

INQUIRY INTO CHILD PROTECTION

Name: Dr Helen Hayward-Brown

Date received: 3 July 2016

General Purpose Standing Committee No. 2
NSW Legislative Council
Parliament House
6 Macquarie Street,
Sydney, NSW 2000.

Dear Sir/Madam,

Re: NSW Legislative Council's Inquiry into child protection

I, the undersigned, am providing a submission to the NSW Legislative Council's Inquiry into child protection that is focusing on the procedures, practices and systems that operate in the area of child protection in New South Wales.

In this submission I will address matters relevant to the inquiry's terms of reference regarding *'the capacity and effectiveness of systems, procedures and practices to notify, investigate and assess reports of children and young people at risk of harm'* and *'any other related matter'*.

My doctoral and post-doctoral research into such child protection cases has highlighted the faulty procedures undertaken by Department of Family and Community Services (FACS), the medical fraternity, police and the judicial system in relation to these matters.

My background:

1. I am a medical anthropologist/sociologist who has completed a doctorate in the specialty expertise of *'False and Highly Questionable Allegations of Munchausen Syndrome by Proxy (MSBP)'*.
2. I have lectured and tutored in health sociology, and in particular, health ethics, at university undergraduate and postgraduate level.
3. I am a trained and experienced early childhood teacher who has supervised and lectured education students. I also directed a research project for the Dean of Education, UWS.
4. I hold counselling qualifications from UNIFAM Australia.
5. I have over 20 years experience consulting with families and lawyers in relation to false allegations of Munchausen Syndrome by Proxy.
6. My experience includes cases in NSW, other Australian states, multiple states in the USA,

- multiple states in the UK, and other countries such as Germany.
7. I have knowledge of multiple child protection systems, forming a good basis for comparison.
 8. I am contacted very frequently, often more than once weekly, by at least one desperate family from somewhere in the world asking for assistance with false allegations made in the child protection courts.
 9. I am the author of a NSW Judicial Bulletin's article on difficulties with allegations of Munchausen Syndrome by Proxy.
 10. It should be noted that I acknowledge that some children may be harmed in the medical context by a parent, but this is rare.
 11. My concern is the **inadequacy and incompetence of the courts, police and child protection authorities to undertake thorough and independent investigations**. These grave failings in the system lead to **inaccurate outcomes** with major losses of financial resources.
 12. In particular, I wish to draw attention to the major costs of launching repeated allegations of Munchausen Syndrome by Proxy against mothers who are innocent.

NSW and child removals

13. NSW has one of the highest levels of removal of children of any state, not just in Australia, but in the world. As expected, Indigenous children remain a high percentage of those removals, although removals are increasing at an alarming rate across the board. According to the *Productivity Commission, Report on Government Services 2015*, Table 1A.18, almost 11 out of 1,000 children (aged 0-17) were in out of home care in NSW as at 30 June 2014. By way of comparison, this compares with 6 out of 1,000 in Victoria.
14. Whilst there is concern raised publicly about the high level of removal of Aboriginal children (rightly so, with work undertaken by Grandmothers against Removals), there is little concern raised for the high level of removals generally. A recent Senate inquiry led by Senator Rachel Siewert has started a conversation in this regard - *The Senate Community Affairs References Committee report on Inquiry in Out of Home Care in Australia 2015*. Senator Rachel Siewert commented that 'the committee found it particularly troubling that children and young people entering and remaining in statutory out of home care has more than doubled [in Australia] in the last 15 years'.

15. There appears to be an assumption by the wider general public (who have not been involved with child protection directly), that the system is one that can be trusted to 'get it right' in the case of non-Indigenous and Indigenous children.
16. My research and experience shows the opposite – **the system does not get it right**. The system is deeply flawed and veiled under silence through closed courts.
17. The incompetence of child protection practices and the over-reporting and over-zealous culture of removal of children in NSW remains.
18. The costs of high levels of removals, rather than preventative and supportive measures, leads to a blow-out in costs. There is a complete negation of the supposed mission that children should remain in the family home wherever possible.
19. In terms of costs, the Productivity Commission reports that expenditure over the past decade in out of home care service in Australia has more than doubled, from \$1 billion in 2004-05 to \$2.2 billion in 2013-14.

The specific issue of Munchausen Syndrome by Proxy

20. I do not have the space in this submission to outline the serious errors which occur in allegations of Munchausen Syndrome by Proxy in the child protection sector.
21. Munchausen Syndrome by Proxy is a widely discredited theory, highlighted by the fall from grace by its major proponents, Sir Roy Meadow and Professor David Southall. Multiple women in the UK were released from prison as a result of false evidence by these proponents of the construct.
22. The major flaw in MSBP lies on the 'research' on which it is based. Such 'research' involved cases that were devoid of authenticity and credibility, based only on the suspicions, opinions, and suppositions of paediatricians, psychiatrists, and social workers. It is not scientifically based nor peer reviewed. Major flaws in terms of statistics relied upon in this literature, have been revealed. For example, the article by Rosenberg (1987).
23. The label of MSBP creates prejudice against the mother, rather than allegations being based on fact and evidence. The profiling of the mother avoids focus on hard evidence. The label usually occurs when there is disagreement between doctors about a medical diagnosis or there is an inability to make a diagnosis.
24. Approximately 80% of the cases which come across my desk are a **direct result of a parent**

making a complaint about medical care or specific doctors. The remainder are often the result of a mother making an allegation of domestic violence or sexual abuse against a father in a family law 'parental responsibility' dispute.

25. It is of some concern that Indigenous mothers who raise issues of domestic violence in court are subjected to threats of contempt of court or, in some cases, face imprisonment. In other words, the MSBP allegation is being used to discredit mothers, placing their families at risk of continued domestic violence. Some allegations do occur without a prior complaint being made about a medical professional or in response to an allegation of domestic violence. I refer to allegations as 'good faith' or 'bad faith' allegations, depending on the manner in which they have been triggered.
26. The recent inclusion in the DMS V of '*Factitious Disorder Imposed Upon Another*' (MSBP) has caused a surge in worldwide allegations of MSBP and an increase in requests for assistance from parents. The inclusion of this category has led to an unscientific and discredited diagnosis being given some semblance of 'legitimacy', despite its seriously controversial inclusion. In particular, this has smoothed the way for mothers to be accused of MSBP in order to discredit them for making allegations of domestic violence against a former partner. Australian psychologists have already utilized this 'category' in 'independent court reports'.
27. Despite its inclusion in the DMS V as an alleged category of psychiatric illness, the DSM V clearly states that the **diagnosis should not be a default position – if the doctor does not know what is wrong with a child, the default position must not be that the mother must have induced the illness.** And yet this is exactly what is occurring, particularly in NSW pediatric hospitals.
28. Additionally, it should be noted that this spurious category of illness is **not** included in the ICD (The international Classification of Diseases – ICD-10).
29. Therefore, it needs to be emphasised that the DSM V states '*it is not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated*'.
30. Child protection doctors are making an allegation of MSBP when they cannot diagnose a child's medical condition, or simply cannot determine why a child is ill. In these circumstances, child protection doctors alleged the mother is causing the child to be ill. They do so without any evidence of wrong doing on the part of the mother and base their allegations on surmise and speculation. Further, in making an allegation against the

mother, these child protection doctors ignore the limits of their own competence and expertise, and the failure of the medical system itself (see below for reference to high levels of medical error in patient death).

31. A Munchausen Syndrome by Proxy diagnosis, even if accepted as valid, is prejudicial and not probative.
32. The labels MSBP or FII should be abandoned. For example, if it is thought that a parent is suffocating or poisoning a child, then this needs to be stated and **clear and substantive evidence needs to be provided**. This does not occur: child protection unit doctors speculate and then place speculation on speculation to make an allegation against a mother.
33. Of serious concern is the fact that many MSBP allegations in NSW are 'personality driven'. In other words, the number of MSBP allegations would seem to depend on the presence, or not, of specific doctors and social workers with a propensity towards the diagnosis.
34. A recent publication by Harvard University and the Fair Punishment Project (2016), *'America's Top Five Deadliest Prosecutors: How Overzealous Personalities Drive the Death Penalty'* highlights the significant impact of personalities in critical contexts. The high number of death penalties in certain counties was not evident **before or after** the appointment of these prosecutors. It is my assertion that a similar difficulty occurs with doctors in relation to MSBP allegations. This was the case in the UK, where a few specific doctors such as Sir Roy Meadow and Professor David Southall spawned copious false allegations of MSBP in the child protection and criminal courts.
35. In NSW, **major** cost savings could occur for child protection and the courts, if families of children with **significant diagnosed genetic illnesses** were not repeatedly targeted in this manner by specific doctors. Additionally, critical resources would not be diverted to these 'MSBP' families, allowing other families to receive further support and investigation where necessary.
36. The utilization by NSW psychologists in the children's courts of the article *'Development of a Risk-Stratification Tool for Medical Child Abuse in Failure to Thrive'* by Mash, Grazier, Nowacki, Worley and Goldfarb (2011) is of grave concern. The writers attempt to 'redefine' MSBP and increase its 'legitimation', but the outcome is the same as previously. It is the original MSBP criteria couched in pseudo-scientific terms. Of even further concern, is the claim that if a child has more than five reported allergies by a mother, this is one of the factors in MSBP. Taking a child for a test for mitochondrial disorder is also seen as a factor. In effect,

this simply underlines the ongoing debate within the medical profession over the diagnosis and symptoms of mitochondrial disorder. Families become pawns in the medical debates. Dr Johanna Goldfarb, one of the authors of this article being relied upon in NSW courts, according to US media reports, was sued by Scott and Tricia Beam for allegedly falsely accusing them of faking their son's illness and for diagnosing their child without seeing him.

37. A further article, *Munchausen Syndrome by Proxy: defining Fabricated or Induced Illness by Carers* by Ellen Fish, Leah Bromfield and Daryl Higgin published in 2005 is another attempt to 'redefine' MSPB. **It is simply MSBP in another disguise.** For example, these authors argue that if the cause of an injury or an episode cannot be explained or remains ambiguous, then this is evidence of MSBP.
38. Clear and substantive evidence of wrong doing rather than profiling is needed if there is concern that a mother may be medically abusing a child. The use of profiling creates prejudice and the perception of danger and risk in the mother. The MSBP profile is nonsensical and paradoxical. It describes normal mothering behaviour, and as Mart (2002) so eloquently suggests, the anti-profile would be far more dysfunctional than the profile.
39. Another significant factor is MSBP allegations is that the medical causes of a child's illness will be minimised or ignored by FACS and doctors, thus causing further detriment to the child. A child's real illnesses are neglected, placing the child in mortal danger. Of grave concern is the tendency for child protection workers to start 'diagnosing' Munchausen Syndrome by Proxy themselves, without any medical knowledge of specific illness issues.
40. This Standing Committee should note that the profile of MSBP is an exact replica of the profile of a witch in medieval times, despite the fact that this information, based in very clear evidence, is regarded with skepticism by authorities.
41. Allegations of medical child abuse should be based on hard evidence and facts, not profiling or speculation.

The child protection legislation and court procedure

42. The current child protection legislation leads to high levels of children being removed from innocent parents, which, in turn, leads to high levels of financial costs for governments. The current legislation is seriously flawed and needs substantive change for the following

reasons:

- a. as a default position the rules of evidence in NSW Children's Courts are not applied unless the court states that the rules of evidence apply, and this almost **never** occurs, unless a specific lawyer makes an application to the court for the rules to be applied issue. A lawyer may be deemed 'an agitator' for making such an application. The removal of rules of evidence results in hearsay, and hearsay upon hearsay ('hearsay squared'), false and misleading evidence, cherry-picking of evidence, misinterpretation and error, and circumstantial evidence, all being admitted into evidence. Whilst Tasmania does have the rules of evidence as a default in the Children's Courts, it does no better than NSW, as these rules are usually dismissed, sometimes without notice to the legal practitioners of the parties. In order to avoid injustice and assure that removal of children is based on facts rather than fiction, **rules of evidence need to be applied**. There needs to be **hard, objective and substantial evidence** for '**risk of harm**'. The continued use of often 'fictionalised' accounts by child protection workers in order to successfully remove a child from a family, places the department at risk of much higher costs and destruction of families.
- b. the child protection legislation protects practitioners such as doctors from liability due to the assumption of 'good faith' in relation to notifications. However, if it can clearly be shown that medical negligence has directly led to a false allegation against a parent, then that notifier or practitioner should not be protected by 'good faith' legislation. In this situation, a parent should be able to sue for medical negligence. In relation to liability, whilst the department does not have a duty of care to parents, it **does** have a duty of care to children. False allegations of MSBP and other removals may ultimately lead to legal action or class action by the children themselves, on obtaining the age of 18 years.
- c. the use of labels and profiles such as MSBP allows prejudicial rather than probative information to be put before the court. This relates to the issue of the need for rules of evidence.
- d. mandatory reporting leads to an overload of the child protection system. There needs to be a serious review of this reporting system, which involves so much time and labour and often places innocent families under the microscope. A 'tiered' system

of voluntary and mandatory reporting, so that serious allegations are still investigated thoroughly, would be an improvement in the system. Many reporters note that they make reports, not because they are concerned about child abuse, but because they are concerned about criminal charges if they do not report even the slightest incident.

43. The Children's Courts are closed courts, which means that these courts are not held accountable and justice is not 'seen to be done'. It is acknowledged by Sir Justice Munby, President of the Family Division of the High Court of England and Wales, that children's courts need to be opened to further scrutiny, even allowing the media some access. Some outcomes of closed courts include:
- a. perjury
 - b. unlawful practices
 - c. removals of children based on medical reports which have never been written
 - d. shouting and abuse by Independent Children's Lawyers
 - e. disrespect and intimidation of parents by magistrates
 - f. bias of magistrates where child protection authorities are favoured at the expense of parents
 - g. children's voices not being heard.
44. The argument that the children's courts are closed to protect the identity of the families and children involved does not stand up to scrutiny. For example, at the Children's Courts, families' names are broadcast across speaker systems for all and sundry to hear. Additionally, the recent proclivity by police to issue concurrent AVOs, when a child is the protected person, to be placed against parents without judicial review, means that parents and families are named in the local magistrate's court anyway, although if a child is involved, suppression orders of the child's name may apply. However, the names can be discovered by the media and other members of the public by inspecting court documents. The name of the child and mother are then published on the internet without apparent sanction.
45. Further, if a mother challenges or defends the AVO, she will disclose the evidence that was to be presented in the Children's and/or criminal court. **The mother is placed in the legal nightmare of defending a similar matter in three different courts** – the child protection matter in the Children's Court, the AVO in the Local Court and criminal charges in the

District Court or Supreme Court. As a consequence, the accused mother is forced into conceding in the AVO and children's court, without being able to present evidence. To do otherwise, would prejudice the more serious matter – the criminal matter - that may involve a potential penalty involving a term of imprisonment. In any event, the mother loses her child.

46. A further difficulty with closed courts is the lack of published judgements. This means that precedent has little place in the child protection courts, leading to *Rafferty's Rules*. Children's Court judgements could be published anonymously to protect identities, as is increasingly the case in the UK and is similar to the Family Court of Australia.
 47. Strict requirements in relation to expert witnesses need to be established. These include the following:
 - a. expert witnesses should not be allowed to give evidence together (e.g. two doctors at the same time in the witness box)
 - b. one expert, such as a psychologist, should not be allowed to attend throughout a hearing, listening to all other witnesses, when the other witnesses are not allowed to do likewise. Parents report that this is extremely intimidating when they are giving verbal evidence.
 - c. experts should be required to provide mandatory material such as copies of documents that they rely upon in preparing their reports for all parties – this is ignored
 - d. experts should be required to attach referenced documents and literature to reports, so that their assertions about 'MSBP' or other medical issues/facts are not simply that – assertions without evidence - that is, the rules of evidence should apply to expert reports.
 48. The notion of 'the best interests of the child' is important, and therefore, the voice of the child should be given weight. The practice of Independent Children's Lawyers (ICLs) seeing children for only about five minutes, or not at all, is not acceptable. The recent Senate Inquiry into Out of Home Care underlines this issue in their key recommendations.
 49. There needs to be some acknowledgement of parent's rights in relation to their children and the courts. Whilst it is understood that 'the interests of the child' should be foremost, it should also be recognised that parents have some rights in relation to their children, including procedural fairness.
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50. Issues such as procedural fairness to all parties, particularly the parents, are often swept aside in the Children's Courts. It should also be noted that funding should be applied to supporting families, rather than practices which are set up to give priority to removal of children from families – despite the official rhetoric to the contrary.

Difficulties with understandings and application of the notion of 'Probability of Harm'

51. The assumption that the removal of a child, based on 'probability of harm' as the end of the equation, is not sustainable. It is not a zero sum equation. **The risks of removal of a child when parents are innocent, harms multiple people** – and it impacts on all members of the family including the child that is alleged to be at risk. Additionally, children are removed from families where there may be some issues, but where additional support and advice is required, which may not require sudden removal.
52. Removal may also place the child at greater risk of abuse – much of the current research clearly indicates that abuse occurs more commonly in foster care than within the biological family. For example, Hobbs, Hobbs and Wynne (1999) reveal that foster children in the UK are 7-8 times more likely to be abused than children in the general population. Sanchez-Gomez (2012) indicates that the risks of abuse in foster care may be increased for children with disabilities, the presence of other foster children, foster parents taking care of more than one child, and the young age of the child in care.
53. If a child is suddenly removed in a medical matter, they should be placed with persons known to the family. This does not occur in MSBP cases because these persons are seen to be supportive of the mother. Families may need many months to get the medical expertise to defend their matter. Meanwhile, their child suffers in stranger foster care, missing their family or individuals close to the family.
54. The Senate Inquiry into Out of Home Care also indicates that there is evidence to suggest that children and young people in out of home care experience poor outcomes across a range of indicators. When they leave care, they are more likely to experience homelessness, drug and alcohol problems and physical and sexual abuse, than their peers (Chapter 1).
55. In relation to MSBP cases, magistrates should not assume that parents are guilty, based on labels and profiling. There should also be some understanding by magistrates about the risk of 'medical error.' For example, a recent article in *the British Medical Journal* by Makary

and Daniel (2016) revealed that the third leading cause of death in USA is medical error. Statistically, it is therefore far more likely that medical error has led to medical harm, rather than any action by the mother, particularly when there is no definitive evidence. There is an erroneous assumption held by magistrates that medical expert witnesses do not make **serious** errors. For example, serious illness as the result of major overdosing or underdosing by medical practitioners in hospitals is blamed on mothers. Additionally, the fact that there is no video evidence undertaken in the vast majority of MSBP allegations is a grave cause of concern. If a parent **was** harming a child in the medical context, then this should be closely monitored by covert video surveillance, as a form of protection for the child. It would also provide definitive evidence of wrong-doing.

56. In cases involving complex medical evidence, the Children's Court places undue emphasis on resolving a matter within a number of months. This is impractical and extremely prejudicial to the person alleged to have harmed the child. In complex medical matters, it can take many months, perhaps a year, to review and analyse some thousands of pages of medical documents and obtain defence expert reports. Rushing this process is prejudicial and shortsighted, as courts will not have the necessary material facts upon which to make a valid and reliable decision. If rushed, courts will operate in a vacuum.
57. Additionally, this places even greater emphasis on the need for thorough initial investigation and also the need for placement of a child with kinship carers or a supervised family scenario. This is particularly important if the child is young. As a case is delayed and a child remains in foster care, it is often argued that a child's primary attachment is to the foster carer, rather than the biological mother, depriving a child of a life with his/her mother, if the mother is innocent.
58. The practice of '**duress**' needs to be acknowledged in the court process. For example, parents repeatedly claim that they are placed under duress to sign 'consent' documents, agreeing without admissions that 'their child was at risk'. Parents report that they are advised that they will never see their children again, or access will be reduced, if they do not sign this document. Some parents are also advised that 'only guilty parents need a lawyer.'
59. The court process leaves parents in a lose-lose situation. If the parent immediately consents that the child is at risk, in order to get access, they lose their child. If the parent defends the matter, and spends a good deal of money doing so, they will also lose the child, as the delay

tactics by the other side (FACS) usually sends the family broke. Most parents must sell their homes in order to defend these complex medical hearings. It does not seem to occur to the courts that this costly defence of the matter by parents may actually point to their innocence.

60. The appeals process, which depends on the lower Children's Court, is dysfunctional and unhelpful. It relies on 'change of circumstances' alone. This needs to be overhauled.
61. The NSW *Crimes (Domestic and Personal Violence) Act 2007*, which allows police to take out AVO's against mothers accused of MSBP, without judicial oversight, has led to serious complications. In relation to a child under 16 years, who is the protected person, only the police can change or dismiss an AVO. Therefore, if child protection authorities or a magistrate believe it is in the best interests of the child to have some supervised face to face contact with the 'offending parent', the police can simply refuse to change the AVO. And NSW police do this – it has happened. This means that the police control the process in this context – that is, in regards to a protected person under the age of 16, there appears to be **no judicial oversight of police power**.

Child Protection Practices

62. Many child protection practices are inefficient, ineffective, and in many instances, are actually fraudulent or based on inaccurate facts. This is an area of serious concern for the following reasons:
 - a. there should be **registration and identification** of child protection workers, with **minimum qualifications** required
 - b. there should be a formal, independent and objective agency where parental and children's complaints can be heard and respected. The Ombudsman is not a satisfactory process.
 - c. if illegal or unethical actions by child protection authorities are uncovered by parents or their lawyers, there needs to be an avenue whereby this can be addressed **prior** to finalised court hearings. Otherwise, an adverse outcome may occur based on false evidence. A metaphor could be used to explain this situation: if a person objects to being beaten up, and is afraid of a serious outcome or murder, it is useless to advise that person to report the matter **after** they have been murdered. According to a court

in the US, the removal of a child from a family is akin to a parent receiving a death penalty - this is the impact on the family of removal.

63. There is a clear tendency for child protection workers to decide that they do not like a particular parent. Independent and objective evaluation disappears.
64. Lawyers report that *'FACS pick a side and stick to it'*, irrespective of further evidence which may be discovered.
65. Parents report misinterpretation and twisting of what has been said by them or their children. For this reason, **all meetings and interviews** with child protection workers need to be audio recorded to avoid 'verballing'. This is a technique required by police, which should also be mandatory for FACS. It should be noted that parents and children are 'awake' to this problem and often record meetings on their phones, irrespective of relevant legislation or FACS policies.
66. There is a very strong culture of removal in NSW child protection, which is probably a major contributor to the high level of removals in this state. There is also a high level of turnover of staff, due to a dysfunctional culture. Former child protection workers across Australian states report being bullied into lying about parents and events at supervised access visits. This staff dysfunction and high turnover leads to excessive training costs.
67. A serious concern is that FACS child protection workers in complex medical cases do not undertake independent investigation. The reliance on JIRT teams and medical practitioners at hospital child protection units is misplaced and leads to injustice, including the wrongful removal of children's from their mothers and wider family. These medical practitioners hold onto beliefs and theories that have been discredited, as noted above.
68. This has repeatedly been raised as an issue in the UK child protection courts. Child protection workers 'believe' the medical evidence of one or more medical practitioners and dismiss alternative medical viewpoints without further investigation. They also dismiss the possibility of medical error.
69. In fact, there is what could be called 'mobbing' (bullying by more than one person) by these medical practitioners at hospital child protection units. This occurs when one doctor makes an allegation against a mother and other doctors join that allegation without question and thorough investigation. It has been observed that **junior medical practitioners at hospital child protection units do not challenge the more senior doctors** by questioning any allegation of medical child abuse.

70. Unlawful acts by child protection workers need to be closely scrutinized and the practice of hacking of parent and lawyers' emails and communication devices should cease. One lawyer had the police track the hacking of a client's email, which was traced back to the IP address of a child protection worker.
71. The provision of permanent dedicated rooms on site at child protection courts for child protection workers and their lawyers, providing facilities such as computers, photocopiers, phones, and the like, is clearly a situation which prejudices families and their lawyers, who do not have access to such facilities on-site. Additionally, this 'ease' of access to resources tends to promote their 'over-use' at additional cost to the state.
72. The use of blackmail by FACS case workers should cease. Fathers who are told that they can have custody or access to their children if they leave their wife or 'give evidence' against their wife, are practices which are not acceptable. Threats to mothers such as 'you will never see your children again unless you confess' should also cease.

Removal of children

73. In MSBP cases, once one child is removed, often other children of the same family are removed later. Some children advise that they sleep with knives under their pillows to 'stop them being taken away'.
74. In one case, a child's mother was removed in the middle of the night, and the child, used to having her mother by her side in the hospital, suffered extreme anxiety. Other family members including multiple siblings, were also removed on a temporary basis, leaving the child, seriously ill, in hospital, with no familiar support for many days.
75. In one case, a child, having been in 'stranger foster care' for over 12 months, was picked up from school and taken to a 'kinship carer' without the child saying goodbye to any members of the previous household or even being told in advance about the move.
76. Police and FACS interviewing of parents in the middle of the night when they are distressed is not acceptable practice. This practice of formally interviewing a mother from, say, midnight to 2.00 am is a technique used by police. Research also indicates that sleep deprivation will leave persons confused and unable to function in an interview capacity.
77. FACS and the police have employed techniques of removing children late on a Friday afternoon or evening with court hearings scheduled the next Monday or Tuesday. This

leaves parents unable to access legal advice and therefore legally disadvantages any parent whose child is removed. This is not acceptable practice.

78. Parents regularly report that they are not advised about their children's progress at school or their medical progress.
79. The practice of overwhelming opposing lawyers with thousands of pages of irrelevant documents on the first hearing date is a device employed by FACS which should cease. All records should be accurate and pages numbered to avoid removal of pages.
80. Refusal to return all parent's phone calls and emails is a tactic which should be ceased.

Independent children's lawyers (ICL)

81. Independent children's lawyers have too much power in court procedures and tend to take on a 'de facto' role of directing other parties' lawyers so that other lawyers have no part in the direction of the proceedings. In fact, many families report that they regard the ICL as the de facto magistrate. In the UK, it has been formally documented that some child protection authorities were writing judgements for children's court magistrates.
82. Independent children's lawyers do not appear to be '*independent*' in most instances. An international survey of parents undertaken by myself a number of years ago, classified ICL's as a major problem in terms of independence and mistreatment of parents.
83. Magistrates have a tendency to follow the directions of the independent children's lawyer, who may have 'cherry picked' evidence which has been forwarded to 'independent reporters'. Independent children lawyers often show little respect for parents, with tactics such as shouting at parents in court.
84. Independent children's lawyers usually spend the least amount of time with the children compared with other parties and witnesses. In fact, in some instances, the independent children's lawyer does not meet the child. Five minutes with the child is common. Children report feeling intimidated by the ICL. Children report being fearful of ICL's, particularly just prior to having a psychological assessment being undertaken. In my view, this is not an independent assessment, if an ICL is present in this capacity just prior to assessment.
85. There has been some evidence to suggest that evidence can 'disappear' in the custody of ICL's, and at the least, is ignored or excluded.

86. Many ICL's are not qualified psychologists and yet are making vital decisions about 'the best interests of the child.' Often, their reliance on reports based on cherry picking evidence are not independent. Additionally, even if child protection authorities argue that a child should have some contact with a specific parent – and they have more access to the family – an ICL may object to this, without the experience or knowledge of the family.

Access Visits and Use of Non-Government Organisations

87. Access visits with children should not be used as a system of 'reward and punishment' in relation to parents. Parents repeatedly report that if they attempt to defend their child protection matter, their access is reduced or cancelled. If they are seen as not being 'co-operative', access visits are reduced or cancelled.
88. Court orders should be more specific in relation to access by parents with their children. Access visits are regularly cancelled, delayed or reduced, without 'make-up' visits being offered or undertaken. Reasons are not required to be provided by FACS.
89. The practice of rotating and removing supervisors of access visits, so the child and family do not become 'close' or attached, should be ceased.
90. The financial exploitation by non-government organisations of access visits should cease. For example, the quote of \$200 for supervision of a mother's 10 minute telephone call with her child is exorbitant. This suggests that profit is the motive, rather than the 'best interests of the child'.
91. Parents are very wary of non-government organisations such as Brighter Futures, particularly in rural NSW. Parents report that they approach these organisations for assistance and after 90 days find their children removed. Parents report that originally they were unaware that these organisations were a fast track pathway to removal. These organisations need to re-focus their attention on supporting families, without a philosophy of removal as the end goal in most instances. Families of children with disabilities report particular problems. The high level of suspicion of these organisations means that their mission of 'supporting families' is not successful. It is my view that NSW has made a serious error of judgement in out-sourcing these services. It is clear that these organisations do not prioritise 'the best interests of the child' in many instances.

Embedded practices

92. There is a difficulty in relation to embedded workers or witnesses in the hospital system, in relation to allegations of MSBP or other forms of child abuse.
93. Child protection units are embedded within hospitals and tend to 'agree' with hospital based doctors, without independent investigation. These units are often run by general paediatricians without any specific expertise, so that they are making decisions outside their level of expertise in a specific specialty. It is particularly unacceptable for child protection doctors to refer to specialist medical reports in court affidavits, when they do not exist. It is also not acceptable that courts refer to such issues as 'simple mistakes'.
94. Mothers report that they regret acknowledging any post-natal depression or anxiety, as this is used against them in MSBP allegations. This discourages parents from seeking the support that they may need.
95. The NSW Children's Court Clinic cannot be considered to be independent. The clinic is embedded within the system, where medical professionals are usually the notifiers in relation to child abuse allegations. Directors of Children's Court Clinics in all states should be markedly independent professionals, without biased allegiances to controversial theories such as MSPB and shaken baby. Such individuals should not act as a resource for doctors at child protection units. There needs to be extreme caution on the part of all participants in relation to conflict of interest in this context.
96. JIRT (Joint Investigation Response Teams) – these case worker teams are embedded with police. For this reason, their investigation is not 'independent'; it is deeply embedded within the police investigations. The tactic of charging a mother with criminal charges only days before a child protection hearing means that the child protection hearing must be aborted by the parent's defence team – who cannot jeopardise the criminal case by revealing their evidence: to do so would prejudice the mother's criminal matter.
97. A father, who may have seen the evidence showing his wife's clear innocence, will be berated by a magistrate for not revealing this, despite his lawyer's instructions. He may be denied custody of his child based on his insistence on his wife's innocence.
98. All parents complain about intimidation and threats by JIRT.

Foster care and adoptions

99. The use of 'professional carers' who look after many, many children at the same time, attracts carers who are driven by financial concerns rather than more altruistic motives.
100. Foster carers are paid too much for the care of the children in their care. Many families regard this as their 'occupation' and rely on the financial incentives. Individuals should not rely on children being in care as a basis for their income.
101. Fast track adoptions place the biological parent's rights and the child's rights at risk. Fast track adoption does not leave much room for error – if the courts get it wrong.
102. In the UK, this has become a huge problem, with local authorities relying on the income from fast track adoptions to balance their budgets.
103. Children and families report neglect and abuse by professional foster carers with multiple children in their care. Some report that their children are literally starving, craving for food. Others report holes in shoes in winter and inadequate warm clothes. Many report abuse by other children who are in the care of the same foster carer.
104. Children also report that they feel worthless and like 'banned' or bad people. They are often not allowed access to internet or mobile phones, even if older. Some report that their rooms are searched and they report that they dislike being stalked.

Outcomes of these court and child protection practices

105. Parents in my research and experience report a deep sense of betrayal, loss and grief. Parents report that they no longer believe in the justice process. Their children report that they are no longer able to trust adults. They report that their children have a changed world view. All families report children who cry endlessly for days on end.
106. There is no doubt that children wrongfully removed never recover from the psychological trauma of sudden removal. Some children become ill when removed from appropriate medical care.
107. In the last few months, in relation to allegations of MSBP, I have been able to stop five mothers from committing suicide as a result of false allegations of MSBP and the removal of their children (with or without criminal charges). In relation to two parents, I was too late, and two attempted suicide – this occurred before they found assistance from my research and consultancy. I have recently been working with one 15 year old child interstate to try to

- stop him committing suicide, as he misses his family so much and knows his mother did nothing to harm him. He faces serious illness himself.
108. Children are reported to being engaged in 'self-harm' as a result of removal.
109. Short case study: whilst this case is in another Australian state, it gives an accurate reflection of the difficulty faced by families. In this matter a mother, accused of MSBP, has been denied access to all medical care, despite documented evidence of strokes, seizures, blood clots, renal failure and genetic illness. This documented information was not put to the courts by her previous legal teams, and was refused admission to court at the Supreme Court level. It was not accessed by the pediatrician making the allegation. In fact, the genetic illness itself was not diagnosed until the mother received independent medical treatment in Sydney after contact with me.
110. This mother must travel interstate for medical care for her complex genetic illnesses. She is unable to get her prescriptions filled in her home state to date. She is unable to get dental care under the public system for six infected teeth requiring removal which are thought to be exacerbating her seizures. She recently had a serious stroke and can no longer speak without severe slurring. Recently, whilst I was speaking to her on the phone, she had a major seizure and collapsed. Her two children were removed and also accused of MSBP. The older child, on turning 18, was also diagnosed with the same serious genetic illness as his mother and other family members. The younger son, now 15, was homeless for months when he ran away from care. He is very ill with severe abdominal pain, a symptom of the same genetic illness, but has been told it is all in his head. He is now suicidal. He just wants to go home.
111. The mother is now so ill, it appears as if she will die. Her doctor in Sydney has arranged end of life documents for her, I believe. Legally, a Queens Counsel is now attempting to assist the family on a pro bono basis, but it may be too late, and the younger child's health will continue to deteriorate whilst his illness is left unacknowledged and untreated by the relevant child protection authorities.
112. For a case based in NSW, which is not explicitly a MSBP case, but which highlights erroneous and serious cruelty by FACS in a case within a medical context, refer to the book, *Sarah's Last Wish* by Eve Hillary. It outlines the most extraordinary mismanagement and waste of financial resources by FACS.
113. Nearly all the cases which come across my desk are similar to this case study. The stories
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are hidden as they occur in closed courts where public and media access is denied.

Conclusion

114. I conclude by stating that the continued use of MSBP as a reason for removal of children in NSW reflects a system ignorant of developments overseas. I have personally witnessed countless wonderful families being destroyed by such false allegations.
115. A thorough examination of the faulty process of MSBP allegations highlights the general systemic problems in the processes and procedures of FACS, doctors and the police which affect all case study investigations.
116. There is absolutely no doubt that there are serious concerns about the manner in which these allegations are made and the inadequate manner in which FACS, doctors and the police investigates them.
117. Additionally, if social services, doctors, police and the courts were able to dispense with these cases, that are clearly wasting valuable resources, more time could be dispensed to families where abuse is really occurring and children really need protection.

For the committee's consideration.

Kind regards,

sent by email

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