Leaders collecting data for the purposes of future analysis – its reliability as an indicator of compliance needs to be considered with this in mind.
1014 While there are now 23 CAS sites, the data collected for this survey was based on the 22 sites operating at the time.
1015 The survey did not collect data about Health's participation in interviews. However, Health's participation in monitoring the interview is dependent on a range of factors, the critical issue being the need to notify Health so it can determine whether and how best to provide therapeutic support to the child.
1016 FACS was contacted in relation to 503 of the 556 interviews conducted. Of these, FACS was present to monitor 434 interviews.

- FACS agreed to Police-only response in the circumstances
- typed transcript/statement by a 16-17 year-old child/young person
- CAS provided an on-call response and disclosure was made in the field
- rejected by JRU, and
- witness interview conducted for a LAC.

The most common reasons recorded by the CAS Team Leaders as to why FACS did not monitor the interview were 'interview was conducted interstate/victim interstate' and 'request for assistance by LAC', followed by 'child witness interview' and 'after-hours'.

In our view, it would be beneficial to develop a standard list of accepted categories to give a more meaningful view of compliance with the newly agreed processes for conducting interviews. For example, if the CAS is responding to a request for assistance by a LAC who received a report of child abuse directly (including prior to the JRU assessment), this should not remove the obligation to inform FACS of the need to interview a child victim (as FACS CRT or CSC staff may attend even where FACS JIRT is not available) even if this is not currently a requirement for matters that have not yet been JIRT accepted. In addition, if the reason FACS did not attend the interview is because it was not a child victim but rather, a child witness, then this should also be made clear.

Of the recorded criminal interviews conducted, 503 (91%) were conducted within business hours. This finding is critical given it provides a clear picture of how often interviews are in fact being conducted after-hours (including during the evening and on weekends), which has been an area of contention during the inquiry. While the data suggests that interviews are only being conducted after-hours on a relatively small number of occasions, in light of the widely accepted view that interviews should only occur later in the day/early evening in exceptional circumstances, it is important for a record to be made of the reasons why a recorded criminal interview was necessary after-hours.

In our view, while valuable, the data collected by the CAS could be further refined, and it would be relatively easy to capture at an operational level by individual CAS teams. In this regard, it would not be productive for all three agencies to collect the same data on compliance with the interview process. However, it will be critical for the data to be verified by the local JIRT managers of all three agencies (to avoid any dispute about its reliability). This could be facilitated through Local Management Groups.

Table 13 below provides an example of how data could be collected to track compliance with interview participation. The proposed data collection will also enable an analysis to be undertaken of the proportion of interviews conducted after-hours. Health also suggested that there would be value in indicating whether or not an interview was conducted before or after a medical forensic examination or crisis counselling.

Table 13: Sample Interview participation data for accepted JIRT matters

CAS/JIRT site	Was FACS JIRT/FACS CRT contacted prior to I/V	If yes, amount of notice prior to I/V?	If no, provide reason.	Was the I/V conducted after hours?	Did FACS monitor the I/V?	If no, provide reason.
Ballina	Yes	60 mins	N/A	No	Yes	N/A
Bankstown	Yes	30 mins	N/A	Yes	No	Unable to attend within 30 mins

Note: We have not sought to depict Health's engagement in the interview process; however, similar categories would apply.

In addition, in Chapter 25 we have recommended that, as part of implementing a broader JIRT performance monitoring and reporting framework, the JIRT SMG should analyse interview participation data regularly and report on this issue along with other key performance indicators.

22.2.3. Interview breaks

Another outcome from our conciliation during the inquiry was an agreement by the CAS that 'Police, as a matter of best practice and in the interests of the child, [will identify] an appropriate point during interviews for a break to occur,[1017] for purposes including consultation with FACS and Health about any additional care or protection matters, or clinical issues that may have arisen'.[1018]

The SMG's Joint Communication establishes a basis for continuing to hold one 'JIRT interview' in most situations. In this regard, the introduction of a structured break[1019] during the recorded criminal interview is an important opportunity for FACS and Health to provide input. Ensuring FACS is able to electronically monitor the recorded interview is critical to informing its care and protection assessment, and assisting FACS to determine whether any additional questions need to be asked at the conclusion of the recorded interview.

It will be important for the partner agencies to monitor compliance with practice in this area via the escalation mechanisms we recommended in our chapter on the LPR.

Obviously, the ability for FACS and Health to provide valuable input during an interview break is dependent on them being able to clearly monitor the interview as it unfolds. Previously, this has been difficult if an interview occurs outside of a JIRT interview suite. Issues relating to the available technology (including the reliability of electronic monitoring devices and the fact that they do not enable the listener to see the child) are discussed further below.

22.2.4. Monitoring equipment

During the inquiry, FACS expressed concern about its ability to effectively monitor recorded criminal interviews of children under the new arrangements due to:

- inadequate or unreliable equipment for electronically monitoring interviews that are not conducted in an interview suite, and
- an inability, when interviews are not conducted in an interview suite, for FACS staff to observe the child's body language/non-verbal cues – this is considered to be an important factor for assessing children's care and protection needs.

For this reason, the SMG's Joint Communication in December 2016 included a statement highlighting the importance of 'FACS and Health being able to electronically monitor interviews for the purposes of listening to and observing children to inform assessments and investigations as to whether a child or young person is at risk of significant harm, as well as other issues concerning safety, risk, health and wellbeing'.

Late last year, FACS and the CAS advised us that they had negotiated a technical solution to improve FACS' ability to visually monitor interviews in locations without an interview suite. FACS indicated its intention to provide all JIRT caseworkers with Portable Interview Monitoring Device Kits, comprising an iPad, Go Pro Camera and wireless microphone, to facilitate audio-visual monitoring of recorded criminal interviews conducted by police off-site. In a recent memorandum announcing the implementation of the technology in 14 of the 22 JIRT sites, FACS stated that the kits will enable both FACS and CAS staff to perform core functions under the JIRT program.

While the intention was for these devices to be in place state-wide by March this year, FACS advised us that a world-wide shortage of the necessary IT components delayed full implementation. FACS has now rolled out the technology to its staff. FACS has also advised that it has secured an ongoing internal source of funding for maintaining this technology into the future. The use of iPads by FACS is a sensible solution to meet the needs of both agencies given the changes to interview practice.

1017 'Unless there are valid reasons why a break should not occur, such as where [the child is] very young … or it would interrupt the free flow of an interview'.
1018 JIRT SMG, *Joint Communication,* December 2016, p.2.
1019 The structured interview break, drawn from the WA MIST model, is an essential component of the child interview.

The CAS has emphasised that the use of any technology must be strictly limited to monitoring and not the recording of interviews by caseworkers for any purpose. FACS has distributed guidance for its staff on using the monitoring devices, together with a security policy that sets out the restrictions on the use of the technology.[1020]

An outstanding issue that requires resolution concerns ambiguity in a March 2017 Directive, issued to all CAS staff following the release of the SMG communication in December 2016, which stated that, 'While as a matter of best practice the blue tooth kits [or electronic device] should be utilised for field interviews, Team Leaders will still have the discretion based on individual circumstances for this not to occur if deemed appropriate'.[1021] The CAS has recently clarified that this statement is meant to indicate that a Team Leader may exercise discretion to allow FACS to 'live' monitor an interview if appropriate, for example, if electronic equipment fails. It does not mean that a Team Leader can exercise discretion to prevent FACS from electronically monitoring an interview. We suggest that the relevant Directive be amended by the CAS to clarify the intended meaning.

22.3. Enhancing police interviews

A key finding of the Royal Commission's Complainants' Evidence Research was that there is considerable scope to improve the quality and consistency of police interviews of children.

Informed by this research and its related work, the Commission has proposed a number of possible principles to guide police investigative interviewing:

- All police who provide an investigative response (whether specialist or generalist) to child sexual abuse should receive at least basic training in understanding sexual offending, including the nature of child sexual abuse and institutional child sexual abuse offending.
- All police who provide an investigative response (whether specialist or generalist) to child sexual abuse should be trained to interview the complainant in accordance with current research and learning about how memory works in order to obtain the complainant's memory of the events.
- The importance of video-recorded interviews for children and other vulnerable witnesses should be recognised, as these interviews usually form all or most of the complainant's and other relevant witnesses' evidence in chief in any prosecution.
- Investigative interviewing of children and other vulnerable witnesses should be undertaken by police with specialist training. The specialist training should focus on:
  - a specialist understanding of child sexual abuse, including institutional child sexual abuse, and the developmental and communication needs of children and other vulnerable witnesses, and
  - skill development in planning and conducting interviews, including use of appropriate questioning techniques.
- Specialist police should undergo refresher training on a periodic basis to ensure that their specialist understanding and skills remain up-to-date and accord with current research.
- From time to time, experts should review a sample of video recorded interviews with children and other vulnerable witnesses conducted by specialist police for quality assurance and training purposes and to reinforce best-practice interviewing techniques.
- State and territory governments should introduce legislation to remove any impediments, including in relation to privacy concerns, to the use of video recorded interviews so that the relevant police officer, his or her supervisor and any persons engaged by police in quality assurance and training can review video-recorded interviews for quality assurance and training purposes. This would not be intended to require legislative authority to allow the use of video-recorded interviews for general training purposes.

1020 FACS Chief Information and Operating Officer, Tim Hume, *Information Security measures for FACS JIRT interview monitoring technology,* 28 April 2017; NSW FACS, *FACS JIRT Interview Monitoring Technology – Technical Solution Specifications Sheet.*
1021 NSW Police Force Memorandum, *Police interviews – including the use of blue tooth kits*, 13 March 2017.

- Police should continue to work towards improving the quality of video-recorded interviews so that they are as effective as possible, from a technical point of view, in presenting the complainant's and other witnesses' evidence in chief.
- Police should recognise the importance of interpreters, including for some Aboriginal and Torres Strait Islander victims, survivors and other witnesses.
- Intermediaries should be available to assist in police investigative interviews of children and other vulnerable witnesses.[1022]

Many of these principles/elements are already in place in NSW. During the Royal Commission's Roundtable on multi-disciplinary and specialist policing responses, one of the experts representing the state of Victoria, Patrick Tidmarsh – a criminologist and forensic interview advisor with Victoria Police's Sexual Offence and Child Abuse Team within the Family Violence Command – explained the benefits of using the 'whole story' narrative approach when conducting child interviews.

When interviewing children, Mr Tidmarsh indicated that the aim should be to reduce the duration of the police interview while at the same time encouraging a narrative telling of the event, focusing on the quality of the detail rather than quantity of detail provided by the child complainant to obtain relevant evidentiary information.[1023] He gave evidence that, when interviewing children, most police in Victoria use the narrative interviewing methodology developed by Professor Martine Powell from Deakin University and the Centre for Investigative Interviewing, which encourages a better recollection from the child and is now considered best practice.[1024] The whole story approach essentially involves looking at sexual offending as a crime of relationship. Investigative interviewers are taught to elicit free narrative to understand the entirety of the relationship between the suspect and the victim, which places the relationship in context, and enables the identification of relevant evidence within the narrative. According to Police, NSW investigators who undertake the Child Interviewing Course are taught to use a similar 'free narrative' approach, but to also limit the amount of unnecessary detail that is canvassed in order to reduce the potential for the child's evidence to become contaminated or vulnerable to cross-examination.

In order to be confident that a whole story approach was being implemented effectively, Victoria Police evaluated child interview transcripts to assess the types of questions asked and phrasing to encourage the child to tell their story. According to Mr Tidmarsh, the evaluation showed that poor question style diminished the quality of the interview content. While initial training was largely the responsibility of sergeants and senior sergeants, 'of all the elements of the evaluation we conducted, interestingly, with investigative interviewing, their skill set diminished over time because we haven't got the refresher right'.[1025]

In response to the Royal Commission's observations in its *Consultation Paper – Criminal Justice* and evidence given at its Roundtable on multi-disciplinary and specialist policing responses, the CAS has shown initiative in reviewing the training it provides to its investigators. In addition to the specialist Child Interviewing Course, which is compulsory for all CAS officers (and open to LAC police), newly trained CAS officers are required to undertake practical assessments and are intensively supervised by a senior CAS officer during their first few weeks in the CAS. In addition, the CAS have been proactive in engaging external stakeholders, including ODPP Crown Prosecutor, Gina O'Rourke SC, to provide expert guidance and interview training to lift the quality of child interviews. In June this year, the CAS also commenced a review of interviewing, which involves an experienced Team Leader[1026] reviewing interviews conducted by investigators who have not undertaken the Child Interviewing Course within the last 12 month, and providing them with structured feedback. Finally, ERISPs[1027] are being enhanced state-wide, including through the roll-out of portable high definition interview kits.

1022 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, pp.138-139.
1023 Royal Commission into Institutional Responses to Child Sexual abuse, *An evaluation of how evidence is elicited from complainants of child sexual abuse*, August 2016, p 304; Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper – Criminal Justice*, September 2016, p.368.
1024 Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.23933.
1025 Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016.
1026 The Team Leader has over 15 years of experience and also lectures on the Child Interviewing Course.
1027 Electronically recorded interviews of suspects.

The CAS has also acknowledged the need to further review its interview training after considering the recommendations from this inquiry. In this regard, we recommend that the CAS consider adopting a similar approach to Victoria Police in conducting 'interview refresher training' informed by an ongoing program of reviewing CAS interview transcripts. Throughout our report, we have made observations about areas where police interviewing practice could be further strengthened. We have emphasised the importance of police having regard to relevant information provided by FACS and Health before and during the recorded criminal interview, and we recommended that the Police Child Interviewing Course include guidance about the purpose of the structured interview break.

In addition, we have recommended that the CAS review the specialist interview training provided to police officers to ensure it includes adequate guidance on interviewing particularly vulnerable cohorts of children and young people. We also discussed the need for Aboriginal and CALD consultation to be more solidly embedded in the LPR.

Recommendations

52. As part of implementing a broader JIRT performance monitoring and reporting framework, the JIRT partner agencies should, until jointly satisfied that it is no longer required, collect data that enables regular monitoring of the participation by FACS and NSW Health in attending/monitoring child victim recorded criminal interviews (and other child interviews conducted by Police), including but not limited to the following data:

- **a) The number of child victim and other child interviews where FACS and/or NSW Health were notified prior to the interview**
- **b) Of the total number of interviews conducted, the proportion which occurred before or after medical forensic examinations and/or crisis counselling.**
- **c) The amount of notice provided to FACS/NSW Health prior to the proposed interview time where contact was made.**
- **d) The number of child victim and other child interviews where contact was made that were attended/monitored by FACS and/or NSW Health.**
- **e) Where FACS/NSW Health did not attend/monitor the interview, the reasons provided by each agency for this.**

53. The NSW Police Force should ensure that the Child Abuse Squad reviews and revises its Child Interviewing Course, having regard to the observations in this report about:

- **a) The importance of Police considering relevant information provided by FACS and Health to inform the recorded criminal interview (Chapters 21 and 22).**
- **b) The purpose of providing a structured interview break and how this should be implemented.**
- **c) Factors to consider when interviewing particularly vulnerable cohorts of children (Part 5).**
- **d) The benefits of adopting a similar approach to Victoria Police in conducting 'interview refresher training', informed by an ongoing program of reviewing child interview transcripts (Chapter 22).**

54. The JIRT partner agencies should further refine the JIRT Foundation Skills Program and, in particular, training about interviewing, having regard to the observations in Part 5 of this report about improving the response to particularly vulnerable groups of children and young people.

PRACTICE SUGGESTION

- The NSW Police Force should consider amending the Child Abuse Squad Directive of March 2017 about interviewing to clarify the intended meaning of the reference to the discretion that a Team Leader may exercise, based on individual circumstances, in relation to permitting FACS to monitor an interview using electronic equipment.

Chapter 23. The JIRT *Local Contact Point Protocol*

> *when you have an organisation or an institution … where children are being cared for daily by a limited group of workers, and an allegation surfaces that one of those children has been abused, it's just inevitable that for the rest of the parents in that group it will be a crisis … [they need] to have information which is reliable and consistent and which does something to provide … assurance that appropriate steps are being take* – Justice Peter McClellan AM.[1028]

During Case Study 2, which examined YMCA NSW's response to the conduct of Jonathon Lord, the Royal Commission heard evidence which highlighted the absence of JIRT procedures and guidelines for responding to allegations of child sexual abuse in an institutional setting (for example, a school or childcare centre) where a 'class of children' is potentially at risk.[1029] In matters of this type, where multiple children may have been at risk as a result of their contact with the alleged offender, promptly disclosing appropriate information to parents, caregivers and other relevant stakeholders can assist them to identify and report any concerning behaviours they may have observed, and provide reassurance that appropriate action is being taken to ensure there is no further risk to their children.

In the case of Jonathon Lord, who was convicted of multiple sexual offences against several children who attended the YMCA facility where he worked, the Royal Commission heard that the information and support provided by the JIRT agencies to the parents of children exposed to Lord was inconsistent, and at times delayed. The former CAS Commander gave evidence that a protocol was being developed to facilitate the provision of consistent and timely information and support, to parents and other relevant community members, during the course of a JIRT investigation.[1030] The JIRT *Local Contact Point Protocol* (LCPP), prepared by the JIRT partner agencies, was subsequently released in March 2014.

At its public Roundtable on multi-disciplinary and specialist policing responses, the Royal Commission commended the JIRT partner agencies for the leadership they have shown in developing the LCPP, identifying it as an example of an approach that fulfils the good practice requirement for 'procedures or protocols to guide police, institutions and the broader community on the information and assistance they can provide to children and parents, the broader community and the media when a (current) allegation of institutional child sexual abuse is made'. [1031] Other states, including Western Australia and Victoria, have indicated that they will now consider developing similar protocols.[1032]

Three years have now passed since the LCPP was developed. While a significant initiative to improve the JIRT program's response to reports of institutional child sexual abuse, our work in the employment-related child protection area has informed our views as to how the LCPP can be further strengthened. In particular, there is scope to increase awareness of the Protocol, enhance aspects of the guidance it provides to both JIRT staff and institutions, and improve monitoring of its application.

23.1. Royal Commission Case Study 2: YMCA NSW's response to the conduct of Jonathon Lord

Jonathon Lord worked in various roles at YMCA NSW for over two years. He was suspended from work on 30 September 2011, following a disclosure that he had sexually abused a child during an excursion. His employment was terminated in November of the same year. The initial disclosure

1028 Hon Justice Peter McClellan AM (Chair), Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.107.
1029 Royal Commission into Institutional Responses to Child Sexual Abuse, *Case study 2: YMCA NSW's Response to the Conduct of Jonathon Lord*, 2013.
1030 NSW Family and Community Services, NSW Police Force, NSW Kids and Families, and NSW Health, *JIRT Local Contact Point Protocol 2014* p.3.
1031 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper — Criminal Justice*, September 2016, p 20. See also Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.107.
1032 Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.105.

was reported to Miranda LAC by the parents of the alleged victim and the matter was subsequently referred to Kogarah JIRT. On 10 October 2011, a second allegation was made against Lord by another child. Lord was eventually convicted of 13 sexual offences involving 12 children.[1033]

While knowledge of Lord's suspension from the YMCA had quickly spread among the community, the CAS advised the YMCA not to disclose Lord's name (or the names of the alleged victims) to parents of children who had been exposed to Lord.[1034] The YMCA did not inform parents of the allegations against Lord until nearly two weeks after the initial allegation. After the second disclosure, Kogarah JIRT set up a hotline to respond to calls in relation to allegations against Lord and to triage the flow of incoming information from families, parents and caregivers.[1035] However, the hotline was not adequately 'marketed' to the relevant stakeholders and its effectiveness was limited.[1036]

The Royal Commission's 2013 Case Study about the YMCA's response to the conduct of Lord highlighted that the JIRT program's operational procedures provided no specific direction about the handling of reports involving allegations of child sexual abuse in an institutional context. The Commission heard evidence from parents and caregivers, who were critical of what they regarded as poor communication and information sharing by relevant agencies during the investigation into the allegations against Lord. The parents of a number of the victims suggested a single point of contact to facilitate better access to information.[1037] Our recommendations about the establishment of a Child and Family Advocate role in the JIRT program are relevant to this suggestion (see Chapter 6).

23.2. The application of the *Local Contact Point Protocol*

The objective of the LCPP is to provide clear operational guidelines for staff from the JIRT agencies, the Helpline, CSCs, and relevant stakeholders.

The LCPP establishes a system for communicating with parents, caregivers and other relevant stakeholders during the investigation of allegations of child sexual abuse in an institutional setting carried out through the JIRT program by 'the activation of a Local Contact Point'. The primary purpose of activating a Local Contact Point is to ensure that parents receive appropriate, accurate information about risks to their children. The provision of this information can encourage other disclosures, draw out potential witnesses, counter the spread of misinformation and rumour, and facilitate access to support services.

The LCPP directs the JIRT agencies to consider the need to apply the protocol where:

- a report of child sexual abuse has been accepted by the JIRT Referral Unit (JRU); and
- initial investigation and assessment obtains sufficient evidence to indicate further children are at risk or the potential for broader community concern; and
- the alleged offender works in a paid or a voluntary capacity at, or attends, an institution providing services to children and young people; or
- Senior Officers determine that implementation of the LCPP is warranted.[1038]

Initially, the LCPP only applied to circumstances involving an alleged offender over the age of 18; however, following feedback from the Royal Commission at its June 2016 Roundtable, the criteria were expanded to apply to matters that involve harmful sexual behaviour by young people under 18 years of age.[1039]

1033 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, p.4.
1034 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, p.77.
1035 Royal Commission into Institutional Responses to Child Sexual Abuse, *Written submissions of Senior Counsel assisting the Royal Commission: Public Inquiry into the Response of YMCA NSW to the conduct of Jonathon Lord,* Case Study 2, p.68 at [240].
1036 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, p.79.
1037 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 2: YMCA NSW's response to the conduct of Jonathan Lord*, June 2014, p.81.
1038 *JIRT Local Contact Point Protocol 2014*, p.5.
1039 As at October 2016, there had been one application of the LCPP to a matter involving allegations of sexual assault of a young child by older children at a school. (NSW Government, *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation Paper – Criminal Justice*, October 2016, p.9.)

Where local JIRT agency managers[1040] identify, through the Local Planning and Response (LPR) process, that an accepted JIRT referral meets the above criteria, they are required to liaise with the relevant institution's senior representative (for example, school principal) and make a joint decision about whether to recommend activation of a Local Contact Point, which requires the approval of the local JIRT agency line managers.[1041] The local JIRT agency managers then jointly determine the most appropriate agency (usually FACS or Health) to act as the Local Contact Point, and a staff member of the agency is designated for this purpose. The agencies determine the information that can be disclosed by the Local Contact Point.[1042]

In addition to information about the specific allegation, the Local Contact Point may also provide advice to parents and caregivers about protective behaviours, what to do in the instance of a disclosure, and the availability of relevant resources and support services.[1043] The Local Contact Point records the details of all contact received and exchanges this information with the local JIRT agency managers (identifying details are exchanged with caller consent).

Prior to August 2016, once notified by the JIRT agencies that a Local Contact Point would be activated, the relevant institution would prepare a communication to notify parents, caregivers and other relevant stakeholders about the allegation and provide them with the contact details for the Local Contact Point. Local JIRT agencies managers would confirm the suitability of the information to be provided and approve the communication.[1044] However, as we discuss in section 23.4.1, the LCPP does not provide guidance to institutions on the factors to consider when releasing communications to parents/staff/stakeholders.

23.3. How has the LCPP been used so far?

Between July 2014 and February 2017, a Local Contact Point was activated in accordance with the LCPP on 20 occasions.[1045] Evidence provided by FACS to the Royal Commission in April 2016 indicates that the protocol has been applied to a wide range of institutions, including sport and recreation clubs, family day care services, childcare centres, schools and at least one church.

According to FACS, in the majority of the 13 matters where they supported the activation of a Local Contact Point between July 2014 and March 2016, the appointed staff member did not receive any calls. Matters where the Local Contact Point did receive calls usually involved allegations of abuse against young children rather than adolescents. For example, in a matter involving allegations of sexual assault against an employee of a child care centre, the Local Contact Point received 17 phone calls from individual families. Callers largely required support and information about how to talk with their children about abuse and the types of behavioural changes or indicators that could be suggestive of abuse having occurred. Similarly, in a matter involving a family day care service, families were reported to be 'generally appreciative of the information and opportunity to discuss strategies to manage conversations with their children'.[1046]

FACS has suggested that, in addition to the age of the alleged victim(s) of the abuse, other reasons for the variable utilisation of the LCP could include:

- Police media statements acting as a stronger trigger for other victims to come forward directly to authorities.
- The amount and intensity of contact between the alleged perpetrator and the relevant class of child/ren.

1040 Police Team Leader, CS JIRT Manager Casework and JIRT Senior Health Clinician or as required JIRT agency line managers.
1041 Inspector, CAS, Manager Client Services, FACS and Manager, Health. The line managers must also approve the deactivation of the LCP in consultation with the institution.
1042 *JIRT Local Contact Point Protocol 2014,* p.6.
1043 Testimony of G Newbery, Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.103.
1044 Advice provided by FACS, March 2017.
1045 Advice provided by FACS, March 2017.
1046 NSW Family and Community Services, 'Summary and assessment of activated JIRT Local Contact Point Protocols between July 2014 – March 2016', exhibit 39-039, *Case Study 39*, April 2016, Sydney.

- Other proactive actions taken by agencies to address immediate concerns, such as hosting community information sessions with JIRT agency staff in attendance.[1047]

Now that the LCPP has been in place for three years and has been applied on a number of occasions, it would be timely for the SMG to review how the document and related processes could be enhanced.

23.4. Enhancing the LCPP

We agree with the Royal Commission's finding that, as a result of the LCPP, the JIRT partner agencies now 'have more detailed systems and procedures to respond to abuse in an institutional setting where an alleged perpetrator has access to a large number of students and criminal proceedings have not yet commenced'.[1048]

Although the implementation of the LCPP has been informally reviewed in light of the Royal Commission's observations, there has been no comprehensive review by the SMG since the Protocol was released in 2014. In our view, there is scope to enhance the LCPP and doing so will further strengthen the overall systemic response to child sexual abuse in institutional settings.

We recommend that, in undertaking a review of the LCPP, the SMG should have regard to our observations in the following section. In light of our role in oversighting allegations of child abuse in 'institutional settings', our office is also well placed to provide feedback to inform such a review, particularly in relation to opportunities for greater utilisation of the LCPP, given its relatively limited use when compared with the number of reportable allegations of sexual misconduct and sexual abuse we oversight each year (around 420 matters combined).

23.4.1. Disclosure of information about 'reportable' allegations to parties not directly involved in a matter

An allegation that a child has been a victim of child abuse (in an institutional setting) will be of interest and concern to many people. They will naturally be interested in receiving further information about the allegation, how it is being handed and whether there are broader implications for members of the community.

As noted earlier, the LCPP is principally concerned with disclosures of information about institutional allegations of child abuse (or reportable conduct),[1049] to parties who are not directly involved in a matter, but have an interest or concern through their association with the agency in which the reportable allegation has arisen, such as a school, child care centre, out-of-home care service or religious community. This wider group – which we refer to as the relevant 'agency's community' – includes agency staff and volunteer workers, parents or carers of other children receiving services from the agency, and in the case of historical allegations, former service receivers such as former students or adults who were in care as children.

The decision to disclose information in response to an allegation of child abuse in an institutional setting necessarily involves 'a judgment … that balances the needs of the investigation and future prosecution with the need to inform the community'.[1050] It must consider a range of complex factors including legal principles derived from privacy and defamation law, and legal doctrines of duty of care and procedural fairness. In addition, for matters that involve an alleged offender under the age of 18, steps must be taken to ensure the child or young person's identity is not disclosed in order to comply with section 15A of the *Children (Criminal Proceedings) Act 1987.*

1047 NSW Family and Community Services, 'Summary and assessment of activated JIRT Local Contact Point Protocols between July 2014 – March 2016', exhibit 39-039, *Case Study 39*, April 2016, Sydney.
1048 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No. 37: The Response of the Australian Institute of Music and RG Dance to allegations of child sexual abuse*, January 2017, p.22.
1049 Section 25A of the *Ombudsman Act 1974* defines 'reportable conduct' as any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence); or any assault, ill-treatment or neglect of a child; or any behaviour that causes psychological harm to a child; whether or not, in any case, with the consent of the child.
1050 Royal Commission into Institutional Responses to Child Sexual Abuse, *Written submissions in reply on behalf of the State of New South Wales*, Public Inquiry into the Response of YMCA NSW to the conduct of Jonathan Lord, 18 December 2013, p.15 at [47].

Sharing information about a reportable allegation with an agency's community:

- may assist to identify, warn and protect other alleged or potential victims
- can be a trigger to obtain additional information about an allegation
- can prompt parents and carers to raise relevant concerns with their children
- can encourage parents, carers and agency staff to be alert to and report any concerning behaviour
- can provide information to the agency community about available support services
- may counter the spread of inaccurate and unreliable information
- may enable Police and FACS, to advise parents, carers and staff about the risks of contaminating evidence or compromising investigative or judicial proceedings, and
- can reassure the community that the agency is responding adequately.

In June 2016, our office hosted a Privacy Roundtable to consider what might constitute best practice in relation to the public release of personal information by agencies within our child-related employment jurisdiction.[1051] Our Roundtable was prompted by a matter, brought to our attention by an agency within our reportable conduct jurisdiction that had released a communication to parents within its community in accordance with the LCPP, which subsequently led to the subject of the allegation commencing a defamation action. The Roundtable brought together the state and federal privacy commissions, lawyers and experts from across government and non-government sectors to discuss what information should be communicated; who should release the information; when the information should be released; and who the target audience should be.

There was agreement at the Roundtable that, for any future applications of the LCPP, Police would prepare information for dissemination to an agency's community. We proposed this practice change because of the specific exclusions for Police in relation to some of the legal constraints on disclosure of personal information that apply to other agencies. Police are not required to comply with the Information and Privacy Principles, except in the exercise of administrative and educative functions. Consequently, the limitations on disclosure of personal information do not apply to a police investigation of a reportable conduct allegation. As well, Police are best placed to ensure that the disclosure promotes, rather than interferes with or compromises, any investigative or judicial process. This is particularly crucial when a Local Contact Point is activated in circumstances where the subject of the allegations is not yet aware that an investigation is underway.

When timely disclosure cannot reasonably be made by Police, and FACS is discharging its investigative functions consistent with its statutory child protection responsibilities, it may be appropriate for FACS to make the disclosure. FACS is an investigative agency for the purpose of privacy legislation. It is therefore open to FACS to communicate specific information about a reportable conduct allegation to an agency's community, if this is required for the effective discharge of its complaint handling or investigative functions. Disclosure by FACs also helps avoid any child protection investigation being compromised.

In addition to minimising the risk of legal proceedings being threatened to restrain information being communicated to an agency's community, a disclosure from a law enforcement or child protection authority is also more likely to reassure the community that appropriate investigative and enforcement action is being taken.

Regardless of which agency makes the disclosure, it does remove the need for the disclosing agency to liaise appropriately with the other JIRT partner agencies, as appropriate.

1051 Participants included representatives from the NSW Information and Privacy Commission and the Officer of the Australian Information Commissioner as well as representatives from the Royal Commission, NSW Police Force, Department of Family and Community Services, Department of Premier and Cabinet, Department of Education and a wide range of non-government stakeholders, including Scouts Australia, the Catholic and Independent schools sectors and various services that provide out-of-home care. In addition, representatives from Victoria and the ACT observed the Roundtable to inform the development of their respective reportable conduct schemes.

At the conclusion of our Roundtable, we undertook to provide guidance to stakeholders on the legal principles underpinning the sharing of information about reportable conduct allegations with parties not directly involved in a matter, and the operational factors to consider in the context of current (or potential) criminal and/or child protection investigations into such allegations. The fact sheet we prepared – *Sharing information about reportable conduct allegations with non-involved parties* – is available on our website.

23.4.2. Extending the LCPP to historical abuse allegations and Local Area Commands

Apart from stating that Local Area Commands (LACs) should be informed when a Local Contact Point is activated,[1052] the LCPP does not contain any guidance to assist LACs when investigating allegations which involve an institution such as a school or childcare centre.

In NSW, historical allegations of child sexual abuse by adults are investigated by LACs, and in a limited number of cases, the Sex Crimes Squad. However, the current threshold for application of the LCPP – that is, for consideration of whether a Local Contact Point should be established – is the acceptance of a referral for a JIRT response *and* where there is sufficient evidence to indicate that further children are at risk or potential broader community concern.

Limiting the Protocol's application to matters accepted by the JIRT program prevents LACs and the relevant institutions from utilising this critical operational guidance when investigating historical allegations of child sexual abuse where a class of children are potentially at risk. These investigations are often complex and still require the LAC to liaise with the institution, organisation or agency; manage the same information sharing priorities and address potential broader community concerns.

The capacity of the LCPP, and its early information sharing procedures, to assist in the identification of other potential victims, is directly applicable to historical allegations where there may be not only a current class of children at risk, but also a class of adults who potentially have not yet disclosed historical child sexual abuse, but may be willing to do so upon learning that a new allegation has come to light relating to a particular individual. For example, we worked closely with an LAC in relation to a matter where they wrote to former students of a boarding school who were supervised by a particular Dormitory Master over a three year period. This action led to 18 adult victims coming forward and the offender ultimately pled guilty to 18 offences.

In our view the LCPP should be extended to include historical allegations of child sexual abuse, and that the role of LACs in liaising with institutions is specifically addressed in the protocol.

23.4.3. Improving awareness of the LCPP and which entities it covers

It was apparent during our 2016 Privacy Roundtable that there is confusion about the applicability of the LCPP; for example, whether its use extends to institutions other than schools, and if it can be applied for matters that involve non-government as well as public schools.

The introductory text in the Protocol lacks sufficient clarity in relation to the type of entities it covers. While the Protocol defines 'institution' widely in a footnote to the criteria in the second section of the document, the introductory text focuses on the Department of Education as the regulator of early childhood services rather than being explicit about the Protocol applying to individual early childhood providers. And, while the LCPP mentions 'principals of schools', it would be useful to state 'government and non-government schools'.

Evidence presented to the Royal Commission also exposed the limited knowledge of the LCPP within the schools sector.[1053] This low awareness likely exists among other institutional sectors (for example, early childhood, sport and recreation) for whom the LCPP is also relevant.

1052 *JIRT Local Contact Point Protocol* 2014, p.3.
1053 Testimony of T. Ladogna, Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.49.

The level of awareness is not particularly surprising given the relatively limited number of occasions on which the LCPP has been utilised to date, and that the LCPP, in its current form, is primarily geared towards directing the JIRT response to institutional child sexual abuse rather than providing guidance to institutions. We believe there is potential for the LCPP to guide the JIRT agency response and act as an educative tool for institutions.

In our view, there would be benefit in more clearly stating the LCPP's applicability to relevant institutions at the outset of the document, and in encouraging wider circulation of the Protocol and awareness of its purpose among peak bodies for the schools and early childhood sectors.[1054] This would assist in better preparing institutions to respond appropriately when they initially become aware of an allegation of child sexual abuse.

23.4.4. Outlining the role of the Ombudsman in oversighting investigations involving institutions

Currently, the LCPP does not include any reference to the oversight role of the Ombudsman with respect to reportable conduct allegations.

In our view, the LCPP provides an opportunity to briefly reinforce the notification obligations of institutions under Part 3A of the Ombudsman Act, of which smaller, less experienced agencies may not be aware. In addition, the activation of a Local Contact Point is also relevant to our ongoing monitoring of agency investigations, and there will be occasions where our office may be able to provide information to the JIRT agencies and/or the institution to inform any planned communication.

It would also be useful to include a link within the LCPP to the NSW Police Force's Standard Operating Procedures (SOPs) for employment related child protection allegations. The SOPs clarify what agencies can expect from Police when they are required to investigate a criminal allegation of reportable conduct, including the steps Police should take to keep the agency informed of the progress of their investigation (agencies cannot undertake their own investigation until any police investigation is completed).

23.4.5. Clarifying requirements in relation to liaison with institutions following deactivation of the Local Contact Point

The LCPP does not contain any requirement or guidance for liaison between the JIRT agencies and the institution after an LCP has been deactivated and/or following the completion of the JIRT response in circumstances where doing so would be prudent; for example, if criminal charges are withdrawn or struck out due to insufficient evidence at trial. If charges are dropped, an institution will require relevant information to guide its decision-making in relation to an employee or volunteer.

While our office, through the reportable conduct function, ensures that this type of information is monitored and passed on, liaison should ideally occur directly between Police and the institution to enable the agencies to be satisfied that any risks have been appropriately managed. It would be beneficial to amend the LCPP to include a requirement for police to advise institutions about the outcome of criminal matters, and provide related guidance to institutions.

23.4.6. Linking the LCPP with the *Local Planning and Response Procedures*

In Chapter 21, we noted the need to update and enhance the *Local Planning and Response Procedures* for JIRT agency staff. As the procedures were developed prior to the introduction of the LCPP, they do not contain any related guidance. Given that the threshold for application of the LCPP is the acceptance of a referral for a JIRT response and an assessment of whether there is sufficient evidence to indicate further children at risk or broader community concern (which would be undertaken as part of the LPR process), this omission should be rectified.

1054 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper Criminal Justice*, September 2016, p.149; Testimony of T. Ladogna, Transcript of Royal Commission into Institutional Responses to Child Sexual Abuse, Public Roundtable: Multi-disciplinary and specialist policing responses, 15 June 2016, p.49.

In addition, the *Local Planning and Response Procedures* should require the activation of a Local Contact Point to be flagged in the JIRTS database in a way that can be systemically monitored. Sufficient detail about the activation should be recorded, including the number of occasions it was utilised and the outcome of each contact. Guidance about this should be included in the *Local Planning and Response Procedures*.

23.4.7. Improved monitoring of the LCPP

In addition to carrying out a comprehensive review of the LCPP, there is scope for the SMG to improve their continuous monitoring of the use of the Protocol. The LCPP states that local JIRT agency managers and line managers should evaluate the operation of the LCP following its activation; however, the extent to which this has occurred or been documented is not clear. For example, there are no references to activation of the Protocol in any of the Local Management Group (LMG) records we have reviewed. LMGs should be required to brief the SMG about the outcome of their evaluations.

Recommendation

55. The JIRT partner agencies should:

a) Review the *Local Contact Point Protocol*, having regard to the observations and recommendations contained in section 23.4 and any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse, to evaluate its implementation and inform its future direction.

b) Ensure, to inform the review, that JIRT LMGs brief the JIRT SMG about the outcome of their evaluations of Local Contact Points.

PRACTICE SUGGESTION

- The JIRT partner agencies should:
  - Ensure the key purpose of the Local Contact Point Protocol is reflected in the updated Local Planning and Response Procedures.
  - Develop and implement a strategy for raising awareness of the Local Contact Point Protocol and its applicability among relevant sectors, particularly (but not limited to) the schools and early childhood sectors.

Chapter 24. The JIRT Training Program

> [To be] *a truly collaborative response, all agencies should be able to demonstrate the ability to cooperate and learn to function together from day one.*[1055]

As part of our inquiry, we have considered the adequacy of the joint training that is provided to the JIRT workforce.[1056] As reported in Chapter 5, the literature about multi-disciplinary responses to child abuse identifies joint training and professional development as an important strategy for increasing knowledge and understanding of relevant processes, and building rapport and trust between workers across agencies. In this regard, the Australian Centre for Child Protection has found that, nationally, NSW has the most comprehensive training and professional development supporting a multi-disciplinary response to child abuse.[1057]

While joint training has been a hallmark of the JIRT program for many years, at the outset of our inquiry, there was a question mark about the ongoing delivery of certain aspects of the joint program. The future of these aspects of the joint program was flagged as an issue that the JIRT agencies were keen to resolve during the inquiry. After initial discussions facilitated by our office, the JIRT SMG requested that the JIRT Statewide Training Sub-committee review and develop a new course structure and curriculum that is designed to more effectively address each agency's training needs.

In further refining and implementing the new training program, the JIRT agencies should take into account the observations and recommendations contained in this chapter and the related chapter on Interviewing (Chapter 22), as well as our recommendations in Part 5 about the need for JIRT to improve its response to particularly vulnerable groups of children.

As we discuss in this chapter, in addition to providing high quality training to the JIRT workforce, the JIRT partner agencies have an important role to play in contributing to the education of key stakeholders about their own obligations in relation to appropriately reporting and handling disclosures of child abuse, managing risks to children and young people and exchanging relevant information with the JIRT agencies.

24.1. JIRT Statewide Training Subcommittee

Membership of the JIRT Statewide Training Subcommittee comprises executives and senior officers in learning and development, policy and operational branches from Police, NSW Health (represented by ECAV) and FACS. The role of the sub-committee is to monitor all training activities to ensure they support the priorities of the JIRT program. Reporting to the SMG, the sub-committee manages and evaluates the development and delivery of all joint training activities.

24.2. The JIRT Foundation Skills Course

The JIRT Foundational Skills Course (JFSC) originated as the Investigative Interviewing of Children Training Package, which was developed for FACS in 1995 and subsequently reformulated as the Joint Interviewing Children Training Package in 1997.[1058] The package was further reviewed by FACS and the NSW Police Force in 1999 and 2000, and in 2001 by Dr Martine Powell of Deakin University. Following a further review by an external consultant in 2008, the course became known as the JFSC. Between November 2010 and December 2014, the course was amended on five occasions. An e-learning component was added in 2011.[1059]

1055 A Health response to the JIRT workforce survey.
1056 It is important to acknowledge that each agency also provides its own foundational training and professional development to their staff. The focus of this chapter, however, is the joint training specifically provided to the JIRT workforce.
1057 J. Herbert, and L. Bromfield, *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse – A Report for the NSW Ombudsman's Office*, Australian Centre for Child Protection, University of South Australia, August 2017, section 5.5.
1058 NSW Family and Community Services, NSW Police Force, NSW Kids and Families, and NSW Health, *JIRT Foundational Skills Course: Facilitators Guide*, December 2014, p.2.
1059 This component ceased in June 2017.

The JFSC consisted of a series of online modules over ten days, participation in face-to-face training during a two week workshop, and a final field assessment during a three month period. The online modules provided an introduction to JIRT – including its history, purpose, structure, key processes and each partner agency's specific roles and responsibilities.[1060] The face-to-face training component, jointly delivered by trainers from each agency and consisting of lectures and small group practical activities, focused on a range of topic areas built around the broader JIRT investigative (criminal and care/protection) interviewing framework, including:

- the JIRT referral criteria
- child development and dynamics of child sexual abuse
- interview planning
- rapport building
- interviewing a child, including raising the allegation, particularising and using electronic equipment
- interviewing children and young people from Aboriginal communities
- working with culturally and linguistically diverse clients and children and young people with disabilities, and
- managing vicarious trauma.[1061]

Since the implementation of the witness intermediary pilot scheme, the training has also included information about the scheme's purpose and operation.

For FACS and Police participants, the field assessment involved interviewing a child from a local school. Participants were expected to demonstrate the investigative interviewing framework taught during the workshop, using the same questioning techniques to elicit information and details from the child about the event they witnessed. The participant's competency was assessed by a FACS or Police trainer, with an assessment of competency required prior to the participant being able to conduct real interviews in the field. For Health participants, the field assessment consisted of a role play, based on a case study allocated during the workshop, requiring participants to demonstrate how they would respond in their role as a JIRT health clinician.

24.3. Changes to the Police Child Interviewing Course component

As we have discussed elsewhere in the report, since January 2016 the CAS has led all recorded criminal interviews of children accepted by the JIRT program.[1062]

The adequacy of investigation and interview training for specialist police who respond to child abuse has been of considerable interest to the Royal Commission. Against this background, in August 2016 the CAS raised a number of concerns about the JFSP with the other partner agencies, including that it no longer accurately reflected operational practice (particularly criminal interviews being conducted by the CAS) or provided the required standard of training for CAS investigators. The CAS indicated that they had recently commenced delivering a Police only Child Interviewing Course that would provide CAS staff with more specialised training, particularly in relation to the admissibility of recorded criminal interviews and establishing evidentiary proofs; other methods of evidence collection, including covert techniques; and relevant case law. The course would also have the capacity to accommodate LAC officers – an important factor given that, as discussed in Chapter 10, a significant proportion of matters that do not meet the JIRT criteria are referred to LACs for a response.

1060 Joint Investigation Response Team, *Joint Investigation Response Team (JIRT) Induction Package* (endorsed 4 September 2013).
1061 NSW Family and Community Services, NSW Police Force, NSW Kids and Families, and NSW Health, *JIRT Foundational Skills Course: Participants Manual*, December 2014, pp. 2, 13-17.
1062 NSW Police Force, Memorandum to the Child Abuse Squad, *Interviewing Child Victims*, 21 December 2015.

The CAS advised their partner agencies that they would now require their staff to complete the Police only Child Interviewing Course rather than the modules of the JFSP focusing on the JIRT investigative interviewing framework. They indicated that, despite this decision, they retained a strong commitment to joint training about other aspects of the JIRT program. The CAS suggested that FACS and Health could continue to present the existing JFSP to their staff using an amended format, with Police attending for three days to participate in particular modules about 'core' topic areas,[1063] or that the partner agencies could jointly develop a three day induction workshop, presented and attended by staff from each agency, to replace the face-to-face component of the JFSC.

FACS and Health expressed concern about the proposal put forward by the CAS. In particular, while acknowledging that FACS and Health staff may not require the same detailed level of training about criminal investigation and interviewing techniques, they emphasised that they still require a comprehensive understanding of this aspect of the JIRT program's response so that they can fulfil their interview monitoring role effectively. They also highlighted the importance of joint training as a strategy for fostering respect and rapport, and building a 'team culture' between colleagues who work in different agencies but under the same JIRT arrangement. Health also pointed out that JIRT health clinicians and other clinicians are required to undertake additional specialist training, separate from the JFSP, and that Health has continued to prioritise both internal and joint training.

24.4. Review of JIRT training needs

In November 2016, we facilitated a meeting with the partner agencies to discuss the issue of training. All agencies agreed on the value of maintaining an element of joint training for the JIRT workforce – acknowledging the importance of FACS and Health staff continuing to receive adequate training about the criminal investigation component of the JIRT program's response, and the equal importance of Police gaining an understanding of FACS and Health obligations to assess and respond to the safety, wellbeing and health needs of children.

As a result of the meeting, the agencies agreed that the JIRT Statewide Training Subcommittee should review the structure of the JFSP and consider how the course content and delivery could be refined to better meet joint training needs about core practice areas, such as the Local Planning and Response (LPR). In particular, the agencies identified a need to consider ways of providing more dynamic and effective 'scenario based' training that demonstrates the separate yet interconnected role of each agency in planning and executing a 'JIRT response'. In their December 2016 Joint Communication, the SMG affirmed that:

> *Joint training is fundamental to developing successful partnerships and the ability of staff to gain a practical understanding of how each agency operated under the JIRT MoU. While the JIRT Foundations Training Skills Course previously met the needs of each agency in this regard, it now requires review in order to ensure it reflects best practice and is consistent with changes in operational procedures. Accordingly, the SMG has agreed that work commence on the development of an updated joint JIRT Training Course which will consolidate interagency learning and address agency specific needs.*[1064]

24.5. The JIRT Foundation Skills Program

A new JIRT Foundation Skills Program has since been designed by the tri-agency training working group. While the program retains the same overarching purpose as the JFSC and includes much of the same content, its structure and delivery is considerably different. The new format consists of:

1. JIRT Training Course (CAS, FACS, Health) – three days
2. Child Interviewing Course (CAS/LAC Police only) – five days
3. FACS Interviewing Course (FACS only) – five days
4. JIRT Simulated Exercise (CAS, FACS, Health) – one day
5. JIRTS database training – one day

1063 The suggested topic areas included the majority of existing modules.
1064 JIRT SMG, *Joint Communication*, December 2016. p.3.

The structure and content of the course is depicted below.

9:00am–10:30am	9:00am–10:30am	9:00am–11:00am
Course Introduction and Welcome JIRT Roles and Responsibilities – working together and separately Course Opening Address	Child Development	Dynamics of Child Sexual Assault, Process of Disclosure
10:30am–10:45am Morning tea	10:30am–10:45am Morning tea	11:00am–11:15am Morning tea
10:45am–12:30pm	10:45am–12:45pm	11:15am–12:15pm
JIRT Criteria Local Planning and Response (LPR)	Children's Champion/Witness Intermediaries Interviewing Children & Young People with a Disability	Sibling Abuse – Dynamics and Responses – Legal/Criminal Child Protection & Treatment
12:30pm–1:15pm Lunch	12:45pm–1:30pm Lunch	12:15pm–1:00pm Lunch
1:15pm–3:00pm	1:30pm–3:00pm	1:00pm–3:00pm
LPR Continued JIRTS Database	Child Protection Unit (CPU) Sexual Abuse	Interviewing Children & Y/P from Aboriginal Communities Working with Culturally and Linguistically Diverse Clients
3:00pm–3:15pm Afternoon tea	3:00pm–3:15pm Afternoon tea	3:00pm–3:15pm Afternoon tea
3:15pm–4:45pm	3:15pm–4:45pm	3:15pm–4:45pm
First Contact with Families, Rapport Building and Personal Awareness	Child Protection Unit (CPU) Physical Abuse	FACS Legal FACS Person Causing Harm Process

The JIRT Training Course is now a condensed version of the former two week face-to-face workshop, minus the investigative interviewing component. The course is already being delivered to new JIRT agency staff.

Following the commencement of the Police only child interviewing course, FACS has developed its own five-day training program to equip its staff with the necessary knowledge and skills to undertake their role in monitoring recorded criminal interviews, including using interview equipment. Importantly, the training also covers interviewing in the context of care and protection, consistent with FACS' statutory child protection role.

As part of the new training program, Police have agreed to present a one hour session on legal issues during the FACS interviewing course which covers the legislative and judicial requirements surrounding the admissibility of evidence and essential components of police investigative practice.

While we appreciate why the CAS decided to develop its own separate child interviewing course for police officers, and that they will continue to support the FACS interviewing course, it is unlikely that the one hour legal issues session will also cover the practical and operational advice both CAS and FACS staff will require to execute the new interviewing processes effectively.

It is particularly critical for FACS staff to understand how they can meaningfully contribute to the recorded criminal interview process through their monitoring role. FACS has submitted that the changes to interviewing practice have led to uncertainty amongst FACS staff in terms of their 'role' and 'boundaries' in relation to the recorded criminal interview. This view also came through strongly in the JIRT workforce survey responses from FACS staff. As we noted in Chapter 22, both FACS and Health staff have expressed concern about their contributions to the interviewing process not being given due consideration. Similarly, the CAS workforce surveys cite 'FACS staff over-stepping boundaries' as a key concern for them. These factors combined have contributed to disharmony between FACS and Health staff and the CAS in certain locations.

In our view, including an additional joint session (which could occur either mid-way or at the end of the separate Police and FACS child interviewing courses) to give both agencies a practical understanding

of the new interviewing process, and an awareness how each agency can add value at each key stage, would strengthen the frontline JIRT response. A session of this type would allow FACS and Police staff to gain an appreciation of where care and protection issues are likely to intersect with establishing the proofs for offences – enabling staff to better identify when it may be appropriate to canvass care and protection issues during the recorded interview. There would be value in inviting the ODPP to participate in the session to share their insights from a prosecutorial perspective.

It is also important for FACS and Police to identify how they can execute the interviewing process as seamlessly as possible in situations where it is decided that certain care and protection questions should be asked after the recorded interview, particularly in light of concerns expressed about the need to minimise additional questioning of child victims. Providing joint training on these issues is consistent with the views expressed by the Royal Commission and legal experts that extraneous detail should not be included in forensic interviews. It also aligns with the current research relating to best practice interviewing techniques, and supports the need for quality interview planning to be carried out that addresses the child's needs and particular vulnerabilities. This joint session is also a good forum for reinforcing the importance of structured interview breaks.

This proposed session would also help to inform the response by participants during the interview component of the simulated training exercise discussed below.

24.5.1. JIRT Simulated Exercise

The major new component of the JIRT training program is the JIRT Simulated Exercise (JSE), which is designed to support the development of strategic and critical decision-making skills in a team-based environment. The JSE is being developed by the NSW Police Force's Education and Training Unit in conjunction with FACS and Health. Utilising the Hydra Minerva Suite (HMS), a technological simulation program that is used to train police,[1065] the JSE will employ video and audio clips, written and practical tasks to present participants with a complex scenario that recreates a JIRT referral and response. The scenario, which will include all stages of the JIRT response, unfolds in 'real time'– changing and progressing depending on the decisions made and actions taken by participants. The consequences of these decisions and actions are depicted, including the outcomes for the child if the response is not timely, procedures are not properly followed, or the agency partners do not effectively cooperate.

The JSE is expected to commence in August 2017. It will be conducted over one to two days with participants divided into tri-agency teams and each team undertaking a unique simulation. The HMS software develops the scenario by communicating information to teams (for example, photos, criminal records, telephone calls, eye witness statements etc) at any time and all phone calls and electronic forms are displayed in the control room. Facilitators from each agency will observe participants through CCTV to evaluate their real-time decision-making and actions in response to the scenario, and are able to release 'triggers' to test various aspects of knowledge and competency. An investigative interview component will be included, involving attendees reviewing an interview transcript and thereafter making decisions during the JSE that relate to the interview.[1066] It is envisaged that down the track, this component will involve observing a 'live' simulated interview.

While the face-to-face workshop component of the JFSC included 'group work' scenarios and case studies, these exercises lacked the dynamic required to realistically replicate the level of collaboration that is demanded of the partner agencies in the field. The JSE is an innovative training model that has the capacity to achieve this. Importantly, while focusing on each agency's individual roles and responsibilities in the tri-agency JIRT process, the JSE will highlight, in a very practical way, how these roles and responsibilities intersect, together with the agencies' joint obligations. In our view, this new training component creates a valuable opportunity to help re-focus the JIRT partnership at a time when – as evidenced by feedback to the JIRT workforce survey – there is a clear need to do so.

The development of the refined JIRT Foundation Skills Program is a significant tri-agency achievement and a strong example of the productive, collaborative approach that should drive the overall JIRT partnership.

1065 The Hydro Minerva Suite was developed in Britain by the National Centre for Applied Learning Technologies and is used to train police in a variety of scenarios.
1066 JIRT Training Sub Committee meeting minutes, 6 February 2017, part 3.2.

24.6. Responding to particularly vulnerable children and young people

In Part 5 we observed the need for the JIRT program to improve its response to particularly vulnerable groups of children and young people. Acknowledging the positive initiative that has been shown by the JIRT agencies in relation to enhancing JIRT's responsiveness to Aboriginal children and young people, we identified the importance of applying a similar focus to other groups of children who are also at increased risk of sexual abuse and face significant barriers to accessing timely and effective responses.

Our recommended changes to the current JIRT referral criteria (see Chapter 9) are designed to provide better access to JIRT for children and young people with cognitive and/or communication impairment, and those living in residential out-of-home care (OOHC). We have also emphasised that better guidance should be provided to JIRT staff about the specific factors and considerations that should be taken into account during the LPR for referrals involving these groups of children, as well as Aboriginal children and children from culturally and linguistically diverse (CALD) backgrounds. We have further emphasised the importance of each JIRT agency building effective local relationships with key 'external' stakeholders who can inform and support the JIRT multiagency response to particular groups of children.

In addition to the strategies already noted, enhanced training should be provided to the JIRT workforce about the needs of these very vulnerable cohorts of children and young people, the systemic challenges they face and practical ways of addressing these challenges, to ensure they receive an effective JIRT response.

Presently, tailoring the JIRT program's response to particularly vulnerable groups of children and young people is covered in three modules of the JFSC, which have been retained in the new JIRT Training Course:

1. Working with Children and Young People with a Disability
2. Interviewing Children and Young People from Aboriginal communities, and
3. Working with Culturally and Linguistically Diverse Clients.

While the training provided is useful, there is scope for a more sophisticated approach to imparting the requisite knowledge and better equipping participants to negotiate the factors that impact a particular child or young person's ability to disclose abuse and engage in the criminal and care and protection interview process. In this regard, there is particular scope for an increased focus on trauma and communication issues.

As discussed in Chapter 16, the current absence of any specific training about children and young people in OOHC is a significant gap, given that they are at considerably heightened risk of sexual abuse and have frequently been impacted by complex trauma that is likely to directly influence their participation in and experience of a JIRT response.

24.6.1. Training for 'external' stakeholders

Throughout this report we have identified the critical importance of ensuring that key 'external' stakeholders to the JIRT arrangement who work with children – including schools, disability services, child care centres, OOHC agencies and carers, and health care providers – have the knowledge and guidance necessary to support the effective systemic response to criminal child abuse and neglect.

As the recognised specialists in this area, the JIRT agencies have a responsibility to help build the capacity of other agencies and organisations. In Part 5 we emphasised the importance of the JIRT partner agencies, through the JIRT program but especially at a local 'non-JIRT' level, building strong, consistent relationships with the local communities they service – including agencies and organisations that work with children and their families. There is also a role for more targeted, sector-based training, which the JIRT Statewide Training Subcommittee has previously delivered on a tri-agency, ad hoc basis.

While it is not realistic for the JIRT agencies to deliver a comprehensive training program, there is scope for the SMG to develop a strategy for partnering with key agencies and sector peak bodies to identify effective ways of utilising existing forums, networks and training programs to communicate important messages about particular practice areas. For example:

- Understanding the JIRT referral criteria. Although it is not the role of other agencies and organisations to determine whether a report meets the JIRT referral criteria, from the perspective of understanding what is likely to happen once a report is made to the Helpline, it is useful for them to be aware of the types of matters covered by the criteria. If our recommendations in relation to amending the JIRT referral criteria are accepted, it will be important for these changes to be communicated not only within the JIRT partner agencies, but also to key external stakeholders.
- Good practice when a child initially discloses abuse. This is particularly important for carers, teachers and others who have regular, close contact with children and young people. JIRT agency staff provided training about handling disclosures at the Out of Home Care Critical Incidents Forum hosted by FACS in 2015. This was a good example of JIRT leveraging off an existing training opportunity.
- The importance of reporting criminal allegations of child abuse to local police as well as the Helpline (or 'de-centralised Helpline' models). This is an issue we have been placing a spotlight on for some time. While the Helpline (and other relevant FACS business units including CSCs and the Reportable Conduct Unit) are required to forward criminal allegations of child abuse that they receive from reporters to Police (via either the JRU[1067] or directly to a LAC), as an additional safeguard, reporters should also report criminal child abuse to local police to lessen the risk of matters 'falling through the cracks'. For this reason, in our training workshops for agencies about handling criminal allegations of reportable conduct, we recommend that agencies routinely report criminal allegations to both the Helpline and Police.
- Awareness of the *Local Contact Point Protocol* (LCPP). We are aware that the CAS is keen to prioritise working with the various schools sectors, via the Department of Education and Catholic Dioceses and peak bodies (such as the Association of Independent Schools and Christian Education Network), to generate increased knowledge of the LCPP and how schools should involve Police when they become aware of a criminal allegation of child abuse, including when the allegation constitutes reportable conduct but also in cases of peer sexual abuse or harmful sexual behaviour to develop safety plans and undertake risk management relating to alleged offenders.[1068] As we discussed in Chapter 10, there is scope for the NSW Police Force to consider the benefits of establishing a permanent education and training position within the CAS. While the position's main responsibility would be providing training for police, it could also play a key role in undertaking the work described above.
- The responsibilities on agencies to cooperate with JIRT investigations by exchanging relevant information, taking appropriate action to manage risks and effectively supporting children and young people. As profiled in Chapter 16, the OOHC agency and police forum hosted by our office in 2014 is a good example of building sector capacity in this area.
- The importance of agencies ensuring that their specific obligations (for example, reporting criminal allegations to police) to support the effective systemic response to criminal child abuse and neglect, are appropriately reinforced in relevant internal policies, role descriptions and training – and that adequate resources are available to ensure this.

It is important to emphasise that any training for 'external' stakeholders should deliver current, consistent and accurate messages about the JIRT program and related practice areas.[1069]

1067 Or the on-call CAS Duty Officer outside business hours.

1068 During our inquiry we became aware of a recent District Court judgement (*R v MG* [2016] NSWDC 374) which highlighted additional consequences of a school's failure to promptly report to police an allegation that a child was sexually abused by another child at the school. Both children had an intellectual impairment. The Court criticised the school principal for interviewing the accused child and obtaining admissions of wrongdoing from him, which he only then reported to Police. This case illustrates the need for schools to have appropriate guidance about handling allegations of peer sexual abuse/harmful sexual behaviour.

1069 In this regard, it is relevant to note the 2012 SMG directive which agreed that all JIRT-related curriculums or presentations (excluding single agency training and operational 'case study' reviews between local JIRT partners) must first be submitted to the JIRT Training Subcommittee for endorsement.

In developing a strategy for partnering with agencies and sector peak bodies, our office is happy to provide advice and support to the JIRT partner agencies, drawing on our existing strong relationships with key stakeholders and our experience in providing community education and training.

24.7. Continuous improvement

We recommend that the partner agencies take an approach of 'continuous improvement' to the JIRT Foundation Skills Program, seeking ongoing opportunities to engage both internal and external expert advisors to ensure the training reflects current operational requirements and best practice guidelines. In this regard, we note the recent initiative shown by the CAS in requesting the input of Crown Prosecutor Gina O'Rourke SC as part of refining the Child Interviewing Course. We also consider there would be value in the JIRT training sub-committee undertaking a review of the new JIRT training program in 12 months time to assess whether it is operating effectively, with participant evaluations of the program forming a critical part of such a review.

In addition, we recommend that, as part of further refining the JIRT training program, the partner agencies have regard to our observations and recommendations about the need for enhanced training about responding to the particularly vulnerable groups of children and young people we discussed in Part 5.

Recommendations

56. The JIRT partner agencies should take an approach of 'continuous improvement' to the JIRT Foundation Skills Program, which includes but is not limited to the following:

- **a) Updating the course materials to ensure they reflect current operational practice and any changes made as a result of the recommendations in this report.**
- **b) Developing an additional joint session (which could occur either mid-way or at the end of the separate Police and FACS child interviewing courses), to give both agencies a practical understanding of the new interviewing process, and of how each agency can add value at each key stage.**
- **c) Engaging external experts (including but not limited to the Office of the Director of Public Prosecutions) to provide advice about whether and how to ensure that the training, particularly in relation to conducting child interviews, reflects best practice.**
- **d) Enhancing guidance, having regard to the observations and recommendations contained in Part 5, about responding to particularly vulnerable children and young people.**
- **e) Undertaking a review of the new JIRT Foundation Skills Training Program in 12 months time, informed by participant evaluations and expert feedback, to assess whether it is operating effectively.**

PRACTICE SUGGESTIONS

- The JIRT partner agencies should develop a joint strategy to partner with key agencies and sector peak bodies to identify opportunities for communicating messages about key practice areas relating to responding to criminal child abuse and neglect.
- The JIRT partner agencies should, if recommendation 56(b) is accepted, invite the Office of the Director of Public Prosecutions to participate in presenting the additional joint session about interviewing.

PART 8

Leadership and accountability across the JIRT partnership

Governance and accountability

Contents

Chapter 25. Governance and accountability

The research we commissioned from the Australian Centre for Child Protection (ACCP) as part of our inquiry has confirmed that the JIRT partnership is a highly sophisticated multi-disciplinary model for responding to child abuse, comparable to the international body of practice. It includes several features of good governance and accountability, including:

- a documented interagency protocol
- an interagency steering group consisting of senior representatives of the partner agencies
- local partner agency forums
- a shared data system, and
- avenues for joint case review.

While the governance and accountability framework for the JIRT program is largely solid, it can and should be further strengthened and consolidated. The foremost task for the partner agencies is reviewing and clarifying the desired outcomes of the JIRT program, and embedding them in an updated MoU. To support the effective implementation of the MoU, the key JIRT policies and procedures need to be developed and made easily accessible to all JIRT agency staff.

Our inquiry has also highlighted the need for the partner agencies to re-instate a tri-agency leadership and oversight mechanism for the program at Deputy Secretary/Commissioner level. For several years now, overall accountability for the performance of the JIRT program has essentially rested with those responsible for leading its day to day operations. Additionally, we have recommended that the terms of reference for Local Management Groups (LMGs) and the State-wide Management Group (SMG) be refocused and more closely aligned.

In our 2012 report about responding to Aboriginal child sexual abuse, we recommended that the SMG develop and implement a JIRT performance monitoring and reporting framework, supported by the implementation of improved data collection and case management systems, to enable better monitoring of, and reporting on, outcomes for children accepted into the JIRT program. In response, the SMG identified and endorsed a performance management and reporting framework in 2013. Although many of the indicators in the framework are sound, most have not been utilised and, to date, there has been very limited performance monitoring and reporting. As a result, there is a lack of transparency about the outcomes for children and young people facilitated by the JIRT program.

In again recommending that this gap be addressed, we emphasise the need for the partner agencies to agree on key performance indicators for measuring whether the desired outcomes of the JIRT program are being met; and to ensure that there are adequate systems to support the collection, analysis and reporting of relevant data.

Finally, the most critical factor in determining the future success of the JIRT program is strong and constructive leadership by the SMG. While it is expected, and indeed healthy, for contentious issues to arise in any interagency partnership, it is how the agencies seek to resolve them that matters most in maintaining a good relationship.

Of the 313 responses to the JIRT workforce survey, almost half discussed the 'culture' of the JIRT partnership. Comments were made by staff from across all three agencies. In the main, feedback centred around tension between the JIRT partner agencies affecting staff morale, and concern that a growing 'power imbalance' is undermining the health of the partnership. It is important to note, however, that some respondents reported a positive tri-agency culture:

> *I believe we have a great working relationship with our professional partners. … we are lucky to be working in the same office as police – this partnership is one of professional respect which filters through to our clients* – FACS Caseworker.

Our local JIRT team works well together and have mutual respect. Each agency works within their role which makes the collaborative practice work much better – Senior Health Clinician.

The LMG works extremely well [here]*, all players have a mutual respect for each other* – Health Manager.

I find having the agencies working together is really good. Police/FACS/Health all have a role and it is good to have [FACS and Health] *working with us because … they can follow up with the welfare of children whilst we police concentrate on criminal investigation* – CAS Investigator.

Overall, the survey feedback indicates the need for more cohesive leadership from the JIRT agencies going forward to ensure that the JIRT partnership is a healthy and productive one. In this regard, respondents particularly emphasised the need for greater clarity about respective agencies' agreed roles and responsibilities; clear and consistent communication about responsibilities to the JIRT workforce; and decisive leadership in relation to the collaborative and respectful behaviours expected of staff. It is apparent that, at least in some areas, there are cultural issues impacting on the wellbeing and productivity of JIRT agency staff. The ongoing ability of the partner agencies to attract and retain quality staff – and of the JIRT program to prioritise and meet the needs of vulnerable children, young people and their families – depends on their willingness and effectiveness in tackling these issues.

Throughout this report, there are many examples of the excellent leadership shown by members of the current SMG and their senior management teams in improving their own agency's performance. There are also many examples of these (and other) JIRT leaders having worked constructively over the last ten years on joint initiatives – the enhancements to the JIRT response to Aboriginal children and young people being a prime example. In many ways, some of the tensions that have arisen more recently are directly linked to the genuine commitment of each agency to fulfilling its brief to the best of its ability.

This inquiry has provided an opportunity for reflection and a re-examination of what the JIRT response into the future should look like. Compromises have been made and new agreements have been reached – it is now up to the JIRT SMG to ensure these agreements are well executed in the field.

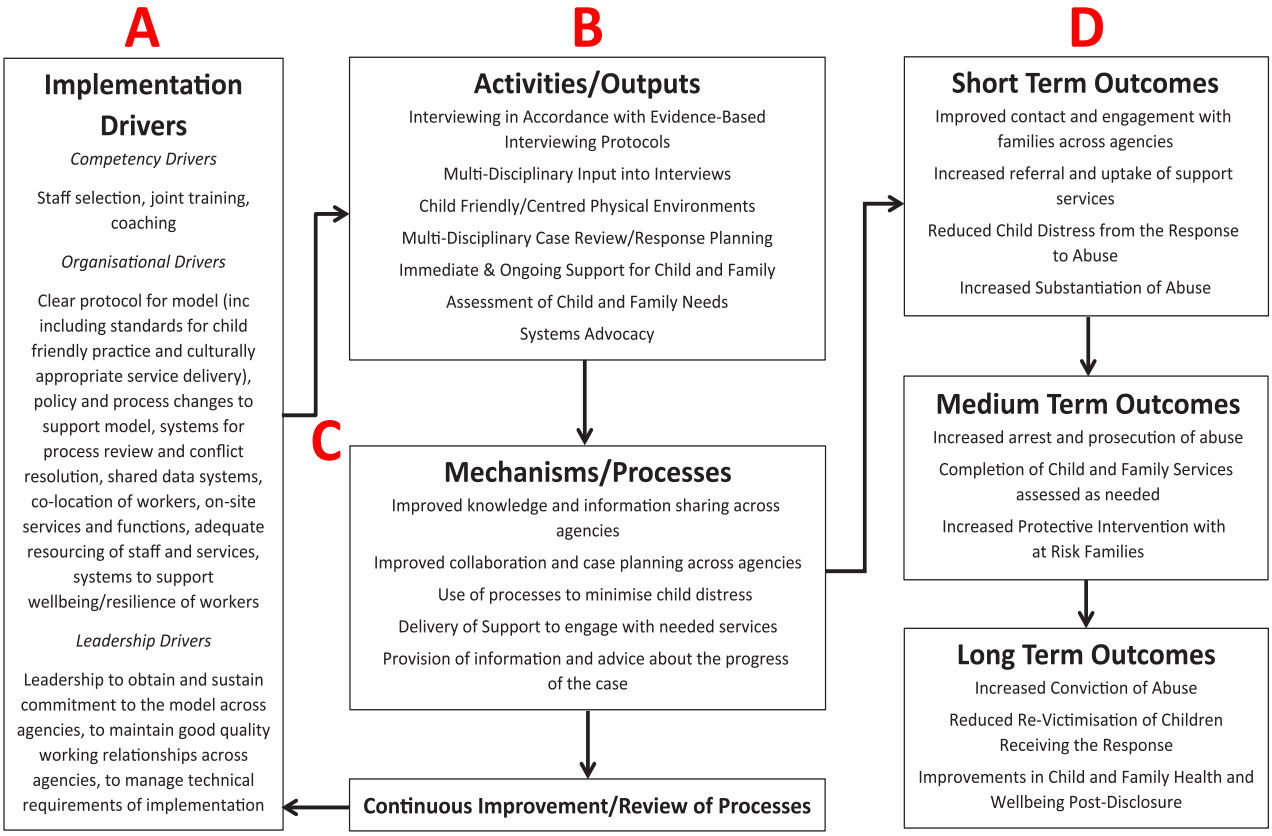
25.1. Reviewing and clarifying the desired outcomes of the JIRT arrangement

Central to strengthening accountability across the JIRT program is a pressing need for the partner agencies to revisit and clarify the desired outcomes. Presently, these outcomes are not clearly articulated, but are scattered across a number of strategic and operational policy documents – some of which are mutually inconsistent and/or no longer reflect contemporary practice. The ACCP developed an evidence-based multi-disciplinary team program logic (see Figure 10) which the JIRT agencies may find useful in settling their own priorities, strategies and outcomes.[1070]

The most obvious source of authority in relation to the desired outcomes is the JIRT MoU – the overarching document that governs the JIRT partnership. While the MoU defines the role of each agency (however, as we noted earlier in this report, the description of Health's role requires updating), it does not clearly specify the desired outcomes for the overall JIRT program. The lack of clear and jointly agreed outcomes for the JIRT program increases the risk of unilateral, rather than collaborative, action by the partner agencies. This gap undermines the purpose of the collaborative arrangement and should be addressed. At the outset of this inquiry, the SMG acknowledged that the MoU needs to be updated following consideration of the observations and recommendations in this report.

1070 J. Herbert and L. Bromfield, Australian Centre for Child Protection, *Components of Effective Cross-Agency Responses to Abuse*: *A report for the NSW Ombudsman*, August 2017, section 5.3. More detailed descriptions of each component (A, B, C, D), including definitions of the terms used in the key mechanisms/processes at (C), are provided at pp.80-88 of the report.

Figure 10: Program logic of multi-disciplinary teams[1071]



25.2. Updating and streamlining policies and procedures supporting the JIRT program

As the JIRT arrangement has evolved over the last 20 years, the number of related policy and procedural documents has proliferated. In addition to the JIRT MoU and Referral Criteria, the key jointly endorsed documents are the *JIRT Policy and Procedures Manual*, *JRU Process Guidelines, Local Planning and Response Procedures* and *Local Contact Point Protocol*. In addition, there are the JRU *APS Guidelines*, three joint documents that provide guidance about responding to Aboriginal children and young people[1072] and two NSW Police Force policies that apply to the application of the JIRT referral criteria.[1073] Each agency also has its own internal policies and procedures.

The documents listed above lack appropriate integration/cross-referencing and several are out-of-date. In addition, there is no common platform which brings them together in a way that is readily accessible to JIRT agency staff. This situation creates a risk that policies and procedures will not be well understood or adhered to by staff across the three separate agencies.

Having reviewed a multitude of documentation for this inquiry, we do not believe that an updated 'version of the *JIRT Policy and Procedures Manual* is needed. Instead, the partner agencies should create an electronic portal/intranet site where all up-to-date JIRT policies and procedures (reflecting the recommendations in this report) can be readily accessed by JIRT agency staff.

The SMG has previously recognised the need to review and update a number of key documents, but has been unable to prioritise this work. During our inquiry, they have committed to updating and better integrating joint policies, having regard to the observations and recommendations in this report.

1071 NSW Health has advised us of its view that other medium term outcomes worthy of consideration include (a) improved communication between JIRT and forensic paediatricians (b) improved quality of expert witness statements (c) improved confidence amongst general paediatricians providing child protection services outside the Level 6 hospitals (d) better training of emergency department MOs in report writing (Advice provided by NSW Health, 20 June 2017).

1072 *JIRT Aboriginal Consultation Protocol; JIRT Aboriginal Community Engagement Guidelines; Maintaining enhanced access to the JIRT Program for Aboriginal children and young people* (Enhanced Aboriginal Services Protocol).

1073 *Policy and SOPS for Investigation of sexual assault victims 16-18 years; Adolescent Peer Sex Guidelines.*

25.2.1. JIRT Memorandum of Understanding (MoU)

Given the range of variables impacting on the local operation of the JIRT program – for example, geographic context, accommodation arrangements and service infrastructure – it is essential that the MoU articulates both the 'core' elements (that is, the activities that must occur to deliver a 'valid' JIRT response) as well as 'adaptive' elements of the arrangement (that is, acceptable differences in how the JIRT response is delivered across NSW, having regard to local variables).[1074] If our recommendation to establish a trial of a Child and Family Advocate position is accepted (and later implemented), incorporating this aspect of the JIRT arrangement within the MoU will also be critical. Further, it would be helpful to ensure the policing, child protection and specialist health services provided by each partner via their 'line agency staff' to support the intended aims of the program are also clearly reflected in the MoU.

The MoU should clearly articulate the shared objectives of the JIRT program, and the governance and accountability arrangements oversighting the JIRT partnership. In this regard, the MoU should include links to the terms of reference for each layer of governance as well as the performance monitoring and reporting framework.

Dispute resolution and escalation

Currently, the JIRT MoU provides limited guidance about dispute resolution, specifying only that all disputes should, where possible, be resolved at a local level by line managers, or referred to the SMG. There is no reference in the MoU (or in the SMG terms of reference) to disputes that cannot be resolved by the SMG. The *Local Planning and Response Procedures* echo the limited advice provided in the MoU.[1075]

It is essential that the JIRT partnership has transparent processes for resolving and where necessary, escalating, disputes between the agencies. The processes should cover all stages of the JIRT program, including assessment and decision by the JRU, the local planning and response (LPR) process as well as disputes at both LMG and SMG level about systems and operational practice. Achieving timely yet appropriate resolution should be a strong focus.

In addition, we believe there is value in embedding within the JIRT model a systemic case practice review process. This would enable important insights to be drawn from particularly challenging cases to shape future practice. Systemic case review also enables more objective assessments to be made on issues that arise in an inter-agency context as the process is removed from the often high pressure circumstances unfolding at the frontline. This type of case review process exists in the United Kingdom. The UK guide – Working Together To Safeguard Children – provides an interagency framework to guide the work of Local Safeguarding Children Boards and organisations in discharging their statutory child protection responsibilities. The guide includes a 'Learning and Improvement' framework which addresses the need for organisations to reflect on service quality and learn from their own practices and the practices of others, by conducting a 'rigorous, objective analysis of [serious cases] what happened and why, so that important lessons can be learnt'.[1076]

We recommend that the partner agencies should first settle and then reflect the dispute resolution and escalation processes for each stage of the JIRT process in the amended MoU. In our view, the MoU should make clear that the partner agencies will not document criticism of another JIRT agency without having utilised the appropriate dispute resolution and escalation process. Data about dispute resolution should be tracked locally and state-wide by the LMGs and SMG, and reflected as a specific indicator in the JIRT performance monitoring and performance framework.

Consideration should also be given by the partner agencies to the benefits of including a provision for requesting mediation from an external source when significant strategic issues are unable to be effectively resolved by the partner agencies at the executive level.

1074 The description of 'core' and 'adaptive' elements is drawn from the Australian Centre for Child Protection's research into components of effective cross-agency responses to child abuse. (J. Herbert and L. Bromfield, Australian Centre for Child Protection, *Components of Effective Cross-Agency Responses to Abuse: A report for the NSW Ombudsman*, August 2017, section 6.4.)

1075 FACS, NSW Police Force, NSW Health, *JRU Process Guidelines*, May 2016, pp.26-27.

1076 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p.65.

Finally, each agency must ensure that its internal processes for addressing concerns relating to staff conduct and performance are sufficiently robust. It is inevitable within an interagency service delivery model that, on occasions, a staff member of one agency will raise concerns about a staff member from another agency. When this occurs, the relevant agencies need to ensure that the matter is appropriately handled in a way that complies with their respective policies and procedures. While acknowledging that differences between these policies and procedures can add a layer of complexity – and that agencies cannot direct each other about how to respond – as far as possible, the JIRT partner agencies should aim to resolve matters in a way that focuses on reinforcing the strong tri-agency relationship necessary to effectively delivering the JIRT program.

25.2.2. Rationalising and updating operational policies

In Chapter 8, we recommended that the current JIRT referral criteria be replaced with a document which includes the criteria together with a formal set of 'factors' that can be considered by the Helpline and JRU when applying the criteria to the individual circumstances of the children and young people the subject of relevant ROSH reports.

We also indicated that the *JRU Process Guidelines* – which document the responsibilities of the JRU in assessing referrals and deciding whether they meet the JIRT referral criteria – should be amended if our recommendations in relation to the JIRT referral criteria and JRU decision categories are accepted. As well, a new section should be inserted in the *JRU Process Guidelines* to document 'action required during the Helpline/JRU assessment phase'. The section should provide a description of the process of engaging each agency when an urgent or an after-hours response to a referral is required – and the key responsibilities for each agency during this phase.

Like the JIRT MoU and JIRT referral criteria, the *Local Planning and Response Procedures* are a critical joint document. However, as discussed previously, they require some amendments to reflect agreed operational changes that have occurred since 2013, and in order to provide more practical guidance to JIRT staff about implementing the procedures. The SMG has acknowledged that updating the document is a priority. The *Local Planning and Response Procedures* should become the authoritative reference for implementing each aspect of the LPR – and wherever possible, immediately updated to reflect agreed changes in key practice areas.

As explained in Chapter 23, we have suggested amendments to the *Local Contact Point Protocol* (LCPP) to strengthen its application. Regardless of whether those suggestions are adopted, the importance of the LCPP needs to be reflected in the updated versions of other key JIRT policies.

25.3. Implementing a robust performance monitoring and reporting framework

In our December 2012 report about responding to child sexual abuse in Aboriginal communities, we noted that a key finding of the 2006 JIRT review had been a lack of reliable and accessible data about JIRT processes and outcomes. At the time of our report, the main ongoing performance monitoring mechanism for the JIRT program was an annual 'CEO report card' prepared by the SMG for the heads of the JIRT partner agencies. The report card contained a range of 'headline indicators' for measuring JIRT's performance; however, we observed that many of these were activity-based rather than outcome-focused.

As a result, we recommended that the respective heads of the JIRT partner agencies should establish a more robust (than the annual CEO report card) framework to enable more effective monitoring of the performance of the JIRT program. In particular, we identified a need to enhance the JIRT program's case management information system(s) (the SMG had endorsed the concept of a tri-agency 'case management' system for JIRT one month before we released our report)[1077] and enhance the output/performance data reported by the SMG to the respective heads of the partner agencies.

1077 SMG meeting minutes for February 2013. Note that the concept was endorsed by SMG in November 2012.

25.3.1. Joint Investigation Response Tracking System (JIRTS) – data collection

Following the release of our 2012 report, during 2013 FACS led the development of the Joint Investigation Response Tracking System (JIRTS) – a tri-agency database for the JIRT program. Settling the arrangements for JIRTS consumed a significant amount of the SMG's time during that year. FACS also developed a user guide for JIRTS,[1078] and secured an agreement from the Crown Solicitor's office to assist with the preparation of a tri-agency MoU to govern the administration of JIRTS.[1079]

JIRTS was initially rolled out in May 2014 to the JRU. From 1 July 2014, it became the primary source of data about referrals to the JRU. In December 2014, the LPR component of JIRTS was piloted in Parramatta and Wagga Wagga, followed by Liverpool and Northern Rivers in June 2015. The SMG endorsed state-wide implementation of JIRTS in September 2015. After this time, JIRTS was progressively rolled out to all areas, with Queanbeyan the last location to come 'on line' in September 2016.

Almost three years after JIRTS began, the JIRTS MoU remains incomplete, with unsettled legal issues apparently contributing to the delay. In the interim, FACS has retained administrative responsibility for JIRTS, including the provision of technical support. Notwithstanding the development of the JIRTS user guide – and a 'splash screen' prior to log in which requires the user to agree to certain confidentiality and disclosure provisions – the absence of an MoU is a problematic gap in governance.

A significant number of respondents to the JIRT workforce survey provided commentary about JIRTS. A small number of positive comments were made about JIRTS having improved information sharing as well as compliance with the LPR process and overall accountability. Some respondents observed that JIRTS has created better transparency in relation to incoming referrals accepted by the JRU, with local managers able to see the same information about the referral, as documented by the JRU, at the same time. The benefits for managers in relation to capacity to track workflow (for both their unit overall and individual staff) in real time and 'at a glance' were also noted.

Negative feedback was more frequently given and mainly related to JIRTS being cumbersome, inefficient and unnecessarily duplicative of individual agencies' information management requirements/systems. In relation to the latter criticism, CAS respondents expressed frustration about having to upload information onto three separate systems – COPS, e@gle.i[1080] and JIRTS. However, JIRTS is not intended to be used to manage a criminal investigation. The CAS senior management team have confirmed that there is very limited 'duplication' e@gle.i is infrequently used for JIRT matters and most information recorded on COPS does not need to be uploaded to JIRTS. FACS staff also said that too much of their time is taken up with entering the same data in both JIRTS and KiDS.

In our view, many of these frustrations appear to stem from staff in the field not being given a clear sense of the main purpose of JIRTS. While FACS took lead responsibility for developing JIRTS in consultation with the other partner agencies and should be commended for their efforts in this regard, the effectiveness of the JIRTS database has been hampered by the agencies inability to settle an MoU outlining its purpose and governing its use. With better alignment, where required, between JIRTS and other case management systems, and if the link between data input and performance monitoring and reporting was better explained to staff, it is likely there would be greater support for JIRTS.

JIRTS is an improvement on the data collection and reporting processes that were used at the time of our 2012 report. In particular, it has enabled the collection of more consistent data about incoming referrals to the JRU and the JRU's decision-making. However, the use of JIRTS as primarily a case management tool has meant that its full capacity to collect and facilitate analysis of performance data – particularly data about outcomes for children and young people facilitated by the JIRT program – remains unrealised.

In order for the shared JIRTS database to facilitate the collection of joined up data about each child's journey 'through the system', each agency would first need to identify high level outcome data reflecting the child protection, therapeutic and criminal justice responses provided per child accepted into the JIRT program. We are not suggesting that the JIRTS database should be used as

1078 The current version of the user guide was updated in May 2016.
1079 SMG meeting minutes, 2013.
1080 e@gle.i is the NSWPF's web-based application for capturing information (for example, photographs, statements) gathered during a criminal investigation.

the repository for storing all data an agency holds about a child accepted into the JIRT program, as this should continue to be held in each agency's primary database. However, unless and until a data solution is developed for recording agreed outcomes per child, it is difficult to see how the JIRT program can demonstrate the outcomes it is achieving for children who receive a JIRT response.

During our inquiry, we were advised by FACS that 'JIRTS was developed as an interim measure until its function is incorporated into ChildStory'.[1081] We have been told that ChildStory 'will accommodate FACS JIRT data requirements as well as the tri-agency component of the JIRT'.[1082] In this regard, FACS has committed to liaising closely with the other JIRT partner agencies in relation to the case management component of ChildStory. The first release of the JIRTS component of ChildStory is due to be implemented in October 2017 with further rollout of the 'shared' functions in 2018.[1083]

Ideally, the process of transferring the JIRTS functionality to ChildStory would allow current weaknesses in JIRTS to be addressed to enable relevant data, as discussed throughout this report, to be systematically collected in relation to children referred to the JIRT program. We understand from recent discussions with FACS that, if all agencies agreed, further enhancements to the JIRTS component of ChildStory could be considered in future releases of ChildStory (beyond those already planned) – however, this would need to be considered in the context of other priorities for FACS at that time. In the meantime, FACS has indicated that the case management functionality of JIRTS is likely to be enhanced through the ChildStory platform.

We discuss key processes for capturing and reporting performance data further in the next section.

25.3.2. Further enhancing performance monitoring and reporting

The JIRT Monitoring and Reporting Framework, endorsed by the SMG in October 2013, includes 41 performance measures; the purpose of collecting data against each measure; the relevant agency/s; the current data source; and the current/future capacity of JIRTS to supply the data. With the exception of agency 'case reviews', the 41 measures in the framework are mostly quantitative. The measures are organised under the headings of volume and capacity; JIRT criteria; Aboriginal measures; joint operations; and individual agency core business.

Twelve indicators are 'outcome focused'; that is, designed to measure outcomes for children and young people facilitated by the JIRT program. While a number of indicators in the framework are sound, the framework itself has not been progressively reviewed or updated, and its implementation has been limited.

In September 2015, the SMG decided that it would no longer produce an annual CEO report card. The rationale for this decision was that by the time the annual report card was compiled, the data it incorporated was out-of-date and therefore of limited value. As well, it was noted that the report card was originally developed to report to governance structures (that is, the JIRT CEOs group through the Human Services and Justice CEOs Forum) that no longer existed. There was some disagreement among the partner agencies about the value of joint performance reporting about the JIRT program.[1084] The SMG agreed that the issue of performance reporting should ultimately be considered by a broader review of JIRT.

While FACS has continued to provide monthly reports to the partner agencies based on data extracted from JIRTS, this data does not relate to the implementation of the LPR or key outcomes for children and young people accepted into the program. In addition, although a number of the indicators set out in the JIRT Performance Monitoring and Reporting Framework – particularly those which are outcome focused – are sound, as noted previously, what is missing is an attempt to collect data in a way that allows the relationship between outcomes achieved for children and young people and the various components of the JIRT response they received to be measured. For example, of those matters accepted by the JIRT program that were prosecuted, how many involved the child or young person receiving counselling and/or a protective intervention by FACS?

1081 ChildStory is the database that will replace KiDS, the current database used by FACS.
1082 Advice provided by FACS, March 2017.
1083 Evidence given by Mr Michael Coutts-Trotter (Secretary, FACS) to the Royal Commission into Institutional Responses to Child Sexual Abuse, Public Hearing into Commonwealth, State and Territory Governments, *Case Study 51*, 8 March 2017.
1084 SMG meeting minutes, March and September 2015.

In its submission to our inquiry, Health commented that:

> *The JIRT partner agencies should commission a high level strategic review in relation to the data-related recommendations of this report, with a view to ensuring that future performance monitoring and reporting provides a comprehensive view of the child's journey through the JIRT process, is consistent with other government initiatives in information techniques, data linkage and child protection system reporting and provides the basis for robust governance and accountability in JIRT.*

At present, there is no real capacity to track the progress of a child through 'the system' and to consider the impact of key variables in the JIRT response and other relevant factors (such as demographic data). This weakness in the evidence base for the JIRT program is exacerbated by the current poor alignment of child protection and criminal justice data that we discussed in Chapter 10. A key strategic priority for the JIRT executive leadership group (discussed in section 25.4.3 below) should be exploring how 'enduring data linkage' (that is, bringing together, in an ongoing way, relevant data from each agency's information holdings) can be facilitated to enable monitoring and reporting of high level outcomes that demonstrate the value of the JIRT program. Whatever solution is identified, it will be important that it does not impose an unacceptable administrative burden on already very busy operational staff.

Throughout this report we have identified key data that we believe each agency should be collecting about child protection, criminal justice and health interventions for children referred to the JIRT program, as well as better demographic data for particularly vulnerable cohorts of children. We recommend that the SMG has regard to our observations and recommendations about data in formulating its key performance indicators for the JIRT program.[1085] In the interests of transparency and accountability over the expenditure of public funds – and given that the public interest in child protection issues is arguably stronger than ever – certain data about the outcomes delivered by the JIRT program should be publicly reported. We acknowledge that careful consideration will need to be given to the nature of the data reported; however, at present, there is a dearth of accessible information which demonstrates the value of the tri-agency approach to responding to serious child abuse and neglect that has been endorsed by the NSW Government.

However in saying this, we recognise the challenges associated with effectively implementing a robust performance monitoring and reporting framework in the absence of a position with dedicated responsibility for doing so. It is not realistic to expect that the SMG – whose representatives have direct, day-to-day operational responsibilities – can also be responsible for ensuring that performance data is extracted, analysed and reported in an ongoing way if it does not have access to a dedicated resource to undertake the practical work involved.

We recommend that the partner agencies give consideration to establishing a senior position with responsibility for providing executive support to the SMG to implement the performance monitoring and reporting framework through regular data analysis and reporting against the jointly agreed performance indicators, supported by whatever additional resourcing is deemed necessary. The position could also support other governance and accountability requirements, such as updating the JIRT policy and procedure framework and providing secretariat support to the Deputy Secretaries meeting, SMG and LMGs.

25.4. JIRT governance mechanisms

Our many years of oversighting interagency service delivery models has continually reinforced that strong governance mechanisms are critical to driving and monitoring successful implementation. While the governance mechanisms supporting the JIRT partnership are, for the most part, appropriate in their design and membership, our inquiry has identified that they need to be further strengthened.

1085 In this regard, we note that Health, in its submission to the inquiry, suggested that the JIRT agencies consider the value of commissioning research about the medium to longer term outcomes for children (and their families) following JIRT intervention. While we think this is a valuable suggestion, until the agencies are able to resolve how to collect and report on outcome data, this type of research may be premature at this point in time.

25.4.1. Local Management Groups (LMGs)

Membership of LMGs includes the CAS Team Leader and Zone Inspector; FACS JIRT's Manager Client Services and Manager Casework, and the Senior Health Clinician and Manager, Sexual Assault Service. The LMG may invite other people to attend in an advisory capacity.

The 2006 JIRT review recommended that Local Coordination Groups (as they were then known) should be strengthened. In March 2008, following a survey of JIRT staff, the SMG renamed the groups to more accurately reflect their revised role, and endorsed new terms of reference (ToR) and business rules. In December 2015, the SMG again reviewed and amended the ToR for LMGs.

According to the new ToR, the purpose of the LMG is to enhance the operation of JIRT at a local level; facilitate communication between agencies at a local level; and provide advice to the SMG about any operational or strategic issues. In relation to the latter, the LMG is expected to communicate with the SMG about issues with potential state-wide implications; unresolved policy or strategic disputes between the local JIRT partners; cases involving significant issues of concern or organisational risk; and positive outcomes of the JIRT process or practice improvement initiatives. The ToR state that, where the LMG agrees that a matter should be escalated to the SMG for review or resolution, the agency with chair and secretariat duties (which rotate yearly) should prepare a briefing, signed by all members, using the template included in the ToR.

How LMGs are operating

We asked the partner agencies to provide us with copies of LMG minutes for the period 2013-2016. We received 49 sets of minutes covering 2013, 2015 and 2016.[1086] As there are 22 JIRT locations, this figure indicates that LMGs are not meeting as frequently or consistently as the ToR require (that is, bi-monthly prior to 2016 and quarterly thereafter).

The LMG minutes we reviewed provided valuable insights into a number of operational areas, particularly the LPR process, tri-agency resourcing and the availability of counselling and forensic medical services. Some also contained useful information about Aboriginal community engagement and training activities. However, while the quality of minutes varied, in a large number of cases it appeared that LMGs were primarily discussion based rather than outcome focused.

There was limited evidence of appropriate issues being escalated to the SMG, and of the SMG providing feedback about these issues. There was scant evidence of LMGs reviewing 'case studies', or alerting the SMG to individual cases illustrating significant issues of concern or organisational risk. There was somewhat more evidence of LMGs communicating positive outcomes of the JIRT process to the SMG via their participation in presenting 'case studies' at SMG meetings – a practice that appears to have been informally discontinued in 2014-2015.

There was evidence of confusion about what the SMG expects of LMGs more broadly, and what LMGs can expect from the SMG in return. In some areas, there was evidence that various issues of contention discussed throughout this report were affecting relationships at a local level. However, in other locations, this tension was much less apparent, or even non-existent. This was a useful finding, indicating that the contentious issues have not universally affected the partnership.

In addition to reviewing meeting records, we elicited feedback about the operation of LMGs through the JIRT workforce survey. Less than 20% of respondents from across the three agencies said they consider their LMG to be effective. Senior staff generally reported that the LMG's effectiveness at resolving tri-agency issues was 'inconsistent'. A high proportion of less senior staff indicated that their managers should provide them with more feedback about LMG business.

Concern about the extent to which the LMG is a truly tri-agency governance mechanism was a predominant theme in survey responses. A significant proportion of CAS respondents indicated they did not perceive the LMG as being particularly relevant or useful to their operational priorities and needs. This feedback is consistent with SMG and LMG minutes from 2015 which document that, in some areas, the CAS had stopped attending LMGs. In response, the Commander of the CAS issued a directive requiring CAS participation in LMGs pending completion of the SMG's review of the LMG ToR.

1086 No minutes could be provided for 2014.

More recently, the CAS has indicated that, 'given that local issues are generally resolved at the time they arise', there is a need to review the frequency of LMG meetings.[1087]

Strengthening LMGs

In our view, the JIRT program should retain LMGs; however, the survey feedback strongly suggests that the way they operate needs to be reviewed. It is productive for JIRT agency managers to convene as a group to jointly focus on local implementation issues. If they function as intended, LMGs should be an effective mechanism for the management of these issues, providing a source of important information for the SMG about the 'health' of the JIRT partnership, enabling it to 'nip in the bud' any emerging problems or identify critical practice issues.

LMGs would be more effective if they had a broader strategic purpose. While the LMG ToR specifies the types of activities that LMGs should undertake, it does not provide specific guidance about the outcomes that LMGs should be striving to demonstrate. LMGs should be primarily focused on whether they are meeting the KPIs that should be included in the overarching JIRT performance monitoring framework once it has been settled.

It is also critical that busy frontline staff are not burdened with paperwork associated with LMG meetings. In this regard, the current process for LMGs to escalate issues to the SMG is unnecessarily cumbersome. Rather than require the agency with LMG secretariat duties to prepare a separate briefing that must then be signed by all agencies, the SMG should insert a section in the LMG agenda template for recording 'matters to be escalated to SMG' and the response provided. In addition, there should not be a requirement that LMG members must reach agreement about matters to be escalated to the SMG. This requirement makes little sense when many issues that will require escalation to the SMG are precisely those where local resolution/agreement cannot be reached.

Finally, the SMG should monitor whether LMGs are regularly meeting and operating effectively, and where this is not the case, take steps to resolve any problems.

25.4.2. State-wide Management Group (SMG)

The JIRT State-wide Management Group (SMG) drives, monitors and develops JIRT governance, reporting mechanisms, practice and operational policy and procedure. It comprises the Director, Prevention and Response to Violence, Abuse and Neglect (Health); the Commander, Child Abuse Squad (NSWPF); and the Directors and Principal Project Officer, JIRT Policy and Strategy and Operations (FACS). The Director, Child Wellbeing, Sydney Children's Hospitals Network (Health), the position responsible for leading the JRU Health team, also attends.

Terms of reference

According to the SMG terms of reference (ToR), which were last updated in February 2013 – the role of the SMG is to:

> *provide strategic support to the JIRT Chief Executive Officers (CEOs) group via the Human Services and Justice CEOs Forum. The SMG provides a system for achieving the priorities of the JIRT CEOs. It does this in the following ways:*
>
> - *Annual development and review of JIRT SMG Strategic Priorities for endorsement by JIRT CEOs.*
> - *Achievement of milestones and deliverables according to the JIRT SMG Strategic Priorities.*
> - *Reporting to JIRT CEOs meetings on the status and progress of projects related to JIRT SMG Strategic Priorities.*
> - *Acting on directions from the JIRT CEOs.*
> - *Providing timely agency comment and/or endorsement of policies.*
> - *Taking action and providing advice to the JIRT CEOs on state-wide operational issues relating to JIRT.*
> - *Coordinating combined response to reports and recommendations that have state-wide impact on JIRT.*

1087 SMG meeting minutes, February 2017.

As is the case for LMGs, chair and secretariat responsibilities for the SMG rotate each calendar year. Prior to 2014, the SMG met bi-monthly. Since 2014, it has met quarterly, with additional meetings convened as required (the group met on five occasions during 2014 and 2015).

The Human Services and Justice CEOs forum referred to in the ToR no longer exists and for several years there has been no formal tri-agency CEO governance mechanism for oversighting the JIRT arrangement.

Strategic Priorities

The SMG prepared (and endorsed) Strategic Priorities in 2013 and subsequently developed a draft set of Strategic Priorities in 2015.

In 2013, developing a JIRT Performance Monitoring and Reporting Framework and the Joint Investigation Response Tracking System (JIRTS) were key priorities, as was revising the SMG ToR. These priorities were either met or, in the case of JIRTS, well progressed.

The 2015 draft Strategic Priorities is a highly ambitious document that lists 18 projects organised under the categories of governance, policy review and development, practice support, funding and forensic medical services. Reviews of the JIRT MoU, JIRT neglect criteria, SMG and LMG ToR, JIRT Manual, *JRU Process Guidelines*, JIRT administration operating guidelines and Aboriginal community consultation guidelines, among other items, were all identified as priorities for the SMG.

The SMG delivered on some of the 2015 priorities it identified; however, it is difficult to envisage how the SMG could have delivered on all of the identified priorities within a year, particularly given the significant day-to-day operational leadership demands on the senior officers involved. It appears that the SMG has not updated its Strategic Priorities since 2015.

Strengthening the SMG

The effectiveness of the SMG as the state-wide governance mechanism for the JIRT program appears to have been impacted by the lack of a performance monitoring and reporting framework, as well as by the SMG's preoccupation with a range of operational issues that well-functioning LMGs should be able to manage. Although the ToR envisage that the SMG's work will be informed by the development of annual 'Strategic Priorities', these are mostly activities and do not appear to be informed by data about trends (for example, the rapidly increasing number of referrals to the JRU in the last few years) or information about JIRT locations that are operating well or experiencing challenges.

The implementation of a performance monitoring and reporting framework will provide a stronger evidence base to inform the SMG's strategic priorities. In addition, the re-instatement of a formal, tri-agency governance mechanism for the JIRT program at Deputy Secretary/Commissioner level will further strengthen – and support – the SMG. We recommend that the ToR for the SMG should be aligned with an updated performance monitoring and reporting framework, and reflect the link between the framework and the development of annual (or bi-annual) Strategic Priorities.

Feedback from the JIRT workforce survey revealed a desire on the part of JIRT agency staff to receive clearer information about the SMG's agreed positions and expectations. In this regard, we note the SMG's acknowledgement in July 2016 of 'a perception among LMGs that the SMG is silent on growing tension in some units between criminality and child protection'.[1088] The Joint Communication issued by the SMG in December 2016 was a significant step in the right direction towards countering this perception, reaffirming the partner agencies' commitment to interagency collaboration and compliance with LPR processes. At this time, the SMG acknowledged that there was a need for 'improved joint change management going forward', and that convening SMG meetings at JIRT units in 2017 would be one way of modelling a tri-agency partnership and ensuring consistent messaging.[1089] The SMG's ToR should clearly articulate the SMG's reporting responsibilities to LMGs, and an agreed process for communicating with the JIRT workforce about policy or operational issues impacting on the JIRT program.

1088 SMG meeting minutes, July 2016.
1089 SMG meeting minutes, December 2016.

To further support this commitment to joint change management, we also think it is critical for the JIRT agencies to consult each other when they plan to issue formal directives to their own staff if these directives are likely to impact on the operations of partner agencies.

During our review, FACS and Health strongly criticised the CAS for having issued directives to its officers, without adequate prior consultation with the JIRT SMG, which have had a significant operational impact on the other partner agencies and the JIRT program as a whole. As we discussed in Chapter 22, in December 2015 the CAS decided that police should solely conduct all recorded interviews with children and/or young people in all criminal matters accepted by the JIRT program. This significant operational change took effect in January 2016.[1090]

The current JIRT MoU states that:

> *Any significant policy change being considered by any of the three departments that may impact on the JIRT service delivery must involve full consultation with each department prior to implementation.*
>
> *Any child protection concern or operational issue that may impact on the JIRT program area should be the subject of a joint response or from the most appropriate agency following consultation with the key stakeholders.*[1091]

In our view, it is critical that this aspect of the current MoU be retained, and faithfully adhered to by the partner agencies. In circumstances where agreement cannot be reached about the nature of proposed communications by one agency (to its own staff) which will impact on the operations of another, an appropriate escalation mechanism needs to be identified beyond the SMG to promptly resolve the way forward. The SMG's ToR should set out a process for escalating unresolved issues to the Deputy Secretaries/Deputy Commissioner of the partner agencies.

Finally, it was apparent from our review of SMG records that, at times, the rotating chair and secretariat arrangements for the SMG (and LMGs) may impede the continuity and effectiveness of strategic oversight of the JIRT program. While there is not necessarily a viable alternative to this arrangement – given the need for responsibility to be equally shared by the three agencies – there is a risk that each time the chair/secretariat rotates, momentum is lost and the 'wheel' is reinvented. This is exacerbated by the significant level of operational responsibility that is carried by SMG members. The risk could be reduced if the partner agencies establish the senior position with responsibility for providing executive support to the SMG that we have recommended earlier in this chapter.

25.4.3. JIRT executive leadership group

The JIRT MoU states that the JIRT CEO Committee, consisting of the heads of each partner agency, will meet at least twice yearly to 'monitor service quality, budget allocation and make recommendations and adjustments as required'.[1092]

As noted earlier, there has been no formalised JIRT governance structure at CEO level for several years and no joint annual CEO report card since 2013-2014. While the partner agencies have continued to individually report to their respective CEOs, the absence of a tri-agency executive oversight mechanism has created a gap in governance and accountability for the JIRT program. In our view, this gap has weakened the partnership, contributing to issues of interagency contention remaining unresolved, and in some cases intensifying, for lengthy periods of time.

The more recent involvement of Deputy Secretaries/Commissioner[1093] from the three partner agencies in instigating and endorsing an independent review of the JIRT program has been a positive development. In our view, to strengthen overall governance and accountability of the JIRT program, a formal arrangement for ongoing executive leadership and oversight of the JIRT should be reinstated

1090 NSW Police Force, *Memorandum: Interviewing Child Victims,* 21 December 2015.
1091 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding* (incorporating February 2013 interim changes), August 2006, pp.1, 3.
1092 NSW Police, Department of Community Services and Department of Health, *JIRT Memorandum of Understanding* (incorporating February 2013 interim changes), August 2006, p.2.
1093 Acting Deputy Commissioner, Field Operations, NSWPF; Deputy Secretary, Strategy and Resources, Ministry of Health; Deputy Secretary, Northern Cluster (responsible for Community Services State-wide Services), Family and Community Services.

as an immediate priority. In this regard, at a meeting of the JIRT senior officers and Deputies in December 2016, it was agreed that at least bi-annual meetings of the Deputies should occur, in alignment with the SMG's quarterly meeting schedule, with additional meetings to be convened as required. The meetings would provide a forum for decision-making about tri-agency JIRT issues unable to be resolved by the SMG, or requiring strategic endorsement at an executive level. We suggest that, initially, there would be value in the CEOs of the partner agencies joining the meeting to settle key priorities.

We further recommend that in oversighting the performance of the JIRT program, the meeting of the Deputies should have regard to appropriate data and analysis, against an agreed set of performance indicators, as part of the implementation of a JIRT performance and reporting monitoring framework.

Finally, given that the JIRT program has not been the subject of a comprehensive independent review for ten years, there are understandably a range of areas where we have recommended improvements be made to enhance the program. However, it is unrealistic to expect that the necessary reforms can be implemented by the SMG alone given their already significant operational responsibilities. For this reason, there would be merit in the JIRT agency executives – individually and collectively – examining what arrangements are needed to respond to the issues raised in this report.

Recommendations

57. The JIRT partner agencies should amend the JIRT Memorandum of Understanding, ensuring that the document:

- **a) Clearly states the respective roles and responsibilities of each partner agency (and the Child and Family Advocate, if recommendation 2 is accepted).**
- **b) Identifies the desired outcomes of the JIRT arrangement.**
- **c) Links to the performance monitoring and reporting framework containing the indicators that will be used to measure the desired outcomes.**
- **d) Clearly articulates the 'core' and 'adaptive' elements of the JIRT arrangement.**
- **e) Makes clear that the child protection and specialist health services provided by the NSW Police Force, FACS and NSW Health, beyond the JIRT arrangement, support the desired outcomes.**
- **f) Outlines the purpose of each governance mechanism and links to their terms of reference.**
- **g) Maintains the requirement in the existing MoU that any significant change to the operation of the JIRT program must involve full consultation between all three agencies prior to implementation, and articulate a process for communicating such changes to the field.**
- **h) Includes a dispute resolution and escalation mechanism which covers each stage of the JIRT partnership, including disputes relating to the *Local Planning and Response Procedures* and systemic case practice review process we have proposed.**
- **i) Includes external facilitation for disputes that cannot be resolved by the JIRT partner agencies.**
- **j) Specifies when the MoU will be reviewed.**

58. The JIRT partner agencies should update the JIRT performance monitoring and reporting framework, having regard to the observations in Chapter 25 and ensuring that the framework:

- **a) Includes appropriate performance indicators for measuring whether the JIRT arrangement is meeting the desired outcomes and demonstrating the relationship between the outcomes achieved for children and young people and the components of the JIRT response they received.**

b) **Identifies, having regard to relevant cross-government data and information technology initiatives, the necessary data to support each performance indicator, how the data will be sourced, the frequency of reporting and the related governance processes where results will be analysed.**

59. **The JIRT partner agencies should:**

    a) **Update the shared policies and procedures supporting the JIRT program, having regard to the observations and recommendations throughout this report.**

    b) **Store the shared policies and procedures on an electronic portal/website that is accessible to staff from all three JIRT agencies.**

60. **The JIRT partner agencies should amend the terms of reference for the SMG to:**

    a) **Align with the JIRT performance monitoring and reporting framework.**

    b) **Clearly articulate the SMG's reporting responsibilities to LMGs and relevant Deputy Secretaries/Commissioner, including the provision of relevant data and related analysis and the process to be followed in relation to the recommended meetings of partner agency deputies.**

    c) **Specify an agreed process for the JIRT agencies to consult each other when they plan to issue formal directives to their own staff if these directives are likely to impact on the operations of partner agencies; and, where agreement cannot be reached about the nature of proposed communications by one agency (to its own staff) which will impact on the operations of another, to escalate the issue to the Deputies/Commissioner of the partner agencies.**

    d) **Requires the SMG to regularly review data relating to 'escalated concerns' about the implementation of the LPR in individual matters, to assess the frequency and nature of concerns, and any location trends.**

61. **The JIRT partner agencies should:**

    a) **Support the continued operation of LMGs.**

    b) **Amend the LMG terms of reference (and agenda template) to align with the JIRT performance monitoring and reporting framework; include a stronger focus on routine case reviews; provide practical guidance about the outcomes that LMGs should aim to demonstrate against relevant performance indicators; and create a simple pathway for matters to be escalated to the SMG.**

    c) **Require LMGs to report to the SMG, using the amended LMG agenda template, against the relevant performance indicators and the outcomes of case reviews.**

    d) **Require the SMG to verify, by quarterly receipt of LMG meeting records, whether all LMGs have occurred as scheduled.**

    e) **Require the SMG to identify if an LMG is regularly failing to meet as required, take steps to determine the reason for this, and jointly address it.**

62. **The relevant Deputy Secretaries/Commissioner of the partner agencies should:**

    a) **Meet biannually, and additionally as required, to provide a forum for executive oversight of the JIRT arrangement, having regard to relevant data and related analysis against the agreed performance indicators set out in the JIRT performance monitoring and reporting framework.**

    b) **Convene, within three months of the agencies' receipt of this report, to determine terms of reference and an ongoing meeting schedule aligned with the SMG quarterly meetings.**

63. **The JIRT partner agencies should give consideration to establishing a senior position with responsibility for:**

    a) **Supporting the SMG to implement the performance monitoring and reporting framework through undertaking regular data analysis and reporting against the jointly agreed performance indicators.**

    b) **Undertaking other tasks related to the governance and accountability of the JIRT arrangement, including updating and maintaining the shared policies and procedures supporting the JIRT program and providing secretariat support to the JIRT Deputies, SMG and LMGs.**

64. **The JIRT partner agencies should review the adequacy of the shared JIRTS database (or any shared other data platform), having regard to our observations about the need for the database to enable:**

    a) **Systematic and non-exclusive 'flagging' of referrals that involve Aboriginal children and young people; children and young people with disability; children and young people from CALD backgrounds; and children and young people in OOHC.**

    b) **Systematic flagging of children and young people identified as causing sexual harm in JIRT referrals, including their OOHC status and other demographic data (where known).**

    c) **Abuse or neglect type to be selected against the relevant primary referral category of sexual abuse, physical abuse or neglect.**

    d) **Systematic recording of escalated concerns about the implementation of the LPR in individual matters (and the related outcomes), and interview participation data by each agency.**

    e) **Relevant data to be systematically recorded, extracted and analysed against agreed child protection, criminal justice and health outcomes for individual children and young people referred to the JIRT program, having regard to the observations and recommendations in this report.**

65. **The JIRT partner agencies should continue to liaise with FACS to determine whether the enhancements specified in recommendation 64 can be incorporated into the JIRTS functionality once it is transferred to ChildStory in future releases of ChildStory. If the enhancements cannot be incorporated in the short to medium term, the agencies should identify a solution for obtaining and reporting on the data needed to support the agreed key performance indicators for the JIRT program, having regard to the benefits of 'enduring data linkage' and the need to minimise the administrative burden on frontline JIRT staff.**

66. **The JIRT partner agencies should finalise a Memorandum of Understanding to support the shared JIRTS database (or any other future shared data platform).**

67. **In light of the public interest in the ongoing effectiveness of the JIRT program, the JIRT partner agencies should make public their response to this report within 12 months of it being released to the agencies.**

Glossary

AbSec	Aboriginal Child, Family and Community Care State Secretariat (NSW)
ACCP	Australian Centre for Child Protection, Division of Education, Arts & Social Sciences, University of South Australia
ACIF	*Aboriginal Cultural Inclusion Framework*
ACLOs	Aboriginal Community Liaison Officers
ACMAG	Aboriginal Communities Matter Advisory Group
ACWA	Association of Children's Welfare Agencies
After-hours response	Outside of regular business hours (Monday – Friday, 9am-5pm)
APS	Adolescent peer sex
BOCSAR	Bureau of Crime Statistics and Research, NSW
CAC	Child Advocacy Centre
CALD	Culturally and linguistically diverse
Care Act	*Children and Young Persons (Care and Protection) Act 1998* (NSW)
CART	Child Abuse Response Team, NSW Police Force
CAS	Child Abuse Squad, NSW Police Force
CAS-WA	Child Abuse Squad, Western Australia Police
CASA	Centre Against Sexual Assault, Victoria
CASAC	Child and Adolescent Sexual Assault Counselling Service
Child	A person under the age of 16 years
Child abuse or neglect	Includes the abuse or neglect of a young person, unless otherwise specified
Cognitive impairment	We use cognitive impairment as an umbrella term that includes, but is not limited to: intellectual disability, borderline intellectual disability, autism, acquired brain injury, dementia and other communication difficulties.
Co-location	Co-location involves multi-disciplinary team workers from different agencies being located 'within the same general location' (Wood Inquiry, 2008, Vol.1, p.310), for example, in the same building or complex. It does not require those workers to share a workspace, although it is common for parts of the building/complex to be set aside for joint work or common use.
COMPASS	The NSW Police Force intranet-based corporate performance management system
COPS	NSW Police Computerised Operational Policing System
CPCS	Child Protection Counselling Service, NSW Health
CPIU	Child Protection and Investigation Unit, Queensland Police
CPS	Child Protection Service, NSW Health
CPU	Child Protection Unit, NSW Health

CRT	Crisis Response Team (FACS)
CS-CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW)
CSC	Community Services Centre, NSW Department of Family and Community Services
CWS-WA	Child Witness Service, Western Australia
CYDA	Children and Young People with Disability Australia
DCP-SA	Department for Child Protection, South Australia
DCPFS	Department for Child Protection and Family Support, Western Australia
DEP	(NSW Police Force) Detectives Education Program
DHHS	Department of Health and Human Services, Victoria
DoCS	(former) Department of Community Services (now incorporated into the NSW Department of Family and Community Services)
EAP	Employee Assistance Program
EASP	*Enhanced Aboriginal Services Protocol*
ECAV	Education Centre Against Violence, NSW Health
EY	Ernst & Young
FACS	NSW Department of Family and Community Services
FACS JIRT	JIRT arm of the Department of Family and Community Services
FRS	Family Referral Service
FTE	Full-time equivalent
GMAR	Grandmothers Against Removals
Health JIRT	The JIRT arm of NSW Health
IAB	Internal Audit Bureau
Interagency Plan	NSW Government, *NSW Interagency Plan to Tackle Child Sexual Abuse in Aboriginal Communities 2006-2011*, January 2007
Interview	Delineation is made between a criminal/police interview and a care and protection interview
ITC	Intensive Therapeutic Care
JFSC	JIRT Foundational Skills Course
JIR	Joint Investigation Response – a precursor to the JIRT, involving non-co-located Police and Department of Community Services staff in rural areas.
JIRT	Joint Investigation Response Team
JIRT agencies	NSW Family and Community Services, NSW Health and NSW Police
JIRT units	The units within FACS, Health and NSW Police that are designated to, and operate as part of, the JIRT Program.
JIRTS	Joint Investigative Response Tracking System – the tri-agency database for the JIRT program.

JIT	Joint Investigation Team – a precursor to the JIRT, involving co-located Police and Department of Community Services (FACS predecessor) staff
JJ	Juvenile Justice, Department of Justice, NSW
JRU	JIRT Referral Unit
JSE	JIRT Simulated Exercise
KiDS	FACS' child protection database
KPI	Key Performance Indicator
LAC	Local Area Command. NSW Police Force is organised into 76 operational LACs across six regions. Each LAC takes in several police stations.
LCPP	JIRT Local Contact Point Protocol
LHD	Local Health District, NSW Health
LMG	JIRT Local Management Group
LPR	JIRT Local Planning & Response
MASH	Multi-Agency Safeguarding HUB, United Kingdom
MDC	Multi-Disciplinary Centre, Victoria
MDT	Multi-Disciplinary Team
MIST	Multi-Agency Investigation and Support Team, Western Australia
MoU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
NSWPF	New South Wales Police Force
OCG	Office of the Children's Guardian, NSW
ODPP	Office of the Director of Public Prosecutions, NSW
OOHC	Out-of-home care
PARVAN	Prevention and Response to Violence, Abuse and Neglect – a division of NSW Health
PASAC	Police Aboriginal Strategic Advisory Committee
PCH	Person Causing Harm
POI	Person of Interest
PWDA	People with Disability Australia
Recorded criminal interview	An interview conducted by the NSW Police Force for the purposes of conducting a criminal investigation
ROSH	Risk of significant harm
Royal Commission	Royal Commission into Institutional Responses to Child Sexual Abuse
SAIK	Sexual Assault Investigation Kit
SAPOL	South Australia Police

SARA	Safety and Risk Assessment (includes Risk Re-Assessment)
SAS2	Secondary Risk of Harm Assessment
SAS	Sexual Assault Service, NSW Health
SCAN Team	Suspected Child Abuse and Neglect Team, Queensland
SCC	State Crime Command
SCHN	Sydney Children's Hospitals Network
SDM	Structured Decision-Making
SMG	JIRT State-wide Management Group
SOCIT	Sexual Offence and Child Abuse Investigation Team, Victoria
SOPS	Standard Operating Procedures
ToR	Terms of Reference
TTO	Therapeutic Treatment Order, Victoria
WAS	Witness Assistance Service, Office of the Director of Public Prosecutions, NSW
Witness intermediary	A person appointed (pursuant to Division 3, ss88 of the *Criminal Procedure Act 1986*) to communicate and explain: • to the witness, questions put to the witness, and • to any person asking such a question, the answers given by the witness in replying to them, • and to explain such questions or answers so far as necessary to enable them to be understood by the witness or person in question.
Wood Inquiry	Special Commission of Inquiry into Child Protection Services in New South Wales, 2008
Wood Royal Commission	Royal Commission into the New South Wales Police Service, 1997
WWCC	Working With Children Check
Young person	A person who is between 16 and under 18 years of age.

Annexure A – External stakeholders and experts we consulted

Listed below are the external bodies and persons consulted for the JIRT review.

Aboriginal Child, Family and Community Care State Secretariat (NSW) (AbSec)

- Chairperson, Dana Clarke
- Manager, AbSec – Good Practice Unit, Dana Hogg
- Practice Support Officer, AbSec – Good Practice Unit, Wade Mahoney

Aboriginal Communities Matter Advisory Group (ACMAG)

- Chairperson ACMAG and Director, Yamurrah, Rowena Lawrie
- Acting Director, ECAV, Joanne Campbell
- Senior Aboriginal Child Protection & Violence Prevention State-wide Educator, Education Centre Against Violence (ECAV), Ivan Clarke
- Aboriginal Counsellor, Rural New Street Western, Margaret Forrest
- Aboriginal Family Health Worker – Dubbo Neighbourhood Centre, Trevor Forrest
- Consultant and Educator, Pam Greer
- Senior Educator – Aboriginal Programs, ECAV, Sigrid Herring
- Aboriginal Family Health Worker, Senior Educator/Team Leader ECAV, Marlene Lauw
- Senior Educator, ECAV, Victor Morgan
- Aboriginal Counsellor, New Street Sydney, Julie Shelley
- Senior Educator, ECAV, Natalie Short
- Aboriginal Family Clinician/Caseworker Rural New Street Tamworth, Tiffany Stacey
- Clinical Advisor, Sydney Children's Hospital Network, Dale Tolliday OAM
- Acting Associate Director, ECAV, Catharina Webb
- Independent, Lee Murphy
- Independent, Laurel Russ

Association of Children's Welfare Agencies

- Deputy Chief Executive Officer and Director Policy and Membership, Dr Wendy Foote

Catholic schools sector

- Diocese of Parramatta (OSPS), Nick Randall and Asante Viswasam
- Catholic Archdiocese of Sydney, Karen Larkman and Tania Orsienko
- Catholic Education, Archdiocese of Canberra Goulburn, Agata Pukiewicz
- Catholic Education, Broken Bay, Tamara Hughes and Cathy McClellan
- Catholic Education, Parramatta, John Honan
- Catholic Education, Wilcannia-Forbes, Steven Reissig
- Catholic Education, Wollongong, Christa Sangster
- Catholic Education, Wollongong, Margaret Chittick
- Catholic Commission for Employment Relations (CCER), Nevine Piperides
- Catholic Education Office, Bathurst, Anne Burke
- Catholic Diocese of Lismore, Toni Russell
- Catholic Schools Office Armidale, Stefan Sorensen
- Catholic Schools Office, Broken Bay, Marina Best
- Catholic Schools Office, Lismore, John Thompson
- Catholic Schools Office, Wagga Wagga, Sue Delaney
- Sydney Catholic Schools, Jamon Thomas
- Sydney Catholic Schools, Sandy Reynolds
- Zimmerman Services, Maitland-Newcastle, Zoe Trypas
- Diocese of Wagga Wagga, David Collie

Children and Young People with Disability Australia

- Chief Executive Officer, Stephanie Gotlib

Combined Schools Sector

- Association of Independent Schools, David Pryde and Cara Langley
- Christian Education National, Heritage Christian School, Geoff Brisby
- Christian Schools Association, Cassandra Pendlebury and Richard Taylor
- Department of Education, Employee Performance and Conduct Directorate (EPAC), Jane Thorpe and Victoria Myerscough

Department of Education

- Director, Child Wellbeing Unit, Trisha Ladogna
- Director, Regulatory Strategy and Performance, Early Childhood Education, Graham Humphreys
- Director, Student Engagement and Interagency Partnerships, Robyn Bale

Department of Family and Community Services

- Secretary, Michael Coutts-Trotter
- A/Deputy Secretary Operations, Northern Cluster, Simone Walker
- Executive Director, Office of the Senior Practitioner, Kate Alexander
- Executive Director, Statewide Services, Clare Donnellan
- Director (Operations) JIRT, Grace Romeo
- Director (Strategy and Policy) JIRT, Cherie Smith
- Former Director JIRT, Statewide Services Mary Maher
- Director, Cross Cluster Issues Management Team, Briony Foster
- Director, Child Protection, Legal, Catherine Samuels
- Principal Project Officer, JIRT Statewide Services, Patricia Aliferis
- Manager Client Services, James Price (FACS JIRT, Bourke)
- Manager Casework, Leigh Bennett (FACS JIRT, Bourke)

Department of Justice, Victims Services

- Commissioner of Victims Rights, Mahashini Krishna
- Senior Manager, Kristy Crepaldi

Disability Council NSW

- Chair, Mark Tonga

District Court of New South Wales

- Her Honour, Judge C M Traill
- Her Honour, Judge J A Girdham SC

Educational Centre Against Violence (ECAV), NSW Health

- Acting Director, ECAV, Joanne Campbell
- A/Associate Director, ECAV, Catharina Webb
- Aboriginal Family Health Worker, Senior Educator/Team Leader ECAV, Marlene Lauw
- 15 Aboriginal workers at ECAV Certificate IV training in Tweed Heads, NSW

Juvenile Justice

- Executive Director, Melanie Hawyes

NSW Bureau of Crime Statistics and Research

- Information Service, Jessie Holmes
- Information Service, Kylie Routledge

NSW Health

- Deputy Secretary, Strategy and Resources, Dr Nigel Lyons
- Director, Prevention and Response to Violence, Abuse and Neglect, Lorna McNamara
- A/Director, Prevention and Response to Violence Abuse and Neglect, Dr Sally Gibson
- Senior Clinical Advisor, Child Protection and Wellbeing, Professor Graham Vimpani
- Director Child Wellbeing NSW Health, Sydney Children's Hospitals Network, Rosemary Fitzgerald
- Acting Director Child Wellbeing, Deanne Dale
- Manager, Prevention and Response to Violence Abuse and Neglect Unit, Jenny Marshall

- Manager Children and Violence Prevention, Central Coast Kids and Families, Donna Curtis
- Senior Policy Officer, JIRT, Prevention and Response to Violence Abuse and Neglect, Louise Wordon
- Senior Analyst, Data Management, Prevention and Response to Violence, Abuse and Neglect, Sen Lin
- Senior Health Clinician, Mignon Aistrope
- Acting District Manager, Sexual Assault Services & JIRT Health, Yulia Taylor

New Street Adolescent Service Program

- Clinical Advisor, Sydney Children's Hospitals Network, Dale Tolliday OAM

NSW Police Force

- Detective Superintendent Greig Newbery APM, Commander, State Crime Command, Child Abuse Squad
- Detective Chief Inspector Peter Yeomans APM, Acting Commander, State Crime Command, Child Abuse Squad
- Detective Chief Inspector Andrew Waterman APM, State Crime Command, Child Abuse Squad
- Detective Chief Inspector Michael Stoltenberg, Zone Manager, Child Abuse Squad Western
- Chief Inspector Sean Hannen, Manager, Planning Team, Performance Improvement & Planning Command
- Detective Inspector Tom Barnes, State Crime Command, Child Abuse Squad
- Acting Intelligence Manager, Rachelle Graves, State Crime Command, Child Abuse Squad
- Detective Sergeant Simon Peddle

Office of the Director of Public Prosecutions

- Senior Counsel, Gina O'Rourke
- Manager, Witness Assistance Service, Gavin Rowan

Office of the NSW Advocate for Children and Young People

- NSW Advocate for Children and Young People, Andrew Johnson
- Senior Policy Officer, Kelly Tallon

People with Disability Australia

- Advocacy Project Manager, Violence Prevention, Dr Jessica Cadwallader

Royal Commission into Institutional Responses to Child Sexual Abuse

- Special Counsel, Leigh Sanderson
- Policy & Research, Mark Johnstone

University of South Australia

- Deputy Director, Australian Centre Child Protection, Professor Leah Bromfield
- Post-Doctoral Research Fellow, Australian Centre for Child Protection, Dr James Herbert

The University of Sydney

- Professor of Socio-Legal Research and Policy, Sydney Law School, Dr Judith Cashmore AO

Victoria, Department of Health and Human Services

- Senior Program Officer for the Victorian Therapeutic Treatment Board and Department of Health Human Services, Lisa Rodda

Victoria Police, Sexual Offences and Child Abuse Team

- Senior Sergeant Brett Meadows and Senior Program Advisor, Laura Meese

Western Australia Consultations

Consultations held with Multiagency Investigation and Support Team interviewers, Child Protection and Family Support staff, Child and Family Advocates and Child Interviewers.

Department of Attorney-General (WA)

- Coordinator, Child Witness Service, Christine White

Department of Child Protection and Family Support

- Director of Child First and Crisis Care, Julie Newsham
- Interview Team Leader, Mike Bastow
- in-house CPFS District worker for MIST, Caitlin Sullivan
- CPFS Interview, Anastasia Naumova
- Armadale Team Leader, Rory Cornelius

George Jones Child Advocacy Centre, Parkerville Children & Youth Care

- Chief Executive Officer, Basil Hanna
- Director, Amanda Patton

Princess Margaret Hospital for Children

- Elizabeth Sorenson (A/Manager, Child Protection Unit, Princess Margaret Hospital for Children)
- Dr Alice Johnson (Head of Dept, CPU, PMH)

Western Australia Police Force

- Detective Inspector Mark Twamley, Child Abuse Squad, Sex Crime Division
- Detective Inspector Paul Boult, Sexual Assault Squad, Sex Crime Division
- Detective Senior Sergeant Tim Lines
- Detective Senior Sergeant Gary Saunders
- Detective Sergeant John McTernan

The Advocate's Gateway, London, United Kingdom

- Co-founder and Chair of The Advocate's Gateway, Professor Penny Cooper

NSW Ombudsman
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