Submission No 57

CHILD PROTECTION AND SOCIAL SERVICES SYSTEM

Organisation: NSW Ombudsman

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25 January 2021

Mr Matthew Mason-Cox MP
Committee Chair
Committee on Children and Young People
NSW Parliament
Parliament House
SYDNEY NSW 2000

By email: childrenyoungpeople@parliament.nsw.gov.au

Dear Mr Mason-Cox,

Inquiry into Child Protection and Social Services System

The NSW Ombudsman is pleased to provide this submission to assist the Committee in its examination of the effectiveness of the NSW child protection and social services system in responding to vulnerable children and families. Our role in relation to the child protection system is outlined later in this letter.

The service system for vulnerable families, including early intervention and family support, statutory child protection and out-of-home care (OOHC) is complex. Responsibilities for the protection of children and support for vulnerable families is shared across numerous government and non-government providers, and services are delivered through multiple program areas.

The challenges affecting this system are in the main not new. In addition to numerous independent inquiries and reviews over the past decade, our office's work under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* has also highlighted systemic issues in the provision of services for vulnerable children and families.

Below is a list of our most recent and relevant reports, all of which have been previously tabled in the NSW Parliament and are available on our website:

- The JIRT partnership – 20 Years On
  The JIRT Partnership - 20 years on - NSW Ombudsman (October 2018)
- Biennial report of the deaths of children in New South Wales 2016 and 2017 - incorporating reviewable deaths of children
  https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths/biennial-report-of-the-deaths-of-children-in-new-south-wales-2016-and-2017 (June 2019)

- NSW Ombudsman submission to Committee inquiry into child protection https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-protection/nsw-ombudsman-submission-to-the-legislative-council-general-purpose-standing-committee-no.2-inquiry-into-child-protection-august-2016 (April 2017)
- Review of the NSW Child Protection System – Are things improving? https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-protection/review-of-the-nsw-child-protection-system-are-things-improving-special-report-to-parliament-april-2014 (April 2014)
- More than shelter – addressing legal and policy gaps in supporting homeless children: A progress report
  'More than shelter – addressing legal and policy gaps in supporting homeless children' A progress report - NSW Ombudsman (October 2020)
- Causes of death of children with a child protection history – 2002-2011
  https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team/causes-of-death-of-children-with-a-child-protection-history-2002-2011-special-report-to-parliament (April 2014)
- OCHRE Review Report
  OCHRE Review Report - 28 October 2019 - NSW Ombudsman (October 2019)
- Responding to child sexual assault in Aboriginal communities
  https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0005/7961/ACSA-report-web1.pdf (December 2012)

These reports identify a range of important issues that – notwithstanding ongoing reform – illustrate the ongoing challenges in providing effective support to vulnerable families and the protection of children at risk.

We will not repeat the findings of our work in this submission, but will:

- outline some of the most persistent challenges identified through our work and other previous inquiries and reviews
- provide a brief commentary on the scope of change – which has been a constant in the child protection system over the past 15 years – and the degree to which these changes have resulted in improved outcomes for vulnerable children and families
- describe our role in monitoring the community services sector as it relates to child protection and how this has changed, and
- outline current and future work being undertaken by our office in relation to the child protection system.

Persistent challenges in child protection

At a high level, ongoing issues of concern to this office that are relevant to the Inquiry's terms of reference include:

System capacity to respond to children at risk of significant harm

In our 2014 report *Review of the NSW child protection system – Are things improving?* we drew attention to the limited capacity of the system to respond to all children at risk of significant harm.

As of 2012-2013, the (then) Department of Family and Community Services (FACS) was able to provide a face-to-face response for less than a third (28%) of the children reported to be at risk of significant harm (ROSH).

The Department of Communities and Justice (DCJ) has made some changes to the way it reports this information and to its counting rules, including introducing a new definition of 'children seen' in 2018-19. While this means that more recent data is not comparable with previous years, the most recent published information shows that, as of 2018-19, the overall average percentage of children reported at risk of significant harm who are 'seen' by a caseworker remained at around 29%.

It is unacceptable that 70% of children who are assessed as being at risk of significant harm do not receive a face-to-face response. It is also concerning that there is no information about what response children who are not seen by a DCJ caseworker receive (such as a referral to a non-government service) or whether they receive any response at all.

Case example

> In our *Biennial Report of the deaths of children in NSW in 2016 and 2017*, we reported on our review of the deaths of 17 infants who died suddenly and unexpectedly over that period, and who had been the subject of at least one prenatal report to FACS. Most of the infants who died were in unsafe sleeping environments.
>
> Almost all prenatal reports involved concerns about maternal drug or alcohol misuse, and/or risks associated with parental drug abuse. In five cases, reports triggered a 'high risk birth alert' to ensure FACS was informed of the birth by NSW Health.
>
> Most of the families (12) did not receive a face-to-face response. Of those 12 families:
>
> (a) in five, FACS made referrals to, or liaised with, early intervention services and then closed the report,
>
> (b) in three, FACS obtained further information from other services (such as NSW Health) and then closed the case, and
>
> (c) in the other four, the matter was closed without a response, generally after a single prenatal report.
>
> The five families that did receive a casework response were characterised by significant parental drug abuse, domestic violence, neglect, physical harm and/or maternal mental health issues. FACS conducted risk assessments in each case. Three of the cases were closed prior to the infant's death.

Our reviews identified issues in relation to the adequacy of child protection assessment, including premature case closure despite evidence of ongoing risk.

Case example

In our October 2020 report, *More than shelter – addressing legal and policy gaps in supporting homeless children: A progress report*, we drew attention to DCJ's capacity challenges in the context of its responsibility to respond to unaccompanied homeless children who are reported at risk of significant harm. As we noted, the current DCJ policy for responding to unaccompanied homeless children aged 12-15 appears to be is inherently contradictory; while it outlines DCJ's responsibilities, it then states that the Department will not always meet them, but provides no clear guidance to youth specialist homelessness services about dealing with cases where DCJ is required to respond but does not.

The policy requires services to report to the DCJ Helpline all children aged 12-15 who present alone to a homelessness service; it allocates to DCJ responsibility to assume lead case management for those children who are assessed as being at risk of significant harm, as well as those who are in OOHC placements managed by DCJ. However, the policy also states "not all reports made to the child protection helpline are allocated for a response by [DCJ]. Also, competing priorities – such as case complexity and vulnerability – may mean that a report 'screened in' [as meeting the risk of significant harm threshold] will not be allocated for a period of time, or be closed."

Linked to lack of capacity, we have consistently raised concerns about the premature closure of child protection cases due to 'competing priorities'.

It is apparent that demand exceeds available resources in this area, and DCJ finds it necessary to prioritise cases. However, the fact remains that this system requires judgements about which children - who are assessed as reaching the threshold of being at risk of significant harm – receive a response.

It has been some years since DCJ reported publicly on the number of cases it closes due to competing priorities.

Case example

In our *Biennial report of the deaths of children in NSW in 2016 and 2017*, we reported that for one family, five separate risk of significant harm reports were made raising concerns about the behaviour of a parent caring for an 18-month-old child. The reports raised concerns relating to parental substance abuse, domestic violence, physical and supervisory neglect, psychological harm and transience. Together, the reports suggested a pattern of poor parenting and behaviour that placed the child at high risk of harm. All five reports were closed due to competing priorities. The child's sibling subsequently died in suspicious circumstances, while the parent was intoxicated.

Over-representation of Aboriginal children and families in child protection and out-of-home care

Over-representation of Aboriginal children and families is a chronic feature of the child protection system. It has been subject to extensive work by our office and, most recently, the scrutiny of the *2019 Independent Review of Aboriginal Children and Young People in Out-of-Home Care*.

As of June 2019, 40.4% (5,789) of the children and young people in statutory OOHC were Aboriginal.

Our work in reviewing child deaths has shown that over the 15-years from 2003 to 2017, Aboriginal children have a mortality rate that is twice that for non-Indigenous children. Aboriginal children are consistently over-represented in deaths from both natural and injury-related causes; for example, the mortality rate for Aboriginal children and young people who died by suicide in 2017 was 3.8 times higher than for non-Indigenous young people, and between 2008-17, one in every five of the children who died in circumstances of abuse or neglect was Indigenous.

In our 2019 *OCHRE Review Report*, we noted that positive outcomes for these vulnerable children and families are unlikely to be achieved until there is a genuine place-based approach to the funding, design and delivery of services in communities. We said such an approach needs to go beyond merely 'interagency coordination'; it requires fundamentally changing how services are planned, funded and delivered to high-need communities.

The need for a better understanding of the operations and effectiveness of early intervention programs

The NSW Government funds non-government organisations to deliver a range of early intervention and prevention services under the Targeted Earlier Intervention Program. The broad aim of the early intervention approach is to support families to keep children safe at home and prevent their entry into OOHC.

In the context of a system where there is insufficient capacity to respond to the most urgent child protection cases, it is critical that outcomes can be delivered and be seen to be delivered through investment in early intervention.

The 2014 evaluation of the *Keep them Safe* reforms found continuing challenges limited the extent to which early intervention is able to make a difference, including *'workforce issues, availability of services for lower risk children, continuing difficulties with complex referral pathways, and a continuing focus by many practitioners on assessment, referral and reporting rather than intervention and support'*. It is not clear if or how these issues have been fully resolved in the contemporary service system.

In 2020, the Audit Office of NSW published a performance audit of *Their Futures Matter*. A main finding was that *'an evidence-based whole of government early intervention approach for vulnerable children and families in NSW – the key objective of the reform – was not established'*, and further, that '*The TFM evidence base is insufficient to drive greater direction of resources from crisis to early intervention. The current evidence base is not yet robust enough to determine which interventions, of those piloted by TFM and those already provided by agencies, are most effective in terms of supporting vulnerable children and families'*.

Achieving outcomes for families in the context of 'shared responsibility'

Shared responsibility for protecting children has been a hallmark of the NSW child protection system over the past decade. Our work has repeatedly highlighted the need for greater coordination between the child protection, education, health and justice sectors in this context.

Our previous reports of reviewable child deaths have noted the ongoing and significant challenges for agencies in engaging and responding effectively to families with complex needs. We have also highlighted the importance of early assessment and intervention, and effective coordination and collaboration between agencies working with these families. When multiple agencies are providing a service, with each targeting different needs or aspects of family functioning, it can be challenging for any one agency to understand the family's overall needs and holistically review the effectiveness of service interventions/casework strategies to meet these.

There is also a risk that a clear focus on child protection may be lost if there is a lack of clarity across agencies about respective roles and responsibilities and ineffective interagency communication. Collaborative approaches to service delivery are a critical component of shared responsibility, and a pre-condition for effective service responses to vulnerable families who have complex needs that cannot be met by any one agency.

Case example

In 2019, the NSW Coroner finalised an inquest into the deaths of TC and SN, a mother and her young child. Our investigation of the case informed the Coroner's findings and illustrates some of the issues that may arise in complex cases where multiple agencies need to provide support.

The child and family had complex needs. As a result, the family was provided with a high level of support from a number of agencies. In this context, it was important that the actions of all involved agencies were co-ordinated and informed by the interventions, strategies, identified issues and outcomes of work by other involved agencies. Our investigation found that this was not the case. Despite the family's significant contact with services, we found that none of the involved agencies sought to bring all of the parties together to:

- clarify the roles and responsibilities of each agency
- discuss the child protection risks and how these would be monitored and escalated if required
- discuss what and when information needed to be shared between the agencies, and
- agree on a plan for coordinating the provision of services.

There was inadequate communication between relevant services about the progress and outcome of respective service interventions. As a result, it appears that agencies often made assumptions about the nature, effectiveness and protective impact of work by other agencies.

> Some practitioners tended to respond to changes in family circumstances by making new referrals, rather than reviewing the effectiveness of existing interventions or therapeutic strategies, then adjusting the intensity or focus as indicated. Although it was not always evident what improvements were being achieved by the involvement of multiple services, it appears that for some practitioners, the number of services involved was in and of itself considered protective for the child. The circumstances of the child's death resulted in internal reviews by involved agencies, and interagency discussions to identify barriers to good practice and strategies for change.

In raising these issues, we note that agencies, particularly DCJ, continue to implement new initiatives to attempt to address identified issues. However, as we outline below, lack of robust performance information makes it very difficult to assess how effective change has been in achieving improved outcomes for vulnerable children and families.

The impact of change

Over the past 15 years, the child protection system has been subject to extensive review and restructure. Subsequently, new programs, pilots and frameworks have been a constant feature.

In 2008, following the deaths of two children that became the subject of intense media scrutiny and community interest, the NSW Government established a Special Commission of Inquiry into Child Protection Services in NSW.

The Inquiry led to a significant overhaul of the child protection system, and extensive reform to its structure, the functions of agencies, and delivery of services. Among other significant changes, the Inquiry recommended:

- A move to shared accountability and responsibility between government and non-government agencies for child protection. This led to the creation of child wellbeing units in key agencies, referral and intake services in the community, and greater involvement of non-government providers in the delivery of child protection, early intervention and OOHC services.
- Replacement of the 'risk of harm' threshold for a statutory response to child protection concerns with 'risk of significant harm'. This change was premised on the view that too many reports were being made about families for whom support and early intervention was the appropriate response, and that the Department should be equipped to respond to those needing formal statutory intervention.

  Linked to this higher threshold, the Inquiry envisaged a systematic approach to assisting families and children at risk. Reports assessed as relating to a child or young person at risk of significant harm would be investigated by the Department if the risk was urgent or high; if not, eligible families would be assisted through referral to the Brighter Futures early intervention program. Families not eligible for that program would be referred to intake services which would then link the families to the most appropriate local service to meet their needs.

To support this system, the Inquiry also envisaged *'integrated, multidisciplinary and co-located child and family services'* in areas of greatest need to deliver the needed services to vulnerable families.

Legislation enacting these proposals was introduced in 2009.

Changes since the Special Commission of Inquiry

In 2014, six years after the conclusion of the Special Inquiry, and six years before this current Committee Inquiry, the NSW Ombudsman published a report entitled: *Review of the NSW child protection system – Are things improving?* Our conclusion then was that there was insufficient evidence to demonstrate the effectiveness of that system in identifying and effectively supporting vulnerable children and families, notwithstanding considerable investment, effort and activity to improve it.

In subsequent years the child protection system has been subject to further reviews, reforms and the introduction of new initiatives and programs. These include:

Legislative changes

- Safe Home for Life (2014)
- Permanency Support Program (2017)

New initiatives

- Their Futures Matter (2016 - 2020)
- Intensive Therapeutic Care (2018)
- Targeted Earlier Intervention Program (2016)

Inquiries

- Independent Review of Out-of-Home Care in NSW (Tune Review - 2016)
- NSW Parliament Committee of Inquiry into the role of the Department of Family and Community Services in relation to child protection (2017)
- Independent Review of Aboriginal Children and Young People in Out-of-Home Care (Family Is Culture - 2019)
- NSW Auditor-General Performance Audit of Their Futures Matter (2020).

Arising from these inquiries and initiatives have been a range of reforms that aim to improve outcomes for vulnerable children and families. Much of the reform agenda has involved pilot programs to test service solutions.

However, there is limited publicly available information that would allow assessment of the success of new initiatives and other reforms in providing for the safety, welfare and wellbeing of children and young people, supporting vulnerable families, reducing entries to OOHC, minimising children's time in OOHC, and improving their care experience.

For example, there is currently no publicly available information about:

- The number and type of responses to all children who are assessed at risk of significant harm
- Outcomes (relating to safety and permanency) for more than 3,000 children in guardianship placements
- Performance of non-government organisations across the child protection system
- Outcomes for children in government and non-government OOHC placements
- Outcomes for families accessing early intervention.

Various initiatives have been put in place to enable the production of information about performance, outcomes and service targeting. These include the:

- Data Exchange (Targeted Earlier Intervention)
- DCJ statistics dashboards and reports
- Pilot Quality Assurance Framework (OOHC)
- Human Services Data Set (Their Futures Matter)
- DCJ Pathways of Care Longitudinal Study (OOHC).

These initiatives have not yet delivered information that demonstrates whether and the extent to which the reforms described above are achieving their goals. The current main source of published performance information – DCJ's statistical reports – is characterised by significant time lags, inconsistency between various publications, absence of outcomes information, predominance of input/output data, and changes from year to year in counting rules and data reported.

In addition to performance data, not all program initiatives have been subject to adequate review or evaluation. In its performance audit of the Their Futures Matter initiative for example, the Audit Office noted the inconsistency of evaluations across programs to support vulnerable children and families, particularly with regard to demonstrating effectiveness.

Without adequate performance information, it is difficult to draw conclusions about the overall effectiveness of the child protection system, or how well agencies are responding – separately and collaboratively – to critical challenges such as responding to children reported at risk of significant harm, the need to reduce the number of children entering care and the over-representation of Aboriginal children throughout the child protection system.

The role of the NSW Ombudsman

The NSW Ombudsman has statutory functions relating to oversight of the provision of community services, including those provided by a range of government and non-government organisations that together comprise what can be described as 'the child protection system'.

We do this through functions outlined in the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and the *Ombudsman Act 1974*. In particular:

- We handle complaints about community services, including child protection and OOHC. Under the *Ombudsman Act*, we can investigate matters. We can also review the complaint handling systems of service providers.

  In 2019-20 our office finalised 1,027 complaints about child and family services. Just over 30% of these complaints related to DCJ's management of statutory child protection functions, most of these were from parents who objected to having their children removed. Another 59% of all finalised child and family complaints related to OOHC.

- We convene and support the work of the NSW Child Death Review Team. Separately, we have responsibility for reviewing 'reviewable' deaths of children (children who die while in OOHC or detention, and children whose deaths occur in circumstances of abuse or neglect).

- We can monitor, review and inquire into the delivery of community services. These functions are expressed in broad and discretionary terms but, in practice, the extent to which we can undertake these functions is constrained by our limited resourcing.

The delivery of community services – including child protection and OOHC – has been increasingly devolved to the non-government sector. More government agencies have also assumed direct responsibilities in child protection. In terms of oversight, this has meant an expansion of agencies within our jurisdiction - from what was previously a single statutory child protection agency with select non-government agencies to what now comprises thousands of individual providers.

The Ombudsman's future work

In 2019-20, our office underwent a restructure and in 2020 we published a five-year strategic plan. As part of this process, we have embarked on a new approach to monitoring and reviewing the delivery of community services in NSW and planned a program of work that may be relevant to the Committee's Inquiry.

In the coming year, as well as our continuing work in complaint handling and death reviews, we intend to focus our work in this area on the following:

- Examining whether the right performance information is being collected, reported and evaluated to demonstrate how well the child protection system is delivering on its main goals of keeping vulnerable children safe and reducing entries to OOHC
- Assessing whether DCJ has achieved a 10% reduction in the number of Aboriginal children in OOHC by 30 June 2020, in line with the Aboriginal Outcomes Strategy 2017-2021
- Conducting a series of complaint-handling audits of providers of community services.

Proposed review of CS-CRAMA

In recent years there have been significant legislative and machinery of government changes that have impacted our jurisdiction and functions under CS-CRAMA. These include most recently the transfer out of the child-related reportable conduct scheme to the Children's Guardian (OCG) and the transfer of responsibility for the co-ordination of Official Community Visitors to the OCG (for children and young people living in OOHC) and to the Ageing and Disability Commission (for people with a disability in residential care).

While supported by the Ombudsman's Office, these changes have included a significant reduction in our remaining funding and resources to perform our community services oversight functions. They have also had practical impacts on that work – for example in terms of our ability to leverage the information and expertise obtained from reportable conduct functions and the Official Community Visitors for the purpose of assisting in the monitoring of the child protection system and community services generally.

These changes have also occurred in the context of broader contextual changes in the community services sector. These have included the wide-scale devolution of community services to the non-government sector that we referred to above, as well as the roll-out of the National Disability Insurance Scheme and the consequent shift in State and Commonwealth responsibilities in that area.

In light of these changes, we have asked the NSW Government to consider a review of the remaining provisions of CS-CRAMA to ensure that our continuing functions are properly resourced and can be conducted effectively.

Please do not hesitate to contact [redacted] if you would like more information.

Once again, thank you for the opportunity to contribute to the Committee's consideration of these issues.

Yours sincerely

[redacted]

Paul Miller
Acting NSW Ombudsman