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Royal Commission into Institutional Responses to Child Sexual Abuse
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Dear Commissioners,

NSW Ombudsman submission to the Royal Commission into Institutional Responses to Child Sexual Abuse: Issues Paper 4 – Preventing sexual abuse of children in out-of-home care

The NSW Ombudsman's office welcomes the opportunity to provide a submission to the Royal Commission in response to the abovementioned Issues Paper.

As the Commission 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*. We refer in more detail to these functions in responding to the questions about oversight.

In light of the distinct but complementary oversight functions exercised by our office and the Office of the Children's Guardian (OoCG), it was important for our office to consider the submission prepared by the OoCG in finalising our own submission – where appropriate, we make reference to the OoCG's submission.

This submission responds to each of the questions in the Issues Paper; however, we have provided more detailed commentary in relation to those issues where our office has had significant involvement. In preparing this submission, we have also drawn from our experience in conducting a three year legislated audit of the implementation of the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*. Our final audit report was tabled in the NSW Parliament in January 2013.

Preventing sexual abuse of children in out-of-home care requires a responsive service system

Irrespective of the quality of an out-of-home care system, the capacity to protect children within that system from sexual abuse, and to respond to victims once abuse has been identified, is heavily dependent on the effectiveness of the mainstream service system – including the child protection, criminal justice, and therapeutic response to child sexual abuse.

Our audit of the *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities* (the Interagency Plan) identified a number of fundamental service challenges that if left unaddressed, will continue to impede government efforts to respond effectively to child sexual abuse not only in Aboriginal communities but more generally.

Our audit also highlighted (and made recommendations about) a range of other policy and practice issues that are relevant to the work of the Commission and the themes covered in this Issues Paper, including the need to:

- improve the response to allegations of historical child sexual abuse
- develop consistent practices relating to the threshold for reporting child abuse allegations to police, and
- address existing weaknesses in the regime for the cross-border exchange of child protection-related information.

As the Commission is aware, our office highlighted these and other systemic issues in our confidential submission in May 2013, and provided relevant case studies.

We discuss other findings from our audit of the Interagency Plan throughout this submission.

Question 1: An essential element of OOHC is for a child to be safe and secure. Are there core strategies for keeping children in OOHC safe from sexual abuse and what is the evidence that supports them?

Question 2: Is there evidence for having different strategies for keeping children in OOHC safe from sexual abuse depending on whether a child is in relative or kinship care, foster care or some other form of residential care?

Given the complex and multi-faceted nature of child sexual abuse, a range of strategies must be employed to reduce the risk of abuse of children in care generally.

Our oversight of Part 3A reportable conduct matters – and our broader review work – have shown that where children suffer abuse or neglect in out-of-home care, it is often in the context of poor carer recruitment (including inadequate probity checks and screening); unsuitable placement decisions – particularly in relation to placing children who have a history of displaying sexually abusive behaviours with other (typically younger) children; and/or inadequate monitoring of the placement and support for children and carers during their placement.

The non-government out-of-home-care sector in NSW is currently undergoing rapid and significant growth, with the transfer of most out-of-home-care placements from Community Services to the non-government sector. As this transition occurs, the extent to which the non-government sector can strengthen the safeguarding systems which currently exist will be critical to whether children in out-of-home care in NSW will be better protected from sexual abuse. It will therefore be more important than ever for the bodies responsible for the funding, regulation and oversight of the out-of-home care sector to closely scrutinise, and be responsive to, the changing dynamics of the sector as the transition unfolds.

- **Good agency governance combined with a robust accreditation scheme**

Keeping children safe from sexual abuse first and foremost requires out-of-home care agencies to embed a child-focussed approach within the culture of their organisation. This approach needs to be reinforced in these agencies' policies and procedures; staff and carer recruitment; risk management practices; and the quality of its supervision and casework. In practice, this will need to include:

- 'upfront protections' to ensure that agency staff and carers are thoroughly screened and assessed, and children are placed in suitable placements
- ensuring that children are given the opportunity to have meaningful input into their care planning and that they have someone with appropriate skills who is outside of the placement who they feel comfortable talking with about their circumstances
- making children aware of their right to complain and ensuring that agencies actively respond to identified concerns

- good quality casework and supervision of care placements, including effective support and regular monitoring of children and carers during placements, and
- a robust system for identifying, investigating and managing risks relating to allegations of abuse of children in care.

The *NSW Standards for Statutory Out-of-Home Care* have a strong focus on good governance (Standards 21 and 22). The Standards also provide clear information to agencies about the types of policies and systems that need to be in place to promote child safety in out-of-home care settings. From our regular liaison with the OoCG, we are also aware that together with peak bodies such as the Association of Children's Welfare Agencies (ACWA) and the Aboriginal Child and Family Secretariat (AbSec), there will be a strong focus during the out-of-home care transition on working closely with smaller agencies (including many Aboriginal agencies) to develop a greater understanding across the sector of what good governance looks like – for example, selecting an effective and experienced board and managing potential conflicts of interest that can arise when board members also take on a caring role.

The regulatory role played by the OoCG, which is exercised principally through its accreditation program, is an important safeguard and is critical to improving and monitoring the quality of out-of-home care in NSW. However, with the rapid expansion of the non-government sector as a whole it will be even more important that the OoCG continues to have the capacity to actively monitor the performance of agencies through its accreditation program. Our own consultations with agencies have confirmed that the shift away from desk-based monitoring by the OoCG (following the 2007 review of the accreditation program) towards on-site visits has been welcomed by the sector. In our view, active agency monitoring by an independent regulator is a necessary component of a quality out-of-home care system.

- **Carer probity screening**

In both our reviewable child death and employment-related child protection work, we have seen where the inadequate screening of carers, or adults living in or closely associated with carer households, has resulted in significant risk, and in some cases serious physical harm to children.

As we previously advised the Commission in our submission on the Working with Children Check (WWCC), we strongly support the implementation of a nationally consistent approach to WWCCs, and believe that such a scheme should apply to those authorised to care for children, as well as any adults who reside at the home of an authorised carer. In NSW, designated agencies may make criminal record and other probity checks relating to individuals over 14 years who reside in the prospective carer's household as part of assessing a carer's suitability.[1] Assessments of carer suitability also need to consider any other risks associated with the proposed 'place' where the care will be provided.

However, in NSW the only legislated screening requirement relating to carers is the WWCC. There are a range of other important checks that should be performed that are left to the discretion of the designated out-of-home care agency. For example, the WWCC does not automatically include a review of a person's full criminal history, which is why agencies should conduct National Criminal History Record Checks and referee checks. In addition, the information holdings of Community Services, other out-of-home care agencies and police, can also be highly relevant to whether or not a person should be authorised as a carer.

We note that the OoCG's submission outlines the current work being undertaken in NSW to strengthen the assessment framework for carers and other household members, including enhancing the assessment processes for relative/kin carers. In this regard, our office supports the proposed introduction of minimum assessment requirements which will be incorporated in the Carers Register (discussed below).

[1] Children and Young Persons (Care and Protection) Regulation 2012, clause 30(4)

Following the introduction of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, we have taken an active role in promoting the use of these information exchange provisions in the context of encouraging agencies to obtain relevant information to assess the suitability of carers and employees. After extensive negotiations, Community Services has agreed to provide non-government out-of-home care agencies assessing a prospective carer with advice on whether it holds information which, if the individual applied to be a carer with Community Services, would result in the agency determining that the involved individual was unsuitable to be authorised. In addition, Community Services has agreed to provide any relevant 'safety, welfare or wellbeing' associated information that it holds about carer applicants, and their household members, which it believes the agency would need to be aware of in order to undertake a comprehensive assessment of the applicant and/or manage potential risks to children who could potentially be placed with the applicants if they are approved as carers.

In 2011, we hosted a Carer Screening (Probity) roundtable discussion with Community Services, the OoCG, the Commission for Children and Young People and out-of-home care peak organisations to help develop a more rigorous approach to screening and assessment. Community Services and ACWA subsequently led additional related roundtable discussions which resulted in agreement being reached on a number of important policy issues, including the need to have consistent types of information considered in relation to carer probity checks. This led to the OoCG's establishment of a Carers Register in NSW.

The Carers Register will provide agencies with information about a potential carer's previous care history and guide agencies through the carer assessment process. The Register will require agencies to indicate that they have undertaken certain steps in assessing a carer applicant before they are able to authorise that applicant including that: they have undertaken referee checks; confirmed a current WWCC and National Criminal History Record Check; obtained relevant information from Community Services; assessed the carer's suitability; and conducted pre-authorisation training with the applicant. The plan is for the Register to be operational by July 2014. The OoCG is currently developing a range of legislative proposals and standards to support the operation of the Register.

We believe that the Carers Register is an important additional safeguard in promoting robust and consistent probity checking of carers in NSW. However, we note carers will only be brought under the scrutiny of the Register system if they are newly applying for authorisation, or if they are applying for authorisation with a different out-of-home care agency.

- **Carer assessment and placement suitability**

While we have worked with others to promote improved probity screening in NSW in recent years, we recognise there is a risk that, as probity screening processes are improved, undue weight could be placed on the outcome of this screening at the expense of a thorough carer/placement assessment.

For example, we have reviewed matters in which children in care have been abused by people who have been part of a carer's extended family or close network. Having an effective and ongoing carer assessment process that goes beyond probity screening, can increase the likelihood of identifying situations where there are people who are regularly engaged with a household who may pose a risk to children.

In addition to addressing the issues associated with carer suitability – and the suitability of their household members and close associates – there are a range of other factors which ought to be considered in relation to placement suitability, including the number of children who should reside in particular placements, and the related capacity of individual carers (including their ability to care for children with complex needs), and those children who may present a risk for others in the placement. One area which is particularly challenging concerns identifying the most appropriate care setting for children who have a history of displaying sexually abusive behaviours and/or young people who have sexually abused.

- **The need for 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 wherever 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.[2] We also found evidence of inadequate caseworker resources in both our 2010 and 2013 reviews of young people due to leave statutory care.[3] 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, the then Department of 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.

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.

Another important part of casework involves developing a care plan for the child. These plans should include a focus on children building connections with their peers and with significant adults who are external to the child's placement; as well as community-based recreational and cultural activities. As we discuss in the section below, school can provide a protective environment for children, and disengagement from school can create a range of risks associated with children losing their connections with positive adult influences and potentially being at greater risk of exposure to sexual predators. Our audit of the Interagency Plan found a strong link between disengagement from school and child sexual abuse.

- **Tackling child sexual abuse in Aboriginal kinship care settings**

The Issues Paper posed a question about whether different strategies were needed to prevent sexual abuse in kinship care settings.

In NSW, more than one third of the out-of-home care population is made up of Aboriginal children and around 60% of these children are in kinship placements.[4] Aboriginal children are also significantly

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

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

[4] Australian Institute of Health and Welfare 2013. *Child protection Australia: 2011–12*. Child Welfare series no. 55. Cat. no. CWS 43, Table A25. Canberra: AIHW.

over-represented in child abuse reports. Therefore, responding to the particular needs of this significant cohort of children should be a focus in seeking to prevent abuse of children in out-of-home care.

We believe that the same strategies and standards for supporting children in out-of-home care and keeping them safe from sexual abuse should apply to all children, irrespective of whether they are in kinship or foster care. During the Carer Screening (Probity) Roundtable we convened in 2011, there was strong support for the same standards to be used for kinship carer assessment and authorisation, as those used for other foster carers.

As we have previously advised the Commission, our oversight has shown that because it is preferable to place children with family/kin wherever possible, we have seen evidence of inadequate assessment practices involving a number of these placements, including failures in recognising significant risk factors. (In this regard, we have provided to the Commission details of specific investigations undertaken by our office where the inadequate assessment of kinship carers has contributed to children being placed at risk of harm and suffering serious harm). We note that the enhancements to the assessment framework currently being developed in NSW are likely to provide additional protections to children in kinship care. While the assessment framework will still enable emergency relative placements, it is proposed that relative/kin carers and other members of their household will now be required to undergo the same level of checking as other fully authorised foster carers. We welcome these proposed changes.

Our review work has consistently shown that in the past, children in kinship placements have often been at greater risk for a variety of reasons including that: kinship carers are less likely to have an allocated caseworker, and that placements with kinship carers are 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). 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.

One of the areas where it is vital for caseworkers to play an active role with kinship carers is ensuring that children are regularly attending and engaging in school. 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.

It is worth noting that six of the 12 communities we examined were located in Western NSW, where there is still no Aboriginal out-of-home care agency. We know from our work with Aboriginal communities over more than a decade that many of the kinship carers in the Western region are in need of a range of supports, as are the children in their care.

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 face to face response rate for risk of sexual harm reports for Aboriginal children in NSW was 55%, the response rates in the 12 communities were only half the state wide average at 26% – in some locations the rate was as low as 15%.

Our *Responding to Child Sexual Assault in Aboriginal Communities* report highlighted that child sexual abuse cannot be addressed in isolation of the underlying causes of disadvantage in many vulnerable Aboriginal communities. For this reason, we made a range of recommendations aimed at improving school attendance and educational outcomes for Aboriginal children, and building the economic capacity of Aboriginal people. In considering the particular needs of Aboriginal children in kinship care, it is therefore necessary to have regard to the broader issues facing many children in kinship care and those family members that are caring for them, who are often living in isolated areas where service provision has been poorly coordinated and largely ineffective for many years.

Another strong theme in our report was the need to recognise the role that should be played by Aboriginal leaders at both a community and state-wide level in making decisions about improving the circumstances of Aboriginal people. The expansion of the Aboriginal out-of-home care sector taking place in NSW is strongly supported by this office. And, in our view is a practical demonstration of self-determination and the application of 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.

- **Children in out-of-home care in youth refuges and homelessness services**

Although not referenced in the Issues Paper, another particularly vulnerable group of children in out-of-home care in NSW are those who self-place in, or are referred to, temporary refuges run by homelessness services – many of these young people are often at serious risk of harm and are especially vulnerable to sexual predators.

Our 2012 discussion paper[5] on service provision challenges in responding to very vulnerable older children and young people, illustrated the policy and service provision challenges in providing an effective and timely child protection response to this group.

Our paper highlighted the need to:

- better define and identify those older children and young people who are most vulnerable and intervene much earlier
- explore strategies for better engaging marginalised older children and young people in the education system
- provide a comprehensive and integrated response to highly vulnerable older children and young people
- provide therapeutic residential support to those older children and young people whose circumstances place them at extreme risk, and
- improve responses to young people who are exposed to sexual predators.

As a direct outcome of the paper, the Government announced last year that FACS would establish a 'Vulnerable Teenagers Review' to recommend strategies to reduce the number of older children and adolescents re-entering juvenile justice and/or affected by homelessness and long-term instability of accommodation. FACS also convened a panel of leading Australian child protection and youth sector experts to explore 'what works' and what obstacles must be overcome as part of its review process.

[5] *Service provision challenges in responding to very vulnerable older children and young people,* NSW Ombudsman, July 2012.

We have provided feedback on various iterations of the review – now known as *Better Lives for Vulnerable Teens*. FACS has accepted our advice that the Vulnerable Teens strategy must form part of an over-arching whole of government framework for addressing the needs of this group. At a local level, a strategy of this type will only succeed if it is supported by a truly integrated approach to case management that includes government and non-government agencies operating in the human services and justice sectors.

When young people drift away from home-based placements into homelessness services, it is critical that solid casework continues to be performed by Community Services and agencies funded to manage out-of-home care arrangements in conjunction with the homelessness service. The youth homelessness sector as well as other specialist homelessness services in NSW are currently undergoing significant change as a result of the NSW Government's *Going Home Staying Home* reforms – these reforms will involve the implementation of new service delivery models and service configuration across the specialist homelessness sector – service funding will be driven by a resource allocation model based on identified need. The fact that a significant percentage of children who are in out-of-home care end up spending time in homelessness services highlights the significance of this work to this submission on out-of-home care.

- **The importance of robust systems for detecting, investigating and reporting allegations of workplace child abuse**

The literature on the development of child safe organisations recognises that an important element of creating an abuse resistant environment is the implementation of quality systems for detecting, investigating and reporting allegations of workplace child abuse. While we do not hold the view that such systems will on their own adequately protect children, we consider that the absence of a nationally consistent and robust system for addressing allegations of workplace child abuse – which includes independent oversight – puts children's safety at risk.
Our experience in oversighting matters under Part 3A of the Ombudsman Act has highlighted a number of critical elements that relate to agencies' identification of, and response to, individual cases involving the potential abuse of children. These include the need for:

- Staff and relevant volunteers to have a clear understanding of the types of behaviour which should be reported and the related systems for the making of reports (see also Questions 5 and 6 on training).
- Relevant agencies to possess, or have access to, the necessary technical skills to enable a sophisticated investigative and risk management response to the complex challenges that can arise in relation to serious incidents of child abuse.
- There to be scope for relevant agencies to receive independent advice and support in relation to their handling of these matters. (In terms of our oversight role, we have seen the need to move towards a much more active support role over recent years – particularly in relation to more serious abuse allegations – because we have recognised the importance of intervening in circumstances where an agency is struggling to meet the complex risk management and investigative challenges that can arise in these cases. In addition, in certain cases, we will also seek to take active steps to facilitate a strong working relationship between the NSW Police Force and the involved agency. Furthermore, it is pleasing to note that the current Commander of the Child Abuse Squad and her senior staff have demonstrated a strong commitment to working closely with our office, and this, in turn, has strengthened our capacity to support agencies in some of the more difficult cases. Finally, our access to both Police and Community Services' information systems has been invaluable in enabling us to both identify, and develop an appropriate response to certain high risk cases).

Our oversight not only enhances the identification and management of individuals who may pose a risk to children, it also enables us to identify systemic issues which have contributed to children being placed at risk. When systemic issues are identified, we recommend changes to practice to assist in the prevention of further abuse, and monitor agencies' implementation of our recommendations. Our May 2013 submission to the Royal Commission provides evidence

of the range of relevant systemic issues our office has identified and pursued, arising from our oversight in this area.[6] We discuss a number of these issues at Question 9.

- **Ensuring the necessary capacity and expertise exists in the out-of-home care sector to conduct investigations into employment-related allegations**

One of the risks associated with NSW's transition of out-of-home care to the non-government sector concerns the capacity of the non-government sector to manage the substantially increased number of reportable allegations that they will inevitably experience from greater numbers of children in care. In 2012, ACWA convened a roundtable discussion with non-government providers and other key stakeholders to consider Part 3A.

Currently, Community Services has a specialised central unit – the Reportable Conduct Unit (RCU) – responsible for handling all Part 3A reportable conduct matters relating to Community Services' authorised foster carers. The RCU helps to ensure consistency in the handling of reportable allegations, as well as ensuring that appropriately skilled investigators with experience in investigating reportable conduct allegations are available to the agency.

We believe that there is merit in considering whether the non-government out-of-home care sector should have access to a centralised unit similar to the RCU. In any event, careful consideration needs to be given to ensuring that the non-government sector is adequately resourced to deal with the substantial increase in 'reportable conduct' matters that they will inevitably experience from the out-of-home care transition process. A failure to address this issue will pose a significant risk to children in out-of-home care.

- **Training for agency staff and carers about sexual abuse**

Ongoing and relevant training for workers and carers is an essential prevention strategy for reducing child sexual abuse in out-of-home care, and ensuring that when abuse does occur, it is responded to in an effective manner. The Commission posed the following specific questions (at 5 and 6) in relation to training:

Question 5: What are the core components of the training needs of those working with children who might be sexually abused including carers, caseworkers and staff of regulatory bodies? What priority should be given to training in relation to sexual abuse compared to other training needs?

Question 6: Is there adequate and effective training and information available to carers who are caring for children who have sexually abused other children?

In its submission, the NSW Government's response to questions 5 and 6 provides a comprehensive summary of relevant training topics. In addition to the topics referred to in the NSW Government's submission, we believe the areas of training outlined below also warrant consideration.

Caseworkers need to be well trained to identify and assess safety and risk issues for children in care. As we noted in our submission in response to the Commission's Child Safe Institutions Issues Paper, this includes having a clear understanding of the types of behaviour which should be reported, and the systems for making such reports. This can be particularly challenging in terms of understanding the type of behaviour which may indicate the presence of serious abuse – such as sexually predatory behaviour. For this reason, agencies need to ensure that caseworkers have access to sufficient support, training and expertise in this area.

[6] *Systemic issues relevant to the handling of sexual abuse/sexual misconduct allegations and related cases*, NSW Ombudsman, May 2013.

When a child enters out-of-home care and is placed into a close relationship with their carer, it is not uncommon for this to be the point where a disclosure of abuse is first made in relation to an earlier placement or in some other setting. Carers, agencies and peak bodies, have raised concerns with us that carers are often not well-equipped to deal with these situations when they arise – this issue has been expressed most strongly through our consultations with Aboriginal communities and care agencies. As part of the training and support available for carers, they need to have access to sound advice at the point that a child makes a disclosure, particularly in relation to encouraging the child to explain what happened without prejudicing any future criminal investigation that might result. In our view, there would be merit in a specific course on this issue being developed for carers/workers in conjunction with the NSW Police Force (and equivalent state policing agencies). Our community education and training unit is considering developing such a course next year.

It is also critical that agency staff have a solid understanding of the legislative and policy framework in which they work (including understanding their Part 3A reportable conduct notification and their general child protection mandatory reporting obligations). It is also necessary for frontline staff, supervisors and managers to understand the best way to handle reportable conduct allegations. Our office provides training workshops to agencies in relation to handling child-related employment allegations, including an advanced course for senior managers on handling serious reportable allegations. A focus of both courses is providing advice to practitioners in relation to working with police where criminal conduct has been alleged.

In 2012, we worked with the NSW Police Force to develop Standard Operating Procedures for the handling of employment-related child abuse allegations. While the procedures are important, it is also critical that both employing agencies and police are able to apply these procedures to the circumstances of various cases in a way that conforms with best practice in this difficult area of work. It is our view that both 'on-the-ground' and informal training would greatly assist to improve practice in this area.

Question 3: What are the strengths and weaknesses of models that check OOHC practices by an audit approach, a regular visit, or an irregular visit by someone like a community visitor?

As the Commission is aware, our office is responsible for coordinating the Official Community Visitor (OCV) scheme in NSW, which extends to children living in residential services. Children in visitable residential services currently account for less than 500 of the almost 18,000 children in out-of-home care in NSW. As a result of our involvement in the OCV scheme, we are aware of the benefits of the scheme for children in residential out-of-home care who are often particularly vulnerable.

As indicated previously, whether children in out-of-home care are living in residential services or family placements, the critical factor in ensuring they are effectively supported is that they have someone – in addition to their carer(s) – with whom they have a sufficiently strong relationship to feel comfortable raising concerns about their placement.

Our review work supports the notion that effective and active casework is one of the most successful strategies for promoting the safety, welfare and wellbeing of children in out-of-home care. While not discounting the potential value of an extended OCV scheme in NSW, we believe that resources would be better directed to ensuring that, as the transition of out-of-home care continues in NSW, non-government out-of-home care providers have sufficient capacity to maintain and improve on the level and quality of casework being provided to children in care.

We note that the Queensland Community Visitor scheme extends to all children in out-of-home care, with visits typically made to children on a monthly or bi-monthly basis.[7] Under this type of regime, there is the potential for children in out-of-home care to have an additional person with whom they can develop a relationship. However, the scheme has significant resource implications. In this regard, the Queensland Child Protection Commission of Inquiry (the Carmody Inquiry) recently recommended

[7] The Queensland Community Visitor scheme was extended to all children in 2004 in response to concerns that the heavy caseloads of departmental caseworkers meant that they were rarely able to make personal contact with children.

that the scheme be rolled back, with regular visits continuing only for those children who are 'most vulnerable'. The Carmody Inquiry concluded that resources would be better directed to ensuring that Child Safety officers have regular contact with, and provide active casework for, children in out-of-home care. [8]

We note that the submissions made by the OoCG and ACWA comprehensively outline the strengths and weaknesses of an auditing based approach to out-of-home care practice. In light of the OoCG's lead role in this area, we do not propose to make any additional comments apart from those observations made at Question 1 (particularly in relation to our support for the on-site visits conducted by OoCG staff as part of the accreditation program).[9]

As part of our Part 3A oversight role, we have a specific function to 'keep under scrutiny' the systems put in place by agencies under our jurisdiction for preventing reportable conduct and for handling and responding to reportable allegations.[10] Each year, we develop an auditing program which targets particular sectors and individual agencies across our jurisdiction. We formulate our program based on a range of factors including: an analysis of reporting trends (for example, low notification rates); issues identified through complaints and reportable allegations; and those agencies/sectors that are new to our oversight (such as the out-of-school-hours sector) or experiencing rapid growth. Our office and the OoCG liaise closely in relation to our respective auditing/monitoring functions.

While our keep under scrutiny function is a valuable method of checking on agency practice, it is important to appreciate that this function is used to supplement the information we obtain from our exercise of our other functions under both Part 3A and CS-CRAMA.

In addition, the various components of checking and auditing in NSW which are carried out by the OoCG, FACS and our office in relation to the out-of-home care sector should be seen as complementary. However, we recognise that there will always be scope to further enhance the collaboration with other stakeholders to maximise our collective impact. In this regard, we note that the OOHC Taskforce in NSW is proposing to examine the best way to coordinate and integrate the roles of all three agencies in this area and we will support this initiative.

Question 4: What are the strengths and weaknesses of having the OOHC providers regulated by the child protection department, or regulated by a body separate from the child protection department?

We note that the OoCG's submission provides an overview of the regulation of out-of-home care in NSW, including the events leading to the establishment of the independent role of the Special/Children's Guardian. One of the main reasons behind the establishment of the Children's Guardian was to separate the funding agency for out-of-home care from the body responsible for ensuring the quality of services. As a provider of out-of-home care, the former Department of Community Services was, and continues to be, subject to a regulatory regime established for other providers.

The OoCG has submitted that:

> *'the independent role of the Children's Guardian remains critical while FACS remains a significant provider of out-of-home care services.*
>
> ....
>
> *FACS cannot be expected to independently assess its own performance against the NSW standards.'*

[8] Queensland Child Protection Commission of Inquiry, 2013, *Taking Responsibility: A Roadmap for Queensland Child Protection*, pp414-415.

[9] We also note that the NSW Government's submission indicates that FACS will take on a monitoring role in relation to the health and wellbeing of individual children as the transition evolves and that any potential systems issues identified will be shared with the OoCG and factored into the accreditation process.

[10] Section 25B of the Ombudsman Act.

The Ombudsman's office agrees with the Children's Guardian's submission on this issue. We also note that the NSW Government's submission highlights a range of strengths and weaknesses with the existing regulatory framework, but that overall, it endorses having a body separate from the child protection department regulating out-of-home care. We particularly endorse the NSW Government's view that this approach 'provides a stronger, more transparent regulatory framework.'

Question 7: How should the rate of sexual abuse of children in OOHC be determined, noting that the National Standards for Out-of-home care require reporting of substantiated claims of all types of abuse? Would a form of exit interview assist in capturing information? What should be introduced to ascertain whether information on child sexual abuse in OOHC is resulting in changed practices?

We support any move towards national consistency in relation to the collection and reporting of out-of-home care data. However, achieving this will be a challenging task given the different processes and rules for determining 'substantiated abuse' by child protection departments in each jurisdiction.

The Issues Paper acknowledges that both of the nationally agreed measures for safety of children in out-of-home care require 'substantiation' – these are:

- the proportion of children in out-of-home care who were the subject of a notification which was substantiated, and
- the proportion of children in out-of-home care who were the subject of substantiation and the person responsible was living in the household.

In developing a consistent national approach in this area, it will be necessary for child protection departments to align their definitions of 'sexual abuse' and 'substantiation'. And, in relation to 'reportable conduct',[11] agreed definitions for sexual abuse and substantiation should also be developed to ensure reportable conduct investigation outcomes are captured consistently. These definitions should also accord with data held in relation to individuals who are the subject of allegations on the child protection department's system.

In order to ensure that high-level data captured at the national level is not misinterpreted, it will also be important to differentiate the context of the alleged abuse beyond whether the perpetrator 'was living in the household', as required by the National Standards. In addition to capturing data on whether the alleged perpetrator is/was the child's carer, it is will be critical to collect other types of relationship data, for example, if the perpetrator is the foster carer's child or partner (in certain circumstances there may also be an associated allegation of carer neglect, which in NSW would be 'reportable').

A range of other distinctions should also be made in the manner of recording, including those circumstances where the child discloses abuse which occurred before they entered care – the National Standards currently do not make this distinction. Under the reportable conduct scheme in NSW, all allegations of sexual abuse involving a carer are reportable to our office even if the child is not in their care. Therefore, in seeking to rely on reportable conduct data to determine rates of sexual abuse of children in out-of-home care and related outcomes, it will be important for this distinction to also be made. Capturing details that relate to the profile of the perpetrator (including age/relationship to

[11] Under section 25A of the *Ombudsman Act 1974*, the definition of 'reportable conduct' includes 'any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence or an offence involving child abuse material)...' The inclusion of the term sexual misconduct is significant because it includes conduct that does not necessarily constitute a criminal offence, but is nonetheless conduct which in the context of child-related employment is inappropriate. Sexual misconduct includes, among other things, behaviour that can reasonably be construed as involving an inappropriate or overly personal or intimate relationship with, conduct towards, or focus on a child (or a group of children). Source: *Defining Reportable Conduct,* Fact Sheet 1/2013, NSW Ombudsman, 2013.

victim/carer) will provide important contextual information about the settings in which abuse occurs in relation to children in out-of-home care.

In establishing consistent standards for data collection which can also be used to 'measure whether information on child sexual abuse in out-of-home care is resulting in changed practices'; it will be critical that outcome data is recorded in such a way that the various components of the 'response' can be identified and measured (including the child protection; criminal justice and agency investigative responses).

Although collecting consistent high-level sexual abuse data across jurisdictions would be a valuable exercise, in order for it to be operationally useful, the data also needs to be broken down by agency to enable meaningful interpretation of any trends. In noting this, we are not suggesting that this type of data be made publicly available; however, it would be useful if agencies and those operating in the relevant regulatory, oversight and funding spheres, were in a position to examine meaningful operational/performance data. In addition, this type of data could be used to inform research and ongoing practice improvements.

As with other contexts of sexual abuse reporting, it will be important for any spikes in reporting to be carefully considered and to be not necessarily seen as a negative indicator. For example, if the transition of out-of-home-care in NSW to the non-government sector leads to a substantial improvement in the quality of casework and supports provided to children, then a corresponding increase in disclosures of abuse could possibly arise.

Our office is in a unique position to monitor and assess notification rates of sexual abuse allegations and how these allegations are investigated – both in terms of out-of-home care and more broadly – as a result of our oversight of the reportable conduct scheme in NSW. We understand that the Commission plans to convene a roundtable forum on reportable conduct in 2014 – we look forward to providing further information to the Commission in relation to the issue of data collection and analysis in that context. We have previously provided some headline data to the Royal Commission for a five year period, demonstrating the number of reportable allegations notified to our office involving sexual misconduct and sexual offences, broken down by industry groups. The Royal Commission also provides us with an opportunity to more thoroughly consider what improvements need to be made to our practices in relation to data capture.

We have a number of concerns in relation to the Commission's question about the potential role for an exit interview to be used as a means of capturing information about rates of sexual abuse. For example, we note that children and young people are often particularly vulnerable at the time they leave care, and attempting to elicit disclosures at this point would require very careful consideration of the risks to the child/young person.

Ideally, if children and young people are made aware of their rights to complain and are being provided with regular support during their time in care, then this can assist in disclosures being made. Our work with Aboriginal out-of-home care agencies has revealed that children are more likely to disclose abuse that occurred prior to entering care if a rapport has been established with their carer and/or caseworker.

However, it is also possible that a young person may wish to disclose abuse as part of the leaving care process. For this reason, it is critical that agencies are in a position to ensure that the appropriate mechanisms are available both to provide support for a young person to make a disclosure, and to respond appropriately to any allegations which are made – including referring matters for criminal investigation to police where relevant, identifying and addressing any current risks to a class of children, and arranging for therapeutic supports.

Finally, notwithstanding any systems improvement in the future, some will still not feel that they were able to disclose abuse at the time of leaving care. In our opinion, designing a suite of initiatives aimed

at ensuring that individuals are encouraged to come forward to disclose their abuse – even if it is well after their time in out-of-home care – will hopefully be one of the legacies of the Royal Commission.

Question 8: Are the current appeal processes for carers fair? What other appeal processes should be made available to carers?

In responding to this question, we note that a distinction should be made between those individuals who are currently authorised carers and those who are seeking to become carers.

In NSW, both of these groups have a right of appeal to the Administrative Decisions Tribunal (ADT) – to be integrated into the new NSW Civil and Administrative Tribunal from the start of 2014. In our opinion, consideration needs to be given to whether there are sufficient grounds for justifying providing those who are seeking to become carers with a right of appeal. In this regard, requiring an out-of-home care agency to enter into a critical 'partnership' with an individual who it considers is unsuitable to be engaged as a carer, appears somewhat problematic.

However, we believe that it is appropriate for an appeal mechanism to be made available for existing carers. In considering what these appeal mechanisms should be, we believe that a central issue requiring careful consideration and debate is the application of the principle of unacceptable risk. In our opinion, there would be merit in the Commission convening roundtable discussions with relevant stakeholders to examine the challenges associated with the practical application of this principle in the context of the high-risk out-of-home care environment.

Question 9: What measures could be used to assess whether the safety of children from sexual abuse in out-of-home care is enhanced by independent oversight of the handling of allegations of sexual abuse?

There are a range of qualitative measures that could be utilised to assess whether independent oversight enhances the safety of children in out-of-home care, insofar as sexual abuse is concerned. Some of these measures include:

- Examining whether the oversight results in the identification of significant systems issues which have a direct bearing on promoting children's safety, including protecting them from sexual abuse. For example, in May 2013 we provided the Commission with a summary of systemic issues we had identified from our reportable conduct oversight activities. These issues included:
    - Working collaboratively with the OoCG to improve carer screening and risk assessment processes.
    - Promoting the need for improved practice in relation to: the identification and reporting of allegations of serious criminal child abuse to police; and the identification and handling of historical allegations of child sexual abuse.
    - Successfully advocating the adoption of a simplified legislative provision to allow prescribed bodies to exchange information to promote the safety, welfare and wellbeing of children, and actively monitoring and promoting the use of the provision.
    - Successfully negotiating Standard Operating Procedures with the NSW Police Force for the handling of employment-related child abuse allegations (see Question 5).
    - Regularly consulting with police in relation to serious sexual and other abuse cases. Our work in this regard is enhanced by our direct access to the NSW Police Force and Community Services databases.
    - Identifying weaknesses in the regime for exchanging child protection information across state borders. Our recommendations to address these weaknesses have been accepted by the NSW Government.

- Conducting audits of both the out-of-home care and oversight agency's handling of individual reportable conduct allegations. In this regard, the audits could examine issues such as whether:

- the safety and welfare of the involved child – and other children in the same placement (including a carer's own children) – were promptly assessed and responded to
- procedural fairness was afforded to the carer and appropriate supports provided
- the investigative approach was technically competent, timely and commensurate with the seriousness of the allegations
- there was effective interagency communication and collaboration (where required), and
- the findings made about the carer's conduct and any risk management action taken were appropriate.

In relation to the above indicators, evidence of practice improvement over time could also be examined.

- Examining the effectiveness of the oversight agency's systems for monitoring reporting trends across the out-of-home care sector, and its related activities for conducting targeted audits of those parts of the sector where there are apparent anomalies in the abuse notification rates.
- Examining the nature and quality of sector-wide training (and practical advice and guidance) provided by the oversight agency.
- Obtaining feedback from the out-of-home care sector – and other key stakeholder agencies (for example, the Child Abuse Squad and other JIRT partner agencies) about the value of the oversight.

Question 10: What are the strengths and weaknesses of different oversight mechanisms in keeping children safe from sexual abuse in OOHC?

Our answers to Questions 1 and 9 are also relevant to this question.

There are a number of different but complementary oversight mechanisms which, in our view, contribute to the overall effectiveness of the provision of out-of-home in NSW – most notably, the Children's Guardian's accreditation and monitoring roles and the WWCC function, and our roles in oversighting the reportable conduct scheme and in monitoring and reviewing the delivery of community services more generally.

The Ombudsman's child protection oversight role

Our Part 3A jurisdiction involves overseeing the handling of child abuse and neglect allegations that are made against employees of more than 7,000 government and non-government agencies. Relevant government and non-government agencies – including non-government schools, approved children's services and agencies providing substitute residential care – are required to notify the Ombudsman of any reportable allegations or convictions involving their employees within 30 days of becoming aware of them.[12]

The Ombudsman oversees how agencies investigate and respond to reportable allegations, and scrutinises the systems which agencies have in place for preventing child abuse and neglect conduct and for responding to this conduct.

Reportable conduct includes:

- sexual offences and sexual misconduct involving a child
- physical assault of a child
- neglect and ill-treatment of a child, and
- behaviour causing psychological harm to a child.[13]

[12] In this context, 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, and any individual engaged by the agency to provide services to children (including in the capacity of a volunteer).
[13] *NSW Ombudsman Act 1974*, section 25A.

The Ombudsman: receives and assesses notifications from employers concerning individual matters; responds to complaints and inquiries; convenes meetings with agencies to discuss individual and systemic issues arising from investigations; and audits agencies' processes in relation to responding to reportable allegations. We also have the power to directly investigate both an allegation of reportable conduct made against an employee[14] and the handling of a reportable conduct matter by the involved agency.

The allegation based system which triggers a notification under Part 3A of the Ombudsman Act complements the WWCC system. 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 *Child Protection (Working with Children) Act 2013*, relevant misconduct findings have been notified to the Children's Guardian.

In this regard, under section 35 of the Working with Children Act, prescribed reporting bodies are required to notify the Children's Guardian of findings of misconduct in relation to:

1. Sexual misconduct committed against, with or in the presence of a child, including grooming of a child.
2. Any serious physical assault of a child.

In addition, Schedule 1, Clause 2A of the 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*'.[15] 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.

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.

Furthermore, under Chapter 16A of the Children and Young Persons (Care and Protection) Act, 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. Since the commencement of Clause 2A, our office has provided a significant number of notifications of concern to the OoCG, and has exchanged critical risk-related information under Chapter 16A.

As discussed in response to Question 9, through our Part 3A oversight role we have identified and pursued solutions to address a broad range of systemic issues relating to the safety of children in out-of-home care.

It is also important to stress that our reportable conduct jurisdiction is informed, and enhanced by, our broader functions under CS-CRAMA. These functions include (but are not limited to) the following:

- 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.

[14] The definition of employee includes volunteers who are engaged to provide services to children (for example, foster carers).
[15] *Child Protection (Working with Children) Act 2013*, Schedule 1, Clause 2A

- 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 dual Part 3A and CS-CRAMA oversight functions have been in place for over ten years (following the merger of the Community Services Commission with the Ombudsman's office in 2002). This combined jurisdiction places us in a unique position to identify systemic issues that specifically relate to the out-of-home care system, as well as those which intersect with the broader child protection system.

In NSW, the OoCG is responsible for: accreditation, registration and monitoring of agencies which arrange, provide or supervise out-of-home care; carrying out WWCCs; and establishing a centralised Carer's Register.

We believe that our office and the OoCG have established an effective business relationship. The continuation of a strong and strategic working relationship between our agencies will continue to be critical to both our agencies ensuring that we carry out our distinct (but related) functions in a complementary and productive manner. In our view, there are significant benefits in having two independent bodies with separate mandates examining issues relating to out-of-home care. As the Commission is aware, the Wood Special Commission of Inquiry endorsed the existing regulatory roles (apart from recommending that the child death review team function, previously performed by the CCYP, be transferred to our office).

FACS is the funding agency for out-of-home care. It carries out a distinct role of monitoring and assessing agencies' compliance with service agreements/contracts. In our view, as part of the transition of out-of-home care placements from Community Services to the non-government sector, there is the potential for Community Services to enhance the provision of out-of-home care through the development of a more comprehensive outcomes-based performance framework for funded organisations.

Question 11: What implications exist for record-keeping and access to records from delayed reporting of child abuse?

We regularly access the Community Services and Police databases in oversighting individual matters. In doing so, this has provided us with insight into issues associated with delayed reporting.

By way of background, the policing database, COPS, was created in the 1990s. Although police hold records pre-dating the creation of COPS, these records are not available electronically and hardcopy records have not always been preserved. Community Services' KiDS database contains records from 2003. Records created prior to this time are held on an earlier database, known as CIS (established in the 1990s);[16] however, CIS records tend not to be as fulsome as KiDS records. Although, like Police records, hardcopy files may have been created, they may not be readily accessible or sufficiently comprehensive.

The Care Act[17] requires FACS to keep all records relating to Aboriginal and Torres Strait Islander children in statutory or supported out-of-home care permanently. The Act also requires designated agencies to keep records regarding the placement of children in out-of-home care for seven years after its responsibilities have ceased. At the end of the seven year period, or when the agency ceases to be a designated agency in relation to a child's out-of-home care arrangements, the relevant records must be

[16] CIS records can be accessed as an attachment on the KiDS system.
[17] *Children and Young Persons (Care & Protection) Act 1998*, section 14.

delivered to the Director-General of FACS (at which time they become state records for the purposes of the *State Records Act 1998*).

The delayed reporting of child sexual abuse is not uncommon. Given the lack of support for victims of child sexual abuse in the past, combined with the inherent difficulty for children and young people to disclose their abuse, it is not surprising that many cases of child abuse that require attention are historical in nature. While investigating historical allegations can present many challenges, we have found that past records can be invaluable in a number of contexts (for example, they may establish a consistent pattern of allegations and/or shed light on matters relevant to particular historical allegations). On the other hand, the absence of past records or poor documentation can severely limit an investigator's capacity to adequately pursue historical cases.

Fortunately, record-keeping practices by government agencies have improved significantly over the last two decades. However, with the transfer of out-of-home care to the non-government sector, it will be critical for organisations to keep accurate and detailed records and associated cataloguing systems into the future – these systems should also ensure appropriate back-capture of existing records.

The issue of record-keeping being an important component of child safe practice is obviously relevant to all organisations that provide services to children.

Yours sincerely

Bruce Barbour
Ombudsman

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner