

## **INQUIRY INTO CHILD PROTECTION**

**Name:** Charis Law

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Confidential

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**By email only:**     [gpsc2@parliament.nsw.gov.au](mailto:gpsc2@parliament.nsw.gov.au) [18 pages]

Secretariat  
General Purpose Standing Committee No. 2  
Parliament House  
Macquarie Street  
SYDNEY NSW 2000

Dear Sir/Madam,

**RE:    GPSC2 INQUIRY INTO CHILD PROTECTION SUBMISSIONS**

I am grateful for the opportunity and extension of time granted to make submissions to this Inquiry.

As a legal practitioner, my areas of practice have largely been in criminal law and family law, and in this regard, I do not profess to have extensive expertise in the area of child protection. However, to the extent that I have had dealings with the Department of Family and Community Services (FaCS), I am aware of the profound and lasting impact that the decisions of FaCS have on families. I will be referring to two case studies in these submissions to illustrate the nature and effect of such profound impact, then make submissions in support of my recommendations.

I welcome the opportunity to provide further information to the Inquiry and/or to participate in any Inquiry hearing and I can be contacted on

Yours sincerely,

Sun-Jae An  
Legal Practitioner Director

Encl.

**NSW LEGISLATIVE COUNCIL  
GENERAL PURPOSE STANDING COMMITTEE NO. 2  
INQUIRY INTO CHILD PROTECTION**

**SUBMISSIONS OF CHARIS LAW**

**TERMS OF REFERENCE TO BE ADDRESSED**

1. These submissions focus on the following terms of reference:
  - (a) The capacity and effectiveness of systems, procedures and practices to notify, investigate and assess reports of children and young people at risk of harm;
  - (c) The amount and allocation of funding and resources to the Department of Family and Community Services for the employment of casework specialists, caseworkers and other frontline personnel and all other associated costs for the provision of services for children at risk of harm and children in out of home care; and
  - (i) Any other related matter.
2. Under the “any other related matter”, I make submissions regarding the intersection between the child protection system and other jurisdictions, in particular, the family law jurisdiction.

**CASE STUDIES**

3. I provide two case studies arising from my legal practice. The names of parties, children and family members have been changed to protect their identities. However, the names of any and all government departmental workers are retained for the purposes of accountability and authenticity.
4. In providing these case studies, I note that some details may be omitted. However, any omissions are not made with the purpose of distortion or deception. Instead, my intention is to capture critical details to outline significant concerns.

***Case Study 1(a): Grace and Max***

5. Max was    years old when he began to “act out” with aggressive, anxious and sexualised behaviours. At that time, there were court orders for Max to live with his mother, Grace, and to spend fortnightly overnight time with his father, Kevin.
6. As Max’s behaviours escalated, particularly his sexualised behaviours, a report was made to the FaCS (then DOCS) helpline on                   . The primary complainant at that time was a male friend of Grace, Sam, who had observed disturbing sexualised behaviours.

7. [redacted] caseworker at [redacted]; CSC was allocated to the case. [redacted] contacted Grace on numerous occasions over the next couple of weeks advising that Kevin was constantly calling her and leaving messages for her, almost in a threatening manner, suggesting that he was a psychologist. [redacted] confides that Kevin is the most manipulative man that she has ever dealt with.
8. On [redacted] and her [redacted]
9. On [redacted] Kevin communicates to Grace that the DOCS matter has now been resolved. Grace has not received any communication from DOCS to suggest that this is true.
10. On [redacted] refers Grace to a psychologist for assistance with Max's behavioural issues. This is effectively the last time Grace has any communication with [redacted] in relation to the DOCS case.
11. In late [redacted] Grace becomes aware of a document produced by DOCS entitled, "Analysis" (undated). It reads, in part:

12. So whilst Grace was never formally informed by DOCS that Max's case was closed, she certainly learned through this document that the investigation into Max's circumstances was deemed to be "inconclusive".
13. Relevant to the investigation into the DOCS notification, Grace had only two instances of contact from [redacted] and/or DOCS – firstly to arrange the child interview and secondly, to refer the child to a psychologist, the former by telephone and the latter by email. Grace was never invited to participate in an interview. Sam, the original complainant was never invited to participate in an interview. There was no risk assessment conducted, no safety assessment conducted, no parenting capacity assessment conducted, and no further communications with either Grace, as Max's mother, or with Sam as the original complainant.
14. Unbeknownst to Grace, however, [redacted] and DOCS were in **frequent** communication with Kevin and gave Kevin numerous opportunities to provide information, and even informed Kevin, as early as on the afternoon of [redacted], that the case was closed.

***Case Study 1(b): Grace and Max***

15. Around [redacted], FaCS received several notifications regarding the risk of harm to Max, now [redacted] years old. These risk of harm reports resulted from disclosures made by Max himself about his father, Kevin, physically assaulting him.
16. [redacted] of [redacted] CSC was allocated as the caseworker on or about [redacted]
17. On [redacted] [redacted] attended Max's school and interviewed Max, his classroom teacher, the school counsellor and the principal. She interviewed Max first and she recorded in her notes:

Elsewhere it is documented that Max disclosed to : that his father punches and kicks him and hurts him all the time, that he is afraid to sleep because his father enters the room and hurts him.

18. Despite these alarming and concerning disclosures by Max, then interviews the school counsellor and classroom teacher, which she starts by saying:
19. As at this date, on had not had any communications with Grace whatsoever.
20. The first time : spoke to Grace was by telephone on At this time, after introducing herself, proceeded to speak in a hostile manner to Grace and explained that there had been strong claims made against Grace by Kevin and the two agreed to meet on
21. Prior to this meeting, on : completed a Safety Assessment Decision Report assessing Max to be “safe” and reported, among other things:

22. In other words, [REDACTED] had completed a Safety Assessment concluding that Max had serious emotional and psychological problems likely arising from Grace programming Max on the strength of Kevin's suggestions – the alleged perpetrator under all of the notifications and who was *actually* the subject of the investigations.
23. It is also significant to note that [REDACTED] : had recorded that the [REDACTED] case was closed “due to lack of evidence, and **concerns that Grace was programming Max to believe the abuse had occurred.**” I have not found any independent evidence to suggest that this was in fact a concern to DOCS in [REDACTED], and certainly, given the sparse investigations in [REDACTED], as indicated above, it is difficult to understand the basis upon which [REDACTED] : would have formed this view as at [REDACTED].
24. After a meeting with Grace on [REDACTED] [REDACTED] concluded that Max was safe in her care and that there was no evidence that Max was at risk of emotional harm in Grace's care. When Grace suggested that [REDACTED] might provide psychological counselling assistance for Max, [REDACTED] indicated that Kevin was strongly opposed to any such psychological assistance to be arranged by FaCS.
25. On [REDACTED] [REDACTED] : prepared her Family Risk Assessment Decision Report, assessing Max's risk for neglect as “moderate” and risk for abuse as “high”, recording, amongst other things:  
  
[REDACTED]
26. Apart from other concerning aspects of this report, a review of all the material available to FaCS would have disclosed at least 7 years of counselling notes disclosing that Kevin did indeed have a childhood history of abuse and/or neglect.  
  
[REDACTED]

27. Whilst continued to encourage that Max be provided with psychological counselling assistance, this was strongly opposed by Kevin.

28. On sent an email to Grace saying:

*I wish to let you know that the outcome of Family Court does not affect or influence my involvement with, or assessment of, Max. I will continue to ensure his safety and wellbeing is prioritised and I would like you to be part of the case plan.*

29. However, despite this reassurance, Max's safety was not prioritised and Grace was not involved in any case planning at all. On Acting Manager for CSC, confirmed that the case was closed on explaining:

30. That is, despite all the red flags and the serious emotional and psychological problems identified by , despite the fact that FaCS had originally received notifications regarding the risk of harm to Max in the care of Kevin, because of **Kevin's** resistance, FaCS closed its case for the protection and welfare of Max.

31. Numerous complaints have been lodged in respect of FaCS' conduct in relation to both the case and the case. In relation to the case alone, the complaints have generated three reviews by a casework specialist, has involved the FaCS complaints team, the FaCS Legal team, communications with the Office of the Secretary, communications with the Minister's Office, and a review by the Ombudsman's office.

### **Case Study 2: Brendan**

32. On CSC intervened in relation to alleged incidents of domestic violence occurring on

33.

34. Sonia gave birth to baby Michael on but before their discharge from hospital on , the caseworker from : CSC, , gave her



an ultimatum – if she returns to her husband, they will remove Michael from her. Sonia chose to leave her husband and she and baby Michael were taken to alternative accommodation by FaCS.

35. Brendan did not become aware of the allegations until he was served with a Provisional Apprehended Domestic Violence Order on . He was then called into the police station on , where he was interviewed and charged with assault occasioning actual bodily harm.
36. Whilst Brendan denies the allegations and is awaiting a hearing of the criminal charge against him, meanwhile the interim AVO conditions prevent Brendan from seeing his newborn child.
37. In addition, unbeknownst to Brendan, FaCS have devised and implemented a “Safety Plan”. The contents of this plan have not been disclosed or otherwise made known to Brendan, but he has been informed by Sonia’s Legal Aid lawyer that Sonia is effectively prohibited under the Safety Plan from allowing Brendan to spend any time with his newborn baby.
38. As at the date of these submissions, Brendan has not seen his newborn baby for almost 3 months, at a critical time of attachment and bonding for both the father and child.
39. Despite requests by Brendan for short periods of supervised contact, these have been refused by Sonia’s Legal Aid lawyer. FaCS have not made any provision for supervised contact at all.
40. Brendan now not only bears the burden of having to defend the criminal charge against him, he also now has the burden of initiating family law proceedings as the only means of seeing his newborn baby.

## SUBMISSIONS

41. In the first case study of Grace and Max, FaCS decided not to intervene any further and effectively chose to leave the child at potential risk of harm in the care of the alleged perpetrator.
42. In the latter case study of Brendan, FaCS decided to intervene and remove the child from potential risk of harm in the care of the alleged perpetrator.
43. Whilst the circumstances and outcomes in the two case studies are vastly different, it is submitted that there are three key similarities in both case studies:
  - (a) The failure of FaCS to adequately *investigate* allegations;
  - (b) The failure of FaCS to adopt *principles of fairness and natural justice*; and
  - (c) The failure of FaCS to prioritise and explore ways to *keep families together safely*.

44. These key failures, consistent in both case studies, effectively mean that the decision to intervene or not intervene is random and contingent upon the bent of the particular caseworker involved. The paramountcy principle to protect and preserve the best interests of the child becomes a function of poor investigation and is relegated to the mere opinion of a caseworker according to his or her perspective only.
45. In my respectful submission, these are not issues of funding and lack thereof:
  - (a) In the former case study of Grace and Max, the inadequacy of investigations exacerbated by the lack of procedural fairness (a “cost-saving” in effect), has necessitated an allocation of enormous funding to review the original investigations and to address complaints involving higher paid executive and legal personnel. The State Government’s purse has had to stretch beyond the realm of the investigating CSC and has extended to the Complaints Unit, the Legal Team, the Office of the Secretary, the Minister’s Office, and the Office of the NSW Ombudsman.
  - (b) In the latter case study of Brendan, the inadequacy of investigations, again exacerbated by the lack of procedural fairness, has necessitated the provision of refuge accommodation, additional Centrelink benefits, legal and domestic violence support and possibly more. No doubt, these are all critical services for genuine victims of domestic violence. But in circumstances where FaCS were aware of the allegations throughout a period of almost 3 months during which the alleged victim continued to reside with the alleged perpetrator before FaCS issued a sudden ultimatum with the threat of removing the child from the mother, the additional expenditure in preference for exploring safe ways to keep the family together demonstrates that lack of funding is not the explanation for the failures of FaCS.
46. Apart from adopting a practice of seriously misallocating funding in preference over thorough investigations and proper processes, the failures of FaCS have serious implications for other legal processes, at further cost to individuals and the State:
  - (a) In Grace and Max’s case, the failures of FaCS have subjected them to adverse factual findings in family law proceedings leading to serious consequences – Max (now years old) has been prevented from seeing his mother, Grace, for over 12 months.
  - (b) In Brendan’s case, the failures of FaCS will now necessitate family law proceedings, and the conduct of FaCS have prevented Brendan from seeing baby Michael at all for the past 3 months.
47. And of course, in both cases, the decisions of FaCS have left profound, lasting and irreversible impact on families of a traumatic nature. In both cases, there is a serious discord between the practice of FaCS from its published values of:

*Service – we put people at the centre of everything we do*  
*Integrity – we act professionally with honesty, consistency and impartiality*  
*Trust – we build relationships based on mutual respect*  
*Accountability – we take responsibility for our decisions and actions*

(Taken from FaCS Strategic Statement found at  
[http://www.facs.nsw.gov.au/\\_data/assets/file/0008/298700/FACS Strategic Statement.pdf](http://www.facs.nsw.gov.au/_data/assets/file/0008/298700/FACS_Strategic_Statement.pdf))

48. Based on the two case studies above and the absence of thorough investigations and procedural fairness common to both, it is reasonable to suggest that had Grace and Max attended upon \_\_\_\_\_ : CSC, the father would have been excluded from Max's life and had Sonia attended upon either of \_\_\_\_\_ ; or \_\_\_\_\_ CSC, the case would have been closed and Michael would have remained with Brendan.
49. How can there possibly be any confidence in the decisions of any of these caseworkers? How is it acceptable that these families have been devastated and so seriously impacted by the decisions of these caseworkers in circumstances where there can be no confidence in their decision-making at all?
50. FaCS have a mandate under the *Children and Young Persons (Care and Protection) Act 1998* to intervene in circumstances requiring the care and protection of vulnerable children and young persons. Their practices are guided by legislation, regulations, practice guidelines and policies.
51. Where are the systems failures located to generate such unsatisfactory and unacceptable outcomes? Are they located with the legislation, regulations, policies and guidelines themselves? Is there an absence of adequate safeguards to preserve the rights and dignities of all people who engage with the child protection system? If so, where is the legal community in advocating for stronger protections and safeguards to ensure that adverse decisions are not made against people without proper processes?
52. I make the observation that any discussion about a broadening of police powers and a relaxation of safeguards under the *Law Enforcement (Powers and Responsibilities) Act 2002* would have been met with fierce debate from the legal community and human rights advocates. The exercise of FaCS' mandate under the *Children and Young Persons (Care and Protection) Act 1998* impacts upon the fundamental human rights of people no less, especially the rights of children and young persons. And yet the two case studies above demonstrate a serious disregard for such fundamental human rights and result in outcomes in which can there be absolutely no confidence.
53. Alternatively, are the systems failures not so much located in the structures, but in its implementation through inadequately qualified or trained staff and inadequate allocation of resources and support? Are caseworkers with qualifications and training in social work the best qualified people to conduct investigations into allegations of child

abuse and then to make extraordinary decisions to remove a child from or leave a child with an alleged perpetrator?

54. In my submissions, there must be a thorough examination of why investigations into allegations of child abuse are so poorly handled by FaCS. The two case studies alone demonstrate how little confidence can be placed on the decisions made by the relevant case workers where there has been little or no investigations and absolutely no procedural fairness. But these case studies do more – they demonstrate how **dangerous and devastating** the decisions made by FaCS are when they are not supported by evidence gathered through thorough investigations.
55. I explore the case study of Shannon McCoolle in the South Australian Child Protection Systems Royal Commission below. But for present purposes, I raise the case study of McCoolle to raise the question – is FaCS confident that its systems and processes are adequate to ensure that a person like Shannon McCoolle is not committing serious offences against young children under their very noses?
56. I would suggest that FaCS systems and processes are not adequate, and would even go so far as to suggest that the present culture, systems and processes of FaCS allows the breeding of many Shannon McCoolles and allows them to run rampant with impunity. At the same time, its culture, systems and processes allow for the unfair targeting of other people, victimising them as though they were Shannon McCoolle, without fair or reasonable basis. Neither situation is acceptable. And yet these are the circumstances to which Grace, Max, Kevin, Brendan, Sonia and Michael have been subjected.
57. In the case of Grace and Max:
  - (a) Despite the fact that all of the notifications received by FaCS were about the risk of harm posed by Kevin, little or no background checks were conducted of Kevin, about his family background, educational background, psychological or employment background. Such background checks would have disclosed at the very least that he, himself, was the product of sexual assault and interrupted schooling because of behavioural disturbances.
  - (b) There was extensive communication with Kevin and Kevin was allowed to make counter allegations against Grace.
  - (c) The investigations were then diverted away from Kevin and the risk of harm to Max, and focused on Grace, and whether or not she was manipulative and brainwashing Max. However, Grace did not even have the benefit of being made aware that she was at the centre of investigations, and was never given an opportunity to respond to these counter-allegations.
  - (d) Grace was not interviewed about her concerns for Max, the history of behavioural disturbances demonstrated by Max, her relationship with Kevin and her own history of psychological and emotional abuse suffered at the hands of Kevin.

(e) Then, most disturbingly, **knowing** that Max had seriously disturbed behaviours and was suffering from emotional and psychological harm, **knowing** that Kevin was preventing Max from seeing with his mother, **knowing** that Kevin was not providing any psychological or counselling assistance for Max, and **knowing** that Kevin was refusing to allow FaCS to arrange independent psychological assistance for Max with the consent of the mother, knowing all of this, they closed the case.

(f) FaCS effectively pushed this case into the jurisdiction of the family law.

58. In the case of Brendan:

(a) FaCS sat on allegations of family violence for almost 3 months and did nothing, even though they were aware that Sonia was continuing to reside with Brendan, the alleged perpetrator

(b) FaCS accepted the allegations made by Sonia without any further investigations and suddenly issued an ultimatum and acted to remove the baby from Brendan, threatening to remove the baby from Sonia if she did not leave Brendan.

(c) Sonia's background was not checked – her family, employment, residency, psychological and medical backgrounds were not checked at all.

(d) Brendan was not interviewed at all until FaCS had already intervened to remove the newborn baby from Brendan. He was given no opportunity to respond to the allegations at all until after they had already made a determination as to the allegations

(e) FaCS not only were aware that Brendan had not seen his son since his birth, but ensured that Brendan would not see his soon his birth through a Safety Plan – the contents of which are still unknown to Brendan.

(f) FaCS have effectively pushed this case into the family law jurisdiction.

59. In the former case, FaCS could well be harbouring a Shannon McCoolle and in the latter case, FaCS could well be wrongly identifying someone as Shannon McCoolle. Either way, FaCS could not be sure because the relevant caseworkers have simply **NOT DONE THEIR JOB**.

60. Whether the systems failures are attributable to inadequate safeguards in the law itself, to inadequate implementation processes, or to serious cultural flaws, the current system is dangerous leading to dangerous outcomes.

61. Whilst a different allocation of funding model might address some of these concerns, I am doubtful that it is simply a matter of throwing more money into a system that is fundamentally flawed.

## REPORTS & RECOMMENDATIONS FROM OTHER COMMISSIONS

62. Whilst Charis Law welcomes the present Inquiry and the opportunity to participate in it, reference is made to the Final Report released in October 2010 by the Australian Law Reform Commission jointly with the NSW Law Reform Commission, *Family Violence – A National Legal Response* (located at <http://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>) and to the South Australian Child Protection Systems Royal Commission, from which lessons can be learned. The report of the Royal Commissioner, the Honourable Margaret Nyland AM, is due to be soon released on 5 August 2016.

### *Family Violence – A National Legal Response Final Report*

63. This report addressed many of the issues that the present Inquiry is likely to address, albeit under different Terms of Reference.
64. From the 1,559-page report, the following excerpts, relevant to the present submissions, are highlighted:

19.53 ...family courts do not have a mechanism to investigate allegations of child abuse. They rely upon the parties, independent children's lawyers, family consultants and state child protection agencies to provide them with information to make a decision about children who are at risk. The relationship between family courts and state agencies in this regard has not always been mutually satisfying...

19.75 ...Family courts need information to assist them in making decisions about children's safety in cases where there have been allegations of child abuse. **They have no investigatory arm through which they can acquire independent evidence.** They want the information from child protection agencies, but the agency does not always respond in the way that the court wishes [emphasis added]....

19.77 The first gap between the family courts and the child protection system is what might be called the '**investigatory gap**' – caused by the fact that the family courts have no investigatory arm to provide them with independent investigations in cases where child abuse is raised as an issue. **The children who are vulnerable in this gap are those who:**

- **are the subject of family law proceedings involving allegations of child abuse;**
- **state child protection authorities decide not to assist; or**
- **are not included in a program such as the Magellan case management program for cases involving serious child abuse** [emphases added]...

19.95 ...the Commissions are also concerned that the problems outlined above have been identified for many years...and that...no solution has been found... In the



interests of the children concerned, **these problems should not be allowed to persist**. [emphasis added]...

19.97 ...**the difficulty of the task does not remove the pressing need to do it...**[emphasis added]

19.106 In a family violence context...the mother may be advised by the child protection agency to go to a family court for a parenting order...

19.107 ...However, there may be problems involved in referring these cases to the family courts, especially if the applicant does not receive support from the child protection agency in making the application...

19.118 Greater support for parents with family violence and child protection concerns who litigate in family courts may be achieved by a change of practice of child protection agencies, in favour of staying engaged with more families at an appropriate level....

65. The concerns raised by the joint Law Reform Commissions are clearly seen in the case study of Grace and Max – where Max was left vulnerable in the investigatory gap of the family court system, completely unsupported by FaCS, and placed at risk of further abuse.
66. In Chapter 16 of the Report, the Commissions explore the jurisdiction and practice of State and Territory Courts in their interactions with the family law. The Commissions outline the jurisdictional limits and/or reluctance of State Courts in relation to the making, varying, discharging or suspending parenting orders under the *Family Law Act*.
67. The Commissions set out a framework informed by the principle that “victims of family violence should, as far as possible, be able to have as many of the legal issues relating to the violence resolved by the same court” (paragraph 16.2):

16.67 As state and territory magistrates courts are often the first point of contact with the legal system for separating families who have experienced family violence, the Commissions consider that it is important that state and territory magistrates courts can deal with as many issues relating to the protection of victims of family violence as possible.

16.69 The Commissions consider that state and territory courts, when making or varying a protection order, should also be able to make parenting orders ‘until further order’—a reinstatement of the jurisdiction under the *Family Law Act* that was removed from state and territory courts in 2006. Making an interim parenting order at this time may take the heat out of the situation by regulating how separating parents spend time and communicate with their children. For example, while a protection order may include conditions to protect a person from violence or

*harassment, a parenting order may prescribe handover arrangements to minimise contact between the parents*

68. The concerns of the Commissions are relevant to the case study of Brendan, where pending the outcome of his criminal charge and restrained by interim AVO conditions and the Safety Plan implemented by FaCS, he has no way of seeing his newborn child without commencing family law proceedings in the Federal Circuit Court of Australia. Not only would this course place greater strain on Brendan, it would also place significant strain on the alleged victim and the child.

### ***South Australian Child Protection System Royal Commission***

69. The Child Protection System Royal Commission was launched by the South Australian Premier Jay Weatherill in August 2014 and the commission hearings focused largely on the circumstances surrounding Families SA employment of convicted paedophile, Shannon McCooles.
70. The report of the Commissioner, the Honourable Margaret Nyland AM, is not due to be released until 5 August 2016.
71. Media reporting of the hearings have been limited due to non-publication orders, but to the extent that reports of the hearing have emerged, it is submitted that there are striking similarities between the case study of Grace and Max above and the Shannon McCooles case study.
72. Candice Prosser of ABC News reported on the closing submissions of counsel assisting the commission, Emily Telfer, on 14 May 2016 (<http://www.abc.net.au/news/2016-05-13/shannon-mccooles-child-protection-systems-royal-commission/7413130>):

*Counsel assisting the commission Emily Telfer outlined in written submissions a series of failures in training, policies and departmental culture, adding the investigation gave too much emphasis to McCooles's rights.*

*She said the agency missed its best opportunity to investigate McCooles after an employee reported the suspected rape of a six-year old girl.*

*"The opportunity was squandered because the systems that were in place to respond to this exact situation were not utilised," her submissions said.*

*She said child safety had not remained paramount for those with the decision-making powers.*

*McCooles was stood down during an investigation, then cleared, re-employed and promoted.*



*"The barriers to raising concerns, the consequences of reporting and the deficits in organisational culture, management and competence of senior staff all culminated in the events which followed [the] observations of McCoole's behaviour in early June 2013," Ms Telfer said.*

...

*Ms Telfer said an investigation had been "entirely inadequate" with too much focus on McCoole's rights and why a work colleague might have fabricated the allegation.*

*"At no stage was a clear focus drawn on the high level of vulnerability of a six-year-old child in care, who had no obvious advocate for her interests or safety," she said.*

...

*"If the system functioned in the way it was designed to, the disastrous failures... may well have been avoided."*

*"...what is ...important is the lessons that can be learnt from both individual and system failures"*

73. Counsel assisting's closing submissions could apply almost verbatim to the case study of Grace and Max, with names replaced, to describe the entirely inadequate investigations of ; CSC in and CSC in to describe the disproportionate focus on Kevin's rights and the threat of possible legal action he might take, to describe the lack of focus on the high level of vulnerability of Max as a -year-old and as an -year-old whose only advocate, his mother Grace, was demonised and discredited as having fabricated allegations.
74. Shannon McCoole was not arrested until a global investigation into a child pornography website administered by McCoole led police to McCoole in June 2014. By then, he had already uploaded numerous and sickening images of his offending behaviour against children as young as 18 months old since January 2011.
75. Candice Marcus's ABC News article of 26 February 2016 outlines the **series of red flags missed** during McCoole's employment history (<http://www.abc.net.au/news/2016-02-26/red-flags-missed-during-mccooles-employment/7169066>).
76. If Grace and Max's case were the only case in which FaCS failed to investigate allegations adequately, even then, FaCS would be at risk of harbouring and protecting a potential Shannon McCoole under their watch. Regrettably, I suspect that there are many more instances of FaCS failing in their obligation to thoroughly investigate allegations and there may be many Shannon McCooles who FaCS is currently harbouring and protecting, squandering its many opportunities to provide care and protection for the most vulnerable children in New South Wales.
77. Must we wait for the next international police operation to locate and capture the next Shannon McCoole who currently operates with impunity under the very nose of FaCS? Must we wait for another child to die because of FaCS's systems failures?

## RECOMMENDATIONS

78. Based on the two case studies above, the case study of Shannon McCoolle, I make the following recommendations:
- (a) FaCS should not decline to do its job in preference for pushing matters into the family law jurisdiction
  - (b) There must be a significant cultural shift to ensure that FaCS does not engage in victim-blaming
  - (c) In every allegation of child abuse, there must be a thorough investigation based on principles of natural justice, ensuring that all background checks are conducted and all relevant witnesses are interviewed and statements obtained in relation to the allegations, with a focus on the allegations of child abuse and a clear focus on the vulnerabilities of the child
  - (d) FaCS must not engage in extensive communications with the alleged perpetrator, and should only engage with the alleged perpetrator to the extent necessary to ensure that the principles of natural justice are adhered
  - (e) FaCS should avoid making any comment or offering any opinion about the investigations to anyone until the investigations have been completed
  - (f) Unless there is clear and current evidence that a child is at imminent risk of harm, FaCS should not intervene to remove a child from either birth parent pending an outcome of the investigations
  - (g) Investigations should be conducted within a framework of working together with families, especially victims, and not against families
  - (h) Any review of investigations should also follow best practice for the conduct of investigations, ensuring that all witnesses have been interviewed and statements obtained, adhering to principles of natural justice, with a focus on the allegations of child abuse and a clear focus on the vulnerabilities of the child
79. In relation to the structural, procedural or cultural deficiencies in the present system, I make the following recommendations:
- (a) There should be a detailed review of funding allocation within State Government organisations dealing with child protection issues, whether FaCS or other organisations, with a view to ensuring that funding is not being disproportionately allocated to secondary and tertiary level interventions, whether in the way of reviews, legal action or in some other way, as a result of poor decision making by frontline workers.

- (b) There should be a detailed review of job descriptions and the level of training and education required for each role with a view to ensuring that each frontline worker is adequately trained and equipped to do their job. There should be a clear delineation of roles for frontline caseworkers delivering case management services once children have entered the child protection system and those providing investigatory services to determine whether children should enter the child protection system or in relation to any other allegations.
  - (c) There should be adequate funding for frontline caseworkers, ensuring they have proper and thorough training to deliver on all aspects of their role, thereby minimising the need for secondary and tertiary level interventions.
80. Finally, rather than duplicate much work that has already been done in relation to child protection systems and its interactions with other jurisdictions, the Inquiry should refer to reports emanating from other Commissions and Inquiries, in particular, the Final Report of the 2010 ALRC and NSW LRC and to the soon-to-be-released report of the Honourable Margaret Nyland in relation to the South Australian Child Protection Systems Royal Commission.