Ombudsman
New South Wales

NSW Ombudsman submission to the Legislative Council General Purpose Standing Committee No.2 Inquiry into Child Protection

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1 About this submission

The NSW Ombudsman's office welcomes the opportunity to provide a submission to the Committee's inquiry into child protection in NSW.

As the Committee is aware, the NSW Ombudsman has a broad range of functions relating to the delivery of child protection services in NSW. These functions are outlined in the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and Part 3A of the *Ombudsman Act 1974*.

Under CS-CRAMA, we have a broad set of functions in relation to protecting children. These functions include (but are not limited to):

- Promoting and assisting the development of standards for delivering community services, and educating service providers, clients, carers and the community generally about those standards.
- Monitoring and reviewing the delivery of community services and related programs, including making recommendations for improvement in the delivery of community services and promoting the rights and best interests of service users.
- Inquiring, on our own initiative, into matters affecting service providers, visitable services and persons receiving or eligible to receive a community service.
- Receiving, assessing, resolving and investigating complaints and working with agencies to improve their complaint handling procedures.
- Reviewing the situation of individual children or groups of children in out-of-home care.
- Reviewing the causes and patterns of child deaths and identifying ways in which these deaths could be prevented or reduced.

Our combined CS-CRAMA and Part 3A oversight functions assist us in identifying systemic issues that specifically relate to the out-of-home care system, as well as those which intersect with the broader child protection system.

Throughout this submission we also discuss our functions relating to the monitoring and assessment of Aboriginal programs (Part 3B) and the protection of people with disability (Part 3B) where relevant.

This submission addresses the Committee's terms of reference; however, we have provided more detailed commentary in relation to those issues where our office has had significant involvement.

- Children and young people in out-of-home care
- Aboriginal children and families
- Victims of domestic and family violence
- Children and young people at risk of educational neglect
- Vulnerable older children and adolescents, including children who are homeless
- Children and young people with a disability

We also discuss a range of systems issues including the current capacity of the child protection system; issues relating to the safety and wellbeing of children in out-of-home care; information sharing; and place-based service delivery.

2 The capacity of the child protection system

We have examined the overall 'health' of the child protection system in two reports to Parliament – *Keep them safe?* in 2011 – and in a follow up report, *Review of the NSW Child Protection System: Are Things Improving?* in 2014.

2.1 *Keep them safe?* – Key findings and recommendations

The legislative and structural reforms introduced through *Keep Them Safe*[1] in 2010 following the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry), were intended to allow Community Services to concentrate its efforts on seeing children at risk of 'significant' harm. The suite of *Keep Them Safe* reforms introduced substantial changes to the systems for reporting concerns about the safety, welfare and wellbeing of children and young people.

Our 2011 report examined whether there was improvement in the post-reform capacity of the child protection system after the reporting threshold was lifted from 'risk of harm' to risk of significant harm.

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 Community Service Centres (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 risk of significant harm (ROSH).

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 closure rate due to competing priorities remained unacceptably high at 25% of all reports screened in by the Helpline.

In outlining our concern about these findings, we also acknowledged that the ROSH face-to-face response rate is not the only indicator of whether a child protection system is functioning effectively. In this regard, we stressed that an efficient child protection system must be able to identify those children who are most in need in order to direct an appropriate level of resources to this group. While a single piece of intelligence may be able to identify that extreme risk exists, an effective 'intelligence-driven' child protection system involves the systematic analysis of risk-related information held by key agencies, including identifying each agency's high-end users. We argued that this approach is consistent with the notion of 'shared responsibility' for child protection, which was central to the recommendations of the Wood Inquiry.

We made a series of recommendations aimed at improving capacity and accountability, including:

- improved public reporting on responses to risk of significant harm reports
- filling positions in rural and remote areas; setting average caseload and case completion targets; enhancing caseworkers supervision and support; and lifting staff morale staff
- 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

[1] 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 OOHC services.

- with key partners, adopting and implementing an intelligence driven child protection system.

FACS supported our recommendations, and acknowledged that its capacity to respond to children at risk of significant harm was inadequate. FACS outlined its plans to maximise caseworker time in the field; improve its IT systems; and other measures to improve overall productivity. FACS also committed to employing a full complement of caseworkers by January 2012.

2.2 *Are things improving?* – Key findings and recommendations

In our follow up report, we examined progress made by FACS in lifting the ROSH response rate and filling caseworker vacancies. We also discussed a number of issues relating to the quality of intra and inter agency child protection practice. In addition, we highlighted (as we had in earlier reports),[2] that poorly integrated and inefficient service systems were the norm in many communities, and advocated for the adoption of a place-based approach to delivering community services, particularly in high need locations.

2.2.1 Progress made – new initiatives

We reported on a range of significant improvements made by FACS since our last report; these changes better equipped FACS to assess, and accurately report on, its capacity to meet demand – they included:

- enhancements to IT systems to support more efficient risk identification and management
- improvements to governance structures and accountability measures, including capacity to measure, monitor and report on issues which impact on the ability to respond appropriately to ROSH reports
- establishing the Office of the Senior Practitioner (OSP) in 2012 to provide leadership in child protection practice by reforming and improving casework practice and systems; providing expert advice and training to practitioners; and supporting the implementation of 'Practice First' pilots in a number of locations across NSW[3]
- implementing a new Performance Reporting Framework and a renewed Quarterly Business Review process for monitoring district performance, and
- the introduction of a Caseworker Dashboard to provide a snapshot of the caseworker workforce and ROSH response by district.

2.2.2 Capacity to meet risk of significant harm demand

While acknowledging that some progress had been made in lifting the ROSH response rate from 21% to 28%, we also noted that there was still a significant gap to bridge before the response rate was at an acceptable level. (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%. In this regard, we were advised by FACS that the 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 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

[2] See for example, NSW Ombudsman, special report to Parliament, *Inquiry into service delivery to the Bourke and Brewarrina communities*, 2010.
[3] Practice First was an important element of the drive to improve quality and consistency throughout Community Services. The initiative is based on a multidisciplinary approach with a strong focus on enhancing practice culture through active engagement with very vulnerable and high risk families.

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.

Following significant public discussion about caseworker numbers that occurred leading up to the release of our report, we were pleased that FACS had, by then, provided greater transparency about caseworker numbers and vacancy rates through its publication of the quarterly *Caseworker Dashboards* on its website. We also signalled the importance of FACS not just tracking overall vacancy rates but directing its attention to filling long-standing vacancies in those districts with significantly higher rates, such as Western NSW.

Our report also stressed that FACS initiatives alone were unlikely to enable it to adequately meet ROSH report demand. We argued that it was important to expand the roles of other agencies, including the non-government sector, to improve the response to ROSH reports and to vulnerable families more generally. We said that more effective collaborative work could potentially:

- improve the identification of those most at risk
- lift the direct response rate, and
- improve the effectiveness of support provided to those below the ROSH threshold and therefore, potentially lower the number of ROSH reports over time.

While it was, and still is, clearly necessary to further increase the number of children at ROSH who receive a child protection response, we observed that there also needed to be an emphasis on ensuring that a 'quality' response was provided.

2.2.3 Improving the quality of interagency child protection practice

In light of the capacity constraints across the child protection system, we argued for the adoption of more innovative approaches. We said there were a number of ways agencies using a shared approach in working with high-risk families could strengthen their practice and expand their roles to improve the responsiveness of the overall service system. We also observed that it is particularly vital to explore flexible and innovative shared practice responses because of the expanding role of the NGO sector; this included the transfer of OOHC placements, together with NGOs increasingly working with families with complex needs, where risks to children can be high.

In addition, our report noted common and recurrent problems that we continued to see through our oversight, that also demonstrated the need to enhance communication and related case management responses between all relevant agencies at the local level, including:

- agencies failing to provide or request critical child protection related information from each other
- a lack of clarity on the part of agencies with respect to their joint child protection responsibilities (this is particularly the case with high risk cases), and
- the failure of agencies to strategically involve each other in decision-making around child protection cases at critical points in time.

We also recommended that a robust quality assurance framework was required to assess and drive ongoing improvements to NGO practice. In this regard, we noted FACS was in the process of developing a Quality Assurance Framework to monitor outcomes for children in OOHC. And, that

FACS was intending to implement a new contract governance approach that set out clear expectations of NGO partners in relation to the delivery of services.

In relation to key government human service agencies – NSW Police, Education and Health – we highlighted that they had undertaken a range of important initiatives, and with FACS, had improved collaborative practice. However, we went on to note discrete areas (which we cover later in this submission) where there was scope for further improvement, including:

- the identification and exchange of relevant information between Police and FACS; in particular, in relation to serious violent offenders, high risk domestic violence offenders and victims, and welfare checks
- the identification and responses to educational neglect, and
- child protection practices in the health sector, such as responses to children of a parent with mental illness.

Given the significant scope for collaboration between FACS and other agencies in working with high-risk families, we recommended that a clear framework be developed to guide interagency practice at both a local and central level to ensure that this work is of a high quality, together with comprehensive systems to monitor, and report on, the nature of outcomes delivered by funded agencies.

We also recommended that the Department of Premier and Cabinet consider our observations as part of its ongoing work to develop and implement a place-based approach to service delivery. In doing so, we argued that to effectively drive place-based work, it is important to have well formulated and sophisticated community engagement strategies, governance arrangements, and related accountability mechanisms.

Finally, we recommended that FACS report publicly every 12 months from the date of our report on its progress in implementing our recommendations.

2.2.4 FACS' response to our 2014 report – significant developments

FACS indicated its support for our recommendations and agreed to report on the progress made in implementing them. In this regard, FACS published its first progress report in April 2015 – a copy can be found on FACS' website.[4]

The FACS 2015 progress report not only addresses policy and practice concerns that we identified in our report, but also takes account of 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.

2.2.4.1 Safe Home For Life

We have summarised below some of the more significant developments in response to our report.

Safe Home For life is a four year program aimed at strengthening the child protection system through a variety of measures, including 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

[4] FACS website, 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

- providing support earlier to families to prevent their children entering care, and
- providing greater permanency for children and young people in care.

The reforms also emphasise the use of place-based approaches to delivering child protection services. As we discuss further in section 8 under the banner of 'co-design', FACS is giving its district directors greater flexibility to use their resources and services in their districts to better meet the needs of their local community. A number of co-design projects are being implemented across the state.

FACS has also put in place a number of additional measures to address both demand and quality. These include:

- Developing a new child protection database designed to collect and share key data with other agencies – ChildStory.
- Decreasing vacancy rates at the time of our report from 11% to 5% (as at the December 2014 quarter).
- Implementing a range of recruitment initiatives focusing on attracting and retaining caseworkers in hard to fill locations.
- Rolling out a range of practice improvement initiatives, in light of concerns raised by Ombudsman case reviews, in the Western District – for example:
    - filling staff vacancies
    - establishing the Mobile Child Protection Unit for two years with the aim of improving responses to ROSH reports
    - establishing the Bourke Community Hub located on a FACS site to provide a one stop shop for families to access supports, and
    - establishing the Bourke case coordination committee to strengthen case management by providing joint agency responses to high need children and families.
- Engaging the Parenting Research Centre, the Social Policy Research Centre at the University of NSW and the University of Melbourne to evaluate its Practice First Model – the draft evaluation report was due in June 2015.
- Creating 73 caseworker support positions to work with Family Referral Services.

In relation to our recommendation about the need for FACS to develop and implement interagency operational frameworks to enhance and more clearly define the role of partner agencies in relation to their work with high risk families, FACS indicated that Safe Home For Life was not intended to establish an 'interagency operational framework'. Instead, it envisaged that the district led co-design process would focus on 'integrated intervention and assessment'.

However, FACS also reported that it was developing and implementing 'a number of operational frameworks' designed to improve interagency collaboration and strengthen the capacity of partner agencies to respond to high risk families. These frameworks include strategies to promote practice improvement and improve the rate of face-to-face assessments of ROSH reports. For example:

- Co-design pilots which bring together local stakeholders in a District service system to work together to tailor solutions and respond to the needs of local communities.
- Expanding the 'out-posted caseworker pilot' which involves posting FACS caseworkers to a further four Family Referral Service locations, as well as having caseworkers operate out of various other NGOs.[5]

[5] Such as: domestic and family violence services, a disadvantaged housing estate, a public hospital with Children's Social Service workers, and at two community one-stop-shops – Coniston and Bourke.

- Establishing complex case panels in all districts – five districts were involved in developing a monitoring and evaluation framework for case panels.
- Utilising NGOs to respond to referrals to the Brighter Futures program – from July 2014, the Brighter Futures target group was changed to include eligible children and families where the ROSH threshold has been met (prior to this NGOs worked with 'non-ROSH families').

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.[6]

Earlier this year, we were invited to attend (with observer status) FACS' Safety and Permanency Advisory Group[7] (SPAG) – the new state-wide strategic/cross-sector governance group – set up this year to provide leadership on the design and delivery of services in partnership with government agencies and the NGO sector. The SPAG will report to the Child Protection Taskforce on the outcomes of Safe Home For Life initiatives and relevant Premier's Priorities under *NSW State Priorities Making It Happen*. The SPAG is supported by a number of cross sector working/advisory groups: Aboriginal Safety and Permanency State-wide Advisory Group: Service Delivery System Working Group; and Permanency Strategy Leadership Advisory Group.

2.2.5 Continuing to track progress

Over the past year, FACS has continued to brief our office on the progress of significant child protection system initiatives, particularly those relevant to the issues and recommendations contained in our 2014 report. We meet quarterly with the FACS Secretary and deputy secretaries to track progress and address critical concerns stemming from our oversight.

On a related note, we have also worked with FACS over the past year to establish the 'FACS/Ombudsman Integrated Governance Framework' (IGF). A key component of the IGF is a joint document used to track FACS' progress towards implementing systemic reforms and addressing discrete practice issues that we have identified from our oversight work. The Auditor-General noted the importance of developing this governance framework in his 2014 FACS financial audit report. We have discussed with FACS the scope to make a version of the IGF public for the purposes of promoting transparency and accountability.[8]

[6] FACS website, FACS 2015 Progress report in response to the Ombudsman's report – Review of the child protection system –Are things improving? Accessed 30 July 2016.
[7] Membership includes representatives from FACS, ACWA, AbSec, NSW Family Services, CREATE, NSW Health, NSW Justice, NSW Police, Department of Education, and the Children's Guardian.
[8] NSW Auditor-General, NSW Auditor-General's Report, Financial Audit, Volume Nine 2014, Focusing on Family and Community Services, November 2014.

3 The child protection system – future challenges and opportunities

As we discuss throughout this submission, the child protection system has undergone more than a decade of extensive reform. There is now an increased focus on ensuring that investments in child protection, early intervention and prevention and OOHC, deliver value for money. This approach is evidenced by the use of social benefit bonds directed at achieving specific child protection outcomes, such as restoration and adoption.

While significant efforts have been made by FACS and its agency partners to improve the efficiency of the child protection system and the quality of child practice since we released our 2011 report, there is still more to be done.

Despite the improvements made by FACS to its own systems and practices, the caseworker response rate for ROSH reports remains unacceptably low at 29%.[9, 10] As of the last published data, even the best performing district was only able to provide a face-to-face response to 40% of the children reported to be at ROSH.[11] And while there has been an increase over time in the number of children seen by FACS,[12] this gain has been off-set by FACS having to deal with a 20% increase over the last two and a half years in the number of children reported to be at ROSH.[13]

It is important to note that FACS has succeeded in reducing its overall staff vacancy rate (from 11% at the time of our last report to 3%).[14, 15] However, as the data shows, even with much lower vacancy rates, FACS has been unable to significantly lift the ROSH response rate.

In our 2014 report to Parliament, we said FACS needed to publish more information on reports closed due to competing priorities, so that the community could ascertain the nature of the response given to reports. Although FACS now publishes more detailed quarterly and annual data linked to a range of child protection measures, the type of responses provided to ROSH reports that are 'closed due to competing priorities,' remains somewhat unclear.[16] In our view, it may be useful for the Committee to explore the extent to which the community ought to be able to access more meaningful information about the nature of responses provided to those children reported to be at risk of significant harm (regardless of whether FACS or another agency delivers the response).

We believe that the overall data confirms our observation in 2014, that meeting ROSH demand cannot be achieved by FACS initiatives alone. It is therefore critical that the various co-design initiatives unfolding in districts, such as the Central Coast and Western Sydney which are discussed

[9] The current state-wide average for children receiving a face to face assessment is 29% of 75,423 unique children reported to be at ROSH. Source: FACS Caseworker dashboard – March 2016.
[10] The reporting on the Caseworker Dashboard is now based on 'children' who received a face to face assessment' as opposed to 'reports' which received a face-to-face response. Therefore, the ROSH response rates from our first two reports to Parliament are not directly comparable with the current published data. Source: FACS Caseworker dashboard – March 2016.
[11] Sydney had the highest response rate, with 40% of the 2,638 unique children reported to be at ROSH receiving a face-to-face response.
[12] Figure taken from FACS Caseworker dashboard – March 2016.
[13] In the last quarter of 2012/13, 17,981 unique children were reported to be at ROSH. As at December 2015, this figure had increased to 21,547 (representing a 20% increase). Source: FACS Caseworker dashboard – March 2016.
[14] The vacancy rate represents the difference between the funded full time equivalent (FTE) and actual FTE during the reference period. Source: FACS Caseworker dashboard – March 2016.
[15] The caseworkers numbers reflect both frontline and specialist caseworkers working across community services, including in statutory child protection and OOHC. FACS has also used a resource allocation model to deploy caseworkers where they are most needed, reflecting changes in demand over time.
[16] For example, FACS notes on its data report website that '[T]hose office-based reports closed due to competing priorities may receive additional work prior to closure.' FACS' published data also now includes seven categories of response to ROSH reports however each category does not identify the proportion of reports that were 'closed due to competing priorities', so it is clear what type of action was taken prior to closure.

below, are closely examined to see whether they lead to more at risk children being seen by FACS or another agency, together with the provision of a quality response.

The Macarthur Intake and Referral Service trial in Western Sydney District, which commenced in October 2014 and has recently been extended until December this year, is a 'local [rather than centralised] helpline' that refers reports to local services when FACS determines that there is no risk of significant harm. The service aims to reduce child protection reports and improve outcomes for children by creating an integrated local services network, and gives advice to stakeholders on applying the Mandatory Reporter Guide. An initial evaluation has commenced but the findings have not yet been released. More recently, FACS advised us that it is considering extending the trial to include certain ROSH reports which are allocated a less than 10 day response time.

In November last year, the Central Coast district commenced trialling the multi-agency local intake and service point centre, which is staffed by FACS, Education and Health with input from Police. The centre aims to provide better service responses, including more comprehensive and timely joint assessment of child protection reports that are diverted from the central Helpline. Where risks do not require a statutory response and it is appropriate to do so, intake staff will assist reporters to explore options for continuing to support the child and family. For reports that do not meet the ROSH threshold – which constitute nearly half of all reports received in the district – staff work with other co-located services to support families to respond quickly and prevent them from having to tell their story multiple times. This approach is intended to free up caseworkers to deal with the most serious cases.

The most recent published data is too early to show the impact of these initiatives. However, if they prove to be successful, it will be critical that the key elements of these approaches are adapted for rollout elsewhere.

Looking for opportunities to better integrate existing structural components of the child protection system, such as Family Referral Services, should also be considered. For example, this could include in locations such as Hunter-New England (which has the highest number of children reported to be at ROSH in the state), exploring whether the role of the Family Referral Service[17] could be expanded from simply being a service referral point for children and families below the statutory threshold, to also working in an integrated way with government agencies in supporting families identified as being 'ROSH'.

In addition, FACS also needs to be confident that its increased reliance on the NGO sector is supported by appropriate quality assurance systems. In this regard, it will be important to collect and report on the actual outcomes being delivered by the NGOs which are working with families across the whole spectrum of need (from those who might require a statutory child protection response, to those in need of early intervention and support). And as the role of the NGO sector expands, the quality of interagency practice will need to be increasingly examined to ensure government agencies and NGOs are working effectively together. As we noted in our last report, if there is a lack of clarity around roles and responsibilities, children can fall through the cracks. Our child death review work continues to demonstrate that clarity in this area is critical, at both a casework and broader systemic level.

[17] FRSs assist children and young people who do not meet the statutory threshold for a child protection intervention but would benefit from accessing support to address current problems and prevent future escalations. FRSs provide information and links to vulnerable children and their families to a range of support services in their local areas. Source: www.pathfinders.ngo/projects/family-referral-service-frs/

4 Children and young people in out-of-home care

A number of the Committee's terms of reference relate to the provision of out-of-home-care (OOHC) and the associated allocation of funding and resources. In this section, we discuss our role in oversighting OOHC and make a number of observations about the reforms that are currently underway to improve outcomes for children in OOHC in NSW. We discuss issues relating to carers and the safety of children in care in the next section.

The NSW Children's Guardian has the lead role in relation to the accreditation and monitoring of designated agencies delivering OOHC. The Office of the Children's Guardian (OCG) works closely with OOHC agencies to improve the quality of care they provide, principally through ensuring compliance with the *NSW Child Safe Standards for Permanent Care*.[18] The OCG also has several other related functions, including administering the WWCC check; the operation of the Carers Register; and promoting the development of child safe organisations. Our office works closely with the OCG to ensure that we carry out our functions in a complementary manner (we discuss this further in the context of the Working With Children Check in section 6).

Although we have a broad oversight mandate in relation to the child protection system, given the lead role played by the Children's Guardian in the OOHC area, it is critical that we target our resources towards monitoring the OOHC system from a high level, structural perspective together with responding to discrete systemic issues which we identify from the exercise of our reportable conduct and CS-CRAMA functions.

4.1 The out-of-home care population

As at the end of the first quarter of 2015-16, there were 17,951 children and young people in OOHC. More than one-third (6,618 or 37%) were Aboriginal. There were 8,407 (47%) in relative/Aboriginal kinship care placements, 7,953 (44%) children in foster care placements, and 579 (3%) in residential care.[19]

Like Aboriginal children and young people, children and young people with disability are over-represented in the OOHC system.[20] In February this year, FACS advised us that recent sampling work had indicated that around 12% of children in OOHC have a disability.

Compared with the same quarter last year, there was a 13.7% increase in the number of children entering care, but a 6.5% decrease in the overall number of children in care. This decrease can be partially explained by the introduction in October 2014 of guardianship orders, which led to a substantial number of children leaving OOHC in the second quarter of 2014-15 (as at 30 June 2015, there were 2,418 children on guardianship orders).[21]

4.2 The transition of OOHC to the NGO sector

The OOHC landscape has changed dramatically over the eight years since Justice Wood, in his 2008 report on the Special Commission of Inquiry into Child Protection Services, recommended that the management of OOHC be transferred to the NGO sector.

[18] Office of the NSW Children's Guardian, *NSW Child Safe Standards for Permanent Care*, November 2015.
[19] FACS quarterly report on services for children and young people, Quarter 1, 2015-2016.
[20] Senate Community Affairs References Committee Out of Home Care Inquiry, August 2015.
[21] FACS quarterly report on services for children and young people, Quarter 1, 2015-2016.

The transition of OOHC services to the NGO sector started in early 2012. Since then, 57% of OOHC placements have been transferred to the NGO sector.[22] FACS aims to transfer all children in statutory care to the NGO sector by mid-2022.

The transition has led to an increase in the number of designated agencies providing OOHC and a rapid expansion of existing agencies; in particular, across the Aboriginal OOHC sector. FACS has been working with the peak bodies – ACWA and AbSec – on a variety of initiatives aimed at expanding and strengthening the capacity of the NGO sector. As we discuss later in section 9, we have targeted our attention towards supporting new and rapidly expanding OOHC agencies to fulfil their responsibilities to prevent, detect and respond to allegations of child abuse against their employees (including foster carers) under the reportable conduct scheme.

In September 2015, the NSW Auditor-General released his performance audit report – *Transferring out-of-home care to non-government organisations* – which examined how well FACS had developed the OOHC sector and managed the transfer of services to NGOs. While the audit found that FACS had invested 'considerable effort into developing the sector and progressing towards its goal of transferring statutory care to NGOs', it was difficult to assess whether the outcomes for children in care had improved. In this regard, the report acknowledged the work underway to develop a quality assurance framework for OOHC, which we discuss further in section 4.

4.3 Reforming the delivery of OOHC

As noted earlier, the Safe Home For Life reforms were intended to reduce the number of children and young people entering the statutory out-of-home care system, and increase the number of children and young people exiting the system through restoration, guardianship or adoption. The reforms emphasise the need for early decision-making around permanency – including options such as guardianship or open adoption. Guardianship orders were introduced as part of the suite of initiatives to support the Safe Home for Life reform agenda. These orders aim to give children and young people greater stability without cutting 'legal ties' to their family. In terms of legal status, the child is regarded as being in the care of their independent guardian; not in foster care.

The Permanent Placement Principles that were introduced into the *Children and Young Persons (Care and Protection) Act 1998* in 2014, are intended to guide decision-making around providing a safe and stable home for children and young people, and setting timeframes for when the Children's Court must decide if returning a child to their parent is possible.

In circumstances where restoration is not possible, the preferred order for the permanent placement of a child or young person is guardianship, open adoption (for non-Aboriginal children) and only where these options are not appropriate or possible, parental responsibility to the Minister and placement in foster care.

Over the past two years, FACS has been undertaking several important initiatives to facilitate the delivery of better outcomes for children and young people in OOHC. A number of these initiatives are informed by evidence-based models of care largely from the United States, which are focused not only on securing safety and permanency for children taken into care, but also on ensuring OOHC agencies are addressing the cumulative effects of complex trauma and acute stress experienced by many children who come into care. Over the past decade or so, the OOHC population dropped dramatically in a number of US states as a result of 'child wellbeing' focused OOHC models being implemented. These results were largely achieved by implementing performance-based contracting with NGOs which were aligned to specific wellbeing outcomes (as

[22] FACS Submission to the Legislative Council Inquiry into Child Protection, July 2016.

well as safety and permanency). The NGO contracts included incentives to achieve better outcomes for children; adoption and guardianship were subsidised; and the departments reinvested in higher performing NGOs.

4.3.1 The Pathways of Care Longitudinal Study

This study is examining the 'pathways of children and young people during their time in OOHC' to help identify the factors that influence their experience and ultimately, the outcomes for them. The study is the first large scale prospective longitudinal study on OOHC of its kind in Australia.[23] The study cohort is all children aged 0 to 17 years entering OOHC, on interim and final orders, within an 18 month period between May 2010 and October 2011 (a total of 4,126 children and young people). The aim is to use the results of the study to improve the trajectory for children and young people in OOHC.

FACS is leading and funding this study which will cost $7.5 million over five years ($1.5 million committed per year).[24] In light of the significant investment by FACS, it will be important to see how FACS uses the data obtained from this very comprehensive research to drive improvements in future OOHC practice.

4.3.2 Quality Assurance Framework for OOHC

FACS commissioned the Parenting Research Centre to develop a Quality Assurance Framework (QAF) for OOHC as part of its Safe Home For Life reforms.

The aim of the QAF is to identify and measure specific wellbeing outcomes for children and young people in OOHC, and to give caseworkers a tool to guide their practice and more reliably identify areas of support. The QAF will include a set of safety, permanency and wellbeing outcomes for individual children in OOHC across the following domains:

- Safety and permanency
- cultural and spiritual identity
- mental health
- cognitive functioning
- social functioning, and
- physical health and development

The QAF has been designed to help agencies use data to inform and improve the services they provide to children in OOHC, and to obtain a better picture of how children are actually faring. The information contained in the QAF will be collected from a range of sources including FACS, Health, Education, NGOs, carers and young people, and it will become a central repository of information about children in care. The intention is to integrate the QAF with the ChildStory database which will be accessible to both FACS and NGOs.

The QAF is designed to complement, not duplicate, the accreditation process driven by the Children's Guardian through the *NSW Child Safe Standards for Permanent Care* compliance program. In this regard, it will be worth debating what the respective roles of FACS (as funder) and

[23] FACS is funding and leading the study with a team of experts contracted to provide advice on the study design and undertake data collection and analysis. The study has significant potential to inform policy, program and service development to achieve the best outcomes for children and young people in OOHC. Source: FACS Submission to the Legislative Council Inquiry into Child Protection, July 2016.

[24] Source: FACS Annual Report, 2014-15, p68.

the Children's Guardian (as regulator), will ultimately be in relation to driving 'quality and better outcomes' for individual children and young people in OOHC.

Last year, the QAF was released by FACS for public consultation.[25] We understand that FACS recently called for expressions of interest from NGOs keen to participate in a trial of the QAF in four sites to test its feasibility and whether it is actually leading to better outcomes for children. The trial is expected to run for 12 months.[26]

For the QAF to deliver on its dual goals, that is, improving casework practice as it unfolds and providing more reliable data on the wellbeing of children and young people in OOHC, a challenge for FACS will be securing the participation of key human service and justice agencies in the collection and reporting of data.

If the QAF is successfully implemented, it has the potential to make a significant contribution towards driving better outcomes for children in care, and greater accountability for FACS and NGOS involved in delivering care.

Finally, once the QAF has been fully implemented, public reporting on the results will be critical.

4.3.3 Recontracting processes for NGOs

In his 2015 report, the Auditor-General observed that the QAF has the potential to provide qualitative evidence about the outcomes for children and young people in OOHC that ideally, should be reflected in the future re-contracting of NGOs. However, he went on to note that the existing performance measures in NGO contracts focus mainly on outputs. The Auditor-General said that having baseline information about children's wellbeing across domains such as health and education would also enable NGOs to be accountable for their contribution to these outcomes. In addition, the Auditor-General noted that the current NGO funding model offers limited incentives for NGOs to initiate adoption or to restore children to their birth families.[27] FACS has since indicated that to address these issues, it will introduce outcome-based contracts with clearer links to the Department's overall goals.[28]

According to FACS' submission to the Committee, the OOHC recontracting process has a focus on rewarding NGOs that are able to demonstrate improved child wellbeing outcomes, including those which lead to more permanent placements for children such as adoption; and where NGOs are operating in a way that is efficient and/or contributes to a more effective and sustainable system overall.[29] We understand that FACS expects the recontracting process to be completed next year.

While we support performance-based contracting, it will be essential that the operating framework is both rigorous and reliable. Furthermore, our comments about the need to clarify the respective roles of FACS and the OCG are also relevant to this issue.

4.3.4 The review of the OOHC system – recent commitments

The NSW Government recently commissioned David Tune, a former federal public servant, to conduct an independent review of the NSW OOHC system. In June this year, the Government

[25] See Parenting Research Centre website, www.parentingrc.org.au. Accessed 21 July 2016.
[26] FACS website, http://www.facs.nsw.gov.au/reforms/children,-young-people-and-families/quality-assurance-framework
[27] NSW Auditor-General, Report to Parliament – Contracting out-of-home care, September 2015, pp9-10.
[28] FACS Submission to the Legislative Council Inquiry into Child Protection, July 2016.
[29] See FACS Submission to the Legislative Council Inquiry into Child Protection, July 2016.

announced that it had adopted the findings of the interim review which found that "the current OOHC system required immediate change and was financially unsustainable".[30]

According to the announcement, the Tune review recommended resourcing the current growth in OOHC while at the same time 'investing substantially in interventions to change the long-term trajectory of the number of young people in care and the outcomes for those young people'. Consistent with our call for intelligence-based child protection practice, the Tune review also highlighted the need to identify families and children that have the poorest outcomes and prioritise targeted intervention initiatives, including:

- New internationally proven, evidence-based intensive preservation and restoration programs for more than a thousand additional families and children.
- Addressing the over-representation of Aboriginal children in care through dedicating 50% of the new intensive family preservation places for Aboriginal children and families.
- Increased funding of $6.4 million in 2016-17 ($11.8 million over four years) for resources and initiatives to improve the rate of adoptions.[31]

The Government also announced that it would be funding a "massive expansion in evidence-based intensive intervention programs, targeting family preservation and restoration." The Government's approach has been informed by the results achieved through a variety of intensive intervention programs that were operating in the City of New York which saw the number of children in foster care drop by half between the years 2000-2010.

The Government has committed more than $1 billion for OOHC in the 2016-17 budget (which includes new funding of $190 million over four years to reform the system and a further $370 million over four years to meet the increased demand for OOHC).

It is clear why the Government has adopted an OOHC policy agenda which is focused on securing permanency for as many children as possible. However, what will be critical is how well the policy is executed. Ultimately, it will be important for any longer term evaluation of the effectiveness of Safe Home For Life to seek to test whether those children who are the subject of restoration, adoption, and guardianship arrangements, are in fact any better off overall than the cohort of children who remain in OOHC.

4.4 Discrete OOHC practice issues

Over recent years, we have been involved in a range of activities focused on improving particular components of the OOHC system. The following activities are discussed below:

- The need to develop a therapeutic framework to guide the delivery of OOHC, including reducing the over-criminalisation of young people in residential care.
- Advocating for the establishment of a reporting scheme to oversee the handling of allegations of 'child-to-child' abuse, starting with children and young people in OOHC.
- Examining, with the OCG and FACS, options to reduce the number of children under the age of 12 in residential care.
- The adequacy of leaving care planning, with a focus on the needs of children and young people with disability.
- Improving processes for identifying and making claims for victims' compensation for children and young people in care.

[30] Minister for Family and Community Services, Media Release, 18 June 2016.
[31] Minister for Family and Community Services, Media Release, 18 June 2016.

4.4.1 Therapeutic responses to children and young people in OOHC

It is well documented that children in OOHC have often experienced significant trauma before entering care, with consequences that affect them deeply into adulthood. It is also widely acknowledged that appropriate and timely therapeutic responses are needed to address trauma and associated behaviours.

Psychologist and former Northern Territory Children's Commissioner, Dr Howard Bath, has written and spoken about the important contribution that "all who interact with traumatised children at home, school and in the community can make to their healing and growth". Bath says this care involves actions to strengthen **'Three Pillars' – safety, connections and managing emotional impulses**. He argues that much of the growing body of literature conveys the impression that to effectively respond to 'trauma-related conditions, it is necessary to have advanced therapeutic skills and years of formal study', when in fact, there are consistent propositions appearing in the research which suggest that 'much of the healing from trauma can take place in non-clinical settings'.[32]

For several years, FACS and ACWA have been developing a framework for therapeutic OOHC in NSW to help address the impacts of trauma and abuse for this particularly vulnerable group of children, including those with high and complex needs in residential care. A draft framework was made available for comment following a comprehensive consultation process.

FACS, ACWA and residential care providers have recently developed the following definition of therapeutic care:[33]

> *Therapeutic care for a child or a young person in statutory OOHC is a planned, team based and intensive approach to the complex impacts of abuse, neglect and separation from families and significant others. 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 attachment and developmental needs.*

From our perspective, we are keen to see the framework finalised so that there is a common understanding of what therapeutic care means across the sector, and a clear framework is put in place for providing such care; including benchmarks and measurements. We understand that the therapeutic care framework, once finalised, is intended to inform the residential care service system redesign and recommissioning process that is currently taking place.[34]

4.4.2 Trauma-informed responses to young people in residential care

Until recently, one manifestation of the gap in systematic approaches to the complex behaviours and needs of children and young people has been in residential care, where there has been a tendency to overuse police as a behaviour management tool, leading to the criminalisation of behaviours that would often not attract such responses in family settings.

In 2008, the link between OOHC and contact with the criminal justice system was highlighted by the Special Commission of Inquiry into Child Protection Services in NSW, which observed that

[32] Howard, I. Bath, PhD, Amazonaws.com. Fall 2008, volume 17, number 3

[33] Definition provided by FACS, 1 August 2016.

[34] See NSW Government submission: Child Sexual Abuse in Out-Of-Home-Care to the Royal Commission into Institutional responses to child sexual abuse, May 2016.

significant proportions of juvenile detainees had a history of being placed in care.[35] In its 2011 issues paper, *The Drift from Care to Crime*,[36] Legal Aid NSW has also identified a growing trend towards the criminalisation of young people living in OOHC. 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 services.

Many young people in OOHC have experienced 'complex trauma' – exposure to multiple and ongoing interpersonal trauma such as abuse, neglect or emotional or physical deprivation.[37] The impact of past experiences of trauma often surface for young people in a range of disruptive and difficult behaviours harmful to themselves and/or others. These behaviours are often referred to as 'challenging behaviours' which can involve risk taking, poor impulse control, resistance to boundaries (for example being absent from care without permission) and in some situations, can escalate into violent and/or criminal behaviour.[38]

Challenging behaviours need to be managed in the residential care environment in a way that not only supports the young person who is exhibiting the behaviours but also ensures the safety of all residents and workers. Residential services have a duty to ensure the safety of their staff and the young people in their care. In appropriate cases, police are also responsible for taking action to ensure community and individual safety.

A 'trauma informed' approach recognises the presence of trauma symptoms; acknowledges the role of trauma in patterns of behaviour; and aims to support young people to manage their emotions and regulate their behaviour. A key responsibility for those involved in providing care to this group of young people is to provide planned, positive and supportive strategies to assist them to work towards more positive patterns of behaviour, and where possible, to avoid more punitive approaches. In this regard, individual behaviour support plans can be very important in identifying strategies to assist carers and young people to manage behaviour.

A trauma informed approach also seeks to protect young residents in residential services from further trauma caused by conflict with, or victimisation from, other young people living at the service. It is important that 'client mix' is a key consideration in the placement of young people and that the needs and views of any victim are always taken into consideration when responding to incidents at a residential service (we discuss the issue of harmful behaviours between children in care in the next section).

Over 2014-2015, our office worked with a range of stakeholders to develop and implement a state wide 'care and crime' protocol to reduce the contact of young people in residential OOHC with the criminal justice system – see the case study below.

Reducing the contact of kids in residential care with the criminal justice system

We initiated our work in developing a protocol to reduce the contact young people in residential care had with the criminal justice system after Legal Aid NSW approached us with their concerns that the most frequent users of the Children's Legal Service had a history of being in residential

[35] Special Commission of Inquiry into Child Protection Services in NSW, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, 2008. The Commission reported that between 2003 and 2006, 28% of male and 39% of female juvenile detainees had a history of OOHC.

[36] Legal Aid NSW, The Drift from Care to Crime: A Legal Aid NSW Issues Paper, October 2011.

[37] Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012, cited in Youth Health Resource Kit, NSW Kids and Families, 2014, p.84.

[38] 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. (Source: *Out-of-home Care Service Model – Residential Care*, April 2007.)

care. After extensive consultation with a wide group of stakeholders, we released a draft of the protocol for comment at the end of 2014.

The protocol aims to:

- Reduce police involvement in responding to behaviour by young people living in residential services, particularly behaviour that can be better managed within the service.
- Improve relationships, communication and information sharing between residential services and police.
- Facilitate a shared commitment by police and residential services to a collaborative early intervention approach to challenging behaviour by certain young people in these services.
- Enhance police efforts to divert young people from the criminal justice system by providing them with better information to inform the exercise of their discretion.
- Ensure that appropriate responses are given to young people living in residential services who are victims, including referring reports of abuse to police.

The implementation of the protocol will be supported by procedures for residential workers and a document outlining policing responses to incidents in residential care services.

After incorporating feedback from the draft protocol – and then conducting a second round of consultations that included frontline residential care workers and senior police personnel – the proposed protocol was endorsed at a roundtable meeting in August last year. The roundtable brought together over 50 representatives from across the human service and justice sector and focused on working through issues associated with the protocol's implementation – such as establishing a governance structure to oversee the rollout of the protocol, preparing a strategy for promoting awareness of the protocol and related training, and identifying the key components of an evaluation process.

As a result of the roundtable, participants agreed to the state-wide rollout of the protocol and the formation of a State-wide Steering Committee (SSC) to oversee its implementation. The SSC includes representatives from the NSWPF, FACS, the Association of Children's Welfare Agencies, AbSec, Department of Justice, Legal Aid NSW, Youth Action, Office of the Children's Guardian, Aboriginal Legal Service and residential service provider representatives.

To support the work of the SCC, two working groups were established to focus on priority issues such as:

- the involvement of young people
- identifying the type of data needed to inform the ongoing implementation and evaluation of the protocol
- processes for identifying and sharing good practice, and
- developing a training strategy.

An important part of the consultation process involved our office working with the Children's Guardian to ensure that its revised OOHC Accreditation Standards (which had not yet been released) reinforced the need for residential care providers to better support young people with challenging behaviours; more effectively manage behaviour within individual residences; and develop strong collaborative relationships with police to engender better engagement of them in responding to incidents. Standard 11 'Behaviour Support' now includes the following indicator of compliance – providers should have clear protocols regarding the use of police as a behaviour management strategy or in response to risk taking behaviour by children and young people'.[39]

[39] Office of the NSW Children's Guardian, *NSW Child Safe Standards for Permanent Care*, November 2015.

The signatory agencies have undertaken a range of actions to implement the protocol and raise awareness of its benefits for young people and agencies alike. An evaluation strategy is still being developed. The aim is to ensure that the evaluation method is simple and practical, so that frontline police and residential care workers are not subjected to unnecessary reporting burdens. In this regard, a number of larger providers already collect useful data on incidents and callouts to police as part of managing individual residences and young people's behaviour, which provide a sound template for the evaluation.

We intend to audit the implementation of the protocol once it has been fully rolled out.

4.4.3 Child-to-child sexual abuse in OOHC

Currently in NSW, serious child-to-child sexual abuse in out-of-home care, and in other institutional settings, is not comprehensively caught by the reportable conduct scheme. In evidence to the Royal Commission into Institutional Child Sexual Abuse during its hearing into Case Study 29, our Community and Disability Services Commissioner gave evidence about the lack of a formal reporting scheme in NSW for what the Royal Commission has described as 'child-to-child abuse'.[40]

Under Part 3A of the Ombudsman Act,[41] the Ombudsman is only notified of a subset of alleged incidents of child-to-child abuse; that is, any incident where neglect on the part of a carer or other worker is alleged to have contributed to this form of abuse occurring.

Some child-to-child abuse incidents will be the subject of a police report, and may or may not receive a further response via the criminal justice system. Some of these incidents will also be the subject of a 'risk of significant harm' report to FACS. However, there is currently no legislative requirement to report this type of incident to our office or another body to allow oversight of the handling of such matters; nor is there any centralised, systematic data capture about the incidence of 'client-to-client' abuse in NSW.

By way of contrast, Part 3C of the Ombudsman Act does require certain disability accommodation providers to notify the Ombudsman of allegations of client-on-client abuse, breaches of apprehended violence orders, and unexplained serious injuries. Under section 25P(1) of the Act, a 'disability reportable incident' includes:

b) an incident involving an assault of a person with disability living in supported group accommodation by another person with disability living in the same supported group accommodation that:

   i) is a sexual offence, or

   ii) causes serious injury, including for example, a fracture, burns, deep cuts, extensive bruising or concussion, or

   iii) involves the use of a weapon, or

   iv) is part of a pattern of abuse of the person with disability by the other person, or

c) an incident occurring in supported group accommodation and involving contravention of an apprehended violence order made for the protection of a person with disability,

[40] There has been legitimate debate around the most appropriate term to use to describe these types of incidents.

[41] See overview of scheme in section 6.

regardless of whether the order is contravened by an employee of the Department or a funded provider, a person with disability living in the supported group accommodation or another person, or

d) an incident involving an unexplained serious injury to a person with disability living in supported group accommodation.

The disability reportable incidents scheme was introduced in December 2014. Part 3C was largely modelled on the Part 3A legislation which came into operation 16 years ago. However, the more recent Part 3C legislation departs from the Part 3A model, in that it requires the notification of incidents of client-to-client abuse, in recognition of the special vulnerability of people with disability.

In 2015-16, we received 686 Part 3C notifications, of which 38% involved client-to-client abuse – most involved allegations of a pattern of physical abuse by one client against another – followed by allegations of sexual offences, and physical assault causing serious injury.

Given that children and young people are also a vulnerable group – particularly those in out-of-home care – our view is that a centralised approach should be introduced within NSW to govern the identification, reporting and response to alleged *serious* child-to-child abuse incidents.

4.4.4 Children under 12 living in residential care

As noted at the outset of this section, as of the first quarter, 2015-16, there were around 579 children and young people living in residential OOHC (3% of the OOHC population). We understand this population has increased since then. A particular concern is the significant number of children under 12 years of age currently in residential care.

FACS' policy envisages placement of younger children in residential care in certain circumstances, including when the child is in need of care and protection and:

- is part of a sibling group where placement in a residential care setting is sought to keep the sibling group together, or
- has special needs pertaining to a disability, medical condition or challenging behaviour which require specialised intervention and support that cannot be provided in a family home setting.

The placement of a child under 12 years of age in residential care must first be endorsed by the relevant FACS District Director and the agency is also subject to various reporting requirements to both FACS and the OCG, so that the placement can be closely monitored throughout its duration – which ideally, should only be for a short period of time.

The increasing number of very young children being placed in residential care is a concern. We have started discussions with both the OCG and FACS to collectively examine the main drivers for the increasing use of residential care for children under 12, and to identify whether sufficient suitable options are available for these very vulnerable young children.

4.4.5 Leaving care and aftercare – assisting young people to transition to independence

All children and young people who are placed in out-of-home care have a statutory right to assistance when they leave care. Designated agencies are required to develop and implement plans to assist those leaving care in their transition to independent living.

Section 165 of the *Children and Young Persons Care and Protection Act 1998*, allows the Minister for Family and Community Services to: 'provide or arrange such assistance for children of or above the age of 15 years and young persons who leave out-of-home care until they reach the age

of 25 years as the Minister considers necessary having regard to their safety, welfare and well-being.'

The type of assistance envisaged by section 165 is based on need and might include financial assistance and help to obtain accommodation, setting up house, education and training, finding employment, legal advice, accessing health services, and counselling. Section 166 mandates that, 'The designated agency having supervisory responsibility for a child or young person must prepare a plan, in consultation with the child or young person, before the child or young person leaves out-of-home care.'

In 2009 we reviewed leaving care practice for a group of young people in OOHC and released our findings in a June 2010 report.[42] We found that many young people were leaving care without an endorsed leaving care plan; administrative arrangements were cumbersome and protracted; that Community Services staff had little understanding of Ageing, Disability and Home Care's leaving care program; and young people with high support needs were generally not supported (we discuss planning for young people with disability further in section 13). We also identified concerns about FACS' handling of victim's compensation claims for some of these young people.

In 2010 we tabled a separate report in Parliament detailing serious deficiencies in how FACS identified and handled claims for victim's compensation on behalf of children and young people in OOHC.[43]

The following year, we reviewed another sample of care leavers to see if practices in supporting young people to successfully transition from statutory care had improved since 2009. We found no significant improvement in the proportion of young people who left OOHC with a completed leaving care plan. We also again found significant delays in assessing and lodging claims for victim's compensation.[44]

In monitoring progress, we were advised in 2014 that FACS had commenced a comprehensive review of its procedures to ensure that they met the then new NSW Charter of Victims Rights (and related application requirements for seeking support from Victims Services). A working party was established to develop Community Services' response to its responsibilities under the Charter. Community Services also conducted a case file audit of children aged 15 and above who were preparing to leave care (including children being case managed by the NGO sector). In addition, the audit identified all potential legal claims prior to young people leaving care.

In relation to leaving care planning generally, FACS has recently advised us that it has acted to address the problems we identified through our reviews – that it had specifically developed and implemented, practice guidelines, supporting tools and monitoring processes on leaving care for both FACS and NGO OOHC providers. FACS has also developed a Casework Practice Guideline to ensure children and young people in OOHC who have been victims of crime have access to their rights and entitlements.[45] We are keen to settle with FACS a process for ensuring that these recent improvements are embedded in ongoing casework practice.

More recently, it is worth noting that a number of submissions made in response to the Royal Commission's March 2016 Consultation Paper – Institutional Responses to Sexual Abuse in

[42] NSW Ombudsman, Review by the Ombudsman of planning and support provided by Community Services to a group of young people leaving statutory care, June 2010.
[43] NSW Ombudsman, The need to support children and young people in statutory care who have been victims of crime –special report to Parliament, June 2010.
[44] NSW Ombudsman, The continuing need to better support young people leaving care, August 2013.
[45] Advice provided via the Ombudsman/FACS Integrated Governance Framework, June 2016.

OOHC, also raised concerns about the current quality of leaving care planning, and suggested various ways to improve the process. For example, in its submission, Legal Aid NSW drew attention to the findings of our 2013 report and noted that its findings mirrored their experience in advocating for clients. Legal Aid also highlighted that it had identified a number of other systemic issues including:

- inconsistency in the quality of the planning
- a lack of participation and involvement by the young person
- not allowing sufficient time for planning or adequate supports
- the need to build in sufficient flexibility to allow plans to be tailored to suit the needs of the young person, and
- young people leaving care without adequate ID, leading to difficulties in obtaining employment or Centrelink allowances.

While FACS has indicated that it expects the transfer of OOHC to the NGO sector will lead to enhanced capacity to meet the leaving care standards, we are yet to be advised of how FACS intends to implement a uniform sector-wide system to monitor and report on performance in leaving care practice and victim support. It is therefore timely for FACS to take stock of the practical suggestions put forward by stakeholders in various submissions and research, and look at developing a best practice framework for leaving care planning and aftercare support.

If OOHC agencies fail to adequately prepare young people in their care so that they have the best chance at a healthy and productive life, then the consequences for the young person involved and the cost to the community, are likely to be significant.

4.4.6 Supporting young people with disability to transition from care

In 2009, the Public Guardian raised concerns with our office about leaving care planning for young people with disability. Specifically, the Public Guardian reported that Community Services was not taking action to identify young people with disability who would be likely to require the appointment of a guardian/substitute decision-maker at a sufficiently early point to enable appropriate planning. The Public Guardian told us that applications for guardianship were being lodged shortly before the person was due to leave care, at which point it was difficult for the Public Guardian to influence a better outcome, including appropriate accommodation and support options for the young person.

In March 2010, we held a meeting with representatives of the Public Guardian, the (then) Guardianship Tribunal, and Community Services. It was agreed that a protocol would be developed to ensure that Community Services would commence guardianship applications without undue delay after a young person turns 16, where an assessment had been made that the young person was likely to require at least some aspects of guardianship after leaving care. The purpose was to ensure that the Public Guardian was appointed with an advocacy function to enable them to be actively involved in the transition planning process for the young person. The Protocol between FACS and the Public Guardian commenced on 24 June 2011.

In September 2013, the Guardianship Tribunal provided feedback to Community Services as part of FACS' review of the Protocol, and raised concerns about its implementation and associated monitoring. In particular, the Tribunal noted that:

> *There were potentially 703 young people with disability in the leaving care program, and since the start of the protocol, the Tribunal had received applications for the appointment of a guardian for 69 young people in the leaving care program (and only one of these applications satisfied the requirements of the Protocol – for example, the applications were continuing to be made when the person was close to 18 years old).*

In our view, it will be important for the Committee to consider exploring with the Public Guardian and the Guardianship division of the NSW Civil and Administrative Tribunal, whether they have seen any significant improvements in the application of the Protocol by FACS since 2013. We understand that the Public Guardian has also been working with ACWA to achieve compliance with the Protocol across the NGO sector.

5 Support, training, safety, monitoring and auditing of carers

Carers play a critical role in the safety and wellbeing of children in care. We have consistently advocated for more effective assessment of carer suitability and capacity, and for better supports to be provided to carers. These factors are crucial for placement stability and for achieving positive outcomes for children in care. They also featured significantly in feedback from participants in the recent Ministerial forum on Aboriginal children in OOHC – including parents whose children had been removed, young people who had since left care and carers themselves.

5.1 Assessing and monitoring carers

Foster caring is a particularly high-risk form of child-related employment because it occurs in a domestic setting, and much of the work takes place without supervision. Children who receive statutory OOHC are particularly vulnerable.

As the Committee is no doubt aware, the Royal Commission into Institutional Responses to Child Sexual Abuse has paid considerable attention to the issue of children's safety in OOHC. In April 2014, the Commission held the first of a series of roundtables on OOHC in Sydney– informed by the release of Issues Paper 4: Preventing Sexual Abuse of Children in Out-of-Home Care, which generated 63 submissions. The Commission released a further consultation paper on OOHC in March 2016 which generated another 55 submissions.

We provided submissions in response to both consultation papers, and our Community and Disability Services Commissioner and Deputy Ombudsman, Steve Kinmond, appeared at the OOHC roundtable in 2014. A number of the issues considered by the Commission are also relevant to the Committee's terms of reference relating to the support, training, safety, monitoring and auditing of carers. For this reason, we have not sought to document our feedback on these issues in detail in this submission. However, to assist the Committee, the following summary is provided.

In recent years, a focus of our work has been outlining the need for improved carer screening practices in NSW – including the need to ensure that the assessment of carers also extends sufficiently to an assessment of the suitability of their household members and close associates; and, notwithstanding the need to have appropriate interim provisions to enable emergency placements, the need for relative/kin carers and members of their household to undergo the same level of checking as other authorised carers. In NSW, children in relative/kinship care placements account for 47% of children in OOHC.[46] In the past, our work has consistently shown that certain children in kinship placements have been placed at risk of harm and suffered serious harm for reasons including inadequate assessment practices, involving a failure to recognise significant risk factors.

5.1.1 Carers registers

The recent establishment of the NSW Carers Register is a highly significant development in the regulation of out-of-home care in NSW. The Register – which applies to all carers – is an important component of the system in place to enhance the protection for children in care by helping to identify applicants who are unsuitable to be authorised as foster carers; and also by providing a mechanism through which the Children's Guardian can review whether agencies are completing appropriate probity checking and assessment processes prior to the authorisation of a carer (including relative/kin carers).

[46] Family and Community Services, *Quarterly report on services to children and young people*, first quarter 2015-16.

We played an active early role in the establishment of the Carers Register in NSW. In 2010, we began investigating the adequacy of FACS' actions to promote information exchange with other designated out-of-home care agencies for the purposes of authorising carers. We did so because we knew of cases where FACS had not shared relevant risk information about foster carers with that carer's employing agency at the time of assessment. The failure to share information had resulted in actual significant harm, or risk of significant harm, to children later placed with those carers. Following our investigation, from 2011 onwards, we took part in an interagency working group set up by the Children's Guardian to develop the Register.

The Register commenced operation on 15 June 2015 and is administered by the Children's Guardian. Out-of-home care providers and the Ombudsman can access it directly. Out-of-home care providers are required by law to enter certain information onto the Register, including:

- a carer's application and authorisation history (including application refusals, cancellations and suspensions of authorisation)
- associations between carer households
- carer household composition, including whether any household members over the age of 16 have been cleared to work with children
- prospective carers' relationships (past and present) with other designated agencies
- addresses, dates of birth and cultural background, and
- reportable allegations against a carer.

The Register is designed to complement the existing background checking and the holdings which form part of the reportable conduct scheme. It fills certain information gaps that previously existed during the assessment and authorisation of carers, by centrally recording risk information about carers and allowing out-of-home care agencies to access this information as needed, and to share information with each other. Not all risks can be identified by the WWCC and criminal record checking alone, for example:

- The WWCC will consider a 'finding of misconduct' reported by an employer, in the category of 'sexual misconduct' and/or 'physical assault'. However, some carers will have been the subject of a reportable conduct investigation that did not result in a sustained finding of sexual misconduct or serious physical assault, but where a degree of risk nevertheless exists.
- Some carers may have been investigated for a relevant criminal allegation, but this may not have resulted in a charge of the kind that will be detected during a criminal record check. If the criminal allegation was also reportable, it will now be flagged on the Register and prospective employers will know to seek further information from the prior employer, police and FACS.
- Some carers will have risks associated with members of their extended family or their household. The Register records information about all the members of a person's household and whether those aged over 16 have a clearance to work with children. It also allows for other risk information about household members to be flagged.
- The Ombudsman may be aware of information that is unlikely to become known to a prospective employer through standard probity checking or through contacting any previous out-of-home care providers who have employed the individual. For example, we may be aware of risk information about a carer who has other child-related work in a different sector, or we may know about previous criminal investigations in a setting other than out-of-home care. In these circumstances, we can place a flag on the Register, advising the prospective employer to contact the Ombudsman for further information.

As noted above, the Register has improved the protection of children by helping to identify applicants whose past history contains information that might indicate a risk to children. We will

play an ongoing role in flagging critical matters on the Register to facilitate effective interagency exchange of relevant information.

5.2 Extension of the reportable conduct scheme to household members

The *Ombudsman Act 1974* was amended in November 2015, via the insertion of section 25AAA. This amendment has the effect of extending Part 3A to cover persons who reside with authorised carers.

Section 25AAA(1) provides that 'this Part applies to an individual (other than a child) who resides for 3 weeks or more on the same property as an authorised carer in the same way as this Part applies to an employee and in any such case the individual is, for the purposes of this Part, taken to be an employee of the designated agency that authorised the authorised carer'. Under section 25AAA(2), 'reside on a property' has the same meaning as in the *Child Protection (Working With Children) Act 2012.*

Prior to the amendment, while an adult household member was required to hold a WWCC, there was no requirement for out-of-home care agencies to notify us of allegations of (for example) sexual abuse by a household member – unless the alleged abuse involved an allegation of neglect by the authorised carer.

The amendment, which was partly in response to our advocacy on this issue, is a significant development in terms of ensuring that these matters are the subject of appropriate investigation and response.

5.3 Alerting prospective employers to possible child protection risks

In our view, NSW now has the most rigorous WWCC in Australia. Despite this, we have concerns that – because the new WWCC scheme is based on issuing either a blanket 'bar' or 'clearance' to work with children – an employer (including an OOHC agency) cannot be confident that a person who has been cleared to work with children does not have any past known conduct issues which indicate that they 'may pose a risk to the safety of children'. The legal threshold for issuing a bar means that a person who has had, for example, a finding of sexual misconduct made against them in the past will not necessarily be barred from child-related work.

We have therefore argued that the OCG should develop a system for using the information exchange provisions in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* to ensure that, in administering the WWCC scheme, they provide the most comprehensive possible responses to employment screening. As a result, in February 2015, the OCG facilitated a working group with representatives from five government agencies – Education, FACS, Police, Health and Justice – and the Information and Privacy Commission, to consider the potential operational and resourcing implications. However, we were advised by the OCG in August 2015 that the overall view of the attendees was a "reluctance to receive 'below the bar' information". We note that this position is at odds with the information made available under the Carers' Register.

We are continuing to explore this issue with stakeholders. It is important to note that we do not believe addressing the issue will, in and of itself, provide all the necessary safeguards. It is critical that the mechanism we have proposed is complemented by a much more sophisticated understanding across the child-related employment sector in relation to pre-employment screening processes and child safe practices more generally.

5.4 Support for carers and children

Carers of children in OOHC may be required to manage situations that are considerably more demanding than usual parenting, particularly if the children in their care have increased physical, emotional, behavioural and developmental needs. Carers of children with disability may encounter particular problems associated with obtaining specialised services and equipment, dealing with multiple service providers and having less time for themselves. In addition, many kinship carers are grandparents, who, as a group, are generally older, less financially stable, and in poorer health than other foster carers.

Our child death reviews have particularly highlighted risks for children in care with intensive support needs, including chronic health needs; the importance of carers having adequate knowledge of safe sleeping practices and swimming pool safety; and the need for sophisticated responses to children with mental health issues, as well as those children who are the victim or perpetrator of violence and abuse.

Inadequate foster and relative/kinship carer assessment and support was evident in a number of our reviews of reviewable child deaths that occurred in 2012 and 2013. Through our review work, we have particularly identified that kinship carers are less likely to have an allocated caseworker; and kinship placements more likely to receive minimal casework (despite the fact that the circumstances of many kinship carers are such that they often require the same – or in some cases more – support than other foster care placements).

Caseworkers can play an important role in stabilising placements; therefore, it is essential to ensure that good caseworker support is provided to the child and their carer. It is also widely accepted that a caseworker who can develop a trusting relationship with a child is one of the most critical out-of-home-care safeguards. By providing good support to carers, placements can be better managed through early identification of problems and specific supports required for the child or carer, making it less likely that a placement will break down. A closer and more supportive relationship between carers and their caseworkers leads to early identification of placements that are either inappropriate or have the potential to cause harm.

As noted earlier, the Wood Inquiry found that the NGO sector was better equipped to provide the type of supports that children in care and their carers require.

5.4.1 FACS initiatives

In addition to the initial training package for foster carers, *Shared Stories, Shared Lives*, FACS currently provides a range of ongoing support and training opportunities for carers, including:

- carer support teams and peer support groups in FACS Districts
- resources for carers including *Fostering our Future* magazine and downloadable fact sheets
- additional training to support carers to positively manage trauma-related behaviour, as well as during critical periods such as when placement breakdown is at risk
- access to FACS psychologists with training to address the effects of trauma in children and young people.

FACS is also a partner, together with non-government OOHC agencies, in Fostering NSW, a 'one-stop' website providing information, support and resources for carers and prospective carers.

Specific support initiatives for Aboriginal kinship carers include *Raising them Strong*, a 'train the trainer' package delivered to Aboriginal caseworkers to coach Aboriginal carers on a range of topics including health, education, grief, loss, trauma and challenging behaviour.

During our review of support for carers of Aboriginal children, we found that, for the most part, carers' primary support need was for regular contact with the child's caseworker and for caseworkers to acknowledge and respect carers' efforts to provide a healthy and nurturing home environment. Carers who had a sense that their caseworker understood and appreciated the important role they played tended to feel adequately supported by Community Services generally, even if they had experienced difficulties in identifying and accessing the supports needed to address the sometimes complex needs of children in their care.

Our 2008 report included several recommendations aimed at better supporting carers, including:

- Ensuring appropriate regular and ongoing communication between caseworkers and carers in order to better support carers and facilitate a cooperative approach to achieving case plan objectives.
- Strengthening and monitoring carer support initiatives, such as carer support groups.
- Improving coordination of the identification of carers' training needs and the delivery of training.
- Promoting carers' awareness of and participation in support and training initiatives.
- Ensuring a prompt and appropriate response to complaints raised by carers.

Through our complaint and review work, we continue to see mixed examples of support to carers. While in some cases, it is clear that there has been a strong working relationship between a child's carer and caseworker, in other cases, there have been significant inadequacies in the support provided. Our reviews of reviewable child deaths in 2012-13 found that, in several cases, it seemed that not enough consideration was given to what effect the additional responsibility of caring for a foster or related child would have on the carers' existing health, financial and psychosocial concerns.

Often (but not always) inadequate support for carers is attributed to competing priorities in the context of capacity shortages. Therefore, in addition to targeted initiatives for carers, efforts to enhance caseworker capacity are a necessary component to ensuring that carers receive the support they need to fulfil their role in fostering the safety and wellbeing of the children they care for.[47]

Finally, we note that AbSec has raised concerns about the impact of guardianship orders on the level of practical support that is available to relative and kin carers caring for children who are subject to these orders. Under Safe Home For Life, existing orders of the Children's Court granting parental responsibility to relatives and kin changed to guardianship orders in October 2014.[48] According to FACS, the reform is designed to provide greater stability for children and young people who are not able to live with their parents and an acknowledgement of feedback provided by many relative and kinship carers indicating they wanted less involvement of FACS with their families. [49]

Unless there are other Children's Court orders in place that require FACS to remain involved, for instance a contact order or a supervision order, FACS does not provide ongoing casework support

[47] The Mobile Child Protection Unit that is currently being trialled in Western NSW is a good example of this link. MCPU caseworkers are based in Dubbo and travel to communities including Bourke, Brewarrina, Walgett and Cobar to complete child protection assessments as the primary caseworker. Local caseworkers retain responsibility for supporting families and act as the secondary caseworker. The separation of the roles enables the local caseworker to support the family and spend more time engaging with them to build ongoing relationships. According to FACS data, the expanded team and the changed working arrangements allowed staff to spend 23,808 casework hours in 2015, compared to 16,214 during the same period in 2014.

[48] As at 30 June 2015, there were 796 Aboriginal children subject to guardianship orders (FACS Statistics).

[49] Family and Community Services, *Safe Home For Life information sheet*, October 2014.

or supervision. However, guardians continue to receive financial support in the form of carer payments.

We understand that FACS has been working with AbSec to address their concerns, and that FACS has committed to trialling different models of providing guardianship supports.

6 The role of the reportable conduct scheme in the NSW child protection system

Our employment-related child protection jurisdiction 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 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 *Ombudsman Act 1974* (the Act) involves the Ombudsman:

- Receiving and assessing notifications concerning reportable allegations or convictions against an employee
- 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.

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).

Currently, the scheme is the only one of its kind in Australia. However, the ACT and Victoria have now both announced that they will establish reportable conduct schemes. As well, in April this year, COAG agreed, in-principle, to *"harmonise reportable conduct schemes, similar to the current model in operation in NSW and the schemes announced in the ACT and Victoria."*[50]

We recently provided the Royal Commission into Institutional Responses to Child Sexual Abuse with feedback[51] about the reportable conduct scheme.

In February this year, we held a forum on the reportable conduct scheme. The event provided an important opportunity for us to join with our stakeholders in reflecting on the reportable conduct scheme's operation over the last 16 years. It attracted almost 800 delegates from across the

[50] Council of Australian Governments (COAG) Communiqué, 1 April 2016.

[51] NSW Ombudsman, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation Paper on OOHC, March 2016.

education, out-of-home care, disability, early childhood, religious, sporting and recreation sectors. A summary of the feedback from the forum can be found on our website.[52]

More recently, at a reportable conduct roundtable convened by the FACS Secretary on behalf of the Minister for Family and Community Services in May this year, the majority of participants representing both long-standing agencies in our jurisdiction and those within the 'new and emerging' jurisdictions such as the sporting and recreation sectors, spoke of the value of the reportable conduct scheme, and endorsed the need for legislative amendments to extend its reach by aligning it with the Working with Children Check (WWCC) scheme. As we discuss below, we highlighted the coverage of the scheme in a special report to Parliament in February this year. A copy of this report can be found on our website.[53]

6.1 Why the reportable conduct scheme is effective

The reportable conduct scheme (together with our broader functions under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*) allows us to play a proactive role in identifying and responding to individuals who may pose a risk to children. 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. In fact, our office is often the only agency with access to the most key information about a particular matter, and in these circumstances, we take an active role in ensuring information is shared with the right parties and that appropriate action is taken.

The timely reporting by relevant employers of criminal allegations to Police, and where appropriate, the reporting of risk of significant harm (ROSH) concerns to Community Services, are critical to supporting any criminal and/or child-protection responses which might be required. 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 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 Children's Guardian and employers to ensure that critical child protection information is identified, appropriately shared and managed.

A number of peak bodies and agencies within our jurisdiction have spoken of the benefits of our role in facilitating the provision of information to Police, Community Services and other agencies, and have regularly sought advice and support from our office in liaising with these agencies on their behalf. For example, the peak child and family bodies and religious denominations have noted the practical support we provide to them, including our capacity to leverage off our solid and constructive working relationship with Police to drive strong outcomes in this complex and critical area of practice.

We currently have 383 open cases involving matters where the alleged conduct is, or has been, the subject of a police investigation. Of these matters, 134 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.

[52] http://www.ombo.nsw.gov.au/training-workshops-and-events/community-education,-events-and-forums/reportable-conduct-forum-

[53] http://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-protection/special-report-to-parliament-strengthening-the-oversight-of-workplace-child-abuse-allegations

Our reportable conduct jurisdiction, combined with our broader child protection/community services jurisdiction, has allowed us to advocate for change to child protection and out-of-home care practice in critical areas such as:

- successfully advocating for the introduction of streamlined information exchange provisions in NSW during the Special Commission of Inquiry into Child Protection Services[54]
- providing overwhelming evidence of the need for legislation to enable critical child protection information to be provided across state/territory borders based on a consistent set of principles that serve to protect children
- playing a pivotal role in recent changes to substantially improve the screening of foster carers, as well as other household members in foster care placements
- working with the OCG in identifying potential gaps in the WWCC system, and
- providing strong evidence of the need for Community Services to substantially improve its policy and practice in relation to its staff reporting criminal child abuse allegations to Police.

6.2 The intersection of the reportable conduct scheme with the Working With Children Check

The reportable conduct scheme in NSW feeds into the Working with Children Check (WWCC) scheme administered by the Office of the Children's Guardian in a number of ways. For example, the scheme ensures that any workplace records that are notified to the Children's Guardian for the purpose of informing the WWCC have been the subject of independent oversight. Both schemes are significantly enhanced by the information sharing provisions in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998.*

6.2.1 Assessing the quality of employer investigations and related findings

Under section 35 of the *Child Protection (Working with Children) Act 2012*, a reporting body must notify the Children's Guardian of the details of any child-related worker, where the body has made a finding that the worker has engaged in sexual misconduct committed against, with, or in the presence of a child; or any serious physical assault of a child.

In determining whether an investigation into a reportable allegation has been properly conducted, and whether appropriate action has been taken in response, we check to see whether, as required under the Working with Children Act, relevant misconduct findings have been notified to the Office of the Children's Guardian (OCG).

Another important part of our oversight is assessing the quality of the agency investigation and the validity of the related findings. Both of these elements need to be properly addressed so that they can be relied upon by the OCG for the purposes of informing the WWCC screening process. However, there is currently no mechanism to oversight the quality of investigations carried out by those reporting bodies under the Working With Children Act that are not covered by the reportable conduct scheme. This is because organisations outside of our scheme handle their own investigations and provide their findings to the Office of the Children's Guardian without the benefit of independent scrutiny of the quality of their investigations.

[54] Justice Wood's finding on this issue followed a recommendation that we made to His Honour for a legislative provision of this kind, in Part 3 of our submission to the Wood Special Commission of Inquiry into Child Protection Services in NSW dated April 2008.

6.2.2 Our Notification of Concern function and Chapter 16A information referrals

In June 2013, we were required to commence a new legislative function to support the then new WWCC. Schedule 1, Clause 2A of the Working With Children Act, enables the Ombudsman to make a 'notification of concern' to the Children's Guardian if we form the view, as a result of concerns arising from the receipt of information by our office in the course of exercising our functions, that 'on a risk assessment by the Children's Guardian, the Children's Guardian may be satisfied that the person poses a risk to the safety of children'. It is also important to note that this clause is not limited to matters arising from the exercise of our functions under Part 3A. If sufficient concerns arise from information which we have received from exercising any of our wide-ranging functions, we can refer the matter to the Children's Guardian.

Under the legislation, both section 35 referrals and Schedule 1, Clause 2A referrals by our office trigger a 'risk assessment' by the Children's Guardian in relation to whether the involved individuals pose a risk to children. Under this function, the information we supply to the OCG about individuals who pose a risk to children triggers formal risks assessments by the OCG of that person's suitability to work with children. Through this function, we have helped identify individuals of concern whose histories would not have been scrutinised under the WWCC processes if not for the information we have supplied.

Furthermore, under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, our office – and other agencies – can also refer information to the Children's Guardian to assist her in developing profiles of individuals where there is some information indicating possible emerging risk. We routinely provide information to the OCG under Chapter 16A to inform its administration of the WWCC. In this regard, it is worth noting that many of our Chapter 16A referrals relate to persons for whom a risk assessment trigger already exists, but we hold additional relevant information that may not be known to the OCG. This practice recognises that our office does not hold or have access to every piece of information about an individual that may be relevant to a WWCC risk assessment. Similarly, the information held or that is otherwise accessible by the OCG about persons applying or being verified for child-related work can be complemented in significant ways by the Ombudsman's holdings.

Since the new WWCC commenced in June 2013, we have made 627 releases of information to the OCG under Chapter 16A and more than 40 Notifications of Concern. As well, we have responded to more than 345 requests for information by the OCG, and have issued the OCG with more than 188 requests for information under Chapter 16A.

6.3 The reach of the reportable conduct scheme

Notwithstanding the value of the NSW reportable conduct scheme, we believe there is scope for further strengthening it. In our February report we brought to Parliament's attention the practical implications of the Solicitor-General's advice on *'substitute residential care'*; and put before Parliament the views expressed by key stakeholders affected by that advice regarding the need to clarify the reach of the Ombudsman's jurisdiction.

Inter alia, the Solicitor-General's advice states that:

> *'[O]n its face the notion of "substitute residential care" in the care of children would appear to extend to any arrangement where an organisation has the care and control of children of a kind that would otherwise be provided by parents and caregivers, were a child in his or her place of residence'.*

Up until receiving this advice, we had applied a narrower definition of 'substitute residential care' in determining whether agencies fell within our jurisdiction.

In our subsequent consultations with organisations that run camps – including religious denominations, organisations in the recreational camping sector, and sporting associations – we consistently received feedback that stakeholders believe there would be merit in Parliament reconsidering what ought to be the reach of our reportable conduct jurisdiction. In this regard, a number of stakeholders indicated that there is a need to better align the coverage of the reportable conduct and WWCC schemes.

We also received consistent feedback from stakeholders that they valued the support provided by our office in the context of the reportable conduct scheme, and as such, they believed the reach of the scheme should be extended.

In light of the significant implications associated with a broader range of organisations now deemed to be within our jurisdiction as a result of the Solicitor General's advice, we noted in our February report that there is a compelling case for Parliament to review what ought to be the reach of the reportable conduct scheme for the following reasons:

- We believe that the nature of 'organisations' involvement with children, rather than their particular legal structures, should determine whether they fall within our reportable conduct jurisdiction.
- We believe there are no sound public policy reasons for allowing the coverage of the reportable conduct scheme to be determined by factors extraneous to risks to children, such as whether or not an organisation's camps use tents or fixed structures, and distinctions between whether camps are held for a weekend or longer.
- We support the view of key stakeholders that there is a need to better align the coverage of the reportable conduct and WWCC schemes. A review of the coverage of both schemes provides the opportunity to consider whether other legislative amendments are required which are relevant to child protection practice in this area.[55]
- If Parliament takes the view that a broader range of organisations should fall under the reportable conduct scheme, then there will be a need to consider whether they are adequately resourced to fulfil their responsibilities.

The Royal Commission has engaged KPMG to conduct research into the nature and components of the NSW reportable conduct scheme. The NSW Government has indicated it will not respond to our report until the Royal Commission has reported its overall findings. In the meantime, we will continue to proactively work with organisations in those sectors affected by the Solicitor General's advice in order to raise sector awareness of relevant issues and build capacity to respond to allegations of reportable conduct.

[55] As noted in our report to Parliament, matters that we believe are worth considering include whether amendment is required to clarify the reach of the prescribed body definition in Chapter 16A of the Children and Young Persons (Care and Protection) Act; and whether the term 'sexual misconduct' should be defined in Part 3A of the Ombudsman Act.

7 Information sharing by agencies

For a number of years, we have been advocating for the need for strengthening information sharing by agencies, particularly in relation to child protection risks.

7.1 Chapter 16A

In our submission to the 2008 Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry), we argued for the introduction of legislation allowing relevant agencies to be able to share information that promotes the safety, welfare and well-being of children.

In particular, we suggested that certain agencies with significant responsibilities relating to the safety, welfare and well-being of children (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 Community Services 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 NGOs, should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (Rec 10.7). In response, the 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 regarding children and young people. Since Chapter 16A commenced, we have consistently worked to raise agencies' awareness of its availability and to ensure they have appropriate policies and procedures in place to facilitate its use.

As the Committee is no doubt aware, the Royal Commission has covered the issue of information exchange extensively in its March 2016 Consultation Paper – *Institutional Responses to Child Sexual Abuse in Out-Of-Home Care*. Currently, NSW is the only jurisdiction with a provision as comprehensive as Chapter 16A. However other jurisdictions such as Victoria and the ACT are now looking at implementing a similar provision. The Commission's paper discusses the far-reaching benefits of Chapter 16A, particularly in the context of OOHC, and notes the strong support expressed for nationally consistent approaches to information sharing in submissions and other evidence given to the Commission. The paper singles out Chapter 16A as an 'example model' and states [at pp74-77]:

....

Unlike other jurisdictional information sharing arrangements which refer specifically to government contracted or funded organisations, Chapter 16A clearly and comprehensively captures relevant organisations regardless of contractual arrangements or funding source.

The application of Chapter 16A to the NSW Children's Guardian and the NSW Ombudsman, as well as OOHC service providers, can complement and support regulatory and oversight processes with effective information sharing and collaboration between service providers and regulatory/oversight bodies for prevention and risk management.

.....We heard that Chapter 16A enables information from a variety of sources to be easily gathered to better inform assessments of and responses for children at risk. We also heard that the operation

of Chapter 16A has resulted in significantly more information being shared than was the case prior to its introduction.

....

Importantly, the paper also highlighted that despite Chapter 16A's 'explicit prioritisation of information sharing for the safety, welfare and wellbeing of children over the protection of privacy and confidentiality, together with clear protection against criminal and civil liability, should promote timely and appropriate information sharing', there still appeared to be a reluctance to share information in some quarters. The Commission concluded that this suggests that NSW needs to do more to promote 'understanding and confidence in sharing information to protect children in OOHC contexts'.

7.2 An intelligence-driven approach to child protection – "data-driven decision-making"

Our submission to the Wood Inquiry also proposed the need to adopt a more rigorous interagency practice to identify the most vulnerable children in need of a child protection response. Since then, we have persistently called for the implementation of an intelligence-driven child protection system that, as part of a broader, place-based model of service delivery, promotes identifying, analysing, prioritising and acting on information held by agencies with child protection responsibilities. This is consistent with the principle of 'shared responsibility' embedded in the *Keep Them Safe* reforms introduced following the completion of the Wood Inquiry.

In our 2011 report examining the initial impact of *Keep Them Safe* on the capacity of the child protection system, we specifically recommended the development and implementation of an intelligence-driven child protection system. In addition, in our 2012 report about responding to child sexual assault in Aboriginal communities, we recommended that FACS improve the quality of mandatory reporting data it provides to other agencies to enable those agencies to make evidence based safety decisions for the vulnerable children and families within their service delivery ambit, and to develop/implement informed programs that meet community need.

In our more recent *Review of the NSW child protection system: Are things improving?* (2014) we noted that despite Keep Them Safe's considerable focus on improving information exchange between agencies, including through the introduction of Chapter 16A, the impact of these reforms has been uneven at best, with evidence suggesting that available provisions are still not being utilised in a systematic way to identify which children and families need support in individual locations and the kind of services they require.

We also highlighted in our 2014 report that intelligence-driven child protection practice was beginning to be embraced internationally. The first conference on 'intelligence-led safeguarding' was held in the United Kingdom in late 2012 and a follow up conference took place in 2014 to showcase the latest thinking around intelligence-led outcomes through multi-agency and integrated working, with a focus on systems for sharing data. We again recommended that FACS should build an intelligence driven approach to child protection practice and embed this approach within interagency initiatives.[56]

[56] The conference profiled the information sharing model known as 'MASH' – the 'Multi Agency Safeguarding Hub'. Intelligence-led safeguarding – enhancing intelligence outcomes through multi-agency and integrated working, Conference 24 February 2014, London, UK.

Since then, FACS has been involved in a range of data-driven decision-making initiatives, and discrete projects aimed at improving information sharing. For example, as we discuss in section 10, it is currently examining the quality of information about child protection risks which police collect and provide to FACS; assessing whether certain designated police positions should have direct access to the child protection database (KiDS); and developing a plan for improving the availability of policing information to inform child protection risks assessments.

8 Place-based service delivery

We have been advocating for the adoption of place-based service delivery approaches in high-need communities since 2010, and have continued to closely monitor developments unfolding in various sites across the state.

Starting with our Inquiry into service provision to the Bourke and Brewarrina communities, we have emphasised that efficient and effective place-based models of service planning, funding and delivery are an integral part of improving the identification of, and response to, vulnerable families in high needs communities. We have noted the impact of poorly integrated and inefficient service systems operating in local communities, including: the failure to identify and meet the needs of those most vulnerable; the continued funding of NGOs that are failing to provide a good quality service; and the limited return on investment from a number of agency programs.

Our work has highlighted that particularly in small, relatively isolated towns, the funding of programs designed to enhance service availability can create multiple and often 'competing' programs, reference committees and multi-agency case management groups – often with overlapping objectives and target client groups. We have been critical of the 'top-down' approach that too frequently characterises service delivery to high need communities, resulting in the failure of 'off the shelf' programs to deliver intended outcomes.

Our various review activities over a number of years have clearly demonstrated the need for an overarching framework to be in place which is tailored to the needs of individual communities that:

- relies on evidence to identify need and to determine priority areas for funding, as part of an ongoing 'whole of community' service planning and mapping exercise
- funds services based on the priority areas that have been identified (and according to a rigorous procurement process that assesses the capacity of individual services to deliver), and
- ensures that the level and nature of services which are provided by funded agencies are tracked, and the related outcomes are monitored.

Our work has also emphasised the need for robust and effective governance arrangements to drive a genuinely integrated service approach.

In addition, effective governance must also include ongoing assessments of funding contracts to determine whether those who are being referred for support are actually receiving a service, and whether the desired outcomes are being achieved by both individual services and the local service system as a whole. In our view, for funding bodies to effectively discharge their planning and contract administration responsibilities, they also need to be constantly assessing where there are service gaps, and taking this into account in their service planning processes. Further, funding bodies should be ascertaining those services which are not being fully utilised – this should inform service planning (and related procurement decisions).

From our experience in reviewing human and justice systems in relation to a number of communities, we are convinced that a more disciplined approach to planning, funding and related governance arrangements is essential to building an effective and seamless place-based service system. Such a system is also dependent on the planning and funding decisions (and related governance arrangements) being driven from a 'whole of community' perspective. In order for this to be achieved, the decision making related to planning and funding, and the related governance arrangements, need to be jointly driven by all relevant federal, state and local government agencies working in partnership with key non-government and community representatives in building an effective place-based service system. Key issues around the leadership (and associated authority) that is required to break down siloed decision making, and to drive integrated planning and service

delivery in local communities, must also be addressed before such a system can be built. In this regard, giving an individual responsibility without also giving them the requisite authority is unlikely to be successful.

Our 2012 report to Parliament, *Responding to child sexual assault in Aboriginal communities*, recommended that the Department of Premier and Cabinet (DPC), together with other key stakeholders, should develop and implement a strategy for delivering effective place-based planning and service delivery within a number of high need communities in rural and remote locations.[57]

8.1 Recent progress

In response to our 2012 report, the NSW Government indicated a commitment to developing and implementing place-based service delivery reforms in Aboriginal communities. It has since launched a number of initiatives that reflect our suggestions about the need to redesign the service system to better identify and meet local needs.

In particular, the NSW Government committed to developing and implementing place-based service delivery reforms in Aboriginal communities in response to our 2012 report about responding to child sexual abuse in Aboriginal communities. The DPC was tasked with leading these reforms through its Service Delivery Reform Initiative. The Far West Initiative is the main vehicle DPC is using to examine a new whole-of-government model for service delivery and governance in Far West NSW. A paper summarising consultations so far was released by DPC in February 2015. Our most recent advice is that DPC will release a discussion paper outlining various governance models for consideration before the end of the year. We will continue to track progress closely.

Given the extent and reach of the services it funds and provides, FACS is also playing a critical role in leading service reform, and over recent times, has launched 'co-design projects' in a number of its districts, including Western Sydney, Nepean Blue Mountains and Central Coast. These projects bring together stakeholders to develop solutions that respond to the specific needs of local communities – with a particular focus on improving outcomes for vulnerable children and their families.

8.1.1 Connected Communities

The implementation of the Department of Education's *Connected Communities* strategy in 11 locations across NSW also provides a clear rationale to pursue a place-based approach to service delivery in high-need communities, while simultaneously implementing innovative approaches to educational engagement and achievement. When the strategy was launched in March 2012, we recognised it as a promising initiative with the potential to address many of the concerns we have identified through our work. The strategy aims to build genuine partnerships between schools and their local Aboriginal communities, and gives executive principals unprecedented authority to tailor education responses to the needs of the involved communities. Participating schools are intended to operate as 'service hubs', playing a lead role in identifying the most vulnerable Aboriginal families and ensuring they are connected with the necessary supports.

Connected Communities is one of the key components of OCHRE – the NSW Government's plan for Aboriginal Affairs. Under Part 3B of the *Ombudsman Act 1974*, we are required to monitor and assess OCHRE. As such, we are closely monitoring the implementation of this initiative.

[57] Recommendation 89. NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012.

Although our consultations with schools and community leaders in Connected Community sites to date have identified a range of positive initiatives and outcomes, it is also important to recognise the extent of the challenges facing many of these communities. As we have previously observed, the success of Connected Communities ultimately depends on its ability to realise the 'service hub' model envisaged by the strategy. Although schools have a critical role to play in addressing entrenched disadvantage in vulnerable communities, they cannot effectively address the complex issues involved in the absence of a holistic, long-term, whole-of-government and community approach.

Despite observing examples of positive interagency cooperation in Connected Communities locations, it is clear that an effective place-based approach is yet to be embedded in practice in high need locations across the state. A recent interim evaluation of Connected Communities made similar observations.[58]

Over the last several years, we have focused our monitoring on the work taking place across a number of sites where OCHRE initiatives are being rolled out, and the collaborative approaches being used such as the Central Coast, which is covered by the Barang Local Decision Making initiative; and Bourke and Coonamble – both Connected Communities school sites.

The Central Coast

In November last year, the Central Coast district commenced trialling the multi-agency local intake and service point centre, staffed by FACS, Education and Health with input from Police. The centre aims to provide better service responses, including more comprehensive and timely joint assessment of child protection reports, which are diverted from the central Child Protection Helpline. Where risks do not require a statutory response and it is appropriate to do so, intake staff will assist reporters to explore options for continuing to support the child and family. For reports that do not meet the risk of significant harm threshold – which constitute nearly half of all reports received in the district – staff work with other co-located services to support families to respond quickly and prevent them from having to tell their story multiple times. This approach is intended to free up caseworkers to deal with the most serious cases.

We note that the December 2015 report on the Legislative Council Standing Committee on Social Issues' inquiry into service coordination in communities with high social needs included a recommendation that the NSW Government evaluate the Central Coast co-design project. In response, the Government indicated that DPC would coordinate a review of the project which would inform a broader examination of how the Central Coast model could be adapted and rolled out in other locations.

Western NSW

The work unfolding in Bourke and Coonamble which we discuss below, is also consistent with the Standing Committee's key recommendation to Government that it engage in collaborative decision-making around planning and funding in communities with high social needs.

Coonamble

We were encouraged by recent advice from FACS that it had launched another co-design project in Coonamble. The project aims to give clients the help they need regardless of how they may have accessed the service system by getting services to work together to deliver an integrated response which removes duplication and fills service gaps. For many years, the Coonamble community has reported concerns about not being well served by the mostly drive-in/drive-out services from other

[58] Department of Education's Centre for Education Statistics and Evaluation, 2015.

larger regions. We know from our monitoring of the Connected Communities strategy that Coonamble has a number of strengths, including positive gains made by both its primary and secondary schools in engaging services to support students and their families; and strong local Aboriginal leadership. In July this year, we were asked to participate in the first meeting of the project Steering Committee which includes community representatives in July. The Committee will guide the development of a new service model and determine how resources should be allocated to respond to identified community need.

Bourke

FACS Western District Director and the former CEO of NSW Kids and Families established the state's first joint community and agency family referral service in Bourke. The service, known as the Maranguka Community Hub, is a multi-purpose centre which seeks to provide families with a place to discuss issues or problems they may be experiencing, and to facilitate the provision of appropriate assistance in relation to their needs. The Hub was conceived by community leaders in response to our 2010 inquiry into service provision to the Bourke and Brewarrina communities, and commenced operating in May last year. The Western NSW Family Referral Service has two staff at the Hub. FACS Western NSW District provides the premises, and has located a caseworker and an administration assistant at the Hub. As well, Western NSW Local Health District will contribute to the Hub. More recently, a federal agency has agreed to explore providing financial support to Maranguka to enable it to employ a senior operations manager.

We have continued to closely track, and contribute advice to, the work government agencies are undertaking with the Bourke community. More recently, the FACS Minister has also been appointed by the Premier as the Government Champion for Bourke. The Minister then recently established a new Cross-Sector Leadership Table in support of the Maranguka Justice Reinvestment project. This group comprises senior leaders from all sectors and aims to foster collaborative action around the project's main goal – reducing Aboriginal incarceration and creating a safer community.

Along with senior representatives from key government agencies, we were invited to participate in the first leadership group meeting in Dubbo in June to consider the community's *Growing our kids up safer, smart and strong* strategy – which sets out the areas where Aboriginal leaders want to see better outcomes for their young people. The document also includes a number of strategies and measures for delivering on the stated goals. At the meeting, we suggested it was critical for key human service and justice agencies to have greater 'buy-in' in relation to setting with community leaders the major priorities and related measures proposed by the community, so that as far as possible, agencies and the community are working together on the same objectives and maximising their collective expertise, resources and efforts. This issue will be the focus of a meeting scheduled in September.

While the initiatives outlined above are indicative of positive work on the part of government agencies – demonstrating a genuine willingness to explore new ways of engaging with the communities they serve – it will be important to ensure that any successes and failings are informing work unfolding elsewhere and are appropriately integrated within an overarching interagency governance structure. Without strong, rationalised governance arrangements, there is a risk that the weaknesses which place-based service delivery approaches are intended to remedy, will instead be reinforced.

It is important to recognise that this type of innovative work poses significant challenges for agencies and communities alike. It is therefore critical that participants are given 'permission to make and learn from, mistakes; and the opportunity to refine practice overtime.

Finally, the establishment of the Data Analytics Centre (DAC) within the NSW Department of Finance in August 2015 provides considerable scope to support place-based service delivery approaches, and embed data-driven decision making across the government and NGO sector to improve child protection outcomes. We understand that FACS is playing an active role in building

the DAC's information holdings and is participating in a range of whole-of-government analytics projects.

The main purpose of the DAC is to facilitate data sharing between agencies to 'inform more efficient, strategic, whole-of-government evidence based decision making'. It is also envisaged that amongst other things, the DAC will provide advice to the NSW government on emerging problems and propose potential solutions using data analytics; provide and manage a secure environment for data sharing; and establish and maintain a register of data assets.[59]

The DAC promises, through the use of world class data collection tools and analytic expertise, to help agencies overcome the 'silos and duplication that currently exist across government agencies'.

[59] Source: Department of Finance, Services & Innovations website - https://www.finance.nsw.gov.au/nsw-data-analytics-centre

9 Keeping Aboriginal children and young people safe

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."[60] A strong focus of Justice Wood's report concerned building capacity in Aboriginal organisations, and "the need for the adoption of other methods of reducing Aboriginal representation in the child protection system, and of securing greater participation of Aboriginal agencies in that system."[61]

In our submission to the Wood Inquiry, we observed that in many ways, the measures needed to address child protection issues are the same for both Aboriginal and non-Aboriginal communities, with some crucial differences stemming from significant cultural and historical issues affecting the former. This remains the case. In the short term, Aboriginal and non-Aboriginal communities both need ready access to quality services with the capacity to support families and respond to those children and young people who are most at risk. At the same time, the potential to foster longer term positive change and develop preventive solutions depends on addressing entrenched indicators of social disadvantage – which are heightened in Aboriginal communities.

For more than a decade, our systemic work with Aboriginal communities – which has involved consulting with 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 recognition of our extensive involvement with Aboriginal communities, in December 2013, the NSW Government announced their intention to introduce legislation to enable the appointment of a Deputy Ombudsman to independently monitor and assess designated Aboriginal programs. The function is aimed at providing better transparency and accountability for the provision of services to Aboriginal communities and the outcomes achieved. Part 3B of the *Ombudsman Act 1974* took effect on 1 July 2014. The first program to be prescribed under the Act is OCHRE – including Connected Communities, Local Decision Making, Opportunity Hubs and Aboriginal Language and Culture Nests.

We are monitoring a range of initiatives aimed at improving outcomes for Aboriginal communities through our OCHRE function and our broad functions under the *Community Services (Complaints, Review and Monitoring) Act 1993*.

9.1 Progress by FACS

FACS' policy commitment to protecting vulnerable Aboriginal children and their families is embedded in its overarching Aboriginal Cultural Inclusion Framework 2015-2018. 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 out-of-home care.[62]

[60] Report of Special Commission of Inquiry into Child Protection Services in NSW, 2008. piv

[61] Report of Special Commission of Inquiry into Child Protection Services in NSW, 2008. pix

[62] 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

As noted previously, FACS has recently created an Aboriginal Safety and Permanency State-wide Advisory Group as one of three 'implementation working groups' sitting under the Safety and Permanency Advisory Group (S&PAG). FACS has also launched the *Guiding Principles for strengthening the participation of local Aboriginal communities in child protection decision making* (the principles are discussed further in section 9.2.1).

In 2010, following the Wood Inquiry, Community Services signed a Memorandum of Understanding with AbSec – the peak Aboriginal organisation providing child protection and out-of-home care policy advice in NSW – recognising the need for ongoing collaboration to ensure a culturally appropriate and effective response to protecting Aboriginal children at risk of harm.

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 the following outcomes:

- Aboriginal children and young people showing improved outcomes across domains, including education, health, justice, transition to employment/education etc.
- 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.
- 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.
- A robust (good governance, well-resourced, sustainable) network of Aboriginal community-controlled organisations delivering quality services in community.
- Aboriginal kids in out-of-home care are supported by Aboriginal community-controlled organisations.

Supported by 32 actions, the plan identifies the following 'levers for change':

- Driving cultural and good practice through implementation of the Aboriginal Child Placement Principles
- Enhancing the existing Aboriginal sector
- Establishing Aboriginal policy driven by stakeholders
- Building a safety net of Aboriginal agencies across NSW
- Delivering on the immediate transition of Aboriginal children and young people.

In addition to mainstream early intervention and support initiatives, there are a number of Aboriginal-specific early intervention and support initiatives in place in various locations across the state, which FACS either delivers, or participates in delivering, in partnership with other agencies. These include:

- Aboriginal Child, Youth and Family Strategy, which has a particular focus on supporting Aboriginal families expecting a baby or with children aged up to five years.[63]
- Aboriginal Maternal and Infant Health Strategy, which aims to improve the health of Aboriginal women during pregnancy and reduce mortality rates for Aboriginal babies.
- Aboriginal Child and Family Centres, which provide integrated services in a community hub model within four categories: early childhood education and care; maternal and child health; parent and family support; and other relevant early childhood support.[64]

Aboriginal Impact Statements to ensure the effect of any changes to policies, programs and services on Aboriginal people is properly considered.

[63] According to FACS, in 2014-15, a total of 75 funded projects were delivered state-wide under the strategy.

- Protecting Aboriginal Children Together (PACT), which aims to ensure that Aboriginal families understand the child protection process and are supported in their engagement with FACS.[65]
- Aboriginal Intensive Family Based Services (IFBS), a time-limited, intensive support program providing crisis intervention to families at risk of having their children removed due to care and protection concerns (or those needing intensive intervention to assist with the safe return of children from out-of-home care back home to their families).

A number of these initiatives, most notably PACT and the Aboriginal IFBS, address recommendations made by the Wood Inquiry and have now been operating for a sufficient period of time to enable sound observations to be made about their implementation and effectiveness. It is timely that this takes place, particularly against a background in which AbSec has recently reiterated the need for early intervention services aimed at preventing children from coming into care to be "accountable to the Aboriginal communities they service".[66]

9.2 Aboriginal children and young people in OOHC

The significant over-representation of Aboriginal children in OOHC is a well known and long established trend. As noted earlier in the submission, 37% of children in OOHC in NSW are Aboriginal. The high number of Aboriginal children in OOHC was the catalyst for a forum convened by the Minister for FACS, the Hon. Brad Hazzard, in May this year. While reducing the numbers of Aboriginal children and young people in statutory care is an urgent priority, it is accepted that for those Aboriginal children for whom it is not safe to remain at home, it is of critical importance that they remain connected to their family, community and culture. Like all other children and young people in OOHC, quality casework is also critical.

9.2.1 Aboriginal Child Placement Principles

The Aboriginal Child Placement Principles are enshrined in the Children and Young Persons (Care and Protection) Act and are aimed at keeping Aboriginal children close to their family and kin, wherever possible, if circumstances require them to be removed from their parents' care. At the heart of the principles is a requirement that FACS involves Aboriginal communities in decisions about the care of their children. This means that local Community Service Centres (CSCs) need to know who their communities are and build strong relationships with the Aboriginal leaders in those communities. In turn, the strength of FACS' relationship with Aboriginal communities is highly dependent on its ability to demonstrate compliance with the principles. Weak relationships with local Aboriginal communities substantially undermine the ability of CSCs to discharge their responsibilities, particularly in locations with significant Aboriginal populations.

In our 2008 report on supporting the carers of Aboriginal children,[67] we identified concerns about the extent to which meaningful and consistent consultation with communities in relation to placement decisions for Aboriginal children was occurring. We also found that critical deficiencies in Community Services' collection of data about Aboriginal children in OOHC and their carers significantly undermined its capacity to demonstrate its compliance with the Aboriginal Child Placement Principles. In addition, we made a number of observations about inadequacies in Community Services' cultural support planning processes for Aboriginal children in care and we recommended a number of ways to address these issues. The Wood Inquiry subsequently also

[64] According to FACS, in 2014-15, the centres provided services to 3,572 children in nine locations.
[65] According to FACS, in 2014-15, 46 families were engaged with PACT in Moree and Shellharbour.
[66] AbSec, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation paper on OOHC, June 2016.
[67] NSW Ombudsman, Supporting the carers of Aboriginal children, 2008.

recommended that Community Services develop guidelines for staff to ensure compliance with the principles,[68] and that priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.[69]

Since then, FACS has shown a strong policy commitment to strengthening the connections of Aboriginal children in care to their culture and community. In addition to the ACIF, MoU and co-design plan with AbSec, and the Aboriginal-specific early intervention and support initiatives outlined above, FACS has committed as part of its broader child protection and OOHC reform agenda to:

- monitoring compliance with the Aboriginal Child Placement Principles
- increasing the use of and measuring compliance with Aboriginal cultural care planning through a cultural competency strategy and implementation of revised care plans, and
- reviewing the cases of Aboriginal children and young people entering care.[70]

Most significantly, in November 2015 FACS launched the Guiding principles for strengthening the participation of local Aboriginal communities in child protection decision making. We worked closely with FACS and the Grandmothers Against Removals group (GMAR) for more than 18 months to facilitate the development of the principles.

The GMAR formed in Gunnedah in 2014 to provide an avenue for concerned grandmothers to have a say about the implementation of child protection practices in the Gunnedah community. The group included women from communities across the Western and New England regions. In particular, the group wanted to improve the level and manner of communication between Aboriginal families and FACS.

GMAR's approach to our office followed a request by the Wirringah women's group in Lightning Ridge some years earlier who were concerned about a decision by Community Services to place a family of six children, aged from 14 days to 14 years, with four separate carers at Walgett, Bourke, Cobar and Mudgee. In that case, we worked closely with the community and Community Services to facilitate exploration of more suitable care options for the children, which were ultimately secured. As a result of our intervention, Community Services also began working with Wirringah and other groups to significantly increase the availability of out-of-home-care care placements in Lightning Ridge. This led to the signing of a service level agreement between Community Services and the Lightning Ridge Aboriginal Community Working Party. In addition, our work with the Wirringah Women's Group and Community Services also led to two of the women gaining jobs with Community Services and a substantial drop in the number of Aboriginal children entering care in that area in the following years.

In response to the more recent concerns expressed by GMAR, we established a working group to inform the development of a set of guiding principles. While it was intended at the outset that the principles would operate locally, we recommended to GMAR and FACS that a document be developed for state-wide implementation and they agreed. We prepared the document, which was ultimately endorsed by FACS and the GMAR and officially launched by the Minister for Family and Community Services in Tamworth on 9 November 2015.

[68] Recommendation11.5. Report of Special Commission of Inquiry into Child Protection Services in NSW, 2008.

[69] Recommendation 16.12. Report of Special Commission of Inquiry into Child Protection Services in NSW, 2008.

[70] AbSec has emphasised the need for the review to be "broad in scope, including the processes and practices around decision making from the child's earliest contact with the child protection system through child removal, placement decisions and the development of care plans" (AbSec, 'Review of practice regarding Aboriginal children and young people', Media release, 28 July 2016).

The guiding principles envisage Aboriginal communities forming their own local advisory groups to:

- Ensure Aboriginal communities participate in decision making about the care and protection of Aboriginal children, as required under the legislated Aboriginal Child Placement Principles and the FACS ACIF.
- Support Aboriginal families and reduce the number of forced removals of Aboriginal children from their immediate and extended families.
- Improve the access of Aboriginal people to local services and supports.
- Develop pathways of family restoration for Aboriginal children currently in OOHC.

Since the launch, we have continued to play a role in supporting and monitoring the implementation of the guiding principles. Governance arrangements have now been settled, with FACS' newly established Aboriginal Child and Family Reform Group to include two GMAR representatives. A dedicated implementation working group will also be established. FACS has also agreed to work with GMAR to plan and deliver initiatives to promote awareness and implementation of the guiding principles in local communities across the state.

FACS has recently invited a GMAR representative to meet with the Western District Director to discuss ways of building on new local protocols the district had already started to develop with Aboriginal community members prior to the launch of the guiding principles.[71] We understand FACS has committed to ensuring GMAR plays a role in the planned evaluation of these protocols and in designing a model to trial a support service for Aboriginal family members involved in kinship care to better understand their rights and responsibilities.

Since the launch of the Guiding Principles, we have been approached by emerging community groups in other areas for advice about how we worked with the GMAR group in Gunnedah and FACS to develop the document.

In future, we intend to audit the implementation of the principles. If well implemented across communities, the guiding principles 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.

Another positive FACS initiative with the potential to support the practical implementation of the Aboriginal Child Placement Principle is the NSW Winangay Aboriginal Kinship carer resources assessment pilot which commenced at Tamworth CSC in 2015. The resources are designed to assist caseworkers in their engagement and assessment of prospective Aboriginal kinship carers, with the aim of increasing the number of Aboriginal children who can be raised by family. The pilot has recently been expanded to include Mt Druitt and St Marys CSCs, as well as the Nye Gurung Aboriginal Foster Care team in Nepean Blue Mountains District.

While the developments reflected above are all positive, the test will be the extent to which they make an effective difference for Aboriginal children and their families on the ground.

[71] Agreements have been finalised in both Dubbo and Bourke, with Bourke becoming operational in May this year.

9.2.2 Cultural support planning

It is now well acknowledged that "the historical treatment of Aboriginal people in Australia and their current overrepresentation in OOHC make an explicit focus on culture especially important for Aboriginal children."[72]

FACS has strengthened its approach to cultural support planning for Aboriginal children and young people in care since our 2008 report about supporting the carers of Aboriginal children. This report observed that despite there being a range of cultural activities targeting carers of Aboriginal children in place across the state, Community Services had *"no specific policy, procedure or document referred to as a 'cultural care plan' and... no specific casework practice manual or template which is used to assist cultural planning."*[73]

The vast majority of carers we interviewed as part of our review indicated that they had not received support from Community Services in relation to cultural planning. This was a particular concern in relation to Aboriginal children placed with non-Aboriginal caregivers. However, those carers who were managed by Aboriginal OOHC agencies reported a very different experience. All of the Aboriginal OOHC services we spoke to indicated that helping children maintain links with their community and culture should be seen as a priority area of casework and that, irrespective of whether or not the service had responsibility for case management, they provided support and guidance to carers in this regard. Our report recommended that Community Services develop, implement and monitor appropriate and consistent cultural support planning processes.

Since then, cultural plans have become a requirement for all Aboriginal children and young people in OOHC and must be included with care plans submitted to the Children's Court. The Aboriginal cultural plan structure was developed by FACS in partnership with the Children's Court and AbSec. We understand that ChildStory will have the capacity to include Aboriginal cultural plans and that this will assist with monitoring and reporting on compliance.[74] In addition, the AbSec/FACS 'co-design plan' identifies as an action *"the development of Cultural Practice Standards, driven by AbSec and FACS, that are mandated for all services working with Aboriginal children, spanning from first report EI/Prevention (incl. non-ROSH) through intensive support/OOHC and beyond"*. AbSec has stated that the standards *"would work to embed greater accountability and transparency to Aboriginal communities, ensuring a more self-determined approach to addressing the needs of Aboriginal children"* and *"would not replace existing accreditation processes, but seek to enhance these processes."*[75]

A current challenge for FACS in relation to cultural planning concerns the creation, as part of Safe Home for Life, of guardianship orders. Since October 2014, these orders have replaced existing orders of the Children's Court granting parental responsibility to relatives and kin. Under a guardianship order, a child or young person is not in OOHC but is in the independent care of their guardian. Unless there are other Children's Court orders in place that require FACS to remain involved, for instance a contact order or a supervision order, FACS does not provide ongoing casework support. As at 30 June 2015, there were 796 Aboriginal children on guardianship orders.[76]

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[72] Parenting Research Centre and University of Melbourne, *NSW statutory out-of-home care: Quality Assurance Framework*, August 2015, p4.

[73] NSW Ombudsman, Supporting the carers of Aboriginal children, 2008. p27.

[74] We note that the recent NSW Parliamentary Committee inquiry into reparations for the Stolen Generations recommended that FACS review the quality and effectiveness of cultural care planning for Aboriginal children and young people placed in out-of-home care.

[75] AbSec, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation Paper on OOHC, June 2016. p6.

[76] FACS Statistics.

AbSec has expressed concern about the appropriateness of guardianship orders for Aboriginal children – particularly those living with non-Aboriginal relatives – arguing that "there is no monitoring of the child or young person's engagement with their family or extended family, there is no accountability with regard to the cultural plan and no demonstration of connection to culture that is supported by ongoing oversight and safeguarding." To address this, AbSec has called for the establishment of cultural advisers to ensure "effective cultural safeguarding" for those Aboriginal children or young people subject to a guardianship order, and to provide strong support to guardians in their performing their caring role.[77] (See section 4 above for further discussion on guardianship orders in section 4).

9.2.3 Quality casework

One of the most significant protective factors for children in care is the regular presence of an allocated caseworker who, at a minimum, has the capacity to:

- develop a sound understanding of the health, education and wellbeing needs of the child
- establish a positive relationship with the child that encourages them to talk openly about their placement
- provide good quality support to the child's carer
- maintain regular contact with the child through home visits and phone calls
- conduct placement reviews, and
- conduct regular case planning reviews which involve active participation of the child, whenever possible.

Our past reviews of groups of children in care have shown that caseworker resources have been a significant issue in NSW, particularly for children in placements managed by Community Services. In our 2007 review of children under five, a quarter of the Community Service Centres (CSC) reported that between 50% and 80% of their cases were unallocated.[78] We also found evidence of inadequate caseworker resources in both our 2010 and 2013 reviews of young people due to leave statutory care.[79] At one CSC, our 2010 review found that 73% of the out-of-home care cases were unallocated because of limited caseworker resources.

Our reviews have demonstrated that non-government agencies have had better success in maintaining adequate caseworker allocation than Community Services. In evidence given to the Wood Special Commission of Inquiry, Community Services acknowledged its poor performance in this area of practice, and this was ultimately a significant factor in the decision to transfer out-of-home care to the non-government sector.

Notwithstanding the transition, and Community Services' progress in addressing critical caseworker shortages, the need to ensure quality, consistent casework remains a challenge for the child protection system, particularly in a context of increasing numbers of children coming into care; the diversification of the OOHC sector; and the flow-on effect of lifting the rate of face-to-face responses to ROSH.

[77] AbSec, Media release, 17 June 2015.

[78] NSW Ombudsman, Situation of children younger than five in out-of-home care and under the parental responsibility of the Minister for Community Services, November 2007.

[79] NSW Ombudsman , Review by the Ombudsman of the planning and support provided by Community Services to a group of young people leaving statutory care, June 2010; The continuing need to better support young people leaving care, August 2013.

9.2.4 Building the capacity of Aboriginal OOHC agencies

Consistent with key recommendations of the Wood Special Commission of Inquiry, FACS has made a considerable investment in building the capacity of the Aboriginal OOHC sector as part a broader commitment – reflected in the ACIF and OCHRE: the NSW Government's plan for Aboriginal affairs – to building the capacity of the Aboriginal NGO sector more broadly.

The expansion of the Aboriginal OOHC sector in NSW to accommodate the transition of the case management of Aboriginal children in care to Aboriginal controlled organisations is a practical recognition of the doctrine of self-determination and the Aboriginal Child Placement Principles. Building the capacity of the Aboriginal caring sector provides a valuable opportunity for children to remain connected to their kin and country, while offering these children the same safeguards and rights as other children in out-of-home care.

There is overwhelming agreement that it is in the overall best interests of Aboriginal children and young people who cannot live with their parents to live, whenever possible, with Aboriginal carers and to receive case-management support from an Aboriginal organisation. However, the significance and rapidity of the growth presents inherent risks. In the period since the Wood Inquiry, we have focused significant efforts on supporting the capacity of the Aboriginal OOHC sector as its responsibilities grow.

We undertake a range of activities to support Aboriginal OOHC agencies to meet their legislative obligations in relation to child protection and to improve the way they respond to complaints. Developing the sector's capacity to identify and adequately respond to allegations of child abuse is therefore critical.

We have visited a number of Aboriginal OOHC agencies over the last three years to promote awareness of the reportable conduct scheme, our role, and agencies' responsibilities. We continue to deliver tailored employment-related child protection workshops for Aboriginal OOHC providers. As part of this training, we arrange for local police crime managers to attend workshops to discuss how the service can work with police when handling serious allegations.

Aboriginal agencies have participated in our training courses on handling reportable conduct more so than mainstream OOHC agencies. In this regard, it is important to recognise the pivotal role AbSec has played by funding and promoting training to its member agencies. We have also continued to provide the AbSec Board with figures relating to notification rates for employment-related child abuse allegations by its member agencies, to reinforce reporting obligations and the need to promptly address risks.

Our Aboriginal Unit also works closely with staff from our reportable conduct division in regularly providing advice and support to Aboriginal agencies about making reportable conduct notifications; handling investigations; liaising with Police; and ensuring appropriate risk management action is taken. Many of the agencies – particularly those who have attended our training courses – feel comfortable calling our staff for advice and as a result, a number of these agencies have benefited from our hands-on support. By taking a supportive approach, agencies are more likely to make contact with us, and let us know if they may have failed to identify the need to report notifications to us within the required timeframe.

As with many other small OOHC agencies, the issue of developing the requisite capacity and expertise to conduct reportable conduct investigations – particularly those which involve criminal conduct – is a significant challenge for the sector. Increasingly, Aboriginal OOHC agencies will need to work alongside police in investigating and responding to allegations of reportable conduct against carers that may involve criminal offences. In recognition of this, in December 2014 we

hosted a forum in partnership with AbSec – the peak body providing advice on issues affecting Aboriginal families involved in child protection and the OOHC system – to strengthen understanding of the respective responsibilities of Aboriginal OOHC agencies and police in responding to reportable allegations under Part 3A of the Ombudsman Act.

The forum was attended by 160 participants from Aboriginal OOHC agencies, Police, FACS, the OCG and the Association of Children's Welfare Agencies. A range of presenters provided participants with information about key components of the reportable conduct scheme and the responsibilities of agencies in relation to it. In addition, the forum provided an opportunity for local police and Aboriginal OOHC agencies to establish or further develop relationships, share information and discuss ways of working together in the future to build capacity and improve outcomes in a range of areas.

To ensure that the momentum generated by the forum is ongoing, a number of outcomes and commitments will be built into the monitoring and accountability framework for the NSW Police Force's Aboriginal Strategic Direction (ASD). For example, Police will invite their local Aboriginal OOHC agencies to participate in their Police Aboriginal Consultative Committees across the state (PACC). In addition, 'strengthening the relationship between Aboriginal OOHC agencies and police commands' will be a standing agenda item for the Police Aboriginal Strategic Advisory Committee (PASAC) forum for 12 months, so that good practice and systemic concerns continue to be identified and acted upon.

Recently, our Assistant Ombudsman (Strategic Projects) was invited to sit on the Strengthening Aboriginal OOHC Providers Governance group newly established by AbSec to guide sector development.

A significant issue we have been canvassing with AbSec concerns the need to consider the merits of government exploring with relevant stakeholders, including the Aboriginal OOHC sector, whether to establish a single entity, similar to a peak body, to conduct certain complex investigations; provide advice on risk management strategies relating to children; develop policies; and deliver training to smaller agencies which lack the required depth of knowledge and expertise to handle serious reportable allegations (including allegations of sexual abuse).

9.3 Child sexual abuse in Aboriginal communities

In light of the Committee's specific interest in initiatives and outcomes for at risk Aboriginal children and young people, we considered it important to provide an overview of the main findings of our three year audit of the implementation of the *NSW Interagency Plan to Tackle Child Sexual Abuse in Aboriginal Communities*, and the response from Government to date.

Our office was tasked with auditing the Plan after legislation was passed in 2009 in response to a recommendation of the Wood Special Commission of Inquiry.[80]

While three years have passed since our report was released, we are aware from our ongoing oversight of child protection that the issues we highlighted – many of which are in the process of being addressed – continue to have relevance in NSW. In this way, the report and the response so far provides the Committee with a useful benchmark to assess the progress NSW has made in responding to a range of important systems issues which impact on the capacity to respond effectively to child sexual assault in Aboriginal communities and more widely.

[80] Recommendation 18.1. Report of Special Commission of Inquiry into Child Protection Services in NSW, 2008.

While our audit focused on child sexual assault in Aboriginal communities, in doing so, we also put a spotlight on the capacity and effectiveness of a range of frontline services for all child sexual assault victims. In this regard, we draw the Committee's specific attention to the section on the operation of the Joint Investigation Response Team (JIRT) and the changes stemming from our recommendations, particularly given their relevance to the terms of reference.

Our statutory role to audit the Interagency Plan, under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act, concluded when our audit report was tabled in NSW Parliament in January 2013. We recommended that the NSW Government publicly report on its progress in responding to our recommendations within two years of the tabling of the report.[81]

In June 2015, the Minister for Family and Community Services, Brad Hazzard MP, provided us with a formal response to our audit report – *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report* (the progress report).[82] The Minister indicated that the progress report constituted the final stage in responding to our report, and that FACS would continue to coordinate the work being undertaken by the government to effectively support vulnerable children and families.[83] The progress report was published on FACS' website.

Notwithstanding the conclusion of our formal monitoring role, we will continue to follow the response to our recommendations in the course of exercising our broad statutory functions in relation to child protection and our ongoing role to audit the implementation of designated Aboriginal programs.

9.3.1 Overview of our audit findings

Our *Responding to Aboriginal Child Sexual Abuse* report was the fourth in a series our office completed during the three year audit period. Each report focused on the need to significantly improve the quality and efficiency of services delivered to Aboriginal communities. As noted previously, for many years we had been highlighting that poorly integrated services, a failure to deal with chronic staffing shortages in high-need locations, and weak accountability mechanisms, were undermining the ability of agencies to identify and respond effectively to some of the most vulnerable Aboriginal children in NSW.

In recommending that we be required to audit agencies' implementation of the Interagency Plan, the Special Commission of Inquiry emphasised the need to assess the actual impact of the significant levels of activity generated by the Plan. Our strong links and experience in working with Aboriginal communities assisted us in performing this auditing role. Our work was greatly informed by the valuable insights Aboriginal people shared with us throughout the audit.

Despite some good initiatives resulting from the Interagency Plan, the statistics showed that there was, and still is, a long way to go in improving the social and economic conditions needed for Aboriginal communities to tackle this very complex issue and its underlying causes.

Aboriginal children and young people are significantly over-represented as victims of sexual assault. In 2011, 55% of the 8,857 victims of sexual abuse in NSW were children younger than 16.

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[81] Recommendation 91. Responding to Child Sexual Assault in Aboriginal Communities: A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, NSW Ombudsman, December 2012, p. 285.

[82] http://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/318292/NSW_Government_Progress_Report to_the_2012_Ombudsmans_Report.pdf.

[83] Correspondence from Hon Brad Hazzard MP, Minister for FACS, 22 June 2015.

While just 4% of all children in NSW are Aboriginal, they comprise 10% of all child sexual abuse victims.[84]

We found that overall, the Interagency Plan appeared to succeed in raising awareness of child sexual abuse in Aboriginal communities. Reporting of this issue rose strongly over the five years of the Interagency Plan; an indicator of Aboriginal people's increased confidence in the systems established to respond to child sexual abuse. Nonetheless, reported child sexual abuse represents only the 'tip of the iceberg'. We highlighted that creating an environment where Aboriginal people feel safe to come forward in greater numbers to report abuse, had to remain a priority.

To assess the impact of child sexual abuse at a community level, we examined information relating to reported abuse and related responses for 12 target communities with significant Aboriginal populations. Between 2007 and 2011, we found that Aboriginal children in these communities made up 23% of all sexual abuse reports, despite only representing 12% of the population in these locations. Aboriginal people were also over-represented as suspects. Much of this alleged abuse was at the hands of Aboriginal people.

The child protection histories of each of the victims we identified from the 12 communities revealed that almost all of these children were known to Community Services (as it was then known). Two-thirds of these victims had already been the subject of 10 or more child at risk reports before the sexual abuse incident. However, state-wide data at the time showed that while 55% of all risk of sexual harm reports to Community Services received a face-to-face caseworker assessment, the comparable figure for the communities was just 26%.

In recognition that poor school attendance and behavioural problems often provide a window into the circumstances of vulnerable children, we looked at school attendance and suspension data for Aboriginal students enrolled in public schools. Almost a third of all Aboriginal students from these 12 communities had missed 30 days or more of school in 2011, and a significant number had missed the equivalent of half a school year. Aboriginal students from these communities also received suspensions at a higher rate than non-Aboriginal students, and were more likely to be suspended on multiple occasions. We observed that this disengagement from school also distances young people from the supports offered by the school environment, putting them at greater risk of abuse and involvement in anti-social and criminal behaviour.

We also highlighted that more than half of all juvenile detainees in NSW at the time were Aboriginal. And that in parts of Northern and Western NSW, the incarceration rate was more than 80%. While the overall number of young people in juvenile detention has decreased since we released our report, the proportion of Aboriginal young people has not changed.[85] Significantly, the proportion of Aboriginal young people remanded in custody has increased from 42% in 2011/2012 to 47% in 2014/15.[86]

As discussed earlier in this submission, we noted the need for agencies with a shared role in child protection to identify and respond to at-risk children and young people. Yet many of the early intervention and 'integrated' case management programs operating in high-need communities are failing to reach those who need them most. The single biggest investment under the Interagency Plan, the $22.9 million Safe Families program, was intended to deliver an integrated agency response to child sexual assault in five communities in Western NSW. This program raised high

[84] NSW Ombudsman, Responding to child sexual assault in Aboriginal communities, 2012. piv.

[85] Juvenile Justice, Department of Justice, *Key Service Measures for 2014/2015 – Custody* (July 2015)

[86] Juvenile Justice, Department of Justice, Percentage of Admissions of Aboriginal and Torres Strait Islander Young People (July 2015).

expectations, but fell well short on delivery – providing important lessons for future program design.

We also highlighted the need to address a range of service system challenges for victims of child sexual abuse. Our audit of the Interagency Plan put a spotlight on the capacity and effectiveness of a range of frontline services for all child sexual assault victims. In addition to Community Services' 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. And, we also noted that the multi-agency vehicle for responding to child sexual abuse – the Joint Investigation Response Team – is also facing serious state-wide resourcing challenges. (These issues are discussed later in this submission.)

Finally, we argued that there was a need for targeted spending in priority areas, and cautioned that simply directing additional funds to more programs and services was not the solution. Our report stressed the need for a streamlined, overarching approach by government to help communities address high levels of disadvantage and dysfunction. We said that establishing strong governance and accountability arrangements were integral to delivering an efficient and responsive service system.

9.3.2 The Government's response

The NSW Government accepted all but two of our 93 recommendations.[87]

In response to our recommendations relating to the need to address, in a sustainable and significant way, the underlying causes of disadvantage, the Government released OCHRE – which, consistent with our recommendations, commits to addressing a number of priority areas identified in our audit report, including investment in education;[88] building economic capacity;[89] community development; leadership; and participation in decision making.[90] A number of our recommendations are now being progressed through OCHRE.[91]

As previously noted, in response to our recommendations about the need to strengthen accountability and transparency relating to the delivery of Aboriginal programs and services, legislation was passed in June 2014 to establish a new Deputy Ombudsman (Aboriginal Programs) role – an Australian first – and our office was tasked with monitoring and assessing designated Aboriginal programs, starting with OCHRE.

So far, we have released two public reports relating to our OCHRE functions.[92] Our 2014-15 annual report detailed our initial observations of the implementation of OCHRE.[93] In May this

[87] In relation to recommendation 7(d) that community child protection groups should be formally recognised in legislation to enable them to provide advice to Community Services on the placement of Aboriginal children in need of care – the government indicated that it considered this to be more effectively dealt with through policy mechanisms rather than by legislation. The work by this office, the Grandmothers Against Removals group and FACS since then to develop the Guiding principles for strengthening the participation of local Aboriginal community in child protection decision making is relevant in this regard. In relation to recommendation 28 that NSW Health consider utilising the funding previously allocated to the operation of Cedar Cottage to establish a specialist service to support the victims of intra-familial abuse and their non-offending family members – the government indicated that funding previously allocated to Cedar Cottage had been reallocated to a New Street service. We note that the recent Joint Select Committee report on Sentencing of Child Sexual Assault Offenders recommended creating a program to replace Cedar Cottage for treatment of low risk offenders.

[88] Notably through the Connected Communities strategy.

[89] OCHRE commits to the development of a state-wide Aboriginal Economic Development Framework (now known as the Aboriginal Economic Prosperity Framework).

[90] Notably the Local Decision Making initiative.

[91] Recommendations 1, 3, 5, 82, 83, 87, 88, and 89.

[92] NSW Ombudsman, Annual Report 2014-15 (see Working with Aboriginal Communities), 2015; Fostering economic development for Aboriginal people in NSW, May 2016.

[93] NSW Ombudsman, *Annual Report 2014-15*, 2015.

year, we also tabled a special report to Parliament, *Fostering economic development for Aboriginal people in NSW*. The report sets out what we believe are the key areas of reform needed to deliver tangible and sustainable improvements to economic outcomes for Aboriginal people in NSW.

Outlined below is a snapshot of progress in relation to other key areas examined by our audit report about responding to child sexual assault in Aboriginal communities.

9.3.2.1 Encouraging community reporting

We recommended[94] that additional funding should be provided to the NSW Health Education Centre Against Violence (ECAV) to support an extension of its training programs targeting child sexual abuse to Aboriginal communities across NSW. In response, ECAV has been funded to provide community awareness programs[95] in Aboriginal communities across the state.[96]

The JIRT State-wide Management Group (SMG) also determined that Aboriginal community engagement was a priority for 2015, with local management groups required to develop a plan and report back to the SMG by June 2015.[97]

9.3.2.2 Responding to children who display sexually abusive behaviours

Our audit identified an urgent need for NSW to review its current arrangements for providing therapeutic treatment for children and young people who have problematic and abusive sexual behaviours.

Consistent with recommendation 66, NSW Health has undertaken demand modelling of the New Street service with a view to increasing the availability of the service. In their June 2015 progress report on work undertaken in response to our audit, FACS indicated that an additional New Street service was to be established in 2015; and that NSW Health was developing New Street service standards to ensure that the model is delivered at a consistently high standard as it is expanded.

Notwithstanding this, those who live outside the areas where these specialist programs are currently based, have little chance of receiving the help they need. And while Juvenile Justice offers important specialist programs and interventions, there are numerous impediments to helping young people with multiple and complex needs within the relatively brief time allowed by either a control order or a community supervision plan.

In our audit report we also recommended that all agencies and services with responsibilities in relation to responding to children who display sexually abusive behaviours come together to consider creating a cohesive legislative and policy framework that explicitly sets out their respective roles in supporting effective treatment strategies – including the use of treatment orders.[98] We also recommended that consideration should be given to adopting elements of the scheme introduced by the Victorian Government in 2007 for identifying and diverting into treatment young people found to be engaging in sexually abusive behaviours.[99] We understand that

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[94] Recommendation 7c. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.
[95] Weaving the Net; Strong Aboriginal Women; and Strong Aboriginal Men.
[96] 21 programs had been delivered since 2013 and a further seven programs were to be delivered by the end of 2015. (NSW Government, Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report, June 2015, p4).
[97] NSW Government, Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report, June 2015, p5.
[98] Recommendations 65-73. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.
[99] Recommendation 65. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.

NSW Health has now recommended that a combined interagency review consider whether a similar model to the Victorian scheme should be established in NSW.

The Royal Commission into Institutional Responses to Sexual Abuse is also examining the issue of therapeutic responses for children who display sexually abusive behaviours, particularly in light of the reported extent of child-to-child abuse in institutional settings (including out-of-home care) and in the community more broadly.

9.3.2.3 Managing sex offenders in the community

Our audit report highlighted the need to improve interagency cooperation in responding to risks posed to children by registered child sex offenders. In 2014, FACS – as the lead agency – acknowledged that there had been an unacceptable delay in completing guidance for frontline staff from Corrective Services (CSNSW), the NSW Police Force (NSWPF) and Community Services about their respective roles and responsibilities.[100]

In August 2014, an instrument was signed by the Commissioner of Police enabling relevant Community Services staff to disclose (or approve the disclosure of) information about the criminal record of a registered offender to ensure the safety or protection of children. In light of this positive development, we sought confirmation from FACS about whether they had finalised – in partnership with NSWPF and CSNSW – interagency guidelines clarifying the relevant roles of frontline staff in each of the agencies, and a strategy to promote awareness of these guidelines.

In July 2015, FACS provided us with a copy of the interagency guidelines on information exchange relating to offenders on the register – together with a copy of the procedures which they have developed for their frontline staff about responding to child protection risks and disclosing information on registered offenders. We are in the process of giving feedback to agencies on these procedures. FACS also advised us that a collaborative information session for staff from all three agencies was to be held in September 2015.

The government has also advised us that Corrective Services is implementing strategies to better manage sexual offenders in the community. The results of these strategies so far include:

- 50 offenders in custody have completed sex offender treatment through Community Maintenance Program groups and have been released on parole;
- 38 offenders have participated in three community-based sex offender treatment groups; and
- 106 offenders engaged in one-on-one community-based treatment in 2013-14 with 51 completing the program during the period.[101]

9.3.2.4 Increasing the number of Aboriginal sexual assault counsellors

Our audit report recommended[102] that NSW Health designate responsibility to ECAV for developing an Aboriginal recruitment and staff development plan with the specific aim of increasing the number of Aboriginal sexual assault counsellors across NSW.

We recommended that such work should be undertaken collaboratively with the Public Service Commission (PSC). Under the banner of OCHRE, the PSC is now developing a sector-wide approach to Aboriginal employment, leadership and career development. The NSW Public Sector

[100] Recommendation 80. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.

[101] NSW Government, Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report, June 2015, p20.

[102] Recommendation 27. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.

Aboriginal Employment Strategy 2014-2017 was released by the PSC in April 2015. We also understand that in line with our recommendations on this issue, new options are being developed by the NSW Government for the recruitment, retention and development of Aboriginal staff across all disciplines (not only sexual assault counsellors) in consultation with ECAV.

In response to our audit recommendations, (then) NSW Kids and Families established a new Aboriginal Senior Policy Analyst position whose functions include the promotion of health equity for Aboriginal people and championing Aboriginal health in government initiatives addressing sexual assault, in collaboration with ECAV.

9.3.2.5 Recruitment and retention

Our audit report highlighted the need for a whole-of-government approach to recruiting staff to high needs areas in NSW; noting the discrepancies in the incentives offered to staff by different government agencies and across different employment categories. In our view, a whole-of-government structure for incentives is critical to resolving these issues. We recommended that the Public Service Commission consider the observations made in our audit report in developing and implementing a whole-of-government recruitment and retention strategy.

In the absence of such a structure, we recommended that NSW Health review the locations and positions with high vacancy rates and poor staff retention, and put in place stronger incentives schemes for these areas.

In response, the government has recommended the development of a new incentive scheme for counsellor, caseworker and other positions in difficult to recruit locations. In addition, the revised *NSW Health Professionals Workforce Plan 2012-2022* was released in September 2015 and aims to increase the number of health professionals working in regional, rural and remote communities, support rural training and improve capacity planning. The *NSW Rural Health Plan towards 2021* released in 2014, also provides a strategic framework to build the rural NSW Health workforce through enhanced recruitment, training, career development and support, including e-Health.

9.3.2.6 Enhancing the Joint Investigative Response Team (JIRT)

Consistent with recommendation 22 of our report, recurrent funding has been provided for the permanent establishment of the JIRT Referral Unit and Bourke JIRT.

With regard to the capacity of the JIRT at a state-wide level, the Child Abuse Squad (CAS) – the policing arm of the JIRT – conducted a review in 2013 (consistent with recommendation 20 of our report) which resulted in an additional 30 staff being allocated to the CAS in May 2013.

Our report also highlighted that it would be counter-productive to examine resourcing without also examining productivity. In the case of the CAS for example, our review of police workload and outcome data highlighted significant performance variance across the JIRTs in areas such as child interview and arrest rates.

A subsequent review by the NSWPF of the productivity and performance of the CAS (in response to recommendation 21) led to a range of positive initiatives being introduced, including:

- The allocation of four new Inspectors to support the Commander to implement a range of systems to address identified problems.
- An annual team development process to review the performance of individual squads and promote best practice.

- Inspectors tasked with tracking the performance of the squads within their area of responsibility; increasing their mentoring activities with individual squads, and conducting more regular field visits for this purpose.
- The establishment of the Child Abuse Response Team to provide support to squads in relation to complex and protracted investigations, and a commitment by the State Crime Command to supply additional support when necessary.

As a result of both these initiatives and the increase in staffing, the number of interviews conducted by the CAS in 2014 was more than 50% higher than the number conducted in 2012. By 3 December 2014, the CAS had made 733 arrests during the calendar year, compared to 455 in 2012 – an increase of more than 60%.

In March 2015, the Government announced a further 50 investigators and four specialist staff to be allocated to the CAS.

A review of FACS' JIRT resourcing led to an extra 10 caseworker positions being allocated in 2014. We also understand that 10 additional NSW Health JIRT positions have been funded for the 2015-16 financial year, and that it is likely that a further 12 positions will be funded for 2016-17.

Our audit report noted that it was important to recognise that any increase in the productivity and resourcing of the police arm of the JIRT would inevitably place a greater burden on its JIRT interagency partners.

Recently, the JIRT agencies advised us that they had committed to undertake a joint review of the JIRT and requested that our Community and Disability Services Commissioner provide independent oversight of this process. We agreed, and are currently liaising with the agencies in relation to making the necessary arrangements.

9.3.2.7 Improving the criminal justice system process for victims

Our audit report outlined a number of areas where further investment in, or reform of, the criminal justice system was required, including the need for:

- Further work to ensure that the reasons for the attrition of child sexual abuse matters from the criminal justice system are better understood, reported on, and where possible addressed.
- Additional funding for the Witness Assistance Service to enable it to consistently provide appropriate specialist support to victims.
- A review of the current case management processes for sexual offence cases heard in both the District and Local Courts, in order to determine the extent to which improvements can be made to minimise delays and encourage earlier guilty pleas.
- The expansion of remote witness facilities and audio-visual links to ensure that high quality facilities are available to victims and other witnesses across the state.
- Legislative reform to enable an option for a child's entire evidence – including any cross-examination and re-examination – to be pre-recorded at a pre-trial hearing.
- The creation of a registered intermediary scheme to facilitate better communication between victims and the police or court.
- A review of section 66EA (which relates to the offence of persistent sexual abuse of a child) of the *Crimes Act 1900*.
- Legislative reform to create a presumption in favour of joining trials for sexual assault matters.

Last year, the Government announced that it would pilot a range of supports for child sexual assault victims; namely, allowing for the pre-recording of a child's cross-examination, and the introduction of 'children's champions' or witness intermediaries to support child witnesses through

the trial process. The relevant legislation (passed in November 2015) prescribes that the pilot scheme will operate from 31 March 2016 until 31 March 2019; and will apply to complainants aged under the age of 18 who are witnesses in prescribed sexual offence matters heard in the Newcastle and Sydney District Courts.

In June 2015, the Government also announced that it would trial a specialist judicial program for child sexual abuse matters. In August 2015, two additional judges were appointed to the bench of the district court. We understand that the specialist judges were to receive intensive training on child sexual assault matters and dedicate most of their time to the conduct of such matters. These are positive initiatives. We are not aware of whether there has been progress in relation to responding to the other recommendations outlined above.

9.3.2.8 Forensic medical examinations

Our audit report included a number of recommendations relevant to data capture by NSW Health and to forensic examinations of children more broadly.[103]

The Government's June 2015 progress report stated that NSW Health is developing a data collection solution for Sexual Assault Services, and that the project was being led by NSW Kids and Families. At that time, the government advised that a minimum data set and report specification had been developed to address the requirements outlined in our audit report. The response states that the database was to be 'piloted from July 2015 with three LHDs and state-wide implementation will follow in August 2015'.[104]

We have not been provided any further information relating to the pilot and state-wide rollout of the database; however, it would appear that there were delays in the state-wide implementation.

In relation to the steps taken to improve access to forensic medical examinations, the response to our recommendations has been positive. The government's June 2015 progress report notes that:

> *The AIRS [the Access for Isolated and Remote Sexual Assault Victims] Model pilot project was replaced in 2013-14. This followed a decision by NSW Health to purchase service enhancements from all rural and regional LHDs to ensure the availability of 24/7 integrated psychosocial, medical and forensic crisis responses for child and adult victims of recent sexual assault. Targeted funding for these additional services totalled $334,603 in 2013-14 and $1,867,105 in 2014-15 with provision made for recurrent funding of $1,789,605 from 2015-16.*
>
> *These funds allow rural and regional LHDs to implement locally responsive service models involving a range of initiatives as piloted with the AIRS Model. Workforce initiatives include recruitment and training of medical and counselling staff (all LHDs), clinical leadership positions and payments for on-call services. 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*

[103] Recommendations 30-41. Recommendations 30, 31 and 32 relate specifically to the collection of data relating to forensic medical examinations. Recommendations 33 and 34 relate to the use of that data and are therefore contingent on the implementation of recommendations 30-32.

[104] NSW Government, Responding to Child Sexual Assault in Aboriginal Communities: NSW Government Progress Report to the 2012 Ombudsman's Report, June 2015, p8.

specifically for flights and vehicle costs to retrieve victims and transport medical and counselling staff.

...NSW Health has renewed the payment determination arrangements which were noted by the Ombudsman for another year in 2014-15. The scheme provides incentive payments for general practitioners to undertake medical and forensic examinations in areas where there are shortages of doctors undertaking this work. Future arrangements for this scheme are now under review in light of the range of other initiatives now being implemented by LHDs as outlined above.[105]

While we are not aware of further details regarding these initiatives or their implementation, on the face of it they appear to address the substance of several of our recommendations pertaining to the conduct of forensic medical examinations.[106]

Our audit report also highlighted that the policies and procedures of the JIRT agencies were inconsistent and unclear, which can result in friction between workers from different agencies when urgent decisions need to be made about if, and when, a forensic examination needs to be performed.

We recommended that clear decision making processes be developed and included in the updated JIRT manual.[107] We are not aware of whether progress has been made in this regard but as noted above, a review of the JIRT is currently underway.

[105] 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.
[106] Recommendations 36-41. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.
[107] Recommendation 35. NSW Ombudsman, *Responding to child sexual assault in Aboriginal communities*, 2012.

10 Domestic and family violence

In 2014-15, domestic violence featured in 17.8% or 22,429 ROSH reports. During the same period, 2,433 families accessing *Brighter Futures* had domestic violence identified as vulnerability and 1,815 households accessed the Start Safely rental subsidy scheme, which offers short to medium term financial assistance to clients who are homeless or at risk of homelessness due to domestic or family violence.[108] And, between April 2015 and March 2016, police recorded 29,227 incidents of domestic violence assault.[109] Reducing domestic violence is one of the Premier's Priorities.

The presence of domestic violence in the lives of children places them at significant risk of harm. In June 2015, we reported the findings of our review of 83 children who died during the 10 years to 2013 in abuse-related circumstances, and where the person of interest in the death was a family member.[110] Domestic violence featured in almost half of the families involved in the abuse-related deaths of children over the 10 years. The largest group of persons of interest in the child's death were birth parents. Intimate partners of birth mothers, particularly new partners, also featured significantly. Well over half of the persons of interest were known to police as perpetrators of violence, including assault and domestic violence prior to the child's death. Most strikingly, the majority of those with a history of violence were known to police as serious violent offenders.

Our reviews also show that usually, at least one agency was aware of the existence of domestic violence, and that agency was often the police. Over three-quarters (58) of the 75 families had come to the attention of police at some point before the child's death; 41 within the year prior to the child's death. For the majority of these families, contact related to criminal activity on the part of either or both carers, including 20 families with very extensive criminal histories. In the main, contact was in response to reports of domestic violence, including eight families who had repeated contact with police in relation to multiple instances of domestic violence.

Domestic violence was also a notable issue in our reviews of the deaths of children in circumstances of abuse and neglect in 2012 and 2013 (the most recent cohort of child deaths we have reported on).

In addition to physical harm, domestic violence may also have long-term emotional, developmental and behavioural impacts on children. Children who are subjected to domestic violence are often frequently exposed to other risks, including those associated with parental drug and/or alcohol abuse, parental mental health issues, neglect and failure to thrive. As well, young people from families experiencing domestic violence are at risk of becoming involved in dangerous, anti-social or criminal behaviour.

For a decade, we have been drawing attention to the clear need for improvement in agencies' recognition and reporting of, and response to, the child protection implications of domestic violence. In particular, through our investigation of the policing of domestic violence in 2006 and our ongoing reviews of child deaths, we have identified the need for improvements in:

- considering the child protection implications of domestic violence, and agencies recognising the significance and impact of the violence in their work with families
- reporting to FACS the risks to children associated with domestic violence (including when children may not be present at an incident, but police are aware the parties involved are parents), and

[108] FACS Statistics

[109] Bureau of Crime Statistics and Research, NSW Recorded Crime Statistics April 2011 to March 2016

[110] NSW Ombudsman, Report of Reviewable Deaths in 2012-13, Volume 1: Child Deaths, June 2015

- reporting domestic violence to police.

Most recently, we provided advice to the COAG Advisory Panel on Reducing Violence against Women and their children to inform their draft report. We recommended that the report, and key recommendations, make explicit acknowledgement that the children of women who are subject to violence are often themselves directly subjected to domestic and family violence. In addition, even if the children are not directly subjected to violence themselves, they are nonetheless victims who should be provided with appropriate support. Pleasingly, the final report, which will inform the Third Action Plan of the *National Plan to Reduce Violence against Women and their Children 2010-2022*,[111] reflects this view.

10.1 Significant reforms

Our 2006 report to Parliament, *Domestic violence: improving police practice*, followed extensive consultations with a wide range of stakeholders and made a number of recommendations about systemic and practical reforms needed to improve the overall response to domestic violence. The report included a significant focus on child protection issues.[112]

Since then, there have been a number of changes to the way the NSWPF and other agencies respond to domestic and family violence, including:

- the release of the Code of Practice for the NSWPF Response to Domestic and Family Violence
- a significantly expanded domestic and family violence team within NSWPF to better develop and monitor the capacity of police to respond to domestic violence; and a comprehensive review of domestic violence training for frontline police
- the funding for 35 additional officers to work in high-risk areas, with a particular focus on targeting repeat offenders; the introduction of a domestic violence prosecution specialist role within the NSWPF to develop and monitor good prosecution practices; and the rollout of domestic violence evidence kits for use by frontline police
- the establishment of a Domestic Violence Death Review Team within the Office of the Coroner
- legislative amendments to better protect children affected by domestic violence by requiring the court to include them, where relevant, as protected persons on Apprehended Domestic Violence Orders (ADVOs)
- amendment of NSW Health's Domestic Violence – Identifying and Responding policy directive, which will make explicit that all cases of serious risk from domestic and family violence must be reported to police[113]
- the development of two new Health Education and Training Institute (HETI) online modules, which focus on identifying and responding to domestic violence in Emergency Departments and on Domestic Violence Routine Screening
- the Domestic Violence Safety Planning training package developed by FACS' Clinical Issues Unit, which aims to improve caseworker skills and confidence to engage in holistic safety planning and risk assessment in families where there is domestic and family violence
- the Integrated Domestic and Family Violence Services Program – a multi-agency response administered by FACS that is meant to provide flexible, needs-based casework to people experiencing domestic and family violence

[111] COAG Advisory Panel on Reducing Violence Against Women and their Children, Final Report, 2016.
[112] NSW Ombudsman, Domestic violence: improving police practice, 2006.
[113] The policy is due to be reviewed in October 2016.

- the development of the Domestic Violence Justice Strategy 2013-2017, including legislative amendments enabling police to issue 'on the spot' ADVOs

Most recently, in February 2014 the NSW Government launched *It Stops Here – Safer Pathway* to improve the consistency and effectiveness of the system response to domestic and family violence. Safer Pathway will be rolled out across NSW in a staged approach over five years. It reflects a number of observations and recommendations contained in our 2006 report *Domestic violence: improving police practice* – most notably, our recommendations that a common risk assessment tool be developed and that consideration be given to the benefits of implementing specific domestic violence interagency models and/or practices in NSW, particularly in locations identified as high-risk.

10.2 It Stops Here – Safer Pathway

Safer Pathway incorporates:

- a Domestic Violence Safety Assessment Tool (DVSAT) to better and consistently identify the level of domestic violence threat to victims. The DVSAT was initially launched at five local area commands (LACs) before being implemented state-wide in June 2015.[114]
- a Central Referral Point to electronically manage and monitor referrals of victims
- a state-wide network of Local Coordination Points (LCPs) that facilitate local responses and provide victims with case coordination and support, established initially in Orange and Waverley, then in Tweed Heads, Parramatta, Bankstown and Broken Hill. The NSW Government has committed $53 million over four years to expand Safer Pathway state-wide, with 21 new locations rolling out in 2016-17.[115]
- Safety Action Meetings (SAMs) in which members develop plans for victims at serious threat of death, disability or injury as a result of domestic and family violence. SAMs are currently operating in those areas which have LCPs.
- information sharing legislation ('Part 13A') that allows service providers to share information about victims and perpetrators so that victims do not have to retell their story multiple times, and to hold perpetrators accountable and promote an integrated response for victims at serious threat.
- The Domestic Violence Disclosure Scheme, which helps people who may be at risk of domestic violence to find out if their current or former partner has a history of violent criminal offences. The scheme is being piloted in four LACs.[116]

One of the stated aims of the Safer Pathway reform is to 'seek to ensure better integration between new domestic and family violence referral pathways and those in the child protection system'.

The Safer Pathway Domestic Violence and Child Protection Guidelines were released in September 2014. Developed by the Department of Justice in collaboration with key government agencies, including FACS, Education, NSW Health, Police, Legal Aid and Women NSW, the guidelines are intended to *"clarify the intersection between the domestic violence and the child protection systems, and help service providers navigate those systems"* in acknowledgement that a *"significant number of victims who are supported by the Safer Pathway model will have children in their care and service providers must consider the safety, welfare and wellbeing of children as well as that of the adult victim in their interventions."*[117]

[114] http://www.police.nsw.gov.au/__data/assets/pdf_file/0009/349434/NSWPF_DVSAT_SUMMARY_SHEET.pdf

[115] Hon. Pru Goward, Minister for the Prevention of Domestic Violence and Sexual Assault, 'Domestic violence victims on a Safer Pathway', Media release, 18 July 2016.

[116] Oxley, Shoalhaven, Sutherland, St George.

[117] Safer Pathway Domestic Violence and Child Protection Guidelines, 2014, pv.

The guidelines outline:

- what constitutes a domestic violence threat to a child or young person
- the assessment, reporting and referral mechanisms for children at risk of harm and for adult victims under Safer Pathway, to ensure families receive the support they need
- relevant legislative frameworks for sharing information and how child protection responsibilities may be addressed at SAMs.

Importantly, the guidelines clarify that the introduction of Safer Pathway does not replace existing child protection processes or interventions. They clearly state that *"Where service providers identify an adult victim of domestic violence, they must consider the needs of the victim as well as any concerns for the safety, welfare and wellbeing of children and young people, and vice versa. This means that service providers must take parallel action to address the domestic violence threats and to ensure the protection of any children"*[118] and that *"Child protection issues are a priority in any discussions about the safety of the victim, and child protection related interventions must be considered in Safety Action Plans."*[119] The Safety Action Meeting Manual also sets out the child protection obligations of SAM members.

In addition to mandatory reporting requirements and the availability of Chapter 16A to prescribed bodies, Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* allows the sharing of personal and health information about domestic violence victims, their children and perpetrators, between service providers in defined circumstances. Under Part 13A, service providers can share victims' and perpetrators' information to facilitate access to support services for victims identified as 'at threat', and to reduce or prevent a serious threat to a victim and any other person where the victim is identified as 'at serious threat'.

We were consulted at a late stage during the development of the DVSAT – the tool used to determine the level of domestic violence threat to victims and whether a victim will be referred to a SAM. We noted that the questions were primarily aimed at identifying risk to the safety of the primary adult victim of a domestic violence incident and pointed out that, in contrast, tools used in other jurisdictions (including South Australia and parts of the UK) included more specific questions aimed at identifying risks to children. For example, we suggested that specific questions be included aimed at eliciting information about the offender's violence/threatened violence/controlling behaviours and any other history of behaviour that may place the victims (including children) at risk. As the rollout of the trial was imminent, we were advised by the partner agencies at the time that these concerns could be considered in the evaluation.

The NSW Government committed to implementing a comprehensive evaluation strategy – including a process and outcomes evaluation – of the Safer Pathway reforms. Given that one of the main aims of the Safer Pathway reform is to ensure better integration of child protection issues in the context of domestic and family violence, it will be vital that the evaluation has specific regard to the extent to which the reforms have contributed to better outcomes for children victimised by domestic violence.

10.3 Enhancing the police role in child protection assessments

In response to concerns highlighted by our child death review work, FACS and NSWPF have acknowledged that more work is required at a local level to ensure that community service centres (CSCs) and local area commands (LACs) are systematically exchanging risk-related information

118 Safer Pathway Domestic Violence and Child Protection Guidelines, 2014, p9
119 Safer Pathway Domestic Violence and Child Protection Guidelines, 2014, p20

about high risk domestic violence offenders. In 2014, FACS and NSWPF commenced working together to develop criteria for identifying serious violent offenders on KiDS (Community Services' child protection database) to better inform child protection assessments.

In June 2015, we recommended that this work should lead to the implementation of an effective system for defining, identifying and providing to FACS information about serious violent offenders (SVO) when such information is relevant to risk of harm assessments and related child protection casework.[120]

In June 2015, against the background of detailed discussions with FACS and NSWPF about work that could be undertaken to improve information exchange, we also recommended that FACS and the NSWPF should examine the possibility for police officers to be co-located at, or otherwise made available to, the Helpline in order to:

- provide advice to inform FACS' assessment of, and response to, relevant reports of children at risk of significant harm
- assess whether allegations contained in reports warrant a police response, and
- in appropriate cases, actively liaise with police commands to improve the effectiveness of responses to welfare checks and other requests for assistance.[121]

In order to progress this recommendation, in late 2015 we established a project team together with FACS and NSWPF to conduct an audit of a sample of ROSH reports, with a view to exploring what information could be gleaned if FACS had immediate access to police holdings at the time that a report is made to the Helpline.

The project highlighted a number of areas where Police could improve their provision of information to FACS at various points in the child protection system, including:

- Improving current police processes for responding to Chapter 16A requests from FACS business units; for example, possibly introducing a triage process to ensure the most urgent requests are responded to first.
- Identifying the points in the child protection system where the exchange of policing information is best targeted. For example, it was noted that the exchange of information by Police at the CSC level to inform its triage of ROSH reports via weekly allocation meetings, is more likely to make a practical difference to whether or not a particular case is prioritised for a face-to-face response rather than targeting this information at the initial Helpline assessment.

Consistent with the findings of our 10-year review of familial abuse-related deaths of children, which was undertaken as part of our June 2015 report of reviewable deaths, our joint project with FACS and NSWPF also indicated that there may be scope for the more systematic exchange of information about individuals who are known by police to be 'serious violent offenders' (SVOs). For example given the number of child death cases we have reviewed where there was SVO involvement, there would be merit in exploring the scope for an IT solution which involves a linkage to, and automatic flagging of, data from police systems, when child protection reports are being assessed by FACS staff at the Helpline.

Prior to the joint project commencing, FACS (with assistance from NSWPF) had already separately undertaken work relating to SVOs. This work included the development of a criteria (based on the Australian New Zealand Standard Offence Classifications) for defining SVOs; and a preliminary analysis of child protection reports made by the NSWPF to determine whether the presence of an

[120] NSW Ombudsman, Report of reviewable deaths in 2012-13, Volume 1: Child deaths, June 2015. Recommendation 4.
[121] NSW Ombudsman, Report of reviewable deaths in 2012 -2013, Volume 1: Child deaths, June 2015. Recommendation 8.

SVO is likely to assist in identifying children and young people most at risk, so that they can be prioritised to receive a service or assessment.

Given the relevance of this work to our ongoing joint project, we recently sought advice from FACs about the outcomes of their SVO analysis. We are currently reviewing this information in the context of working with FACS and Police to further consider areas where information exchange between the agencies can be improved.

11 Educational neglect

For almost a decade, we have been highlighting the strong link between educational neglect and other child protection risks, including the presence of educational neglect as a significant factor in a number of child deaths from abuse and neglect.

The death from starvation of a seven year old girl, known as Ebony, in 2007 illustrated the importance of an effective interagency approach to child protection and was one of the main catalysts for the Wood Inquiry. Our review of that case identified extreme educational neglect for Ebony and her siblings.[122] We recommended to the Inquiry that consideration be given to establishing habitual non-attendance at school as a specific statutory ground for reporting concerns to Community Services; following the inquiry, section 23 of the *Children and Young Persons (Care and Protection) Act 1998* was amended to this effect.

11.1 The link between non-attendance and other child protection risks

As noted earlier, in our 2012 report *Responding to Child Sexual Assault in Aboriginal Communities*, we observed that a high proportion of Aboriginal children reported as victims of sexual assault had records of lengthy school absenteeism and suspension.

In recognition that poor school attendance and behavioural problems often provide a window into the circumstances of vulnerable children – including children at risk of sexual abuse and serious physical abuse – we looked closely at the school attendance and suspension data from around 60 schools in 12 communities with significant Aboriginal populations across NSW as part of our audit of the *Interagency Plan to Tackle Child Sexual Abuse in Aboriginal Communities*.

We found that almost a third of Aboriginal students from the 12 communities had missed 30 days or more of school in 2011, including three schools where more than 80% of Aboriginal students missed 30 days or more of school. We also looked closely at the child protection and education histories of 46 Aboriginal children from the 12 target communities who had been the subject of a sexual abuse report. This showed:

- 61% had missed 30 or more days of school in the six months before the incident and 15% had been suspended at least once in the same six month period; and
- 67% had missed 30 or more days of school in the six months after the incident and 38% had been suspended at least once in the same six month period.

Our examination of the child protection histories of the child victims from the 12 communities identified that two thirds had already been the subject of 10 or more child at risk reports before the sexual abuse incident. And, that although the Community Services face to face response rate for risk of sexual harm reports for Aboriginal children in NSW was 55%, the average response rate in the 12 communities was only half the state wide average at 26% – in some locations the rate was as low as 15%.

Our 8-11 year old review

In 2012, we conducted a separate review of a group of 8-11 year old children from two Western NSW towns[123] which also found a strong correlation between children's non-attendance at school and their identification by police as being 'high risk'. Using Education and Police records, we identified children who had missed lengthy periods of school through unexplained absences (at least

[122] NSW Ombudsman, The death of Ebony: the importance of an effective interagency response to children at risk, October 2009.

[123] NSW Ombudsman, Review of a group of school-aged children from two Western NSW towns: Towards intelligence driven child protection (confidential report), July 2012.

50 days a year) or suspensions, and/or had frequent contact with police because of their repeated exposure to violence and other risks at home or due to their own risk-taking behaviours. The group included 14 children on a 'priority' list created by local police analysts because of particular concerns about their suspected involvement in offending or because of incidents that highlighted specific child protection risks.

When we scrutinised the records that Police, Community Services, Education, Health and other agencies held about the children and others in their households, we found that most had been exposed to violence at home. The mothers of 46 children (96%) had been reported as victims of domestic violence, including the mothers of 26 children (54%) who had been the victim of 10 or more domestic assaults in the two year period checked. The fathers of 42 children (88%) had been criminally charged, some repeatedly. One father had accumulated 140 charges and 118 convictions over his lifetime, and another had 117 charges and 83 convictions. There were criminal charges against the mothers of 36 children (77%), and despite their young age seven of the children had also been charged.

Education records showed that 36 (75%) of the 48 children had been absent from school for 50 or more days in at least one of the years we checked, and 32 (67%) had been suspended at least once.

When we cross-referenced the agency information holdings on the 48 children we found that:

- For this age cohort, the children at greatest risk were readily identifiable through Education and Police records alone. There was also a high correlation between the children identified as being at risk due to school absences and/or suspensions and those identified as a 'priority' by police.
- Most were known to be at risk from an early age – 60% of the 48 children were aged two or younger when they were first reported to Community Services as being at risk, mostly because of their exposure to domestic violence.
- Those whose parents had extensive criminal records were among the children at greatest risk, as indicated by the high volume and seriousness of reported child protection issues. These children were also much more likely to be in statutory care or living in an informal care arrangement.
- All the children who were the alleged victims or perpetrators of sexual abuse had a range of other risk factors present – including disengagement from school, exposure to domestic and family violence, exposure to parental substance abuse and comparatively high numbers of abuse and neglect reports. These associated risks were present in all of the sexual abuse cases, irrespective of whether the abuse allegations had been substantiated.

From this work, it was clear that the collective information holdings about this cohort, rather than each agency's holdings in isolation, painted a vivid picture of the risks associated with the circumstances of each child and family. However, our review found that there was not an adequate system in place to systematically share and analyse the information held collectively by agencies. We also identified that both locations lacked a clear governance framework to facilitate this type of work.

The need for streamlined, effective and accountable governance structures was also recognised by the regional directors from Community Services, Education and Police who took part in our review. In emphasising the benefits of agencies coming together to share critical information on priority families, they highlighted the need for existing local governance structures to be rationalised. They commented on the program-centric nature of 'existing case coordination bodies established for specific purposes, such as the Supporting Children, Supporting Families program or the Safe Families Case Co-ordination Groups'. And they expressed concern about the lack of an efficient mechanism for ensuring that vulnerable families from both communities were being identified and referred for help. They also saw the need to track whether identified families were receiving the assistance that they actually required, rather than having to adjust to suit the particular parameters of the programs on offer.

The regional directors concluded that:

> *There may be value in re-thinking and broadening case co-ordination for these remote communities so that they can address issues of child protection and safety more broadly. There is a need for a mechanism by which information about children and families can be appropriately shared in order to enable a coordinated and early response. Utilising a tiered approach more broadly within the community could reduce duplication of case co-ordination activities and improve early intervention outcomes. It is of course critical that we do not add another layer of coordination, but look to streamline and simplify.*[124]

11.2 The need for innovative approaches to keep 'at risk' children at school

During our audit of the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*, our consultations with Aboriginal communities revealed significant concern about the high number of Aboriginal children being suspended from school. The authority to suspend a student rests with the principal, and under the Education Act, suspension means the student is suspended from attending school.

When suspended from school, young people usually either stay at home or, for students on long suspensions, attend a 'suspension centre', where available. Both methods of suspension involve exclusion from the student's regular school environment.

From our work with Aboriginal communities over many years, we are aware of numerous examples of young people deliberately taking action to become suspended because they see it as a bonus. Suspensions which simply exclude students from school for a period of time are also seen by many community leaders and educators as negative in that they remove the potential protective factor a school can offer, placing vulnerable young people at risk of either engaging in, or becoming the victims of, criminal behaviour. Against this background, it is worth noting that a number of principals and education regional directors have indicated to us their preference for a more systematic use of 'in-school' suspensions – exercising the use of exclusionary suspensions only in situations where very serious risks are evident.

Our 2012 report *Responding to child sexual abuse in Aboriginal communities* recommended that further consideration should be given to what type of alternative arrangements could be put in place to avoid 'suspensions', enabling students with challenging behaviours to remain within the school environment. Given the critical importance of education, it is essential that this issue is addressed in the most appropriate way.

11.2.1 Positioning schools as 'service hubs'

It is important to emphasise that finding solutions for better supporting high-risk adolescents who are not receiving an adequate education should not be seen as solely Education's responsibility. In our 2012 report about responding to sexual abuse, we also identified scope to consider the extent to which support services for vulnerable children, delivered by a range of government and non-government agencies, could be expanded and embedded within local school environments. The Connected Communities strategy, which positions schools as integrated 'service hubs' in 11 communities (involving 15 schools) across the state, provides the opportunity to test and develop innovative collaborative interagency work in this area of practice. However, as we noted in section 8, a recent interim evaluation of Connected Communities reported that there is still some way to go

[124] Joint response provided by Community Services, Department of Education and Communities and NSW Police Force on review of school-aged children, 26 March 2012.

before the service hub model is realised in practice and there is a need for key human service agencies to work together to identify solutions to the barriers that have been identified.[125]

11.2.2 FACS' progress in addressing educational neglect

In our 2014 report to Parliament about the child protection system, we noted that, despite the introduction of various measures to improve the way agencies identify and respond to educational neglect, ROSH reports because of educational neglect were still among those least likely to receive a response from the statutory child protection system. We reported that, in 2012-2013, only 11% of educational neglect ROSH reports received a face to face response from a Community Services caseworker.

Last year, the Department of Education advised us that an independent evaluation of a pilot project conducted in 2013-2014 had confirmed the value of schools working with local service providers to respond to poor school attendance. They said that the pilot – involving government and non-government agencies – aimed to identify issues underlying poor school attendance. For some participating students, the project contributed to improved family functioning and school attendance. FACS has also conducted pilot work on improving multi-agency responses to children at ROSH due to educational neglect. In addition, they have included issues relating to educational neglect in their review of FACS' child neglect policy and guidelines, and have developed online resources aimed at increasing professional awareness of education neglect for both FACS and Education staff.

We have previously recommended that FACS should develop and implement interagency operational frameworks to, among other things, deliver a more effective and integrated response in the area of educational neglect. However, FACS has advised that a specific strategy or response to educational neglect will not form a component of Safe Home for Life. Instead, they have pointed to the 'co-design' initiatives being implemented in districts as having the potential to support the development of local service responses to educational neglect.[126] We are also monitoring developments in this area through the joint FACS/Ombudsman Integrated Governance Framework (see p.7).

Despite improvements in recent years, particularly in relation to the identification of habitual school non-attendance, more needs to be done to ensure an adequate response to the needs of children at risk due to educational neglect.

In our view, while developing responses that reflect local needs is vital; addressing such a significant issue will also require overarching state-wide arrangements. The challenge for FACS and the Department of Education – and their other government and NGO partners – is to translate their work into an interagency operational framework that delivers a more effective and integrated response to children and young people at risk of educational neglect. It is important to recognise that developing a more sophisticated response to this issue will also involve identifying and addressing other abuse and neglect issues in the lives of children and young people.

We will also continue to monitor this issue through our function to monitor and review the delivery of community services (in particular, the co-design initiatives currently being pursued by FACS) as well as through our oversight of the implementation of Connected Communities (as part of our function to monitor and assess OCHRE).

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[125] NSW Department of Education, Centre for Education Statistics and Evaluation, *Connected Communities Strategy – Interim Evaluation Report*, January 2016.

[126] See NSW Ombudsman, Report of reviewable deaths in 2012 and 2013: Vol 1: Child deaths, June 2015. p65.

12 Responding to vulnerable adolescents

Since 2012, we have been arguing for a framework to drive whole of government responses to vulnerable adolescents.

In particular, our work has focused on how agencies – especially Police, Education and Community Services – identify young people who are most vulnerable. In this regard, we have considered the kinds of multiple child protection concerns that put young people at greater risk of drifting from the child protection system to the criminal justice system, and opportunities for agencies to intervene early. In this context, 'early intervention' to prevent juveniles becoming entrenched in the criminal justice system means interventions 'early in the pathway' of this drift into offending behaviour, not just interventions 'early in life'.

Despite repeated attempts by various individual agencies to manage the multiple issues affecting highly vulnerable young people, and other high-end users of services, the two main multi-agency case management models that were operating in NSW following the Wood Special Commission of Inquiry, failed to deliver. In our 2014 report, *Are things improving?*,[127] we noted that an evaluation of the Supporting Children, Supporting Families program highlighted concerns about weak governance processes and poor accountability, and confirmed that there had been disappointing practical outcomes from the program over its seven years of operation. We also observed that an evaluation of Family Case Management found that its trial sites in Western NSW experienced acute difficulty in getting families with complex needs to engage with the program, and that contributing factors to this difficulty included limited capacity of staff to case manage clients with multiple and complex needs; a lack of training; and local community distrust of participating services.

Both programs demonstrated the central importance of creating strong local and regional governance arrangements to drive interagency case management initiatives, and the need to build a comprehensive, integrated service system over time.

We know that various iterations of integrated case coordination panels/committees continue to operate across the state – some more successfully than others. Regardless of the particular label under which these initiatives are operating, if the longstanding issues of cross-agency governance and leadership are not effectively addressed, then it is unlikely newly badged initiatives will be any more successful than earlier attempts to coordinate agency efforts. We have also argued that integrated case coordination groups need to be embedded in the overarching governance structures that should be driving a broader place-based service delivery approach in high need communities.

Following a discussion paper we provided to FACS in July 2012, *Service provision challenges in responding to very vulnerable older children and young people*, the NSW Government established a FACS-led review called 'Better lives for vulnerable teens'. The goal of the review was to recommend strategies to reduce the numbers of older children and young people:

- re-entering Juvenile Justice
- affected by homelessness and long-term instability in their accommodation, and
- entering out-of-home care.

While we welcomed the review, in our 2012 report on responding to Aboriginal child sexual assault and again in our 2014 report, *Are things Improving?*, we recommended that the review and other important related initiatives form part of a broader, more cohesive state-wide framework for

[127] See section 4.2.2 Addressing identified problems in relation to integrated practice

identifying and responding to children and adolescents with complex needs. We also suggested that the framework actively incorporate all major service providers (especially Education, Health and other universal services; together with community and non-government providers, and specialist agencies such as Juvenile Justice).

FACS subsequently committed to contributing to the development of a whole of government framework to ensure the delivery of effective and integrated support services and achievement of improved outcomes for highly vulnerable teenagers.[128]

More recently, FACS advised us that it is now working with the NSW Child and Youth Advocate to develop a whole of government plan to deliver more effective services to vulnerable adolescents. However, we note that the *NSW Strategic Plan for Children and Young people*[129] released by the Advocate on 26 July, does not specifically address this issue. As we noted in our 2014 report, *Are Things Improving?* in the absence of such a framework, the system will continue to be characterised by piecemeal responses that result in young people continuing to get lost in the system.

Finally, it will be important for FACS in developing a framework, to have regard to the approach used by the Department of Justice in developing and implementing 'Youth on Track' in light of recent positive results achieved by the program.

Youth on Track

The Youth on Track program is an integrated case management scheme for young people aged 10-17 who are at risk of long term involvement in the criminal justice system. The program is funded by the Department of Justice and delivered by non-government organisations. It aims to identify and respond to young people at risk of long term involvement in the criminal justice system through the provision of one-on-one case management and targeted services aimed at responding to the underlying causes of a participant's offending.

The program has been operating in the Mid North Coast, Hunter, and Blacktown areas (covering eight NSW Police Force Local Area Commands) since 2013. From December 2016, it will be expanded to a further five Local Area Commands in the Central West, New England, and Coffs Clarence areas.

To-date the results have been promising. Between 1 July 2013 and 31 March 2016, more than 250 young people participated in the program. 62% of participants reduced or stabilised their offending risk score following 3 months of intervention; and 87% of participants who completed the scheme reduced or stabilised their offending risk score. Of those participants who were initially assessed as being high risk, 85% had improved their behaviour on completion of the program; 83% improved their education engagement and family circumstances; and 67% improved their attitudes and peer relations. The Department of Justice has commissioned a social outcome evaluation which is due to be completed by March 2017; and a reoffending evaluation will be conducted by mid-2018. The results of the evaluations will inform the state-wide expansion of the program.[130]

[128] FACS response to NSW Ombudsman, *Are things Improving?* 2014

[129] NSW Strategic Plan for Children and Young People, Advocate for Children and Young people, July 2016.

[130] Department of Justice, Youth on Track snapshot 1 July 2013 - 31 March 2016, www.youthontrack.justice.nsw.gov.au/Documents/snapshot-march-2016-youth-on-track-v3.pdf

12.1 Supporting young people who are homeless

In August 2014, following a request from the peak bodies in the homelessness sector – Homelessness NSW; the NSW Council of Social Service; Domestic Violence NSW; and YFoundations – we agreed to oversee FACS' post-implementation review of the Going Home, Staying Home (GHSH) reforms affecting the specialist homelessness service sector. Children and young people are among the most vulnerable users of these services.

In carrying out our oversight role, we adopted a resolution focused approach. Our aim was to identify lessons that might inform future reforms across the human services sector and provide independent advice on any areas where there might be scope for remedial action.

Between August and October 2014, we received feedback about the implementation of GHSH from more than 70 service providers, consumer representatives, peak bodies and various other stakeholders. We gave FACS a schedule outlining the issues that had been identified through our consultations and asked them to provide us with a response to each. We had planned to host a stakeholder forum in November 2014 to discuss some of the key concerns that had been raised with our office.

On 23 October, the Legislative Council passed a motion ordering that certain documentation relating to the GHSH reforms be provided to Parliament. Given the scope of the documentation requested, it appeared that the parliamentary process was akin to a forensic investigative approach. As a result, we decided that it would not be appropriate for us to continue to simultaneously proceed with the stakeholder forum.

However, we did ask that FACS provide to Parliament a copy of the schedule of issues which we had developed following our consultations (together with its response to each issue), and we understand that this information was tabled in May 2015. The schedule was also used by KPMG (who were commissioned by FACS to complete the post-implementation review) to inform their review report, which was finalised in August 2015.

The need for a targeted approach for unaccompanied children and young people who are homeless – or at-risk of homelessness – was highlighted by stakeholders during both the GHSH consultation and planning processes; and during our own consultations in 2015.

As the GHSH reforms were unfolding, in June 2014 the NSW Government also announced that, in addition to the funding for youth services under GHSH (approximately $50m per annum), a further $27 million over three years would be provided to NGO services under the Homeless Youth Assistance Program (HYAP) to deliver integrated support and accommodation models with the aim of reconnecting this cohort to their families or support networks, or enabling them to transition to independence. However, notwithstanding the announcement of the HYAP funding, at the time of our consultations in 2015, the youth sector raised concerns about their ability to deliver appropriate services based on the GHSH and HYAP funding model – in particular, their ability to provide 24/7 staffing support at youth SHS services.

In September 2015, the Premier announced 12 'Premier's Priorities', underpinned by 30 key policy objectives. One of the 12 priorities is to reduce youth homelessness by increasing the proportion of young people who successfully move from SHS to long-term accommodation by 10%.

We understand that, in addition to the GHSH and HYAP reforms, a number of initiatives are being progressed in order to achieve this priority, including the expansion of the Youth Private Rental Subsidy pilot in the Hunter New England District to a further two FACS Districts. In addition, in

May 2016 the Minister for Family and Community Services announced an additional $23m over the next two years for youth SHS services, to support 24/7 service delivery.

We will continue to monitor the SHS Monitoring and Evaluation Strategy through our ongoing observer status on the Monitoring and Evaluation Advisory Group and our regular liaison with the peak bodies. In doing so, it will be important to track the impact of the government's recent funding enhancement for youth crisis accommodation on service gaps for young people, and the work undertaken during the two year period to ensure the sustainability of the 24/7 support model for youth SHS services.

12.2 Unaccompanied children in homelessness service

As part of our focus on at risk adolescents, we have been monitoring the adequacy of systemic responses to unaccompanied homeless children and young people.

Following discussions with the peak body for youth homelessness[131] in 2004, FACS started to develop a policy for meeting the needs of unaccompanied children living in homelessness services. A consultation draft of the policy was released in early 2006; the same year we initiated a review of a group of children under the parental responsibility of the Minister and residing in refuge accommodation.

We recommended that FACS provide us with detailed advice about the progress it had made in settling the policy. Despite subsequently issuing several draft policy positions, a final policy was not endorsed. We continued to actively raise concerns about the delay in finalising the policy, including in our 2014 *Are things improving?* report. Around the time of publishing that report, FACS advised us that an interim policy had been released to inform the tendering approach for the Going Home Staying Home reforms to specialist homelessness services that was subsequently the subject of an extensive consultation process with FACS districts, peak bodies, youth specific specialist homelessness providers and other key stakeholders.

It is now more than two years since FACS implemented a policy that outlines its role and responsibilities, and those of Specialist Homelessness Services (SHS), towards unaccompanied homeless children aged 12-15. In that period, FACS has also developed a draft district-level interagency protocol to support the policy. We provided feedback on the draft protocol last year. We suggested that the draft could be strengthened by including practical guidance that reflected legislated responsibilities and promoted a more consistent response to unaccompanied homeless children throughout the State.

Late last year, FACS told us that it would revise the draft protocol and that further consultation on this would take place. In particular, FACS said the revised version would provide greater clarity about FACS' role in relation to unaccompanied homeless children for whom there were safety concerns. The document remains in draft form and subject to stakeholder consultation.

It will be important to implement the protocol to support the policy and to promote consistency in practice across districts. We will be examining the extent to which the new policy and related protocol address the need to provide adequate support to vulnerable unaccompanied children in homelessness services.

Over the next twelve months, we will review the adequacy of key aspects of the legal, policy and practice framework for homeless children living in SHS.

[131] Formerly Youth Accommodation Association now known as YFoundations

13 Children and young people with disability

Children and young people with disability are at increased risk of abuse compared to children without disability. The risk is heightened for children with communication impairments and high behaviour support needs. While there is no reliable national data, children with disability are also believed to be overrepresented in statutory OOHC.[132]

Our disability functions

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, we have specific functions relating to people using community services, people with disability, and disability services. These functions include:

- handling and investigating complaints about disability services, including any supports funded under a National Disability Insurance Scheme participant's plan
- inquiring into major issues affecting people with disability and disability services
- reviewing the care, circumstances and deaths of people with disability in residential care
- monitoring, reviewing and setting standards for the delivery of disability services
- coordinating the Official Community Visitors in their visits to people with disability in supported accommodation and assisted boarding houses.

Under Part 3C of the Ombudsman Act, we also oversight the actions of disability services to prevent – and respond effectively to – serious incidents involving people with disability living in supported group accommodation in NSW. Our Deputy Ombudsman, Steve Kinmond, is also the Disability and Community Services Commissioner for NSW.

Reforms to improve the provision of disability services to children

Over the past decade, we have advocated for improvements in the provision of disability services to children. In a special report to Parliament in 2004,[133] we raised concerns about the way services to children and young people with disability were being provided in NSW. Among other things, we found that Ageing, Disability and Home Care (AHDC) was not effectively implementing its policy on supporting families at risk of relinquishing care of a child or young person with disability; and was not acting in accordance with its policy on supporting children and young people with disability placed in voluntary care. ADHC developed a comprehensive action plan in response to our report.[134]

In 2006, we tabled a follow up report to Parliament – Services for children with a disability and their families: DADHC progress and future challenges – about ADHC's progress to address the problems we had identified in 2004. We highlighted that, while progress had been made to improve systems to support the provision of disability services, there had been no evaluation of the longer term impacts of the reforms on families requiring those services. We said that effective evaluation of the reform process must include identifying the extent of the need in critical areas and then determining the degree to which implementation of new and expanded programs makes a difference to families.

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[132] Children with Disability Australia, Submission to Royal Commission into Institutional Responses to Child Sexual Abuse, Consultation paper on OOHC, April 2016.

[133] http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0020/3368/DADHC-the-need-to-improve-services.pdf

[134] The plan included actions to expand Local Support Coordination; provide clarity on AHDC's role in relation to providing family support; improve the access of children and young people with disability to appropriate support; improve respite capacity; and improve planning and case management for children with disability at risk of OOHC placement.

- **Stronger Together**

Shortly after our 2006 report, the NSW Government released *Stronger Together 2006-2016*, which provided $1 billion over the first five years to significantly reform the disability sector and increase service capacity. The plan substantially reflected the observations we had made in our 2004 report about the changes needed to improve services for children with disabilities and their families. In this regard, *Stronger Together* focused on three key strategies:

- expanding agencies' capacity to respond more quickly and appropriately
- enhancing the support to parents and other carers and intervening earlier; and
- structuring services in a way that better supports families.

In February 2007, the NSW Government also released *Better Together* – a four-year plan designed to make government services work better for people with disabilities and their families. While *Stronger Together* focused on improving the specialist disability service system, *Better Together* focused on improving 'universal' and 'adapted' services such as childcare; school; before and after school care; and vacation care. *Better Together* also aimed to improve the linkages between specialist, adapted and universal services.

Against this background and the approaching the mid-way point of *Stronger Together*, in 2010 we decided to consult with the families of children with disabilities[135] about their recent experience in seeking and obtaining specialist disability services and support; and whether the type and amount of support they had been provided had met their needs. We also asked about people's experiences in accessing universal and adapted services.[136] In the main, families spoke positively about the increase in services and the development of new initiatives and programs that had occurred since the commencement of *Stronger Together*. However, it was clear that families continued to experience problems in getting access to information and support, including therapy, respite and equipment.

Many of the issues raised during our consultations were addressed in plans for the second phase of *Stronger Together* (including $2 billion additional funding) announced in 2011, which included a strong focus on person-centred support and identifying opportunities to intervene at significant life stages and transition points in children's lives. In this regard, for children with disability in OOHC, 'leaving care' is one such significant transition point. As we discussed in section 4, in 2010-11 we worked with Community Services and the (then) Guardianship Tribunal to develop a Protocol to facilitate guardianship applications being made without undue delay after a young person turns 16, where an assessment had identified that a young person in care was likely to require at least some aspects of guardianship after leaving care. The purpose of the Protocol was to ensure that the Public Guardian was appointed with an advocacy function to enable them to be actively involved in the transition planning process for the young person. The Protocol was implemented in June 2011.

- **The National Disability Insurance Scheme**

The launch of the National Disability Insurance Scheme (NDIS) in July 2013 marked the beginning of a dramatic shift in disability service delivery. Since then, we have been working with other disability complaints commissioners across Australia and New Zealand, as well as with Commonwealth and NSW representatives and other key stakeholders, to develop a quality and safeguarding framework for the NDIS. In conjunction with the other disability complaints commissioners, we have advocated for the adoption of certain key functions as the minimum

[135] http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0019/5464/Final-consultation-report-families-of-children-with-disabilities.pdf

[136] Between late May and August 2010, we talked with over 300 parents and carers of children with disabilities. All of the children were under 18 years of age and living at home. Families provided information via telephone interview, written survey, focus group and email.

requirements of a national framework. These are outlined in our Safeguards and the NDIS document.

It will be critical to ensure that, in the context of the transition to the NDIS, the gains that have been made under *Stronger Together* in relation to services for children with disabilities are retained. While there is a clear commitment to early intervention in the NDIS, on a practical level, there will need to be strong links between the NDIS; Local Support Coordination; NDIS-funded supports (particularly support coordinators and early childhood intervention providers); mainstream services (including FACS), and families.

13.1 What our reportable conduct data shows us

We also have a focus on the particular needs of children with disability through our oversight of the reportable conduct scheme.

Our reportable conduct data for the period 1/7/2013 to 30/6/2015 indicates that 29% (588) of all notifications closed during that period involved a child with disability or child with additional support needs.[137]

By way of comparison, recent sampling work carried out by FACS in relation to the OOHC sector, indicates that around 12% of children in OOHC have a disability. However, 36% of all closed notifications from the OOHC sector for the same period involve a child with disability or a child with additional support needs.

The government school sector reports that 12% of the school population has a disability or additional support needs. However, 21% of all reportable conduct notifications we receive from this sector involve a child with disability.

For both the OOHC and government school sectors, children with disability are over represented in connection with reportable conduct notifications.

Children with disability are also over-represented (22%) in notifications of sexual misconduct/sexual offences.

Given the widely held view that abuse involving people with disability is often more difficult to prove, it is significant that across all allegations notified to our office over the past two years, the sustained rate for allegations involving a child with disability was 23% (compared to 22.4% for all children).

However, despite the fact that 29% of all notifications which we close involve a child with disability or additional needs, they represent only 6% (8 of 135) of all open matters that involve a criminal charge. This data demonstrates the challenge in the justice system providing people with disability with equal justice in the courts. In this regard, it is hoped that the establishment of the specialist child sexual assault evidence program known as 'Children's Champions' or witness intermediaries (see also section 9) to support child witnesses through the trial process, will lead to better criminal justice outcomes for all children, including children with disability. A critical part of

[137] 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. After consulting the education sector, FACS and People With Disability, we agreed to redesign our agency notification form so that our disability categories aligned with the four categories used by all schools for the Nationally Consistent Collection of Data (NCCD) on School Students with Disability – physical, cognitive, sensory, social/emotional. While the NCCD process only relates to schools, the categories provide a simple and consistent way for us to capture data relating to alleged victims from across the various sectors within our jurisdiction.

the role of the intermediary is to help child witnesses give their best evidence in criminal investigations and at trial. The Champions will help child witnesses understand the questions they are asked and get their answers across effectively.

13.2 Disability Reportable Incidents scheme

In addition to the reportable conduct scheme under Part 3A of the Ombudsman Act, in December 2014 a reportable disability incidents scheme commenced. Part 3C of the Ombudsman Act requires the Ombudsman to keep under scrutiny the systems of FACS and funded providers for preventing, handling, and responding to reportable incidents involving people with disability who live in supported group accommodation.

During its operation to date, the scheme has placed an increased spotlight on issues relating to the abuse and neglect of people with disability generally, including:

- what disability and other service providers need to do to advance the rights of people with disability to live their lives free from abuse
- the need for a person-centred approach to those who have been abused
- the need for a sophisticated initial and early response to the abuse of people with disability by service providers, and
- the challenges for police in providing an adequate response to the alleged abuse of people with disability which enables us to systematically capture these practice challenges and feed this information back to senior police.

All of these issues are very relevant to children with disability and to our oversight of the reportable conduct scheme.

13.2.1 Improving initial and early responses to serious abuse

This year, we have developed draft guidance for staff in disability services about the initial and early response they need to make to serious incidents – including a comprehensive resource guide, a quick guide, and a one-page flowchart. The resources have been developed in consultation with a range of NSW agencies. However, we are conscious that anything we develop in this area must have an eye to the national landscape. In November 2015 we therefore convened a roundtable meeting in Melbourne to discuss the draft resource guide with key NSW, Victorian and Commonwealth parties – including representatives of NSW and Victorian Police.

13.2.2 Enhancing the criminal justice response

Our work has particularly highlighted the importance of building the capacity of the NSWPF to effectively respond to serious incidents involving people with disability – including victims, offenders and witnesses.

In our recent submission to the Royal Commission into institutional responses to sexual abuse in relation to its public hearing into disability service providers, we noted evidence previously given to the Commission about the need for a specialised team within JIRT to work with children with disability, and for:

- more consultation by interviewers on the child's capabilities, including with families, and
- more funding and training for police dealing with, and interviewing, children with disability.

We advised the Commission that, in our experience, there is a need to improve investigative interviewing of people with cognitive impairment more broadly – including children and adults – to maximise their ability to give evidence and gain effective access to justice.

Last year, FACS engaged us to deliver a 'Rights project for people with disability' – a capacity-building project to develop a practical framework that enables people with disability and their supporters to better understand and exercise their rights. A focus of the project will be enhancing the rights of children with disability. In this regard, we will look closely at the findings from recent research undertaken by Dr Sally Robinson for the Royal Commission into institutional responses to child sexual abuse, into what helps children and young people with disability and high support needs to feel safe in institutional settings.[138] One of the key findings of the research was the need for evidence-based educational resources and strategies to improve the capacity of children and young people with disability to identify and respond to potential harm. An aim of our project is to identify good quality resources and where needed, commission their development.

As part of the project, we have also commenced work to develop a guidance and training package for complaint handling staff and investigators in disability services to improve their communication skills 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. The resources will provide practical advice about the impact of trauma and cognitive disability on communication, fundamental principles of investigative interviewing, specific interview techniques, and practices to avoid. The resources will also include a broad disability awareness component which focuses on cognitive disability, and will be tailored for use by police in their training of investigators and other officers.

To assist us to develop these resources, we are engaging an expert with extensive knowledge and experience in relation to communication with people with a cognitive disability in an investigative environment. We will also seek input and advice from a range of stakeholders in the disability and criminal justice sectors.

For further information about our recent work in relation to people with disability, we have attached a link to a recent submission we provided to the Royal Commission into Institutional Responses to Child Sexual Abuse to inform its recent public hearing into disability services – https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0006/35934/Letter-to-Royal-Commission-re-NDIS-and-safeguards-19-July-2016.pdf

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[138] Dr 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*, Centre for Children and Young People, Southern Cross University, February 2016.