

4 November 2016

The Honourable Greg Donnelly MLC,
Chair, General Purpose Standing Committee No. 2
Parliament House
Macquarie Street
Sydney NSW 2000

By email: gpsc2@parliament.nsw.gov.au

Dear Mr Donnelly,

General Purpose Standing Committee No. 2 Inquiry into child protection – Supplementary questions for the NSW Ombudsman

Thank you for the opportunity to review the uncorrected transcript of evidence I gave before the Committee at the 26 September 2016 hearing.

I am pleased to advise that the uncorrected transcript received on 6 October 2016 is accurate. I am also pleased to provide at Attachment A the additional information in response to the supplementary questions from the Committee.

As you may recall, in my opening statement I indicated that I would be happy to provide some broad observations about out-of-home care and Aboriginal children at a later stage. I have therefore taken this opportunity to provide the Committee with these observations which we have outlined at Attachment B.

In light of the important issues being traversed by the Committee, I also want to take this opportunity to suggest that the Committee might consider hosting a roundtable discussion with key stakeholders, to further inform its deliberations and recommendations.

I trust that the information provided will assist the Committee. If further information is required, please do not hesitate to contact Julianna Demetrius, Assistant Ombudsman (Strategic Projects) by email at _____ or by telephone on _____.

Yours sincerely

Steve Kinmond
**Community and Disability Services Commissioner and
Deputy Ombudsman**

Attachment A - NSW Ombudsman response to supplementary questions

Supplementary Question 1

1. What do you consider is an acceptable ROSH response rate? (page 3 of submission)

FACS indicated in its submission to the Inquiry (at p.8) that the Child Protection Helpline uses tools based on actuarial science and comprehensive research to assess whether reports reach the Risk of Significant Harm (ROSH) threshold. Given this, it is difficult to argue that those reports assessed as ROSH, and referred for further action, should not all receive a face-to-face response, unless (as noted in the evaluation of the *Keep Them Safe* reforms) there is a change in the circumstances of the child or the initial assessment was wrong.

However, as we reported in our submission to the inquiry, child protection data published by FACS confirms the view that FACS initiatives alone are unlikely to enable it to adequately meet ROSH report demand. We have argued that it is important to expand the roles of other agencies, including the non-government sector, to improve the response to ROSH reports and to vulnerable families more generally. We have said that more effective collaborative work could potentially:

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

It is also critical that the various co-design initiatives unfolding in districts, such as the Central Coast, and Western Sydney, are closely examined to see whether they lead to more at risk children and their families being seen by FACS or another agency, together with the provision of a quality response (and ideally, fewer reports being made over time).

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

Supplementary Question 2

2. Has the Ombudsman reported on or observed any changes in the 'quality' of responses arising from the introduction of the Practice First model? (page 4 of submission)

- a. How do non-Practice First CSC's compare to Practice First compliant CSC's in the 'quality' of their ROSH responses?*
- b. Have you observed any tendency for these Practice First CSC's to deliver a greater quantity of child protection responses at the expense of higher quality responses?*
- c. If so, is the issue simply that the resources aren't there for the Department to provide a high quantity and high quality child protection response that we expect?*

We have not undertaken a separate review of Practice First because we were aware that FACS had commissioned the Parenting Research Centre, the Social Policy Research Centre at the University of NSW and the University of Melbourne to evaluate the model. We have asked FACS to keep us advised of developments relating to the evaluation. In this regard, FACS recently advised us that:

“the evaluators undertook a review of Practice First throughout 2015. The final report on the evaluation was submitted to FACS in January 2016. The evaluation provides overall support for the model, finding that it offered a good foundation for FACS to meet its priority goals.

Further rollout of Practice First will be informed by the evaluation about how best to maintain implementation fidelity and position this model so that it has the best chance of helping FACS meet its broad goals. To this end, work is currently being scoped to refresh the Practice Framework in a way that makes all initiatives, including Practice First, explicitly linked.”

We have asked FACS for a copy of the evaluation report and will continue to monitor implementation of Practice First via the FACS/Ombudsman Integrated Governance Framework.

Supplementary Question 3

3. Please elaborate on the need to enhance communication - see comments about agencies failing to provide or request critical child protection related information from each other. (page 4 of submission)

a. Are there particular examples where this was highlighted?

The related issues of poor information exchange and interagency collaboration have been a focus of the more than 200 child protection investigations and inquiries in connection with our oversight of individual complaints, reportable conduct allegations, and child deaths, as well as our three year audit of the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*.

For more than ten years, we have been highlighting (in various public and agency reports) the problems associated with poor practice relating to information sharing and interagency collaboration, and have made numerous recommendations to improve practice in these areas at both an individual case level and at a systems level (see for example, Ombudsman annual reports, reviewable child death reports, our reports on Aboriginal child sexual abuse and strengthening the oversight of workplace child abuse, and our special reports to Parliament about the deaths of Ebony and Dean Shillingsworth).

We have used our public and agency investigation reports to remind agencies of what can go wrong for children when they fail to work effectively, fail to work together, and fail to take shared responsibility for the care and protection of children.

Over recent years, we have also provided a number of confidential case studies to the Royal Commission highlighting the importance of information sharing both within this state and across borders. In this regard, our 2012 report *Responding to child sexual abuse in Aboriginal Communities* includes case studies that highlight inadequate intra and interagency information exchange, communication and collaboration. In particular, we refer you to case studies 13, 15 and 25 (see pp. 118, 129 and 178). For further examples, the Committee may wish to review case study 1 in our February 2016 report, *Strengthening the oversight of workplace child abuse allegations* (see p. 6); and

case studies 4,5 and 8 in our *Reviewable Deaths in 2012 and 2013. Volume 1: Child Deaths* (see pp 53, 54 and 68). All of these reports are available on our website www.ombo.nsw.gov.au.

As we noted in our submission, the Royal Commission has covered the issue of information exchange extensively in its March 2016 Consultation Paper – *Institutional Responses to Child Sexual Abuse in Out-Of-Home Care*. While the paper highlighted the strengths of both the breadth and nature of the information sharing provisions in NSW as compared to other jurisdictions, it also highlighted that despite Chapter 16A's 'explicit prioritisation of information sharing for the safety, welfare and wellbeing of children over the protection of privacy and confidentiality, together with clear protection against criminal and civil liability, should promote timely and appropriate information sharing', there still appeared to be a reluctance to share information in some quarters. The Commission concluded that this suggests that NSW needs to do more to promote 'understanding and confidence in sharing information to protect children in OOHC contexts'.

b. Is this still the case? How far has the ChildStory system gone to address this issue?

We continue to have significant concerns about interagency information exchange, collaboration and coordination of child protection responses. For this reason, this year we convened an interagency roundtable discussion to examine issues relating to shared responsibility in this context. The issues arose from an investigation we conducted into the involvement of a number of government and non-government agencies with the family of a child who died in 2014. This work is ongoing. We are also convening a second interagency round table to further examine issues arising from a separate recent investigation through which we also identified concerns about how agencies exchanged information, collaborated and failed to coordinate their child protection work.

Should the Committee require further information to illustrate weaknesses in information exchange practice, we would be happy to provide detailed examples, including redacted copies of relevant investigations. However, given the potential for distress to family members should these reports be published, we would ask the Committee to treat them on a confidential basis.

In relation to the Committee's question relating to the extent to which ChildStory will address issues relating to information sharing and collaborative practice, FACS would be better placed to inform the Committee about both the progress of ChildStory's implementation and its functionality. However, we expect that ChildStory should be an important tool for child protection practitioners and should provide FACS and NGOs with much greater visibility over information holdings and case management; however, it will never be a substitute for the professional judgements that practitioners must exercise in analysing and exchanging information for child protection purposes.

Supplementary Question 4

4. With respect to initiatives like the Mobile Child Protection Unit or the Community Hub, are you aware if they drew on existing resources, or were they new funding allocations? (page 6 of submission)

a. Have these additional initiatives led to a reduction of capacity in other service areas within the Department?

We are not aware of whether additional funding was provided for the Mobile Child Protection Unit or whether FACS drew on existing resources to implement it. The Committee may be aware that since making our submission, the Mobile Child Protection Team won this year's premier's award for "protecting our Kids". This award recognises those who have worked on programs, initiatives, innovations or improvements that reduce the number of children and young people re-reported at risk of significant harm.

Supplementary Question 5

5. *With respect to the Macarthur Intake and Referral Service, and the Central Coast Multi-Agency Response Centre, are you aware if they drew on existing resources, or were they new funding allocations? (page 9 of submission)*
- a. *Have these additional initiatives led to a reduction of capacity in other service areas within the Department?*

We are not aware of whether additional funding has been provided or whether FACS drew on existing resources for this initiative.

Supplementary Question 6

6. *With your meetings with FaCS, are they clear about the impact of these new initiatives across the Department? (page 9 of submission)*
- a. *Does the Ombudsman or the Department conduct any cost-benefit analyses on the transfer of these functions and resources out of central operations into these localised systems? i.e. Does the increase in outcomes for children in these particular regions potentially come at the expense of children generally?*

We have a longstanding and keen interest in the potential of co-located and co-designed initiatives to deliver better outcomes for vulnerable children and families. We have continued to promote place-based approaches to service delivery in high-need communities because we are firmly of the view that, if well implemented, they are far more likely to deliver better value for money as well as better integrated responses.

Although our work to-date has not involved undertaking a cost benefit analyses of particular initiatives, our experience in reviewing the delivery of human services and justice responses in a significant number of vulnerable communities, has convinced us that a more disciplined approach to planning, funding and related governance arrangements is essential to building an effective and seamless place-based service system.

Such a system is also dependent on the planning and funding decisions (and related governance arrangements) being driven from a 'whole of community' perspective. Key issues around the leadership (and associated authority) that is required to break down siloed decision making, and to drive integrated planning and service delivery in local communities, must also be addressed before such a system can be built. In this regard, giving an individual responsibility for 'whole of community' service reform without also giving them the requisite authority is unlikely to be successful.

Our reviews over a number of years have clearly highlighted the limited results achieved by approaches that have not been informed by 'data driven' decision-making about the particular needs of vulnerable children and their families in individual communities and the availability of services to match identified need.

In our 2011 report *Addressing Aboriginal Disadvantage: The need to do things differently*, we highlighted that the absence of a genuinely integrated approach had resulted in a complex landscape in which multiple agencies were separately making their own independent decisions about what services they would deliver and/or fund in various locations. This system, which lacks coherence and promotes inefficiency, has led to the uncoordinated proliferation of services in many high-need communities. In some locations, the number of such services is huge. For example in Wilcannia, there were around 67 services for a population of approximately 600 people in operation at the time.

In the same report we highlighted the very limited impact of the Safe Families program led by Aboriginal Affairs. At the time we released our report, the program was more than two and a half years into its commencement, yet it was operational in only two of the five proposed locations; and at that time only six families in Wilcannia and two families in Lightning Ridge had received case management. This was a significant concern given that Safe Families had been designed to be a major instrument for achieving the goals of the Interagency Plan to Tackle Aboriginal Child Sexual Abuse, and was provided funding of \$22.9 million. Shortly after the release of our report the funding was redirected.

Although it is now five years since we wrote about Safe Families program, it serves as a good reminder of the opportunities lost when off-the-shelf programs are overlaid on communities. A number of factors undermined the effective implementation of the program. From the outset, it was a 'reactive' initiative that was announced and developed without adequate time for genuine consultation with Aboriginal leaders and target communities, or consideration of how the program would operate in the context of existing services in those communities.

It will be essential that various co-design initiatives have built in performance measures so that outcomes can be closely monitored and assessed, and that regular reporting is provided to the community.

Supplementary Question 7

7. *With respect to the new contract governance approach, is there any indication that there will be increased resources to assist in the delivery of these 'outcome based' service delivery contracts? (page 13 of submission)*
- What program design is being undertaken by the Department?*
 - What sort of outcomes are you looking for? Can they be broken down into raw statistics? Does a data driven approach create the potential for a system that seeks KPI's at the expense of quality outcomes*
 - Are you aware if the Department has made any progress in this area, since the Auditor-General's 2013 report into OOHHC? (The report stated 'It is difficult to assess whether overall outcomes for children have improved. This is because the Department has not yet determined what wellbeing outcomes it wants to achieve, such as improvements in a child's health, education, and welfare.')'*

In relation to questions 7a, b and c, our submission has highlighted our understanding of relevant work that FACS is doing in this area. We have no additional information to provide to the Committee on these issues. However, in our view, well designed programs must have clearly defined key performance indicators that capture both qualitative and quantitative information to assess whether programs are achieving intended outcomes and to allow meaningful comparisons to be made in relation to the relative performance of funded agencies. Also, the Committee may wish to consider FACS' response to the Auditor-General's report about the department's commitment to implementation timeframes. (See <http://www.audit.nsw.gov.au/publications/latest-reports/performance/transferring-out-of-home-care-to-non-government-organisations/appendices/4-appendices>)

Supplementary Questions 8, 9 and 10

8. *How is it acceptable that child-to-child sexual abuse is not considered reportable conduct? (page 18 of submission)*
9. *Does the Ombudsman believe there is a need for changes to the legislative requirements around child-to-child abuse? Has the Ombudsman advised the Minister to this effect? (page 18 of submission)*
10. *Just how big a problem is it, given the Ombudsman is not informed unless it occurred due to carer neglect? (page 18 of submission)*

In relation to questions 8, 9 and 10, our view is that designated agencies should be required to notify serious child-to-child abuse to an independent oversight agency. The absence of a protective statutory framework to address this issue means that there is no comprehensive mechanism to scrutinise the adequacy of service responses to these matters in order to inform and drive practice important at both individual case and broader systems levels.

We know from our audit of child sexual abuse in Aboriginal communities, that there are significant capacity challenges across the sexual assault counselling sector (and in relation to therapeutic programs for young people who display sexually abusive behaviours and children under ten who display sexualised behaviours). Ensuring that alleged victims and young people who display sexually harmful behaviours are in safe placements and receive appropriate treatment at an early stage, is one of the key reasons why oversight in this area is critical.

Given that we do not have direct oversight in this area (apart from overseeing allegations of reportable conduct relating to neglect – a subset of which include a failure to protect from sexual harm), our information about the prevalence of child-to-child sexual abuse across the OOHC sector is limited. In relation to the data we do hold, it is worth noting that the sustained rate for allegations of neglect in the out-of-home care sector is 31.7% (145 out of 457 matters), which is relatively high compared to the sustained rate for sexual misconduct/sexual offence matters which is 17.1% and 22.4% for physical assault matters for the same sector (based on notifications closed from 1 July 2013 to 30 June 2016).

Finally, our office has been raising the need to address the lack of a formal reporting scheme for child-to-child sexual abuse in various forums: including at the June 2015 Royal Commission hearing in relation to out-of-home care; and more recently in a submission to the Royal Commission in April

2016. We have also participated in consultations with FACS and the Office of the Children's Guardian about this issue during the course of the year.

Supplementary Question 11

11. Regarding reporting in June of this year in the Sydney Morning Herald - How is it acceptable that the Department doesn't know how many cases of sexual abuse of children in the Minister's care occur every year? (page 18 of submission)

We believe that it is critical that all serious abuse allegations of children in OOHC are reported centrally and that the handling of these matters is scrutinised in terms of investigative, risk management and child-centred practice. If such a system was in place, then the Minister and Department, along with other key stakeholders, would be aware of all such allegations relating to children in his care. It is our understanding that FACS has been recently obtaining and analysing this type of information. From our perspective, while capture of this information is necessary, it is not on its own sufficient. What is critical is that affected children receive a high quality child protection and therapeutic response, and that information from these cases is used to inform practice improvement at both the individual and broader service system levels.

Supplementary Question 12

12. Given revelations about abuse in residential care and numerous reports of abuse by carers, does the Department meet the Ombudsman's expected standards for screening and monitoring of care provided by NGO's? (page 23 of submission)

The OCG has the lead role in relation to the accreditation and monitoring of designated agencies providing OOHC, principally through ensuring their compliance with the NSW Child Safe Standards for Permanent Care. The OCG has other related functions, including administering the Working With Children Check (WWCC); operating the Carers Register; and promoting the development of child-safe organisations. Our office works closely with the OCG to ensure that we carry out our functions in a complementary manner. We have an ongoing role in flagging critical information on the Register and facilitating effective interagency exchange of relevant information. Our reportable conduct functions intersect with the WWCC, including by ensuring that any workplace records that are notified to the Children's Guardian for the purpose of informing the WWCC have been subject of independent oversight.

Since the commencement of the current WWCC function in June 2013, we have issued to the OCG 1,337 referrals of information about persons who may pose a risk to children. Of these, 27% (367) related to individuals employed in the OOHC sector.

Also, in the three years from 1 July 2013 to 30 June 2016, we closed 3,429 notifications of reportable conduct. Of these:

- nearly 50 per cent (1,706) were from the OOHC sector
- of the 1,706 notifications, 48 per cent related to NGO providers
- almost 45 per cent of the 1,706 notifications resulted in disciplinary or remedial action, including carer de-authorisation, dismissal, resignation and demotion.

As we noted in our submission, although we have a broad oversight mandate in relation to the child protection system, given the lead role played by the Children's Guardian in the OOHC area, it is critical that we target our resources towards monitoring the OOHC system from a high level, structural perspective together with responding to discrete systemic issues which we identify from the exercise of our reportable conduct and CS-CRAMA functions. In this regard, our oversight has focused strongly on improving the systems in place for probity checking and screening of carers, and as outlined below, over recent years there has been significant practice improvement in this area. Our investigative work also put the spotlight on the need to extend the reach of the prospective carer assessment process to new adult members of a carer's household.

For example, several years ago we were concerned about the adequacy of risk assessments carried out in relation to the partners of carers, including when household circumstances changed. In some instances, relevant FACS and police information – which pointed to unacceptable levels of risk – was not passed on to designated agencies. Even when relevant information was available, it was not always properly considered in risk assessments. We also identified instances where the standard of assessment for kinship carers was particularly inadequate. One of the observations we made from overlooking kinship care placements, was that because of the preferable nature of placing children with family, there can be a tendency for assessments to be conducted in a way that seeks to identify all of the positives about these placements but sometimes this can lead to insufficient weight being given to risk factors. The risks associated with this type of approach are often compounded by the fact that kinship care placements were generally receiving minimal casework.

Against this background, we highlighted that developing a common practice framework for carer screening and assessment was particularly important with the transition of OOHC placements from FACS to the NGO sector.

As part of a 2011 investigation, we stressed the need for FACS to take proactive steps to provide non-government OOHC agencies with information it holds that is relevant to each agency's assessment of potential foster carers.

As a result, FACS wrote to heads of designated agencies to promote awareness of their right to request relevant risk related information from Community Services about prospective carers.

We also hosted a roundtable discussion in 2011 with Community Services, the Children's Guardian, the then CCYP¹ and OOHC peak organisations to develop a consistent and rigorous approach to screening and assessment. Further roundtables were held and as a result, agreement was reached on a number of critical policy areas, including:

- Ensuring equivalent standards are applied when assessing kinship carers and general foster carers
- Requiring all members of carer households to be included in the carer assessment process
- Having consistent types of information considered when doing probity checks.

The outcomes from the carer screening roundtable informed the work of the Children's Guardian in establishing a carers' register and changes to the OOHC Standards. As we outlined in our submission, the register provides agencies with information about a potential carer's previous care history and

¹ Commission for Children and Young People.

guides agencies through the carer assessment process. Current practice means that carer applicants will not be able to be authorised unless they pass the required checks contained in the Carer's Register. The Register also assists the Children's Guardian in its assessment of agency performance against accreditation criteria relating to the screening and management of carers and staff.

Significantly, although the Carers Register provides a common resource that all designated agencies must use to share information about foster carers and prospective foster carers, it currently holds no information about residential care workers. This means that there is currently no systematic way to alert prospective employers via the Register to concerns arising in relation to former residential care workers. Our data shows that over the past three years, more than 100 people have been dismissed or permitted to resign as a result of reportable conduct matters; many of them were workers in the residential OOHC sector. We understand that steps are currently being taken to add residential care workers to the Carers Register.

We are confident that the Carers Register and WWCC represent significant contributions to a more robust protective mechanism for children in OOHC.

In relation to monitoring standards of care provided by NGOs, FACS contracts designated agencies to provide OOHC and monitors compliance with contractual requirements. As we have noted, FACS is planning to introduce performance-based contracts for NGO OOHC providers and to implement outcomes-based monitoring of children and young people in OOHC via the Quality Assurance Framework. In 2017, there will be a complete retendering of a re-designed residential care sector based on an evidence based therapeutic service model.²

a. Given the increasing number of placements of children in OOHC with NGO's, is there an appropriate level of resourcing being provided to facilitate the interagency information exchange of the sort described on pg. 24?

We initiated an investigation in September 2013 about information provision and subsequently made a number of recommendations to FACS aimed at improving their:

- provision of information to carers that is relevant to the management of risks to children
- provision of information to police regarding criminal allegations of child abuse
- practice in assessing and providing to stakeholder agencies relevant holdings on KiDS about both existing carers and potential carers (as part of the carer assessment process)
- general provision of information to other agencies in relation to persons who may pose a risk to children and young people
- engagement with parents and other family members to enhance a child protection response in relevant cases.
- Identification of individuals as 'persons of interest' and 'persons causing harm'.

Of the seven case studies included in our final investigation report to demonstrate particular areas for improvement in FACS' identification, assessment, management and exchange of critical information,

² See NSW Government submission on the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation paper on out of home care, May 2016.

four highlighted failures by FACS to provide critical risk-related information to carers or non-government OOHC providers. FACS accepted our recommendations and we continue to monitor FACS' progress in these areas through the FACS/Ombudsman Integrated Governance Framework.

In relation to whether an appropriate level of resourcing is being provided to facilitate interagency information exchange, we believe that this type of practice should not generally pose a significant resource burden on agencies, and in fact, it will on occasions result in resource savings.

Supplementary Question 13

13. Given your advocacy on changes to the reportable conduct scheme as addressed in the November 2015 amendments to the Act, are there any further recommendations in this respect you would have to this legislation? (page 25 of submission)

As noted earlier, we believe there is merit in addressing the legislative gap in relation to child-to-child sexual abuse, particularly in relation to children in OOHC.

We have also suggested that it is worth considering whether amendment is required to clarify and potentially broaden the definition of prescribed bodies in accordance with Chapter 16A of the *Children and Young Persons (care and protection) Act 1998*. To illustrate, some organisations may not be prescribed bodies but still retain management responsibility over an agency or agencies which are prescribed bodies; for example, the relationship between a Catholic Diocese and a Catholic school or a community service agency under the 'management' control of the Diocese. In these and other similar circumstances, it is important the organisation exercising 'management' responsibilities can both receive and provide information under Chapter 16A.

Supplementary Question 14

- 14. Do you perceive there is real risk that individuals who achieve a 'clearance' under the WWCC scheme may pose a risk to children whilst not qualifying for a total 'bar'? (page 25 of submission)*
- a. Is there a need to diversify the types of clearances or flags that appear on a WWCC clearance?*
 - b. What would the Ombudsman recommend be done to address the concerns raised in part 5.3 of their submission?*

In relation to clearances, we generally support the binary bar/clearance option. However, we believe there would be merit in the OCG having the option, in exceptional circumstances, of issuing certain individuals with a clearance to *only* work in *certain* child-related employment spheres subject to certain conditions.

For example, we have been made aware of a matter involving a young person found to have perpetrated sexual abuse that was reportedly living in a stable care placement with his siblings and had been responding well to therapeutic treatment, however he was unable to continue to reside in his home as a result of being the subject of a WWCC bar. (The young person was required to undergo a check as a member of a household where other children in care were residing.)

Regarding the specific concerns raised in paragraph 5.3, we have argued that the OCG should develop a system for using the information exchange provisions contained in the Children and Young Persons (Care and Protection) Act, in cases where there is insufficient evidence to bar but there is *compelling* evidence to indicate that an individual *might* pose a significant risk to children. In these cases, we believe that the OCG should advise any employer who seeks to verify the WWCC clearance of the individual to contact those who might hold relevant information about the individual when the employer seeks to verify the individual's WWCC clearance to contact those agencies who the Guardian is aware holds relevant 'risk-related' information. In making this observation, we note that such practice conforms with Chapter 16A, and it would only provide employers with information of a kind which would be revealed under a 'foolproof' reference checking system. We also note that our proposal is consistent with the wide scope of information made available under the Carers Register.

In relation to this issue, we have suggested that the OCG work with relevant stakeholders (that is agencies which employ people in child related employment) to determine in what circumstances it should be systematically sharing information with agencies under Chapter 16A, and to develop processes which ensure that information is exchanged efficiently and systematically. As we noted in our submission, the OCG held a meeting with a number of stakeholders on 18 February 2015 to discuss the circumstances in which information exchange of the type we have proposed should occur, and related operational and policy implications.

We have said that it will be important for the OCG's ongoing discussions with stakeholders to focus on determining what constitutes best practice in relation to the type of information that should be shared with employers. Obviously, there is also scope to further consider the role of all stakeholder agencies in relation to ensuring that significant information relating to the safety of children is effectively being exchanged, both under the Part 3A regime and via other avenues.

Finally, while it is critical to address the issues identified above, we stress that doing so will not be sufficient to ensure that all the necessary employment-related child protection safeguards are in place. Indeed, it is critical that the enhancement we have proposed is complemented by a much more sophisticated understanding across the child-related employment sector of pre-employment screening processes and child safe practices more generally.

Supplementary Question 15

15. Please elaborate on the recommendations made regarding changes to the reportable conduct scheme? (page 33 of submission)

- a. Is it the case that if a child was sexually assaulted on a weekend camp in a tent, that would be not reportable? But if that same child was assaulted on a week-long trip in a cabin, it would be? Is that the case?*

In relation to this question, it is important to firstly distinguish between whether an agency falls under our Part 3A jurisdiction from whether the particular conduct falls under our jurisdiction. If an agency would not otherwise fall under our jurisdiction, then the factors to which you have referred in your question are material to whether the agency is caught by the reportable conduct scheme. However, if the agency falls under our jurisdiction, then any alleged reportable conduct, or conduct which might involve reportable conduct, by any of the agency's employees, or the volunteers it engages to work with children, falls under our jurisdiction. In particular, if the agency is a 'designated agency' under

Part 3A of the Ombudsman Act, it does not matter in what circumstances the alleged reportable conduct took place (this also includes 'off duty' conduct).

Background to the Solicitor-General's advice

By way of background to this issue, we were prompted to seek advice from the Solicitor General about the meaning of the term 'substitute residential care for children', after receiving an inquiry in June 2013 from a family member of a child who had allegedly been sexually abused whilst attending a five day residential therapeutic camp.

The Solicitor General expressed the view that in the particular case, the camps operated by the organisation did constitute the provision of 'substitute residential care'. (A copy of advice from the Solicitor-General is attached).

In light of the practical implications of his advice, we joined with the Department of Premier and Cabinet in seeking clarification from the Solicitor General on specific issues related to his initial advice. In particular, we were interested in exploring more fully which types of circumstances and organisations (such as sporting associations, social clubs, churches and other religious bodies) would fall within the definition of 'an agency providing substitute residential care for children'.

We also asked the Solicitor General to clarify related issues such as whether the mere fact that an organisation has run a camp in the past will, in and of itself, bring the involved entity within our jurisdiction, and whether the frequency with which an organisation conducts camps was relevant to determining whether it is providing 'substitute residential care for children'.

The Solicitor General noted that single night or weekend religious camps run by smaller religious organisations, such as local churches, did not constitute substitute residential care. He went on to provide a list of indicators as to whether an agency could be deemed to be providing substitute residential care for children. These included:

- the camps extending beyond two nights' duration
- the camps being provided in fixed accommodation (that is, the campers sleep in rooms/cabins/dorms rather than temporary or improvised accommodation such as tents or bivouacs)
- the camps providing food and other care services, and
- the camps providing supervision and support by adults for the purposes of supporting a child's physical, emotional and psychological well-being (and in circumstances where their parents/usual caregivers are not present).

The implications of the Solicitor General's advice are far-reaching and bring within our reportable conduct scheme a large number of social and religious organisations in this state. Many of these organisations employ a vast number of individuals and rely heavily on a volunteer base to run their valuable activities that benefit many thousands of children and young people.³

³ Advice sought by the Department of Premier and Cabinet and the Ombudsman's Office on 10 December 2013.

The extent of the impact of the advice is clear when one considers the significant number of organisations in NSW that run camps for children – including churches and other religious bodies, Christian non-denominational organisations, sporting and recreation/adventure/community organisations, artistic/music/cultural clubs, and organisations that promote children's health and wellbeing.

There has been a consistent view put forward by those we have consulted that the impact of adopting the Solicitor General's advice regarding the meaning of substitute residential care, results in the coverage of the reportable conduct scheme being determined by factors extraneous to risks to children; such as, whether or not an organisation's camps use tents or fixed structures, and distinctions between whether camps are held for a weekend or longer.

It is also important to note that some church denominations operate under a single legal entity, whereas other denominations are structured so that each local church and/or diocese are their own legal entities. The practical effect of this is that if a local church operating within a broader denomination comprised of a single legal structure provides camps which fall within the parameters of the Solicitor General's advice, then the entire denomination falls under the reportable conduct scheme. Conversely, where a local church of a broader denomination that runs a relevant camp is a separate legal entity from the 'parent' entity of the same denomination, then only that local church is deemed to fall under our scheme.

This means that under the current scheme, different organisations which essentially perform the same role in working with children will either fall within or outside of the reportable conduct scheme based on their particular legal structures, rather than because of the nature of their work with children.

In our February 2016 special report to Parliament, we made the following concluding remarks:

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

- *We believe that the nature of 'organisations' involvement with children, rather than their particular legal structures, should determine whether they fall within our reportable conduct jurisdiction.*
- *We believe there are no sound public policy reasons for allowing the coverage of the reportable conduct scheme to be determined by factors extraneous to risks to children, such as whether or not an organisation's camps use tents or fixed structures, and distinctions between whether camps are held for a weekend or longer.*
- *We support the view of key stakeholders that there is a need to better align the coverage of the reportable conduct and Working With Children Check schemes. A review of the coverage of both schemes provides the opportunity to consider whether other legislative amendments are required which are relevant to child protection practice in this area.²⁴*

And finally, if Parliament is of the view that a broader range of organisations should fall under the reportable conduct scheme, there is a need to consider whether they are adequately resourced to fulfil their responsibilities.'

As I outlined in my evidence, we have been advised by Government that it will respond to our report to Parliament once it has had the benefit of reviewing the Royal Commission's recommendations in relation to the value and reach of the reportable conduct scheme.

Supplementary Question 16

16. How can FaCS better utilise information exchange provisions? (page 35 of submission)

- a. What causes this shortfall? Does FaCS need more resources to utilise these provisions?*
- b. Is the training provided to staff adequate to ensure they are used to their full potential?*

In our submission, we noted that the Royal Commission has made observations about information exchange practice in NSW:

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

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

.....We heard that Chapter 16A enables information from a variety of sources to be easily gathered to better inform assessments of and responses for children at risk. We also heard that the operation of Chapter 16A has resulted in significantly more information being shared than was the case prior to its introduction."

This is relevant because, as we have consistently argued, the responsibility for exchange of information for child protection purposes is not limited to FACS alone but applies to all agencies – government and non-government – with child protection responsibilities.

Please refer also to our response to question three in relation to interagency information exchange, collaboration and communication. In addition, we also note that our work over time has highlighted recurring instances of agencies applying narrow or inflexible interpretations of the information exchange provisions, and/or a lack of proactive approaches to intra and interagency collaboration. In this regard, it is important to note that the purpose of Chapter 16A of the *Children and Young Persons (Care and Protection) Act* is not simply to authorise or require agencies to exchange information, but to facilitate the provision of services to children in a child protection context, including by requiring those agencies to take reasonable steps to co-ordinate the provision of those services with other agencies.

To date, there has been only limited evaluation of the impact of the use of Chapter 16A and whether it is operating as intended. Given the pivotal role which FACS performs in the child protection and broader community service spheres, we believe that it is reasonable to assume that the introduction of Chapter 16A has imposed on FACS an additional resource burden. As to whether FACS has been adequately funded to meet this impact, we are not well placed to provide an informed response. However, we also note that the efficient, strategic use of Chapter 16A can also lead on many cases, to significant resource savings.

Attachment B - Additional observations on Aboriginal Children and young people in care and out-of-home care in general

Keeping Aboriginal children and young people safe

1. The Challenge

The challenge is well illustrated by the data:

- 22% of all reports to the Helpline involve Aboriginal children and young people
- 31% of all secondary assessments where actual risk of harm is determined involve Aboriginal children and young people
- 37% of the OOHC population are Aboriginal children and young people.

2. The response

2.1 Long term

- We must address entrenched indicators of social disadvantage evident in Aboriginal communities.
- We are monitoring a range of initiatives aimed at improving outcomes for Aboriginal communities through our OCHRE function, together with our functions under the *Community Services (Complaints, Review and Monitoring) Act 1993*.

2.2 Immediate action

- Aboriginal communities need ready access to quality services and quality staff with the skills to identify and support vulnerable families and at risk children.

Quality casework

Perhaps the most important requirement for local casework managers and their staff is to build excellent relationships with Aboriginal leaders within the communities they serve in order to tap into the great strengths of Aboriginal community and family networks. In this respect, we note that in November 2015, FACS launched the *Guiding Principles to strengthen participation of local Aboriginal communities in child protection decision making*.

The principles aim to improve Aboriginal community participation in decision-making by developing local advisory groups; supporting Aboriginal families and reducing the number of forced removals; improving access to services; and developing pathways for family restoration. The test will be the extent to which these principles are properly implemented in local community settings.

Aboriginal service delivery

- The Tune Review is correct in identifying the importance of making it a priority to ensure that a substantial proportion of proposed “new internationally proven,

evidence-based intensive preservation and restoration programs" are targeted to Aboriginal families.

- In this regard, we note that the AbSec/FACS co-design plan also aims to improve outcomes for Aboriginal children in areas such as education, health, justice, transition to employment, and OOHC via a holistic person-centred approach which includes utilising Aboriginal community-controlled organisations delivering quality services.
- Finally, it is important to stress the need for service delivery in local communities with significant Aboriginal populations which is both effective and efficient (see our comments on 'place-based' service delivery).

3. Other issues:

3.1 Cultural support plans

In our 2008 report regarding supporting the carers of Aboriginal children, we recommended that Community Services implement and monitor appropriate and consistent cultural support planning processes.

Since then, cultural plans are required for all Aboriginal children in OOHC and must be included with care plans submitted to the Children's Court.

On a related note, it will be important that the introduction of Guardianship Orders made to Aboriginal family members in connection with Aboriginal children are well executed and closely monitored and refined, as they are rolled out over time.

3.2 Building the capacity of Aboriginal OOHC agencies

We actively support Aboriginal OOHC agencies meeting their legislative obligations. In this regard we regularly:

- Visit Aboriginal OOHC agencies to promote awareness of the reportable conduct scheme, our role and agencies' responsibilities.
- Provide data to AbSec Board on notifications for employment-related child abuse allegations.
- Deliver employment-related child protection workshops for Aboriginal OOHC providers.

It is pleasing that a significant number of Aboriginal agencies have participated in our training courses on handling reportable conduct.

- Our Aboriginal unit has been able to work closely with and support staff from our reportable conduct division.
- We hosted a forum with AbSec and the NSW Police on the need for closer cooperation between Aboriginal OOHC agencies and police in responding to reportable allegations. (Around 160 representatives attended the forum).

Key statistics and reforms

At the end of the first quarter of 2015-16, there were 17,951 children and young people in OOHC.

- **More than a 1/3 are Aboriginal** children and young people – 47% in relative/kinship care, 44% foster care, 3% residential care.
- Around 12% of children and young people in OOHC are children with a disability.
- FACS aims to transfer all children in statutory care to the NGO sector by mid-2022. Currently, 57% have been transferred. This has led to an increase in the number of agencies providing OOHC together with an expansion in the size of existing agencies – particularly from the Aboriginal OOHC sector.
- The Safe Home for Life (SHFL) reforms relating to the delivery of OOHC, emphasise the need for early decision-making around permanency (guardianship/adoption) through the introduction of the Permanent Placement Principles:
 - building parenting capacity and increasing parental responsibility
 - providing early support to families to stop kids entering care
 - providing permanency to kids who enter care.
- FACS is seeking to utilise US evidence-based models to ensure OOHC agencies address permanency issues, security and trauma, leading to a growing shift to 'child-wellbeing' focus.

Background

It is important to consider the OOHC field in context. During the nineties, the child protection system was moribund. The reform of the system commenced with the injection of over \$1 billion early this century.

Around that time, there were **9,273** children in OOHC. However, once there were additional child protection workers on the ground, then the inevitable happened – the number of children in care dramatically increased (particularly in the absence of other measures to lower the OOHC population).

Today, the OOHC population is around 18,000.

In response to this unsustainable growth and related suboptimal outcomes for the involved children and young people – SHFL was launched. One cannot argue with its broad priorities of:

- building parenting capacity and increasing parental responsibility
- providing support earlier to families to prevent children entering care
- providing greater permanency for children and young people in care, and
- measures to address demand and quality

However, achieving success in reducing the numbers in OOHC will be a challenge. And, as we have said in our submission, the more important challenge is to ensure that the reduction in the number of children and young people in OOHC – from fewer children/young people coming into care and from

more of them leaving care – is also accompanied by improved outcomes for these children/young people.

In making these observations, it is important to acknowledge that over a substantial period of time there have been a number of important initiatives aimed at supporting the OOHC system in NSW.

For example:

- Increased funding for OOHC. Whether or not it is adequate is currently being tested.
- The OCG's accreditation scheme has provided a core set of standards.
- The growth of AbSec following our 2008 report – *Supporting the carers of Aboriginal children*.⁴
- Important collaborative work between FACS and the non-government sector associated with the transfer of kids from government to NGO care.
- The reportable conduct scheme.
- The Carers Register.
- The outstanding reform work of the Children's Court – Koori courts; cultural care planning; alternative dispute resolution.

Having made these observations, the growth has been rapid, and particular parts of the OOHC system need attention. Some of the issues which require close examination are outlined below:

Residential care:

Recent events have illustrated the need for close examination of the residential care sector. The **650** plus children and young people who are now in residential care indicates a system under stress. The large number of children in OOHC who are **under 12** who are in residential care, provide further evidence of the need to examine this part of the OOHC system.

On a related note, we also need to consider the specialist homelessness services sector – i.e. youth refuges. In particular, there are around **1200** children and young people who are residing in youth refuges (FACS 2013-2014). It is also significant that during the 2014-2015 financial year, the AIHW reported that **540** children and young people in NSW youth refuges were under a care order.

The need to roll out a robust Quality Assurance Framework (QAF) for OOHC

FACS commissioned the Parenting Research Centre to develop a Quality Assurance Framework (QAF) as part of the SHFL.

The QAF aims to identify and measure specific wellbeing outcomes for children and young people in OOHC, improve casework practice, and help agencies to provide and use more reliable data to improve provision of services.

The proposed QAF Safety, Wellbeing & Permanency outcomes relate to the following domains:

- Safety and permanency
- Cultural and spiritual identity

⁴ At the time of our report, AbSec had only 3 to 4 staff and today it has close to 30.

- Mental health
- Cognitive functioning
- Social functioning
- Physical health and development.

One challenge for FACS is to secure the participation of key human services and justice agencies in the collection and reporting of data.

If the QAF is successfully developed and implemented, it will hopefully drive better outcomes for children in care and increase the accountability of FACS and the NGOs who are involved in the delivery of care.

It is worth debating what the respective role of FACS (the funder) and the Children's Guardian (as regulator) will ultimately be in relation to monitoring and/or enhancing quality and better outcomes for individual children and young people in OOHC.

The QAF and the recontracting process

The Auditor-General noted that existing performance measures in NGO contracts, focus on outputs and that the funding model offers limited incentives for NGOs to initiate adoption or to restore children to their birth parents. Therefore, the proposed QAF, together with well targeted contractual conditions, should potentially create an opportunity to address quality outcomes via the recontracting process.

According to FACS's submission to the Commission, the OOHC recontracting process has a focus on rewarding NGOs that demonstrate improved child wellbeing outcomes, including those leading to more permanent placements, such as adoption; and where NGOs are operating in a way that fosters an effective system.

While we support performance-based contracting, it will be essential that the operating framework is both rigorous and reliable.

Responding to the Tune Review

In June 2016 the Government announced that it had adopted the findings of the interim Tune review which found that "the current OOHC system required immediate change and was financially unsustainable."

The Tune review recommended resourcing the current growth in OOHC while at the same time 'investing substantially in interventions to change the long-term trajectory of children and young people in care.

The review emphasised the need to prioritise targeted intervention initiatives at children and families with poorest outcomes. (This perspective is consistent with our call for intelligence-based child protection.) Tune also emphasised the need to prioritise targeted initiatives, including:

- new internationally proven, evidence based intensive preservation and restoration programs

- addressing the over-representation of Aboriginal children in care (with 50% of new family preservation places for Aboriginal families)
- increased funding for resources and initiative to improve the rate of adoption.

In response, the Government has announced that it will fund expansion in evidence-based intensive intervention programs, targeting family preservation and restoration for more than an additional 1,000 families and children.

The Government has also committed more than \$1 billion for OOHC in the 2016-17 budget (incl. new funding \$190 million over 4 years to reform the system, and a further \$370 million over 4 years to meet the increased demand for OOHC).

We also support the policy agenda which is focused on securing permanency for as many children as possible.

However, what will be critical is to determine how well the policy is executed. In this regard, we again note that it will be essential that any evaluation of the effectiveness of Safe Home for Life tests whether children subject to restoration, adoption and guardianship arrangements, are in fact better off overall than those who remain in OOHC.

Other specific OOHC issues

Other discrete areas which are relevant to improving particular components of the OOHC system include:

- The need to develop a therapeutic framework to guide the delivery of OOHC
- The need for measures targeted at reducing the over-criminalisation of young people in residential care (see reference to the Care and Crime protocol on p.16 of our submission).
- The need for the establishment of a reporting scheme to oversee the handling of allegations of serious 'child-to-child' abuse.
- The need to improve leaving care planning – including for children and young people with a disability.
- The need for ongoing refinement of and improvements to the practice relating to the assessment, training, support and monitoring of carers.⁵

⁵ In the last three years, 257 carers were de-authorised and 107 workers were dismissed or permitted to resign, as a result of reportable conduct investigations in the OOHC sector. Over the same period, 43 involved individuals were charged with one or more child-related offences.

