



**Report of the
Special Commission of Inquiry into
Child Protection Services in NSW**

Volume 3

The Hon James Wood AO QC

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Acronyms

<i>Acronyms</i>	<i>Phrase/meaning</i>
1987 Act	<i>Children (Care and Protection) Act 1987</i>
AAE	Allegations Against Employees
AAS	Area Assistance Scheme
Aboriginal Affairs	Department of Aboriginal Affairs
Aboriginal Placement Principles	Aboriginal Child Placement Principles
ABS	Australian Bureau of Statistics
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACSAT	Aboriginal Child Sexual Assault Taskforce
ACWA	Association of Children's Welfare Agencies
ACYFS	Aboriginal, Child, Youth and Family Strategy
ADR	alternative dispute resolution
ADT	Administrative Decisions Tribunal
AHS	Area Health Service
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMIHS	Aboriginal Maternal and Infant Health Strategy
AODP	Alcohol and Other Drugs Program
Attorney General's	Attorney General's Department
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
CALD	culturally and linguistically diverse
Care Act	<i>Children and Young Persons (Care and Protection) Act 1998</i>
CCYP	Commission for Children and Young People
CCYP Act	<i>Commission for Children and Young People Act 1998</i>
CCYP Act	<i>Commission for Children and Young People Act 1998</i>
CDC	Caseworker Development Course
CDCRU	Child Deaths and Critical Reports Unit (DoCS)
CDRT	Child Death Review Team
CEC	Chief Executives Committee
CEO	Chief Executive Officer
CIW	Corporate Information Warehouse
Clinic	Children's Court Clinic
COAG	Council of Australian Governments
Community Welfare Act	<i>Community Welfare Act 1987</i>
Corrective Services	Department of Corrective Services
CRC	Children's Research Center
CS CRAMA	<i>Community Services (Complaints, Reviews and Monitoring) Act 1993</i>
CSC	Community Services Centre
CSGP	Community Services Grants Program
CYP	Children and young persons
DADHC	Department of Ageing, Disability and Home Care
Discussion Paper	DoCS Discussion Paper, <i>Statutory child protection in NSW: issues and options for reform</i> , October 2006
Displan	NSW State Disaster Plan

<i>Acronyms</i>	<i>Phrase/meaning</i>
District Court	District Court of NSW
DoCS	Department of Community Services
DPP	Office of the Director of Public Prosecutions
Education	Department of Education and Training
EOI	expression of interest
ESD	Enhanced Service Delivery
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
Family Court	Family Court of Australia
Family Law Act	<i>Family Law Act 1975</i>
FGC	family group conferencing
FTE	full time equivalent
Health	NSW Health
HNEAHS	Hunter New England Area Health Service
Housing	Housing NSW
HREOC	Human Rights and Equal Opportunity Commission
HRIP Act	<i>Health Records and Information Privacy Act 2002</i>
IFBS	Intensive Family Based Services
Interagency Guidelines	<i>Interagency Guidelines for Child Protection Intervention 2006</i>
Interagency Plan	Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011
JIRT	Joint Investigation Response Team
JRU	JIRT Referral Unit
Juvenile Justice	Department of Juvenile Justice
KiDS	Key Information and Directory System
LAC	Legal Aid Commission NSW
LAC proposal	Draft Proposal for a Care and Protection Mediation Pilot (Legal Aid NSW)
LAT	Less Adversarial Trial
Law Society	Law Society of NSW
Magellan	Magellan Case Management Model
MOU	Memorandum of Understanding
NCOSS	Council of Social Services of NSW
New Street	New Street Adolescent Service
NGO	non-government organisation
NTER	Northern Territory Emergency Response
OHS	Occupational Health and Safety
Ombudsman	NSW Ombudsman
Ombudsman Act	<i>Ombudsman Act 1974</i>
OOHC	out-of-home care
PANOC	Physical Abuse and Neglect of Children
Police	NSW Police Force
PPIP Act	<i>Privacy and Personal Information Protection Act 1998</i>
PPR	Personal Planning and Review
Premier and Cabinet	Department of Premier and Cabinet
PSA	Public Service Association
RACP	Royal Australian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCMG	Regional Coordination Management Group

<i>Acronyms</i>	<i>Phrase/meaning</i>
Regulations	<i>Children and Young Persons (Care and Protection) Regulation 2000</i>
Rules	<i>Children's Court Rule 2000</i>
SAAP	Supported Accommodation Assistance Program
SACS Award	Social and Community Services Award
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment State 2
SCAN	Suspected Child Abuse and Neglect
SCI	Special Commission of Inquiry
SDM	Structured Decision Making
SDRC	State Disaster Recovery Centre
SERM Act	<i>State Emergency and Rescue Management Act 1989</i>
SNAICC	Secretariat of National Aboriginal and Islander Child Care
Treasury	NSW Treasury
Triple P	Positive Parenting Program
Usher Review	Review of Substitute Care Services in NSW 1992
Young Offenders Act	<i>Young Offenders Act 1997</i>

20 Young people, leaving care and homelessness

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Introduction

- 20.1 This chapter is concerned with the problems that are likely to be experienced by adolescents and young persons while in statutory care, and when leaving care. For the purposes of this chapter ‘adolescents’ are taken to be children within the age group of 12–15 years, and ‘young persons’ are those who are aged 16 years or above and under the age of 18 years.¹ Collectively the two groups are referred in this chapter to as ‘young people.’
- 20.2 Some young people will have had multiple placements in statutory OOHC or in supported care before reaching the age of 12 years. They are particularly likely to experience breakdown in their placements during their teenage years, this being a period of intense and rapid development, and they are likely to face substantial challenges in making the transition to independent living. Often the experience of transition will be one of inadequate accommodation, emotional vulnerability, difficulty in securing employment, early parenthood, homelessness, substance abuse, mental health problems, lack of support, relationship difficulties and poverty. Save where they have had the benefit of high quality and enduring foster care, most will have limited education and vocational training as well as unaddressed physical, mental and dental health problems.² Homelessness and involvement with Juvenile Justice, both while in care and after leaving care, will not be unusual.³ Reluctance to accept guidance and counselling will be common.
- 20.3 The lower priority given to young people has been recognised by the NSW Ombudsman who noted the observations of the National Youth Commission in its report on Youth Homelessness:

In every hearing, the systems of care and protection in the different jurisdictions were reported as being under-resourced and under-staffed. This resulted in priority allocations that focus on younger children, creating major issues of access for older youth.⁴

...

Despite positive work in many areas, there remain many indicators that care and protection systems are both under-resourced and suffering an acute workforce crisis. Early intervention and prevention in child protection, while laudable, is

¹ *Children and Young Persons (Care and Protection) Act 1998* s.3.

² J Cashmore and M Paxman, “Longitudinal Study of Wards Leaving Care: four to five years on,” *Social Policy Research Centre*, University of New South Wales, January 2007; C Smyth and T Eardley, “Out-of-Home Care for Children in Australia,” *Social Policy Research Centre*, University of New South Wales, February 2008, p.4.

³ C Smyth and T Eardley, “Out of home care for children in Australia: A review of literature and policy. Final Report,” *Social Policy Research Centre, University of New South Wales*, February 2008, p.7.

⁴ A Report of the National Youth Commission Inquiry into Youth Homelessness, *Australia’s Homeless Youth*, 2008, p.125.

being prioritised at the expense of support for older children who are being regarded as 'less vulnerable'. In another practical sense, they are often seen as too difficult to deal with and manage and a drain on limited resources. As a result of what can only be described as system neglect, these children and young people are experiencing homelessness and reliance on the SAAP system for support. This is despite legislation that is meant to give responsibility to the state and territory child protection authorities for young people under the school leaving age.⁵

- 20.4 The priority which DoCS gives in responding to younger children at risk of harm, and the eligibility criteria for services under the Brighter Futures program,⁶ have meant that less attention has been given to young people.
- 20.5 In this chapter, the inadequacies of the current system so far as it impacts upon young people are identified, and recommendations for reform are developed. In order to place that analysis into perspective, it is helpful to note the following statistical profile.

What the data tell us about young people

- 20.6 Reports, involving adolescents (12-15 year olds) comprised 24.2 per cent of all reports to DoCS in 2007/08 (preliminary) which is slightly higher than in 2001/02, when such reports accounted for 23.3 per cent of all reports.
- 20.7 Reports involving young persons (16-17 years old) comprised 4.2 per cent of all reports to DoCS in 2007/08, which, like reports involving adolescents, is slightly higher than in 2001/02 when such reports accounted for 3.8 per cent of all reports.
- 20.8 As discussed in Chapter 5, there has been an 89.8 per cent increase in the total number of reports between 2001/02 and 2007/08. Over the same period, reports involving adolescents have increased by 96.4 per cent and reports involving young persons have increased by 112.5 per cent. Therefore the number of reports involving adolescents and young persons have increased at a greater rate than for reports across all age groups.
- 20.9 Adolescents comprised 22.6 per cent of all children and young persons involved in reports to DoCS in 2007/08. This is slightly higher than in 2001/02 when adolescents accounted for 21.5 per cent of all children and young persons involved in reports.

⁵ *ibid.*, p.136.

⁶ That program is reserved for families with at least one child aged eight years or younger or who are expecting a child.

- 20.10 Young persons comprised 5.1 per cent of all children and young persons involved in reports to DoCS in 2007/08. This is slightly higher than in 2001/02 when young persons accounted for 4.4 per cent of all children and young persons involved in reports.
- 20.11 There has been a 54.0 per cent increase in the number of children and young persons reported between 2001/02 and 2007/08. Over the same period, there was a 61.5 per cent increase in the number of adolescents and a 77.2 per cent increase in the number of young persons who were reported to DoCS.
- 20.12 After children aged less than one year, the percentage increase in reports since 2001/02 was greatest among adolescents and young persons.
- 20.13 In both 2006/07 and 2007/08 (preliminary) the average number of reports for each child or young person reported was 2.3. For every adolescent the average number of reports in both years was 2.5 and for every young person the average was 1.9 reports. Based on this data, adolescents are likely to be the subject of a slightly higher than average number of reports per year and young persons are likely to be the subject of a slightly lower than average number of reports per year.
- 20.14 The highest average number of reports per child or young person in 2006/07 were for children aged less than one year, and adolescents aged 13 years and 14 years. Not only do people of these ages receive the highest number of reports about them, the rates of reporting per 1,000 population for these ages are also relatively high.⁷
- 20.15 While adolescents accounted for 22.6 per cent of all children and young persons involved in reports in 2006/07, they accounted for:
- 22.8 per cent of all children and young persons reported to DoCS between one and three times
 - 22.2 per cent of all children and young persons reported to DoCS between four and 10 times
 - 25.4 per cent of all children and young persons reported to DoCS between 11 and 20 times
 - 56.8 per cent of all children and young persons reported to DoCS over 20 times.
- 20.16 Of most significance is the number of adolescents who were the subject of more than 20 reports as a proportion of all children and young persons.
- 20.17 In 2006/07, 43.2 per cent of all children and young persons who were the subject of a report to DoCS were reported for the first time ever. In the same year, 9,892 adolescents were reported for the first time in 2006/07, which accounted for 35 per cent of all adolescents who were the subject of a report in

⁷ DoCS, *A closer look: Recent trends in child protection reports to DoCS*, December 2007.

- 2006/07. There were 2,174 young persons reported for the first time in 2006/07, which accounts for 34.9 per cent of all young persons reported.
- 20.18 Therefore, compared with the children and young persons who were the subject of reports across all age groups, a higher proportion of adolescents and young persons who were reported to DoCS already had a child protection history. However, this finding is to be expected.
- 20.19 10.3 per cent of all children and young persons reported in the period 1 April 2007 to 31 March 2008 received at least one secondary assessment that determined harm or risk of harm. 9.8 per cent of all adolescents reported and 4.8 per cent of all young persons reported received at least one secondary assessment that resulted in a determination of harm or risk of harm. Therefore adolescents were slightly less likely than children and young persons across all age groups to be the subject of a report that proceeded to SAS2 and resulted in a determination of harm or risk of harm. Young persons who were the subject of a report were significantly less likely to be the subject of a completed SAS2 that resulted in a determination of harm or risk of harm.
- 20.20 As at 31 March 2008, adolescents accounted for 25.7 per cent and young persons accounted for 8.7 per cent of all children and young persons in OOHC.
- 20.21 Of the 4,686 children and young persons who entered OOHC from 1 April 2007 to 31 March 2008, 18.7 per cent were aged 13-17 years. Of this group 28.1 per cent were Aboriginal, which is slightly lower than the 31.3 per cent of children and young persons in OOHC in the same period who were Aboriginal.
- 20.22 Over half (56.3 per cent) of the 13-17 year olds who re-entered OOHC in 2006/07 had been in care two or more times previously (with an average of three times). This group had spent an average of 1,390 days in care previously (total of all their OOHC episodes).⁸
- 20.23 As at 31 March 2008, 63.4 per cent of children and young persons in OOHC were in statutory care and 35 per cent were in supported care.⁹ The percentage of young persons in supported and statutory care is similar to the average across all age groups, but for adolescents, a higher proportion (42.2 per cent) were in supported care.
- 20.24 As at 31 March 2008, 66.7 per cent of young people in DoCS statutory care had an allocated caseworker compared with 74.5 per cent for younger children. Similarly, young people in DoCS supported care were less likely to have an allocated caseworker when compared with younger children (26.7 per cent compared with 38.0 per cent).

⁸ DoCS, *Analysis of children and young people who entered OOHC in 2006/07*.

⁹ The remaining 1.6 per cent of children and young persons in OOHC were either in other voluntary care arrangements or their care arrangements were not stated.

- 20.25 This is largely because the allocation rates for children two years and younger are significantly higher than for all other age groups. Across statutory and supported care, the allocation rates for children aged 5-11 years are only slightly higher than for young people.

Funding for youth projects

- 20.26 DoCS funds a range of youth specific services through the CSGP. It also provides funding for adolescent counsellors, child sexual assault services, youth support services, drop in and social support networks. Through SAAP, funding is provided for accommodation, case management and brokerage to support homeless young people and young people at imminent risk of homelessness. Better Futures is a program for 9-18 year olds which focuses on youth participation, keeping older children and young people at school and helping them make a safer transition to adulthood.
- 20.27 The Inquiry notes that additional service models have been developed in other states with a particular focus on young people, and which depend on a 'wraparound' process or interagency coordination.
- 20.28 Several submissions to this Inquiry made the point that key programs, such as Better Futures and the CSGP, have been unable to provide sufficient interventions for young people with at risk behaviours or high support needs, in part due to the lack of sufficient funding and in part due to a lack of any clear focus on this group. The point has also been made that Families NSW is primarily focused on those cases where there are children up to eight years of age, and that there is no matching strategy for adolescents and young persons.¹⁰
- 20.29 The Inquiry favours the development of models that will advance interagency cooperation and collaborative responses for young people, together with an increase in funding that would permit greater attention to be given to the provision of early intervention services particularly for the 9-14 years of age group, as discussed earlier in this report.

¹⁰ The current Inquiry by the Parliamentary Joint Committee for Children and Young People into Children and Young People aged 9–14 years should provide additional insight into the sufficiency of the current system to address the needs of this group.

Casework practice with young people in statutory care

Casework skills relating to young people

- 20.30 The Inquiry has the benefit of a limited study that was undertaken in 2007 by DoCS in relation to the perceptions of its staff in relation to casework practices with young people. The resulting report noted:

...that it is common for workers to be overwhelmed by the complexity of presenting problems and the limited time that is available.¹¹

- 20.31 Caseworkers reported that they did not really have time to engage young people with the crisis nature of their work and that:

we may have a conversation in the car and then refer them to a worker at the end of a phone ... our intention is to set up a relationship with them to establish boundaries and to follow that through, but in terms of following through we are not so good.¹²

- 20.32 The study identified the limited extent to which effective casework practice with young people had been the subject of study or research, that could provide guidance to staff in working with this group.¹³

- 20.33 Significantly, it would suggest that special skills training and experience are required for caseworkers working with young people, and that a delicate balance needs to be established in:

- a. working with young people while respecting the interests of their family
- b. establishing an ongoing relationship of support without taking over the life of those within this group
- c. establishing boundaries without being too authoritarian.

- 20.34 Caseworkers in this study also identified the almost chronic lack of services to meet the needs of young people as a factor determining poor outcomes. They pointed to the waiting lists for many services, such as mental health services and reported spending hours and days on the phone trying to secure an OOHC placement for these young people.¹⁴

¹¹ DoCS, *Effective casework practice with adolescents: perceptions and practice of DoCS staff*, December 2007, p.1. Although that report employs the term 'adolescents' that is defined as including people within the age range of 12-18 years.

¹² *ibid.*, p.19.

¹³ *ibid.*, p.1.

¹⁴ *ibid.*, p.19.

- 20.35 Notwithstanding these difficulties, effective interagency work was seen as crucial to assisting positive outcomes,¹⁵ as was the need for reciprocal sharing of information.
- 20.36 One of the Inquiry's case studies highlighted the difficulty in finding stable and suitable accommodation for an adolescent.

Case Study 23

Due to difficulties living at home a series of Temporary Care Orders were signed for A, a 15 year old girl, with the mother's consent. DoCS tried to find appropriate placements for A. Initially A stayed with her maternal aunt but after it was alleged that A sexually assaulted the maternal aunt's daughter another placement was required.

In December 2006 A's mother consented to a care application for A. Further reports on A continued to be received by DoCS concerning A's ongoing conflict and risk taking behaviour. On 23 March 2007 the Court expressed 'very serious concerns' about the level of supervision provided to A while she was in the refuge.

A then had 3 foster care placements all of which broke down due to her escalating violent behaviours. After another short term placement A was placed in crisis refuge accommodation in February 2007 until a stable long term placement could be found.

A number of crises, and an allegation of sexual assault, occurred whilst A was in the refuge, particularly in regard to one of the other residents. A was no longer attending school.

During her time at the refuge over 40 reports were made about her violent outbursts, ongoing conflict with residents, self harm, risk taking behaviours. DoCS continued to seek appropriate alternatives but none were available for A as she had high and complex needs.

In July 2007 A made an allegation of sexual assault by her (former) foster carer.

A's placement continued until August 2007 when she self placed with her boyfriend. DoCS raised concerns about A while she was with the boyfriend as he had a significant criminal history, was violent towards her and had mental health issues.

A DoCS funded placement for high needs children became available in December 2007 which was appropriate for A's needs. A moved into new placement but stayed only one night and left to be with her boyfriend.

¹⁵ *ibid.*, p.16.

A absconded from the placement repeatedly. When A became pregnant significant support and information was provided to her regarding her options and available services, including a number of discussions regarding the possibility that DoCS may remove the child. Significant supports were also provided when she terminated her pregnancy.

In January 2008 the specialist accommodation service was advised that the bed was no longer required for A and that it could be allocated to another client. DoCS arranged two emergency placements on a crisis basis should the need arise and A would need to leave her boyfriend.

A's boyfriend was charged with assault of A in February 2008 and arrested. DoCS and the Domestic Violence Liaison Officer provided support and assistance to A. A self placed with 'friends' (referred to as drug users/dealers) but was found and taken back to her former placement at the refuge on. She stated to her caseworker that she was having problems in the placement and wanted to move. DoCS tried to find alternate accommodation but she absconded again.

- 20.37 Included in the study referred to earlier were some caseworkers who worked in one of the three now defunct adolescent casework teams which DoCS had in place at the time of the study. Their experience, the need for specialist skills in this area, the absence of any specific practice directions concerning young people, and the reported difficulties which new caseworkers have in coping with this age group, suggest that more needs to be done by DoCS and others to cope with a sector that is now a significant part of its client base.
- 20.38 The Inquiry notes that the Department of Human Resources in Victoria has specialist adolescent care workers located within each region. Their special skills and experience in dealing with high needs and difficult adolescents has been seen as critical to successful casework practice. This Inquiry is of the view that similar positions should be considered in NSW initially in the regions and eventually at the CSCs, with equivalent status of a casework specialist.
- 20.39 So far as the Inquiry has been able to ascertain the members of DoCS staff with a specific focus on young people have been the caseworkers attached to street teams, for example, at Kings Cross and at Cabramatta, the 50 intensive support service caseworkers dealing with the high needs client group (which includes a high proportion of adolescents) and the caseworkers forming the Hunter Youth Support Team, who work exclusively with adolescents and provide a consultancy service to other community service centres. While these caseworkers can provide expert assistance for the young people who they can reach, there would seem to be a potentially larger group who could benefit from similar assistance.
- 20.40 Equally needing additional training and support following authorisation as a carer are the foster carers and kinship and relative carers responsible for the day to day care of young people in care.

Interagency cooperation

- 20.41 The need for close interagency cooperation in responding to the needs and vulnerabilities of young people in care cannot be understated, as has been indicated by the work of the Ombudsman and the CCYP in the reviews of the deaths of those within this group,¹⁶ which revealed numerous system deficiencies.
- 20.42 It is understood that DoCS and Health have identified a number of strategies and have taken several initiatives to address these concerns as follows:
- a. A DoCS research project looked at practice issues in engaging with young people and aimed to identify serious suicide and self harm patterns in vulnerable young people and to promote models for successfully delivering services to young people in care.
 - b. A DoCS panel was established to meet on a quarterly basis to focus on suicide/risk taking deaths of young people known to it.
 - c. DoCS has worked with the Child and Adolescent Mental Health Services Network with the aim of developing a draft framework for ensuring that appropriate mental health services were provided to children and young people.
 - d. DoCS and Health have an MOU in place which provides for priority access to health services by people under the parental or care responsibility of the Director-General, DoCS or the Minister,
 - e. An addendum to the MOU has been developed to improve linkages between the two Departments in relation to the care of young people, with a key consideration being risk management and suicide prevention with the aim of providing effective interagency coordination and establishing a system that could meet the needs of those within this age group, in terms of their mental health and risk of self harm or suicide.
- 20.43 These initiatives are positive and their implementation will need to be monitored. As DoCS informed the Inquiry, mental health, disability and drug and alcohol issues generally emerge during adolescence. There is a risk that these issues will progress unless addressed. As a result, the Inquiry is of the view that attention needs to be given to making the services necessary to deal with these problems more available, and to facilitate their coordination and ease of access.

¹⁶ For example: NSW Commission for Children & Young People, "Suicide and Risk-Taking Deaths of Children and Young People," *National Centre for Classification in Health*, 2003; NSW Ombudsman, *Causes of death of reviewable children in NSW, 2003-2006*, June 2007; NSW Ombudsman, *Reports of Reviewable Deaths, 2004, 2005, 2006*.

Leaving statutory OOHC

Leaving care statistics

- 20.44 In the period 1 April 2007 to 31 March 2008, 2,703 children and young persons exited care. Of these 24.2 per cent (655) were adolescents and 19.6 per cent (529) were young persons. Of the 1,184 young people exiting OOHC, 26.9 per cent (319) were Aboriginal.

Outcomes for young people leaving care

- 20.45 Those leaving care have uniformly been recognised as one of the most disadvantaged and vulnerable groups in society, yet they do not always receive the support they need to settle their lives and to find accommodation and employment.¹⁷
- 20.46 Longitudinal studies on young people leaving care, for example that of Cashmore and Paxman, provide evidence that as a group, they:

fare more poorly than other young people their age in the general population. They are less likely to have completed school and to have somewhere safe, stable and secure to live; and they are more likely to rely on government income support, to be in marginal employment, and to have difficulties in 'making ends meet'.

*Most cannot call upon the level of support from their families and the wider networks, which are usually available to young people in the general population.*¹⁸

- 20.47 The assumption that like other young people they will access welfare benefits for support is not necessarily well founded. Nor is the assumption that by the time they leave care they will have become 'street smart' and able to care for themselves.
- 20.48 In addition to their adverse circumstances, including the complicating factors that may intrude while in care such as placement instability, and the limited support available to them, young people leaving care will also have to cope with a number of major changes in their lives in a shorter period of time and at a younger age than many of their more advantaged peers.
- 20.49 The findings from the Cashmore and Paxman study of wards leaving care indicate that how well this group were faring four to five years after leaving care is a result of what happened to them in care (as well as their experiences before

¹⁷ Australian Senate Community Affairs Committee, *Protecting vulnerable children: A national challenge. Second report on the Inquiry into children in institutional or out-of-home care*, March 2005.

¹⁸ J Cashmore and M Paxman, 2007, op. cit., p.135.

coming into care), the timing and circumstances of leaving care, and the amount of support they had around them after leaving care.

- 20.50 Cashmore and Paxman found that within the first 12 months of leaving care:
- a. care leavers had moved on average three times
 - b. almost half were unemployed
 - c. nearly one third of young women were pregnant or had a child soon after transition
 - d. just over half had completed only year 10 or less schooling
 - e. over half had thought of or attempted suicide.
- 20.51 Maunders et al found from their national overview that:
- a. 42 per cent of their sample had been discharged from care before the age of 18 years
 - b. half had experienced a period of homelessness
 - c. almost half had committed criminal offences since leaving care.¹⁹
- 20.52 The most significant in-care factors identified by Cashmore and Paxman were stability and, more importantly, a sense of security in care.²⁰ Stability is important because it allows young people to 'put down roots' and develop a network of relationships. Clark similarly found that:

*the single most important ingredient of effective service provision with these young people is the quality of the direct care staff and their capacity to either offer caring and connectedness to these young people or to foster this kind of relationship between the young person and some other nurturing adult.*²¹

- 20.53 Given the number of transitions these young people face, one approach suggested has been to stagger the timing of these transitions.²² One example is to delay the transition from care for those young people still in secondary school until after they have completed their schooling. This is likely to improve their chances of completing their secondary education significantly, and to give them better employment prospects and the possibility of going on to further education. It also provides them with some continuity of connection and relationships, together with continuing practical and emotional support.

¹⁹ D Maunders, M Liddell, M Liddell and S Green, *Young People Leaving Care & Protection: A report to the National Youth Affairs Research Scheme*, 1999, cited in CREATE Foundation, "Report Card: Transitioning from Care," March 2008, p.16.

²⁰ J Cashmore and M Paxman, 2007, op. cit., p. 124.

²¹ R Clark, "It has to be more than a job; A search for exceptional practice with troubled adolescents," *Melbourne: Deakin University – Policy and Practice Research Unit*.

²² J Cashmore and M Paxman, 2007, op. cit., p.128.

- 20.54 For most young people the transition to adulthood is gradual, yet most jurisdictions relinquish their parental responsibilities for young people in care once they reach 18 years of age. This is in contrast to the experience of many other young people of this age who continue to receive financial and emotional support from their families. The Midwest Evaluation of the Adult Functioning of Former Foster Youth is a prospective study following a sample of young people in Iowa, Wisconsin, and Illinois as they make the transition from foster care to early adulthood. The Midwest study presents an opportunity to compare the outcomes of young people who 'aged out' of care in states with different policies (that is, at 18 years of age, 21 years of age, and with differing types of entitlements). Data from the Midwest study suggest that allowing foster youth to remain in care past age 18 years increases their likelihood of attending college and their likelihood of receiving independent living services after age 19. It may also increase their earnings and delay pregnancy.²³
- 20.55 DoCS Economics, Statistics and Research Directorate, at the request of the Inquiry, completed an estimate of the costs of implementing the following two scenarios in NSW:
- a. Scenario A: 15 per cent of young people exit at age 18 years, a further 10 per cent exit at age 19 years, a further 15 per cent exit at age 20 years, and remaining 60 per cent exit on their 21st birthday, with after care support provided to eligible exited young people up to age 25 years.
 - b. Scenario B: 100 per cent of young people exit on their 21st birthday with the same after care supports as for scenario A.
- 20.56 DoCS analysis included estimating the number of young people in each scenario, assuming it was not retrospective. If the policy allowed OOHC young people to remain in care (statutory and relative/kinship care) up to age 21 years in NSW, then the incremental costs would be as follows:
- a. policy scenario A: \$42 million per annum
 - b. policy scenario B: \$55 million per annum.
- 20.57 The trend in most jurisdictions, which this Inquiry supports as an alternative to extending the date for leaving care, is to start preparing young people for their change of status well before the transition occurs. If this preparation occurs while they are in care they should be given the life skills to manage greater independence for example, through the funding of driving lessons and through encouraging them to earn their own income through part time work. However, care needs to be taken that those in stable placements do not become destabilised by the process.

²³ ME Courtney, A Dworsky, and H Pollack, "When Should the State Cease Parenting? Evidence from the Midwest Study," *Chapin Hall Centre for Children*, Issue Brief 115, December 2007, p.8.

- 20.58 Morgan Disney's study on the transition from care provides information about the current alternative pathways for young people after they leave care and the comparative cost of these pathways to governments. The study aimed to:

establish the extent of potential savings if a proportion of young people were successfully diverted, through better support at the point of transition, to lower usage service pathways and to pathways, which are economically and socially more productive.²⁴

- 20.59 The study estimated that:

costs to government of this cohort²⁵ over the life course from age 16 to 60, is just over \$2 billion.....This is equivalent per annum to an estimated cost of approximately \$46 million for a cohort of 1150 persons and to an average estimated cost of approximately \$40,000 per person per annum.²⁶

- 20.60 This compares with the estimated costs of government services to 1,150 persons in the general population of approximately \$3.3 million, or an estimated \$3,000 per person per annum.²⁷

- 20.61 In the 16-24 year age group estimated costs are highest in family services. These costs are incurred mainly in the child protection system. There are also high costs in income support and housing support. In the 25-60 year age group, mental health is estimated as the highest cost service system, however income support and housing are also high cost services.²⁸

- 20.62 Morgan Disney's study concluded that:

there would be significant economic and social benefits if more young people leaving care were better supported in ways which reduced the likelihood of their progression into prolonged use of high cost services.....This raises the importance of transition services for young people and the role such services might play in supporting people into productive and supportive environments, before their life challenges are profoundly complex and entrenched.²⁹

²⁴ Morgan Disney and Associates and Applied Economics, *Transition from Care: Avoidable Costs to Governments of Alternative Pathways of Young People Exiting the Formal Child Protection Care System in Australia, Volume 1, Summary Report*, November 2006, p.8.

²⁵ The cohort refers to 1,150 young people who have been subject to a formal care order within the child protection legislative frameworks across all jurisdictions, post care and who leave care between the ages of 15 and 17 years.

²⁶ Morgan Disney and Associates and Applied Economics, 2006, op. cit., p.25.

²⁷ *ibid.*, p.26.

²⁸ *ibid.*, p.26.

²⁹ *ibid.*, p.10.

- 20.63 Bromfield and Osborn's summary of the Australian research and literature on leaving OOHC showed strong support in the literature for minimum leaving care standards, and an integrated model of leaving care support up to 25 years of age.³⁰ A Commonwealth OOHC Inquiry that reported in 2005 recommended the introduction of national standards for transition planning, particularly when leaving care, as a matter of priority.³¹ The same Inquiry in its earlier 2004 report commented unfavourably on the lack of a gradual and functional transition from dependence for care leavers.³²

Preparation for leaving statutory OOHC

- 20.64 The designated agency having supervisory responsibility for any person in care is required to prepare a plan, in consultation with him or her, before the time arrives to leave OOHC, and then to implement the plan.³³
- 20.65 The plan must include reasonable steps that will prepare that person and, if necessary, his or her parents, the authorised carer and others who are significant to him or her, for leaving care.³⁴
- 20.66 Most jurisdictions stipulate the development of a leaving care plan when the person in care reaches the age of 15 years. Current practice in NSW requires that planning commence at least 12 months before departure from care.
- 20.67 As a result of the MOU between DADHC and DoCS, however, DoCS is required to notify DADHC at least two years prior to expiration of a care order in any case where a person with a disability is likely to have significant support needs upon leaving statutory OOHC. DoCS and DADHC then commence joint casework and planning. DoCS maintains case management until expiry of the care order, after which DADHC assumes responsibility for the well-being and welfare of the care leaver as an adult.

Entitlements to support and financial assistance

- 20.68 The Minister is directed by the Care Act to provide or arrange such assistance for those above the age of 15 years who leave OOHC until they reach the age of 25 years, as the Minister considers necessary, having regard to their safety, welfare and well-being.³⁵ Such assistance may include:
- a. the provision of information about available resources and services

³⁰ L Bromfield and A Osborn, "'Getting the Big Picture': A Synopsis and Critique of Australian Out-of-Home Care Research". *Australian Institute of Family Studies, No 26, 2007*, p.22.

³¹ Australian Senate Community Affairs Committee, 2005, op. cit., p.110.

³² Australian Senate Community Affairs Committee Inquiry, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, 2004, p.124.

³³ *Children and Young Persons (Care and Protection) Act 1998* s.166(1) and (3).

³⁴ *Children and Young Persons (Care and Protection) Act 1998* s.166(2).

³⁵ *Children and Young Persons (Care and Protection) Act 1998* s.165(1).

- b. assistance based on an assessment of their needs, including financial assistance and assistance for obtaining accommodation, setting up house, education and training, finding employment, legal advice and accessing health services
- c. counselling and support.³⁶

- 20.69 Ministerial guidelines for the provision of assistance after leaving care were issued in May 2008. These guidelines now stipulate that all young people leaving care must have a leaving care plan. The guidelines state that whenever available young people should be assisted to access mainstream services. The purpose is to encourage them in their move towards independence. According to these guidelines specific provision of further assistance, including financial support, is to be based on assessment of need and is not an automatic entitlement. Financial assistance can be provided in the form of fortnightly after care payment and/ or one off payments and must be approved by the Regional Director. Further a time limited fortnightly payment up to a maximum \$200 may be paid by DoCS to assist a care leaver to secure accommodation where he or she is undertaking full time training or education and would be at risk of homelessness if such assistance was not provided.
- 20.70 The Minister has a discretion to provide or arrange appropriate assistance for OOHC leavers after they reach the age of 25 years.³⁷ The provision of assistance also extends to children and young persons who were in care but were subsequently adopted.
- 20.71 The expenditure by DoCS in relation to after care support and assistance for the year ended 30 June 2007 was approximately \$1.2 million for brokerage funds; for the last six months of that year just over \$200,000 was paid through allowances and contingencies.
- 20.72 In 2007/08, brokerage payments decreased slightly to just over \$1 million and allowances and contingencies were nearly \$700,000 for the full year.
- 20.73 The Inquiry understands that DoCS has had discussions with Education with a view to obtaining an TAFE fee exemption for care leavers. The Inquiry supports DoCS' attempt to achieve this exemption given the importance for care leavers to gain qualifications that will equip them to enter employment.

Access to records and personal information

- 20.74 On leaving, or after leaving OOHC, young people have an entitlement to have access, free of charge, to personal information directly relating to themselves, in any records held by the designated agency that had supervisory responsibility for them, or their authorised carer, or the Director-General where such person

³⁶ *Children and Young Persons (Care and Protection) Act 1998* s.165(2).

³⁷ *Children and Young Persons (Care and Protection) Act 1998* s.165(3).

was under the parental responsibility of the Minister and the Department was not the designated agency entrusted with their supervisory responsibility.³⁸

- 20.75 Such persons are also entitled to possession, free of charge, of the originals of documents held in a file of personal information by the designated agency, or authorised carer, or by the Director-General respectively, including their birth certificates, school reports, medical reports and personal photographs.³⁹
- 20.76 To facilitate this access, and in order to ensure the preservation of the records, designated agencies are required to keep the records of children and young persons placed with them for seven years after cessation of their responsibility for any such placement, and thereafter to deliver those records to the Director-General.⁴⁰
- 20.77 Additional provision is made in relation to the records concerning Aboriginal and Torres Strait Islander children and young persons, requiring the Director-General of each designated agency, that supervises the placement of such people in OOHC, to make a record of the date of their entry into OOHC, the period of time spent in such care, and the plan for leaving OOHC.⁴¹
- 20.78 The 1996 Cashmore and Paxman study noted that participants reported not being properly informed about their current situation, their history or their entitlements.⁴² A substantial minority of those in the study did not know that they could access their files or even that such files existed. Furthermore, when some members of this group did approach the Department to look at their files, they encountered various difficulties including delays associated with the need to find a suitable time when a worker could be with them, being asked to pay a fee (\$30 for an FOI request), and a lack of privacy in having someone else with them or controlling what they were allowed to see in the file.
- 20.79 DoCS informed the Inquiry that many care leavers choose to apply under FOI, particularly those represented by solicitors as:
- a. it is quick and statutory time limits apply
 - b. they obtain a photocopy of all releasable documents whereas when CSCs manage the release of information, they limit the number of pages they copy
 - c. there are clear appeal paths – Ombudsman, ADT and Supreme Court.

³⁸ *Children and Young Persons (Care and Protection) Act 1998* s.168.

³⁹ *Children and Young Persons (Care and Protection) Act 1998* s.169.

⁴⁰ *Children and Young Persons (Care and Protection) Act 1998* s.170.

⁴¹ *Children and Young Persons (Care and Protection) Act 1998* s.167.

⁴² J Cashmore and M Paxman, "Longitudinal Study of Wards Leaving Care," *Social Policy Research Centre, University of New South Wales*, 1996, p.142.

Issues arising for those leaving care

Planning for exit from care – casework practice

- 20.80 Of immediate concern is the question whether sufficient attention is given to the statutory requirement to prepare those in OOHC for independent living.
- 20.81 One of the key NGO providers of after care has advised the Inquiry of its experience, and of that of SAAP services within its umbrella, that those leaving care often seem to be unaware that they are entitled to after care support, that after care plans are often not well developed, that the provision of funds by DoCS for assistance is patchy at best, that care plans are commonly not implemented or are undermined by local CSCs, and that the compliance with DoCS administrative procedures can operate as a barrier to receiving assistance.
- 20.82 This would accord with information received from CREATE that, despite the requirements of the Care Act, those about to leave care do not seem to be sufficiently involved in the planning process.
- 20.83 Current casework practice does recognise the desirability of authorised carers playing an earlier role in preparing people for leaving care. In this respect it notes that caseworkers should discuss with carers the basic skills that young people need to develop towards achieving independence, and the means of imparting these skills to them. This is a matter addressed in the Ministerial guidelines which were published in 2008 and which now provide comprehensive guidance in relation to this topic, in place of the several practice and policy documents that previously existed.
- 20.84 CREATE, in its submission to the Inquiry identified, as a result of its annual reviews, the following areas as deserving of attention:
- a. the provision of departmental caseworkers who have time and resources for after care support, the delivery of which is not as readily provided by departmental caseworkers who often carry larger caseloads and lack the time and resources to engage effectively with young people after leaving care, than is the case with the NGOs
 - b. the provision of improved communication in casework with young people that informs them of their leaving care and after care entitlements and procedures for making a submission for assistance
 - c. the adoption of a consistent approach to leaving care and after care provisions across the State
 - d. an increase in the funding for after care to meet the rapidly increasing demand for after care support services and the increasing cost of living for young people

- e. the establishment of arrangements for priority access to all services (in particular health, dental and educational services) for young people leaving care
 - f. the development of leaving care plans for all young people 12 months prior to independence, even where they are not assigned a caseworker.
- 20.85 In a meeting with the Inquiry, CREATE also drew attention to the desirability of a systematic study of those leaving care. The Inquiry notes the two Cashmore and Paxman studies which have undertaken this form of analysis. It sees benefit in the continuation of longitudinal studies that can address outcomes and that would also seek to isolate those strategies that have and have not worked.
- 20.86 DoCS informed the Inquiry that it had agreed to be an industry partner in an Australian Research Council Linkage projects grant being submitted in the November 2008 round on a national evaluation of leaving care services. Most of the other state departments are also partners. This was initiated and approved through the Community and Disability Services Minister's Advisory Council and the outcome of the application will be known in June 2009. If approved it should be a source of valuable information that could lead to improvements in the support needed by care leavers, and in the planning for their exit from care.

Provision of support and assistance

- 20.87 Eligibility for after care assistance, beyond the provision of information as to available services and referral to those services, currently depends on the care leaver being assessed as at risk of not making a successful transition to independent living based on a number of indicators.
- 20.88 Under the current practice, however, there are several limitations upon the eligibility of care leavers to receive NSW Government funded assistance, and upon the extent of that assistance, including the age of the care leaver. Assistance is not an automatic entitlement and the process of seeking it and awaiting approval can be an occasion for frustration and possible disengagement.
- 20.89 A significant barrier identified by the Inquiry has been the likely difficulty experienced by those leaving care in negotiating their way through the available referral points for support and assistance, having regard to their multiplicity, and to the fact that, for some services, they will need to seek assistance from DoCS, while for others they may need to approach one or another of DADHC, Housing, Education, Health, FaHCSIA, Centrelink, a relevant NGO or after care service. The extent to which the NGOs and after care services can provide assistance also varies considerably between the metropolitan area, larger regional cities, and the more remote locations. Those living in rural and remote areas of the State, where NGOs for example have less of a presence, are at a potential disadvantage.

- 20.90 As noted earlier the funding for after care assistance is very limited. Although it is a laudable objective of DoCS to ensure that any financial support that is given will encourage a growing independence rather than the care leaver remaining in a continuing state of dependence,⁴³ the order of expenditure involved seems to border on the insignificant, given the number of care leavers aged 15-25 years who could benefit from assistance. While the Commonwealth Transition to Independent Living allowance (a one off payment of \$1,000) for the purchase of goods or services may supplement the DoCS allowance, it too is of limited value, and may not be known to some care leavers.
- 20.91 The Inquiry is satisfied that greater attention needs to be given to ensuring that care leavers are given adequate assistance and information concerning their entitlements to after care assistance from DoCS or via one or other of the several Commonwealth sources for benefits available to young people generally, and that sufficient funding be available to provide the assistance needed.

Safe housing

- 20.92 Secure safe housing for care leavers, is obviously important, and in this respect Housing is likely to be the most obvious first port of call.
- 20.93 The Supported Independent Living program provides an integrated accommodation and support program that is designed to assist the transition from care to independent living, through the provision of public or private rental accommodation, case management and support services for up to 24 months. The target group for this program comprises those within the 16-18 years age group at the time of entry into the program who, among other things, are in the parental responsibility of the Minister.
- 20.94 The 'lead tenant' programs, under which a volunteer tenant lives rent free with a household of young people and helps them develop independent living skills would also seem to be of value and to be consistent with other initiatives that would encourage the use of mentors to guide young people through the transition.
- 20.95 Another option is the shared access model for young people leaving care which is being trialled by Housing and DoCS in the Hunter area and is discussed in Chapter 7.
- 20.96 Worthy of further research is the 'foyer' model of combined accommodation, employment, education and support for disadvantaged young people leaving care, which was originally developed in France and has been adopted with some success in other jurisdictions, most particularly in the UK. The interim evaluation of the pilot model Live 'N' Learn Campus, that was established at the Miller Campus in Sydney in 2002, has been reported as providing support for

⁴³ DoCS, *Financial Support for Children and Young People in OOHC, Policies & Guidelines*, December 2006.

expansion of this model, in that it has helped to stop young people aged 16–25 years (including care leavers) dropping out of education and becoming homeless, and encourages their entry into employment.⁴⁴ Further development of this model was advocated by the National Youth Commission in its report on Youth Homelessness.⁴⁵

Interagency involvement

- 20.97 It is clear from the foregoing that given the varying needs of young people leaving care, an interagency approach is critical. Young people leaving care need priority access to affordable and stable housing, income support, assistance with the costs of education and further training, dental treatment, physical and mental health care, and general guidance towards achieving independence. No one agency is able to meet all these needs. This provides further support for the proposal elsewhere developed in this report to ensure, wherever practicable, the co-location of state agencies, and the compilation of a comprehensive local index of after care services and resources that is kept up to date and readily accessible.
- 20.98 The problems in this area will be compounded if there is limited amount of up to date information available to the staff of the individual agencies as to the type and range of services available. The tendency of some government agencies to wait for DoCS to become involved rather than offering their services also does not help.
- 20.99 In relation to the desirability of an integrated model, CREATE observed:
- The transition phase, where the impact of support services is maximum, requires more attention to its integration so that young people are informed appropriately of what support is available and how they might go about accessing it.*
- After-Care has been the most neglected area largely because it can be confusing where responsibility lies for maintaining the assistance. Is after-care support a right that should be available to all eligible young people and provided to those assessed as in need, or must the young people seek out particular services and actively ask for help? This question lies at the heart of how after-care support is managed.⁴⁶*
- 20.100 CREATE noted that a critical factor that needed to be addressed was ensuring that those who need a service after leaving care know the range of possibilities available and how they might be accessed.⁴⁷

⁴⁴ C Smyth and T Eardley, 2008, op. cit., pp.16-17.

⁴⁵ A Report of the National Youth Commission Inquiry into Youth Homelessness, *Australian Homeless Youth*, 2008, p.4.

⁴⁶ CREATE Foundation, "Report Card: Transitioning from Care," March 2008, p.49.

⁴⁷ *ibid.*, p.27.

- 20.101 This it saw as a major issue confronting care leavers that needed to be addressed by a number of mechanisms including information on the agency's website dealing with the topic along with the issue of hard copy pamphlets and leaving care kits.⁴⁸ The Inquiry agrees that attention needs to be given to this.

Follow up and monitoring

- 20.102 Practice guidelines call for follow up by the agency responsible for supervising the last placement of a care leaver, within three months of leaving care, and then at half yearly intervals for the next two years where that person wishes to have such follow up. The extent to which there is meaningful follow up, or any concerted effort to maintain contact is not known, although it is accepted that a number of young people who have left care do attend CSCs from time to time with requests for limited monetary assistance which are usually met. Casual crisis visits of this kind are however a poor substitute for a systematic approach to providing ongoing follow up.⁴⁹
- 20.103 The question of monitoring outcomes and ensuring appropriate follow up was also seen as important by CREATE. It noted:

*Monitoring of outcomes is the only way the effectiveness and efficiency of the programs can be determined. It is essential to determine (a) the adequacy of the initial Leaving Care Plan, (b) whether or not the necessary support is available, (c) if the necessary services are accessible to those who require them, (d) if the services are being delivered in appropriate ways, (e) if the services are meeting the needs of care leavers, and (f) what are the realistic costs of the services.*⁵⁰

- 20.104 It is CREATE's view that the outsourcing of OOHC functions make it important to establish guidelines for monitoring the authorised agencies and to develop key performance indicators to assess the support performance and outcomes of these agencies.⁵¹ The Inquiry agrees with this assessment and considers it important that there be effective follow up of care leavers, so far as that is possible, given the reluctance of some members of this group to cooperate and also given their mobility. At the least they should be given positive encouragement, through the availability of ongoing support to participate in a systematic follow up.

⁴⁸ *ibid.*, p.35.

⁴⁹ One agency which does provide a two to three year follow-up of some intensity is Youth off the Streets, although it is subject to the request or wishes of the young person leaving care. Phoenix Rising for Children also makes provision for extended formal and informal contact, and for supplying them with emergency contact details.

⁵⁰ CREATE Foundation, 2008, *op. cit.*, p.32.

⁵¹ *ibid.*, p.40.

People with disabilities leaving care

- 20.105 The Ombudsman concluded in his 2004 report, *Group Review of Young People with Disabilities Leaving Statutory Care*, that those within this group needed additional support to that currently provided.
- 20.106 The recommendations from this report were that DoCS should:
- a. take proactive steps to ensure that leaving care planning occurs in accordance with the Department's practice guidelines
 - b. provide clearer guidance to its caseworkers about the Department's expectations concerning the documentation of leaving care plans
 - c. consider the scope for, and potential benefit of, funded after care services providing intensive case management to young people with disabilities who require assistance to develop skills to live independently, or to be linked to appropriate support services.⁵²
- 20.107 In May 2006, DADHC's strategic plan, *Stronger Together*, was released which, *inter alia*, identified the need for new approaches for young people leaving care at the age of 18 years with a disability, as well as additional supports for those exiting the criminal justice system.
- 20.108 DADHC has advised the Inquiry that it now has four 'supported accommodation options' available for young people leaving care. In response to the Ombudsman's Report, DoCS advised that it had also developed an after care policy for this group, which was completed in May 2008. Each initiative is laudable.
- 20.109 The sufficiency of these arrangements to cater for young people with disabilities leaving care and their implementation will require ongoing monitoring.
- 20.110 This is an area where the potential involvement of the Guardianship Tribunal will need to be addressed, by either DoCS or DADHC, for those young people who will lack the capacity to make significant life decisions or to manage their financial affairs.

Access to records

- 20.111 The Inquiry also notes that approximately 300 applications are made each year by care leavers to access their departmental records, and that current practice requires such access to be had in the presence of a Senior Caseworker or intake officer, at a CSC who is able to respond to any questions or requests for support.

⁵² NSW Ombudsman, *Group Review of Young People with Disabilities Leaving Statutory Care*, December 2004.

- 20.112 In some instances this can be an exceedingly time consuming process, for example where there are multiple files or where the files contain materials about third parties to which access needs to be restricted because of the requirements of the *Privacy and Personal Information Protection Act 1998*.
- 20.113 The Inquiry notes the suggestion made by DoCS that resources be made available and funding provided to allow the preparation of records for release to be undertaken centrally, followed by delivery of the records to the applicant by a member of a specialist leaving care team. It has indicated that this could lead to an improvement in response times and service levels.
- 20.114 The Inquiry supports DoCS examining more effective and efficient ways to undertake this function.

Potential savings

- 20.115 The provision of more effective services and preparations for leaving care, and of additional support upon leaving care could result in considerable economic savings as well as better outcomes. CREATE in its 2008 Report Card noted a Victorian study in 2006 which attempted to measure the total cost of leaving care in Victoria by matching the life outcomes of care leavers with their peers in the general population (on factors such as child protection, GST revenue loss, health, drug and alcohol abuse, policing, justice, corrections and housing). The differences in the lifetime cost to the state for each person leaving care was found to be \$738,741, of which 55 per cent was attributable to policing and justice.⁵³
- 20.116 In 2004, the Senate Community Affairs Reference Committee noted that:
- As adults, care leavers face relationship problems; drug and alcohol abuse; loss of educational and work opportunities; long term physical and mental health problems; and antisocial and criminal behaviour. This is a significant cost to the individual and a massive long-term social and economic cost for society which may be compounded when badly harmed adults in turn create another generation of harmed children.*⁵⁴
- 20.117 The Inquiry is unaware of any similar cost benefit analysis having been made in NSW but it would be surprising if comparable savings were not identified. Even if that were not so, any improvement in the lives of a group whose members have been removed from their families by the state can only be regarded as a worthwhile objective.

⁵³ CREATE Foundation, 2008, op. cit., p.18; C Forbes, B Inder and S Raman, "Measuring the cost of leaving care in Victoria," *Monash University*, 2006; and see also the estimate of the lifetime cost to Government of those leaving care attributable to their poorer outcomes on all life trajectories by Morgan Disney and Associates and Applied Economics, 2006, op. cit., p.10.

⁵⁴ Australian Senate Community Affairs Committee, 2004, op. cit., p.166.

Homelessness of young people

- 20.118 The incidence of homelessness of young people is of concern. The inadequacy of the existing systems to deal with this problem, and the lack of refuges and safe alternative accommodation for this group was a theme which was repeated in Public Forums across the State, as well as in the Sydney Public Forums and the submissions.

Issues arising

Reporting homelessness

- 20.119 The Care Act makes provision for the reporting to the Director-General of children who are homeless⁵⁵ and, subject to their consent, of young persons (that is 16-17 year olds) who are homeless.⁵⁶ A person who provides residential accommodation for a child who, he or she suspects is living away from home without parental permission, must make a report.⁵⁷
- 20.120 There is an obligation to conduct such investigation and assessment concerning the person who is the subject of such a report as the Director-General considers necessary.⁵⁸
- 20.121 The Department may provide or facilitate the provision of accommodation, in the exercise of its statutory power to provide assistance, but it is under no compulsion to do so unless the subject of the report is already in care.
- 20.122 The Inquiry's attention was brought to the fact that homelessness is not expressly included in the list of circumstances that can be taken into account in determining whether a child or young person is "at risk of harm."⁵⁹ This, it was suggested, may have been one of the factors behind the response, which was said to be sometimes encountered in individual cases, that "homelessness is not a child protection issue," or that "it is not an issue that DoCS can deal with."⁶⁰
- 20.123 While the Inquiry acknowledges that homelessness is not included as an 'at risk' circumstance in its own right, it would seem to be encompassed as a fact falling within the general criteria applicable where the 'basic physical or psychological needs' of the child or young person are 'not being met or at risk of not being met.' As such the Inquiry does not consider legislative amendment to be necessary. It does however emphasise that casework practice should

⁵⁵ *Children and Young Persons (Care and Protection) Act 1998* ss.120 and 122.

⁵⁶ *Children and Young Persons (Care and Protection) Act 1998* s.121.

⁵⁷ *Children and Young Persons (Care and Protection) Act 1998* s.122.

⁵⁸ *Children and Young Persons (Care and Protection) Act 1998* s.120.

⁵⁹ Within the meaning of the *Children and Young Persons (Care and Protection) Act 1998* s.23.

⁶⁰ Submission: Homeless Persons Information Centre, p.2.

recognise the significance of homelessness as a risk factor, that needs to be taken into account and addressed by DoCS. Other agencies, including Health, Attorney General's and Housing should additionally ensure that mental health and domestic violence services, together with crime prevention activities, are available to address and support the underlying factors associated with youth homelessness.

Use of SAAP services

- 20.124 As has been observed, where a child or young person is one for whom the Minister has sole parental responsibility or parental responsibility in relation to residence, then a statutory responsibility requires the Minister to provide that person with accommodation.⁶¹
- 20.125 Of importance in this area are SAAP services (see Chapter 17). An issue has arisen in the past as to whether the responsibility for administering SAAP should fall within the Housing portfolio which maintains the Homelessness Unit, rather than remain a DoCS responsibility. It is understood that NSW, Western Australia and the Northern Territory child protection agencies have this responsibility. In addition in Victoria and South Australia, SAAP lies in a Department of Human Services which includes both the child protection agency and housing responsibility. Although this was not a matter addressed to any extent in the submissions, a transfer of Ministerial responsibility would seem to run the risk of moving the primary focus of SAAP funding towards the provision of accommodation, at the expense of its associated role in delivering allied support services for the most disadvantaged members of the community who depend on SAAP services, including families with children and young persons at potential risk, a significant proportion of whom become involved with DoCS.
- 20.126 The Inquiry does not consider that there is, at present, a sufficient case for the SAAP responsibility to be transferred to Housing, although it recognises the potential importance of this issue, and the extent to which such a transfer would depend upon comprehensive interagency cooperation, not only between DoCS and Housing, but with all other human service agencies as part of an effective early intervention strategy.
- 20.127 More pressing issues are the appropriateness of the use of SAAP services for young people in care and the sufficiency of SAAP services to meet the demand.
- 20.128 In his Report, *Assisting Homeless People: The need to improve their access to accommodation and support services*, the Ombudsman noted that, of the total number of SAAP clients who were provided with support periods during 2001/02, 34.6 per cent were aged under 25 years and that 44.7 per cent of the

⁶¹ *Children and Young Persons (Care and Protection) Act 1998* s.164.

services that were funded targeted young people.⁶² The Ombudsman observed:

We acknowledge that there are gaps and inadequacies in other service systems, such as drug and alcohol detoxification and rehabilitation services and community-based mental health services. We accept that it is not the core business of SAAP to provide primary health services to people who are acutely ill and who require health, mental health or drug and alcohol services in the first instance. It is also not SAAP core business to provide disability accommodation for those people with disabilities who require specialised assistance as a result of their disability.

*However, it is not sufficient for SAAP to consider every person within these groups to be outside its responsibility. It is the role of SAAP, in conjunction with other service systems, to cater to a diversity of individuals who are homeless, including people with mental illness, disabilities and/or substance abuse issues.*⁶³

- 20.129 This is an assessment with which the Inquiry agrees. It has considerable significance for those who are at risk but not subject to the parental responsibility of the Minister, and also for those who are transitioning from care.
- 20.130 In response to the report some of those concerns were addressed. The Ombudsman, however, has advised, as a result of its further work and feedback, that more is needed to improve the links between SAAP services and those provided by other agencies, for example, in relation to substance abuse and health issues. This Inquiry confirms that its own investigations support this conclusion.
- 20.131 The Ombudsman has, since the inquiries mentioned, conducted a review of the situation of children under the parental responsibility of the Minister who are placed in SAAP services.⁶⁴
- 20.132 The Ombudsman noted that while DoCS had undertaken in 2004 to clarify policy and practices in this area and to develop protocols between DoCS and youth SAAP services, both in relation to children and young people in SAAP where there is no parental involvement and no court order, and in relation to those where there is a court order in relation to parental responsibility, the draft policy which it had released in 2006 was still under review.

⁶² NSW Ombudsman, *Assisting Homeless People: The need to improve their access to accommodation and support services, Final Report arising from an Inquiry into access to, and exiting from, the Supported Accommodation Assistance Program*, May 2004.

⁶³ *ibid.*, p.12.

⁶⁴ NSW Ombudsman, *Children under the parental responsibility of the Minister who are placed in SAAP services and aged 15 years or under, Final Group Review Report*, February 2008.

- 20.133 The Ombudsman's inquiry was confined to a relatively small group of children in SAAP services, some of whom were in crisis accommodation, but others of whom were in long term SAAP accommodation as part of a departmental case plan.
- 20.134 Some of the problems identified in relation to the use of SAAP services, at least on a long term basis, include the fact that these services are exempt from the statutory provisions concerning the provision of regulation of OOHC,⁶⁵ are not accredited by the Children's Guardian and are not subject to the standards required for the provision of OOHC.
- 20.135 The SAAP system is clearly not a care system; it has a lower level of funding and staff supervision than that required for those who should be subject to a properly established placement within the OOHC system. Whatever else it might be, it is not appropriate as a long term accommodation solution for young people in care. Rather its proper role in this context is a transitional or crisis response service *inter alia* for young people. It should, in the view of the Inquiry, be funded on that basis leaving the primary responsibility for providing permanency and support in OOHC for this group with DoCS or with authorised OOHC agencies.
- 20.136 In this regard DoCS has itself acknowledged that SAAP services are not equipped to meet the long terms needs of children and young persons, particularly those in statutory care, although they are capable of providing crisis support. It noted that its policy review would take into account the opportunities that may exist for closer alignment with the policies of the other states that could support good practice. It also noted that the current expression of interest process for the provision of OOHC services statewide was expected to reduce the need for DoCS to rely on SAAP services.

Recommendations

Recommendation 20.1

DoCS should train and appoint to each DoCS Region, specialist caseworkers to assist in the case management of young people.

Recommendation 20.2

DoCS should fund a training package to assist foster carers and kinship and relative carers in preparing young people for leaving care.

⁶⁵ Clause 17 of the *Children and Young Persons (Care and Protection) Regulation 2000* lists SAAP arrangements as one of the exceptions to OOHC falling within the *Children and Young Persons (Care and Protection) Act 1998* s.135(2).

Recommendation 20.3

DoCS should fund the provision of detailed information to care leavers as to the assistance which is available to them through State and Commonwealth sources after they leave care, and as to the means by which they can access that assistance.

21 Children and young persons and parents with disabilities

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Children and young persons with disabilities

- 21.1 Children and young persons with a disability are particularly vulnerable and at increased risk of harm, abuse or neglect.⁶⁶ Issues of social exclusion, additional care stresses or interrupted bonding within families, bullying by peers and communication difficulties can create added risks for them. Socio-economic factors such as limited income, social isolation, poor carer health and parental concerns about the impact of the disability on other siblings, can tax family resources, time and skills.
- 21.2 As in cases involving children without disabilities, the majority of those who have abused or neglected children and young persons within this group tend to be family members. Children and young persons with a disability are also at greater risk of abuse by others outside the home.⁶⁷ These children and young persons are often involved in multiple care contexts, and they may have difficulty in getting away from abusers or in acquiring protective behaviours or in understanding or recognising potential risk situations. They can lack oral and written communication skills and they may be unable to communicate when abuse is occurring.
- 21.3 A child's medical condition or disability can 'overshadow' specific child protection risks as part of the assessment of allegations. For example, particular behaviours may be interpreted as related to the child's impairment and not as indicators of forms of abuse or neglect. Evidence in the UK found a child's lack of communication and/or cognitive impairment was often cited as the reason for failing to proceed with an investigation. Other difficulties cited were:⁶⁸
- a. problems in identifying the perpetrator of abuse or risk of harm where children were exposed to multiple carers
 - b. a greater reliance on medical reports and advice rather than on the perspectives of people in frequent contact with a child (such as teachers, support providers and foster carers providing respite)
 - c. allegations being treated as 'one-off incidents', without understanding the ongoing vulnerabilities and risks for children and young persons with a disability
 - d. assumptions being made about a parent's quality of care, particularly where forms of neglect were less visible, resulting in some children being left in abusive family relationships.

⁶⁶ L Chenoworth, "Children with Disabilities: What evidence do we have for better practice?" Paper presented to the Association of Children's Welfare Agencies Conference, 2000, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.8.

⁶⁷ R Sobsey, "Violence in the lives of people with disabilities: the end of silent acceptance?" *Brooks Baltimore*, 1999, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.9.

⁶⁸ National Society for the Prevention of Cruelty to Children "It doesn't happen to disabled children," 2003 and "Child protection and disabled children, Report of the National Working Group on Child Protection and Disability, London, cited in Submission: Department of Ageing, Disability and Home Care, February 2008, p.9.

- 21.4 Given the particular difficulties facing children and young persons with disabilities, it is unfortunate that DoCS is unable to provide data on the number of those with a disability who are in care and known to DoCS.
- 21.5 The capacity to collect data of that kind is available in KiDS, however DoCS notes that when reporters make a call to the Helpline they may not be aware of the disability, or may not be confident to make that assessment. Notwithstanding, the KiDS data that is available shows that for 2006/07, 4.6 per cent of reports contained disability data, and that 8.2 per cent of records of children and young persons in OOHC, at 30 June 2007 contained disability data.
- 21.6 DoCS advises that the AIHW undertook a pilot collection of disability data earlier this year. All jurisdictions involved in that exercise had similar concerns with regard to the quality of the data. DoCS has also advised that improving the disability database and making the necessary changes to KiDS would involve costs for which budget provision has not been made.
- 21.7 DADHC informed the Inquiry that its services made 252 mandatory reports in 2006/07, over double the number it made in the previous year (112). It was unable to inform the Inquiry of the primary issue reported or the outcome of the report without accessing individual files. It undertook that task for the Inquiry in relation to the number of reports made as a result of a child or young person not leaving respite. The data provided is not at all clear, but it appears that 37 children and young persons were involved, the majority of whom were reported when they did not exit respite and their parents remained involved.
- 21.8 According to a 2008 independent evaluation of the MOU between DoCS and DADHC on Children and Young Persons with a Disability 2003, there were an estimated 481 children and young persons who came within its scope in 2006/07. The three principal groups comprised 155 young persons with a disability leaving OOHC, 161 children and young persons the subject of 224 reports made by DADHC to DoCS, and 165 referrals to DADHC from DoCS for services.⁶⁹ Just under one third of the cases where DADHC made a report to DoCS resulted in DoCS assessing the child or young person to be in need of care and protection.⁷⁰
- 21.9 The evaluation report identified that the inability to source comprehensive data on joint cases means that effective monitoring of the MOU is problematic.⁷¹ The Inquiry supports the recommendation of the evaluation report that a data management system in both agencies be developed and implemented so that joint clients are identified. DoCS has informed the Inquiry that such a system will require extensive changes to KiDS as well as operational changes to collect better information earlier.

⁶⁹ *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability*, 1 September 2008, pp.13-15.

⁷⁰ *ibid.*, p.25.

⁷¹ *ibid.*, p.15.

- 21.10 The actual numbers of children and young persons within this grouping, who need assistance and may not be receiving it, is a matter of considerable concern. Their needs and particularly their health needs can be exceedingly complex, and they can substantially affect their quality of life as well as that of their parents and siblings. Moreover their difficulties and the stress on their families is only likely to increase as they grow older.
- 21.11 In terms of the projected incidence of disability, at the Public Forum on Health and Disability, Dr Matthews from Health cautioned that:

We need to acknowledge and respond to the fact that disability is a rapidly changing world. The traditional model was around intellectual disability syndromes, such as Down's. We now have a very large and growing cohort of children with very significant and complex needs, who are surviving, who previously may not have survived. Ventilator-dependent neonates were unknown in recent memory, and we are now in the position of placing and supporting them to live at home with their parents. We now test at birth for over 30 genetic conditions, as we've said in our submission. Because of the expert interventions of some of the people sitting at this table, we have this increasing cohort of children like the one we're talking about, with extremely complex needs, to which I think we all have to acknowledge we have a responsibility collectively to respond. In fairness to us and Government, the size, the volume and the complexity of the problem has caught people a little bit by surprise, and I think it is fair to say that we all need to respond to it.⁷²

- 21.12 Similarly, the submission received from the Public Schools Principals Forum stated that:

More children are enrolling in schools with undiagnosed or unidentified disabilities and have missed the opportunities provided by early intervention services, support groups and specialised pre schools.⁷³

Parents with disabilities

- 21.13 The Inquiry was informed that the precise number of parents with intellectual disability in Australia is unknown. However, it has been variously estimated that parents with intellectual disability constitute less than one per cent of the general population of parents, that one to two per cent of Australian families with children and young persons aged 0-17 years include at least one parent with a

⁷² Transcript: Public Forum, Health and Disability, 11 April 2008, pp.46-49.

⁷³ Submission: Public Schools Principals Forum, 15 January 2008, p.18.

learning difficulty (that is, those with a diagnosed or self-identified intellectual disability) and that around 40,000 Australian children under five years have a parent with a learning difficulty.

- 21.14 Despite representing a modest number of all parents, parents with intellectual disability are significantly involved in the NSW care and protection system. Disability “is constructed as a risk factor for abuse and neglect rather than as an indicator of possible support needs.”⁷⁴ It is more likely that parents with disability will have at least one child, if not more, removed early in life, and approximately one in six children and young persons in OOHc will have a parent who has a disability.⁷⁵ However, evidence provided to the NSW Legislative Council Inquiry into Disability Services and to this Inquiry demonstrates that when family support programs are provided to parents with a disability the outcomes for their children are not significantly different from those for other children.⁷⁶
- 21.15 One study found that parents with intellectual disability are over represented in the NSW Children's Court's care jurisdiction and have their children removed by order of that Court at a higher rate than children of parents without an intellectual disability. This study found that 8.8 per cent of all cases initiated by DoCS involved parents with intellectual disability. Moreover, of all of the care applications filed by DoCS in this study, a disproportionately large number of children and young persons of parents with intellectual disability were removed from the care of their parents.⁷⁷

Issues arising

- 21.16 From the information provided to the Inquiry, it seems that not all children and young persons who may be at risk of harm because of their, or their parent's, disability are well served by the current system.

‘Passing the buck’

- 21.17 The Inquiry was informed repeatedly of issues between DoCS and DADHC regarding responsibility for relevant aspects of service provision. For example a Regional Director with DADHC stated that:

⁷⁴ Legislative Council Standing Committee on Social Issues, *Care and Support – Final Report on Child Protection Services*, December 2002, p.145; Legislative Council Standing Committee on Social Issues, *Making it Happen: Final Report on Disability Services*, November 2002, p.128; cited in Submission: People with Disability, p.4.

⁷⁵ Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.126; cited in Submission: People with Disability, p.4.

⁷⁶ Legislative Council Standing Committee on Social Issues, December 2002, op. cit., p.147; Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.126; cited in Submission: People with Disability, p.5.

⁷⁷ D McConnell, G Llewellyn and L Ferronato, “Parents with a Disability and the NSW Children's Court,” 2000, cited in Submission: Intellectual Disability Rights Services, 5 March 2008, p.3.

I think sometimes there's tensions around Is this a child protection matter? Is this a parent protection matter? Is this really about disabilities? Is this about an uncontrolled person who needs to be before the court?⁷⁸

21.18 An area of contention is:

whether child protection concerns co-exist with disability issues and assessment of whether any diminished parental capacity pre-existed or is a result of parental stress directly arising from the child's disability. Several cases that have required escalation have involved divergent views about this issue.⁷⁹

21.19 Submissions and representations to the Inquiry identified that there has been a lack of sufficient knowledge or understanding by DADHC caseworkers when assessing child protection risk issues; and a similar deficiency in understanding by DoCS caseworkers of the effects of disabilities.

21.20 It is not the case that there has been an absence of guidelines or protocols to direct caseworkers when dealing with children and young persons at risk because of their or their parent's disability. A key objective of the MOU is to assist staff of both departments to engage in a collaborative approach to assessment, planning and service delivery in relation to children and young persons with a disability and their families. The implementation of the MOU is through regional protocols which address specific communication processes at a local level and includes joint training initiatives.

21.21 Clause 5.4 of the MOU outlines the mechanism whereby issues that cannot be addressed at the regional level are escalated:

Where issues of funding and casework responsibilities cannot be resolved at a regional level within four weeks of the initial communication between the agencies, these cases are to be referred for determination by the Directors-General. No child or young person is to be left without adequate support while interagency issues are being resolved under this clause.

21.22 The MOU specifically identifies that DoCS is required to address risk of harm reports made by DADHC:

DoCS will respond to a risk of harm report made by DADHC in relation to a child/young person with a disability. DoCS will implement a process to identify DADHC referrals to the Helpline and ensure that (a) an appropriate response occurs and (b) that, where circumstances permit, DoCS will make prior contact

⁷⁸ Transcript: Interagency meeting, Dubbo, 3 March 2008, p.38.

⁷⁹ Submission: DoCS, Health and Disability, p.14.

*with nominated DADHC staff before the response occurs, so as to minimise the risk of placement breakdown.*⁸⁰

- 21.23 The MOU provides that if a need for statutory intervention arises from the child's or young person's exposure to risk of harm, then DoCS will provide all supports other than those directly related to the child's or young person's disability. Supports related to the child's or young person's disability will be provided by DADHC. The exception to this is where a child or young person cannot continue to live at home and the disability is so significant that relative or foster care placements are not a viable option.⁸¹ In such cases DADHC will provide all supports, including placement, other than those associated with the legal status of the child or young person.
- 21.24 A key part of the MOU with DADHC involves planning for young persons with a disability who are likely to have significant support needs upon leaving OOHC. Under the MOU joint agency case planning for those within this group is required to start at least two years prior to leaving care.⁸²
- 21.25 The purpose of the 2008 independent evaluation of the MOU was to assess the extent to which agency roles and responsibilities were sufficiently clarified, and whether the arrangements supported collaborative approaches to the provision of care, protection and support for children and young persons with a disability. Most staff reported that they had good working relationships with local colleagues and that the understanding of their different roles had improved since the MOU commenced. However, the evaluation found that only 55 per cent of DoCS staff and 42 per cent of DADHC staff think that the agreement about key definitions in the MOU is now good or excellent.
- 21.26 Three key issues were identified as part of the evaluation. First, it was said that DoCS and DADHC have different definitions or interpretations of when a child or young person is abandoned, when it is possible or not possible to place a child or young person with high needs in foster care, and whether circumstances of concern are due to a child's disability or due to a matter giving rise to child protection concerns. Secondly, it was said that insufficient emphasis on joint assessment and planning is given in the MOU. Finally, it was said that the MOU precipitates a focus on who pays for the support for a family too early in the assessment of needs process.⁸³
- 21.27 As to the first of these issues, staff of both agencies provided examples of a case where a child or young person was residing temporarily in a respite service or other facility, in circumstances where the parents were still the legal guardians and wished to continue to be the decision makers for the child, yet

⁸⁰ Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on *Children and Young Persons with a Disability 2003*, Clause 4.1.2

⁸¹ *ibid.*, Clause 4.2.8.

⁸² *ibid.*, Clause 5.5.

⁸³ *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability*, 1 September 2008, p.39.

indicated that it was no longer possible for them to care for the child or young person in the family home.⁸⁴

- 21.28 The DoCS view is that a case of this kind does not constitute abandonment because the child is not at immediate risk, partly because the child is in some form of care. It suggested additionally that a court is unlikely to make an order for care and protection where the parents continue to be responsible for the child.
- 21.29 DADHC, however, believes that what has occurred in such a case does constitute abandonment. Further, DADHC staff were concerned that a child or young person may be deemed 'not fosterable,' due to a lack of available foster carers who have the necessary skills to provide the high level of care required.⁸⁵
- 21.30 The evaluation also found that the extent to which structures and protocols have been developed and communicated in both agencies to support the MOU has varied and that the process is not complete, noting that:⁸⁶
- a. the metropolitan protocol is the most substantially developed
 - b. reviews of protocols have been inconsistent
 - c. 45 per cent of DADHC staff and 25 per cent of DoCS staff have read the MOU and know it well, while 35 per cent of DADHC staff and 58 per cent of DoCS staff have read it once or twice and 17 per cent of staff in both agencies know about it but have never seen it or read it⁸⁷
 - d. DoCS staff perceive that the MOU and protocols provide greater clarity than DADHC staff
 - e. staff of both agencies agree that the MOU provides effective guidance in managing cases where a child is assessed to be at risk of harm
 - f. only around half of DADHC staff feel the MOU provides clear guidance in circumstances where:
 - i. a family may be withdrawing or relinquishing care of a child or young person with a disability
 - ii. foster care is deemed to be not viable
 - iii. in response to a report of risk of harm, the DoCS assessment is that there is not a risk of harm
 - iv. DoCS determines that the issues for the family arises from the child's or young person's disability rather than a child protection issue⁸⁸
 - g. local level meetings only occur formally in parts of the State, and otherwise occur on an 'as needs' basis.

⁸⁴ *ibid.*, p.19.

⁸⁵ *ibid.*

⁸⁶ *ibid.*, p.20.

⁸⁷ *ibid.*, p.17.

⁸⁸ *ibid.*, p.20.

- h. only seven cases have been escalated to the Steering Committee for resolution over the last two years.⁸⁹
- 21.31 The MOU provides for the establishment of a steering committee comprising relevant senior Head Office executives of both agencies. A number of issues have been raised, considered and resolved at this level but, according to the evaluation, the relevant actions have not been recorded.⁹⁰
- 21.32 The design and implementation of the Leaving Care Program has been a major focus of this group and has reportedly been effective. As part of the evaluation however a number of cases were reviewed to determine whether young persons exiting care had been notified to DADHC two years prior, as required by the MOU. Seventy-six per cent (31) of cases nominated by DoCS indicated that notification was timely compared with 40 per cent (23) of cases nominated by DADHC.⁹¹ It is of concern that joint training has not occurred in the last two years in any of the regions,⁹² nor has joint work occurred in any of the regions on joint recruitment and training of foster carers.⁹³
- 21.33 The cases reviewed as part of the evaluation indicated that joint processes for case management have generally been followed for only about three quarters of the cases.
- 21.34 Most staff in both agencies (DADHC 77 per cent and DoCS 80 per cent) reported that they knew who to contact when there was a need to escalate a contentious case that required more senior legal advice.⁹⁴ However only around half (DADHC 40 per cent and DoCS 60 per cent) thought that ambiguous or contentious cases were able to be satisfactorily resolved.⁹⁵
- 21.35 Overall there was mixed evidence that implementation of the MOU had resulted in organisational changes to practice and increased understanding that can lead to better care and protection work and disability support, for children and young persons with a disability.
- 21.36 The evaluation report recommended that the MOU be clarified in a number of ways including the operational definitions for the kinds of matter set out earlier, the approach to joint assessment and planning, governance matters and early intervention initiatives. A joint approach to staff training and recruitment and training of foster carers was also recommended. DADHC has advised the Inquiry that it and DoCS have accepted all of the recommendations of the report and have commenced implementation of the agreed joint action plan.

⁸⁹ Although it has been suggested by DoCS subsequently that this is an under-estimation.

⁹⁰ *Evaluation of the Memorandum of Understanding between DoCS and Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability*, 1 September 2008, p.22.

⁹¹ *ibid.*, p.22.

⁹² *ibid.*, pp.22-23.

⁹³ *ibid.*

⁹⁴ *ibid.*, p.25.

⁹⁵ *ibid.*

- 21.37 The Inquiry was informed that, while previously meetings between the two agencies had been irregular, meetings between senior officers have been convened, in more recent times, approximately quarterly, to identify trends, to assess data and resolve any issues identified through 'contentious cases'. While this is a positive development it clearly needs to be sustained if the two agencies are to work cooperatively together in implementation of the MOU.
- 21.38 The Inquiry, while supporting the actions identified in response to this evaluation by both agencies, still has significant concerns about children and young persons with disabilities, and their families, not receiving adequate support services which could address the kinds of issues which if left unaddressed could escalate to the point where the risk level was such as to require entry into the child protection system. Similar concerns relate to the entry of children into that system by reason of the unaddressed intellectual disability of their parents. Early and effective intervention in these cases that left the child or young person properly supported at home would be far preferable to their removal into OOHC.
- 21.39 The Inquiry received a number of submissions and information which support many of the findings of the evaluation.
- 21.40 A non-government agency that works with both DoCS and DADHC informed the Inquiry:

...there seems to be at times quite a lot of toing-and-froing, confusion, perhaps disagreement between the two agencies as to who is actually responsible for this particular child. There is a tendency by DoCS with any child that has a disability to just want to move that responsibility across to DADHC when it is not necessarily appropriate.⁹⁶

- 21.41 Another NGO stated that:

We currently have a client who is under 12 years of age with high support needs who is in blocked respite and cannot return home because his safety would be at risk. Our advocate reports that DoCS and DADHC are each refusing to accept responsibility for finding an out of home placement. DoCS say DADHC is responsible and vice versa.⁹⁷

- 21.42 From a carer's perspective:

I am the carer of five children with disabilities and that memo is still a mystery to me. Nobody at DADHC or DoCS seems to be able to explain it to me. I would like more information about it. I

⁹⁶ Transcript: Public Forum, Wollongong, 14 May 2008, pp.9-10.

⁹⁷ Submission: Multicultural Disability Advocacy Association, 4 March 2008, p.26.

*don't think I am the only carer of a child with a disability who is in that boat.*⁹⁸

21.43 A DoCS worker from a CSC in the Northern Region advised the Inquiry that:

*It just seems that the memorandums of understanding, although we have them, that trying to initiate a service to a child who clearly has high disability needs is very protracted and very difficult and actually stops a child getting the service that it is clear that they require.*⁹⁹

21.44 However, not all workers agreed that the MOU was problematic. A DoCS Regional Director stated that the MOU between DoCS and DADHC:

.... has been particularly strong. It was borne out of a group of eight kids. About two or so years ago both agencies were really struggling as to roles and responsibilities for those eight kids, very complex kids, so we used those kids as a bit of a platform to work through a set of issues and to resolve the issues for those kids, which were incredibly well resolved, and to build on that relationship for other kids.

*So there have been a couple of instances now where we have avoided bringing children into out-of-home care because they [DADHC] have come to the party with a family choices package. Otherwise we had no option but to get long-term orders for those kids and to have found alternative long-term carers, so there has been some incredibly good outcomes from that perspective.*¹⁰⁰

21.45 The issue for many was one of inconsistency, as advised by People with Disability Australia Incorporated:

*there are great policies in place and memoranda of understanding, et cetera, but what we find as an advocacy organisation working with children with disability and their familiesis that there is an inconsistency in how policies are applied; sometimes, ignorance across the regions around policies and what they actually mean.*¹⁰¹

Case Study 24

In an investigation into the death of a child, the Ombudsman noted that both the MOU between DoCS and DADHC and the Interagency Guidelines

⁹⁸ Transcript: Public Forum, Lismore, 27 March 2008, p.18.

⁹⁹ Transcript: Inquiry meeting with DoCS staff Northern Region, p.52.

¹⁰⁰ Transcript: Interagency meeting, Ballina, 26 March 2008, pp.20-21.

¹⁰¹ Transcript: Public Forum, Health and Disability, 11 April 2008, p.44.

are clear regarding case management responsibilities for children with disabilities who are reported to DoCS. However, in his preliminary observations and findings the Ombudsman stated:

Although concerns for the ... children's safety and welfare had been identified by both DADHC and [another agency], and the need for a collaborative interagency response to these concerns had been identified by both agencies, in DoCS absence, neither agency pursued such a course. On the contrary, after discussing the need for interagency collaboration to address A's situation, DADHC closed its file for A knowing that DoCS had not allocated her case for risk assessment.

In relation to A's non-attendance at the special school that was arranged for her, the Ombudsman stated:

In our view, the reported arrangement between the school and DADHC effectively abrogated DADHC's responsibility to provide the child with a case management service when this service was demonstrably required.

DADHC made a risk of harm report to DoCS about A however DoCS closed the report without further assessment a month or so later. When DADHC was advised that the report would not be allocated, DADHC advised that they would request a combined meeting between [another agency] DADHC and DoCS, however "DADHC did nothing to pursue this option."

DADHC later closed the matter. The Ombudsman was critical that:

the department closed the matter when it had case management responsibility....DADHC's failure to meet its responsibilities to A was unreasonable.¹⁰²

In response to the Ombudsman's preliminary observations, DADHC identified deficiencies in its documentation and supervision in this case.

21.46 The Ombudsman has taken an interest in this area for some time. Following a critical 2004 report focusing on DADHC support for families at risk of giving up the care of their child, DADHC made changes to its policies and practices. The Ombudsman revisited the issue in 2006 and concluded as follows:

- a. there has been progress in relation to the issues of collaboration between DoCS and DADHC concerning children with a disability who are at risk of being placed in care but significant work is yet to be completed

¹⁰² NSW Ombudsman, *Investigation into the Death of a Child, Provisional Statement*, 2008, pp.119-130.

- b. DADHC has implemented a range of training programs to improve the understanding of working with young children and their families and in responding to risk of harm but all staff should complete relevant training and the training should be evaluated
- c. more needs to be done in the area of collaboration between DoCS and DADHC, for example, in individual planning for children and young persons when the MOU is invoked
- d. more needs to be done to build on existing initiatives to improve coordination between DADHC and Health, local area health services and Education.
- e. DADHC needs to ensure that it has a policy and implementation strategy for individual planning for children living at home and supported by services. This is important for identifying what supports a child and their family need and for making it clear who is responsible for providing that support
- f. more needs to be done to ensure that appropriate long term placements are available for children with disabilities entering care on a permanent basis
- g. DADHC needs to clarify for the community when, and how, its intensive family support services would be available, and to evaluate the effectiveness of the new services.
- h. services provided by DADHC should receive the same level of monitoring as that required for services funded by DoCS. While this is planned for the future, currently there are no such monitoring arrangements
- i. it is not clear how DoCS and DADHC are collaborating to use existing mainstream foster care services.

21.47 Whilst acknowledging the progress DADHC had made since its first review in 2004, the Ombudsman concluded that:

We know through our ongoing work that considerable work still needs to be done. Children and young persons continue to be left in respite beds for extended periods because they cannot go home and there is no alternative care for them. The development of suitable arrangements for children with very complex medical issues remains a priority. For very young children and adolescents with complex behavioural problems—for example with autism—the adequacy of current supports remains a concern.¹⁰³

¹⁰³ NSW Ombudsman, *Services for Children with a Disability and their Families, Department of Ageing, Disability and Home Care: Progress and Future Challenges*, May 2006, p.12.

- 21.48 The 2008 evaluation suggests that while there has been some progress between the two agencies many of the issues raised by the Ombudsman still remain. They should be addressed.

Lack of services

- 21.49 The Inquiry was consistently told that there are not sufficient services in place, primarily, therapy, residential care, foster care, and particularly respite care for those parents who are trying their best to maintain a disabled child or young person at home and with their birth family. The Inquiry notes DADHC's advice to it that it provides in excess of 17,000 services annually to children and young persons with a disability and that just under three per cent of those come under the scope or responsibility of both agencies.
- 21.50 While this appears on its face to be a substantial response, it does not indicate the nature or duration of the services delivered; nor does it answer the question whether there is an unmet need for services by young people with a disability and if so, the extent of it.
- 21.51 DoCS identified in its submission to the Inquiry the following common issues with the provision of DADHC services:
- a. it is difficult to access therapeutic services such as physiotherapy, speech, and occupational therapy
 - b. there are few supported independent living options for young persons transitioning from statutory care
 - c. there are limitations on the capacity to implement Behaviour Management Plans
 - d. it is difficult to get approvals for home modifications to meet the needs of those in OOHC through the Home and Community Care program
 - e. there are shortages in respite and other short term care options.
- 21.52 In 2002, the NSW Legislative Council stated that:

Evidence throughout this inquiry has highlighted the current crisis orientation of the disability service system. Families and advocates have widely reported that they are unable to access supports until they reach crisis point, and programs ... have reinforced a perception that 'creating' a crisis will produce a response.¹⁰⁴

- 21.53 Little seems to have changed. DoCS informed the Inquiry:

At times children with a disability can be reported to DoCS as being at risk of harm, or parents of a child with a disability make

¹⁰⁴ Legislative Council Standing Committee on Social Issues, November 2002, op. cit., p.115.

*a Request for Assistance to gain access to support services to alleviate stress in the family. These reports or requests to DoCS appear to be initiated as a way of gaining access to the limited number of services available within the current disability services system.*¹⁰⁵

- 21.54 In particular, the shortage of respite and other short term care options can push some families into crisis:

*When the pressure on parents who have been actively seeking respite services reaches crisis level, parents request that their child be taken into OOHC as they can no longer cope. Cases have been identified where families have felt that relinquishing parental responsibility was the only option to enable their child access to services. Sometimes parents do not understand that this extinguishes their rights to make most decisions about their child. It is of concern to DoCS that there is a cohort of children with disabilities who enter the OOHC system due to lack of available disability services.*¹⁰⁶

- 21.55 The Inquiry heard of instances where families desperate for assistance found it necessary to refuse to pick up children or young persons who had been admitted to hospital or placed in respite care, in order to attract the attention of DADHC or DoCS. Relinquishment of parental responsibility where that is considered to be the only option for parents to obtain services for their children, should never be necessary in any acceptable health and welfare system. This is an area where DoCS, Health and DADHC should actively work together with parents who have reached this crisis point, in a way that can also maintain their right to participate in decisions involving their children.
- 21.56 The Inquiry has been informed of a growth in the availability of respite care since July 2006, of over 1,000 new places, with more projected, however DADHC did not, when asked by the Inquiry, provide data on current and projected demand for respite care. DADHC did advise that no application for respite is refused, although that response does not sit comfortably with the experiences reported to the Inquiry of those who had found it difficult, and sometimes, impossible to obtain respite care.
- 21.57 This is evident from other information provided by DADHC to the effect that “on average up to 8 families statewide lose access to respite for each respite bed that becomes unavailable due to an overstay.”¹⁰⁷ DADHC has also made it clear that it does not suggest that every request is met. It pointed out that a service request register is maintained, and that families on the register are invited, on a quarterly basis to indicate what respite they would like to be

¹⁰⁵ Submission: DoCS, Health and Disability, p.13.

¹⁰⁶ *ibid.*

¹⁰⁷ Correspondence: Department of Ageing, Disability and Home Care, 10 October 2008, p.6.

considered by the Regional Application Committee. It acknowledged that its attempt to allocate respite may not always match these requests.

- 21.58 DADHC advised the Inquiry that between 1 July 2005 and 30 June 2008, 29 children and eight young persons overstayed their allocated period of respite.¹⁰⁸ The average length of stay for a child was one year, 11 months and 26 days, and for a young person was seven months and 12 days. The significance of this data, however, is limited as DADHC does not maintain data on the period of respite which is booked for each client. Nine of these children and four of the young persons are reportedly still in respite.¹⁰⁹ The Deputy Director-General, Service Development from DADHC advised that:

The issue for us then becomes one of parental responsibility, because for a small number of those children, the parents rightly retain a parental role in their care, but they are reluctant and often refuse consent to allow DADHC to move those children into more permanent accommodation, so some of those children then end up staying in a block respite bed for a long time....

They're abandoned in our sense in that they have been left with us and the parents are saying, 'We're not going to take them home,' but in a DoCS sense they're not abandoned, because they're in a DADHC facility and they're getting care.'¹¹⁰

- 21.59 From information provided to the Children's Guardian by DADHC and in turn given to the Inquiry, between 2005-2007, there were 32 children under the age of 16 years living in DADHC respite care placements. The average period of stay was estimated as 501 days. A similar pattern was observed in the older age group, 16 – 17 years, with the average stay for the 22 people in this age group, being 502 days.
- 21.60 The Inquiry is aware that DADHC has consulted on a new policy to address this issue. It has been advised that following considerable feedback from families, advocacy groups and disability organisations, significant changes have been made to the draft of this policy.
- 21.61 In his 2006/07 Annual Report, the Ombudsman also noted that a number of beds in respite centres have been 'blocked,' further restricting the availability of services. Beds in respite centres become blocked when they are used to house someone for long periods of time, usually because the person does not have alternative accommodation.

¹⁰⁸ Department of Ageing, Disability and Home Care does not have data for persons who overstayed in respite prior to July 2005; *ibid.* p.4.

¹⁰⁹ *ibid.*, p.5.

¹¹⁰ Transcript: Public Forum, Health and Disability, 11 April 2008, p.50.

21.62 The Ombudsman has received complaints on this matter that raise significant issues such as the adequacy of care provided to residents living in blocked respite beds (that is, in relation to individual planning, health care planning and behaviour management), the adequacy of plans to move some residents into permanent accommodation, the assessment of risk and management of incidents for residents in respite services, and a lack of respite for other families due to blocked beds.¹¹¹

21.63 Not surprisingly, there is a significant over representation of children and young persons with a disability in the high and complex needs group. Residential care for high and complex needs children and young persons is generally not a preferred option as those with a disability are extremely vulnerable in that form of care. DoCS stated:

*The provision of adequate resources for DADHC to provide accommodation options for this group of children and young persons is therefore of significant interest to DoCS.*¹¹²

21.64 A parent recounted her experience for the Inquiry:

I have a child who has complex medical needs and who is profoundly disabled. He, in November 2006, was put into care for eight weeks through child protection issues. During that time, he had five different placements, and the last placement he had was in a residential place which was a place for 36 kids. In that place, in his room, there were six children, all with very high medical needs - physical disabilities and intellectual disabilities – and they told me that this was the only place there was for him. They said that, because of the level of his need, there was no foster care situation, no other situation for him to be in.

He returned to my care-and he needed 24-hour care, turning at night, had epilepsy and needed tube feeds and everything else-eight weeks later, and since he has been returned to my care DADHC provides minimal help with my son in the home-they come to shower him twice a day, which was put on me, I didn't actually ask for that-but there is such a gap.

My son was 11 at the time, but if I was to drop dead tomorrow, then there isn't anywhere, really. People say, 'Oh, yes, there is this and there is this and there are family places and this and that', but the reality was that there wasn't anything, in a crisis situation, for my son.

¹¹¹ NSW Ombudsman, *Annual Report, 2006/07*, p.90.

¹¹² Submission: DoCS, Health and Disability, p.15.

So if I drop dead - my son is a little boy first, with emotional needs and physical needs of being needed to be loved and cared for, first and foremost. How can one carer, in a room full of six kids with multiple disabilities and medical needs, have that connection? You can't. It is a real gap.¹¹³

- 21.65 A paediatrician from Sydney Children's Hospital informed the Inquiry that DADHC does not provide holistic services:

So often the service that is provided by DADHC is a goal-orientated service that deals with one issue. When that issue has been dealt with, the case is effectively closed and they are told that they must ring the intake line again...In a six week input in behaviour management, the behaviour for that child and the disability for that child is not going to go away; it is there for life. There seems to be a lack of recognition that these children actually need a lifetime service from somebody.¹¹⁴

- 21.66 It was suggested that DADHC's eligibility criteria can also pose difficulty. For example, a paediatrician from the Sydney Children's Hospital stated that:

We frequently find that, particularly with children with autism, they are unable to get a service from DADHC because they don't meet the eligibility criteria of having an intellectual disability that is in the moderate or severe range. So children who have very significant behaviour problems, being frequently suspended from school, causing major challenging behaviour issues in the home and school environment, may not be able to get a servicebecause they do not meet the eligibility criteria. They meet the broad definitions of a disability, their functioning is very much disordered and the functioning of the family is very much disordered, but they are unable to access services because they don't actually have an intellectual disability.¹¹⁵

- 21.67 Other case studies were brought to the Inquiry's attention which support the comments made above.

Case Study 25

A child with autism was killed in circumstances that resulted in his mother being convicted for his manslaughter. The Deputy State Coroner's findings reveal that the child and his family lived in regional NSW. By the time he was 18 months old, his parents were actively seeking to access early

¹¹³ Transcript: Public Forum, Health and Disability, 11 April 2008, pp.65-66.

¹¹⁴ Transcript: Public Forum, Health and Disability, 11 April 2008, pp.40-41.

¹¹⁵ Transcript: Public Forum, Health and Disability, 11 April 2008, p.41.

intervention services, but were told there were no vacancies at the service in their area. As a result, the child did not receive any early intervention services until he was five years old, and even then, only after his parents threatened the service provider with legal action. The child was only provided with a one hour service once per week, and made little progress in the ensuing 12 months. Once the child reached school age, his parents struggled to find a school with the appropriate resources to deal with his behavioural problems. He eventually attended a special autism class with three other students (after his family moved to Sydney).

The child's family faced a range of crises during the child's lifetime, some probably relating to the stress of caring for a severely disabled child, including marital breakdown and mental health problems. DoCS received a risk of harm report concerning the reporter's fears that the child's father had suffered a mental breakdown and might harm himself and his family.

The child was killed when he was about 10 years old, following an apparent disagreement between his parents in relation to the child's needs. The Deputy State Coroner's recommendations, handed down in October 2006, included:

That DADHC and DoCS establish a high level working party to consider how relevant interagency information can be shared in a timely manner and that such a working party consider the Ombudsman's report of May 2006 "Services for Children with a Disability and their Families," as well as the report of DoCS' Child Deaths and Critical Reports Unit in relation to another child.

That DADHC consider "ear-marking" funding specifically for the provision of early intervention services to severely disabled children (particularly for children with an early diagnosis of autism), and respite and support services for the families of those children.

That DADHC consider implementing a system whereby severely disabled children being cared for by their parents have their needs assessed, and where appropriate, be allocated a caseworker to assist in accessing services.

- 21.68 The Inquiry sought and received a response from DADHC as to the measures which it had taken following the recommendations made in this case.
- 21.69 The Inquiry was informed that DoCS, DADHC and other human service agencies, in the period since the death of the subject child, had made "considerable progress"¹¹⁶ in addressing the need for improved interagency communication, including reconvening the Child Protection Senior Officers

¹¹⁶ DoCS: Letter to Deputy State Coroner, 5 January 2007.

Group and developing the MOU between DoCS and DADHC (signed in November 2003). Additional funds have been made available for children with disabilities generally, including autism, and additional caseworkers were employed in 2006 to coach and mentor staff. The program Stronger Together was also introduced in 2006. DADHC has advised that there has been an \$11.7 million enhancement to the existing investment of \$92 million under this program, but has also flagged that it would require significant additional resources to improve the outcomes for all children and young persons with a disability and to meet community expectations. It has not however provided the Inquiry with any estimate of the additional funding which it considers would be necessary to achieve these objectives, either in full or substantially.

Inquiry's view

- 21.70 The Inquiry acknowledges that the intersection between children and young persons with a disability and their families, and child protection issues can be a fraught and troubled area.
- 21.71 The submissions received and the views expressed to the Inquiry at its many Public Forums, and interagency meetings, attest to the desperation and frustration experienced by families, in getting the right services at the right time and, at times, any services for their children with disabilities.
- 21.72 Families spoke of their frustration in negotiating complex issues within a fragmented service system in which individual agencies were inclined to look to others to take responsibility for an individual matter. Staff echoed many of these difficulties and tensions.
- 21.73 The Inquiry is aware that in some areas and regions the MOU between DoCS and DADHC works better than in others. Some staff from DADHC and DoCS described the existence of goodwill and genuine efforts to make interagency approaches work. This highlighted to the Inquiry the importance of relationships and the difference that particular staff members can and do make. The Inquiry is disturbed, however, to observe a system that may rest on the good fortune of the presence of particular personalities within a local DoCS or DADHC office.
- 21.74 The Inquiry is aware that DADHC was formed in 2001 by bringing together into a new department, the former Ageing and Disability Department, the disability services formerly provided by DoCS, and the Home Care Service of NSW. At that time the Government stated that the creation of DADHC "will help leverage better outcomes for people with disabilities."¹¹⁷
- 21.75 The Inquiry does not advocate a return to the former position of disability services being part of DoCS, however, the need for an improved system for

¹¹⁷ NSW Government response to the NSW Parliament Legislative Council Standing Committee on Social Issues Second Report: A Matter of Priority: Report on Disability Services, 2001.

children and young persons with disabilities who may be at risk of harm, and their families, is clear. There is a need for a whole of government approach to meet the expectation of the community that mainstream agencies will provide the first level of support to people with a disability and to their families or carers.

21.76 In 2006 the Ombudsman stated that:

*many families who care for children and young persons with disabilities may face significant stress, and that this stress can be unduly aggravated by ineffective implementation of key policies and difficulties in accessing essential services.*¹¹⁸

This observation remains strongly relevant today.

21.77 While the Inquiry is mindful that the Ombudsman's report is now two years old, the representations made to the Inquiry suggest that many of these issues are still current in 2008. Further, the Ombudsman's recent investigation into a child death also demonstrated that many of the systemic problems detailed in his 2004 and 2006 reports still exist.¹¹⁹ The 2008 evaluation report also provides evidence that significant tensions and problems remain.

21.78 The Inquiry supports the recommendations made by the MOU evaluation. More, however, is required.

21.79 First, the establishment of a senior position in DADHC, and the development of a common assessment framework as set out in Chapter 10 should improve the joint planning and assessment of children and young persons who need assistance from both DoCS and DADHC, but only if their staff are uniformly or unreservedly committed to participation in that process.

21.80 DoCS acknowledged that its staff are not specialists in disability. DADHC also acknowledged that its staff's core skills are not in assessing risk of harm. The consequences of these respective deficiencies can lead to decisions which are inappropriate and which risk exacerbating the situation for a child or young person with a disability and their family. This means that effective cross agency framing must be provided, and maintained for the benefit of new staff.

21.81 Secondly, the 20 Specialist Casework Consultant positions for children and young persons within DADHC that were established to provide expert advice on casework practice to DADHC staff as well as to agencies such as DoCS, should be used in conjunction with the position referred to above. Similarly, the DoCS Director, Practice Standards positions should work in conjunction with these Specialists Casework Consultant positions to investigate mechanisms for joint training and professional development.

¹¹⁸ NSW Ombudsman, *Services for Children with a Disability and their Families, Department of Ageing, Disability and Home Care: Progress and Future Challenges*, May 2006, Foreword.

¹¹⁹ NSW Ombudsman, *Investigation into the Death of a Child, Provisional Statement*, 2008.

- 21.82 Thirdly, DADHC's concern that there are currently no satisfactory options for formally resolving placement and other key life decisions for children and young persons with a disability, where it is concerned that the parent is no longer acting in the best interests of the child or young person is a legitimate concern. As a consequence, it suggests that it is limited in its ability to respond to the needs of those within this group and that while any such conflict remains unresolved it is also difficult to find suitable placement options.
- 21.83 DADHC stated that it would welcome the introduction of a formal mechanism which would permit mediation in such cases. This could include the development of a legal framework for the appointment of a third party, with authority to make any necessary decision and/or with authority to mediate a resolution which is in the best interest of the child or young person. Without such a framework children and young persons with a disability will continue to be afforded less protection in the OOHC system than other children and young persons. The Inquiry supports this proposal. It may be that the Guardianship Tribunal is an appropriate body with which to discuss such a mechanism.
- 21.84 The recommendations made later in this report concerning a statutory scheme to regulate voluntary OOHC, which would provide a scheme of intensive regulation and services for children and young persons with disabilities who are placed into care voluntarily by their parents, would address this issue in part.
- 21.85 Finally, it is apparent that there are not enough services for children and young persons with a disability and their families or for parents with intellectual disabilities who have children or young persons in their care.
- 21.86 The Inquiry is also aware of Commonwealth-State reforms that should provide additional resources. It agrees that:

Current arrangements for the delivery of disability services by Commonwealth, State and Territory Governments are inconsistent, do not meet existing demand, do not have consistent, enforceable quality standards and have no nationally consistent assessment processes. While other service systems such as aged care and child care have undergone substantial reform over the past 20 years, the disability services system has not had such a broad national reform.¹²⁰

- 21.87 That broad national reform is necessary.

¹²⁰ Briefing Paper, Community And Disability Services Ministers' Conference, Agenda Item 1.2, "Disability Agreement – Policy and Reform Directions" (issued 18 July 2008), 23 July 2008.

Recommendations

Recommendation 21.1

A data management system should be developed in DoCS and the Department of Ageing, Disability and Home Care to identify joint clients.

Recommendation 21.2

The Memorandum of Understanding between DoCS and the Department of Ageing, Disability and Home Care should be revised to provide the operational definitions set out in the 2008 Memorandum of Understanding evaluation and to specify the manner in which joint assessment and planning will occur.

Recommendation 21.3

Joint training should be carried out for DoCS and Department of Ageing, Disability and Home Care staff, in relation to the care and protection of children and young persons with a disability, and in relation to the individual and mutual responsibilities of the two agencies.

Recommendation 21.4

The recruitment and training of foster carers who care for children and young persons with a disability in voluntary and statutory OOHC should occur jointly by DoCS and the Department of Ageing, Disability and Home Care.

Recommendation 21.5

The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community Services, or for those whose disabilities are such that they are unable to continue to reside in their homes.

Recommendation 21.6

Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services.

22 Disaster recovery

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Introduction

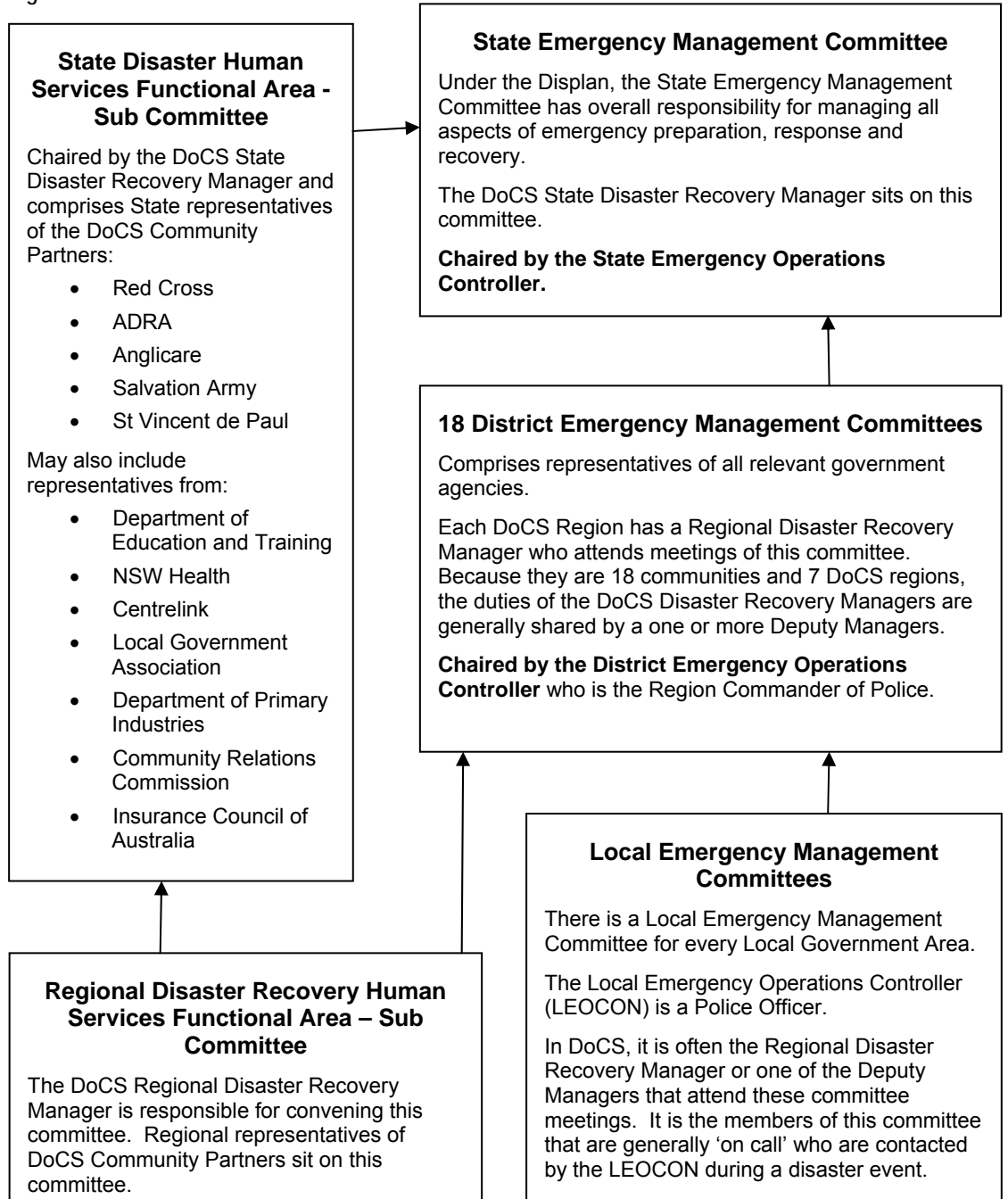
- 22.1 In this chapter the role of DoCS in relation to the coordination of the provision of community welfare services to victims of disasters is examined as well as the question of whether this responsibility should rest partially or wholly with some other department or departments of the Government.
- 22.2 Several agencies have a potential responsibility for responding to a disaster. Apart from the agency specific legislation concerning these bodies, which include the Police, NSW Fire Brigades, NSW Rural Fire Service, the Ambulance Service of NSW, the NSW State Emergency Service, Health and DoCS, the nature of the response and the relevant powers of these agencies are governed by the following legislation:
- a. *State Emergency Service Act 1989*
 - b. *State Emergency and Rescue Management Act 1989* (SERM Act)
 - c. *Community Welfare Act 1987* (the Community Welfare Act).
- 22.3 There is a complex list of obligations, responsibilities and governance.
- 22.4 In relation to DoCS, it is assigned statutory responsibility under the Community Welfare Act to provide a coordinating role for the provision of community welfare services for the victims of those disasters that are declared, by the Minister for Community Services, for the purpose of the application of s.37A of the Act. The Minister is not to make such a declaration unless satisfied that it is of such a nature as to warrant its treatment as such.¹²¹
- 22.5 Although the definition of a 'disaster' is in different terms from that given to 'emergency' under the legislation previously mentioned, it is in sufficiently broad terms to capture substantially the same events, at least once they have occurred.
- 22.6 'Emergency' under the SERM Act contemplates actual and imminent occurrences, and to that extent it may have a wider application than the expression 'disaster' which is defined in the Community Welfare Act to mean an occurrence, whether or not due to natural causes, that causes loss of life, injury, distress or danger to persons or loss of, or damage to, property; while a 'disaster victim' means a person who is in need or distress, or whose property is lost or damaged, as a result of a disaster.¹²²
- 22.7 The Community Welfare Act provides for the coordination of welfare services for victims of declared disasters and financial and other assistance to disaster victims.

¹²¹ *Community Welfare Act 1987* s.37A(2).

¹²² *Community Welfare Act 1987* s.37(1).

22.8 The governance structure for disaster recover operations in NSW is illustrated in the following flow chart:

Figure 22.1 Governance structure for disaster



DoCS responsibilities under the Displan

22.9 Section 12 of the SERM Act provides for the development of a NSW State Disaster Plan (Displan). The Displan can be activated in the event of an emergency whether or not a state of emergency has been declared by the

Premier.¹²³ As an agency responsible for community welfare services under the Community Welfare Act, DoCS is identified in the Displan as the Functional Area Co-ordinator of welfare services during the response and recovery stages of an emergency.

- 22.10 As such DoCS' role is to manage and coordinate the welfare services component of recovery services of the State to assist those in need. *The Disaster Recovery-Human Services Functional Area Supporting Plan* (Human Services Plan) outlines the management and governance arrangements that DoCS is required to have in place to coordinate human services (that is, disaster welfare services) in the event of an emergency.
- 22.11 During those operations, one of the five volunteer agencies later mentioned provides welfare services to victims of incidents and emergencies and perform other functions, including the:
- a. establishment of Evacuation Centres and Recovery Centres to manage the provision of emergency accommodation and essential material needs of victims
 - b. provision of personal welfare support, referral and advisory services to victims
 - c. provision of financial assistance to victims
 - d. management of donations (the Inquiry understands that new arrangements are being made so as to remove this responsibility from DoCS)
 - e. coordination of catering facilities and services to provide meals for victims of emergencies and personnel engaged in emergency response and recovery operations.

DoCS State Disaster Recovery Centre

- 22.12 The State Disaster Recovery Centre (SDRC) is located in Parramatta. It has a small staffing establishment headed by the State Disaster Recovery Manager. Its current staffing consists of three permanent positions and eight temporary positions. Currently 2.5 of the eight temporary positions are vacant.
- 22.13 The SDRC is responsible for:
- a. supporting all regional disaster recovery staff and ensuring that disaster management plans are in place across the State
 - b. training regional staff who have volunteered to work as Disaster Recovery Officers, Team Leaders or Centre Managers
 - c. administering the NSW Disaster Relief Scheme and the Community Disaster Relief Fund, and preparing the necessary paper work to seek reimbursement from Treasury for the cost of responding to a disaster event

¹²³ *State Emergency and Rescue Management Act 1989* s.13(2).

- d. representing DoCS in statewide cross agency planning against the possibility of future major disaster events. This includes planning for emergencies and participation in emergency management exercises such as those potentially involving:
- i. a terrorist attack (especially in the Sydney CBD)
 - ii. a radiation leak at Lucas Heights
 - iii. an outbreak of the (avian) influenza pandemic
 - iv. the activation of safety sites for the Sydney CBD Emergency Subplan.

Role of DoCS community partners

- 22.14 To fulfil its responsibilities under the Displan, DoCS works in partnership with five community partners to deliver disaster recovery services to affected communities, and in particular to meet the immediate needs of people who are evacuated due to an emergency, or who are unable to complete their journey due to an emergency. Each agency's role is defined in an MOU between DoCS and the agencies. The community partner responsibilities are outlined in the table below.

Table 22.1 **Disaster welfare responsibilities of DoCS' community partners**

<i>Agency</i>	<i>Responsibility</i>	<i>Service</i>
Adventist Development and Relief Agency (ADRA)	Emergency accommodation	ADRA provides temporary accommodation assistance to victims of disasters.
Anglicare	General support	Anglicare provides assistance with specific tasks or services as identified by DoCS.
Australian Red Cross	Personal support	The Australian Red Cross provides care and comfort to those affected by disasters and assistance to victims needing information.
Salvation Army	Catering	The Salvation Army arranges food and refreshments for disaster victims, volunteer rescue and recovery workers and, on occasion, for paid emergency workers.
St Vincent de Paul Society	Material and personal requisites	The St Vincent de Paul Society assists evacuees by providing basic necessities such as blankets, toiletries, mattresses and clothing.

- 22.15 Upon activation of the Human Services Plan, DoCS is required by its MOU with community partners to provide:
- a. financial support to the community partners to assist in the discharge of their responsibilities under the MOU during operations
 - b. coordination with other Functional Area Coordinators

- c. Disaster Recovery Centres as operationally necessary, staffed and equipped as approved by the State Disaster Recovery Manager
- d. administrative support services as negotiated
- e. a directory of key personnel appointed to the State and Regional Disaster Recovery Committees
- f. meetings of the State and/or Regional Disaster Recovery Human Services Committee.¹²⁴

DoCS' response to an emergency or disaster

- 22.16 Obviously DoCS' response will vary according to the nature or the seriousness of the event. A number of possible responses may be required. So far as DoCS is concerned, its assistance or involvement is considered by the Regional Disaster Recovery Manager in consultation with the State Disaster Recovery Manager and the DoCS Regional Director, along with one or other of the Local Emergency Operations Controller, or District Emergency Operations Controller, or State Emergency Operations Controller, depending on the magnitude of the event.
- 22.17 DoCS' involvement may then range from assisting with evacuation and recovery measures to providing financial and other support, which may be immediate or for a longer term, and which in some instances may be means tested.

Evacuation Centres

- 22.18 Evacuation Centres are established by DoCS to meet the immediate needs of victims following an emergency situation. They may include travellers (commuters and tourists) who are unable to complete their journey. DoCS works with its community partners to establish the Evacuation Centres and to provide immediate assistance during the first 48 hours following a disaster event. This involves the provision of food, clothing, temporary accommodation, transport and emergency health and safety.
- 22.19 If the services are not available within the Evacuation Centre the preferred option is to provide enough cash assistance to meet the immediate needs of the disaster affected person(s). When assessing a person's needs, staff are guided by DoCS Disaster Recovery-Immediate Assistance Policy.

Recovery Centres

- 22.20 In the case of larger or more protracted disaster events, it may be necessary to establish a Recovery Centre. Recovery Centres operate on a 'one stop shop' model which removes the necessity for victims to seek services at several venues and eliminates the duplication of services provided to individuals and

¹²⁴ Memorandum of Understanding, *Disaster Recovery Services*, July 2005, p.2.

families. Generally, DoCS casework staff are redeployed to work as Disaster Recovery Officers in the Recovery Centres, to take advantage of their training in working with people under stress.

- 22.21 The duties of a Disaster Recovery Officer are to:
- a. assess the needs of the victim and provide referrals to appropriate services as required
 - b. provide information to the victim on the assistance available to alleviate personal hardship and distress, which includes emergency food, clothing, accommodation and if, eligible, the provision of longer term assistance to recover from the effects of a disaster event
 - c. assist the victim in completing the required applications for financial assistance, under various relief schemes, assess the eligibility of victims based on the information gathered against the eligibility criteria and make a recommendation to the Recovery Centre Manager
 - d. provide ongoing personal support services including interpersonal help, active listening and psychological first aid
 - e. maintain case files for all victims including maintaining file notes, undertaking appropriate verification of information supplied by the victim and maintaining a database.¹²⁵

Operations Centres

- 22.22 Depending on the scale of the disaster event, the SDRC may also establish a State or Regional Operations Centre for the purpose of the overall coordination of disaster relief across a wider area. An Operations Centre may be established for instance during a particularly active bushfire season when there are a number of bushfires burning around the State.

NSW Disaster Relief Scheme

- 22.23 The NSW Disaster Relief Scheme allows for the distribution of immediate and longer term assistance to disaster affected victims. People can apply for assistance at Evacuation or Recovery Centres. It is the role of the Disaster Recovery Officer to assess the eligibility and needs of the applicant against a standard set of criteria. The Disaster Recovery Officer makes a recommendation about the application, and it is then either approved or declined by the delegated officer (usually the Centre Manager).
- 22.24 Disaster Recovery Officers are required to inspect the disaster affected premises before making any recommendations, and to comply with the Departmental Guidelines when handling such applications.

¹²⁵ This database is separate from the KIDS database.

Community Disaster Relief Fund

- 22.25 The Director-General of DoCS has responsibility for establishing and administering the Community Disaster Relief Fund for which provision is made in the Community Welfare Act.¹²⁶ This fund is made up of both private donations and public funding.
- 22.26 Assistance available through the Community Disaster Relief Fund is separate from the government assistance provided through the NSW Disaster Relief Scheme. Grants are made on the basis of criteria recommended by the Community Disaster Relief Fund Standing Committee and are not means tested.

Delivery of services and funding

Funding

- 22.27 Disaster recovery expenditure varies from year to year. In the incident involving the floods, in the Hunter for example, it required the services of up to 390 DoCS staff for varying periods over 11 weeks. As the former Director-General observed to the Inquiry:
- You can pretty much guarantee that you will get something in a year, but some years the disaster budget will be very small, and other years you may have raging bushfires across half of NSW and you need a substantial number of staff.*¹²⁷
- 22.28 The annual expenditure, the Inquiry was advised, can be up to up to \$7 or 8 million.
- 22.29 In purely budgetary terms, DoCS is not required to absorb the cost of providing disaster recovery services from within existing resources. Rather, it receives a corresponding increase in revenue to offset these costs, including the costs of backfilling the positions of staff diverted to recovery work, including any overtime worked to cover for their absence or to respond to the disaster, as well as the costs of community partners who have provided assistance at DoCS' request.
- 22.30 Around Australia, the cost of disaster recovery is not solely borne by state governments. Under its *Natural Disaster Relief and Recovery Arrangements Determination 2007*, the Commonwealth "may make payments to a State in partial reimbursement for State expenditure in relation to a natural disaster."¹²⁸

¹²⁶ *Community Welfare Act 1987* ss.38-40.

¹²⁷ Transcript: Inquiry meeting with DoCS senior executives, 11 February 2008, p.73.

¹²⁸ Commonwealth Department of Transport and Regional Services, *Natural Disaster Relief and Recovery Arrangements. Determination 2007*, p.1.

Essentially, the Commonwealth reimburses the states for relief or recovery operations and the provision of assistance to disaster victims, such as emergency food, clothing, temporary accommodation, repair or replacement of furniture and personal effects, removal of debris and repairs to housing.¹²⁹

- 22.31 Under a cost sharing formula with the Commonwealth, NSW pays for the first \$98.9 million of natural disaster costs each year and can claim from the Commonwealth for half of all eligible Personal Hardship and Distress costs within this first threshold. The Commonwealth then matches NSW expenditure for costs between \$98.9 million and \$173.1 million and beyond that covers three quarters of all costs.¹³⁰
- 22.32 NSW Treasury is responsible for seeking reimbursement from the Commonwealth. However, DoCS is required to provide Treasury with appropriate documentation regarding the cost of providing material assistance and of redeploying staff to disaster recovery operations.
- 22.33 In 2007/08 DoCS provided almost \$3 million in financial and material assistance to individuals affected by disaster events, including some cases that carried over from previous years.¹³¹
- 22.34 During 2007/08 DoCS also provided almost \$200,000 for drought-affected families and individuals. More than half of the affected households that received drought assistance lived in DoCS Western Region.¹³²

Delivery of services

- 22.35 The Annual Report for 2007/08 reports that DoCS responded to 27 natural or other disasters across NSW.¹³³

Table 22.2 List of events where assistance was provided 2007/08

<i>Location</i>	<i>Event Type</i>	<i>Date</i>
Auburn	Wall collapse	July 2007
Rosehill	Burst water main	July 2007
Mount Kembla	Bushfire	October 2007
Cowan	Bushfire	October 2007
Lismore	Hailstorm	October 2007
Dunoon	Severe storm	October 2007
Stanmore	Boarding house fire	October 2007
St Marys	Siege	October 2007
Port Stephens	Bushfire	October 2007
Werris Creek	Silo fire	November 2007

¹²⁹ *ibid.*, p.2.

¹³⁰ NSW Office of Emergency Services: www.emergency.nsw.gov.au.

¹³¹ DoCS, *Annual Report 2007/08*, p.18.

¹³² *ibid.*

¹³³ *ibid.*

<i>Location</i>	<i>Event Type</i>	<i>Date</i>
Blacktown	Hailstorm	December 2007
Toowoomb Bay	Potential gas cylinder explosion	December 2007
Lake Cargelligo	Storm and flooding	December 2007
Wallerawang	Fireworks explosion	December 2007
Grenfell	Tyre factory fire	January 2008
Northern Rivers	Flood	January 2008
Tenterfield	Flood	January 2008
Wollondilly	Windstorm	January 2008
Cooma	Storm	January 2008
Shoalhaven	Storm	January 2008
Ultimo	Shop explosion	February 2008
Port Stephens	Storm	February 2008
Merrylands	Apartment block fire	February 2008
Muswellbrook	Storm	February 2008
Waterloo	Burst water main	March 2008
Mid North Coast	Flood	April 2008
Wyong	Flood	April 2008

22.36 Significant events noted in the 2007/08 Annual Report included the following:

- a. The severe weather on 8 June 2007 resulted in strong winds, and heavy rains in the Mid North Coast, Hunter and Sydney metropolitan regions. Recovery activities for the Hunter and Central Coast continued through most of 2007. Recovery Centres operated in Newcastle, Wyong, Cessnock and Singleton. By mid-August, all had closed except the centre in Newcastle, which operated until late October 2007. More than 3,000 people visited these centres. DoCS conducted more than 1,960 home visits and received more than 1,000 applications for assistance with repair or replacement of household contents, or structural repairs.
- b. Flooding was caused by heavy rain on the North and Mid North Coast in early January 2008. To assist flood affected communities, DoCS set up five Evacuation Centres. The Kyogle Recovery Centre had 560 people visit over an eight week period.¹³⁴

Should DoCS continue to be responsible for disaster recovery?

22.37 The first of the issues that concerns DoCS and that has led to earlier submissions to Government to move this responsibility to Premier and Cabinet, is the impact that the diversion of frontline staff to work on disaster recovery has on its core care and protection activities.

¹³⁴ *ibid.*, pp.18-19.

- 22.38 While DoCS is reimbursed for the cost of redeploying staff to work on disaster recovery, this is of little assistance given the difficulty of backfilling any casework positions while the incumbents are redeployed for disaster recovery work. It is the fact that some CSCs are able to call on a pool of caseworkers for temporary assistance, but this is by no means universally available, particularly in country regions.
- 22.39 Prior to 2002, the DoCS workforce included staff who worked in disability services and in human resources (payroll and recruitment). This changed when Businesslink was established and disability services staff were reassigned to DADHC. A significant number of these officers had previously been involved in disaster recovery work.
- 22.40 To ensure that DoCS was still able to call on these officers (and any other interested officers in DADHC and Businesslink), formal agreements were made between the two agencies and DoCS. However, in practice, very few non-DoCS staff have been redeployed during an emergency/disaster, and the formal agreements have now lapsed. The Inquiry understands that the SDRC is currently working to renew the MOU with DADHC and to establish a new MOU with Housing.
- 22.41 Current efforts by the SDRC aside, since 2002, the pool of workers available to work in disaster recovery has shrunk and it is even more likely that disaster recovery staff will be frontline child protection workers.
- 22.42 The problem has been exacerbated by the fact that, through the SDRC, DoCS has been required to extend its involvement in disasters and emergencies beyond the natural disasters which have traditionally required its attention. As noted it is now expected to have a role in the event of terrorist attacks, outbreaks of human pandemics, the equine flu outbreak, the repatriation of residents caught in war zones, accidents at the Australian Nuclear Science and Technology Organisation, Lucas Heights, and serious disturbances of the kind that were contemplated for public events such as the APEC forum, (for which it conducted some preparatory planning even though it was not assigned any specific obligations other than performing its usual functions under the Displan).
- 22.43 Additionally it has been necessary for DoCS to engage in planning and training of its staff, and of its community partners, in responding to the wider variety of circumstances that might potentially fall within its responsibility under the Displan.
- 22.44 The second issue concerns the fact that placing reliance on one agency to coordinate the provision of disaster recovery services leaves the State vulnerable in the event of a large scale emergency or disaster affecting more than one region (as might be the case with multiple valley flooding or widespread bushfires).
- 22.45 It is recognised that disaster recovery has been seen across Australia as a responsibility within the purview of community service agencies. For example,

the Community and Disability Services Ministers' Conference that reports through COAG has a Disaster Recovery Sub-Committee. In the two states that have divided the community services and child protection functions between separate departments, Queensland and Western Australia, responsibility for disaster recovery rests with the Department of (or for) Communities, with the consequence that community service workers, rather than child protection workers, are redeployed to provide disaster recovery assistance in those states. In Tasmania and Victoria, the relevant departments tasked with disaster recovery have broader responsibilities than DoCS, including health, disability, community and child protection services, and it is understood that in the event of a disaster, the recovery staff would be drawn from a wider pool than in NSW. It is only the South Australian Department for Families and Communities that has a similar structure to DoCS, that is more likely to use care and protection staff for its disaster recovery responsibility.

- 22.46 DoCS has in the past sought a formal transfer of the responsibility for disaster recovery to Premier and Cabinet on the premise that:
- a. disaster recovery needs a whole of government approach and is therefore better handled by the central agency
 - b. the central agency would have greater ability to 'direct' other agencies to contribute to the disaster recovery process
 - c. DoCS would not lose the services of its child protection caseworkers who are already fully committed to frontline activities.
- 22.47 This approach was unsuccessful, but has been renewed in DoCS' submission to this Inquiry, which noted that while it can rely upon the voluntary efforts of the five community partners, "there are no formal arrangements with other Government agencies that will guarantee that their staff will attend"¹³⁵ emergencies. The Inquiry understands that the Government has asked that the review of the NSW *Public Sector Employment and Management Act 2002* include a power to deploy human service agency staff to a major disaster response.
- 22.48 The contrary response to DoCS' submission, which was put to the Inquiry at meetings with DoCS staff, was to the effect that engagement in this form of work is likely to be productive of job satisfaction for its staff whose assistance will be appreciated and who will value a change from the more confronting tasks of responding to care and protection issues. It was also suggested that this kind of work is likely to present a better image for DoCS as a whole, that could help to counter the negative reception which it receives in many quarters. Additionally it has been suggested that it is important to involve an agency that has a statewide presence, although it is by no means unique in that front.

¹³⁵ Submission: DoCS, Interagency Cooperation, p.18.

- 22.49 On the other hand, the Inquiry was informed at one of the regional Public Forums by a member of an agency that was involved in disaster recovery work on behalf of DoCS during the June 2007 storms, of the experience that some victims of that disaster declined offers of monetary assistance because of an expressed fear that DoCS would then become involved in their lives.
- 22.50 The Inquiry recognises the force of the argument that DoCS involvement in this form of work can be beneficial for its staff and for the Department as a whole. However, this is not the only area in which the Department, and its workers, provide community assistance, and in overall financial terms it is relatively insignificant, and likely, in most instances, to be of a short duration. Moreover, the extent to which traumatised victims will identify the source of the assistance as DoCS is questionable, particularly in circumstances where the actual assistance is delivered by the community partners.
- 22.51 The alternative to a transfer of the full responsibility for disaster recovery to Premier and Cabinet that was noted by the former Director-General of DoCS is:
- To have a bigger group of people and a training program within other agencies so that you can call on the key staff from other agencies who are trained to deal with disasters We now have an expired MOU with DADHC where DADHC supplied staff and they still do, MOU or not, but getting other agencies to play ball on this has been exceedingly difficult.¹³⁶*
- 22.52 Clearly this option would not justify a diversion of staff from other agencies who have specific responsibilities during an emergency such as Police or frontline Health workers involved in acute and emergency care. However it was suggested that there are several agencies that could share the burden if their staff had the necessary training, including, for example, DADHC, Housing, Education, Community Health Organisations, Primary Industries, Fair Trading and Transport, in addition to DoCS.
- 22.53 There would be sense in maintaining a role for DoCS in those cases where the skills of its workers were required in responding to families in crisis. However much of the work of a purely administrative nature does not call upon their skills and could just as well be provided by staff from other government departments having a human services or client focus.
- 22.54 The Inquiry understands that within Premier and Cabinet, the Office of Strategic Operations has been established, comprising the Counter-Terrorism, Disaster Recovery Directorate and the Strategic Projects Division that supports and provides strategic advice to the Director-General and Premier in coordinating the NSW Government's response to the threat of terrorism and recovery from major disasters. Premier and Cabinet also has Regional Coordinators located in major regional centres.

¹³⁶ Transcript: DoCS, 11 February 2008, Dr Neil Shephard, p.73.

- 22.55 This Office could form an appropriate nucleus of an expanded disaster recovery team that could call upon the services of relevant government agencies, including DoCS, to provide, under its coordination and direction, assistance appropriate for the event. In particular this could spare DoCS from having to divert its staff and resources to respond to events that would seem to have little to do with its area of interest, such as the repatriation of citizens caught in war zones overseas, or the payment of horse trainers whose stables were closed because of equine flu, or an outbreak of illness on a school bus.
- 22.56 An alternative to a transfer of this responsibility to Premier and Cabinet, and specifically to the Office of Strategic Operations, would be a transfer to the State Emergency Service, and the Minister for Emergency Services, leaving it to them to coordinate the full disaster recovery operation, with the authority to call on individual agencies, including DoCS, to provide specific assistance as required. This would reflect the wide powers and functions reserved to the Minister and the Service, although it is acknowledged that the primary role of the State Emergency Service is that of a 'combat agency'.
- 22.57 If the responsibility for coordination of the disaster recovery is to remain with DoCS then the Inquiry considers it essential to:
- a. increase the SDRC staff
 - b. establish full time and mobile Disaster Recovery Manager positions within DoCS to coordinate and deliver services and to arrange training
 - c. implement a whole of government approach, including establishing, training and maintaining a pool of skilled staff within other human services agencies who can be called upon in an emergency, and establishing via an appropriate MOU a commitment by these other agencies to provide services and staff appropriate to their special area of operation
 - d. implement strategies for full cost recovery from the State and Commonwealth Governments
 - e. ensure that the additional positions referred to above as well as the operations of DoCS in fulfilling the disaster recovery function are fully funded
 - f. ensure that DoCS is not required to provide its staff and services save where it is necessary to call on its experience and expertise.
- 22.58 In this respect the Inquiry notes that the current staffing of the SDRC is below establishment, and that as a result training has to some extent been neglected in recent years. Unless the SDRC is properly staffed with sufficient permanent positions, including those who are able to operate on a mobile basis, the capacity of the organisation to respond to any major event or series of events and even to prepare adequately for them is likely to be compromised to an unacceptable degree.
- 22.59 It may also be noted that in the course of an internal audit, Ernst & Young considered DoCS' preparedness to perform its welfare service requirements

under the Displan, had it been called upon to respond to a disaster incident occurring during the APEC Summit. Some issues were identified in that audit which it was suggested could justify a broader review of DoCS welfare and recovery services operations at some future time, including greater documentation of the processes and practices involved, and the establishment of greater clarity as to the division of responsibilities and tasks between state and regional levels.¹³⁷

Drought relief

- 22.60 In past years there has been a response from both the Commonwealth and the State in providing assistance to those affected by the long standing drought in NSW.

Commonwealth assistance

- 22.61 So far as the Commonwealth is concerned an Exceptional Circumstance Declaration can be made where it considers that an event has occurred that has a severe and prolonged impact on a particular area, such as drought.

The NSW Drought Household Assistance Scheme

- 22.62 The Drought Household Assistance Scheme (the Scheme) was established in late 2002. It is a NSW funded scheme that is administered through the DoCS SDRC, to provide financial assistance to rural families suffering financial distress as a direct result of a drought, and in particular to help them with the payment of household expenses. The original aim of the Scheme was to provide support for farm and rural households directly dependent on primary production, or indirectly dependent on a drought affected rural economy, who were living in areas that were NSW drought declared, but not Exceptional Circumstance declared by the Commonwealth.
- 22.63 Payments are in the form of grants, not income support. A maximum of \$2,000 can be paid to eligible applicants, or \$400 for low income rural households needing to purchase household water.

Funding

- 22.64 The table below summarises the funding and allocation of grants for each financial year since the Scheme was established.

¹³⁷ DoCS, Ernst & Young, *APEC Disaster Recovery Readiness Final Internal Audit Report*, August 2007.

Table 22.3 Summary of Drought Household Assistance Scheme funding and allocation of grants

<i>Financial Year</i>	<i>Treasury Allocation</i> \$	<i>Total Grant \$\$ provided to eligible applicants</i>	<i>Number of Applications Received</i>	<i>Number of individual payments made</i>
2002/03	4,060,000	4,511,849	3,376	3,025
2003/04	5,300,000	2,789,402	2,512	1,962
2004/05	2,200,000	933,060	1,052	598
2005/06	800,000	422,949	572	260
2006/07	Nil	613,008	834	372
2007/08	Nil	194,613	281	123
2008/09 YTD	Nil	16,168	30	12

- 22.65 A total of almost \$9.5 million has been expended in grants to drought affected families under the Scheme (as at August 2008).
- 22.66 For the financial years 2002/03 to 2005/06 DoCS received a special consolidated revenue allocation from Treasury to administer the Scheme. The total amount received was just over \$12.3 million.
- 22.67 Since July 2006 however Treasury has not provided any funding for the Scheme and DoCS has been required to cover the total costs of this form of relief from within its general operating budget. This shortfall in funding amounts to more than \$820,000 in grant expenditure, as well as associated administrative costs.
- 22.68 In April 2007, DoCS was advised by Treasury that it would not support funding for the Scheme in the 2007/08 budget. This decision was based on an assumption that the Department had the capacity to fund the Scheme in the short term. In response, DoCS advised Treasury that the Scheme was not a core departmental function and as such it would not have the capacity to provide funding in subsequent years.
- 22.69 Similarly in May 2008, DoCS was advised that additional funding would not be provided by Treasury for the Scheme. The Cabinet Standing Committee approved the continuation of departmental funding (that is from its existing budget allocation) for the 2008/09 financial year.
- 22.70 The administration of the Scheme (including the assessment of applications, liaison with applicants and clerical administration) are additional costs that are also met by the Department. These costs vary from year to year depending on the demand for the Scheme.
- 22.71 A significant question arises as to why DoCS should have any role to play in the provision of this form of assistance, and particularly why it should be a direct cost to its budget. If the Government decides that it is appropriate to complement the Commonwealth assistance in relation to areas of the State that are in fact in drought, although not included in a current Exceptional Circumstance declaration, then it would seem that the funding should be

provided by Treasury, and managed within the Primary Industries portfolio by the NSW Rural Assistance Authority, established under the *Rural Assistance Act 1989*, which already has a statutory function of providing natural disaster relief assistance to the rural sector.

- 22.72 The Inquiry does not consider it appropriate for DoCS to take on the role of distributing drought relief. That is not a role that calls on any special skills, and it can require considerable time and effort in the administration and processing of applications, for relatively little return to individual households. Moreover, if combined with the assistance otherwise available through the NSW Rural Assistance Authority,¹³⁸ a more comprehensive package should be capable of delivery using this agency as a single entry point.

Recommendations

Recommendation 22.1

DoCS responsibilities under the *Community Welfare Act 1987* should be transferred to the Department of Premier and Cabinet or to such other government department as is entrusted with the principal responsibilities for planning for and responding to disasters or emergencies, with DoCS staff being available to be called upon to provide, under the coordination and direction of the Department of Premier and Cabinet or of such other department, assistance appropriate to the event.

Recommendation 22.2

In the event that DoCS retains responsibility under the *Community Welfare Act 1987*, it should be resourced sufficiently to adequately perform that role, without frontline child protection caseworkers being deployed.

Recommendation 22.3

The NSW Government should assign responsibility for distributing drought relief to an agency other than DoCS, and such relief as is provided should not be a cost to the DoCS budget.

¹³⁸ In 2006/07 assistance through the NSW Rural Assistance Authority involved \$253 million in Commonwealth Exceptional Circumstance assistance, extraordinary funding assistance for Irrigators in the Murray and Murrumbidgee Valleys in the order of \$19m, and Natural Disaster Relief Assistance in the order of \$3 million, *NSW Rural Assistance Annual Report 2006/07*.

Part 6 Oversight and interagency cooperation

23 Oversight

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Introduction

- 23.1 DoCS is accountable for its actions pursuant to a range of central and external oversight arrangements, some of which are similar to other government departments and others of which are unique to it.
- 23.2 Premier and Cabinet coordinates NSW Government policy with all agencies including DoCS. NSW Treasury enters into an agreement each year with DoCS as to the services that DoCS will deliver according to the resources the Government allocates to it, and as to the way in which results will be measured. As with other agencies, the Audit Office of NSW performs an audit on DoCS annual financial statements for the year ended 30 June. The Independent Commission Against Corruption can investigate allegations of corrupt conduct in public sector agencies including DoCS. In addition, there are oversight bodies with more limited areas of interest such as the NSW Privacy Commission and the Public Guardian.
- 23.3 The NSW Ombudsman deals with complaints made by the public against NSW Government agencies, including DoCS. In addition, his Office has significant oversight functions specific to DoCS, including its management of allegations against staff, and its involvement with children and young persons whose deaths it reviews.
- 23.4 Unique to DoCS is its relationship to the work of the Children's Guardian, the NSW Child Death Review Team and aspects of the CCYP. The latter two, while not being agencies to which DoCS is accountable, work in related areas. Each of these, and the role of the Ombudsman will be addressed further in this chapter.
- 23.5 The Inquiry accepts, as the starting point for a consideration of the effectiveness of oversight arrangements in relation to child protection services in NSW, their purpose, as enunciated by the Ombudsman in 2005:

*The aim of external oversight is to maintain the integrity of government agencies and public officials by holding them accountable for actions and decisions they will make while carrying out their duties. Accountability is a keystone of representative government, as it enhances public confidence in the government sector and, conversely, helps ensure that government is responsive to the interests of the public.*¹³⁹

¹³⁹ NSW Ombudsman, *Public Sector Agencies fact sheet, No. 15: Oversight of public administration*, December 2005, p.1.

NSW Ombudsman

- 23.6 The role and responsibilities of the Ombudsman in relation to child protection services are prescribed by the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) and the *Ombudsman Act 1974* (the Ombudsman Act).
- 23.7 In December 2002, the Community Services Commission was amalgamated into the Office of the Ombudsman. CS CRAMA was amended to provide the legislative framework for the amalgamation. The responsibilities which are conferred upon the Ombudsman by that Act and which relate to child protection are to:
- a. review the deaths of certain children¹⁴⁰ including children or their siblings who were reported to DoCS as being at risk of harm at some time in the three years prior to their death, children in statutory care and children living in disability accommodation services
 - b. review the situation of a child in care, or of a group of children in care
 - c. receive and consider complaints about the provision of, or failure to provide, a community service or about the withdrawal, variation or administration of a community service
 - d. review the complaint handling systems of service providers
 - e. coordinate and oversight Official Community Visitors, visiting OOHC services
 - f. monitor and review the delivery of community services and inquire into matters affecting service providers and consumers
 - g. provide information, education and training in relation to standards for community services and in relation to complaint handling in community services, and to promote access to advocacy to enable consumer participation in decisions about the services they receive.
- 23.8 The Ombudsman Act confers in the Ombudsman certain powers and obligations, which apply to the exercise and functions under CS CRAMA, including the capacity to make preliminary inquiries and to conduct investigations, to compel statements of information and to interview witnesses.
- 23.9 Since 2003, the Community Services Division of the Office of the Ombudsman has initiated 90 investigations into 59 matters involving DoCS, the majority of which have concerned child protection issues and have arisen from child death reviews. Those of particular interest to the Inquiry are addressed below.

¹⁴⁰ Under s.25A of the *Ombudsman Act 1974*, s.13AB of the *Coroners Act 1980* and s.35 of the *Community Services (Complaints Review and Monitoring) Act 1993*, a 'child' is a person under the age of 18 years. This definition is used throughout this chapter.

Reviewing child deaths

- 23.10 There is some history to the current arrangements whereby child deaths are reviewed. In 2001, NSW was described as having the most complex oversight arrangements for community service providers for any jurisdiction in Australia. In late 2001 the Premier's Department and The Cabinet Office conducted a review of that system. The initial review concluded that it would be considerably enhanced by the amalgamation of the Office of the Ombudsman and the Community Services Commission, the strengthening of the role of the Coroner and the clarification of various objects and functions under CS CRAMA.
- 23.11 The key principles behind the amalgamation were said to be that none of the then current protections in the review and monitoring system of community services should be weakened, the independence of oversight agencies should be strengthened, and client access and complaint handling should be improved.
- 23.12 The key benefits were said to include creating a single responsible organisation with sufficient powers, skills and resources, reducing the chance of gaps in the investigation and handling of complaints, providing clients with better access through a single entry point and increasing the credibility of investigations and reports.
- 23.13 One of the changes effected related to a specific class of child deaths which, until 2003 were reviewed by the Child Death Review Team (CDRT). In the second reading speech for the *Commission for Children and Young People (Child Death Review Team) Bill 2003* the then Minister for Community Services said:
- These review functions sit more appropriately in a watchdog body like the Ombudsman's office, with its monitoring and investigation powers and its existing function of oversighting the child protection system than in a research team that considers all children.*¹⁴¹
- 23.14 Thus, from August 2003, the Ombudsman assumed responsibility for reviewing the class of child deaths which became known as 'reviewable deaths.' The Coroner's jurisdiction was extended to cover the same deaths, except those in residential care or detention. In addition, since early 2004, DoCS has established its own child death review function.
- 23.15 The Ombudsman is required to review the deaths of:
- a. a child in care
 - b. a child in respect of whom a report was made under Part 2 of Chapter 3 of the Care Act within the period of three years immediately preceding the child's death

¹⁴¹ Legislative Council, Hansard, 25 June 2008, 2048.

- c. a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the Care Act within the period of three years immediately preceding the child's death
 - d. a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances
 - e. a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place)
 - f. a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act* 1993 or a residential centre for handicapped persons (in this Part referred to as a person in residential care)
 - g. a person (other than a child in care) who is in a target group within the meaning of the *Disability Services Act* 1993 who receives from a service provider assistance (of a kind prescribed by the regulations) to enable the person to live independently in the community.¹⁴²
- 23.16 An MOU exists between DoCS and the Ombudsman in which DoCS undertakes to cooperate with and assist the Ombudsman to access in a timely manner all information held by DoCS of relevance for such cases. This includes information about DoCS funded service providers.
- 23.17 The Ombudsman described his function in the following way:
- the reviewable deaths function identifies shortcomings in agency (not only DoCS) systems and practice that may have directly or indirectly contributed to the death of a child, or that may lead to children being exposed to risk in the future.*¹⁴³
- 23.18 This is achieved by establishing facts, including errors relating to professional practice, and by identifying systemic issues. Usually the reviews are paper based, although interviews can be and are conducted in more complex cases.

Research

- 23.19 The deaths of children generally are reviewed in order to understand their causes, to hold individuals accountable criminally where the evidence permits and where possible, to devise changes to systems and practices to reduce the instances of preventable deaths.

¹⁴² *Community Services (Complaints, Reviews and Monitoring) Act* 1993, s.35(1)

¹⁴³ Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, p.11.

- 23.20 More particularly, the scrutiny of deaths of children from abuse or neglect or in suspicious circumstances is important to learn what state agencies charged with their protection can or should do.
- 23.21 The starting point is the research on fatal child abuse. DoCS has distilled the following issues about fatal child abuse from a literature review it carried out in late 2005:
- a. International and local data reporting the rates of fatal child abuse indicate that it is a rare event, but it is likely that official figures for child homicides underestimate the incidence of fatal child abuse.
 - b. Child homicides are not considered a likely outcome in most cases of child maltreatment with less than one in every 2,000 cases of children reported for abuse resulting in death in the USA. In many studies, most children who were fatally abused were not known to child protection services.
 - c. Current approaches to risk assessment in child protection services are subject to a high level of inaccuracy in their ability to classify families as being at high, medium or low risk. The small numbers of child abuse cases that occur within the population (less than one in every 100) and the even smaller number of fatal child abuse cases (around one in every 100,000) make it almost impossible to generate accurate risk assessment tools.
 - d. Risk factors present in cases of fatal child abuse are generally similar to those present in many thousands of other child protection cases. There are many variables that contribute to child maltreatment and these factors tend to be extensive, broad, and at times even inconsistent.
 - e. Infants and very young children are at greatest risk.
 - f. Research from the USA suggests that domestic violence is the single major precursor to child assault and neglect in families in that country.¹⁴⁴
- 23.22 Many child abuse inquiries have identified organisational issues as significant contributory factors to child deaths. The CDRT 2003 report, *Fatal Assault and Neglect of Children and Young People*, concluded that the three most common errors made by agencies and practitioners were:
- i. not recognising and reporting serious and unstable conditions
 - ii. inadequate risk assessment
 - iii. poor interagency collaboration and coordination.¹⁴⁵
- 23.23 In 2008, the CDRT published a report *Trends in the Fatal Assault of Children in NSW: 1996-2005*, which contained the following messages:
- a. There is no evidence of an increase in the likelihood of deaths of children from assault in recent years.

¹⁴⁴ DoCS, *Fatal Child Maltreatment, Key messages from the research*, November 2005.

¹⁴⁵ NSW Child Death Review Team, *Fatal Assault and Neglect of Children and Young People*, 2003, p.xii.

- b. The deaths of children from assault are relatively rare.
- c. Nearly 60 per cent of children who died came from families with a child who had been the subject of a report to DoCS within three years prior to the death. Thus, more than one assault death in three occurred in a family with no contact with that system.
- d. The greatest difference found in incident rates was for age and Aboriginality.¹⁴⁶

23.24 In 2008, the CDRT reported on trends in child deaths in NSW between 1996-2005. It found that, after adjusting for age and sex, the likelihood of child deaths from:

- a. all causes declined by 37.98 per cent
- b. external causes declined by 47.24 per cent
- c. diseases and morbid conditions declined by 34.91 per cent.

This report also identified continuing and, in some cases, growing inequities in health outcomes for Aboriginal children and young persons for those from disadvantaged socio-economic locations and for those living in remote parts of NSW.¹⁴⁷

23.25 From data collected in 2007, the CDRT established that:

- a. there was a decrease in the overall death rate (as compared with 2006)
- b. there was a slight decrease in the number of infant deaths (as compared with 2006) with infants comprising 62.7 per cent of all child deaths in 2007.
- c. the rates of death for 1-17 year olds had remained steady (as compared with 2006)
- d. amongst those who died from external causes, vulnerable children were over represented
- e. amongst the total number of child deaths, Aboriginal and Torres Strait Islander children and young persons were over represented
- f. the number of fatal assaults had declined (as compared with 2006)
- g. remote areas had higher rates of child death
- h. amongst the total number of child deaths, children in areas of greatest socio-economic disadvantage were over represented
- i. the distribution of child deaths varied across NSW
- j. age and gender patterns were evident.¹⁴⁸

¹⁴⁶ NSW Child Death Review Team, *Trends in the fatal assault of children in NSW: 1996-2005*, 2008, p.3.

¹⁴⁷ NSW Child Death Review Team, *Trends in Child Deaths in NSW: 1996-2005*, 2008, p.xxxi.

¹⁴⁸ NSW Child Death Review Team, *Annual Report 2007*, November 2008.

- 23.26 The work done by the Inquiry, including its case file audit, its consideration of the various reviews and audits conducted by others, including DoCS and examination of the case studies and the reviewable death reports undertaken or published by the Ombudsman, supports this research.
- 23.27 In particular, while the two children who died shortly before the Inquiry was established did so in awful and tragic circumstances, the characteristics of their lives were not significantly different from thousands of other children and young persons reported to DoCS who did not die. It is known that: one child was aged seven years at the time of her death and the other child was two and a half years of age, each being older than that generally observed in the research; domestic violence was reported in both families, although other factors existed; one child was Aboriginal; and both families were socio-economically disadvantaged. Their deaths could not have been predicted by DoCS, although the reviews following their deaths have identified a number of deficiencies in the operations of more than one government and non-government agency, who had contact with the families.
- 23.28 The deaths of each of these children are subject to criminal proceedings and they are not identified in this report. The Inquiry, however, has had the benefit of reviewing the material from all agencies in relation to their deaths and, in particular the reviews undertaken by the Ombudsman and by DoCS. The findings and lessons from these reviews have informed the considerations and recommendations of this Inquiry.

Reviewable Deaths occurring in 2003-2006

- 23.29 The following table is taken from the Ombudsman's *Report of Reviewable Deaths in 2006*.¹⁴⁹

Reason for reviewable status	Number of children, per cent and additional information			
	2003 deaths	2004 deaths	2005 deaths	2006 deaths
Death resulted from abuse	17 (13%)	7 (7%)	11 (9%)	12 (10%)
Death resulted from neglect	18 (14%)	6 (6%)	12 (10%)	9 (7%)
Death occurred in circumstances suspicious of abuse or neglect	8 (6%)	11 (11%)	10 (9%)	19 (15%)

¹⁴⁹ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.14.

Reason for reviewable status	Number of children, per cent and additional information			
	2003 deaths	2004 deaths	2005 deaths	2006 deaths
The child, or the child's sibling, was reported to DoCS in the three years prior to the child's death	103 (80%): 84 of the children were themselves reported to DoCS. These children were the subject of a total of 286 reports to DoCS. 19 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 143 reports of risk of harm	96 (92%): 72 of the children were themselves reported to DoCS. These children were the subject of a total of 310 reports of risk of harm. 24 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 96 reports of risk of harm.	109 (93%): 69 of the children were themselves reported to DoCS. These children were the subject of a total of 246 reports of risk of harm. 40 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 194 reports of risk of harm.	114 (93%): 81 of these children were themselves reported to DoCS. These children were the subject of a total of 296 reports of risk of harm. 33 of the children were the sibling of a child reported to DoCS. The siblings were the subject of a total of 201 reports of risk of harm.
The child died while in statutory care	10 (8%)	8 (8%)	4 (3%)	4 (3%)
The child died in a detention or correctional facility	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total number of reviewable deaths	128	104	117	123

Note: because a child's death may be reviewable for more than one reason, percentages for any one year will not total 100 per cent.

- 23.30 Almost 90 per cent of the child deaths reviewed in this period were reviewable because the child or a sibling had been notified to DoCS. Over this period, twenty per cent of all child deaths in NSW were reviewable and 42 per cent of the deaths of Aboriginal children were reviewable.¹⁵⁰
- 23.31 All of the Ombudsman's 68 final recommendations which have been directed to DoCS, and which have arisen from its reviewable deaths function, have been accepted or accepted in part and have been implemented or implemented in part. A key issue between the agencies has been the view of the Ombudsman that DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention. This matter has been dealt with in Chapter 9.
- 23.32 The following is a summary of issues raised by the Ombudsman as reflected by his recommendations in the period 2003 to 2006 and the response of DoCS to those matters.¹⁵¹

¹⁵⁰ *ibid.*, p.ii.

¹⁵¹ *ibid.*, pp.11-12.

Concerns underlying recommendations	Relevant agency developments and achievements
Improving the quality of DoCS child protection work	DoCS has implemented a quality assurance project that will include an audit of each of its local offices over a four-year period to 2010.
Improving initial risk assessment	DoCS reviews the quality of work done at the central intake Helpline.
Improving secondary risk of harm assessment	DoCS has implemented a revised policy on secondary risk of harm assessment and provided relevant training to staff.
Improving responses to risk arising from neglect	DoCS has implemented a new neglect policy and provided relevant training to staff.
Decreasing numbers of cases closed without comprehensive assessment due to competing priorities	DoCS has endorsed intake assessment guidelines that require the prioritising of high risk cases for secondary assessment.
Improving responses to child protection reports from police	Police are reviewing operating procedures for responding to domestic violence and child protection. DoCS and Police are working on a joint project to improve risk assessment procedures.
Improving responses to cases involving parental substance abuse	Child protection legislation has been amended to include Parent Responsibility Contracts. These are being used in selected DoCS offices that are also piloting a Parental Drug Testing policy. DoCS is revising training to improve staff expertise on carer substance abuse. NSW Health is working to improve services to women who use drugs during pregnancy. DoCS and NSW Health have established a protocol on information exchange regarding DoCS clients on opioid treatment. The agencies are jointly reviewing methadone-related child deaths. NSW Health has upgraded its systemic response to children presenting with methadone poisoning.
Better response to prenatal reports	Child protection legislation has been amended to allow exchange of information regarding an unborn child, and to expand the definition of a child at risk to include prenatal reports in certain circumstances. DoCS has consulted NSW Health and developed a draft policy on responding to prenatal reports.
Improving responses to Aboriginal children and young persons	DoCS has published its <i>Aboriginal Strategic Commitment 2006-2011</i> outlining plans to provide better services to Aboriginal clients.
Improving responses to adolescents	DoCS is establishing an internal panel to review the suicide and risk taking deaths of young people known to DoCS.
Better interagency child protection responses	A new edition of the <i>Interagency Guidelines for Child Protection Intervention</i> was published in 2006. The effectiveness of interagency practice under the guidelines is to be evaluated during 2007 and 2008. DoCS, Police and Health have reviewed the work of JIRTs and revised criteria for reports of physical abuse. DoCS has memoranda of understanding with agencies including Police, Health and Education. An Anti Social Behaviour Case Coordination Framework is being rolled out as part of an Anti Social Behaviour Pilot Strategy, with a focus on partnerships for improving and coordinating strategies to "reduce risks to, and anti social behaviours of, children and young persons requiring multi agency intervention."
Improving DoCS data collection and reporting	DoCS resumed quarterly data reporting in 2005.

- 23.33 These issues have been dealt with throughout this report. It is fair to say that each remains a challenge, the first mentioned primarily because of opposition by the PSA.

Reviewable Deaths occurring in 2006

- 23.34 The Ombudsman observed in relation to the deaths of the 123 children who died in 2006 (20 per cent of all deaths of children¹⁵²) and were included in the review that: "In most cases, the circumstances of the child's death had no connection to reported child protection concerns."¹⁵³
- 23.35 Of the deaths in that year of the of 114 children known to DoCS, in 81 cases (71 per cent) reports had been made in the preceding 12 months in relation either to them or their siblings.
- 23.36 Of the group of 40 children who died as a result of abuse or neglect, or whose deaths occurred in suspicious circumstances, the following is known:
- a. 31 children had been reported to DoCS within three years of their deaths
 - b. almost one quarter (9) were not known to DoCS. Three of these children died of abuse, and two died of neglect. This number is consistent with the proportion of children not known to DoCS in previous years
 - c. there were twice as many male (21) as female children (10)
 - d. 15 per cent (6) of the children were identified as Aboriginal
 - e. criminal charges have been laid in relation to 10 of the deaths.
- 23.37 Most of the children whose deaths were reviewable in 2006 and who were the subject of a report had two or more reports to DoCS in the three years prior to their death, with the average number of reports being 2.4. This, in fact, is lower than the average ratio of child protection reports for children and young persons reported to DoCS in any one year period. In both 2006/07 and 2007/08 there was an average of 2.3 reports for every child or young person reported.

Reviewable Deaths occurring in 2007

- 23.38 The Ombudsman provided the Inquiry with preliminary information about reviewable deaths in 2007. The number of deaths reviewed that year increased to 169, equivalent to 28 per cent of all deaths of children. However, the percentage of reviewable deaths which occurred due to abuse, neglect or in suspicious circumstances showed little change from 31 per cent in 2006 to 30 per cent in 2007, although the numbers rose from 39 to 51. The percentage of abuse cases decreased from 11 per cent in 2006 to five per cent in 2007, neglect rose slightly from nine per cent to 11 per cent as did deaths from suspicious circumstances, rising from 11 per cent to 15 per cent.

¹⁵² *ibid.*, p.3.

¹⁵³ *ibid.*

- 23.39 The percentage of children or their siblings reported to DoCS in the three years prior to their death remained the same over the two years at 91 per cent of reviewable deaths. In 2006, 71 per cent of this subset of children had been the subject of a report and 29 per cent had a sibling who was the subject of a report. In 2007, the proportions changed slightly with 67 per cent of the children being the subject of a report and 33 per cent having a sibling who was the subject of a report.
- 23.40 The number of children who died in care rose slightly from three per cent in 2006 to four per cent in 2007.
- 23.41 Consistent with previous years, most of the 169 children who died in 2007 and whose deaths were reviewable, were very young, with almost two thirds (110) of these deaths being children aged 0-4 years. Twenty per cent (34) of these deaths were of children aged 13-17 years, which is higher than that reported in the previous two years.
- 23.42 In 2007, there were slightly more male (56 per cent) than female deaths and this is consistent with data from previous years and with child deaths in general.¹⁵⁴
- 23.43 The deaths of Aboriginal children represented approximately 21 per cent of all reviewable deaths in 2007. Twenty-eight per cent of all child deaths in NSW were reviewable in 2007. In contrast, almost two thirds of the deaths of Aboriginal children were reviewable (36 of 58 deaths). This represents an increase, in both number and proportion, from 2006.
- 23.44 The deaths of infants made up the majority of reviewable Aboriginal deaths in 2007. The families of all Aboriginal children whose deaths were reviewable were known to DoCS either through a report in the previous three years in relation to the child themselves (24), or through a report about the child's sibling (12). Two Aboriginal children died in circumstances of abuse and two as a result of neglect. In a further five cases, the deaths occurred in suspicious circumstances.
- 23.45 Of the group of 51 children who died as a result of abuse or neglect, or in suspicious circumstances in 2007, the following is known:
- a. 29 children had been reported to DoCS within three years of their deaths
 - b. almost one third (16) were not known to DoCS. Two of these children died of abuse, and ten died of neglect
 - c. almost two thirds of the children were male
 - d. 18 per cent (nine) of the children were identified as Aboriginal
 - e. criminal charges have been laid in relation to nine of the deaths.

¹⁵⁴ Australian Bureau of Statistics, 1998 cited in Correspondence: NSW Ombudsman, September 2008.

- 23.46 For the 103 children who were themselves known to DoCS, the status of their DoCS case at the time of their death was:
- a. open and allocated to DoCS caseworker (32 children)
 - b. open and unallocated (five children). This means that a report or case plan may have been open at a CSC, but was not allocated to a caseworker for active casework
 - c. open but unable to ascertain its allocation status from available records (one child)
 - d. closed (65 children).
- 23.47 For the 50 siblings of children whose deaths were reviewable and reported to DoCS, the status of the siblings' involvement with DoCS at the time of the child's death was:
- a. open and allocated to a DoCS caseworker (27 children)
 - b. open and unallocated (eight children)
 - c. closed (15 children).
- 23.48 Information was also provided by DoCS about its review of children who died in 2007 in circumstances where they, or a sibling, had been reported to DoCS within three years of their death. That information revealed that the most common possible cause of death for these children was illness or natural causes (31 per cent). Four per cent were killed by alleged abuse, seven per cent of the deaths were indicative of neglect, most of which were supervisory neglect and 11.46 per cent died while co-sleeping.
- 23.49 The most frequently recorded child protection risk factors were domestic violence, parental substance abuse, poor parenting skills and parental mental health concerns. The majority of children and young persons who died had been exposed to more than one risk factor, with neglect being the most frequently recorded abuse type.

Coroner

- 23.50 Under the *Coroners Act 1980*, the State Coroner and Deputy State Coroner (but not other Coroners) have jurisdiction to hold an inquest in relation to a person who at the time of their death met the same criteria as for the Ombudsman's reviewable deaths jurisdiction.¹⁵⁵ In 2006, 210 such deaths were reported to the State Coroner.¹⁵⁶
- 23.51 While reporting an examinable death is mandatory, there is no general obligation on a Coroner to conduct an inquest. The Coroner ultimately decides

¹⁵⁵ *Coroners Act 1980* ss.13A(1)(c) and 13AB.

¹⁵⁶ Local Courts of NSW, *Annual Review 2006*, p.23.

whether to hold or dispense with an inquest. If the Coroner is able to consider all available evidence, such as the statements of witnesses and medical reports, and is satisfied that there are no outstanding matters to be determined, the Coroner can dispense with an Inquest. An inquest into the death of a child must however be held where:

- a. it appears that the child died or might have died as the result of homicide
- b. the child died while in custody, while in or temporarily absent from a detention centre, while in the process of attempting to escape custody, or during the course of a police operation
- c. there has not been sufficient disclosure as to whether the child has died (for example, in missing person cases), or as to the child's identity and the date and place of death
- d. there has not been sufficient disclosure of the manner and cause of the child's death
- e. the Minister or the State Coroner directs an inquest to be held.¹⁵⁷

23.52 If (either before the commencement of an inquest or during the course of an inquest) it becomes apparent to the Coroner that the circumstances of the death may have involved the commission of an indictable offence by a known person, the Coroner may commence or continue the inquest only for the purpose of establishing the death, the identity of the deceased and the date and place of death.¹⁵⁸

23.53 At the conclusion or suspension of an inquest, a Coroner must record his or her finding, as to whether the person died, the person's identity, the date and place of the person's death, and (in the case of an inquest that has been concluded as opposed to suspended) the manner and cause of the person's death.¹⁵⁹

23.54 A Coroner can make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the inquest was concerned.¹⁶⁰

23.55 The State Coroner must notify the Ombudsman of any reviewable death notified to the State Coroner not later than 30 days after receiving the notification.¹⁶¹ The State Coroner must also provide the Ombudsman with access to records held by the Coroner in relation to these deaths.¹⁶²

23.56 The Inquiry sought from the Coroner's Court a copy of the formal findings in relation to all inquests resulting from the death of a child in NSW since

¹⁵⁷ *Coroners Act 1980* (NSW) ss.14A and 14B.

¹⁵⁸ *Coroners Act 1980* (NSW) s.19.

¹⁵⁹ *Coroners Act 1980* (NSW) s.22(1).

¹⁶⁰ *Coroners Act 1980* (NSW) s.22A(1).

¹⁶¹ *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.37(3).

¹⁶² *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.38. See also *Coroners Act 1980* s.12A(3A).

December 2002. The Coroner provided 141 findings which were made between 2001 and early 2008.

- 23.57 Of these, the Coroner has made findings in respect of the deaths of 18 children in circumstances where the Inquiry has identified child protection issues. The issues raised in relation to those deaths are similar to those which the Ombudsman has sought to have addressed by DoCS. They include: criticism of the incident based approach taken by the Helpline; lack of interagency cooperation in relation to children with a severe disability; lack of information sharing between DoCS, Health and Police; the adequacy of recording and assessing reports at the Helpline; assessment of kinship carers; and methadone toxicity.

Child Death Review Team

- 23.58 The CDRT was established in 1995 and since 1999 has been constituted under Part 7A of the *Commission for Children and Young People Act 1998*. The object of this Part of the Act is to prevent and reduce the deaths of children in NSW through the constitution of the CDRT, which is to exercise the functions contained within the Act.¹⁶³ The CDRT considers deaths of children from birth to 17 years of age, excluding still births. The CCYP provides research and secretariat support to the CDRT. It is convened by the Commissioner for Children and Young People and its members include medical practitioners, academics, representatives of Police, DoCS, Health, the Coroner, Education and an Aboriginal representative.
- 23.59 The functions of the CDRT are as follows:¹⁶⁴
- a. to maintain a Child Death Register
 - b. to classify deaths according to cause, demographic criteria and other relevant factors
 - c. to analyse data to identify patterns and trends relating to those deaths
 - d. with the approval of the Minister to undertake research that aims to help prevent or reduce the likelihood of child deaths
 - e. to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths
 - f. to identify areas requiring further research by the CDRT or other agencies.
- 23.60 Pursuant to s.45N(2) of the Act, the CDRT cannot undertake a review of a 'reviewable death'¹⁶⁵ but may include such deaths in any research that examines a sample population of child deaths.

¹⁶³ *Commission for Children and Young People Act 1998* s.45A.

¹⁶⁴ *Commission for Children and Young People Act 1998* s.45N.

- 23.61 Section 45T of the Act imposes a duty on departments, agencies and individuals to provide the team with full and unrestricted access to records for the purposes of CDRT functions.
- 23.62 Section 45P(2)(b) of the Act requires the CDRT to provide details in its Annual Report on the extent to which its previous recommendations have been accepted. Sustained home visiting, reporting and research are the main areas about which recommendations have been made by it which are outstanding.

Child Deaths and Critical Reports Unit, DoCS

- 23.63 The Child Deaths and Critical Reports Unit (CDCRU) is the DoCS internal unit responsible for providing a centralised response to deaths of children known to it and also to cases where there are serious, although non-fatal outcomes for children. It was established in early 2004 as part of the Reform Package. The CDCRU analyses the deaths of all children where they or a sibling have been reported to DoCS within the three years prior their deaths. The CDCRU uses a systems approach to reviewing child deaths. Its focus is broad with the aim of casework being assessed in the context within which decisions are made and actions are taken. The CDCRU facilitates practice review forums in CSCs in response to cases where children have died. This provides staff with an opportunity to reflect on critical practice and decision making issues.
- 23.64 In September 2007 and in September 2008, the CDCRU compiled a report on the deaths of children known to DoCS which occurred in 2006 and 2007.¹⁶⁶ On each occasion, the CDCRU identified similar practice issues and themes to those identified by the Ombudsman and by the Inquiry. Each issue and theme is addressed in Chapter 9.

Other jurisdictions

- 23.65 As with other aspects of child protection, there are differing mechanisms for reviewing child deaths in each state and territory. Generally, the main purpose for reviewing child deaths in each jurisdiction is to recommend strategies and initiatives to prevent or reduce the number of deaths of children occurring, and to provide annual reports on the deaths.
- 23.66 In Victoria, the Office of the Child Safety Commissioner inquires into those children who were clients of child protection at the time of their death or within three months of their death. Those inquiries are reviewed by a multidisciplinary advisory committee, which reports to Parliament annually. The committee's

¹⁶⁵ As defined in the *Community Services (Complaints, Reviews and Monitoring) Act 1993* and referred to above.

¹⁶⁶ Not all of these child deaths were the subject of a full Child Deaths and Critical Response Unit investigation and report.

reports provide quantitative and demographic data and analysis about these deaths in order to identify common themes, issues and opportunities for learning that can influence future policy and practice in relevant service systems.

- 23.67 In Queensland, the death of any child known to its Department of Child Safety within the three years prior to his or her death is subject to a child death case review under the *Child Protection Act 1999*. The Department commissions an independent reviewer to complete child death case review reports. Those reviews do not investigate cause of death, but focus on the adequacy and appropriateness of the Department's interventions, policies, procedures and interactions with other agencies as they related to the child who died. The Department has six months from the time it learns about the death of a child known to it to provide the Child Death Case Review Committee with its report on the original child death review.
- 23.68 The Queensland committee is a multi-disciplinary committee chaired by the Commissioner for Children and Young People and Child Guardian. It acts independently, but the Commission for Children and Young People provides secretariat support. The committee reports on its review of each case to the Department of Child Safety within three months of receiving the report from the Department.
- 23.69 In Western Australia, the Child Death Review Committee reviews deaths which meet one or more of the following criteria:
- a. The deceased child or young person or other children in the deceased child's family had been the subject of an allegation of a child concern report or a child maltreatment allegation recorded by the Department for Child Protection within the past 24 months.
 - b. The family of the deceased child or young person had a number of contacts with the Department for Child Protection within the past 24 months and an emerging pattern was indicated.
 - c. The deceased child or young person was in the care of the Department for Child Protection or a request for Departmental involvement in an OOHC placement for the child or young person had been made within the past 24 months.
- 23.70 One of the recommendations from a review of the former Western Australian Department of Community Development, was that the child death review function be transferred from the ministerial Child Death Review Committee to the Ombudsman. This recommendation was endorsed by the State Government and funding has been approved for 2008/09.¹⁶⁷
- 23.71 In addition, the Inquiry understands from its website that Western Australia has an Advisory Council on the Prevention of Deaths of Children and Young People

¹⁶⁷ Western Australian Ombudsman, *Annual Report 2007/08*, p.58.

which is tasked with reducing or preventing the deaths of children aged from 0-17 years, promoting the health, safety and well-being of children through the review and analysis of relevant information and research and through the making of recommendations. The Council is independent and reports to the Cabinet Standing Committee on Social Policy, through the Minister for Community Development.

- 23.72 In South Australia, the Child Death and Serious Injury Review Committee is an independent statutory body. It reviews cases where there are indications of abuse or neglect, or where a child or family has been known to child protection service within a three year period or is in care.
- 23.73 The Inquiry understands that in the ACT, the criteria for review by the ACT Child Death Review Team relate to the existence of reports on the child, a sibling or family two years before the death. The Inquiry also understands that the Northern Territory is in the process of establishing a reviewable deaths function which will include the deaths of all children.
- 23.74 Notwithstanding the different approaches among the jurisdictions, the Inquiry understands, from a seminar conducted in June 2008 on Australasian Child Death Inquiries and Reviews, that the co-existence of domestic violence, mental health, drug and alcohol issues and concerns about interagency collaboration are common to the equivalent of “reviewable deaths” in all jurisdictions.
- 23.75 It is beyond the Inquiry’s terms of reference to achieve a national approach to child protection or even to the review of child deaths. However, it should be said that the Inquiry supports a move towards a national system of data collection and review on child deaths.

Issues arising

- 23.76 A number of issues arise from the way in which child deaths are scrutinised in NSW. First is the question of whether it remains appropriate for each of the four bodies who are obliged to, or have assumed responsibility for investigating or reviewing these deaths to continue to do so, or whether wasteful duplication exists. Secondly, it needs to be established whether the categories of deaths which are reviewable are appropriate to achieve the desired purpose. Finally, the interval at which reports about these deaths are made public needs to be examined.

Four agencies

- 23.77 DoCS, via the CDCRU, the Coroner and the Ombudsman each inquire into and report on deaths of children. The latter two generally inquire or report in public and by reference to similar criteria. DoCS investigates privately and by reference to broader criteria. In addition, research work into deaths is undertaken and published by a fourth body, the CDRT. Two registers are

effectively kept, one by the Ombudsman and one by the CDRT. Other sources of information include the NSW Midwives Data Collection and Australian Bureau of Statistics data.

- 23.78 At first blush and with reference to other jurisdictions, this appears to be a cumbersome and potentially resource intensive system. DoCS was particularly critical of it.

DoCS view

- 23.79 DoCS carried out an analysis of the recommendations made by the Ombudsman to DoCS between June 2004 and November 2006 and the work carried out by the CDCRU. DoCS concluded, from that analysis, that about 78 per cent of the Ombudsman's recommendations arising from child death investigations, and about 86 per cent of the Ombudsman's recommendations in the three annual reports were either consistent with work DoCS had already undertaken, or related to reporting back to the Ombudsman on work being done. Only five per cent of the recommendations arising from child death investigations, and 13 per cent of the recommendations from the annual reports offered new directions or initiatives, which DoCS had not identified for itself. When fresh recommendations were made, DoCS stated that they did not generally take into account the operating context or limitations, for example, those relating to staffing levels.

- 23.80 As a result of its analysis, DoCS identified what it described as opportunities to improve the future operation of the oversight system. It offered three areas for consideration:
- a. developing a standard approach to individual child death reviews to satisfy both agencies thereby reducing the duplication of effort
 - b. replacing recommendations that either reflect existing work or confirm existing practices, with confirmatory statements
 - c. providing an opportunity to respond to recommendations in the annual reports prior to publication.

- 23.81 In its submission to the Inquiry, DoCS supported one key external review body, rather than several:

One possible model would be a framework similar to that operating in Queensland for the review of child deaths. Under this option a panel would be responsible for the independent oversight of child death reviews. Tapping into superior levels of expertise available via the panel will help ensure that the response to a child death is driven by best evidence in child protection practice. It also provides much clearer lines of accountability... DoCS would be obligated to review its involvement in every case in which a child or sibling was 'known to DoCS' in the previous 12 months. Child death reviews would

be required to be completed within a strict time frame (six months). The extent and nature of the review would reflect the nature of the death - where there is a preliminary finding that the death was related to child protection issues, a detailed review would be necessary.

Findings of the child death review and recommendations for reform or remedial action would be considered by the DoCS senior executive. Every child death review report would be referred to the panel. Where the death related to matters of abuse and neglect, or suspected abuse or neglect the report would be referred to the Coroner as well.

The panel would review the DoCS report, any subsequent advice from the Coroner as well as input from other agencies if relevant, and make recommendations in relation to systemic reform, if warranted. The panel would also be empowered to independently report directly to the Minister on the child death if it considered it necessary and desirable to promote improvements to child protection practices. The panel would also carry out a broader function in relation to all child deaths. Its report would include a report on reviewable deaths and only one deaths register (as opposed to the current two) would have to be maintained.¹⁶⁸

Ombudsman's view

- 23.82 In relation to DoCS' suggested model, the Ombudsman noted that:
- a. DoCS should not have the power to access the necessary information from all the parties who may have had relevant dealings with a child or young person and or their family in the period leading up to their death
 - b. the model would not adhere to the principles underpinning the granting of the jurisdiction to the Ombudsman and in particular, those concerning the transparency and independence of the review process.
- 23.83 In his submission, the Ombudsman stated:

A separate but related issue is the need to recognise that identifying systemic issues is one challenge, ensuring an effective system response to these issues is another. In this regard, the Ombudsman is ideally placed to make an assessment not only as to whether agencies are aware of problems, or have plans to address them, but to also to monitor the adequacy of the subsequent response. From our many years of oversight, we are acutely aware that agencies often

¹⁶⁸ Submission: DoCS, Role of Oversight Agencies, p.13.

*have good capacity to identify problems, but may fail to effect change.*¹⁶⁹

- 23.84 Not surprisingly, the Ombudsman also has taken a different view in relation to the value of his work and believes that it has directly resulted in positive changes. The Ombudsman referred to legislative changes in late 2006 in response to issues that he had raised, including the introduction of Parent Responsibility Contracts, prenatal reports, information exchange relating to unborn children, and the admissibility of evidence in care proceedings about a child previously removed and not restored as *prima facie* proof that a sibling is in need of care and protection. In addition, the Ombudsman stated that the revised secondary assessment procedure, and the neglect policy, address issues that had been identified in his reviews.
- 23.85 He said, in relation to the 13 per cent of the recommendations which concerned 'new initiatives', that they included a proposal that DoCS give priority to risk assessments on children whose siblings had been removed as well as a recommendation for there to be a systematic performance audit of every CSC.
- 23.86 He also noted that other agencies, notably Health and Police who are subject to his oversight through the reviewable deaths function, speak positively of his role in this area.
- 23.87 In relation to the role of the CDRCU, the Ombudsman sees its focus as a 'considerable strength' and has advised that it is his preferred approach that, where his office is aware that the CDRCU is conducting a review, to await the outcome of that review. He noted however that timeliness was an issue with its work.
- 23.88 In the view of the Ombudsman, the system of child death reviews which involve his office and the CDRT has worked well and is effective. He has advised that the functions are complementary and that the legislation provides for procedures that minimise overlap in the conduct of research. For example, the CDRT may not undertake a review of a reviewable death or conduct research about reviewable deaths unless approved by the Minister. In addition he suggested that, the annual reports produced by each agency on child deaths are distinct and complementary.

Other views

- 23.89 The CCYP has stated that there is currently little or no duplication in the roles of the CDRT and the Ombudsman. In relation to child deaths, the CCYP recommended that the Ombudsman be required to seek and consider the view of the CDRT before undertaking research into child deaths, except in relation to his Annual Report into reviewable deaths.

¹⁶⁹ Submission: NSW Ombudsman, Oversight Agencies, p.7.

- 23.90 The Commissioner for Children and Young People who is the convenor of the CDRT expressed the following view at the Public Forum, when asked why the CDRT would not fit functionally well within the Ombudsman's Office:

Because the Ombudsman's purpose is to oversight public administration, if you like, and that is not the purpose of the Child Death Review Team. The purpose of the Child Death Review Team is to look at all deaths, not just those covered by public sector agencies....

...when you are focused on reviewing deaths of a particular group, it tends to absorb the resources, it tends to be the focus of the report, whereas what the Child Death Review Team is focussed on currently and, as a result of the separation, is in fact the epidemiological issues and surveillance and trying to identify patterns that might prevent children's deaths.¹⁷⁰

- 23.91 Police submitted that there was duplication in the review of child deaths, in particular, between the Ombudsman and the CDRT. The Police are of the view that the role of the Coroner remains appropriate.¹⁷¹

Inquiry's view

- 23.92 There is an overlap between the recommendations function of the Coroner and the systemic work undertaken by the Ombudsman. However, the former's primary focus is on determining the manner and cause of death, a finding not made by the Ombudsman. The Coroner usually has the benefit of the DoCS internal review before holding an inquest and, on more than one occasion, has not made any recommendations because of his or her satisfaction with the internal review and DoCS response to it. In addition, the Coroner undertakes relatively few inquests into reviewable deaths. The Coroner also benefits from oral evidence, has public hearings and is subject to appellate review. The Ombudsman frequently relies on the written record, which, from the Inquiry's experience with DoCS files, is often a poor indicator of whether action was or was not taken. The Coronial Inquest also serves the important function of forming a view whether there is evidence that is capable of establishing that an indictable offence has been committed by a known person and, if so, of referring the matter to the Director of Public Prosecutions.
- 23.93 The Inquiry is satisfied that there are sufficient differences and benefits from the work of the Coroner such that no change to the jurisdiction arising under the *Coroners Act 1980* is warranted.
- 23.94 The Inquiry believes, however, that there is a duplication of effort arising from the fact that the CDRT is located in the CCYP. Two primary registers are kept,

¹⁷⁰ Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, p.7.

¹⁷¹ Submission: NSW Police Force, p.43.

and there is clearly some tension in who undertakes research functions and for what purpose, hence the Commissioner for Children and Young People's views set out above. There are also issues in relation to information sharing which were identified in the statutory review of the CS CRAMA.¹⁷²

- 23.95 It is evident to the Inquiry that in considering reviewable child deaths it is critical to examine and compare the contexts in which the deaths occur. This can be enhanced through an integrated function that examines all child deaths in NSW to enable the making of more systemic recommendations to prevent child deaths. Given this fact, and the experience gained by the Ombudsman because of his role in reviewable deaths, it is the Inquiry's opinion that the CDRT should be convened, chaired and supported by the Ombudsman, although with the Commissioner for Children and Young People, or her delegate, continuing to be a member. This would require changes to the *Commission for Children and Young People Act 1998*, and to the Ombudsman Act, to reconstitute the Team and to provide for the processes and powers necessary for its continued operation. It would also require a transfer to the Office of the Ombudsman of the associated research and secretarial support functions and staff. In other respects its operation should remain unchanged, save for the requirement that as between the CDRT and the Ombudsman only one register of child deaths should be kept.
- 23.96 Because of its statutory responsibility for vulnerable children, and because deaths of children and young persons can involve action or inaction by multiple agencies, there must be oversight by an agency external to DoCS. The Inquiry sees no need to establish a separate panel as suggested by DoCS. The Inquiry is also persuaded that the Ombudsman's power to require the production of documents from other agencies is an important aid to reviewing deaths, and is not a power that should reside in DoCS. Independent and transparent review remains important in this respect.
- 23.97 The Inquiry has been impressed by the quality and content of the reports produced by each of the CDCRU and the Ombudsman. They are systemic in focus and contribute significantly to an understanding of the events surrounding deaths of children and young persons. A recent report by the CDCRU noted that it relied on the Ombudsman's investigation summary document as providing the factual basis for the report. While, in that case, its findings were similar to the Ombudsman, specific practice themes were also identified, as was recent research into child protection practices. The Ombudsman informed the Inquiry that it is now rare for his office to conduct single agency investigations involving DoCS, given the review processes of the latter.
- 23.98 It has been raised with the Inquiry that there could be a potential cause for concern in the event that the reviews conducted by the Ombudsman and DoCS

¹⁷² The Committee on the Office of the Ombudsman and Police Integrity Commission recommended that the *Community Services (Complaints, Reviews and Monitoring) Act 1993* be amended to put beyond doubt that members of the Child Death Review Team have a duty to provide the Ombudsman with information and assistance.

resulted in inconsistent messages being delivered to or received by staff. Inevitably and usually properly, there will be different lessons highlighted by DoCS and by the Ombudsman in their reviews. In the Inquiry's review of reports about the same death, differences in approach are evident but not such as to detract from the overall value of the work of each. The staffing context provided by the DoCS report is beneficial and necessary while the scrutiny of the actions of other agencies delivered by the Ombudsman is equally beneficial and necessary.

- 23.99 The Inquiry is satisfied that neither the Ombudsman nor DoCS should cease reviewing and preparing reports into child deaths. In the interests of transparency and public accountability it is important to preserve the oversight role of the Ombudsman. It is equally important that DoCS should retain a responsibility for ensuring that its casework is effective and that it accepts responsibility for systemic failure.
- 23.100 There is, however, merit in the DoCS submission that a standard approach to individual child death reviews be developed and that recommendations that either duplicate existing work or confirm existing practices are replaced with confirmatory statements accepting their approach. The Inquiry understands that DoCS is currently provided with an opportunity to respond to recommendations in the annual reports prior to publication, and can make its views known as to whether draft recommendations should retain that character or be the subject of confirmatory statements.
- 23.101 There is an issue with the timeliness of the DoCS reviews. The Inquiry considers it important that DoCS should complete its reports within six months.
- 23.102 The Inquiry notes that DoCS is currently considering trialling a root cause analysis approach to its internal reviews. That approach has been successful in Health and the Inquiry would encourage DoCS to trial such an approach.

What should be reviewable and when should it be reported?

- 23.103 Assuming that the CDRT function is transferred to the office of the NSW Ombudsman, the question arises whether there remains a need for a separate function in relation to reviewable deaths. The Inquiry firmly believes that the reviewable death function should continue, as its particular focus is necessary and is likely to be enhanced by undertaking research into all child deaths. However, the criteria by which certain deaths are reviewed requires further analysis.
- 23.104 In this latter regard, DoCS made the following recommendation:

The NSW definition of 'reviewable death' should be made more meaningful in two ways: a child's death should be reviewable if the cause of death was, or may have been due to abuse or neglect or occurred in suspicious circumstances AND the child

was 'known to DoCS' based on reports about the child or a sibling in the same household in the 12 months prior to the death (rather than three years, as is currently the case).¹⁷³

23.105 This recommendation was made in the context of a concern that the current system operates punitively by virtue of its emphasis on reports to DoCS and the effect of media reporting of the annual reports produced by the Ombudsman. DoCS quoted Dr Munro who argues that a punitive system of oversight can have a detrimental effect on worker morale and system performance by resulting in an over reliance on procedures, diversion of resources, and difficulty in attracting and retaining staff.

23.106 The Commissioner for Children and Young People and convenor of the CDRT expressed the following view at the Public Forum held by the Inquiry:

In ... the joint submission that I did with Dr Cashmore and Professor Scott we do make a recommendation that the focus of reporting be on child abuse and death or death in suspicious circumstances, and that the [Ombudsman's] reporting period be extended from one year to three years. The reasons for that is that we think that there is insufficient time for change to occur within one year, and if you extend the reporting time frame, then you do allow for change to occur and for the Ombudsman to then more meaningfully comment on the impact of the work of whatever agency it is implementing the recommendation. The reason we have suggested that the reporting should focus on child abuse and neglect is because of the misunderstanding that has continued for 10 years now about the meaning of 'known to DoCS' or, if you like, 'vulnerable children'.¹⁷⁴

23.107 The Deputy Ombudsman's response in the Public Forum was:

So if, for example, it is limited to abuse and neglect, suspicious circumstances, then we'd probably look at between 30 and 40 matters per year. In those circumstances the question would have to be asked as to whether we would actually be well placed to make judgments about the child protection system.¹⁷⁵

23.108 In his written submission, and in response to DoCS' submission the Ombudsman noted that:

- a. the current system is well structured and able to identify causal links
- b. only 27 of the 114 (known to DoCS) deaths in 2006 would meet the revised criteria proposed by DoCS

¹⁷³ Submission: DoCS, Role of Oversight Agencies, p.12.

¹⁷⁴ Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, pp.8-9.

¹⁷⁵ *ibid.*, p.12.

- c. of the 620 deaths reviewed between 2003 and 2008, only 180 would be reviewable
- d. risk factors in the child protection system of many children who die from abuse or neglect are not substantially different from the histories of children who die in other circumstances
- e. observations such as an over representation of Aboriginal children, the effect of maternal substance abuse, adolescent deaths arising from suicide and motor vehicle accidents and police reporting of domestic violence would not have been able to be made under the DoCS proposal
- f. his office has an interest in the deaths of children who were not known to DoCS, but who died in circumstances of abuse or neglect or in suspicious circumstances
- g. the response of the media to his Annual Reports is not considered a sufficient ground for extending the time frame, although it was acknowledged that producing an annual report is resource intensive.¹⁷⁶

23.109 The representative of the Coroner supported limiting the jurisdiction to deaths due to abuse and neglect and to those arising in suspicious circumstances.¹⁷⁷

23.110 It is necessary to first identify the purpose of any investigation into the death of a child in NSW by an agency other than the Police. The Inquiry is conscious of the academic literature which is critical of the bureaucratic response to child deaths. Scott notes that child death inquiries often make matters worse by concentrating on the last link in the chain of events, rather than the structure and role of child protection services generally and their place as part of a wider government and community response.¹⁷⁸

23.111 Under CS CRAMA, the Ombudsman is to formulate recommendations for the prevention or reduction of deaths which are reviewable. His Office does so by identifying shortcomings in agency systems or practice that may have contributed to the death or to children being exposed to risk in the future.

23.112 DoCS submitted the following to the Inquiry:

The objective of a reviewable deaths framework is to ensure that where a child who had some close connection with the child protection system dies, there is a timely and effective review of the circumstances of that death. It must operate on two levels. Firstly it must investigate the individual death in a way to determine whether the cause of death was related to child protection concerns for the child and make

¹⁷⁶ Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, pp.14-18.

¹⁷⁷ Transcript: Public Forum, Role of Oversight Agencies, 28 March 2008, p.15.

¹⁷⁸ D Scott, *Sowing the Seeds of Innovation in Child Protection*, Paper presented to the 10th Australasian Child Abuse and Neglect Conference, Wellington, New Zealand, February 2006, p.10.

*recommendations aimed at the prevention or reduction of such deaths. Secondly it must identify general casework or overall system reform matters that warrant attention or remediation, if they exist.*¹⁷⁹

- 23.113 Put another way, if the purpose of a review mechanism for child deaths known to DoCS is to improve the child protection system and there is no proper causal connection between the deaths and that system, then it is not achieving its purpose.
- 23.114 The Inquiry takes a broader view. Deaths of children and young persons should be reviewed to determine, among other matters, whether the child protection system, at its broadest, should have known about and responded to their circumstances. Much can be learned about the involvement of other agencies in the lives of children who have died from abuse or neglect or in suspicious circumstances when no report has been made to DoCS. The emphasis should be on the circumstances of their death and messages for the child protection system as a whole, not just confined to an examination of what DoCS might have done or did do, in relation to that child.
- 23.115 Equally, the process should focus on systemic matters and acknowledge that predicting the death of child from reports to a child protection agency is not a science attended by certainty. It involves human reasoning and judgement based on available information, in relation to conduct which is not necessarily predictable.
- 23.116 The research informs us that child deaths are not considered a likely outcome in most cases of child abuse; most who die are not known to child protection services and the risk factors that are present in cases of fatal child abuse are generally similar to those present in many thousands of other child protection cases which do not have a fatal outcome.
- 23.117 Consistent with this research, in his report of reviewable deaths in 2006, the Ombudsman said that in most cases, the circumstances of the child's death had no connection to reported child protection concerns. Obviously in some cases a child will die of natural causes or as a result of the actions of a third party for which the carer will have no responsibility or capacity to control.
- 23.118 Accordingly, the Inquiry takes the view that the criteria of 'known to DoCS' is not useful and can be harmful by escalating in the mind of the public, deaths where a report has been made, which would not have justified an intervention, to deaths which could have been prevented by action from DoCS.
- 23.119 A report signifies concerns by the reporter, who is more likely than not to be a mandatory reporter. It may or may not meet the threshold of risk of harm,

¹⁷⁹ Submission: DoCS, Role of Oversight Agencies, p.11.

indeed in excess of 10 per cent of cases it will not do so.¹⁸⁰ Those concerns may or may not be based on factually accurate material. They are not a reliable indicator of whether the child protection system should have known about and, if so, intervened positively in the life of the child.

- 23.120 In 2006 and 2007, 101 deaths were reviewable on the criteria of abuse, neglect, suspicious circumstances or being in statutory care. That is about a third of all deaths reviewable under the current regime. In the likely event that many of these were known to one or more of the agencies which form part of the child protection system, this role can be closely scrutinised by the Ombudsman. Thus causal links can be explored, if they exist.
- 23.121 Further, those deaths which do not meet the revised criteria will still be the subject of scrutiny by the CDRT. By transferring the role of convenor to the Ombudsman, information from those deaths can inform child protection work. For example, the presence of drugs in children is identified in the work of the CDRT as are deaths by suicide or resulting from risk taking behaviours.¹⁸¹
- 23.122 The role of the Ombudsman in commenting on the child protection system is a valuable and necessary one, however, the vehicle of child deaths is not the only, nor the most reliable, basis for enlivening that role. First, since 2003 the Ombudsman has initiated 73 investigations into child protection issues, 66 of which have arisen from child death reviews, thus indicating other sources of information. The Ombudsman has used its 'own motion' power in a number of these cases. Secondly, the Ombudsman's complaint handling function is a role which can be used to identify and comment on child protection matters. Finally, its broad monitoring and review functions have permitted it to inquire into other child protection issues including services for children with disabilities, individual funding arrangements in OOHC and support for Aboriginal foster carers.
- 23.123 The Ombudsman has submitted to the Inquiry that in order to ensure that his office retains an "ongoing and well-informed understanding of child protection practice" a power should be conferred on him to keep under scrutiny the systems for handling and responding to risk of harm reports.
- 23.124 The Inquiry is of the view that the Ombudsman has a sufficient current ability to scrutinise the systems for handling reports without amending the legislation. His powers under s.11 of the CS CRAMA, particularly to monitor and review the delivery of community services and to inquire into matters affecting service providers and consumers, would amply enable him to scrutinise the response of DoCS to risk of harm reports. The Inquiry agrees that it is important that he continue to do so.

¹⁸⁰ See Chapter 6.

¹⁸¹ NSW Child Death Review Team, *Trends in the fatal assault of children in NSW: 1996-2005*, 2008, p.3.

- 23.125 This approach should not affect the work of the CDCRU which should review the deaths of all children where a report has been made in the preceding three years, either in respect of those children or their siblings.
- 23.126 The final question concerns the timing of the reporting cycle. An annual reporting cycle is resource intensive for the Ombudsman and, as pointed out by Ms Calvert, Dr Cashmore and Professor Scott, does not permit much meaningful comment about improvements which may have been made since the previous report. Reporting at two yearly intervals should assist in each of these respects. From the data mentioned above, it is anticipated that the deaths of around 100 children would be reported, a sufficient number to draw useful conclusions, as to any systemic or other issues that need to be addressed.
- 23.127 In conclusion the Inquiry considers that the reviewable death provisions should be amended so as to delete the 'known to DoCS' criterion. This would leave the remaining criteria intact. Although it might still require a review to be made where a child in care dies from natural causes or accident outside the control of a carer or DoCS, the lack of any need for any detailed inquiry, except where the Coroner's jurisdiction was involved, would be obvious. In addition, the Inquiry favours replacing the annual reporting in exercise of the reviewable death function with a bi-annual requirement.

Reviews of children in care

- 23.128 Since 2003, the Ombudsman has conducted five group reviews of individuals in care: two reviews of children under five years of age, a review of young people with disabilities leaving care, a review of children under the parental responsibility of the Minister placed in SAAP services and a review of a group of children aged 10-14 years in OOHC and under the parental responsibility of the Minister.
- 23.129 Eight service based reviews have also been conducted. The issues from each of these reviews have been considered in Chapters 16 and 18.
- 23.130 The Ombudsman and the Children's Guardian each have roles and responsibilities in relation to children in OOHC. The Inquiry has been informed and agrees that the legislative provisions for these roles and responsibilities ensures that the work of both agencies is complementary rather than duplicative. It accordingly does not suggest any change in these arrangements.

Complaints

- 23.131 In 2007/08 the Ombudsman received 839 formal complaints about agencies providing child and family services, of which 755 were about DoCS. This is a sharp increase from 560 formal complaints in 2006/07 and 595 in 2005/06. It is

unclear whether this increase is attributable to changes that have been made in the presentation and classification of this information.¹⁸²

23.132 In 2007/08, about half of the formal complaints received by the Ombudsman about DoCS concerned its child protection services and about half were about OOHC services provided or funded by DoCS.¹⁸³

23.133 For child protection services, the most common complaints were about the adequacy of DoCS' casework, in response to risk of harm reports about children and young persons:

*These concerns primarily relate to DoCS' decisions about whether or not to intervene following a risk of harm report, and the adequacy of DoCS' investigation, assessment of, and decisions in response to allegations that a child or young person has been abused or neglected. Other issues that were the subject of complaint included DoCS' handling of complaints about its activities and the professional conduct of staff.*¹⁸⁴

23.134 Regarding OOHC, the most common complaints were about the adequacy of assessment, planning and provision of services. For example,

*the appropriateness of placements for children and young people; the supports provided to children in care and their carers; decisions to move children between care placements; and arrangements for contact between children in care and their families. ...the quality of 'customer' service provided by service staff, the responses of services to complaints about children in care, and payment of allowances and fees to foster parents to support children in care.*¹⁸⁵

23.135 The Ombudsman resolved and/or made recommendations for improvements to services in 42.3 per cent of the formal complaints finalised during 2007/08.¹⁸⁶ The Ombudsman acknowledges that many of the complaints are difficult to resolve because of the nature of the subject matter.

23.136 The subject matter of most of the complaints were also raised in submissions made to the Inquiry and are addressed in appropriate chapters of this report.

23.137 The Inquiry has dealt with the complaints management system, so far as DoCS is concerned, in Chapter 2.

¹⁸² See Figure 35, NSW Ombudsman, *Annual Report 2006/07*, p.80 and Figure 20, NSW Ombudsman, *Annual Report 2007/08*, p.70.

¹⁸³ NSW Ombudsman, *Annual Report 2007/08*, p.70.

¹⁸⁴ *ibid.*, p.68.

¹⁸⁵ *ibid.*, p.70.

¹⁸⁶ *ibid.*, p.69.

Official Community Visitors

- 23.138 Official Community Visitors are statutory appointees of the Minister for Community Services. Their role is to visit accommodation services for children and young persons in residential OOHC and people with a disability in accommodation that is operated, funded or licensed by DADHC.
- 23.139 Official Community Visitors are independent of the Ombudsman although the Ombudsman has a general oversight and coordination role including determining priorities and allocating visiting hours. Official Community Visitors made 307 visits to services accommodating children and young persons and 137 visits to services for children and young persons with a disability in 2007/08.
- 23.140 The focus of the Visitors is to facilitate and monitor the resolution of issues by services at the local level. Visitors may resolve the issues themselves or refer them to the Ombudsman. In 2007/08, 427 issues were reported to the Ombudsman by Visitors in relation to services for children and young persons, and 204 issues in relation to services for children with a disability. Most were resolved.
- 23.141 The Inquiry regards this process as a valuable adjunct to the complaints system in that it allows the recipients of services to have a voice, and also in that it provides an opportunity for concerns to be addressed before they develop into serious problems as well as an opportunity to monitor the response of the relevant Services to respond to issues that are identified as being of concern.
- 23.142 Additionally, it provides the Ombudsman with a further source of referral for investigation, particularly in relation to the kind of concerns that may have an institutional or systemic origin, and that may have an impact on the relatively small group of children and young persons who are placed in the various forms of residential OOHC services.
- 23.143 The Inquiry is satisfied that the work of the Official Community Visitors is not unduly duplicative of the functions of other oversight bodies, in particular, the accreditation work of the Children's Guardian.
- 23.144 The Children's Guardian submitted that to assist the OOHC accreditation process, the CS CRAMA should be amended to allow her to have access to reports by the Official Community Visitors.
- 23.145 This matter was recently before the Legislative Council's Committee on the Office of the Ombudsman and the Police Integrity Commission during its consideration of the review of CS CRAMA. That Committee took the view that legislative amendments may be counter productive and have the effect of making the work of Official Community Visitors more difficult. It expressed the view that because Official Community Visitors report directly to the Minister there is already an avenue through which serious concerns can be raised. It

seems that the Committee's view was influenced by the evidence of one Official Community Visitor who thought if reports were to go back to funding bodies the role of the Official Community Visitors would be confused. That witness also noted that there were occasions when she wished to share information with such bodies as accrediting agencies.

- 23.146 The Inquiry agrees with the submission of the Children's Guardian. Information obtained by persons appointed by the Minister should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards. Section 8 of CS CRAMA and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* would need to be amended to achieve this outcome.

Reportable allegations

- 23.147 The Director-General of DoCS and the heads of designated agencies are required to notify the Ombudsman of any reportable allegation made against an employee, and of any reportable conviction, within 30 days of becoming aware of it, and of the action which the relevant agency proposes to take in relation to the employee.¹⁸⁷
- 23.148 These obligations arise in the context of Part 3A of the Ombudsman Act, pursuant to which the Ombudsman must scrutinise the systems put in place by designated agencies and other public authorities for preventing reportable conduct by employees and the way in which those agencies handle and respond to allegations of reportable conduct or convictions.¹⁸⁸ In the performance of these obligations, the Ombudsman:
- a. receives and assesses notifications concerning reportable allegations or convictions against an employee
 - b. monitors investigations of reportable allegations and convictions against employees
 - c. conducts investigations concerning reportable allegations or convictions, or concerning any inappropriate handling, of or, response to, a reportable notification or conviction
 - d. conducts audits and engages in education and training activities to improve the understanding of, and responses to, reportable allegations.
- 23.149 In addition to reporting allegations of reportable conduct of employees which arise in the course of their employment, DoCS is also required to notify allegations where they arise from conduct which takes place outside of their employment.

¹⁸⁷ Ombudsman Act 1974 s.25C(1).

¹⁸⁸ Ombudsman Act 1974 s.25B.

- 23.150 'Reportable conduct' means:
- a. any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offences), or
 - b. any assault, ill-treatment or neglect of a child, or
 - c. any behaviour that causes psychological harm to a child,
- whether or not, in any case, with the consent of the child.¹⁸⁹
- 23.151 Reportable conduct does not extend to:
- a. conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards, or
 - b. the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation is recorded under workplace employment procedures, or
 - c. conduct of a class or kind exempted from being reportable conduct by the Ombudsman under s.25CA.¹⁹⁰
- 23.152 The note to this definition in the Ombudsman Act states that examples of conduct that would not constitute reportable conduct include (without limitation) touching a child in order to attract a child's attention, guiding a child or comforting a distressed child; and conduct that is established to be accidental.
- 23.153 A 'reportable allegation' is defined to mean an allegation of reportable conduct, or an allegation of misconduct that may involve reportable conduct, while a 'reportable conviction' means a conviction (including a finding of guilt without the court proceeding to a conviction), in NSW or elsewhere, for an offence involving reportable conduct.¹⁹¹
- 23.154 Designated agencies include, *inter alia*, DoCS, those agencies that arrange the provision of OOHC and that are accredited for those purposes, and those agencies that provide substitute residential care for children.¹⁹²
- 23.155 For the purposes of these provisions an 'employee' includes DoCS salaried staff and anyone who is engaged by a designated agency to provide services to children.¹⁹³ DoCS authorised carers, including authorised relative carers are also covered.¹⁹⁴

¹⁸⁹ *Ombudsman Act 1974* s.25A(1).

¹⁹⁰ *Ombudsman Act 1974* s.25A.

¹⁹¹ *Ombudsman Act 1974* s.25A(1).

¹⁹² *Ombudsman Act 1974* s.25A(1); *Children and Young Persons (Care and Protection) Act 1998* s.139.

¹⁹³ *Ombudsman Act 1974* s.25A(1).

¹⁹⁴ DoCS 'authorised carers' are considered employees for the purpose of employment screening and allegations of reportable conduct. Recently DoCS made the decision to include relative carers as authorised carers. As a result they are now also considered employees for the purposes of screening and allegations.

- 23.156 Carers who have kinship placements as a result of an order by the Family Court are not considered authorised relative carers and are therefore not 'DoCS employees.'
- 23.157 In 2007/08 the Ombudsman received 1,850 notifications of reportable allegations and finalised 1,921. Notifications decreased from 1,995 in 2006/07. The most significant decrease (30 per cent) came from the largest notifier, Education. Education attributes this decrease to the class or kind determination and to training initiatives with its staff and students.¹⁹⁵ However the percentage of reportable allegations from DoCS rose from 23.5 per cent in 2006/07 to 31.1 per cent in 2007/08.¹⁹⁶
- 23.158 The most frequently notified issue from all notifiers was physical assault (59 per cent), followed by neglect (10 per cent), sexual offences (nine per cent), sexual misconduct (seven per cent), and behaviour causing psychological harm (four per cent).¹⁹⁷
- 23.159 There is a category of misconduct allegations concerning DoCS salaried staff that DoCS will need to investigate, but that may not need to be notified to the Ombudsman. Essentially this category comprises conduct that breaches the DoCS code of conduct or Public Service guidelines, such as not declaring a conflict of interest, breaching confidentiality requirements, or accepting gifts of more than a token nature. In general, they may be dealt with pursuant to the provisions of the *Public Sector Employment and Management Act 2002*, although, if any allegation involves conduct possibly amounting to corrupt conduct within the meaning of the *Independent Commission Against Corruption Act 1988*,¹⁹⁸ then an obligation will arise for it to be reported to that Commission.
- 23.160 As noted above the staff of accredited non-government agencies, who will normally be employed under the Social and Community Services (SACS) Award, and their authorised foster carers, fall within the definition of 'employee' for the purposes of the reporting and investigation procedures outlined above. Additionally these agencies are required, by virtue of the funding framework, to have adequate human resource management systems in place.¹⁹⁹ They are similarly required by the funding framework to provide an appropriate response to allegations of fraud involving their staff or carers.²⁰⁰

¹⁹⁵ NSW Ombudsman, *Annual Report 2007/08*, p.74.

¹⁹⁶ *ibid.*, p.75.

¹⁹⁷ *ibid.*, p.81.

¹⁹⁸ *Independent Commission Against Corruption Act 1988* ss.7–9.

¹⁹⁹ DoCS, *Performance Monitoring Framework for Funded Services 2006/07* and DoCS, *Good Practice Guidelines for DoCS Funded Services 2006*.

²⁰⁰ DoCS, *Policy for Responding to Fraud in DoCS Funded Services*, June 2007. See also the Fraud Risk Assessment for Service Providers tool, September 2005 and the Practice Notes on Internal Fraud which were prepared by DoCS to assist funded service providers in addressing the risk of fraud within their organisations.

Investigation of allegations by DoCS

- 23.161 Under the Care Act the Director-General of DoCS is required to arrange for any report, alleging the abuse of a child or young person by a person employed within the Department, to be investigated in accordance with arrangements made between the Director-General and the Ombudsman.²⁰¹ Casework Practice in this regard is guided by the DoCS practice document, Responding to allegations against DoCS.
- 23.162 DoCS coordinates its response to allegations against employees through the Allegations Against Employees (AAE) Unit which is located centrally within the Complaints Assessment and Review Branch in the Strategy, Communication and Governance Division of the Department.
- 23.163 When allegations are received by the Helpline, they are referred to the AAE. The determination of whether an allegation of reportable conduct so received will be investigated by the central AAE Unit or within a Region is made on a case by case basis, depending on the potential seriousness of the conduct involved.
- 23.164 Irrespective of where the allegation is investigated, the procedure is the same, being undertaken in accordance with the DoCS policy and procedures manual, Managing Allegations against Employees.
- 23.165 Caseworkers at CSCs and at Regions, who have been trained by the AAE Unit in relation to these procedures, conduct the investigation in addition to their ordinary duties.²⁰² The AAE Unit will, however, provide ongoing support and will review the supporting documentation and outcome report prepared by these investigators, to determine what, if any, action is required.
- 23.166 If, as a result of the allegation, it appears that a child or young person may be in need of care and protection, a child protection secondary assessment will be undertaken separately from the investigation into the allegation of reportable conduct. If the matter fits within the JIRT criteria it will be referred to an appropriate JIRT for investigation, in addition to the AAE Unit investigation.
- 23.167 The investigative process involves collecting evidence via interviews and locating relevant documents, providing the employee with an opportunity to respond to the allegation, and completing an outcome report. Findings are made in relation to each component of the allegation if more than one matter is raised. The standard of proof is on the balance of probabilities although to the Briginshaw Standard, where the allegation is serious.²⁰³ The findings available are:

²⁰¹ *Children and Young Persons (Care and Protection) Act 1998* s.33.

²⁰² DoCS advised the Inquiry that over 600 field staff have received this training.

²⁰³ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

- a. sustained (on balance of probabilities, there is sufficient evidence that the alleged conduct did occur)
- b. not sustained – insufficient evidence (that is, insufficient evidence available to establish whether the alleged conduct did or did not occur)
- c. not sustained – false (conduct did not occur)
- d. not sustained – vexatious (without substance and with the intention of causing distress to the employee)
- e. not sustained – misconceived (the allegation was made in good faith, but it was based on a misunderstanding of what actually occurred)
- f. unable to determine (not possible to complete an investigation)
- g. not reportable conduct.

23.168 Upon the basis of these findings the AAE Unit or the CSC or Region can make recommendations. In the case of a salaried DoCS officer these recommendations could include, but are not limited to, dismissal, caution, warning or other disciplinary or remedial action, and are referred to the Corporate Human Resources Branch in DoCS Head Office. In the case of an authorised carer (including an authorised relative carer), the recommendations could include de-authorisation.

23.169 Once an investigation has been concluded, the Director-General of DoCS, or the head of the designated agency, is required to send a copy of any report made as well as a copy of any statements taken or other documents on which the report is based, to the Ombudsman, and to advise of the action taken or proposed, to allow the Ombudsman to determine whether the matter has been appropriately investigated, and whether appropriate action was taken.²⁰⁴ The Ombudsman has an ‘own initiative’ right to conduct an investigation into any matter that has been notified, or into any inappropriate handling or response by DoCS, or by a designated agency, concerning a reportable allegation or reportable conviction, and may exercise a conciliation power in connection with such an investigation.²⁰⁵

23.170 Since the NGOs who provide services for DoCS are also required to respond to allegations of misconduct on the part of their staff or carers, the situation can arise where both DoCS and the NGO need to conduct an investigation, which can extend the process and run into problems with the exchange or sharing of information.

²⁰⁴ *Ombudsman Act 1974* ss.25F(2) and 25F(3).

²⁰⁵ *Ombudsman Act 1974* s.25G.

Statistics

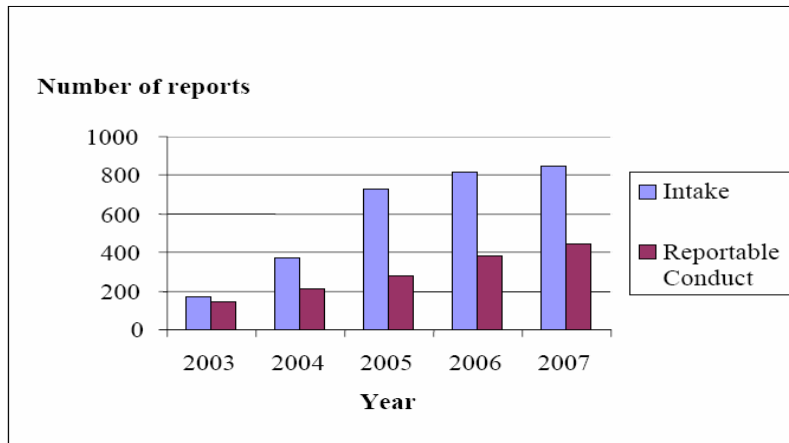
- 23.171 In 2007/08, approximately 31 per cent of all reportable conduct matters notified to the Ombudsman were from DoCS.²⁰⁶
- 23.172 DoCS has advised of an increase in the number of reportable conduct matters involving allegations against employees, which are referred to its AAE Unit.
- 23.173 DoCS reported that there were 389 reportable conduct matters that it dealt with in 2006/07.²⁰⁷ In 2007/08 there were 474 cases of reportable conduct investigated by DoCS.
- 23.174 In 2007/08, DoCS responded to over 800 requests from the Ombudsman for information relating to allegations against employees. DoCS explained that there had been a marked increase in Ombudsman requests which was due to a change in process allowing the capture of a greater number of Ombudsman requests.
- 23.175 In 2007/08, 97 per cent of the reportable conduct matters investigated related to foster carers.
- 23.176 Of the investigations finalised in 2007/08, the outcomes reported by DoCS were as follows:
- a. sustained – 40 per cent
 - b. not sustained – 54 per cent
 - c. other – six per cent.
- 23.177 Of 1,411 finalised investigations in the period 1 January 2000 to 31 December 2007, only 132 (or just under ten per cent) resulted in action to de-authorise a carer. In 2007, only three per cent of finalised investigations resulted in action to de-authorise.
- 23.178 The information supplied to the Inquiry by DoCS would suggest that there has been a considerable increase in the number of reports including allegations of reportable conduct against the employees received since 2001/02, although this has not necessarily met with a corresponding increase of notifications to the Ombudsman.²⁰⁸ DoCS advised that this is because not all reports met the threshold of reportable conduct. They did however require an assessment by DoCS to determine whether they met the threshold.

²⁰⁶ NSW Ombudsman, *Annual Report 2007/08*, p.75.

²⁰⁷ DoCS, *Annual Report 2006/07*, p.90.

²⁰⁸ Submission: NSW Ombudsman, Response to DoCS' submission on the role of oversight agencies, p.5 notes that 352 notifications were made in 2004/05 and that 469 notifications were made in 2006/07 – an increase in the order of 33 per cent.

Figure 23.1 Reports to AAE



23.179 While there is some disagreement between DoCS and the Ombudsman as to the precise extent of any increase in notifications, or in the number of requests made of DoCS by the Ombudsman for further information, there is a consensus that there has been an increase in allegations and reportable conduct notifications, which would seem to be attributable to:

- a. previous under reporting²⁰⁹
- b. a greater awareness of child protection issues and of the requirement to report allegations
- c. the increase in the number of children entering statutory care or receiving services.

23.180 DoCS advised the Inquiry that it takes about 247 days for an investigation to be completed at the CSC or Regional level, and about 300 days for matters to be finalised by the AAE Unit.

Review of decisions in response to allegations of misconduct

23.181 As discussed in Chapter 13, for authorised carers, there is a right to seek an internal review of a relevant decision by DoCS or by a designated agency, and thereafter, by application, a review in the ADT.²¹⁰ The latter right is subject to a request being first made for an internal review, the need for which may be excused,²¹¹ and also to the encouragement of the parties to seek resolution at a local level.

²⁰⁹ A fact identified in an internal audit.

²¹⁰ By reason of the combined operation of *Children and Young Persons (Care and Protection) Act 1998* s.245(1)(c), *Administrative Decisions Tribunal Act 1997* ss.36 and 38 and *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.28.

²¹¹ *Community Services (Complaints, Reviews and Monitoring) Act 1993* s.31, *Administrative Decisions Tribunal Act 1997* ss.53 and 55, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

- 23.182 In any such review the ADT stands in the shoes of the decision maker and reaches a decision on the basis of the material that was relevant at the time of the initial decision, as well as any further material that was relevant at the time of the hearing.²¹²
- 23.183 The Inquiry examined a number of decisions of the Tribunal concerning applications for the review of decisions to revoke the authorisation of carers, or to remove children from the care and control responsibility of carers.²¹³ The correctness of those decisions cannot properly be the subject of any comment by the Inquiry. However, the Inquiry's review does leave it satisfied that the ADT approaches its task appropriately and with considerable attention to the evidence and to the best interests of the child principles, such that there is no occasion to propose any alternative model for the review of decisions of the relevant kind.
- 23.184 The decisions reviewed by the ADT are likely to have been instructive for the Department in so far as they disclosed shortcomings in its case management concerning, for example:
- a. the insufficiency of caseworker support for carers responsible for the care and control of children with challenging behaviours²¹⁴
 - b. the giving of instructions to an expert that identified the opinion or the conclusion that the Department wished – contrary to the Expert Witness Code of Conduct and the ADT Practice Note 14, Expert Evidence and Reports²¹⁵
 - c. a misinterpretation of the Aboriginal Placement Principles²¹⁶
 - d. a failure to advise the carer of the right to seek an internal review in compliance with the Act²¹⁷
 - e. inappropriately placing unrelated children with a carer, in circumstances where the children concerned had troubled histories and serious behavioural problems,²¹⁸ or placing children with a carer outside that carer's authority²¹⁹

²¹² *YG & G G v Minister for Community Services* (2002) NSW CA 246 at [25]; and *A v Minister for Community Services* (2007) NSW ADT 208.

²¹³ For example, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16, *QW & QX v Minister for Community Services* (2005) NSWADT 287, *BP v Minister for Community Services* (2007) NSW ADT 184, *A v Minister for Community Services* (2007) NSW ADT 208, *TF v Barnardos* (2005) NSW ADT 259, *SL v Minister for Community Services* (2005) NSW ADT 228, *QB v Minister for Community Services* (2005) NSW ADT 89.

²¹⁴ For example, *A v Minister for Community Services* (2007) NSW ADT 208, *BP v Minister for Community Services* (2007) NSW ADT 184.

²¹⁵ For example, *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

²¹⁶ For example, *A v Minister for Community Services* (2007) NSW ADT 208.

²¹⁷ *Administrative Decisions Tribunal Act 1997*, s.48(1), *UI & VJ v Minister for Community Services* (2006) NSW ADT 16.

²¹⁸ For example, *TF v Barnardos* (2005) NSW ADT 259, *QW & QX v Minister for Community Services* (2005) NSWADT 287.

²¹⁹ For example, *QB v Minister for Community Services* (2005) NSW ADT 89.

- f. unfair or insufficient assessment by DoCS of the matters raised leading to a removal from care.²²⁰

Commission for Children and Young People

Historical context

- 23.185 In 1997, the Royal Commission into the NSW Police Service: Paedophile Inquiry recommended:

*the creation of a Children's Commission to take over the responsibilities in relation to children currently vested in the Child Protection Council and the Community Services Commission*²²¹

with

*appropriate powers and capacity to oversee and coordinate the delivery of service for the protection of children from abuse (including sexual, physical and emotional abuse and neglect). It should be set up in the context of a rationalisation of roles of existing agencies and should have more than a mere advisory role.*²²²

- 23.186 The Royal Commission also proposed that the Children's Commissioner have authority to perform the role of a special guardian for children in OOHC and have responsibility for collecting information relevant to the suitability of people working in child related employment.
- 23.187 The Inquiry was informed that just prior to the release of the Royal Commission's report, two other reports were released that also called for the creation of a central organisation to address concerns relating to the welfare of children in NSW.²²³
- 23.188 The Commission for Children and Young People (CCYP) commenced operation in June 1999, replacing the Child Protection Council. While the organisation itself notes that the Royal Commission "was a major catalyst for establishing the Commission,"²²⁴ its role differed from that envisaged by the Royal Commission. The CCYP's advocacy role was to relate to all children and young persons, and rather than having an oversight role, it was assigned an 'enabling' role to promote the interests of children and young persons in NSW. While given

²²⁰ *ibid.*

²²¹ Royal Commission into the Police Service: *Volume V: the Paedophile Inquiry*, May 1997, p.1314.

²²² *ibid.*, p.1293.

²²³ Legislative Council Standing Committee on Social Issues, *Inquiry into Children's Advocacy (1996)*, and the NSW Community Services Commission, *Who cares? Protecting people in Residential Care*, 1996.

²²⁴ Commission for Children and Young People, *Annual Report 2007/08*, p.47.

responsibility for employment screening of people involved in child related employment, CCYP was not given specific responsibilities in relation to children in OOHC. In its submission to the Inquiry, CCYP noted that “the enabling role fitted with the inclusion of employment screening responsibilities.”²²⁵

- 23.189 OOHC responsibilities were ultimately given to the Children’s Guardian. This role has been addressed in Chapter 16.
- 23.190 The CCYP is established as a statutory corporation under the *Commission for Children and Young People Act 1998* (the CCYP Act) and has a range of responsibilities including acting as:
- a. an advocate for children and young persons
 - b. a research body inquiring into issues that affect children and young persons
 - c. a body that both undertakes and monitors background checking of people being considered for child related employment
 - d. a body that supports the CDRT in carrying out its functions.
- 23.191 The CCYP is required to report annually to the NSW Parliament.²²⁶ In addition a Joint Parliamentary Committee of Children and Young People oversees its work.²²⁷
- 23.192 The Office for Children was established in April 2006 to provide common administrative and financial support to the CCYP and the Office of the Children’s Guardian. While the roles and responsibilities of these two bodies remain separate, the Office is headed by the Director-General of Premier and Cabinet.²²⁸
- 23.193 As at 30 June 2008, the CCYP employed a full time equivalent of 38.8 positions,²²⁹ against a staff establishment of 41.9.

Background checking

- 23.194 Under s.36 (1) (c) of the CCYP Act, CCYP can agree to conduct background checking on behalf of employers. CCYP has an agreement with DoCS to undertake Working With Children Checks on all prospective DoCS employees. This agreement has been in place since March 2004. Prior to this, DoCS was also an approved screening agency. When this responsibility was transferred to CCYP, the corresponding Treasury allocation for this task was also transferred to it.

²²⁵ Submission: Commission for Children and Young People, p.2.

²²⁶ *Commission for Children and Young People Act 1998* s.23.

²²⁷ *Commission for Children and Young People Act 1998* s.28.

²²⁸ Office for Children, *Annual Report 2007/08*, p.4.

²²⁹ Commission for Children and Young People, *Annual Report 2007/08*, p.49.

- 23.195 CCYP also undertakes background checking on behalf of Police, other government agencies and employers in the non-government child related employment sector. This includes background checks on behalf of non-government welfare and OOHC agencies, child care centres, and religious organisations.²³⁰

Notifying CCYP of relevant employment proceedings

- 23.196 DoCS and other relevant employers, including designated agencies²³¹ that supervise the placement of children and young persons in OOHC, are required to notify the CCYP where employment proceedings concerning allegations of reportable conduct, or the commission of acts of violence, have been completed.²³² This is in addition to notifying the Ombudsman of allegations of reportable conduct. The only exceptions are those cases where the finding is one that the reportable conduct or alleged act of violence did not occur, or that the allegation was vexatious or misconceived.²³³
- 23.197 The purpose of notification is to facilitate the work of the CCYP in administering the Working With Children Checks. The Working With Children Check involves a check of any relevant criminal records, AVOs, and child protection prohibition orders, and is supplemented by probity checks as appropriate and by a check on the outcome of any relevant employment proceedings.²³⁴
- 23.198 CCYP then undertakes a risk assessment based on anything disclosed by these checks. This risk assessment provides potential employers with information to assist in selecting staff for child related employment. Child related employment is defined extensively in the CCYP Act and includes any employment that primarily involves direct contact with children.²³⁵
- 23.199 The performance of the duties of a foster carer engaged by DoCS or by any foster care agency, constitutes employment for the purpose of these provisions.²³⁶
- 23.200 Although there is not a class or kind agreement in existence between DoCS and the CCYP specifying or limiting what needs to be notified, a two tier system has been established pursuant to which DoCS and other agencies are required to categorise employment proceedings as giving rise to either a Category One or Category Two outcome.
- 23.201 Category One matters trigger an estimate of risk where the investigation has found either:

²³⁰ *Working with Children Check Employer Guidelines February 2008*, pp.21-22.

²³¹ *Children and Young Persons (Care and Protection) Act 1998* s.139.

²³² *Commission for Children and Young People Act 1998* s.39.

²³³ *Commission for Children and Young People Act 1998* s.39(1)(a) and (b).

²³⁴ *Commission for Children and Young People Act 1998* s.34.

²³⁵ *Commission for Children and Young People Act 1998* s.33(1)(a).

²³⁶ *Commission for Children and Young People Act 1998* s.33(3).

- a. reportable conduct
- b. that an act of violence took place
- c. some evidence that reportable conduct or an act of violence occurred, however the finding is inconclusive and there is concern that the conduct should be considered in an estimate of risk assessment when the person next seeks child related employment.

23.202 Category Two matters are those where the investigation has found some evidence of reportable conduct or an act of violence, but the finding is inconclusive. By themselves they do not trigger an estimate of risk, if the person has a Working With Children Check. A Category Two matter may however be considered in an estimate of risk, if there has been more than one notification, or if there are other relevant records for the person.

23.203 The risk assessment level that is arrived at by CCYP is provided to prospective employers who have the right to determine whether to employ the person or not. DoCS has advised of the following breakdown of notifications it has made to CCYP by category:

Table 23.4 Notifications to CCYP by DoCS

<i>Year</i>	<i>Category 1</i>	<i>Category 2</i>	<i>Total Notifications</i>
2000	1	2	3
2001	20	28	48
2002	68	33	101
2003	71	19	90
2004	112	33	145
2005	94	50	144
2006	153	68	221
2007	169	67	236

23.204 When an allegation of reportable conduct is sustained, the communication of that fact to CCYP can obviously have considerable ramifications for the person the subject of the allegation. The nature of those ramifications is such that there is a need for sufficient safeguards in relation to the handling and investigation of such an allegation, including a right to be heard and a right of review, particularly in relation to authorised carers.

Issues arising

Reporting to the Ombudsman

- 23.205 The low threshold for reportable conduct and the requirements of the Code of Conduct governing carers,²³⁷ catch what may be considered reasonable responses to sometimes challenging behaviour by children and young persons.
- 23.206 DoCS has advised that the current class or kind agreement with the Ombudsman which exempts some allegations of reportable conduct from the notification requirements has not resulted in any lessening of its reportable conduct workload, as it applies to only five per cent of the allegations received.
- 23.207 DoCS has argued for a higher threshold in relation to the kind or degree of physical abuse allegations that are to be reported to Ombudsman. In addition, in the case of a DoCS employee, it suggested that it should not extend to matters that would more properly fall within the exercise of that employee's professional capacity. One instance of that kind has been the subject of debate between the Ombudsman and DoCS, in which it was asserted that the conduct of a caseworker was reportable where, it was alleged, the worker had failed to initiate protective action even though aware of a physical assault by a carer which had left a child with serious physical injuries.
- 23.208 The Ombudsman has acknowledged that where caseworkers make professional decisions based on approved departmental procedures, then the fact that the child is subsequently harmed should not give rise to a notification to that Office in relation to the employee. The Inquiry agrees with that as a general proposition.
- 23.209 At the Inquiry's Public Forum concerned with oversight arrangements, both parties accepted the need for some revision of the class or kind agreement, although the Ombudsman would expect, as a condition of any revision, an improvement in DoCS' ability to complete its investigations quickly.
- 23.210 The Inquiry agrees with the Ombudsman that if there is to be any change in relation to the allegations that should be reported, it should be effected by an amendment of the class or kind agreement, rather than by an amendment of the Ombudsman Act which would have a flow on effect for over 7,000 government and non-government services. The Inquiry notes from the Ombudsman's 2007/08 Annual Report that it records an improved performance in DoCS in relation to delays and finalising investigations.²³⁸
- 23.211 The Inquiry has been provided with a copy of the class or kind determination which is in place with the Education, and also with the Catholic Education

²³⁷ *Children & Young Persons (Care & Protection) Regulations 2000*, Schedule 2: Code of Conduct for Authorised Carers.

²³⁸ NSW Ombudsman, *Annual Report 2007/08*, p.80.

Commission of NSW, which confines the notification requirement to serious allegations of reportable conduct. Assuming that DoCS management of these allegations can be improved, for example by acceptance of the recommendations contained in this report, and by providing timely determinations, there would not seem to be any reason why the current class or kind determination should not be similarly extended. The Inquiry accordingly favours the adoption of a class or kind agreement which would elevate the reporting requirements to an equivalent level to that adopted for the Education authorities

DoCS responses to allegations – centralised unit

- 23.212 Several issues have been identified to the Inquiry in relation to the way in which DoCS handles reportable conduct allegations including:
- a. the consistency and adequacy of the investigation being undertaken in regions
 - b. the Department's tendency to undertake full blown child protection secondary assessments in cases that raise relatively low level allegations
 - c. delays in the completion of these investigations by regions due to caseworkers having other priority work to complete
 - d. a general lack of expertise in the regions concerning the management of investigations.
- 23.213 DoCS has advised that between January 2006 and December 2007, of the reportable allegations against foster carers which were finalised, 48 per cent had case outcomes of sustained – but in 15 per cent of these cases the recommendation was no further action, while in about a quarter the recommendation was for informal action. In 11 per cent of investigations, the recommendation was for removal of authorisation.
- 23.214 In these circumstances the case for a timely investigation is compelling; as is that for the conduct of a sound risk assessment including a consideration of whether any risk can be satisfactorily managed, before any decision is made to remove a child pending that investigation. Clearly the safety of the child involved remains a paramount consideration in any investigation.
- 23.215 The Inquiry heard from a number of carers, either through written submissions or at Public Forums, who had faced the experience of children being removed from their care following allegations. A review by the Ombudsman of 91 notifications received between 1 April 2007 and 1 April 2008 showed that 16 of the children were removed (17 per cent of the total notifications), in circumstances where the removal was directly related to the fact of the notification.

Case Study 26

Ms W made a submission dated 7 February 2008, which included the following relevant information. In September 2006 she and her partner were approached by DoCS to take two small children for a fortnight. They did so and for various reasons the children were still in her care until 26 May 2007 when the children went into respite care because Ms W was going on holidays. She returned on 12 July 2007 and after attempting to contact DoCS without success in relation to the return of the children, was ultimately told the children would not be returned to her. She was informed that there had been allegations of abuse that were being investigated against her in relation to the two children, one of whom was 20 months old and the other was 37 months old.

Ms W and her partner were interviewed on 4 January 2008 and received a letter from DoCS dated 24 April 2008 advising of the results of the investigation.

It appears there were 13 allegations, four of which had a finding of not sustained, insufficient evidence and each concerned smacking one of the children. An allegation of smacking on the hand was sustained but found to be trivial or negligible. It appears that Ms W admitted that allegation. The sixth allegation was found to be not sustained on the basis that it was false in relation to smacking one of the children.

An additional seven allegations were made, four of which had a finding of not reportable conduct and concerned behaviour such as forcing a child to sit at the table for two hours, serving the previous night's dinner, causing confusion and referring to the children as naughty. Three allegations were found to be not sustained and false in relation to smacking one or other, and locking the children in the room as a form of punishment.

DoCS informed Ms W that a notification had been made to the CCYP as a Category 2 Relevant Employment Proceedings.

DoCS' response to this case study was that workloads and staff shortages contributed to the delays in dealing with these allegations.

- 23.216 One option which has been canvassed as a means of improving the timeliness and sufficiency of these investigations is to centralise the investigative process at Head Office in the AAE Unit, and to remove the responsibility for this function from the regions and operational units.
- 23.217 Of relevance for the adoption of this option is DoCS advice that there is a significant difference in the cost of conducting an investigation centrally and in the regions. The approximate cost of the former is said to be in the order of \$1,500 to \$4,500 per investigation, while that of the latter is of the order of

\$5,500 to \$10,500. The difference is said to lie in the greater experience of AAE staff and in avoiding the need for double handling.

- 23.218 This option is the preferred approach of DoCS, and it has the support of the PSA. The Inquiry agrees that the operations of the AAE unit should be centralised.
- 23.219 It is accepted however that to be effective, a centralised unit with this responsibility would need to have:
- a. adequate staffing and resources
 - b. the capacity to manage reportable allegations that were formerly handled at CSC or regional level
 - c. the capacity to conduct a prompt investigation of both high and low level allegations.
- 23.220 Such a change should lead to more timely investigations, help to contain the costs involved, and encourage a uniform investigation strategy that matches the type and depth of the investigation with the level of risk suggested by the allegation.
- 23.221 This reorganisation would require some increase in the staffing of the AAE Unit, which currently has a staffing of only 9.6 persons, since it would need to assume responsibility for the 85 per cent of the investigations that are currently carried out in the regions. DoCS has placed an estimate of the cost of this restructure as being in the vicinity of \$2.2 million.
- 23.222 A report following an internal audit of one region in 2006, drew attention to the fact that AAE policy did not provide clear guidelines on how to de-authorise a carer following a decision that an allegation was sustained, or whom should have responsibility for effecting that decision. Also, the report noted that there was a lack of timely follow up by the CSC to reports provided by the AAE Unit. Some confusion was also identified as to the status of carers who were to be de-authorised. Recommendations were made for the implementation of standard procedures to ensure prompt execution of AAE Unit actions, and for de-authorised carers to be recorded as 'do not use' in KiDS.²³⁹
- 23.223 Other concerns were identified in this audit *inter alia* in relation to:
- a. the non-reporting of reportable conduct
 - b. the existence of inconsistent practices regarding the retention of documentation generated during the investigation of allegations
 - c. delays in reporting allegations to the AAE Unit, in conducting the initial investigation planning meetings between the AAE Unit and CSCs and in preparing outcome reports.

²³⁹ DoCS, Ernst & Young, *Internal Audit Report Regional Operations – Northern*, June 2006, p.42.

- 23.224 Recommendations were made to address these shortcomings involving additional training and planning,²⁴⁰ which would be addressed to some extent if the investigative responsibility was centralised in the AAE Unit.
- 23.225 Another concern that has been raised relates to the provision of information to carers concerning the allegation process, the implications of an investigation, and the level of support available. It has been suggested that insufficient information or guidance has been provided in this respect, and that carers are sometimes denied the assistance of a support person when providing a response to an allegation.
- 23.226 As a matter of procedural fairness, and in order to maintain the goodwill of carers, this is a matter that clearly needs to be addressed.

Notifying the CCYP

- 23.227 DoCS has reported that the requirement of notifying the CCYP of concluded employment proceedings, and the absence of a class or kind agreement, results in an over reporting of matters that are relatively trivial, which can then have adverse consequences for authorised carers, and can also lead to unnecessary administrative work for both agencies.
- 23.228 It argued for the creation of a class or kind agreement, which would exclude, *inter alia*, the need to notify the CCYP of Category Two matters, by reason of the punitive and unnecessarily stringent effect that this can have on carers.
- 23.229 However, the CCYP has informed the Inquiry that as workers in this sector are quite mobile, there may be more than one agency with a Category 2 issue about the same worker. Thus, if these were not reported, a pattern of conduct might be missed. DoCS was primarily concerned with foster carers, as they are the group mainly the subject of these allegations. As the Inquiry understands that most foster carers can and do move between NGOs and DoCS, the point raised by the CCYP remains valid. However, the Inquiry is concerned that there are matters which are notified which are less serious and do not warrant the attention of the CCYP. DoCS and the CCYP should have discussions with a view to these matters being properly identified and made the subject of a class or kind agreement.

Not sustained findings

- 23.230 The 'not sustained - insufficient evidence' and 'unable to determine' findings can leave foster carers in a limbo both so far as working as a carer is concerned, but also potentially for other child related work. While these findings will not lead to de-authorisation, the uncertainty that persists is likely, in a practical sense, to mean that their services will not be utilised.

²⁴⁰ *ibid.*, pp.43-46.

- 23.231 Additionally, where children in their care were removed pending the investigation, it is unlikely that they will be returned. For all practical purposes they are regarded as ‘inactive carers’, a circumstance that is detrimental for the maintenance of a proper working relationship with this group, as well as for the preservation of a much needed resource.
- 23.232 The Inquiry is of the view that these findings do not serve any useful purpose, and that the available formal findings should be confined to “sustained”, “not sustained” and “not reportable conduct”. Decisions formulated in terms of “insufficient evidence” or “unable to determine” are in effect, non decisions, which do not have any legitimate precedent elsewhere. Having regard to the balance of proof, in most, if not all, instances a decision should be capable of being made that will also take into account the best interests of the child principle.
- 23.233 The reasons for the finding should be formally recorded in the outcome report which should be made available to the complainant and to the persons subject to the complaint.
- 23.234 It is noted that it has been held that the ADT has no jurisdiction to review a decision by a designated agency to notify the CCYP of an allegation of reportable conduct.²⁴¹
- 23.235 Additionally it would appear that the ADT has no power to review a case where there had been a finding to the effect that the allegation was ‘not sustained – insufficient evidence’, or a finding ‘unable to determine’, where that had not led to a decision by DoCS, or by a designated agency, to remove a child or young person from the responsibility of the carer for the daily care and control of a child or young person, or to suspend or to revoke that person’s status as an authorised carer.
- 23.236 There are several examples of cases where decisions to revoke the authority of carers were in fact made and then affirmed by the ADT, where the Tribunal could not be satisfied on the balance of probabilities that the allegations were true, but could also not be satisfied that there was no truth in them.²⁴² In those circumstances, the best interests of the children in removing what was seen to be a possibility of an unacceptable risk prevailed.
- 23.237 The approach which the Tribunal takes in relation to such cases is perhaps explained by the following passage in its judgment in *QB v Minister for Community Services*,

It is almost trite to observe that cases such as this present very difficult evidentiary issues and that applicants in such matters have heavy evidentiary burdens to discharge, even on the

²⁴¹ *CS & Anor v Life Without Barriers* [2007] NSW ADT 249.

²⁴² *HB v Director General DoCS* (2008) NSW ADT 207, *QW & EX v The Minister for Community Services* (2005) NSW ADT 287.

*balance of probabilities. This is because the principles to be applied require decision-makers – the Director-General in this case – to give ‘paramount consideration’ to the safety, welfare and well-being of children in the care of foster parents. As a simple matter of policy, the Director-General, and this Tribunal when reviewing the Director General’s decisions are required, where there is a conflict, to place the interests of children involved in such proceedings above those of any carer or foster parent.*²⁴³

Background checks

- 23.238 DoCS has advised the Inquiry that over the last two years, the CCYP has raised concerns about the increasing number of screening requests from DoCS and as a result, has at times questioned the statutory basis for undertaking screening for some employee categories. DoCS advised that CCYP has argued that not all positions within DoCS have direct and unauthorised access to children and therefore these positions do not require screening.
- 23.239 Further, DoCS has advised that it has received correspondence from the NSW Family Day Care Association stating that CCYP will not conduct checks on adult household members because there is no legislative basis for it. While not currently required to undertake such checking under the relevant legislation, DoCS has advised that these checks are regarded by children’s services licensees as critical.
- 23.240 DoCS argued that a legislative amendment is required to clarify CCYP’s obligations regarding background checking. Specifically, DoCS recommended:

that the CCYP Act be amended to require working with children checks for the following positions:

- a. *all new DoCS staff positions (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)*
- b. *any contractors engaged by the department to undertake work which involves direct unsupervised contact to children, or access to the KiDS system or file records on DoCS clients (eg IT contractors)*
- c. *students working with DoCS officers*
- d. *children’s services licensees*
- e. *authorised supervisors of children’s services*
- f. *adoptive parents*

²⁴³ QB v Minister for Community Services (2005) NSW ADT 89.

*g. adult household members of foster carers, family day carers and licensed home based carers.*²⁴⁴

- 23.241 While not addressing these concerns specifically, the CCYP submission to the Inquiry has raised the issue of extending background checking to volunteers in identified risk groups. Included in the CCYP definition of volunteers are adult household members of family day carers and authorised carers.
- 23.242 Background checking of volunteers is also an issue of importance for both the government and non-government sector. Currently, volunteers involved in child related activities are required to complete a Prohibited Employment Declaration, but are not required to undergo a full background check. Health, Police and Education have all recommended that background checking be extended to certain groups of volunteers. Health recommended the implementation of legislation allowing background checks, including national criminal records checks for volunteers in high risk positions. Police noted that clubs, sporting associations and volunteers are exempt from background checks and recommended an examination of the current gaps in the working with children background checking system with a view to making improvements to assist community based organisations to develop procedures and practices to protect children and young persons.
- 23.243 Education is concerned about volunteers coming into unsupervised contact with students, and also raised concerns about other groups of people such as contracted cleaners and tradesmen that come onto school grounds. Specifically:

*Education considers that any person who comes onto a school site or accompanies children on an excursion or overnight camp in circumstances where that person may have unsupervised contact with children should be subject to a screening process similar to the Working With Children Background Check.*²⁴⁵

- 23.244 The views of the Catholic Commission for Employment Relations, one of the State's approved screening agencies, are similar to those stated by Education regarding background checking for volunteers and people working on school grounds. The Catholic Commission has advised the Inquiry that for many organisations, volunteers are their greatest area of exposure particularly given that the:

sole requirement of a Prohibited Employment Declaration for all voluntary positions is not satisfactory as research indicates that Statutory Declarations have been used both nationally and

²⁴⁴ Submission: DoCS, The Role of Oversight Agencies, p.20.

²⁴⁵ Submission: Department of Education and Training, p.18.

*internationally and in both cases have been found to have been abused by perpetrators.*²⁴⁶

23.245 Other organisations including Centacare Sydney, the Anglican Church of Australia and Life Without Barriers have also raised concerns about the lack of background screening of volunteers.

23.246 The CCYP submission to the Inquiry advised that in 2006, a survey was undertaken to determine whether there was support for extending background checking to volunteers. CCYP advised that the survey results were mixed. CCYP further advised that these results were in line with the findings of a pilot program undertaken by the CCYP from 2002 to 2004, where three-quarters of the participant organisations found it challenging to set up the administrative systems needed to start doing volunteer checks. CCYP stated:

*It is clear from these findings that the issues we need to consider for the volunteer community are complex. We do not want to impose unrealistic administrative burdens on volunteer organisations that may already be struggling with regulatory requirements.*²⁴⁷

23.247 It is not however clear from the survey whether those who opposed an extension of the checking regime did so on principled grounds, or because of matters going to their administrative convenience.

23.248 CCYP cautioned against a system of checking that may discourage volunteers from joining organisations that provide services for children. The final point made by CCYP on this issue was “we don’t want background checks to encourage a false sense of security; we want volunteer organisations to keep working towards being child-safe and child-friendly.”²⁴⁸

23.249 While there are obvious challenges to extending background checking to volunteers, CCYP accepts that there is merit in undertaking the following actions:

- a. extending background checking to volunteers in high risk groups, such as mentoring and adult household members of authorised carer and family day carers
- b. auditing the Prohibited Employment Declarations made by volunteers
- c. increasing support for organisations through CCYP’s child-safe and child-friendly program.

²⁴⁶ H Edwards and J Myers, “Safeguarding: another buzzword or a concrete way of ensuring protection of Children?” 2003: www.nspcc.org.uk/inform/Info_Briefing/Safeguarding.pdf cited in Submission: Catholic Commission for Employment Relations, p.2.

²⁴⁷ Submission: Commission for Children and Young People, p.13.

²⁴⁸ *ibid.*

- 23.250 The Inquiry is of the view that the checking system should extend to those who work directly or have regular access to children and young people in all human service agencies and to volunteers in clearly identified high risk groups. Guidelines would need to be developed to provide greater specificity as to the identity of those who should be subject to checking, following consultation with agencies of the kind mentioned above that are dependent on volunteers.
- 23.251 The above actions have resource implications for CCYP, which are reflected in its recommendations to the Inquiry that its funding be increased.

Oversight tension

- 23.252 It became very apparent in the early days of the Inquiry that significant tensions existed between DoCS and the Ombudsman in relation to the extent of oversight by the latter. DoCS had specific concerns about the Ombudsman's child death review function and reportable conduct powers, each of which is dealt with in this chapter.
- 23.253 More broadly, however, DoCS submitted to the Inquiry that the cost of responding to oversight agencies was a significant impost on DoCS. Further, it argued that responsibilities were blurred in the current oversight arrangements and that the proper role delineation between Government/the Parliament and oversight agencies was not always clear.
- 23.254 In relation to costs, an analysis commissioned by DoCS of the direct costs of the oversight function by the Children's Guardian, the Ombudsman and the reporting to CCYP concluded that they amount to the equivalent of 43.4 full time equivalent positions per annum. The Inquiry has made recommendations elsewhere designed to reduce those costs through the increased use of class or kind agreements.
- 23.255 The view of DoCS is that the Ombudsman strays into areas of policy and resource allocation, matters properly left to the Department, its Minister, and when appropriate Cabinet and Parliament. The key examples given were in the area of reviews of child deaths and, in particular, the Ombudsman's recommendation to establish a risk of harm threshold below which no case would be unallocated.
- 23.256 The Inquiry has found the work of the Ombudsman to be very valuable in carrying out its investigations and in considering reforms to the child protection system. His reports are invariably detailed, comprehensive and sound. It is however the case that his recommendations can concern matters of policy and, if implemented some could have considerable resource and budgetary implications, the precise extent of which may not be obvious to anyone other than DoCS.
- 23.257 While the Ombudsman has no power to enforce his recommendations, the publication of his reports can have and are undoubtedly designed to have the effect of encouraging compliance. In addition, a person aggrieved by a decision

made by DoCS not to take an action recommended by the Ombudsman or to implement only part of the recommended action can apply to the ADT for a review of the decision by DoCS made in response to the recommendation. The ADT must then decide what the correct and preferable decision is and has the power to affirm, vary, set aside or remit the decision to DoCS.²⁴⁹

23.258 DoCS contended that the Ombudsman should be bound by or, at least give effect to the spirit of s.5(1) of CS CRAMA which is in the following terms.

(1) *The determination of an issue under this Act, and any decision or recommendation on a matter arising from the operation of this Act, must not be made in a way that is (or that requires the taking of action that is):*

(a) *beyond the resources appropriated by Parliament for the delivery of community services, or*

(b) *inconsistent with the way in which those resources have been allocated by the Minister for Community Services, the Minister for Aged Services, the Minister for Disability Services, the Director-General of the Department of Community Services or the Director-General of the Ageing and Disability Department in accordance with Government policy, or*

(c) *inconsistent with Government policy, as certified in writing by the Minister for Community Services, the Minister for Aged Services or the Minister for Disability Services and notified to the Tribunal, Commission or other person or body making the determination.*

(2) *This section does not apply to the exercise of any function of the Ombudsman under this Act.*

23.259 The Inquiry disagrees with DoCS. The independence of the Ombudsman is a key cornerstone of public accountability in NSW. That is reflected in subsection (2) set out above. DoCS is given an opportunity to comment on recommendations proposed by the Ombudsman prior to publication, and should do so with respect to those that it considers trespasses into areas with resource allocation implications. Further, the three areas of reform suggested by DoCS and set out earlier should achieve some beneficial change in the relationship between DoCS and the Ombudsman.

²⁴⁹ *Miller v Director-General, Department of Community Services (No2)* [2007] NSWADT 140.

- 23.260 In any event it is noted that the recommendations of the Ombudsman are just that: they are not binding upon DoCS. Nor does the jurisdiction of the ADT rise above requiring DoCS to reconsider its response to the recommendations. DoCS retains its administrative independence to act within its budget and policy as set by the Minister. If it is subject to adverse comment by the Ombudsman in any published report, it has the capacity to respond and to set the record straight from its point of view, in its annual report.

Recommendations

Recommendation 23.1

The relevant legislation including Part 7A of the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that Team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Recommendation 23.2

DoCS should review the death of any child or young person about whom a report was made within three years of that death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.

Recommendation 23.3

The Community Services (Complaints, Reviews and Monitoring) Act 1993 should be amended by:

- i. repealing s.35(1)(b) and (c)
- ii. replacing the requirement for an annual report, in s.43 with a requirement that a report be made every two years.

Recommendation 23.4

Information obtained by persons appointed by the Minister as official visitors should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards and s.8 of *Community Services (Complaints, Reviews and Monitoring) Act 1993* and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* should be amended to achieve this outcome.

Recommendation 23.5

The class or kind agreement between the NSW Ombudsman and DoCS should be revised to require DoCS to notify only serious allegations of reportable conduct and to impose timeframes within which DoCS will investigate those allegations.

Recommendation 23.6

DoCS should centralise its Allegations Against Employees Unit and receive sufficient funding to enable this restructure, and to resource it to enable it to respond to allegations in a timely fashion.

Recommendation 23.7

DoCS should revise the findings available following an investigation into an allegation against an employee so as to and permit one of the following findings to be made but no other: sustained, not sustained, not reportable conduct. Adequate reasons should be recorded, and kept on file, which should note not only why an allegation was sustained, but also the reasons why an allegation was not reportable or not sustained.

Recommendation 23.8

The *Commission for Children and Young People Act 1998* should be amended to require background checks as follows:

- a. in respect of DoCS and other key human service agencies all new appointments to staff positions that work directly or have regular contact with children and young persons (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff)
- b. any contractors engaged by those agencies to undertake work which involves direct unsupervised contact to children and young persons, and, in the case of DoCS, access to the KiDS system or file records on DoCS clients
- c. students working with DoCS officers
- d. children's services licensees
- e. authorised supervisors of children's services
- f. principal officers of designated agencies providing OOHC or adoption agencies

- g. adult household members, aged 16 years and above of foster carers, family day carers and licensed home based carers
- h. volunteers in high risk groups, namely those having extended unsupervised contact with children and young persons.

24 Interagency cooperation

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Introduction

- 24.1 Data on child protection reports, as recorded in Chapter 5, indicate the multi-dimensional nature of the risks facing vulnerable children and families in NSW. Key risk factors reflect trends in other child welfare jurisdictions, both in Australia and internationally, where factors such as domestic violence, drug and alcohol use or mental health and neglect feature in child protection reporting, none of which can be satisfactorily addressed by any one agency working alone.
- 24.2 Few of DoCS' clients present with only one child protection issue. Most families have a range of unmet needs, and working to improve the safety, welfare and well-being of children and young persons involves advocating for services from other agencies. When DoCS is constrained by the lack of immediate access to services of other agencies, this can compromise its capacity to facilitate engagement with the family and to ensure timely and effective responses to their issues.
- 24.3 Effective interagency collaboration has the potential to enhance effective child protection services. It can deliver better assessments of need, improve the delivery of holistic services by minimising gaps and discontinuities in services, achieve greater efficiency in resource use and provide more support for workers.²⁵⁰
- 24.4 In its submission to the Inquiry, DoCS referred to research conducted by Buckley²⁵¹ and Hallet and Birchall²⁵² who state that simply mandating collaboration cannot guarantee its success. DoCS advised that, despite the rhetoric, the responsibility for child protection is not usually shared and ultimately, responsibility remains with the caseworker within the system. Further, child protection interagency work tends to drop off once the initial crisis has passed, suggesting that although interagency collaboration is lauded as a desirable policy goal, there is always the danger of 'collaboration inertia' where efforts are focused on processes rather than on outcomes for service users.²⁵³ There was evidence of this before the Inquiry as well as evidence that DoCS casework practices contribute to the lack of engagement by other agencies. This is addressed in Chapter 9.
- 24.5 The promotion of effective interagency cooperation is consistent with the NSW State Plan, and with the several Plans and strategies that have been developed

²⁵⁰ A Tomison, "Current Issues in child protection policy and practice: Informing the Northern Territory Department of Health and Community Services child protection review," *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2004.

²⁵¹ H Buckley, "Child Protection: an unreflective practice," *Social Work Education, Vol. 19 No. 3*, 2000, cited in Submission: DoCS, Interagency Cooperation, p.6.

²⁵² C Hallett and E Birchall, "Coordination and Child Protection: a review of the literature," *HMSO, Edinburg*, 1992, cited in Submission: DoCS, Interagency Cooperation, p.6.

²⁵³ M Atkinson, "The development of an evaluation framework for partnership working: a review of the literature," *Electronic Journal of Business Research Methods, Vol.3, Issue 1*, Southern Health and Social Services Board, Northern Ireland, 2005 pp.1-10, cited in Submission: DoCS, Interagency, p.7.

in recent years to address domestic violence, anti-social behaviour, and sexual assault and family violence within Aboriginal communities, by project teams whose members are drawn from the key human services and justice agencies.

- 24.6 On a more general basis, interagency cooperation has been guided by the 2006 NSW *Interagency Guidelines for Child Protection Intervention*, (the Interagency Guidelines) by some area specific interagency guidelines and by a series of individual MOUs and protocols that provide more specific direction concerning their implementation at local level. The resulting structure is complex and a serious question arises as to whether that structure provides a sound basis for the kind of cross government and non-government approach to child protection that is necessary, particularly given the non-congruent nature of the regional boundaries of the agencies, discussed later in this chapter.

The Care Act

- 24.7 The Care Act specifies the mechanisms that the Director-General (DoCS) can use to foster interagency coordination in providing services to children and young persons and to families who request services or are reported to DoCS.
- 24.8 Section 16 (2) and (3) of the Care Act provides:

(2) Interagency procedures and protocols.

The Director-General is to promote the development of procedures and protocols with government departments and agencies and the community sector that promote the care and protection of children and young persons and to ensure that these procedures and protocols are implemented and regularly reviewed.

(3) The objects of the procedures and protocols referred to in subsection (2) are:

- (a) to promote the development of co-ordinated strategies for the care and protection of children and young persons and for the provision of support services directed towards strengthening and supporting families, and*
- (b) to co-ordinate the provision of services for assisting young persons leaving out-of-home care.*

- 24.9 Sections 17 and 18 of the Care Act, make specific provision in relation to requests by DoCS for services from other non-government and government agencies, as follows:

17 Director-General's request for services from other agencies.

In deciding what action should be taken to promote and safeguard the safety, welfare and well-being of a child or young

person, the Director-General may request a government department or agency, or a non-government agency in receipt of government funding, to provide services to the child or young person or to his or her family.

18 Obligation to co-operate.

The government department or agency must use its best endeavours to comply with a request made to it under section if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its functions.

- 24.10 Sections 20 and 21 of the Care Act make provision respectively for children and young persons, and for parents of children or young persons, to seek assistance from the Director-General. Under s.22, the Care Act further provides:

22 Director-General's response to requests for assistance and reports

If a person seeks assistance from the Director-General under this Part (whether or not a child or young person is suspected of being in need of care and protection), the Director-General must:

- (a) provide whatever advice or material assistance, or make such referral as, the Director-General considers necessary, or*
- (b) take whatever other action the Director-General considers necessary,*

to safeguard or promote the safety, welfare and well-being of the child or young person.

Note. After assessing the request for assistance, the Director-General need not take any further action.

The Director-General, in responding to a request for assistance or a report, can provide services or arrange for other government departments and agencies, or community organisations, to provide services to assist children, young persons and their families. Some of the services that may be available include:

- assessment of risk or need*
- service co-ordination*
- emergency financial assistance*

- *mediation*
- *counselling for children, young persons and their families*
- *services for people with disabilities*
- *parenting education*
- *out-of-home placement*
- *drug and alcohol counselling*
- *early childhood health services*
- *counselling and support for sexual assault or domestic violence*
- *respite care*
- *children's services*
- *family support*
- *youth support programs*
- *accommodation for the homeless*
- *adoption assistance*

The Department may also play a role in referring people to services provided under Commonwealth legislation, such as Family Court counselling and access to maintenance entitlements or other benefits.

- 24.11 Section 29A of the Care Act makes provision in relation to the ongoing assistance of a child or young person, on the part of persons who make risk of harm reports to DoCS, as follows:

For avoidance of doubt, it is declared that a person who is permitted or required by this Part to make a report is not prevented, by reason only of having made that report, from responding to the needs of, or discharging any other obligations in respect of, the child or young person the subject of the report in the course of that person's employment or otherwise.

Focus of this chapter

- 24.12 Specific areas where interagency collaboration has taken place, or is in the course of development, have been examined in detail earlier in this Report. The focus of this chapter is, accordingly, upon the broader framework for cross

agency cooperation, in particular in relation to the extent to which the Interagency Guidelines and MOUs achieve their purpose, and in relation to the problems likely to be caused by the imperfect boundary alignment of the agencies.

- 24.13 Additionally, consideration is given to the impediments to efficient cross agency work attributable to the current privacy and information exchange structure, and to certain aspects of alternative models in place in other jurisdictions that might possibly be adapted for application in NSW.
- 24.14 The need for a substantial revision of the current structure, and in the practices of individual agencies, has received general support in the Public Forums and in the submissions received from the key human service agencies, many of which have drawn attention to the undesirable 'silo' approach which has developed. Although this chapter addresses this issue in the broad, it is recognised that interagency practice occurs at three distinct levels, namely at policy level, program level and direct service level, and that to be successful it must deal with each. The context in which agencies cooperate in establishing a uniform policy approach and goals differs from that in which they coordinate the availability of the individual programs or services within their respective charters, and in turn from that in which they work together on individual cases.
- 24.15 The Inquiry does not underestimate the difficulty in ensuring effective interagency cooperation, and in overcoming the problems which DoCS noted were:

... well documented in the literature and include issues such as lack of ownership by either senior management or front line staff, inflexible organisational structures, conflicting professional ideologies, lack of budget control, communication problems, and poor understanding of roles and responsibilities.²⁵⁴

- 24.16 Additionally there is the problem of overcoming collaboration inertia where efforts are focused on the presence of service providers rather than on the outcomes for clients.

²⁵⁴ Submission: DoCS, Interagency Cooperation, p.6.

Interagency Guidelines

24.17 The introduction to the Interagency Guidelines notes:

The Guidelines are a resource to promote effective collaboration, cooperation and coordinated effort across all responsible service providers under the Children and Young Persons (Care and Protection) Act 1998 and ultimately to improve the safety, welfare and well-being of children and young people in NSW.

Individual agencies have different responsibilities relating to strengthening families and preventing child abuse, but the best results will occur where agencies are working together and in a complementary way, to deliver the often complex range of responses and supports that are required by children, young people and families.²⁵⁵

24.18 With some exceptions²⁵⁶ the Interagency Guidelines do not purport to regulate interagency coordination. Rather they appear, on their face, to provide a general explanation of the elements of the child protection process, and of the roles of the agencies with a heavy emphasis on the role and responsibilities of DoCS.

24.19 An evaluation of the Interagency Guidelines, including consultation across the sector, has recently been undertaken by the Child Protection Senior Officers' Group in line with the Ombudsman's *Report of Reviewable Deaths in 2004*. The report recommended that the evaluation should focus on the assessment of agency take up and the effectiveness of the Guidelines.²⁵⁷

24.20 A report on the key findings of the evaluation's survey of staff from across the state noted the following:

- a. The Interagency Guidelines are fairly well known across the 12 human services agencies, particularly amongst staff whose position means they are likely to be involved in a child protection matter; agencies where take up has been relatively less successful are Police, Juvenile Justice and Housing.
- b. All respondents, including non-government respondents, reported being well informed about two key facts: knowledge of the circumstances for reporting a child to DoCS and the indicators of child abuse or neglect.

²⁵⁵ NSW *Interagency Guidelines for Child Protection Intervention*, 2006, p.7.

²⁵⁶ For example, the sections dealing with responsibilities of agencies at case meetings, Chapter 3, p.20; the information-seeking powers of DoCS, Chapter 4, p.3; and managing a best endeavour request, Chapter 6, pp.8-9.

²⁵⁷ NSW Ombudsman, *Report of Reviewable Deaths in 2004*, December 2005, p.97.

- c. Two topics covered by the Interagency Guidelines where there appears to be a lack of clarity were DoCS intake and investigation process and the processes for best endeavours requests with more than half the respondents rating their knowledge of the latter as poor or fair only.
 - d. There was a common request for more practical and clearer guidance for working with other agencies. Health respondents were particularly interested in knowing more about privacy and information sharing laws while respondents from DoCS requested contact information for other departments, better clarity in relation to the definition of 'child at risk' and information regarding the responsibilities of other agencies.
 - e. Most respondents, who dealt with child protection matters as part of their normal role, indicated that the Interagency Guidelines had made it easier to work with other agencies on child protection matters, that they assisted in establishing good working relationships and in understanding how to exchange information with other agencies about families that move locations.
 - f. About one in five of the respondents, felt that the Interagency Guidelines had adversely affected their ability to do their job or allowed them less flexibility when dealing with child protection matters or delayed important decision-making about children. These respondents were more likely to be from Police, Health, or Juvenile Justice.
 - g. Some respondents raised issues about conflicts between the requirements of the Interagency Guidelines and the practical ability of core agencies to provide timely handling of cases, to provide feedback, and to fulfil other responsibilities, resulting in the Interagency Guidelines not being followed consistently by frontline child protection staff.
 - h. The Interagency Guidelines were largely congruent with key agency policy and procedures, however this was not the case for NGOs where there is a large potential for conflict with the way the organisations operate.
 - i. A minority of staff from key frontline agencies are yet to take up the Interagency Guidelines and DoCS staff are still seen as having the central responsibility for child protection.²⁵⁸
- 24.21 The evaluation suggested that consideration be given to practice improvements in relation to training, additional content in the Interagency Guidelines, preparation of an abridged version for staff who only use them occasionally, and exploration of problematic issues (for example, lack of synchronicity between NGO policies and procedures and the Interagency Guidelines).
- 24.22 Two further reports have been prepared as part of the evaluation of the Interagency Guidelines: a regional analysis of the findings of the survey of staff

²⁵⁸ ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Interim report, survey findings*, 12 June 2008, pp.13-15.

and a review of human service agencies' policies and procedures related to child protection.²⁵⁹

24.23 The review of policies and procedures noted, in summary that:

There was a marked difference in the coverage of the revised child protection practice commitments in policies and procedures across the agencies. Most agencies covered the commitment, "involvement of partner agencies and NGOs in case planning meetings so that an interagency response can be coordinated," in at least one policy. Two other commitments were covered by at least half the agencies, 'Feedback from DoCS to reporters in response to a risk of harm report' and 'DoCS making greater use of referrals and best endeavours requests, when it is unable to provide a casework response.' Only a minority of agencies covered the remaining commitments.

Just two agencies, Department of Community Services and Department of Education and Training made reference to all the revised commitments in the policy and procedures provided. These agencies would be expected to have operational staff most directly involved with children and their families as part of normal business. The NSW Police and Office of the Director of Public Prosecutions only referenced the commitment, 'Involvement of partner agencies and NGOs in case planning meetings so that an interagency response can be coordinated'. One agency, the Department of Corrective Services has not referenced any of the revised practice commitments in the two documents provided for the review.²⁶⁰

24.24 The Inquiry acknowledges that the Interagency Guidelines do operate as a reference point for agencies concerning the roles and responsibilities of each agency, and as a basis for staff training, although it may be noted in the latter respect that there does not seem to have been any systematic cross agency training, for workers on the ground. There has been training at a higher level within organisations, including that organised by the Child Protection Senior Officers' Group.

24.25 Otherwise, they do not seem to have brought about significant positive change in the ways in which, or processes by which, agencies work together. They do not replace agency specific policies and practices, and their provisions are not necessarily or uniformly replicated in those policies and practices. They do not

²⁵⁹ ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Regional Analysis of Survey Finding*, 5 August 2008 and *Summary of Findings for desktop review of policies and procedures related to child protection*.

²⁶⁰ ARTD Consultants: *Evaluation of the Interagency Guidelines for Child Protection Intervention 2006, Summary of findings for desktop review of police and procedures relating to child protection*.

purport to have a statutory basis, and there appears to be some degree of lack of understanding as to their content and use.

- 24.26 If they are to provide an effective basis for regulating interagency practice then revision in accordance with the findings in the evaluation report would seem to be warranted. Clearly they are not sufficient alone to ensure interagency collaboration.
- 24.27 The Interagency Guidelines exist alongside some area specific guidelines or interagency accords which remain current, including:
- a. *Domestic Violence Interagency Guidelines (2004)*, currently under review
 - b. *Interagency Guidelines for early intervention, response and management of Drug and Alcohol Abuse (2005)*
 - c. *Interagency Action Plan for Better Mental Health (2005)*
 - d. *NSW Housing and Human Services Accord*.
- 24.28 It is understood that an interagency action plan is also under development for the coordination of services for youth, with a particular focus on prevention and early intervention, and implementation of the NSW Government's Youth Action Plan.
- 24.29 The specific guidelines provide a greater degree of direction as to processes and interagency practice than the more general Interagency Guidelines, although the resulting proliferation of documents and instructions does not make for easy navigation. This is further exacerbated by the large number of MOUs and protocols that have also been developed.

Memoranda of Understanding

- 24.30 DoCS has entered into a number of MOUs, as well as generic agreements and local or regional protocols, providing for interagency cooperation and for the regulation of that cooperation, including the following:
- a. MOU between DoCS and DADHC on Children and Young Persons with a Disability (2003), which is currently under review
 - b. MOU between DoCS and Education in relation to educational services for children and young persons in OOHC (2005), which is also currently under review
 - c. MOU between DoCS and Juvenile Justice and regional protocols in relation to the responsibilities of each agency where a child in the parental responsibility of the Minister is also a client of Juvenile Justice (2004)
 - d. MOU between DoCS and Health on prioritising access to health services for children and young persons for whom the Minister for Community Services has parental responsibility or for whom the Director-General of

- DoCS has parental or care responsibility relating to residence and or medical issues (2006)
- e. Protocol between DoCS, Health and Police concerning homeless people affected by or addicted to alcohol or other drugs
 - f. Protocol involving DoCS and 10 other agencies concerning homeless persons in public places (2003)
 - g. Information sharing protocol between DoCS and Health concerning persons participating in opioid treatment who have the care and responsibility for children under 16 years of age (2006)
 - h. MOU between Health, Police, and DoCS concerning Joint Investigation Response Teams (2006)
 - i. MOU between DoCS, Health, Police, Housing and Attorney General's in relation to the establishment of a management model to implement the strategy to reduce violence against women (2002)
 - j. Case management protocol between Commonwealth agencies and State Authorities for Unsupported Young People (the Youth Protocol) for the coordination of welfare, income support and related services for homeless and unsupported young people, and involving DoCS and relevant Commonwealth agencies
 - k. Joint Guarantee of Service (2003) to deliver mental health service and housing support to people with mental health problems and disorders living in or applying for social housing
 - l. MOUs and Protocols between DoCS and the Family Court of Australia and the Federal Magistrates Court respectively concerning the exchange of information, requests for intervention and responses to allegations of abuse.
- 24.31 The Inquiry understands that a draft MOU between DoCS and Police for the exchange of information, which was approved by DoCS in 2007, is awaiting approval by Police.
- 24.32 These MOUs have the capacity to fill out the Interagency Guidelines in that, at least so far as the parties to them are concerned, they:
- a. detail specific roles and responsibilities
 - b. detail expectations about consistency of interagency relationships and practices
 - c. state what agencies and/or sectors have committed to
 - d. provide a basis and process for the negotiation of responses to a situation and for the resolution of differences between agencies.
- 24.33 In general, the MOUs appear to be comprehensive and well structured. However, the preparation of these documents is only the beginning of the exercise, the success of which depends on whether they are known,

understood and then applied by the staff of the participating agencies. As discussed in Chapter 21, the experience with the DADHC/DoCS MOU provides a clear example of a case where implementation has fallen well short of expectations, has sometimes left families in a vacuum between the two agencies, which has required them to resort to drastic action in order to obtain essential services, such as, respite care.

- 24.34 In its submission, DoCS has acknowledged that at a practice level multiple agreements may not be effective in streamlining access to services, and that it can be difficult to navigate through these agreements in order to access the right mechanism for a particular client. Additionally it has noted the risk:

... that these agreements establish an expectation about service levels that simply cannot be met in light of resourcing for services and, particularly in rural and remote areas, workforce and infrastructure availability.²⁶¹

- 24.35 DoCS suggested that rather than having multiple MOUs with separate agencies, it would be preferable to have a streamlined MOU to which all major service delivery agencies was a party.
- 24.36 The Inquiry considers that there is merit in this suggestion. There is clearly a risk that the multiplicity of governance arrangements in the several guideline documents (which do not have either statutory or contractual force), and in the MOUs, protocols and accords, makes for a very complex and inflexible structure.
- 24.37 The MOUs are largely irrelevant for the NGO sector whose engagement in the child protection system occurs as a result of their participation as contracted service providers, although the importance of their contribution has been recognised by the *Working Together for NSW*²⁶² compact which was established in 2005. The Inquiry understands that DoCS has commenced the process of updating the MOUs to include NGOs as part of the case management transfer process.
- 24.38 The compact provides a framework for service delivery and identifies the goals, values and working principles that are intended to guide the working relationship between the government and non government sectors. The Forum of Non-Government Agencies has a potential role in securing the implementation of this compact, but submissions received by the Inquiry question whether it provides much in the way of concrete results.
- 24.39 The Catholic Social Services and NSW Catholic Social Welfare Committee observed:

²⁶¹ Submission: DoCS, Interagency Cooperation, p.10.

²⁶² The *Working Together for NSW Agreement* is an agreement between the NSW Government and the community sector.

*The Working Together for NSW Agreement was intended to improve the quality of human services delivery for the people of NSW by providing a set of shared goals, values and principles that guide working relationships between the two sectors. There is a view within the NGO sector that projects attached to the Agreement are driven by the agendas of government departments and that the NGO sector has little ability to influence the Agreement's implementation.*²⁶³

24.40 NCOSS noted in its submission:

The Agreement was formulated on the understanding that an independent, diverse non government sector is an essential component of a democratic, socially inclusive society. Its purpose is to strengthen the ability for Government and NGOs to achieve better outcomes for the people of this State.

The benefits of 'Working Together' are seen by the parties to be an improved awareness and understanding of the respective contributions made by Government and NGOs, improved constructive dialogue, clearer expectations, promotion of good practice and improved quality of services and programs provided to the community

*While NCOSS does not believe that we or the non-government human services sector have utilized 'Working Together' as effectively as we should, we do believe that it provides a useful framework for development of a more collaborative and productive relationship at a whole of government level, departmental level and within departments at divisional and/or regional levels. This requires commitment both in principle and practice by all concerned.*²⁶⁴

24.41 It is understood that a further NGO development and support initiative is underway led by DoCS, and involving Health, Housing, DADHC and Education, the purpose of which is to identify and progress strategies to improve the sustainability of the NGO sector.

24.42 These initiatives are welcome and supported. The significant contribution of the NGO sector in providing services on behalf of DoCS, as shown by the fact that it receives about 45 per cent of the overall DoCS budget, underlines the need for its active involvement as a partner in interagency operations. As set out earlier in this report, there is a need to build the capacity of the NGO sector to enable it to perform an enhanced role in early intervention and OOHC.

²⁶³ Submission: Catholic Social Services NSW/ACT and NSW Catholic Social Welfare Committee, p.37.

²⁶⁴ Submission: Council of Social Service of New South Wales, pp.8-9.

Acceptance of the need for a cross government response

- 24.43 In submissions to the Inquiry, each of the key human services and justice agencies expressed commitment to their involvement as partners in a cross government response to child protection, and acknowledged deficiencies in the effectiveness of current interagency involvement.
- 24.44 Key issues identified included difficulties in relation to information sharing and resource limitations. Difficulties in dealing with chaotic families and those with complex and high needs were also raised. Suggestions for change included interagency training, joint casework meetings and planning, and the greater involvement of NGOs.
- 24.45 In his submission to the Inquiry, the Ombudsman observed:

While we note that the Guidelines are currently being evaluated, we believe an important issue for the Commission to consider is whether there is adequate guidance for practitioners in relation to those matters which should be the subject of cross-agency work.

Through our work we have identified a range of 'at risk' situations or vulnerabilities which would be very often suitable for a cross-agency intervention including those cases involving:

- *Serious and chronic neglect*
- *Parental substance abuse, particularly in circumstances of heavy substance abuse in households with infants and young children,*
- *High-risk adolescents,*
- *Serious mental health issues, by the parents and carers and/or young person, and*
- *High-risk domestic violence matters involving serious or escalating assaults.*

In many matters of this kind that we have reviewed there has been involvement by a range of agencies without any or minimal joint planning taking place. Furthermore, the problems in many of these situations are quite complex and require the involved agencies that are providing support to be alert to a range of information to assist them to make informed decisions about the nature of support required. Without the agencies coming together to consider these matters, there is a real risk

that significant resources will be expended in an inefficient and ineffective manner.

We also note the potential scope for using information holdings more effectively to identify the individuals and families which warrant an interagency response...

However, we believe that an even more fundamental issue is whether there are adequate structural and governance arrangements in place to ensure good interagency practice. Linked to this is the need to have individual staff whose core responsibilities include making this happen.²⁶⁵

24.46 This submission noted that auditing work in relation to the Police, in the exercise of the reviewable child death function, and in monitoring interagency cooperation, has generally confirmed the need for shared cooperation and improved coordination between government agencies and community service providers, as well as a need for high level support and clear direction when developing fresh approaches to interagency work.

24.47 Similar concerns to those mentioned above were expressed by the NGO sector and by various professional groups involved in the education or health systems, to the effect that, the aim of the child protection system working effectively across organisational barriers was not being achieved to the extent required, and required strengthening.

24.48 The Benevolent Society in its submission, observed:

Our experiences of interagency cooperation are that we are moving backwards not forwards in NSW,²⁶⁶

and suggested that there was need for a strong central leadership which could broker CEO level agreement about the roles and responsibilities of agencies and coordinate implementation of the Interagency Guidelines. It noted that DoCS could not be expected to play this role as it does not have any mandate to instruct other line agencies about what to do or when to intervene if they are not fulfilling their role.

24.49 UnitingCare Burnside observed, in its submission:

Service providers are also concerned that many DoCS workers are unaware of the range of services for children, young people and families available within the non-government sector. They believed this was having a direct impact on the level of service that children, young people and families are receiving. One service provider said, "Getting to know what non-government

²⁶⁵ Submission: NSW Ombudsman, Interagency Cooperation, p.5.

²⁶⁶ Submission: The Benevolent Society, p.19.

*services are available should be part of DoCS staff induction process.*²⁶⁷

24.50 A suggested solution was the introduction of joint training and professional development.

24.51 In its submission NCOSS observed:

*Collaboration and coordination works best where there is a clear understanding of each others' roles and responsibilities and a level of trust that people will do their job properly and well. It requires a sharing of knowledge and a willingness to work constructively to overcome problems. There is, however, amongst NGOs a perception that DoCS does not take criticism well and is often more defensive rather than open to suggestions constructively made. NGOs often feel their input is not sought by government and when it is ignored or not considered relevant. It is sometimes seen that DoCS role as funder of NGOs as well as a direct service provider is contrary to a more open approach to working collaboratively with other agencies to achieving better outcomes for the people we are all working on behalf of. It is also clear that the experience varies based on particular individuals and relationships rather than a universal culture or coordination, collaboration and partnership. For all agencies, Government and NGOs, to work more collaboratively these perceptions and differences in culture must be addressed.*²⁶⁸

24.52 The advantage of, and the need for, better interagency coordination has also been recognised in a number of official reports.²⁶⁹

24.53 An opposing view of the utility of interagency coordination other than at case level was offered by Barnardos Australia to the effect that there is extremely limited evidence that most children are better off if coordination is a focus of services. Barnardos indicated that, in its experience, formalised attempts to direct coordination have been a failure and have "significant costs which draw resources away from direct service provision into endless meetings and coordination attempts"²⁷⁰, and observed:

Over the last decade theories and concepts of interorganisational coordination have been developed and refined ... and practice models examined. This work has

²⁶⁷ Submission: UnitingCare Burnside, p.34.

²⁶⁸ Submission: Council of Social Service of New South Wales, pp.7-8.

²⁶⁹ For example, those of the NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, DoCS and NSW Health, *Methadone related child deaths, issues paper*, April 2008, the Standing Committee on Social Issues, *Realising Potential, Final Report of the Inquiry into Early Intervention for Children with Learning Difficulties*, Report 30, September 2003.

²⁷⁰ Submission: Barnardos, p.18.

shown the considerable level of complexity and challenges in planning coordinating processes. The work in non hierarchical cooperative systems has shown the strength of informal and local situational coordination.

Barnardos believes that the coordination of services at a case level is far better than is recognized as caseworkers negotiate the webs of available services developing multiple collaborative relationships as needed to assist service delivery. We strongly concur with Dorothy Scott that there is effective collaboration²⁷¹ but we are extremely concerned about imposed collaborative attempts which 'rationalise' a complex system to the detriment of children who are already poorly serviced.²⁷²

- 24.54 Despite the reservations expressed by Barnardos in its submission, the Inquiry accepts that the preponderance of opinion is in favour of interagency cooperation and acknowledges that much more needs to be done in NSW to bring about a workable and integrated system which can overcome the current barriers and problems which are identified later in this chapter.

Models for Interagency cooperation in NSW

- 24.55 There is ample precedent in NSW for agencies working together in the course of the management of specific cases at local level. Additionally there have been the several targeted and coordinated responses discussed in more detail elsewhere in this report.
- 24.56 The question which arises is whether the more intensive coordinated model seen in these instances should be confined to specific projects, or used as the basis for a more general cross government approach that would accord with the expectations of the agencies that were reviewed in the preceding section of this chapter.
- 24.57 The targeted models that have been successfully trialled in NSW in recent years, share the following characteristics:
- a. an exemption from or modification to privacy laws
 - b. a commitment from senior management
 - c. a specified target group
 - d. a clear governance structure.
- 24.58 These models include the Redfern-Waterloo Case Coordination Project, the Anti-Social Behaviour Pilot Project, the Child Protection Watch Team Trial, the

²⁷¹ D Scott, "Inter-organisational collaboration in family-centred practice: A framework for analysis and action," *Australian Social Work*, Vol 58 No.2, June 2005.

²⁷² Submission: Barnardos, p.18.

Nowra and Shellharbour Project, the Macquarie Fields Case Coordination Project, the Youth Partnership with Pacific Communities, the Integrated Case Management Programs for Young People of Pacific Islander background or coming from an Arabic speaking background, and their families, the Integrated Case Management Project (West Dubbo) the Schools as Community Centres Program and the Primary Connect Program.

24.59 The Inquiry agrees with the comments made by the Ombudsman that the key issues to be addressed for multi-agency forums to succeed relate to the need to:

- a. identify the target group as those who are most vulnerable and require a coordinated response, and to make the response integral to the child protection work of each agency rather than an adjunct of it
- b. ensure the complete, accurate, timely and easy access to the information held by the participants of relevance for the families and children targeted by these forums
- c. include NGOs, key community groups and local government in local interagency committees and structure processes around case management, to send the message that the government agencies have not adopted a closed shop approach, and to take advantage of the information and advice that NGOs can give and the support they can deliver
- d. establish suitable resourcing through specific funding, and dedicated staff resources; supported by clear agreement on the purpose, objectives, governance, reporting and operational procedures of the forums; and also supported by the appointment of coordinator positions to provide secretariat services, record keeping and program continuity, with suitable reporting and monitoring
- e. establish a structured framework that brings local managers together to coordinate decision making and to make strategic decisions about agency processes and local service provision.²⁷³

24.60 It is recognised, however, that the specific projects are resource hungry and depend for their success on several factors including dedicated resources, co-location, joint ethos, brokerage to access programs available outside those of mainstream agencies, good data and case tracking, and accountability.

24.61 The combination of these requirements and resource implications inevitably means that such programs need to be directed towards those communities where the needs of children and families are more pressing. This does not, however, mean that elements of these projects cannot be usefully incorporated into a wider strategy that with suitable legislative changes would overcome the barriers to interagency cooperation next considered.

²⁷³ Submission: NSW Ombudsman, Interagency Cooperation, pp.15-19.

The discordant boundaries of the human services and justice agencies

- 24.62 The regional boundaries of the human services and justice agencies are not well aligned, as is indicated by the significant differences in the way that the organisational basis of each agency is structured. In summary:
- a. DoCS has seven regions, within which there are 80 CSCs
 - b. Health has eight Area Health Services, each of which includes a diverse range of sub management divisions or clusters, as well as The Children's Hospital at Westmead and the Justice Health Unit
 - c. Juvenile Justice has five regions
 - d. DADHC has six regions
 - e. NSW Police has six Field Operations Regions within which there are 81 Local Area Commands, together with a number of specialist squads that do not have any regional limitations
 - f. Education has ten regions
 - g. Housing has four regions.
- 24.63 The closest alignment of these respective boundaries is that of DoCS and DADHC, the principal difference being that DoCS has three Sydney metropolitan regions for an area that is covered by two DADHC regions. The regional offices of the several agencies mentioned are not necessarily located in the same city or town and, at a regional local level, individual staff may have to deal with multiple access points in order to respond to an emerging problem or an individual case, each of which has a different line of command.
- 24.64 The NSW Regional Coordination Management Groups (RCMGs) effectively span 10 regional areas. Although they are substantially defined by Local Government Areas, their boundaries are also not contiguous with those of the key human services and justice agencies.
- 24.65 Attempts have been made in the past to align the regional planning boundaries of the key agencies based on a similar aggregation of Local Government Areas, which were themselves aligned as closely as possible to Area Health Service boundaries, but that has not led to any reorganisation of their institutional structures.
- 24.66 The current extent of overlap is shown in the following table:

Table 24.5 **Comparison of the boundaries of key NSW human services and justice agencies with DoCS regions.**

DoCS regions (7)

List of regions that lie within DoCS regional boundaries

<i>List of regions that lie within DoCS regional boundaries</i>					
	<i>DADHC regions (6)</i>	<i>Department of Education and Training regions (10)</i>	<i>NSW Health Area Health Services (8)</i>	<i>NSW Police Force regions (6)</i>	<i>Housing NSW Division (4)²⁷⁴</i>
Western (Central West Orana Far West, Riverina Murray)	Western	Western Riverina New England	Greater Southern AHS Greater Western AHS	Southern Western	Southern & Western NSW
Northern (Far North Coast, Mid North Coast, New England)	Northern	North Coast New England	Hunter & New England AHS North Coast AHS	Northern	Northern NSW
Southern (Illawarra, Shoalhaven, Eurobodalla, Cooma, Queanbeyan, Young and Yass)	Southern	Illawarra & South East	South East Sydney & Illawarra AHS Greater Southern AHS	Southern	Southern & Western NSW
Hunter/Central Coast	Hunter	Hunter and Central Coast	Hunter & New England AHS Northern Sydney & Central Coast AHS	Northern	Northern NSW
Metro Central (Northern Sydney, Central and Southern Sydney)	Met North Met South	Northern Sydney Sydney	Sydney South West AHS South East Sydney AHS Northern Sydney & Central Coast AHS	North West Metropolitan Central Metropolitan South West Metropolitan	Central Sydney
Metro South West (Macarthur, Liverpool, Bankstown and Fairfield)	Met South	South Western Sydney Illawarra & South Eastern Sydney	Sydney South West AHS	South West Metropolitan	Greater Western Sydney
Metro West (Cumberland Prospect, Nepean, Blacktown and Baulkham Hills)	Met North	Western Sydney	Sydney South West AHS	North West Metropolitan South West Metropolitan	Greater Western Sydney

24.67 In its submission, DoCS recognised that attempts to determine common service delivery boundaries across DoCS, Health, DADHC and Housing, had not been successful, and that DoCS staff within one region may need to deal with staff of other agencies from several different regions.

24.68 It noted:

Differing Departmental boundaries increases the problem of getting interagency agreement. As a recent example one DoCS Regional Director needed to negotiate regional protocols with three CEOs of Area Health Services, two DADHC regions

²⁷⁴ These Divisional boundaries have been approximated.

and three DET [Education] Regions. It is estimated that senior regional staff (Regional Directors and Directors, Child and Family) spend up to 30 per cent of their time each week in interagency work.²⁷⁵

- 24.69 Any examination of the way in which the overall structure for the care and protection of children and young persons operates, should not overlook the contribution of local government and non-government agencies. DoCS has advised the Inquiry that 13.9 per cent of DoCS funded projects were delivered by local government in 2006/07, a sum amounting to approximately \$20 million, while NGOs received from DoCS in that year a total sum in the order of \$540 million.
- 24.70 Local government funding is derived through a variety of programs or services, and is applied to a wide range of activities that differ from one local government area to another.
- 24.71 A similar position applies to NGOs, whose potential reach for service delivery may not coincide with the regional boundaries of the government agencies.
- 24.72 These circumstances add to the complexity of engaging the local government and NGO sectors in interagency cooperation. Their potential role is however important, and the need for them to be suitably engaged is considered elsewhere in this report.
- 24.73 The Inquiry recognises that there would be significant difficulties in achieving the kind of wholesale restructure of all of the relevant agencies in a single exercise that would provide a total realignment of their boundaries. However, it is of the view that further consideration needs to be given to the possibility of a progressive realignment.

Cross border arrangements

- 24.74 Each of the agencies faces a potential difficulty in dealing with families who move interstate, in relation to the continuation of funding for the services they need and in the provision and sharing of information. This has a particular relevance for DoCS where children or young persons who are subject to the parental responsibility of the Minister in NSW move to another state or territory as well as where children in care in another state or territory move to NSW. It adds a further complexity to the boundary issues.
- 24.75 Provision now exists in Chapter 14A of the Care Act, and in legislation of the other states and territories, for the transfer of care and protection orders, and of care and protection proceedings between jurisdictions. A protocol also exists for these transfers and for interstate assistance. In the case of the transfer and

²⁷⁵ Submission: DoCS, Interagency Cooperation, p.10.

subsequent registration of orders, it is necessary that there be a compatibility between the kind of order made in the home jurisdiction and that which would be available under the legislation of the transfer state. Additionally, there are a number of requirements relating to notification of the affected parties and consent.

- 24.76 Inevitably there are difficulties in dealing with a transient population that is not inclined to assist welfare authorities, or with those people who live in border towns and who tend to move from one side of the border to the other, or seek access to health, education and other services on the other side of the border to their usual place of residence. Some of the problems with residents of border towns of this kind are solved by sensible informal arrangements between local agencies, but as the Inquiry heard in relation to the Toomelah-Boggabilla communities they are not always easily resolved. Otherwise, however, questions can arise as to which state agency should assume responsibility for a case where a report is received from a reporter in one state in relation to a child resident in another state.
- 24.77 DoCS, at the invitation of the Inquiry, identified the following border obstacles which can be encountered:
- a. information can only be lawfully shared between DoCS and child welfare agencies in other jurisdictions: there is no provision to share information with interstate Police, Health or Education authorities or with NGOs
 - b. reporter details cannot be released to other welfare agencies and there is no system for the exchange of carer details
 - c. the meaning of compatible interstate order is unclear
 - d. the implementation of the warrants protocol and in particular, the lack of operational Police procedures to support it renders enforcement difficult
 - e. the incarceration of parents interstate when their child is the subject of care proceedings in NSW results in the parents not being entitled to Legal Aid and not amenable to a NSW order that they be present at the proceedings.
- 24.78 The Women Lawyers' Association of NSW submitted that there is a problem attributable to the differences in the types of final orders that are available in each state or territory, it being suggested that some orders may be registered in one state but not in others. As the submission recognised, this problem if it be one, can only be addressed by a national harmonisation exercise.
- 24.79 Youth Off The Streets similarly suggested that harmonisation of the legislation and improved communications between state and Commonwealth agencies would assist in achieving stronger, seamless and sustained partnerships across borders.
- 24.80 The Inquiry understands that COAG has endorsed recommendations aimed at improving information sharing about children and families at risk, including carers and has agreed to develop new protocol for information sharing between

Centrelink and child protection agencies and to include Centrelink in the alerts system. DoCS is considering legislative amendments in relation to the compatibility of court orders.

- 24.81 Otherwise it is accepted that problems can emerge as a result of delays in the exchange of information between the home and transfer states and in the registration of orders in the new jurisdiction. Where that occurs the home authority may be required to maintain the carer's allowance and other entitlements until the transfer is registered. This, however, is not a system problem; rather it is a matter for resolution by the Interstate Liaison Officers of the two agencies.
- 24.82 While clearly there are differences between the states and territories in relation to the quantum of allowances and in relation to the services that can be provided, and while national uniformity may be a worthwhile long term objective, that is not a matter within the Inquiry's terms of reference.

Privacy and exchange of information

- 24.83 Critical for interagency collaboration is the existence of a clear and workable structure for the flow of information between agencies in NSW. The lack of that structure has been identified as a major barrier to current interagency work.

Legislative framework

- 24.84 The legislative framework governing the collection, storage and exchange of child protection information is as follows:
- a. The Care Act
 - b. The *Privacy and Personal Information Protection Act (NSW) 1998* (the PPIP Act)
 - c. The *Health Records and Information Privacy Act (NSW) 2002* (the HRIP Act)
 - d. The *Privacy Code of Practice (General) 2003*
 - e. The *Health Records and Information Privacy Code of Practice 2005*
 - f. The *Privacy Directions and Guidelines* issued by the Privacy Commissioner, which relevantly include Directions concerning:
 - i. *the Anti-Social Behaviour Project*
 - ii. *the Redfern Waterloo Partnership Project*
 - iii. *information Transfers between Public Sector agencies*
 - iv. *the processing of personal information by certain Public Sector agencies in relation to their investigative functions.*

- 24.85 Annexure A contains a detailed analysis of the key provisions of each Act or instrument.
- 24.86 These documents which regulate how information is collected, stored or passed to another agency, form only part of the overall picture. Apart from the General and Health Privacy Codes, Police, Housing and Education have their own Privacy Codes; most agencies have an internal Privacy Management Plan; and the NSW Human Services and Justice CEOs Cluster has issued a document, *Information Sharing for Effective Human Service Delivery*, which although it does not have statutory force was intended to provide some guidance for agencies in relation to sharing information.
- 24.87 In addition, the legislative instrument pursuant to which individual agencies are established or regulated, often contains a specific secrecy position, the breach of which may constitute an offence,²⁷⁶ while the staff of several of the agencies will be subject to ethical rules or conventions which are directed towards maintaining client confidentiality. It may also be noted that s.254 of the Care Act which makes it an offence to disclose information obtained in connection with the Care Act, is not confined to DoCS staff.
- 24.88 Many restrictions arise in relation to the legislation mentioned above, and their provisions may be modified or made inapplicable, either through specific exemptions from the Information Protection Principles or Health Privacy Principles, or through the Privacy Codes of Practice, or through Privacy Directions or Guidelines.

Criticisms

- 24.89 The complexity of the resulting structure, and its potential impact on the system for the care and protection of children and young persons and specifically for interagency collaboration has been the subject of critical observations from a number of quarters.
- 24.90 For example the Australian Law Reform Commission in its Final Report on Australian Privacy Law and Practice observed:

Inconsistent, fragmented and multi-layered privacy regulation can contribute to confusion about how to achieve compliance with privacy regulation. This, in turn, can result in reluctance by agencies and organizations to share information.

The ALRC heard numerous examples of agencies and organizations using 'because of the Privacy Act' as an excuse for not providing information. In many cases, however, the

²⁷⁶ *Children and Young Persons (Care and Protection) Act 1998 s.254; Housing Act 2001 s.71; Health Administration Act 1982 ss.20 and 22; Police Regulations 2000 cl.46; Children (Detention Centres) Act 1987 s.37D; and the Crimes (Administration of Sentences) Act s.257.*

Privacy Act 1989 (Cth) would not have prohibited the sharing of the information.

The complexity of privacy laws is a particular issue in the context of service provision to vulnerable people. The Community Services Ministers' Advisory Council (CSMAC) noted that the range of differing privacy regimes across Australia creates problems for information exchange between jurisdictions, including in the critical area of child protection, where state and territory specific legislation applies. Issues also arise in relation to information exchange within jurisdictions, where some non-government welfare organizations are subject to the Privacy Act, and state and territory agencies must comply with State and Territory regimes. CSMAC noted that this inconsistency creates difficulties in relation to the development of memorandums of understanding and other protocols governing the exchange of information.

Inconsistency and fragmentation in privacy laws should not prevent appropriate information sharing. Information sharing opportunities, which are in the public interest and recognise privacy as a right to be protected, should be encouraged. Rather than preventing appropriate information sharing, privacy laws and regulators should encourage agencies and organizations to design information-sharing schemes that are compliant with privacy requirements or, where necessary, seek suitable exemptions or changes to legislation to facilitate information-sharing projects.²⁷⁷

- 24.91 The NSW Law Reform Commission in a consultation paper issued in relation to its Privacy Reference, made similar observations. Specifically it stated:

It is obviously essential to have a simple and practical system for the exchange of information between agencies that promotes the safety, welfare and well-being of children ... as the law currently stands agencies or organizations sharing information with each other may be in breach of s.248 of the Care Act or of PPIPA or HRIPA or the Privacy Act or may even be committing an offence under s.254 of the Care Act.²⁷⁸

- 24.92 It noted that there was a 'risk averse' interpretation of the privacy laws encouraged by:

²⁷⁷ Australian Law Reform Commission, *For Your Information Report, Australian Privacy Law and Practice, Report 108, Vol 1, May 2008, pp.508-510.*

²⁷⁸ NSW Law Reform Commission, Consultation Paper 3, *Privacy Legislation in New South Wales, 2008, p.32.*

*the difficulties of complying with inconsistent, fragmented and multi-layered privacy legislation, which results in a reluctance by agencies and organisation to share information,*²⁷⁹

and commented, additionally:

*while this can impact on business as a compliance costs, its most serious impact is in the provision of services to vulnerable people, particularly in the area of child protection.*²⁸⁰

- 24.93 In his *Report of Reviewable Deaths in 2005*, the Ombudsman noted concerns about effective use of s.248 of the Care Act²⁸¹ and his submission to the Inquiry generally mirrors the views of the two law reform commissions.
- 24.94 Similar observations were made by the Children's Guardian and the Commissioner for Children and Young People in correspondence with the Inquiry.

Agency concerns

- 24.95 The Inquiry sought the views of the key human services and justice agencies as to their impression of the extent to which the legislation or cultural impediments operated as a barrier to the sharing of information, and to effective interagency engagement. Each of the agencies that responded reported multiple concerns, and recommended that there be a significant reduction in the complexity of the privacy regime, either by amendment of the legislation, or by the introduction of a new Code of Practice.
- 24.96 The Area Health Services were particularly vocal in their criticism of the workability of the current system.
- 24.97 DoCS had similar concerns and offered the following recommendations:

That principles underpinning the use and disclosure of information within child protection should be clearly enunciated and both State and Commonwealth legislation amended to be consistent with those principles.

These principles should include the ability for those prescribed bodies working within child protection to use and disclose information where this is required, in good faith, for the safety, welfare and well-being of children or young people.

Where staff of these agencies do act in good faith then they should not be liable to suffer from any offence or other civil

²⁷⁹ *ibid.*

²⁸⁰ *ibid.*

²⁸¹ NSW Ombudsman: *Report of Reviewable Deaths in 2005, Volume 2: Child Deaths*, November 2006.

action such as for professional misconduct, disciplinary action or defamation.

Ensure all staff who have access to information on child protection matters have access to appropriate training and testing in regard to privacy compliance and information exchange and this should be part of risk management processes for each agency.²⁸²

24.98 Without ascribing the specific items of concern to the individual agencies that responded to the Inquiry's request for their views as to the operation of the privacy regime, they included, in summary, the following observations:

- a. The various pieces of legislation or related documents can apply differently to the representatives of individual agencies, even where they are working side by side on the same case.
- b. While DoCS can direct other agencies to provide information to it, and can then pass that to another agency, that agency is unable to pass any such information which it receives to another agency, with the consequence that they need to communicate using DoCS as a hub, exercising its power under s.248 of the Care Act. The process can be cumbersome, cause delay and some agencies saw it as exercisable only when DoCS had an open case concerning the child or young person.
- c. The "serious or imminent threat to life or health" criterion in s.18 of the PPIP Act, and in Clause 11 of the Health Privacy Principles, is unduly narrow and does not cater for the kind of case where there is progressive abuse and neglect; and its application is complicated by the differences in terminology used and by the subjective test involved.
- d. The principal privacy Acts apply to different areas, although with some overlap: the PPIP Act being applicable to NSW public sector agencies, the HRIP Act being applicable to the public and the private sector organisations in NSW that provide a health service or that collect, hold or use health information; and the Commonwealth Privacy Act being applicable to Commonwealth Government and ACT Government agencies and to the private sector (with the result that in some circumstances each Act will apply). The combined effect is unduly complicated, a circumstance that is aggravated by the fact that under the NSW Acts, separate regimes exist for health information and for all other kinds of information concerning individuals.
- e. The perceived inability of school principals and of Education, to pass information concerning a report that has been made to DoCS, between schools, can seriously impact on their ability to manage the subject child or young person where he or she transfers to a new school.

²⁸² Submission: DoCS, Interagency Cooperation, p.18.

- f. The perceived inability of the Police to pass information concerning their investigations into alleged criminal conduct, involving the abuse and neglect of a child or young person, to any other agency which might be required, as the alleged perpetrator's employer, to conduct an inquiry into that person's conduct, can adversely affect its ability to carry out that exercise.
- g. The authorisation power for which provision is made in the General and Health Privacy Codes is rarely, if ever used, or understood.
- h. So far as Housing is concerned there was no apparent basis upon which it could receive information from other agencies concerning families who are tenants in public housing, which could be of relevance for it in deciding whether to attempt to sustain or to terminate a tenancy.
- i. Not all of the agencies have a Privacy Code of Practice, and such Codes of Practice as do exist are not necessarily the same.
- j. So far as the Police is concerned, it may not be able, under the current law, to obtain the name of a person who makes a report to DoCS, even though that person may be a critical witness for the investigation and prosecution of a serious criminal offence committed upon a child or young person.
- k. The Directions made by the Privacy Commissioner are of limited duration, require extension, are not easy to apply and are not a satisfactory alternative to legislation or to a Code of Practice.
- l. The power under s.248 of the Care Act to direct the provision of information, and to provide or exchange information is limited to dealings with 'prescribed bodies', as defined by the Act and the Regulations made under the Act, and as a result may not be exercisable in relation to some persons or agencies that do not come within that definition.

24.99 While many, if not most, of the concerns identified by the agencies in relation to the application of the privacy legislation are probably misplaced as a matter of minute legal analysis, the nature and the volume of those concerns and the extent of the misunderstanding displayed, indicates the impracticability of maintaining the present regime in tact.

24.100 Further, the nature of the privacy laws has had the effect of limiting if not preventing state agencies identifying common high end users. Premier and Cabinet has recently carried out work to identify common clients of state agencies who are high users of services, with a particular focus on victims of domestic violence. In DoCS terms, these are the 'frequently reported families.'

24.101 A preliminary report from that work concluded that while some agencies have put in place structured approaches to data and information exchange, those efforts have been largely ad-hoc and limited by privacy concerns. This is a potentially important piece of work which is likely to ultimately be cost effective. If the privacy laws are amended as recommended in this report, the Inquiry supports further work being done to identify those families and offer appropriate assistance. A recommendation to this effect was made in Chapter 10.

- 24.102 As a final observation, the Inquiry notes the existence of an early draft for a DoCS Privacy Code of Practice which is ultimately to comprise two documents, an explanatory memorandum and the Code. The text currently runs to 75 pages without the several appendices, which include nine Privacy Directions and three Codes. Its stated purpose is “to simplify and clarify what the Department is able to do with its clients’ personal and health information under its own Act and under other privacy and health laws.”²⁸³
- 24.103 The draft code observes that:
- a. in order to allow this to occur the code is to modify the existing information privacy principles under the PPIP Act and HRIP Act, so far as DoCS is concerned
 - b. it is recognised that the draft code could not regulate what other government agencies can do with the personal/health information they hold
 - c. it is “considerably different from Codes of Practice currently used in other government agencies.”²⁸⁴
- 24.104 While the hope is expressed that it will be a ‘one shop stop’ for DoCS employees in dealing with privacy matters, the Inquiry notes that in several places it requires or invites hot links to other documents, including various Acts and Regulations, as well as to caseworker manuals, and advises that, where there is an inconsistency with privacy principles under other laws pursuant to which DoCS may carry out various functions, those other laws will prevail.
- 24.105 The reasons for drafting the code are understandable. However, the sheer length and complexity of this document, its expansion by reason of the cross references to a number of other documents, the caution that where it is inconsistent with laws other than the Care Act those laws will prevail, and the further caution that its provisions will differ from the provisions of the code of other agencies, leads to only one conclusion. In its current format, rather than simplifying the work of DoCS staff in managing privacy issues, it will only make that task even more difficult. It will, in the Inquiry’s view, do little to resolve the problems faced by DoCS in exchanging information with other agencies, and its publication would not assist the other agencies.
- 24.106 There is a legitimate and useful, albeit limited, role which codes of practice can play, primarily to assist staff of the agency concerned to understand their obligations in relation to privacy. Their value in enhancing cooperation and collaboration between agencies in relation to matters of child protection, will only be evident if the provisions of each agency’s code of practice are, to the extent legislation permits, consistent.
- 24.107 A key message of this report is the need for a strong interagency response to child protection, which includes both the government and non-government

²⁸³ DoCS, *Privacy Code of Practice (Draft)*, 2008.

²⁸⁴ *ibid.*

sectors. Therefore, it is essential that the current problems in relation to the sharing of information between agencies be resolved. The Inquiry's views as to how this may be achieved are set out in the final section of this chapter. The Inquiry recommends legislative change and notes that the NSW Privacy Commissioner endorses this approach.

Other barriers

Cultural divide

- 24.108 The Inquiry heard that there are times when the perceived or actual differences in the focus of Health and DoCS workers leads to conflict between the agencies.
- 24.109 The existence of this cultural divide was identified by the Northern Sydney Central Coast Area Health Service:

Some Health Services – eg, services working predominantly with adults clients – are reluctant to provide full information in response to s.248 as they are protective of their counselling relationship with client.

Organisations who take a strong advocacy role with their adult clients often are reluctant to exchange information with DoCS or other services working with families to address child protection issues. This is true of both NGOs and some services within Health.

Some client groups are also suspicious and unwilling to agree to information to be exchanged with DoCS – Indigenous families and some cultural groups who come from countries where human rights abuses occur are examples.

Example: adult mental health services until recently asked about the welfare of animals but not children when engaging seriously unwell clients. Any information that is known is often not communicated as it is seen as a breach of confidentiality and/or may lead to what is perceived as a punitive response to parents already struggling with mental health and/or drug use.²⁸⁵

- 24.110 This was also a matter taken up by the Greater Southern Area Health Service in a letter to the Inquiry:

²⁸⁵ Correspondence: Northern Sydney Central Coast Area Health Service, 8 May 2008, pp.6-8.

While the welfare of children is always the paramount consideration, in situations where a child is identified as at risk of harm in a public hospital or through a community health service the interests of their carers or attendants must also be addressed sensitively. In many instances – for example, in the case of domestic violence – a carer may him or herself be a patient of the hospital or client of the health service. The simple question “who is my patient/client?” is in many cases difficult to answer, and may lead to concerns about disclosing information that may be relevant from a child protection perspective.

Health care workers and social workers have a longstanding ethical tradition of maintaining confidences. Full and frank exchange of information between agencies in relation to child protection matters does not always sit easily with that tradition. These sensitivities will need to be addressed in any law reform proposals.

A shift in thinking from formal ‘agency-to-agency’ exchange of information to one in which relevant information is sensitively ‘shared’ between multi-disciplinary and multi-agency care and service providers may go some way in overcoming these sensitivities.²⁸⁶

- 24.111 The potential impact of any cultural divide of this kind on interagency work is significant and needs to be addressed, by way of training, preferably of an interagency kind, and by emphasising in the Interagency Guidelines or otherwise that interagency work must give full effect to the paramount interests of the child.
- 24.112 In Chapter 10 the Inquiry has detailed a way forward in relation to assessment and interventions by DoCS and other agencies that may assist in breaching this cultural divide.

Lack of a common assessment framework

- 24.113 Earlier in this report we have examined the potential, and reasons, for developing a common assessment framework. Such a framework, as recommended, should assist in agencies working more effectively together.

Lack of coordinated structure for interagency meetings at a local level

- 24.114 While the Regional Directors of the human service agencies seem to meet on a regular basis to consider system issues, the Inquiry was informed of varying but

²⁸⁶ Correspondence: Greater Southern Area Health Service, 2 April 2008, pp.4-5.

inconsistent practices and strategies that were adopted for bringing agencies together at a local level outside the pilot and specific projects that were mentioned earlier in this chapter. Some were ad hoc and depended on the initiative of Local Area Commanders or senior DoCS staff at a CSC, such as, the domestic violence initiative at Ballina that was mentioned earlier, and the Aboriginal Alcohol and Drug Harm Reduction Plan under development at Griffith involving Police, DoCS, the Griffith City Council, Health and a number of Aboriginal organisations.

- 24.115 Others were more formalised and regular, but some involved only two or a limited number of human service agencies at a local or regional level, and concentrated on general issues and strategies.
- 24.116 Otherwise it would appear that agencies have tended to meet together only in the context of joint case planning, or on a needs basis, involving a family or group of families in crisis.
- 24.117 There was support at the Inquiry's regional interagency meetings in which problem families, or families moving into a state of dysfunction, could be discussed, on an interagency basis, so as to provide an early response, modelled on the lines of the Anti-Social Behaviour Pilot Project.
- 24.118 A valid point made by an officer from DADHC, but repeated at more than one interagency meeting, was "the service system shouldn't just be about an agency service system. A service system for a family should be about the resources that a family needs."²⁸⁷ In other words, it was pointed out, when a family approaches a government agency for assistance it expects, and is entitled to receive not just the services which the agency can provide which might address only one of several problems, but the range of relevant services which are available across the several government agencies.
- 24.119 There was general agreement that where these meetings were attended at a local level on a continuing basis by sufficiently senior staff, they were productive and brought the agencies into a better working relationship. The problems they identified largely related to potential differences in the interests or objectives of each agency, the identification of which agency should lead the meetings, and the provision of sufficiently senior officers on a continuing basis. In the case of an agency such as Housing, this could be difficult because of its staffing structure which involves a 'hub and spoke' outreach service.
- 24.120 Another problem regularly identified with these meetings, in whatever form they took, was the current restriction on the free exchange of information in relation to individual families and children. A need for clarity was also mentioned in relation to the keeping of minutes and the extent to which they should be circulated and used.

²⁸⁷ Transcript: Interagency Meeting, Bourke, 5 March 2008, p.36.

- 24.121 Having regard to the encouraging results of the Anti-Social Behaviour Pilot Projects, and the experience of those who have worked together on an ad hoc basis in developing a cross agency response, the Inquiry is of the view that this type of model should be encouraged both at the local and regional levels and given a more formal structure. This will require:
- a. a commitment to provide an interagency response
 - b. building on existing interagency relationships where they are sound
 - c. providing a governance and leadership structure
 - d. establishing a proper basis for the sharing of information
 - e. securing a commitment for each agency to support the interagency group and to provide ongoing representation at a senior level
 - f. developing guidelines as to the families or activities to be targeted, and the strategies for providing a response.

Requests for assistance

- 24.122 As has been noted earlier DoCS can request another government department or agency, or an NGO in receipt of government funding, to provide services to a child or young person or to his or her family.²⁸⁸
- 24.123 The other agency is required to use its best endeavours to comply with such a request if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its own functions.
- 24.124 The Inquiry was informed that there were variable practices in relation to the exercise of this power, and of the responses to such requests; even though it can be an effective way of enlivening an interagency engagement with the client.
- 24.125 DoCS does not hold data on the number and nature of responses to requests made by it. However, data from Health as set out in Chapter 5, reveal that few requests to it have been documented.

Agency funding arrangements

- 24.126 Additional complexity has arisen where programs or individual NGOs engaged in interagency activities are funded through difference sources, which can involve money from state government instrumentalities and/or Commonwealth bodies, and can be subject to different funding cycles. Sometimes these programs involve trials having a limited duration, and specific funding.

²⁸⁸ *Children and Young Persons (Care and Protection) Act 1998* s.17.

- 24.127 Continuity of engagement in interagency work can be threatened where there is a need to depend on multiple sources of funding which are subject to the control of more than one body. Suggestions for change are made in Chapter 25.

Models of interagency collaboration from other jurisdictions

- 24.128 There are a range of other models for interagency collaboration that were identified in the submissions received by the Inquiry. Some of these which may have features applicable to NSW, are set out below.

Queensland

- 24.129 A key mechanism referred to in a number of the submissions was the Queensland Suspected Child Abuse and Neglect (SCAN) Teams.
- 24.130 SCAN teams commenced operation in Queensland in 1980 to provide a formal mechanism to coordinate the activities of the various government departments in relation to child abuse and neglect. The SCAN system currently includes 21 assessment and management teams staffed by professionals from Police, Health and the Department of Child Safety. Staff from other agencies (such as juvenile justice and education etc) can be co-opted for SCAN teams if required. The SCAN team provides a forum for formal consultation on child protection matters where there is a need for a multi-disciplinary approach. While the establishment of the SCAN system is mandated in legislation (*Queensland Child Protection Act, 1999, Part 3*) SCAN teams do not have any distinct decision making authority. The individual agencies retain responsibility for actions in accordance with their legislative authority.
- 24.131 SCAN teams meet regularly, not just in times of crisis or where conflict between agencies arise. There are mechanisms to monitor compliance of each agency with assigned tasks in relation to specific case plans for children and families. The threshold for referral to the SCAN team does not depend on the case being a high need or complex case.
- 24.132 A review of the SCAN model planned for 2008 aims to examine issues of interagency collaboration including practice consistency, workload and agency commitment to SCAN. Particular areas of focus for review include: agency adherence to agreed referral criteria; commitment from all agencies to ensure representation from appropriately qualified experienced staff; effective gatekeeping mechanisms to ensure SCAN is not used as a forum when interagency partners are dissatisfied with the Queensland Department of Child Safety's tertiary response; and ensuring that SCAN teams focus on children at risk, rather than children in need.
- 24.133 Queensland has also sought to improve interagency collaboration in child protection matters through the establishment of dedicated Child Safety Director

positions in the major agencies involved in child protection. The role of the Child Safety Directors is to improve the responsiveness of their own department in meeting the needs of children and families that require child protection services, to act as a change agent and expert adviser on child protection matters, to ensure cross department communication and to drive the implementation of whole of government initiatives. The Child Safety Directors meet regularly through the Child Safety Directors Network, chaired by the Deputy Director-General, Department of Child Safety, to help ensure coordinated child safety responses across Government.

South Australia

- 24.134 In 2005 South Australia introduced the Rapid Response initiative, an interagency response to the needs of children in OOHC and those formerly in that system. The strategic framework encompasses case management assessment, service response, information sharing and privacy, and regional guardianship service networks. It is directed at providing a more effective response and priority access to services for children and young persons who are growing up, or have grown up in care, and who are likely to have several areas of disadvantage compare to their peers.

United Kingdom

- 24.135 The UK differs from Australia in that, in the former, responsibility for providing social services and education lies at the local or regional authority level rather than at a central government level. The health system is also structured differently.
- 24.136 There are, however, some useful mechanisms that have been introduced through legislation in the UK to enforce interagency responsibility.
- 24.137 In 2003, issues similar to those raised with this Inquiry were evident in the UK system, that is, poor interagency coordination and a failure to share information. In 2006, Local Safeguarding Children Boards, which included local authorities, non-government services, health bodies, the police and others were established. Under s.14(1) of the *Children Act 2004 (UK)* the Boards:
- (a) *coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and*
 - (b) *ensure the effectiveness of what is done by each such person or body for those purposes.*
- 24.138 While the Boards have a role in coordinating and ensuring the effectiveness of the work of local individuals and organisations to safeguard and promote the welfare of children, they are not accountable for their operational work. All

Board partners retain their own existing lines of accountability for safeguarding and promoting the welfare of children by their home services. The Boards do not have a power to direct other organisations.

24.139 The Department for Education and Skills completed a Priority Review of the operation of Local Safeguarding Children Boards between September and December 2006.²⁸⁹ This Review noted that while it is too early to see the full impact they will have, there is good reason to be optimistic about their potential to make a difference, especially if good practice is more widely shared. Findings from this review included the following:

- a. The evidence emerging from the Priority Review suggests that the launch of Boards has given local cooperation on safeguarding a new energy. In some areas the statutory footing for the Boards appears to be raising the profile and ownership of safeguarding across local agencies. It is also being used locally as a lever to ensure statutory partners provide resources and attend board meetings.
- b. Statutory partners were generally represented on, and showing commitment to their Boards although, in some areas, levels of engagement varied.
- c. There was little evidence of Strategic Health Authority involvement, but this was likely to reflect the fact that they were in the process of substantial changes in their role and a decrease in their number from 28 to 10 authorities.
- d. Most Boards were chaired by the Director of Children's Services or another local authority employee although several were considering appointing an independent chair.

The way ahead

24.140 As identified in the submissions made to the Inquiry, the need for greater collaboration and ownership of the safety, welfare and well-being of the children and young persons, is widely recognised, as are the barriers to achieving that collaboration. The solutions have been well articulated and the Inquiry agrees with the principles enunciated by the Ombudsman and with the areas which he sees are particularly suitable for cross agency work, as set out earlier in this chapter.

24.141 The Inquiry suggests that the following legal and structural changes may enhance outcomes for children through services for them being better coordinated and delivered.

²⁸⁹ Local Safeguarding Children Boards: A Review of Progress, p.5, www.everychildmatters.gov.uk.

A statutory obligation

- 24.142 There should be a strengthening of the obligation of individual agencies to work in partnership in relation to the care and protection of children and young persons, by the introduction of specific legislative provisions calling for that commitment. Such provisions would add significantly to those currently contained in the Care Act (ss.16–18) which, at this stage, place the primary obligation upon the Director-General of DoCS, and contemplates the engagement of other agencies to provide services in response to ‘best endeavours’ requests made by it.
- 24.143 A general provision including an object or principle clause in the founding statute of each agency would need to respect their independence and their capacity to provide, or to refuse, services according to current Ministerial policy and budgetary resources. However, a statutory recognition of their obligation to assume a shared responsibility in this area would help to underpin the Interagency Guidelines and the MOUs. It would also help to overcome the current risk of agencies either positively endeavouring to shift responsibility to another agency, or of refraining from action upon an assumption, which may be unjustified, that another agency will take up the case.
- 24.144 It would also discourage the defensive approach which agencies can adopt, as a response to inquiries or adverse media commentary, in seeking to ascribe blame for any adverse outcome to another agency.
- 24.145 The Queensland *Child Protection Act 1999* contains provisions to a similar effect and provides a useful guide (see ss.159B, F and M). That Act requires chief executives of human service agencies, including principals of schools, to take reasonable steps to coordinate decision making and the delivery of services to children and their families, in order to appropriately and effectively meet the protection and care needs of children. Various principles are set out which assist in the interpretation of these provisions.

Child protection positions/units in each key agency

- 24.146 As set out in Chapter 10 positions should be established in each of the key agencies providing assistance to children and young persons, to be staffed by people with child protection expertise and to have responsibilities for:
- a. triaging risk of harm reports
 - b. case managing or coordinating services for those children, young persons and their families who need assistance but where risks do not require statutory intervention as defined under the Care Act
 - c. more broadly, ensuring communication with other agencies, primarily the human services agencies and relevant NGOs, and providing advice to the Human Services and Justice CEOs Cluster of any problems or emerging trends concerning interagency collaboration.

Leadership and performance agreements

- 24.147 All Directors-General of the human services and justice agencies are, and should be, responsible for ensuring that their agencies commit to and deliver a collaborative approach to child protection matters. Their leadership is essential. There should be a performance requirement in each employment agreement of senior staff of each agency to ensure that interagency collaboration is achieved. In relation to DoCS, the Director-General, Deputy Director-General and Regional Directors, should be subject to such a requirement to achieve effective interagency cooperation.

Align boundaries

- 24.148 The boundaries of key human services and justice agencies should be aligned.

Senior executive responsibility

- 24.149 A member of DoCS senior executive should be responsible for interagency engagement. The present structure in this respect is somewhat ambiguous, and any ultimate decision as to where that position should be located will turn upon the extent to which the current management structure is re-jigged to accord with a new reform process. The tentative view of the Inquiry is that interagency coordination responsibility should sit within the Operations Division, perhaps at Executive Director level.

Regional and local coordination

- 24.150 Structures need to be strengthened which require regular interagency meetings at the regional and local levels. In addition, CSCs should be provided with detailed and up to date information about the range of services available within their catchment area, not only as a way of encouraging networking but also as a strategy to deal with the problem of staff turnover and transfers.
- 24.151 In most regions there are Human Service Senior Officers' Groups chaired generally by the DoCS Regional Director with support from Regional Coordinators from Premier and Cabinet. These seem to be an appropriate model for regional meetings, although they may need to operate differently in rural and remote regions. Local interactions will depend to some extent on the size, location and range of issues. Senior managers should ensure sufficient, relevant structures are in place and that local child protection forums are established that involve all key government and non-government agencies providing services to at risk children and families.
- 24.152 These regional groups need to have formal accountability reporting and linkages with the Human Services and Justice CEOs Cluster and the Child Protection Senior Officers' Group.

Co-location

- 24.153 Co-location and 'hubs' should be used to greater effect to develop relationships, to enable more efficient communication and information sharing, to increase the understanding of each agency's mandate, procedures, knowledge and skills and to integrate and streamline service provision. The Inquiry supports the model being developed by UnitingCare Burnside in relation to early intervention services:

Co-location is helpful and convenient to families, and is also helpful to workers who can more easily communicate and form professional, trusting relationships. We would go further and look to an integrated, place-based service system with family support and early childhood development, including health services and early childhood education and care fully integrated under a common governance model and with a single management. We are actively developing this model. We are opening an integrated child and family centre soon in St Mary's (a disadvantaged suburb in Western Sydney). We are placing a NEWPIN service alongside a quality children's long day care centre and we are offering a community connector to work with families to access the supports they need in the local area. NSW Health (amongst others) will be invited to deliver their services from this convenient base. Other service providers will 'in-reach' at the centre.²⁹⁰

- 24.154 The Inquiry also sees benefit in promoting the greater use of the Schools as Community Centres model, which is funded through Families NSW. The purpose of the Centres is to operate as hubs for family support and development. Having a point of contact at these locations can allow a softer and coordinated entry into services for those families who need assistance, but who have not reached the stage of statutory intervention.
- 24.155 The potential value of hubs with co-located workers in remote areas was raised as a way of responding to workforce issues in those regions, possibly with a single reporting line. In particular this could prove of value in recruiting and in providing career development for Aboriginal staff who could be responsible for ensuring and facilitating the delivery of services by more than one agency.
- 24.156 The creation or greater use of government precincts is also worthy of exploration.

²⁹⁰ Submission: UnitingCare Burnside, 19 May 2008, p.7.

Cross agency training

- 24.157 The Inquiry supports cross agency training. It notes that while the Child Protection Learning and Development Coordination Forum still exists and is led by Education, the unit which delivered cross agency training was disbanded in 2005.
- 24.158 The work of such a unit would be capable of addressing the cultural divide exemplified by the notion that Health is there to support the parent while DoCS is there to support the child.
- 24.159 It would also assist in building a better understanding by the staff of the several agencies as to the services which each can offer, and how they can work together, and in ensuring that the staff of all agencies are kept up to date with any changes to MOUs or to agency practices.
- 24.160 The Inquiry is of the view that consideration should be given to its revival, or to the establishment of a similar program. Such a program could possibly take its place within the Education Centre Against Violence Project. Alternatively and perhaps preferably, it could be delivered through the TAFE career development strategy, Pathways, and by permitting staff to acquire additional qualifications or enhanced accreditation. Moreover, it could incorporate or build upon the work that has been undertaken by DoCS and Health towards establishing cross agency drug and alcohol training.

Involving the NGO sector

- 24.161 The Inquiry has noted the limited extent to which the NGO sector has been involved in the development of the MOUs or Protocols that are intended to assist the government agencies working together.
- 24.162 The need for their greater involvement is acknowledged by the *Working Together for NSW* compact, and is obvious once consideration is given to the extent that NGOs are funded to provide services. This service provision will only increase if the recommendations of this Inquiry are accepted.
- 24.163 The Inquiry accordingly supports the Government encouraging a greater involvement of this sector as a partner in interagency arrangements, and in future planning. It also supports the work earlier identified that is addressed at improving the sustainability of this sector.
- 24.164 In this respect the positive experience of the multi-disciplinary models such as those employed by Barnardos Child and Family Centres, UnitingCare Burnside Family Centres and the Benevolent Society Partnerships in Early Childhood Centres, as well as the Barnardos Substance Use in Pregnancy and Parenting Services which it operates in conjunction with NSW Health and DoCS, and the UnitingCare Burnside NEWPIN Early Intervention Family Support Program

which it operates in conjunction with NSW Health, provide support for their continued engagement within an interagency context.

- 24.165 Although this is discussed elsewhere, the Inquiry is satisfied that increasing the engagement of the NGO sector in early intervention and OOHC requires performance based contracting, and a simplification or rationalisation of the funding process.

Privacy and information exchange

- 24.166 An essential key to achieving the kind of effective interagency involvement, considered in this chapter, is the capacity of agencies to exchange information concerning a child or young person, or their family.
- 24.167 The complexity of the legal and administrative framework governing the exchange of information is such that, once each of the various sources has been examined, it is still not possible to formulate any general rules as to when the exchange of child protection information will be lawfully permitted. Whether a particular exchange is lawful will depend on the circumstances of the exchange, the content of the information that is being exchanged, the agencies between which the information is being exchanged, and sometimes on whether consent has been obtained from a person who is the subject of that information.
- 24.168 While there was general consensus as to the need for a revision and simplification of the laws relating to the exchange of information, there were differing views as to whether this should be addressed by amendment of the privacy legislation, or by amendment of the Codes of Practice, or by additional Directions.
- 24.169 While the Australian Law Reform Commission has issued a final report in relation to the Commonwealth, State and Territory privacy legislation, and the NSW Law Reform Commission is working on its final report, the references given to each agency extend well beyond the area of interest for this Inquiry. The likely timeframe for the introduction of uniform privacy legislation of general application, or for the amendment of the NSW laws, arising from the work of the two Law Reform bodies is likely to be lengthy.
- 24.170 The Inquiry is of the view that the urgency of reform in the application of these laws to the care and protection system is such that it should not await a more general reform.
- 24.171 While this could occur by way of amendment to the PPIP Act or the HRIP Act, or the Codes of Practice, the resulting structure would still be one of some complexity, while the issue of Privacy Directions is a clumsy, ad hoc solution.
- 24.172 The Inquiry believes that the answer lies in amending the Care Act in a way that would achieve the desired objective and be relatively simple in its interpretation and application. In coming to this conclusion it acknowledges that it has paid

careful attention to the solution offered by the Ombudsman in his submission to the Inquiry.

24.173 Amendment to the Act should achieve the following objectives:

- a. The several agencies including NGOs, that have responsibilities for the safety welfare and well-being of children and young persons, should be able to share information without needing to rely on DoCS as an intermediary, where that information is required to promote the safety, welfare and well-being of any such person.
- b. The Care Act should incorporate a statement of principle making it clear that agencies with significant responsibilities of the kind mentioned, are expected to communicate with other agencies having the same responsibilities.
- c. In order for a person or agency to exchange information with another agency or with an NGO, that person or agency should believe, reasonably, that such exchange would assist the other agency or NGO to make a decision, assessment, plan, or investigation relating to the safety, welfare or well-being of a child or young person.
- d. Agencies should have business plans to support the implementation of such a system.
- e. Appropriate thresholds should exist to ensure that the information exchanged is not used or further disseminated or disclosed for any purpose that is not associated with the safety, welfare and well-being of a child or young person, *inter alia* to ensure that information which is untested or unverified is not given any further exposure than is necessary for genuine child protection purposes.
- f. Existing protections from civil and criminal liability and ethical requirements should attach where information is exchanged in accordance with these requirements.
- g. Agencies should be able to supply to Police information as to the identify of a reporter, that would enable Police to investigate a serious indictable offence committed against a child or young person which directly affected that person's safety, where it was impractical to obtain the consent of the reporter, or where obtaining that consent had the potential to prejudice the investigation, subject to an appropriately senior person certifying that those conditions are present.²⁹¹
- h. Principals of schools should be able to exchange details of risk of harm notifications, where there are ongoing concerns about the safety and welfare of students who have moved between schools.
- i. The Police should be able to supply information concerning their investigations into criminal offences, involving the abuse of children and

²⁹¹ Thereby enlarging the circumstances for disclosure currently permitted under s.29 of the *Children and Young Persons (Care and Protection) Act 1998*.

young persons, to the employers of the alleged perpetrator where the latter would be under a statutory obligation to report to the Ombudsman and to investigate an allegation of such conduct concerning that person.

- 24.174 In his submission, the Ombudsman proposed a three tier system which would:
- a. permit DoCS as a first tier agency to direct another agency to supply information to it and to supply information to another agency, as currently is the case
 - b. establish a tier two class of agencies having a significant involvement with vulnerable children and their families, with a power to furnish other agencies with information and to request but not direct its supply from other agencies
 - c. specify a third tier class of agencies or individuals that would be able to furnish information to tier one or two agencies and to receive information from a tier one or two agency

in any such case without any of the participants being in breach of s.254 or of any other privacy law.

- 24.175 At this stage, the Inquiry has concerns that this three tiered system may become unduly complex in its administration and require an elaborate ongoing process for classification of agencies falling within tiers two or three.
- 24.176 For the purpose of this report, the Inquiry prefers to make a more general recommendation concerning the need for an amendment of the Care Act that would deliver the essential elements outlined above. Further development would benefit from input by each of the key agencies in conjunction with the Privacy Commissioner and the Ombudsman and by reference to Chapter 5A of the *Child Protection Act 1999 (Qld)*.
- 24.177 In addition, the Inquiry supports the recommendations endorsed by COAG to improve information sharing on children and families at risk.

Recommendations

Recommendation 24.1

The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons.

Recommendation 24.2

Each human services and justice agency CEO should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.3

The Director-General, each Deputy Director-General and each Regional Director of DoCS should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.4

The boundaries of key human services and justice agencies should be aligned.

Recommendation 24.5

Cross agency training should be delivered in relation to interagency collaboration and cooperation in delivering services to children and young persons.

Recommendation 24.6

The *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person in accordance with the principles set out in Chapter 24. The amendments should provide, that to the extent inconsistent, the provisions of the *Privacy and Personal Information Protection Act 1998* and *Health Records and Information Privacy Act 2002* should not apply. Where agencies have Codes of Practice in accordance with privacy legislation their terms should be consistent with this legislative provision and consistent with each other in relation to the discharge of the functions of those agencies in the area of child protection.

Recommendation 24.7

An improved structure should be established for regular regional meetings between the key human services agencies and NGOs to facilitate collaborative cross agency work, and to be accountable to the Human Services and Justice CEOs Cluster.

25 DoCS funded non-government services

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Introduction

- 25.1 NGOs are significant players in the delivery of child protection services in NSW, across the continuum of universal, secondary and tertiary services. They range in size from small not for profit groups managed by volunteer committees, to multi-million dollar enterprises. Many receive funds from a variety of sources: local, state and Commonwealth tiers of government and, within each tier, from more than one division or department. They are organised into peak bodies, which, generally are funded by the state to act as a conduit for communication with government on behalf of their members.
- 25.2 Child protection could not be delivered without them in NSW. The questions for the Inquiry are whether their reach could and should be extended, and whether the system by which they are funded is sufficiently efficient and effective for the purpose.

The system

The funding

- 25.3 DoCS currently funds approximately 1,850 organisations to deliver over 3,600 projects or services. Over 80 per cent of these services are delivered by not for profit non-government organisations. More than 15 per cent of these services are delivered by other state government agencies (56) and local councils (491). The few remaining services are delivered by a small number of for profit organisations, most of which provide OOHC services under Header Agreements. DoCS advised that an accurate estimate of the services offered by for-profit organisations is not possible without a comprehensive analysis of funding records.
- 25.4 In terms of size, NGOs can be categorised as follows:
- a. micro-organisations receiving funding of up to \$100,000 per annum
 - b. small organisations receiving funding of over \$100,000 and up to \$1 million per annum
 - c. medium sized organisations receiving funding of over \$1 million and up to \$10 million per annum
 - d. large organisations receiving funding of over \$10 million per annum.
- 25.5 Almost 40 per cent of DoCS' external services budget is paid to 20 large organisations. Around 12 medium sized organisations each receive funding of between \$2 million and \$10 million per annum, and the remaining budget is allocated to a significant number of small and micro organisations.
- 25.6 DoCS has informed the Inquiry that there are 55 special rural and remote projects which it funds, representing 1.5 per cent of all funded projects. It has

also advised that it funds 369 projects (9.8 per cent) for Aboriginal clients and 211 projects (5.6 per cent) for CALD clients.

- 25.7 The following case studies illustrate the complexity of the current funding environment for the non-government sector.

Case Study 27

UnitingCare Children, Young People and Families (UnitingCare) is a large non-government organisation providing a range of services to children, young people and their families across NSW. UnitingCare Burnside forms part of this organisation.

In 2007/08, UnitingCare received over \$30 million in Commonwealth and NSW Government funding.

This involved dealing with 11 different government agencies to negotiate 58 service agreements for 104 services.

Of these service agreements, 12 were negotiated with DoCS to fund 59 services across 10 different DoCS funding programs. Six services had separate service agreements, while the remaining 53 services came under six umbrella service agreements for particular areas of the State. For example, UnitingCare has a Metro South Western Sydney Service Agreement with DoCS that covers 15 services.

All the 104 services that received funding had separate reporting requirements. Each required a minimum of annual reporting, with 37 also requiring either quarterly or six monthly reporting.

Case Study 28

Southern Youth and Family Services is a medium sized non-government organisation providing a range of services to young people and their families in southern NSW. The agency covers the four local government areas of Wollongong, Shellharbour, Kiama and Shoalhaven.

In 2007/08, Southern Youth and Family Services received over \$7 million in Commonwealth and NSW Government funding.

This involved dealing with eight different government agencies to negotiate 20 separate service agreements, one for each service that received funding. Of these service agreements, six were negotiated with DoCS across four different DoCS funding programs.

All the services that received funding had separate reporting requirements. Each required a minimum of annual reporting, with six also requiring either

quarterly or six monthly reporting. Monthly or quarterly data entry was also required for 12 of the services.

- 25.8 Clearly, negotiating, administering and reporting on multiple funding contracts with multiple agencies, many with different contractual and reporting requirements or different funding cycles or terms is at best an administrative challenge for NGOs. Managing a system with multiple contracted suppliers and drawing on separate funding streams, similarly can absorb significant resources so far as DoCS is concerned.
- 25.9 The Inquiry understands that as part of its funding reforms, DoCS has commenced rationalising the number of separate service agreements it has with each of its funded services, starting with larger NGOs. This is evidenced in Case Study 27 where UnitingCare is funded to provide 59 separate services through 12 service agreements. The Inquiry supports moves to rationalise the number of separate service agreements that NGOs are required to negotiate with DoCS. However, the Inquiry believes much more is required to rethink fundamentally the way in which these NGOs are funded. This is addressed later in this chapter.

The programs

- 25.10 DoCS has funding contracts with external service providers under the key funding programs detailed in Table 25.1.

Table 25.1 **DoCS key funding programs and 2007/08 funding**

DoCS funding program	2007/08 funding
Brighter Futures program	\$123.5 million over three years
Out-of-Home Care Program	\$164.4 million
Children's Services Program (CSP)	\$116 million
Supported Accommodation Assistance Program (SAAP)	\$120.8 million
Community Services Grant Program (CSGP)	\$79 million
Families NSW	\$29.6 million
Better Futures Program	\$4.6 million
Aboriginal Child, Youth and Family Strategy (ACYFS)	\$4.7 million
Area Assistance Scheme (AAS)	\$8.7 million
Alcohol and Other Drugs Program (AODP)	\$4.2 million

- 25.11 There appears to be significant duplication across the funding programs both in terms of the target client groups and the different services and activities funded as the following table illustrates.

Figure 25.1 **Key types of services and activities funded through DoCS funding programs**²⁹²

<i>Services/ activities</i>	<i>Brighter Futures</i>	<i>Families NSW</i>	<i>CSGP activities</i>	<i>CSP</i>	<i>AODP</i>	<i>Better Futures</i>	<i>ACYFS</i>	<i>AAS</i>	<i>SAAP</i>	<i>OOHC</i>
Volunteer home visiting	♦	♦								
Professional home visiting	♦									
Supported playgroups	♦	♦					♦			
Parenting programs	♦	♦	♦				♦	♦		
Family support services ²⁹³	♦	♦	♦		♦		♦			
Family preservation			♦							♦
Family worker		♦	♦				♦			
Family counselling			♦				♦		♦	
Case management	♦		♦		♦		♦		♦	♦
Youth focused support services			♦		♦	♦	♦	♦		♦
Youth worker			♦			♦	♦			
After school/ youth activities			♦			♦	♦			
Alcohol and other drug support services			♦		♦					
Sexual assault services			♦							
Mobile children's services				♦				♦		
Toy library				♦				♦		
Community capacity building		♦	♦				♦	♦		
Community development worker		♦	♦				♦	♦		
Child protection services			♦							
Information and referral		♦	♦		♦					
Crisis accommodation									♦	♦
Supported accommodation									♦	♦
DV support services			♦						♦	

²⁹² DoCS, *Annual Report 2007/08*, section 8: Funded Services, pp.163-223.

²⁹³ DoCS funds agencies to provide 'family support services.' The actual services provided to clients is based on their needs and can, for instance, include a mix of counselling, home visiting and case management. DoCS also funds agencies to specifically provide such services, as illustrated in the table.

<i>Services/ activities</i>	<i>Brighter Futures</i>	<i>Families NSW</i>	<i>CSGP activities</i>	<i>CSP</i>	<i>AODP</i>	<i>Better Futures</i>	<i>ACYFS</i>	<i>AAS</i>	<i>SAAP</i>	<i>OOHC</i>
Women's refuge									♦	
Youth refuge									♦	
Foster care										♦
Residential care										♦
Temporary care										♦
After care										♦
Long day care				♦						
Vacation care				♦			♦	♦		
Preschool				♦						
Occasional care				♦						

- 25.12 Universal children's services funded by DoCS, with the exception of vacation care, are funded solely through the Children's Services Program. At the other end of the care and support continuum, tertiary OOHC and crisis accommodation services are funded exclusively through the SAAP and the OOHC program. Leaving aside these three funding programs, there is obvious duplication in service funding across the remaining DoCS funding programs that deliver universal, targeted, secondary and some tertiary services, for the most part with an early intervention focus.
- 25.13 There appears to be a particularly pronounced duplication in relation to the types of services funded under the Brighter Futures, Families NSW, CSGP and ACYFS Programs that target vulnerable families. In the case of the latter funding program, the target client group is Aboriginal specific. There is also duplication evident between the CSGP, Families NSW, AAS and ACYFS funding programs in the area of community capacity building where disadvantaged communities form the target client group.
- 25.14 The CSGP also funds a range of secondary services targeting youth and a smaller number of tertiary services targeting women, children and young persons who have been abused or have been the victims of domestic violence. Secondary youth services are also funded through the ACYFS, Better Futures and the AAS programs. There is limited duplication in the source of funding for tertiary services, with the exception of drug and alcohol support services which are also funded through the AODP, and domestic violence support services which are also funded through SAAP.

Funding reform

25.15 In advice to Government in March 2008, DoCS noted:

In 2002, there was no clear relationship between funding and outcomes for clients or even numbers of client services provided. Allocations of funding across services was inconsistent. Services provided virtually no data by which DoCS could manage their performance or hold them accountable. Alterations to funding by DoCS would often prove highly politically sensitive. Because of these vague boundaries, there was often confusion between the concepts of funding for essential services to clients (such as foster care) and 'grants' to NGOs.²⁹⁴

25.16 The DoCS Funding Policy, published in August 2005, signalled a move away from 'historical' or grants based funding to the funding of services based on achieving:

- a. a focus on outcomes for clients and communities
- b. greater flexibility for service providers in integrating services and matching them to clients
- c. better management of service risks and sharing of management responsibility
- d. value for money and use of savings to improve services
- e. longer term funding (where appropriate)
- f. accountability for funding
- g. rewards for enhanced performance
- h. consistent yet flexible processes and practices.²⁹⁵

25.17 To implement its funding reform principles, DoCS has commenced a process of introducing the following three key elements into its funding programs:

- a. Performance based contracting which links funding to results and gives services the opportunity to demonstrate the benefits of the services they provide.
- b. Strengthening the service system to increase the capacity of different community services and to help build a robust service delivery system.
- c. Diverse funding options, with the aim of ensuring that DoCS selects the service provider that is best placed to deliver the service required.

²⁹⁴ Information provided to Government by DoCS, March 2008.

²⁹⁵ DoCS, *Funding Policy*, August 2005, p.5.

- 25.18 These funding reforms represent a significant cultural shift for both funded services and for DoCS staff. DoCS has acknowledged to the Inquiry the concerns expressed by the NGO sector about the operational impact of these reforms, and as a result, has planned a staged implementation of the new policy to allow the NGO sector time to adjust to the changes.
- 25.19 Since 2005, as additional funding has become available, outcome based service specifications and performance based contracting have been part of the funding and contracting process. In the case of existing funding programs that have received no additional funding, the implementation of funding reform is more gradual. DoCS has advised that performance based contracting will be used across all of its funding programs by the end of 2010.
- 25.20 Fundamental to performance based contracting is the collection of accurate data about client and community needs and the establishment of a monitoring process to ensure that funded services are meeting those needs. DoCS acknowledged that this is a cost to the sector.

Competitive tendering

- 25.21 To identify service providers for the Brighter Futures program, DoCS undertook a competitive tendering process using a two-staged Expression of Interest (EOI) in 2005. The DoCS information package for the Brighter Futures EOI indicated a preference for agencies working in partnership through a consortium arrangement.
- 25.22 As a result of this EOI, 14 Lead Agencies were contracted to provide planned early intervention services to families that participate in the Brighter Futures program. There are over 440 partner agencies working with the Lead Agencies to deliver these services. More than 80 per cent of these partner agencies are small to medium sized organisations.
- 25.23 DoCS has reported that the implementation of Brighter Futures has been protracted due to the scale of the program and because of difficulties NGOs have experienced in recruiting staff and in finding suitable accommodation. The integration of DoCS and NGO service delivery has also taken time.
- 25.24 Based on this experience, during 2007, DoCS commenced a reform process of the OOHC funded service system made up of three streams: a service plan review to move existing service providers onto performance based contracting; an EOI process for over \$600 million in additional OOHC program funding; and a direct negotiation process to fill any service gaps left once the EOI process was finalised.
- 25.25 The Children's Guardian was supportive of the reforms to the funding of the OOHC service system and stated that they should lead to an improved range of integrated services with the capacity to better match services to children and

young persons in OOHC. The Children's Guardian further noted that the reforms "will allow DoCS to strengthen its focus on managing demand."²⁹⁶

25.26 The effect of competitive tendering on the relationship between NGOs was however raised by Professor Alan Hayes, Director of the AIFS. He advised the Inquiry that for many NGOs, competitive tendering was antithetical to cooperation.

25.27 Another criticism of the competitive tendering process used for the Brighter Futures and OOHC programs was that it was "designed to provide the cheapest possible service with minimum standards."²⁹⁷ It was recommended that DoCS implement "a process that ensures that the final gate in any gated process of assessment of EOI relates to the quality of the outcomes for children rather than unit costing."²⁹⁸

25.28 A number of organisations have been critical of the EOI process as failing to take into account local priorities and concerns, and as overlooking smaller more locally focused agencies in favour of larger service providers that in some cases did not have an established presence in the area.

25.29 The consortium model favoured in the Brighter Futures EOI was also the subject of some criticism. Barnardos advised the Inquiry that:

*formally endorsed attempts to direct coordination such as the attempts by DoCS in Brighter Futures with concepts such as insistence on 'partners' and 'lead agency,' and formalise relationships have in our experience been a failure, and have significant costs which draw resources away from direct service provision into endless meetings and coordination attempts.*²⁹⁹

25.30 While broadly supportive of DoCS' reforms to the OOHC program, ACWA raised concerns that the OOHC EOI process was unfair on smaller agencies and on existing OOHC service providers whose tenders were unsuccessful or only partially successful. ACWA stated that:

*many children in placements that have been funded through temporary funding known as Individual Client Agreements (ICAs), face the possibility of the service which supports them being closed and they may have to experience placement and agency/case worker change.*³⁰⁰

25.31 In relation to the OOHC EOI process, it has been claimed that services using the costing benchmarks developed by DoCS were generally unsuccessful in the

²⁹⁶ Submission: Children's Guardian, p.36.

²⁹⁷ Submission: Newcastle Family Support Services, p.1.

²⁹⁸ *ibid.*, p.2.

²⁹⁹ Submission: Barnardos, p.17.

³⁰⁰ Submission: Association of Children's Welfare Agencies, p.24.

tendering process. Concerns have been raised about the sustainability of the services that were successful given that they may have underpriced their service delivery. Concerns were also raised as to the demands in terms of the cost, and the time expended by small agencies in preparing the necessary paperwork and in working with lead agencies in preparing a tender.

- 25.32 ACWA stated that some agencies facing possible closure have had considerable experience in providing quality OOHC services and have either gained five year accreditation with the Children’s Guardian or have made good progress in the Guardian’s Accreditation and Quality Improvement Program. ACWA saw this as “an unintended and unfortunate consequence of an EOI process where the final consideration was cost competitiveness.”³⁰¹
- 25.33 DoCS said in reply that the “costs of robust competitive tendering need to be balanced against the benefits of getting the best quality service that provides value for money.”³⁰²
- 25.34 DoCS has accepted that extra work is involved in implementing the Performance Monitoring Framework, but rejects the criticism that its more rigorous monitoring and accountability requirements are an unnecessary burden on the NGO sector, arguing that it is needed in order to develop a culture of continuous improvement in the quality of service provision.
- 25.35 While also acknowledging that the implementation of funding reforms has been a difficult process for the NGO sector, the Inquiry supports the general thrust of DoCS funding reform. The introduction of performance based contracting and its associated reporting requirements are necessary components of a robust and accountable government funded service system, particularly in circumstances of the kind presented by the current economic climate in which resources are limited.

Review of the Community Services Grant Program

- 25.36 The *DoCS Annual Report 2007/08* states that the CSGP “is a funding program to improve the resilience and safety of disadvantaged children, young persons, families and communities.”³⁰³ The very broad aims of the program are largely explained by the CSGP’s history. It was originally established in 1988/89 when community services, funded under a number of different programs, were amalgamated under the one umbrella program.
- 25.37 As a result, the CSGP funds approximately 950 diverse projects operated by 600 non-government organisations and local councils. The CSGP 2007/08 funding base was \$79 million.

³⁰¹ *ibid.*, pp.24-25.

³⁰² Submission: DoCS, Funded service system supporting child protection, p.16.

³⁰³ DoCS, *Annual Report 2007/08*, p.20.

Table 25.2 **CSGP funding by sub-program, 2007/08**

Project categories	Project numbers	Funding (\$million)	% of Funding
Community Development	438	27.63	34.9%
Family & Individual Support	193	26.03	32.8%
Youth Services	288	22.05	27.8%
Child Protection	30	3.48	4.5%
Total	949	79.19	100.0

Source: DoCS submission: Funded service system supporting child protection, Appendix 1, p.40

- 25.38 There has been no growth funding in the CSGP since 1990. DoCS has argued that at the same time, “the cost drivers and demand for services have increased considerably, resulting in significantly decreased level of service comparative to 1990.”³⁰⁴ DoCS engaged Ernst & Young to undertake a review of the CSGP in early 2007, with the aim of developing a program structure that aligned with DoCS corporate priorities and provided the basis for a sustainable service system.
- 25.39 The CSGP review report dated March 2008 identified disadvantaged children, young persons and their families, and disadvantaged communities as the new target group for a reformed CSGP.³⁰⁵ The review report identified a new ‘headline result’ and a set of program results for the CSGP, as follows:
- a. Headline Result: Disadvantaged children, young persons, families and disadvantaged communities are to be made resilient and safe
 - b. Program Result 1: Disadvantaged families and young persons are provided support and are linked to services in their communities
 - c. Program Result 2: Children and young persons at risk are supported in their communities
 - d. Program Result 3: Children and young persons in crisis are supported
 - e. Program Result 4: Disadvantaged communities develop the ability to enhance well-being and participation of children, young persons and their families.³⁰⁶
- 25.40 As part of the review, an assessment was undertaken to determine the extent to which current CSGP projects aligned with the new headline result, program results and activities identified during the review process. It was found that 6.40 per cent of projects fully aligned, 88.05 per cent of projects partially aligned and 5.55 per cent of projects did not align.³⁰⁷
- 25.41 DoCS has indicated that it does not propose to exclude services or to defund those which do not align,³⁰⁸ although new service specifications are to be

³⁰⁴ Information provided to Government by DoCS, March 2008.

³⁰⁵ DoCS, Ernst & Young, *Review of the Community Services Grants Program*, March 2008, p.18.

³⁰⁶ *ibid.*, pp.18-20.

³⁰⁷ *ibid.*, p.22.

³⁰⁸ DoCS, *Update from the Community Services Grants Program Roundtable, Communiqué 3*, September 2007, p.2.

developed in 2008/09 with the aim of ensuring that all services receiving CSGP funding align with the results set out above.

- 25.42 The business case developed in response to the review argues that to meet increased client demand the CSGP would require a budget enhancement of \$45 million per annum to be introduced in \$15 million increments over three years from 2008/09 to 2010/11.³⁰⁹
- 25.43 That business case was provided to Treasury in February 2008. While there was no additional funding allocated to the CSGP in the 2008/09 budget, the Inquiry understand that DoCS has held discussions with Treasury regarding the availability of resources to implement its recommendations. A final decision regarding the proposed budget enhancement for the CSGP will not be made until after this Inquiry reports.

Need for broader reform of DoCS funding structure

- 25.44 The Inquiry agrees that it makes sense to move away from a system that focuses largely on inputs and processes to a system that focuses on improving client outcomes and allows service providers to have a greater role in service system design.
- 25.45 However, the funding reform has largely taken place within each of the funding programs rather than examining the overall basis upon which DoCS funds NGOs and other agencies, and without identifying the outcomes that are needed to address the changing needs of children and families across the continuum of services. As the Inquiry was informed by UnitingCare Burnside:

*The greatest problem, however, is that we continue to describe the service system in terms of the funding streams rather than in terms of what we want to achieve...families do not fit naturally into separate buckets of funding.*³¹⁰

- 25.46 There may be historical or political reasons why DoCS administers 10 funding streams and the Inquiry has not devoted much of its limited time to understanding why, or to what end, these programs have proliferated. It offers the observation that the duplication of the programs developed over decades in a largely ad hoc way as is evident from Table 25.2 is wasteful and costly for both DoCS and those it funds. Its apparent breadth may serve to mask areas of deficiency or it may otherwise lead to duplication of services. Significant administrative effort could be saved by reducing the number of streams and by requiring those seeking funding to provide only one submission that covers each area of work funded by DoCS, and that reflects the continuum of services that children and families need, for example, child care, family support services, or counselling.

³⁰⁹ DoCS, *Community Services Grants Program Business Case, Draft Version 1*, 17 December 2007, pp.7-8.

³¹⁰ Submission: UnitingCare Burnside, 19 May 2008, p.11.

25.47 Administrative effort could also be saved by funding services for at least three years ahead, preferably five years, and by requiring one report rather than multiple reports back to DoCS on outcomes. It is clear that investment in infrastructure and human resources by the NGO sector will not occur without a reasonable period of funding certainty. Employment cannot be offered without that certainty, nor can sensible planning take place.

25.48 The Director-General of Aboriginal Affairs, Ms Jody Broun, made the following comment about Aboriginal agencies which could equally apply to all NGOs:

*there needs to be longer-term commitment to funding of small agencies as well, so that they are not in a continual cycle of making submissions for funding and can then make long term commitments to their planning and how they are developing in the capacity issues. I think too often Aboriginal organisations across the board are caught in this submission based approach to their funding, with continual cycles of having to acquit those funds and then apply again, and they can't plan into the future and they are always on this tenuous sort of circuit.*³¹¹

25.49 Barnardos offered the following observation on the barrier to developing integrated service provision created by the structure of the current funded service system:

*The area of most difficulty is in the provision of integrated services to children and family in their communities. We undertake the support of families whose children are vulnerable to abuse or neglect in five Children's Family Centres in NSW. Each has a range of activities, for example, home visitations, crisis accommodation, group work, domestic violence programs, child care, specialist services. Each activity is separately funded often by the same government department, for example, the Department of Community Services (DoCS), even through the same funding pool, for example, CSGP while on occasion from a separate pool in the same department, for example, SAAP. Each activity needs separate submissions and separate accountability.*³¹²

25.50 The issue of overlap is not confined to DoCS. Many services rely on multiple funding sources within the NSW Government. For example, Juvenile Justice has a Community Funding Program which funds some of the same agencies as are funded by DoCS, to provide similar services, such as drug and alcohol support and accommodation support, to a similar client group, namely children and young persons in or at risk of entering the juvenile justice system.

³¹¹ Transcript: Public Forum, Aboriginal Communities, 24 April 2008, p.28.

³¹² Correspondence: Barnardos, 25 August 2008.

- 25.51 The Inquiry is of the view that a review of all NSW government funding to NGOs delivering universal, targeted and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should occur. The benefits of an integrated funding system are obvious and include reduced administrative costs for government and non-government sectors alike and better targeting of services.
- 25.52 Many services also rely on funding from the Commonwealth. It is hoped that the current COAG initiatives will enable funding reform in that area.

Role of the NGO sector in the child protection system

- 25.53 The Inquiry agrees with Premier and Cabinet that the following three challenges apply to developing better working relationships with the NGO sector:
- a. providing a clear definition of the precise areas where NGOs are best placed to undertake contracted roles
 - b. ensuring that NGOs operate according to clear service accountabilities to drive the delivery of outcomes
 - c. establishing effective coordination mechanisms with the NGO sector, NSW Government agencies and the Commonwealth.
- 25.54 The role the NGO sector should play in supporting the child protection system and its capacity to take on an expanded role are discussed in earlier chapters, as is the challenge of establishing more effective coordination mechanisms between the NGO and government sector. The impact of DoCS funding reforms in ensuring that services provided by NGOs focus on improving client outcomes has been dealt with earlier in this chapter.
- 25.55 Given that almost half the DoCS budget is spent purchasing services from NGOs, it is clear that the NGO sector already plays a significant role in delivering most of the support services within the child protection system in NSW.
- 25.56 DoCS has identified the following advantages to contracting out DoCS services rather than delivering these services directly:
- a. they can be delivered at a lower unit cost
 - b. NGOs are potentially able to engage and maintain some categories of client more readily than a statutory welfare agency
 - c. most services are well established with strong local knowledge and networks
 - d. small services have the potential to be more flexible in responding quickly to emerging need with innovative service models
 - e. DoCS caseworkers can focus on statutory clients.
- 25.57 In an expanded external service system, DoCS has envisaged that:

NGOs will continue to deliver many of the universal and less intensive services within the continuum such as child care, family support and parent education. In addition to this, a proportion of NGOs would deliver services to children and young people with complex needs, and their families. However, statutory child protection will remain the responsibility of DoCS.³¹³

- 25.58 From the submissions received by the Inquiry and comments made in Public Forums, there is no doubt that NGOs wish to have a greater role in the delivery of services that support children, families and the community across NSW. There has also been a corresponding call for DoCS to devolve responsibility for direct service provision, particularly in the areas of early intervention and OOHC to the NGO sector, each of which is dealt with earlier in this report.

Role of peak organisations

- 25.59 Within the child protection context, peak organisations play an important role in representing the interests of the non-government service sector and in advocating for children, young persons and families who come in contact with the child protection system. A number of peak organisations also have a strong training focus. ACWA, in particular, runs a broad range of training programs for the community services sector through its Centre for Community Welfare Training.
- 25.60 In 2007/08, DoCS provided almost \$6 million in funding to peak organisations and advocacy groups in NSW for core operations, training and information services. The key peak bodies in the NSW community services system include:
- a. Council of Social Services NSW
 - b. Association of Children's Welfare Agencies
 - c. NSW Family Services Inc.
 - d. Aboriginal Child, Family and Community Care State Secretariat
 - e. Local Community Services Association
 - f. Youth Action and Policy Association
 - g. Youth Accommodation Association
 - h. Homelessness NSW/ACT
 - i. NSW Women's Refuge Movement Working Party Inc
 - j. Community Child Care Cooperative NSW
 - k. CREATE Foundation
 - l. Foster Care Association

³¹³ Correspondence: DoCS, 29 August 2008, p.3.

- m. Foster Parent Support Network
- n. KU Children's Services
- o. Network of Community Activities
- p. Country Children's Services Association of NSW Inc
- q. Mobile Children's Services Association of NSW Inc.

- 25.61 While at first glance there would appear to be a proliferation of peak bodies operating in NSW, there is actually minimal duplication regarding target client groups. The exception is the Foster Care Association and the Foster Parent Support Network, which have the same target group, although it is noted that in the current EOI round the former body did not receive DoCS funding.
- 25.62 The Inquiry received no submissions that were either critical or applauding of the peak organisations, and nor has there been any study indicating the value or lack thereof of these bodies which has come to the Inquiry's attention. The Inquiry has been advised, however, that DoCS plans to commence a review of the peak bodies late in 2008 and therefore should be in a position to critically assess its funding in these areas. The Inquiry is supportive of what it currently knows of their roles in training and communicating with government, and in their advocacy role.

Capacity of NGOs

- 25.63 Some concern has been expressed by the Human Services and Justice CEOs Cluster that an expansion of the NGO service system would be problematic because NGOs are already suffering from 'reform overload,' and are struggling to maintain long term viability. Further major reform could therefore "create unacceptable instability in the system with possible significant impacts on client outcomes."³¹⁴
- 25.64 In response to these concerns, DoCS advised the Inquiry that the implementation of its funding reforms actually provided a strong base for any further expansion or changes to the funded service system. Specifically it suggests "the funding reforms are necessary to support the development of an integrated, sustainable and effective service system, regardless of the future 'shape' of the system."³¹⁵
- 25.65 While there certainly has been significant reform by DoCS, and concern about aspects of that reform has been expressed to the Inquiry, the Inquiry has not found any clear evidence of the struggle referred to by the Human Services and Justice CEOs Cluster. If the concern does have a firm basis, then more needs to be done to build capacity in the vital NGO sector.

³¹⁴ Correspondence: Human Services and Justice CEOs Cluster, 17 June 2008.

³¹⁵ Correspondence: DoCS, 29 August 2008, p.7.

- 25.66 The ability to recruit and retain appropriate staff is another issue that impacts on the NGO sector ability to expand. This is an issue across the human services sector and is currently being addressed at state level by the Human Services and Justice CEOs Cluster and nationally through the Community and Disability Services Ministers' Conference.
- 25.67 While DoCS has moved to a degree qualification as a prerequisite for its new caseworkers, the qualifications required for employment in the NGO sector are less rigid and vary across agencies. As a result, NGOs are in many cases able to draw from a larger pool than DoCS when employing staff. This can be viewed as an advantage in relation to providing support services at the less intensive end of the care and support continuum. However, the potential shortcoming is that if NGOs are to take on an expanded role providing services for persons with complex and intensive support requirements, they may not have sufficient numbers of appropriate staff available. As the NGOs expand their capacity to deliver more services to children and their families, this may become an increasing issue for the Government.
- 25.68 The Human Services and Justice CEOs Cluster has also raised doubts about whether the NGO sector has the expertise to provide services to clients with complex needs. DoCS noted that there is sufficient expertise in the NGO sector to support an expansion of the current type and level of services to children and young persons with complex needs. While it is the case that the majority of services provided by NGOs are at the less intensive end of the care and support continuum, many NGOs also offer more intensive support services, including sexual assault counselling, intensive family support services and support for children and young persons in OOHC with high and complex needs.
- 25.69 Because wage rates in the NGO sector are lower than in the public or private sectors, NGOs can experience difficulties attracting qualified staff, particularly the clinicians needed to successfully engage with clients with complex needs. The Human Services and Justice CEOs Cluster has informed the Inquiry:
- Most [NGO] workers are paid under the Social and Community Services (SACS) Award - with typical wages at 60 per cent of the average weekly earnings. The low pay scale in NGOs exacerbates the supply and retention problems that are facing the whole of the human service sector.³¹⁶*
- 25.70 A number of submissions to the Inquiry have called for wage parity between DoCS and NGOs³¹⁷ through an increase in the SACS Award to reflect the level of expertise required to undertake community sector work whether by a government worker or an NGO worker.³¹⁸

³¹⁶ Correspondence: Human Services and Justice CEOs Cluster, 17 June 2008.

³¹⁷ Submission: The Benevolent Society, p.23; Submission: Centacare Sydney, p.36; Submission: UnitingCare Burnside, p.37.

³¹⁸ Submission: Association of Children's Welfare Agencies, p.36.

- 25.71 The Inquiry notes that DoCS does not set the amount that it will fund for an NGO caseworker as its funding is performance based for results not inputs, and that it is ultimately the NGO's decision. DoCS advised that its funding manual is based on information supplied by NGOs on the amount they pay their workers, and when negotiating for a service, DoCS funds on a unit cost basis, which includes caseworker cost, administration and operating costs.
- 25.72 Centacare Sydney noted "it is an untenable and unacceptable position for DoCS, as the funder/provider, to only allocate funding to NGO caseworkers, at a rate that is significantly lower than DoCS caseworkers, thus creating an inequitable system."³¹⁹
- 25.73 Ultimately, the Government will need to fund whatever agency is selected to provide services, be that one within the government or non-government sector. The Inquiry does note that there are attractions in working in the non-government sector over employment in a government welfare agency, and that salary levels are not the only consideration in employment choices. Additionally, it is of the view that consideration should be given to cross secondment of staff to provide a mutual increase in knowledge and experience that could be of particular benefit to NGOs.
- 25.74 DoCS acknowledges that the successful implementation of its funding reforms will require intensive continued engagement with the NGO sector, and to this end, it is undertaking a series of training and development projects with its funded services.
- 25.75 DoCS has also developed a series of resources to support DoCS funded service providers in the move to performance based contracting. They include good practice guidelines and a costing manual designed to provide guidance to NGOs in the areas of governance, systems development, human resource development and unit costings when tendering for contracts.
- 25.76 In conjunction with DADHC and Housing, DoCS has also developed a Common Chart of Accounts, which aims to make financial data consistent across human services community organisations in NSW by providing a common approach to accounting and using the same standard terms and categories to refer to the same activities.³²⁰ This work was undertaken in recognition of the fact that consistent approaches to reporting and accountability can assist those NGOs that have multiple sources of income across a number of government agencies.
- 25.77 DoCS has sought to engage with peak organisations to strengthen their role in building capacity among member agencies. Actions include a results based accountability peaks project and the provision of funding to NCOS to develop

³¹⁹ Submission: Centacare Sydney, p.36.

³²⁰ DoCS, *Annual Report 2006/07*, p.74.

- and pilot a training and resource kit for use by smaller agencies when forming consortia.³²¹
- 25.78 Time will tell whether this work is sufficient.
- 25.79 Many small services are governed by volunteer management committees that have variable expertise. The management committees of the 1,600 community based children's services that DoCS funds, for instance, are largely parent based and voluntary, which can result in high turnover and a lack of continuity in governance structure. The Inquiry is aware that the more rigorous performance measurement and financial accountability requirements under the funding reforms can present a particular challenge to such small services.
- 25.80 Small services have raised concerns that DoCS favours consortium arrangements as part of its competitive tendering processes. Consortia are seen by many agencies to advantage large organisations. Because larger agencies have better economies of scale, the smaller services find it difficult to compete. In reference to the Brighter Futures EOI, some agencies reported missing out on funding, even though they had long standing, well accepted services already operating in the local area.
- 25.81 As small funded services comprise a major part of the DoCS current service system, and very often are on the ground in locations in rural or remote communities which are not serviced by the larger NGOs or head agencies, it is in DoCS best interests to ensure their continuing viability. The Inquiry notes that the provision of further support to ensure their viability is identified as a priority in DoCS' Funding Policy.³²² DoCS has stated its support for a mixed service system which includes small organisations. Similarly, with specific reference to community preschools, viability funding has been allocated to 539 preschools as part of the NSW Government's Preschool Investment and Reform Plan.³²³
- 25.82 Further, to assist with skills development, particularly for smaller NGOs, DoCS has established a training program with the aim of improving NGO organisational capacity in the areas of governance, management and child protection. In 2007/08, the program delivered over 4,700 training days to more than 3,500 participants across NSW.³²⁴
- 25.83 In 2008, priorities of the training project include support for the ongoing funding reforms, working with clients with complex needs and facilitating service system integration.³²⁵

³²¹ Human Services CEOs and Forum of Non-Government Agencies, *Working Together for NSW: annual implementation meeting, communiqué*, August 2008.

³²² DoCS, *Funding Policy*, August 2005, p.11.

³²³ DoCS, *Annual Report 2007/08*, p.34.

³²⁴ *ibid.*, p.67.

³²⁵ Submission: DoCS, *Funded service system supporting child protection*, p.30.

- 25.84 The Inquiry appreciates the effect of the funding reform process embarked upon by DoCS on smaller agencies. It acknowledges and supports DoCS' efforts at helping them to keep up the pace as in many parts of the state their viability will be essential. The reform process is vital to the ultimate safety, welfare and well-being of the children for whom the system operates. It will need to take into account the interests of existing providers that have the capacity to deliver relevant services, and establish a system for funding, monitoring and delivery of services that is both affordable and comprehensive.

Recommendations

Recommendation 25.1

All NSW Government funding to NGOs delivering universal, secondary and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should be reviewed, so as to establish a coordinated system for the allocation of their funded resources that will eliminate unnecessary overlap and provide for the delivery of service where most needed.

26 Performance measurements

NSW State Plan.....	1024
DoCS Corporate Plan and Results and Services Plan	1025
Issues arising	1027

- 26.1 DoCS' core activities and objectives are set out in a number of planning documents. At the broadest level, the NSW State Plan sets out the goals to be achieved by the Department, with more detail provided in the DoCS Corporate Plan and its Results and Services Plan.
- 26.2 All of these documents contain a range of performance indicators and measures.

NSW State Plan

- 26.3 DoCS has lead responsibility for NSW State Plan Priority F7- reduced rates of child abuse and neglect. The State Plan notes that for a child born today in NSW, the probability of being reported as at risk of abuse or neglect before reaching adulthood is now one in five, although that does not equate to a finding of established risk. The target for Priority F7 is to reduce the underlying rate of child abuse and neglect in NSW over the course of the plan.
- 26.4 In relation to measuring progress, the State Plan notes that there is no indicator currently available that accurately measures the actual prevalence of child abuse in NSW. Most measures, such as the number of child protection reports, are influenced by community attitudes, mandatory reporting rules, changes in DoCS resources, changes in assessment criteria, or changes in population levels. The State Plan notes that the rate of children and young persons who were the subject of a report that was subsequently referred for further investigation per 1,000 population aged 0-17 years is the most consistent measure that can be used at this stage.³²⁶
- 26.5 As mentioned earlier, from the data provided by DoCS, that rate has increased from 50.1 per 1,000 population aged 0-17 years in 2004/05 to 54.8 in 2005/06 to 65.1 in 2006/07 and 65.7 in 2007/08.³²⁷ There has also been an increase in the rate of children and young persons aged 0-17 years entering OOHC per 1,000 population since 2004/05. At 30 June 2005, the rate was 6.3 per 1,000, increasing to 9.1 per 1,000 at 30 June 2008.³²⁸
- 26.6 Additional State Plan priorities in which Police and Health have lead roles aim to reduce substance abuse, mental health problems and domestic violence. These factors, if prevented or controlled before they have an effect on children should assist in preventing child abuse and neglect.
- 26.7 DoCS also has lead responsibility for State Plan Priority F6-increased proportion of children with skills for life and learning at school entry. Progress towards that goal depends on developing and trialling an appropriate target and

³²⁶ NSW Government, *NSW State Plan: A New Direction for NSW*, 2006, p.83.

³²⁷ DoCS, *Annual Report 2007/08*. p.44.

³²⁸ *ibid.*, p.53.

measure of performance.³²⁹ DoCS is currently considering the use of the Australian Early Development Index as the performance measure for this priority.

DoCS Corporate Plan and Results and Services Plan

- 26.8 Friedman's Results Based Accountability is DoCS' planning model and is also the model used by other NSW Government human service agencies.³³⁰ This model makes a distinction between population level indicators and program or agency level performance measures. Population level indicators measure the community's progress towards a stated result or target, such as the Priority F7 target to reduce the underlying rate of child abuse and neglect. Achieving these population level results often involves a multi-agency response, as is clearly the case with Priority F7. Program or agency performance measures are used to determine how well a service or agency is working and what quality of change has occurred as a result.³³¹
- 26.9 Results Based Accountability has been adopted by NSW Treasury as the model for the Results and Services Plans that NSW Government agencies must submit each year as part of the budget process.
- 26.10 DoCS' Results and Services Plan, along with its Corporate Plan, set out a range of performance measures from which the Inquiry makes the following observations.
- 26.11 A key measure identified in the Corporate Plan is the percentage of children and young persons who were the subject of a substantiated report in the previous year, and were the subject of a further substantiation within the following 12 months. The rationale for this measure is that children and young persons who have been the subject of substantiation should have received attention from DoCS to ensure their safety. A further substantiated report suggests they are not safe. There has been an almost doubling of this percentage since 2002/03, increasing from 13.2 per cent in 2002/03 to 24.0 per cent in 2006/07. The Inquiry understands that DoCS no longer considers this measure useful as it depends at least in part on the number of cases allocated to caseworkers and thus, ultimately on resources.
- 26.12 Another key measure that is identified in both the Corporate Plan and the Results and Services Plan is the percentage of children and young persons in OOHC on final care and protection orders who have had five or more

³²⁹ NSW Government, *NSW State Plan: A New Direction for NSW*, 2006, p.81.

³³⁰ The Results Based Accountability framework was developed by Mark Friedman, Director of the US based Fiscal Policy Studies Institute. In 2004, NSW Human Services CEOs engaged Mr Friedman to advise on a new way for human service agencies to determine performance and results.

³³¹ Institute of Public Administration Australia, *Results based accountability. Learning and development program book*, 2007, p.8.

placements. The assumption is that because placement breakdown is linked to poor outcomes for children and young persons, placement stability is an indication of how well children and young persons in OOHC are travelling. There was no change in the percentage of all children and young persons on final care and protection orders who have had five or more placements, as determined at 30 June 2006 and 30 June 2007. It was steady on 21.2 per cent. The percentage of these children under five years increased from 3.2 per cent at 30 June 2006 to 4.3 per cent at 30 June 2007 and then decreased to 3.8 per cent at 30 June 2008.³³²

- 26.13 Another performance measure identified in the Corporate Plan is the percentage of children and young persons placed in OOHC from IFBS referred families at 12 months after completion of an IFBS program. This would measure the effectiveness of DoCS IFBS program, however DoCS has advised that data for this measure must be collected manually and are not yet available on an ongoing basis.
- 26.14 Similarly, data are not yet available for the percentage of children and young persons in OOHC with a case plan goal of restoration who are restored to their parents within 12 months of entering OOHC. This is also a performance measure identified in the Corporate Plan.
- 26.15 DoCS is in the process of developing a full set of baseline data relating to the effectiveness of its Brighter Futures program. Performance measures will include the proportion of children receiving early intervention services who meet age appropriate developmental milestones. When available, the baseline data should provide useful information about DoCS' early intervention strategy.
- 26.16 DoCS' measure relating to SAAP client outcomes is the percentage of SAAP clients with only one support period per year. Since 2005/06 the percentage has remained steady at 79.1 per cent.³³³
- 26.17 DoCS also has a series of performance measures that relate to: the cost of service provision across its program areas; the number of services that it provides or activities that it performs; and the efficiency of its service provision. Examples of such performance measures are, in order: the annual expenditure per child or young person in OOHC; the number of child protection reports received and assessed and the number of children involved in these reports; and the average waiting time to talk to a caseworker when calling the Helpline.
- 26.18 Ultimately, the Inquiry has not relied upon these measures to ground any conclusions about DoCS' performance. The more detailed analysis performed by DoCS at the Inquiry's request or independently undertaken by DoCS has been more useful. That material is, in the main, set out in Chapter 5.

³³² DoCS, *Results and Services Plan 2008/09*, p.18. Percentage for 30 June 2008 is an estimate.

³³³ *ibid.*, p.13.

Issues arising

- 26.19 Results Based Accountability is an outcomes based framework that encourages agencies to develop performance measures that measure quality and effect rather than quantity and effort. A number of the performance measures identified in the DoCS Corporate Plan and the Results and Services Plan provide an indication of the quality and effect of DoCS services on client outcomes, such as those discussed in the section above. However, many of the measures identified in these planning documents, particularly in the Results and Services Plan are descriptions of quantity and effort; that is, of process.
- 26.20 Generally, DoCS measures process or outputs rather than outcomes for children. This state of affairs is not limited to DoCS. The non-government sector also appears to be characterised by such reporting, however the Inquiry has had access to limited data relating to non-government sector performance measures.
- 26.21 Further, a number of key measures are not matched by available data, thus those families who have received an IFBS are not captured nor is data concerning restoration and breakdown. The Inquiry notes that the DoCS' Performance Management Framework for Funded Services 2005 states that performance measures should be clear, sufficiently detailed and include data sources and/or reporting methods that will allow results to be accurately assessed.³³⁴ This policy also acknowledges that current funding arrangements often focus on inputs of service, rather than results for children, families or communities.
- 26.22 Similar to the current directions for NGOs which aim to link funding to outcomes, the same process should apply to the services DoCS and other government agencies offer. As the child protection system is broader than DoCS there is also a need to develop performance measures for cross agency systems. As identified by Friedman, there is great value in looking at system performance in addition to program and agency performance because of the interconnection and interdependence of different parts of the service system.³³⁵
- 26.23 As Health advised the Inquiry, data collection systems held by different government agencies that monitor and respond to child abuse are not aligned. As a result it is difficult to make comparisons across agencies, or to develop an evidence based whole of government approach, an important matter for gauging the success of the kind of interagency collaboration advocated by this report.
- 26.24 The Inquiry agrees with the comments of Tilbury who suggests that performance measurement has concentrated on the 'child rescue' construction

³³⁴ DoCS, *Performance Management Framework for Funded Services*, 2005, p.4.

³³⁵ M Friedman, "Trying Hard is not Good Enough, How to Improve Measurable Improvements for Customers and Communities," *Trafford Publishing*, Canada 2005, p.92.

of child protection, that is, it conceptualises child protection as investigation and placement. Despite recent moves to position child protection agencies as part of a broader system of child and family welfare, this has not been reflected in a concomitant shift in performance indicators. The vast majority of performance measures still relate to the effectiveness of investigations and placements:

*The underlying values of the indicators promote the perspective that 'good practice' in child protection is mainly about achieving safety and placement stability for children.*³³⁶

- 26.25 Safety becomes the absence of re-abuse, quality becomes placement stability which relates to the numbers of placement moves or duration in placement. This ignores the broader role of child protection services, in not just keeping children safe from further abuse, but promoting well-being and improving life chances. Tilbury concludes that:

*there is a disjuncture between the goals expressed in legislation and policy documents and the goals communicated through performance measurement, or between 'professional' and 'management' concerns.*³³⁷

- 26.26 From the work it has done, the Inquiry suggests that it would be useful to capture the data on several indicators in order to monitor the performance of the Department, and of the other agencies involved in child protection work. They are aspirational in part, as the Inquiry is conscious that privacy concerns and technology limitations will render some of them unattainable, at least in the short term, or will depend on client cooperation in responding to exit surveys or similar follow up questionnaires. The suggested indicators are:

- a. the number of children and families receiving a service
- b. continuity of caseworkers
- c. outcomes of restoration
- d. development of and adherence to case plans/care plans
- e. attainment of case goals
- f. placements with siblings
- g. educational attainment
- h. entry into employment and training
- i. achievement of developmental milestones
- j. health status
- k. client satisfaction

³³⁶ C Tilbury, "Research and Evaluation: Accountability via Performance Measurement: The Case of Child Protection Services," *Australian Journal of Public Administration* 65(3), September 2006, p.58.

³³⁷ *ibid.*

I. experience after leaving care.

- 26.27 To measure the overall effectiveness of the child protection system in NSW, such agency performance measures should also be considered alongside population level indicators such as those used to measure the effectiveness of the Families NSW program. The Inquiry notes with interest the work that is being undertaken to identify national headline indicators for children's health, development and well-being on behalf of the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference³³⁸ and indicates its general support for this initiative.
- 26.28 In summary, performance measurement is important in identifying the most effective allocation of resources and those areas of service that, on the one hand, require modification or remediation, and, that on the other hand, provide good outcomes.

³³⁸ Headline Indicators Steering Group on behalf of the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference, *Headline indicators for Children's health, development and well-being. Final report*, June 2006.

Part 7 Implementation

27 Implementation

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Introduction

- 27.1 The Inquiry acknowledges that much of the 2002 reform process has been implemented, and that within the specific timeframe envisaged by that process, it has achieved significant strategic change, so far as DoCS is concerned.
- 27.2 This report is focused on the further changes to the child protection system in NSW that are needed to take account of the current and projected demands on that system, and the changed environment in which it is to operate, including the extended participation of other government agencies and the non-government sector in providing for the safety, welfare and well-being of children and young persons.
- 27.3 For the purpose of implementation, the recommendations made in this report have been ranked in order of priority, that is: “immediate”, where the Inquiry considers that the necessary changes should be substantially commenced within six months; “short term” where implementation should be substantially commenced within 12 to 18 months; and “long term”, where it is anticipated that such work should be substantially commenced within two to three years.
- 27.4 In a limited number of cases, where it is unlikely that the relevant changes could begin to be achieved within three years, either because of the likely costs involved, or because of the need for other government agencies or non-government agencies to build up capacity, a longer timeframe has been assigned. In other cases where the necessary work is already under way or where an initiative is subject to a trial, or where some general approach is supported as a matter of principle, a timeframe has not been identified.
- 27.5 The Inquiry has not attempted to place a specific cost on the implementation of the individual recommendations. It has, however, categorised them, in a general way, into high cost, medium cost, or low cost. This categorisation has been based on the information, currently available to it, concerning the nature and quantity of the work likely to be involved in giving effect to each recommendation. In some instances, DoCS has advised the Inquiry of provisional allocations, or estimates of the costs of the changes that were the subject of debate or analysis during the Inquiry’s deliberations, or that were identified in its submissions to the Inquiry. Where that is the case, such estimates have helped to inform the Inquiry as to the appropriate ranking of the recommendations in terms of their likely implementation cost.
- 27.6 The ranking of the recommendations in terms of their priority and likely cost levels is intended to assist the implementation process outlined in this chapter, and to allow for future planning that could permit early supplementation and/or progressive increases in the budget for the child care and protection system, across all sectors.
- 27.7 Two remaining observations are necessary. First, a number of the recommendations are inter-dependent, such that unless the primary

recommendation is accepted, either the subsequent recommendation will be superfluous or will require modification. Alternatively their linkage may require a progressive deferral of the implementation of some of them so as to maintain the integrity of the system envisaged in this report.

- 27.8 Secondly, the Inquiry acknowledges that the potential of the Commonwealth to become more directly involved in the child protection system, on a national basis, has long term significance for State welfare agencies, and for the implementation of this report. It notes that a Discussion Paper was released by the Commonwealth in May 2008, that considerable work has been undertaken since that time in developing a possible national framework, and that this is soon to be considered by COAG.
- 27.9 In those circumstances, and without any current or clear guidance as to the likely final terms of any national initiative, or of its timing, this Inquiry does not consider that it is in a position to comment on this development. It does however record its general support for the greater contribution of the Commonwealth in funding the child protection system at a state level, and for its encouragement of a model that involves a coherent and consistent government and community wide response, that can draw on the separate strengths and skills of the human services agencies and of the non government welfare sector.
- 27.10 It assumes from what has been disclosed so far, that any national framework will recognise the imperative of providing, or supporting the provision of, a full range of universal and targeted early intervention services of the kind that are designed to keep families intact and functioning at an acceptable level, while preserving statutory protection as a response of final resort where it is needed to keep children and young persons safe from abuse and neglect.
- 27.11 It also assumes that any such national framework would be directed at closing the gap in life outcomes for all of those children who come within the potential operation of the child protection system of the states and territories and that it would be inclusive of all sectors of the community, with particular attention being given to those within the most vulnerable sectors, and specifically the Aboriginal community.
- 27.12 The current report is framed with these objectives in mind. The suggested procedure for its implementation so as achieve these objectives are as follows.

Implementation

- 27.13 Implementation will necessarily involve two stages:
- a. establishing a whole of government response to the Inquiry's report and recommendations and a high level implementation plan
 - b. carrying into effect those recommendations, or any variation of them, that the Government decides to adopt.

- 27.14 The whole of government response to the Inquiry's report should be coordinated within the Department of Premier and Cabinet by a Special Commission of Inquiry (SCI) Implementation Unit. This should be undertaken in collaboration with the non-government sector.
- 27.15 The SCI Implementation Unit should include senior executives seconded from DoCS, Health, Education, Police and Treasury to coordinate work across the respective agencies.
- 27.16 The SCI Implementation Unit should report on progress against the implementation plan every six months for a period of three years, or for such further period as may be required to complete delivery of the implementation plan. Its progress reports should be made publicly available, including on relevant websites and tabled in Parliament.
- 27.17 Achievement of the implementation plan should be included in the NSW State Plan and incorporated into relevant Priority Delivery Plans.
- 27.18 Achievement of the relevant elements of the implementation plan should be incorporated into the performance agreements of relevant Directors-General and key executives across government.
- 27.19 The recommendations of the Inquiry's report are far reaching and will involve significant change. The successful implementation of change requires committed leadership from the Directors-General of the key agencies and executives, clear and consistent communication about the imperatives for change and what is required of each agency, as well as attention to transparency and accountability. Much will be required of staff to bring about the changes required. There are already significant pressures on staff, some of whom have experienced 'change' or 'reform' fatigue since commencement of the 2002 reform process and timing of changes will need to be carefully managed. The support of the PSA, and its constructive input in relation to the introduction of changes at Helpline and CSC level will be important.
- 27.20 Given the recommendations of the Inquiry with respect to early intervention and OOHC it will be critical to engage effectively with the non-government sector and to commence any required capacity building as soon as possible. The NSW NGO sector is not a homogenous group and in some instances they have competed for funding. NGOs provide different services to different client groups and have varying levels of expertise and scales of operation. There are also different wage rates and industrial arrangements. A well developed transition strategy will be required to support their progressive increased participation in the system.
- 27.21 As noted earlier, a number of the recommendations are interdependent, or at least related, and will need to be implemented in tandem, if accepted. Those that fall into this category are identified at the commencement of the Recommendations section of this report.

- 27.22 The Inquiry emphasises that while the implementation of some recommendations would bring them within the high or medium cost categories, their successful introduction will produce costs offsets, some immediately, and others on a longer term basis. This is a factor that the SCI Implementation Unit will need to take into account. It has a particular significance, for example, in relation to the timeframe which will be required for improved family support and early intervention services to have a significant impact on the number of cases requiring statutory intervention, and removal of children into more expensive OOHC.
- 27.23 It also recognises that where the implementation of recommendations requires the recruitment and training of additional caseworkers for DoCS or NGOs, there is likely to be a considerable lead time before they can become operational. This will have a particular significance for building the necessary additional capacity for Aboriginal NGOs. It means, that subject to acceptance of the recommendations, it will be important to commence that process early, and to establish a plan for its successive development.
- 27.24 This aspect of planning will also need to take into account the need for future flexibility, including the capacity to move caseworkers between different functions, once the reforms are progressively implemented, which will also require forward planning that can address acquisition of the range of skills training that will be necessary.

Annexure A Exchange of Information

- A.1 A number of different agencies hold information relevant to child protection. These include:
- a. DoCS
 - b. NSW Police Force
 - c. Department of Health
 - d. Department of Education and Training
 - e. Department of Ageing, Disability and Home Care
 - f. Department of Corrective Services
 - g. Department of Housing
 - h. Department of Juvenile Justice.

The Legislative Scheme

The Privacy and Personal Information Protection Act 1988

- A.2 The *Privacy and Personal Information Protection Act 1988* (PIIP Act) regulates the exchange of 'personal information' between public sector agencies.
- A.3 Public sector agency, as defined in s.3, includes a government department, a statutory body representing the Crown, and the NSW Police Force. Each of the agencies listed to above is a 'public sector agency' and must comply with the PIIP Act.
- A.4 'Personal information' is broadly defined in s.4 of the PIIP Act to mean information or an opinion about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion. Pursuant to s.4A the definition of personal information in the PIIP Act does not include health information.¹ Personal information that is 'health information' is regulated by the *Health Records and Information Privacy Act 2002* (HRIP Act), which is discussed below.
- A.5 Almost any child protection information, in written or electronic form, is likely to contain information that falls within the definition of 'personal information' The supply of a name, for example, is almost always personal information, even if the document does not contain further information about the person.²

¹ Except as provided by the *Privacy and Personal Information Protection Act 1988* or the *Health Records and Information Privacy Act 2002*.

² *WL v Randwick City Council* [2007] NSWADTAP 58 at [21]-[22].

Documents which do not contain any obvious features identifying an individual can still be 'personal information' by reason of the context to which they belong.³ 'Personal information' does not include information that is seen or heard by agency employees, but is not in written form. Information that is only 'held' in the minds of agency staff is not personal information.⁴ Consequently, the PPIP Act does not govern oral disclosure of information about a person by one agency to another agency if the information is not sourced from a document. However, if information provided orally to an agency is subsequently recorded in written or electronic form, it may become 'personal information.'⁵

- A.6 Frequently, child protection information will contain personal information (or health information or a combination of personal information and health information) relating to one or more persons – for example, such information may contain personal information about a child, a parent or parents and a third party, such as a guardian or carer.
- A.7 The PPIP Act establishes a series of 12 Information Protection Principles that regulate the collection, storage, accuracy, use and disclosure of 'personal information' by public sector agencies. Unless an agency has been exempted from complying with a particular information protection principle each of the information protection principles must be obeyed.
- A.8 There are three places where a relevant exemption might be found. First, a number of specific exemptions are contained in the PPIP Act itself. Secondly, the Minister may make a Privacy Code of Practice that applies to a particular agency or agencies and modifies or overrides the application of one or more information protection principles to that agency or agencies.⁶ Finally, the Privacy Commission may make a written Direction that modifies or overrides the application of the PPIP Act or a Privacy Code of Practice to a particular agency or agencies.

³ *WL v Randwick City Council* [2007] NSWADTAP 58 at [15].

⁴ *Vice-Chancellor Macquarie University v FM* [2005] NSWCA 192

⁵ *Department of Education and Training v MT* [2005] NSWADTAP 77 at [21]. This decision was overturned by the Court of Appeal in *Department of Education and Training v MT* (2006) 67 NSWLR 237, although the Court of Appeal's decision did not make reference to the status of information received orally but later recorded in written or electronic form.

⁶ A Privacy Code of Practice may be submitted to the Minister by the Privacy Commissioner, or any public sector agency. Pursuant to s.30 of the *Privacy and Personal Information Protection Act 1988* a code of practice may:

- a. specify requirements that are different to those set out in the principles or exempt any conduct or activity of the agency from compliance with the principles;
- b. specify the manner in which any of the information protection principles are to be applied or followed by the agency.
- c. Exempt the agency or a class of agencies from the requirement to comply with any of the principles.

A code of practice may apply to a specified class of personal information and, a specified public sector agency or class of public sector agency or a specified activity or class of activity: s.29. A public sector agency must comply with any privacy code of practice applying to it: s.32.

- A.9 Each public sector agency is required to have a privacy management plan, which outlines the business rules of the agency in relation to privacy matters.⁷

The Information Protection Principles

- A.10 The information protection principles are set out in ss.8-19 of the PPIP Act. Sections 8-11 set out principles applicable to the collection of personal information by a public sector agency. Sections 12-14 set out principles applicable to the storage of personal information by a public sector agency. Sections 15-17 set out principles applicable to the accuracy and use of personal information by a public sector agency. Sections 18 and 19 set out principles applicable to the disclosure of personal information by a public sector agency.
- A.11 The information protection principles contained in ss.8, 9, 18 and 19 directly impact upon the ability of public sector agencies to exchange child protection information (in written or electronic form).⁸
- A.12 In order for an exchange of personal information between agencies to be lawful under the PPIP Act of the HRIP Act, it must be lawful for the receiving agency to collect it from the disclosing agency, and lawful for the disclosing agency to disclose the information to the receiving agency.
- A.13 Unless a relevant exemption applies, an agency that *receives* information from another agency must comply with the information protection principles contained in ss.8 and 9 relating to the collection of information.
- A.14 Section 8 provides that a public sector agency must not collect personal information unless the information is collected for a lawful purpose that is directly related to a function or activity of the agency, and the collection of the information is reasonably necessary for that purpose. It also provides that a public sector agency must not collect personal information by any unlawful means.

⁷ *Privacy and Personal Information Protection Act 1988* s.33.

⁸ The Information Privacy Principles contained in ss.10 and 11 of the *Privacy and Personal Information Protection Act 1988* only apply to personal information that is collected "from the individual": *HW v Director of Public Prosecutions (No 2)* [2004] NSWADT 73 at [25]. Consequently, they have no application where personal information is collected by one agency from another. The Information Privacy Principles contained in ss.12-14 govern the storage of personal information. The Information Privacy Principles contained in s.16 deals with the accuracy of personal information used by an agency. Consequently, they do not impact upon ability of agencies to exchange information. The Information Privacy Principles contained in s.17 deals with the "use" of information by an agency. It has been held that "use" in s.17 refers to the handling of information *within* an agency, whereas "disclosure" refers to the giving of information to a person or body outside the agency: *JD v Department of Health* [2005] NSWADTAP 44 at [93]; *Department of Education and Training v MT* [2005] NSWADTAP 77 at [39]. Consequently, s 17 only applies to the internal use of information by an agency. Forwarding personal information to another body is a disclosure but not a use and is therefore governed by s.18 not s.17: *JD v Medical Board (NSW)* [2005] NSWADT 247 at [79].

- A.15 The Information Privacy Principle (IPP) contained in s.8 does not pose any particular obstacle to the exchange of child protection information between key child protection agencies.
- A.16 The IPP contained in s.9 is more problematic. It provides that a public sector agency must collect personal information directly from the individual to whom the information relates, unless the individual has authorised collection of the information from someone else or, in the case of information relating to a person who is under the age of 16 years, the information has been provided by a parent or guardian of the person.
- A.17 The IPP contained in s.9 has the potential to significantly impede the exchange of child protection information by preventing an agency from collecting child protection information (containing personal information) from another agency without the authorisation of *each* individual (or, in the case of a child under 16 years, the parents or guardians of each child) whose personal information will be collected.
- A.18 An agency that *provides* information to another agency must (unless a relevant exception applies) comply with ss.18 and 19.
- A.19 IPP 18 prohibits the disclosure of personal information held by an agency to a person or other body, including another public sector agency, unless:
- a. the disclosure is directly related to the purpose for which the information was collected, and the agency disclosing the information has no reason to believe that the individual concerned would object to the disclosure, or
 - b. the individual concerned is aware or is reasonably likely to have been aware that information of that kind is usually disclosed to that other person or body, or
 - c. the agency believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person.
- A.20 The effect of s.18 is that, where an agency acquires information for some other purpose and discovers that the information is also relevant to child protection, it cannot disclose that information to another agency for the purposes of protecting a child other than in the circumstances set out above. The exception in s.18(1)(c) for disclosures necessary to prevent or lessen a serious and imminent threat to an individual's life or health is narrowly construed.⁹ It would not apply in many cases where a child is or may be in need of protection. Section 18(1)(c) has been relied upon several times by agencies alleged to be in breach of s.18, but the defence has never been successfully established.¹⁰ In

⁹ *MT v NSW Department of Education and Training* [2004] NSWADT 194 at [195].

¹⁰ See *Macquarie University v FM* [2003] NSWADTAP 43 at [91]; *MT v NSW Department of Education and Training* [2004] NSWADT 194 at [197]; *Department of Education and Training v*

addition, as the Northern Sydney Central Coast Area Health Service advised the Inquiry:

an 'imminent threat' definition undermines the serious harm inflicted by sustained and ongoing abuse that may not be perceived as immediately life threatening and yet may have a fatal consequent later eg drug overdose, suicide.¹¹

- A.21 Section 19(1) regulates the disclosure of certain kinds of sensitive information. Where information falls within one of the categories of sensitive information in s.19(1), s.18 does not apply to that information and s.19(1) applies instead.¹² Section 19(1) provides:

A public sector agency must not disclose personal information relating to an individual's ethnic or racial origin, political opinions, religious or philosophical beliefs, trade union membership or sexual activities unless the disclosure is necessary to prevent a serious and imminent threat to the life or health of the individual concerned or another person.

- A.22 The exemption in s.19 is even narrower than the exemption in s18(1)(c). While information can be disclosed under s.18(1)(c) where it would prevent or lessen a serious and imminent threat to the life or health of an individual, information can only be disclosed under s.19 where it would prevent such a threat.
- A.23 Significantly, it has been held that in some instances a dissemination of information within an agency may amount to a disclosure such that, in the case of large public sector agencies consisting of specialised units, the exchange of personal information between units may constitute disclosure that must comply with ss.18 and 19.¹³
- A.24 The IPPs contained in ss.18 and 19 have the potential to significantly impede the provision of child protection information from one agency to another agency and, in the case of larger agencies, the provision of child protection information within the agency.

Exemptions in the PPIP Act

- A.25 There are no exceptions to s.8 under the PIPP Act. There are, however, a number of exceptions to ss.9, 18 and 19.

MT [2005] NSWADTAP 77 at [63]-[79] and *JD v NSW Department of Health (no 2)* [2004] NSWADT 227 at [75].

¹¹ Correspondence: Northern Sydney Central Coast Area Health Service, 5 May 2008.

¹² *Department of Education and Training v MT* [2005] NSWADTAP 77 at [73].

¹³ See *KJ v Wentworth Area Health Service* [2004] NSWADT 84, where a health agency contravened s.19(1) when one part of the agency disclosed psychiatric information about a patient to another part of the agency.

- A.26 A public sector agency is not required to comply with s.9 if compliance would prejudice the interests of the individual to whom the information relates.¹⁴ There is no case law on the meaning of this exemption. It is difficult to assess how useful it is in a child protection context. In particular, it is not clear how the exemption operates in circumstances where child protection information contains personal information about multiple parties and the interests of the child will be prejudiced if s.9 is complied with but the interests of other persons, such as the child's parents or foster parents, will not be. For example, where child protection information contains personal information about parental drug and alcohol abuse or domestic and family violence.
- A.27 A public sector agency is also not required to comply with s.9 if the information concerned is collected in connection with proceedings (whether or not actually commenced) before any court or tribunal.¹⁵ This exception is of limited assistance in facilitating the exchange of child protection information between agencies.
- A.28 A public sector agency is not required to comply with ss.9, 18 or 19 if it is lawfully authorised or required not to comply with the relevant principle, or non-compliance is otherwise permitted, or is necessarily implied or reasonably contemplated under an Act or any other law.¹⁶ This exception is significant, in so far as it allows an agency to provide information about the safety, welfare or well-being of a child under s.248 of the Care Act (or any other relevant law).¹⁷ However, as discussed below, the power to exchange information under s.248 has its own limitations.
- A.29 A public sector agency is not required to comply with s.18 or s.19 if the individual to whom the information relates has expressly consented to the agency not complying with the principle.¹⁸ It has been held that:

*the requirement of express consent must be the subject of administrative action by the agency disclosing the information. It must have gone to the individual concerned and obtained an express consent that is precise as to the kind and, possibly, the exact contents of the information to which the consent relates.*¹⁹

This exemption clearly does not assist in facilitating a direct exchange of information from agency to agency.

- A.30 A public sector agency is also not required to comply with ss.18 or 19 if the disclosure is to another public sector agency under the administration of the

¹⁴ *Privacy and Personal Information Protection Act 1988* s.26.

¹⁵ *Privacy and Personal Information Protection Act 1988* s.23.

¹⁶ *Privacy and Personal Information Protection Act 1988* s.25.

¹⁷ *MY v Department of Community Services* [2004] NSWADT 203 at [26].

¹⁸ *Privacy and Personal Information Protection Act 1988* s.26(2).

¹⁹ *Macquarie University v FM* [2003] NSWADTAP 43 at [97].

same Minister (if the disclosure is for the purposes of informing that Minister about any matter within that administration) or the Premier (for the purpose of informing the Premier about any matter).²⁰ This exception is of limited assistance in facilitating the exchange of child protection information.

- A.31 In addition to these general exemptions, there are a number of specific exemptions. NSW Police are not required to comply with the information protection principles other than in connection with the exercise of their administrative and educative functions: s.27.²¹ Consequently, the principles do not apply to the core functions carried out by police when engaging in the prevention, detection or prosecution of crime.
- A.32 There is also a specific exemption in s.24 of the PPIP Act for investigative agencies. 'Investigative agency' is defined in s.3 of the PPIP Act. None of the agencies listed at the beginning of this annexure is an investigative agency (although it is possible for the regulations to prescribe any of those agencies as investigative agencies for the purposes of the PPIP Act.)
- A.33 An 'investigative agency':
- a. is not required to comply with s.9 if compliance might detrimentally affect or prevent the proper exercise of the agencies complaint handling functions
 - b. is not required to comply with s.17 if the use of the information concerned for a purpose other than the purpose for which it was collected is reasonably necessary in order to enable the agency to exercise its complaint handling functions or any of its investigative functions, and
 - c. is not required to comply with s.18 if the information concerned is disclosed to another investigative agency.²²
- A.34 The exemption in s.24 also applies to any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency or that has been referred from or made by an investigative agency.²³
- A.35 There is also a specific exemption in the PPIP Act for 'law enforcement agencies.' Law enforcement agency is defined in s.3. Of the agencies listed at the beginning of this annexure only the NSW Police, Corrective Services and Juvenile Justice are law enforcement agencies (although it is possible for the regulations to prescribe other persons or bodies as law enforcement agencies).

²⁰ *Privacy and Personal Information Protection Act 1988* s.28(3).

²¹ This exemption also applies to the Independent Commission Against Corruption, the Inspector of the Independent Commission Against Corruption, the staff of the Inspector of the Independent Commission Against Corruption, the Police Integrity Commission, the Inspector of the Police Integrity Commission, the staff of the Inspector of the Police Integrity Commission and the New South Wales Crime Commission

²² *Privacy and Personal Information Protection Act 1988* s.24.

²³ *Privacy and Personal Information Protection Act 1988* s.24(4).

A law enforcement agency is not required to comply with s.9 if compliance would prejudice the agency's law enforcement functions.²⁴

- A.36 In addition, a public sector agency (whether or not a law enforcement agency) is not required to comply with s.18 if the disclosure of the information concerned:
- a. is made in connection with proceedings for an offence or for law enforcement purposes, or
 - b. is to a law enforcement agency for the purposes of ascertaining the whereabouts of an individual who has been reported to a police officer as a missing person, or
 - c. is authorised or required by subpoena or by search warrant or other statutory instrument, or
 - d. is reasonably necessary for the protection of the public revenue, or
 - e. is reasonably necessary in order to investigate an offence where there are reasonable grounds to believe that an offence may have been committed.²⁵
- A.37 A public sector agency (whether or not a law enforcement agency) is not required to comply with s.19 if the disclosure of the information concerned is reasonably necessary for the purposes of law enforcement in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed.²⁶
- A.38 Again, these exemptions only have a limited application in the context of the exchange of child protection information.

Exemptions contained in Privacy Codes of Practice

- A.39 In addition to the exceptions contained in the PPIP Act, there are additional exceptions contained in Privacy Codes of Practice that have been made under the Act.
- A.40 The most significant of these is the *Privacy Code of Practice (General) 2003* that was made under the PPIP Act and which modifies the application of the IPPs to 'human services agencies' (the Privacy Code). A similar Code of Practice was made under the HRIP Act in 2005²⁷ which modifies the application of the HRIPs to 'human services agencies' (the Health Code).
- A.41 A 'human services agency' is defined in the codes to mean a public sector agency that provides:
- a. welfare services

²⁴ *Privacy and Personal Information Protection Act 1988* s.23.

²⁵ *Privacy and Personal Information Protection Act 1988* s.23(5).

²⁶ *Privacy and Personal Information Protection Act 1988* s.23(7).

²⁷ *Health Records and Information Privacy Code of Practice 2005*.

- b. health services
 - c. mental health services
 - d. disability services
 - e. drug and alcohol treatment services
 - f. housing and support services
 - g. education services.
- A.42 Most of the key child protection agencies listed at the beginning of this annexure are human services agencies with the exception of NSW Police, Juvenile Justice and Corrective Services.
- A.43 Clause 10 of the Privacy Code provides that, despite the IPPs, a human services agency may collect and use personal information about an individual and may disclose personal information about the individual to another human services agency or an allied agency²⁸ if the collection, use or disclosure is in accordance with the written authorisation given by a senior officer.
- A.44 The authorisation must specify the period, being no more than 12 months, for which it has effect, the classes of information to which the authorisation is to apply, and the human services or allied agencies to whom the specified information may be disclosed.²⁹
- A.45 The senior officer must not issue an authorisation unless he or she is satisfied that:
- a. the individual to whom the information relates is a person to whom services are to be provided
 - b. the individual (or the individual's authorised representative) has failed to consent to the collection, use or disclosure of the information
 - c. there are reasonable grounds to believe that there is a risk of substantial adverse impact on the individual or some other person if the collection or use or disclosure does not occur
 - d. the collection or use or disclosure is likely to assist in developing or giving effect to a case management plan or service delivery plan that relates to the individual; and that
 - e. reasonable steps have been taken to ensure the individual has been notified of the authorisation.³⁰

²⁸ An allied agency is an agency (other than a public sector agency) that is wholly or partly funded by a human services agency and that is approved in writing by the head of that human services agency for the purposes of the cl.10 of the *Privacy Code of Practice (General) 2003*.

²⁹ *Privacy Code of Practice (General) 2003* cl.10(3); *Health Records and Information Privacy Code of Practice 2005* cl.4(3).

³⁰ *Privacy Code of Practice (General) 2003* cl.10(4); *Health Records and Information Privacy Code of Practice 2005* cl.4(4).

- A.46 'Substantial adverse impact' includes, but is not limited to, serious physical or mental harm, significant loss of benefits or other income, imprisonment, loss of a housing or the loss of a carer.³¹
- A.47 On its face, cl.10 of the Privacy Code and cl.4 of the Health Code appear to provide a useful mechanism for exchanging child protection information outside of the strictures of the PPIP Act and the HRIP Act.
- A.48 However, according to DOCs "the Codes are meant for use in those rare circumstances where clients with complex needs refuse to consent to the sharing of their information between agencies."³²
- A.49 Housing expressed the view that the Code "is not designed to, or capable of, protecting children at risk and was not intended for such a purpose."³³
- A.50 Education appeared to share this view and submitted that the provisions of the Code should be expanded to accommodate circumstances where a service is not being provided but nevertheless access to the information is crucial for the investigation of child protection related issues.³⁴
- A.51 The Greater Southern Area Health Service informed the Inquiry.
- Although it is difficult to gauge precisely, I consider it likely that there is not significant awareness of either code within [Greater Southern Area Health Service] or other public health organisations through the state.*³⁵
- A.52 Presumably, by reason of a combination of the above factors, the ability to issue a written authorisation under the Codes is rarely, if ever, used to facilitate the exchange of information. The Inquiry asked each of the key child protection agencies bound by the Codes to identify the number of occasions on which a written authorisation had been issued by that agency. The Inquiry was informed that, so far as each agency is aware, no written authorisation has ever been issued under the Codes.
- A.53 Clause 11 of the Privacy Code provides that a human services agency is not required to comply with s.9 of the Act if it is unreasonable or impracticable in the circumstances to do so. This is a significant modification of the PPIP Act. It means that a human services agency may collect child protection information from another agency without having to first obtain the individual's consent or, where the information relates to a child under the age of 16 years, the authorisation of the child's guardian.

³¹ *Privacy Code of Practice (General) 2003* cl.10(1).

³² DoCS, *Privacy Management Plan*, p.14.

³³ Correspondence: Department of Housing, 26 March 2008, p.3.

³⁴ Correspondence: Department of Education and Training, 25 March 2008.

³⁵ Correspondence: Greater Southern Area Health Service, 2 April 2008.

- A.54 Housing, Police and Education also have their own Privacy Code of Practice.
- A.55 Police's Privacy Code of Practice has no provisions relevant to the exchange of child protection information.
- A.56 Housing's Privacy Code of Practice relevantly modifies the Department's obligation to comply with the information privacy principle contained in s.9 for the purpose of allowing the Department to administer the Priority Housing Assistance program. The Priority Housing Assistance program requires Housing to seek information from other agencies including DOCs and NGOs in order to determine whether an individual has a need for priority housing. In some cases, it is impracticable for Housing to obtain an authority from the individual consenting to the release of that information. The Code permits Housing to collect personal information from other government and non-government agencies for the purpose of assessing an individual's need for priority housing where it is impracticable to obtain the consent of the person to whom the information relates and disclosure of the personal information by the other body is permitted by the PPIP Act or another law. In addition, where a person under the age of 16 applies for housing, the Department may collect information from a third party other than a parent or guardian where that is in the interests of the minor applicant.
- A.57 Education's Privacy Code of Practice allows the Department to depart from the information protection principles contained in sections 9, 10, 12(a), 13, 14, 15, 17, 18 and 19 if compliance might detrimentally effect or prevent the proper exercise of its complaint handling functions. The provision makes specific reference to the investigation of allegations in relation to child sexual abuse, inappropriate conduct of a sexual nature involving students, and physical and emotional abuse of students. Various other modifications apply in relation to disclosure of personal information to parents, guardians or care givers. Significantly, the Department may depart from ss.17, 18 and 19 of the PPIP Act where the use and disclosure of information is for the purpose of 'child protection.' Child protection is not defined in the Code.
- A.58 While these individual Codes provide useful and significant exemptions, their utility in facilitating information exchange is limited in circumstances where other agencies do not have the benefit of similar exemptions. As Education and Training told the Inquiry:

Other agencies may not necessarily incorporate similar exemptions in their codes or have a code at all nor is there an obligation to do so. In the absence of a privacy code to address the issue, the ability of government agencies to freely exchange information about child protection issues is curtailed.³⁶

³⁶ Correspondence: Department of Education and Training, 25 March 2008.

Directions

- A.59 In addition to the exemptions set out in the PPIP Act and exemptions contained in privacy codes of practice, the Privacy Commissioner may issue a written direction exempting an agency from complying with the privacy principles in the Act or modifying the application of a principle or a code to a public sector agency, on condition that the Commissioner is satisfied that the public interest in making the exemption outweighs the public interest requiring the agency to adhere to the principles.
- A.60 Eight directions have been made under the PPIP Act that are relevant to the exchange of information by agencies involved in child protection. The two most significant are the *Direction on Information Transfers between Public Sector Agencies* (the Direction on Information Transfers) and the *Direction on the Processing of Personal Information by Certain Public Sector Agencies in Relation to their Investigative Functions* (Direction on Processing Personal Information).
- A.61 The Direction on Information Transfers was made by the Privacy Commissioner on 28 December 2007. It has effect from 1 January 2008 to 31 December 2008.
- A.62 The Direction on Information Transfers expressly applies to each of the key agencies involved in child protection listed at the beginning of this annexure. Under the Direction on Information Transfers, exchanges of information that are reasonably necessary for the purpose of referring inquiries between those agencies, for law enforcement purposes or for the performance of agreements (formal or informal) between those agencies are exempt from the operation of the information protection principles. The Direction on Information Transfers does not apply to health information. This Direction on Information Transfers provides a significant exemption. It means that the exchange of any type of child protection information (that does not include health information) can be exchanged pursuant to an MOU or other agreement.
- A.63 The Direction on Processing Personal Information was also made by the Privacy Commissioner on 28 December 2007. It has effect from 1 January 2008 to 31 December 2008. It applies to the same agencies as the Direction on Information, and it does not apply to health information.
- A.64 The Direction on Processing Personal Information exempts relevant agencies from ss. 9, 10, 13, 14, 15, 17, 18 and 19(1) of the PPIP Act if non-compliance is reasonably necessary for the proper exercise of any of the agencies' investigative functions or its conduct of any lawful investigations. Agencies also need not comply with ss.18 or 19(1) if non-compliance is reasonably necessary to assist another relevant agency exercising investigative functions or conducting a lawful investigation.
- A.65 'Lawful investigation' means an investigation carried out by an agency under specific legislative authority or where the power to conduct the investigation is

necessarily implied or reasonably contemplated under an Act or law. It covers only those investigations which may lead to the agency taking or instituting formal action in relation to the behaviour under investigation. 'Investigative functions' of an agency refer to those functions that are directly related to a lawful investigation and that are necessary for the conduct of that lawful investigation. 'Investigation' includes any examination of or any preliminary or other enquiry into a matter, including matters where it is decided to take no further action and matters which arise by way of complaint.

- A.66 It appears reasonably clear that the response of DoCS to a notification pursuant to Chapter 3, Part 3 of its legislation would fall within the definition of lawful investigation.
- A.67 In addition, there are a number of other directions that facilitate the collection, use and disclosure of personal information in relation to specific projects that relate to child protection.
- A.68 On 7 August 2006 the Privacy Commissioner made a Direction concerning the Child Protection Watch Team,³⁷ which is a trial involving a number of public sector agencies which have functions affecting the management of high risk offenders. The aim is to monitor and manage registrable persons who are referred to the trial because they pose a high risk of re-offending violently or sexually against children. The public sector agencies are those key agencies involved in child protection and the Direction states that they need not comply with the information protection principles contained in ss.8(1), 9, 10, 13, 14, 15, 17, 18 and 19 of the PPIP Act in collecting, holding, using and disclosing personal information in a manner which is reasonably necessary for the management of a case by the Child Protection Watch Team.
- A.69 On 2 September 2008 the Privacy Commissioner made a Direction relating to the Anti-Social Behaviour Pilot Project. That is a project intended to improve case coordination across the Anti-Social Behaviour Project participating agencies regarding the management of complex cases and crisis cases involving children, young people and families who live in, or are habitual visitors to certain specified geographical areas. The public sector agencies covered by this Direction include the key child protection agencies. Those agencies, in collecting, using and disclosing personal information for the purpose of implementing the objectives of the Anti-Social Behaviour Project are not required to comply with the IPPs contained in ss. 8(1), 9,10,17,18 or 19 of the PPIP Act.
- A.70 The Ombudsman informed the Inquiry that he had examined the Direction relating to the Anti-Social Behaviour Pilot Project and was of the view that it does not provide a good practical model for a system of information exchange between agencies because:

³⁷ Privacy Commissioner, *Privacy Direction on Child Protection Watch Team*, 2006.

*the decision makers are required to undertake a very complicated process when deciding whether or not to refer cases. Such processes will not be easy to follow in situations where prompt and challenging decisions need to be made. Other elements of the system also seem unwieldy and difficult to follow.*³⁸

- A.71 On 2 February 2006 the Privacy Commissioner made a Direction relating to the Redfern Waterloo Partnership,³⁹ which is a project intended to improve case co-ordination across participating agencies and NGOs regarding the management of complex cases and crisis cases involving children, young people and families in the Redfern Waterloo area. The Direction is to permit the exchange of personal information between those participating agencies and the NGOs. The participating agencies include all the key agencies involved in child protection. While this Direction has a very specific application, in that the operation of the case coordination framework is described in detail with certain criteria needing to be met before a child or young person or family becomes subject to the project, it may be a model that could be followed in relation to other geographic areas.

The Health Records and Information Privacy Act 2002

- A.72 The HRIP Act regulates the handling of 'health information' by both the public and private sectors in NSW. It applies to every organisation that is a health service provider or that collects, holds or uses health information.⁴⁰
- A.73 Health information is a specific type of personal information. Health information is broadly defined in s.6, and includes personal information that is information or an opinion about the physical, mental health or a disability of an individual as well as any personal information collected to provide a health service. In many instances, child protection information will contain health information as well as personal information.
- A.74 The HRIP Act is structured in the same way as PPIP Act. It establishes a set of 15 health privacy principles to regulate the collection, storage, accuracy, use and disclosure of health information. There are some exemptions to the application of those principles contained in the HRIP Act. In addition, a code of practice may modify or override the principles, and a Direction by the Privacy Commissioner may modify or override the HRIP Act or a code. The Privacy Commissioner may also issue guidelines relating to the protection of health information.

³⁸ Submission: NSW Ombudsman, Privacy and Exchange of Information, p.19.

³⁹ Privacy Commissioner, *Direction relating to the Redfern Waterloo Partnership Project*, 2006.

⁴⁰ *Health Records and Information Privacy Act 2002* s.11.

The Health Privacy Principles

- A.75 The Health Privacy Principles are set out in Schedule 1 of the HRIP Act. Unlike the PPIP Act, where there is an exception to a health privacy principle, the exception is set out in the same clause as the principle itself.
- A.76 Clauses 1-4 of Schedule 1 of HRIP Act (the Schedule) set out principles applicable to the collection of health information by an organisation. Clauses 5-7 set out principles applicable to the storage and holding of health information by an organisation. Clauses 8-10 set out principles applicable to the accuracy and use of health information by an organisation. Clause 11 sets out the principle applicable to the disclosure of health information by a public sector agency. Clauses 12-15 deal with the use of identifiers and the anonymity, transfer and linkage of health information.
- A.77 The health privacy principles contained in cls.1, 3, 4 and 11 directly impact upon the ability of public-sector agencies to exchange child protection information that contains health information in written or electronic form.⁴¹
- A.78 An agency that *receives* health information from another agency must (unless a relevant exception applies) comply with cls.1-4 relating to the collection of information.
- A.79 Clause 1 of the Schedule mirrors s.8 of the PPIP Act. It provides that an organisation must not collect health information unless the information is collected for a lawful purpose that is directly related to a function or activity of the organisation, and the collection of the information is reasonably necessary for that purpose. It also provides that an organisation must not collect personal information by any unlawful means.
- A.80 There are no exceptions within HRIP Act to cl.1 of the Schedule. As a result of cl.1, an agency cannot collect child protection information (that contains health information) from another agency unless the information is directly related to a function or activity of the agency.
- A.81 Clause 3 of the Schedule, provides that an organisation must collect health information about an individual only from that individual, unless it is unreasonable or impracticable to do so. There are no exceptions within the HRIP Act to cl.3. However, a statutory guideline has been issued under HRIP Act that identifies particular circumstances in which it will be impracticable or unreasonable to obtain information directly from an individual. None of the circumstances identified in the guideline is relevant in a child protection context. However, the guideline acknowledges that there will be circumstances in which

⁴¹ Principle 2 applies to collection of health information from an individual, not from a third party. Principle 5, 6, 7 deal with the storage of health information. Principles 8 and 9 deals with the accuracy of health information. Principle 10 deals with the use of health information internally within an agency. Principles 12-15 deal with specific uses that are not relevant to the exchange of information between agencies.

it is unreasonable or impracticable to obtain health information about a person directly from the person themselves other than those expressly identified in the guideline.

- A.82 Clause 4(2) of the Schedule provides that if an organisation collects health information about an individual from someone else, it must take any steps that are reasonable in the circumstances to ensure that the individual is generally aware of certain matters including:
- a. the identity of the organisation and how to contact it
 - b. the fact that the individual is able to request access to the information
 - c. the purposes for which the information is collected
 - d. the persons to whom (or the types of persons to whom) the organisation usually discloses information of that kind.
- A.83 However, an organisation is not required to comply with cl.4(2) to the extent that:
- a. making the individual aware of the matters would pose a serious threat to the life or health of any individual, or
 - b. the collection is made in accordance with guidelines issued by the Privacy Commissioner setting out circumstances in which an organisation is not required to comply with cl.4(2).
- A.84 The Privacy Commissioner has issued guidelines in relation to the application of cl.4(2). Those guidelines state that an organisation is not required to notify an individual when it collects health information about the individual from someone else in circumstances where:
- a. it is unreasonable or impracticable to collect the information from the person concerned, and notifying the person would be unreasonable or impracticable in the circumstances
 - b. the information is relevant to a third party's family, social or medical history and the collection of the information is reasonably necessary to the organisation to provide a health service directly to the third-party
 - c. the person is incapable of understanding the general nature of the information in Health Privacy Principle 4(1), the organisation takes reasonable steps to ensure that any authorised representative of the person is aware of that information and, where practicable, explains it appropriately to the person, or
 - d. the health information was initially collected from the person to whom it relates by another organisation and there are reasonable grounds to believe that that organisation has already notified the person of the information in Health Privacy Principle 4(1).

- A.85 An agency that provides health information to another agency (unless a relevant exemption applies) must comply with cl.11 of the Schedule relating to the disclosure of information.
- A.86 Clause 11 provides that an organisation that holds health information must not disclose the information for a purpose (a secondary purpose) other than the purpose (the primary purpose) for which it was collected unless one of the exceptions set out in cl.11 applies.
- A.87 There are a number of exceptions contained in cl.11. Of those, the following are most likely to be relevant to the key child protection agencies. Clause 11 does not apply if:
- a. the individual to whom the information relates has consented, or
 - b. the secondary purpose is directly related to the primary purpose and the individual would reasonably expect the organisation to disclose the information for the secondary purpose, or
 - c. the disclosure is reasonably believed by the organisation to be necessary to lessen or prevent a serious and imminent threat to the life, health or safety of the individual or another person, or a serious threat to public health or public safety, or
 - d. the disclosure is to a law enforcement agency (or such other person or organisation as may be prescribed by the regulations) for the purposes of ascertaining the whereabouts of an individual who has been reported to a police officer as a missing person, or
 - e. an agency discloses the health information as a necessary part of its investigation of unlawful conduct or in reporting its concerns to relevant persons or authorities, or
 - f. the disclosure is reasonably necessary for the exercise of law enforcement functions by law enforcement agencies in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed, or
 - g. the disclosure is reasonably necessary for the exercise of complaint handling functions or investigative functions by investigative agencies, or any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency, or that has been referred from or made by an investigative agency
 - h. non compliance is lawfully authorised, required, permitted, necessarily implied or reasonably contemplated under an Act or any other law
 - i. the organisation is an investigative agency (or any public sector agency, or public sector official, who is investigating or otherwise handling a complaint or other matter that could be referred or made to an investigative agency, or that has been referred from or made by an investigative agency) disclosing information to another investigative agency

- j. the disclosure is by a public sector agency to another public sector agency if the disclosure is for the purposes of informing the Minister about any matter within the Minister's administration, or for the purposes of informing the Premier about any matter.

Codes of Practice

- A.88 As noted above, a Code of Practice was made under the HRIP Act in 2005, which modifies the application of the HRIP Act to 'Human services agencies.'
- A.89 The Health Privacy Code mirrors cl.10 of the Privacy Code, in permitting the collection, use or disclosure of health information by 'human services agencies' without the consent of the person to whom the health information relates provided the collection, use or disclosure is authorised in writing by a senior officer. The definition of human services agency and the requirements in relation to the issue of an authorisation are the same as in the Privacy Code.
- A.90 There is, however, no equivalent in the Health Privacy Code to cl.11 in the Privacy Code.

Directions

- A.91 The Privacy Commissioner had made directions under s.62 of the HRIP Act relating to the Anti-Social Behaviour Pilot Project and relating to the Redfern Waterloo Partnership Project, that are in equivalent terms to the Directions of the same name made under the PPIP Act. As far as the Inquiry is aware, no other directions have been made by the Privacy Commissioner under the HRIP Act that are relevant to the exchange of health information by child protection agencies.

Children and Young Persons (Care and Protection) Act 1998

- A.92 There are various provisions in the Care Act that impact upon the exchange of child protection information.
- A.93 The most significant of these is s.248 which enables the Director-General of DoCS to exchange information with, or provide information to, a 'prescribed body' relating to the safety, welfare and wellbeing of a particular child or young person or class of children and young persons.
- A.94 Prescribed body means the Police Service, a government department, a public authority, a government school, a registered non-government school,⁴² a TAFE

⁴² As defined by the *Education Act 1990*.

establishment,⁴³ a public health organisation,⁴⁴ a private hospital⁴⁵ or any other body or class of bodies prescribed by the regulations.

- A.95 Prescribed bodies are set out in the 2000 Regulation and include private fostering agencies, residential child care centres or child care services, the Family Court, Centrelink and other organisations with responsibility for health care, welfare, education, children's services, residential services or law enforcement in relation to children.
- A.96 Pursuant to s.248 the Director-General may furnish a prescribed body or direct a prescribed body to furnish the Director-General with information relating to the safety welfare and wellbeing of a particular child or young person or class of children or young persons. The provision also provides for unborn children to be the subject of an exchange of information.
- A.97 Where information is lawfully exchanged under s.248, the principles contained in the PPIP Act and the HRIP Act do not apply.⁴⁶
- A.98 However, the ability to exchange information under s.248 is limited. While it allows DOCs to provide and receive information to and from prescribed bodies, it does not enable any of the prescribed bodies to exchange information directly with each other in relation to the safety, welfare and well being of a particular child or a class of children, even when it has been provided by DoCS.
- A.99 As the Ombudsman has observed that:

Section 248... seems to proceed on an assumption that DoCS is at the centre of "hub" of all matters in relation to the care and protection of children and young people.... This assumption is misconceived.⁴⁷

...

The listing of ... agencies as 'prescribed bodies' recognises that these agencies all have some responsibilities for ensuring the safety, welfare and well being of children and that DoCS may need to communicate with them to fulfil its child protection responsibilities. However, limiting the scope of section 248 to only communications between DoCS and other agencies fails to recognise the common scenario where various agencies have different responsibilities in relation to a particular child, and

⁴³ As defined by the *Technical and Further Education Commission Act 1990*.

⁴⁴ As defined by the *Health Services Act 1997*.

⁴⁵ As defined by the *Private Hospitals and Day Procedure Centres Act 1988*.

⁴⁶ *Children and Young Persons (Care and Protection) Act 1998* s.248(5).

⁴⁷ Submission: NSW Ombudsman, Privacy and Exchange of Information, p.13.

need to share information with each other to jointly support the child, without necessarily requiring DoCS to be involved.⁴⁸

...

Our view is that certain agencies with significant responsibilities relation to the safety, welfare and well being of children, ought to be permitted to communicate directly with each other, without having to rely on DoCS to pass on critical information and without being restricted by privacy concerns. We feel that, at a minimum, the police, schools, health services and non government organisations, including those providing major early intervention services and those providing out of home care services for children, should be able to this.⁴⁹

- A.100 It appears that the current practice is for agencies wishing to exchange information directly with each other, to make the exchange through DoCS, in order to fall within the terms of s.248 and avoid the restrictive provisions of the PPIP Act and HRIP Act. As the Greater Southern Area Health Service told the Inquiry

in practice information sharing between agencies often occurs “through” DoCS (essentially as an intermediary) ...Whilst...this satisfies privacy obligations, the process is not necessarily facilitative of an exchange of information that is beneficial to the child or young person. Such a process is formal, inefficient, and time consuming for all parties.⁵⁰

- A.101 Section 185 is in similar terms to s.248. It empowers the Children’s Guardian to furnish to prescribed persons, or to direct prescribed persons to provide to the Children’s Guardian, information relating to the safety, welfare and well-being of a particular child or young person or class of children and young persons. Prescribed persons are defined as the Director-General, a designated agency or authorised carer.
- A.102 Where disclosure of information is not expressly authorised by a provision such as ss.248 or 185 of the Care Act, in addition to the provisions of the PPIP Act and the HRIP Act, an agency must have regard to confidentiality provisions that may apply in relation to the information. A number of Acts may contain confidentiality provision that prevent the sharing of information even where this would be permitted under Privacy legislation. For example, s.254 of the Care Act makes it an offence to disclose information obtained in connection with the administration or execution of the Care Act unless the disclosure is made with the consent of the person from whom the information was obtained, in

⁴⁸ Submission: NSW Ombudsman, Privacy and Exchange of Information, p.5.

⁴⁹ Submission: NSW Ombudsman, Privacy and Exchange of Information, p.3.

⁵⁰ Correspondence: Greater Southern Area Health Service, 2 April 2008, p.4.

connection with the administration or execution of the Care Act or the regulations, for the purposes of any legal proceedings, or with a lawful excuse. Other legislation administered by key child protection agencies has similar confidentiality provisions.

- A.103 Section 29 and Division 1A of the Care Act may also need to be considered. Section 29 provides certain protections to persons who make reports or provide certain information to DoCS in relation to a child or young person or a class of children or young persons. Section 29(f) provides that the identity of the person who made the report, or information from which the identity of that person could be deduced, must not be disclosed by any person or body, except with the consent of the person who made the report, or the leave of a court or other body before which proceedings relating to the report are conducted.
- A.104 Division 1A Part 2 Chapter 8 the Care Act makes provision for the disclosure to parents and other significant persons of information concerning the placement of a child or young person in out-of-home care. A disclosure of information concerning placement made in good faith under the Division does not constitute a contravention of any provision as to confidentiality in the Care Act, the HRIP Act or the PPIP Act.⁵¹ However, s.149E of the Care Act provides that a designated agency must not disclose high level identification information concerning the placement of a child or young person unless the authorised carer has consented in writing to the disclosure. If the authorised carer has refused to consent to the disclosure, or has not consented within 28 days after being requested to do so, the designated agency may disclose the information if it believes on reasonable grounds that the disclosure will not pose any risk to the safety, welfare or well-being of the child or young person concerned, or to the authorised carer of the child or young person, or to any member of the family or household of the authorised carer of the child or young person, and it complies with ss.149F and 149G.⁵²

Commonwealth Privacy Laws

- A.105 The legal framework governing the exchange of information in the child protection context is further complicated by the applicability of Commonwealth privacy laws. The *Privacy Act 1988* (Cth) (the Privacy Act) is the key instrument regulating the handling of personal information in the Commonwealth jurisdiction.
- A.106 The Privacy Act applies to agencies and organisations in both the public and private sectors, although it does not regulate the handling of personal

⁵¹ *Children and Young Persons (Care and Protection) Act 1998* s.149J.

⁵² Section 149F of the *Children and Young Persons (Care and Protection) Act 1998* requires the agency to give the authorised parent (and child if the child is aged 12 years or over) written reasons for deciding to disclose the information without consent and written notice of the right to appeal the decision to disclose the information without consent. Section 149G deals with the process for appealing a decision to disclose the information without consent.

information by the NSW Public Service which, as discussed above, is regulated by PPIP Act. It does, however, apply to private sector health service providers; these are also covered under the HRIP Act, creating some overlap.

- A.107 The Privacy Act contains Commonwealth Information Privacy Principles (Commonwealth IPPs) and National Privacy Principles, which regulate the handling of personal information, including the collection, disclosure, storage and accuracy of such information. Commonwealth IPPs apply to Australian Government agencies, and National Privacy Principles apply to private sector organisations with an annual turnover of over \$3 million that do not have their own approved privacy code.⁵³ The two sets of principles are similar, though not the same.
- A.108 The provisions of the Privacy Act are subject to a broad and complicated range of exemptions, partial exemptions, and exceptions, which “are scattered throughout the Act in the definitions of terms, in the Commonwealth IPPs and NPPs and in specific exemption/exception provisions.”⁵⁴

⁵³ A private sector organisation can develop its own privacy codes, which, once approved by the Privacy Commissioner, replace the National Privacy Principles in relation to that organisation. As at June 2008, there were only three approved and operative codes, and thus the National Privacy Principles continue to have wide application in the private sector. NSW Law Reform Commission, *Consultation Paper 3: Privacy Legislation in NSW*, June 2008, pp.14-15.

⁵⁴ NSW Law Reform Commission, *Consultation Paper 3: Privacy Legislation in NSW*, June 2008, p 16.

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Appendix 1 Glossary

Administrative Decisions Tribunal (ADT) A body established under the *Administrative Decisions Tribunal Act 1997* to review specific administrative decisions of NSW Government agencies, and to deal with other types of matters such as discrimination, complaints and professional misconduct.

After care Services provided to a child or young person who has left out-of-home care.

Affidavit A statement for the court written in a standard format approved by the court. It is sworn or affirmed to be true by the person making the statement (deponent).

Alternative Dispute Resolution (ADR) A process whereby parties to a conflict may attempt to resolve their differences with the assistance of an independent person, usually referred to as a mediator.

Apprehended Violence Order (AVO) A court order placing prohibitions or restrictions on the behaviour of a person to ensure the safety and protection of another person in need of protection and of children from domestic or personal violence. The making of an order does not give rise to a criminal record. However, the breach of an AVO is a criminal offence, and the police may arrest and charge a person who breaches an order.

Authorised carer A person who is authorised as a foster or relative carer by a designated agency, the principal officer of a designated agency, or any person authorised according to the regulations (Section 137 of the Care Act).

Care Act Refers to the *Children and Young Persons (Care and Protection) Act 1998*.

Care allowance Allowance paid to service providers or authorised carers to contribute to the expected costs of caring for children and young people in their care. This includes, but is not limited to, costs such as rent, energy, food, clothing and footwear.

Care application An application lodged at the Children's Court under the Care Act with the intention of commencing proceedings to obtain a care order or to vary or rescind a pre-existing order.

Care Order An order made under Chapter 5 of the Care Act for the care and protection of a child or young person.

Care plans A tool that may be used within the context of casework to formalise agreements made with the family to meet the care and protection needs of a child or young person, or within a legal context to enable the Children's Court to allocate parental responsibility.

Care proceedings Proceedings before the Children's Court and District Court under Chapter 5 of the Care Act concerning children and young persons considered to be in need of care and protection.

Care responsibility of the Director-General DoCS responsibility for organising a placement for the child or young person and day-to-day care and control. This includes consenting to certain medical or dental treatment, correcting and managing behaviour and giving permission to participate in activities (s.157 of the Care Act). DoCS may delegate care responsibility to an authorised carer or a relative of the child or young person.

Case management Case management is the process of assessment, planning, implementation, monitoring and review that aims to strengthen families and decrease risks to children and young persons in order to optimise their outcomes through integrated and coordinated service delivery. Case management may be the responsibility of DoCS or another agency, depending on the circumstances of the individual case.

Case plan Sets out what action will be taken to enhance the child's or young person's safety, welfare and well-being. The case plan identifies goals, objectives and tasks with clearly identified responsibilities and time frames that are realistic and achievable within available resources.

Casework The practical day to day involvement with children, young persons, their carers and families. It generally includes implementing the case plan, coordinating supports and services and monitoring.

Child Under the Care Act, a child is a person who is under the age of 16 years. Under the *Family Law 1975*, the *Crimes Act 1900*, the *Commission for Children and Young People Act 1998*, the *Child Protection (Prohibited Employment) Act 1998* and the *Ombudsman Act 1994*, a child is a person under the age of 18 years. Under the *Young Offenders Act 1997*, a child is a person who is of or over the age of 10 years and under the age of 18 years.

Casework Specialists Regional DoCS officers usually located in CSCs. They provide practice coaching for caseworkers; conduct briefing, training and support on best practice standards; run case review sessions for teams and complex case reviews.

Children's Court Refers to the Children's Court of NSW, which is responsible for care and criminal proceedings relating to children and young persons.

Children's Court Clinic A service established under s.15B *Children's Court Act 1987* and s.58, of the Care Act to provide independent and expert assessment reports to the Children's Court in relation to care matters. The Clinic comes under the administration of the Attorney General's Department.

Children's Guardian Under Chapter 10 of the Care Act, the Children's Guardian is required to promote the best interests and safeguard the rights of

all children and young persons in out-of-home care, and accredit designated agencies and to monitor their responsibilities under the Care Act and the Regulations.

Children's Registrar An officer of the Children's Court who is responsible for the responsibilities described in cl.19 *Children's Court Rule 2000*. This includes arranging and convening preliminary conferences, hearing procedural matters and making decisions on behalf of the court.

Contact can refer to either:

- a. For children and young persons not residing with their birth parents or family it refers to all forms of communication between the child or young person and their family members and/or significant others. Contact may occur through planned visits, letters, telephone conversations or other forms of communication.
- b. As part of the DoCS 'intake' process, contact refers to a record of communication made to DoCS, usually at the Helpline, by the public or by mandatory reporters regarding a concern for a child or young person, a request for assistance, information about adoption or other information.

Community Services Centre (CSC) A DoCS office that delivers child protection, early intervention and out-of-home care services. There are 80 CSCs located across metropolitan and regional NSW.

Corporate Information Warehouse (CIW) An integrated and aggregated source of information and data about DoCS core operations and performance that went live in December 2005. It provides online access to corporate and business reporting measures.

Culturally and Linguistically Diverse (CALD) Refers to people from culturally diverse backgrounds, particularly people who are immigrants or the descendants of immigrants and who define their own cultural, linguistic and religious identity partly or wholly on this basis.

Designated agency Is an agency accredited in accordance with the Regulations to provide out-of-home care services, and includes DoCS and DADHC.

DoCS Helpline A statewide intake assessment and referral call service operating 24 hours a day, 7 days a week.

Domestic and family violence This is violence when one partner in an intimate relationship attempts by physical or psychological means to dominate and control the other. It occurs within a variety of close interpersonal relationships such as between spouses, partners, parents and children, siblings and among kinship relationships.

Establishment The term commonly used within the care jurisdiction to describe the finding by the Children's Court that a child or young person is in need of care and protection.

Foster care General foster care is defined as 24 hour care for children and young people aged 0-17 years which is provided on a short or long term basis by authorised carers in their own homes, or in a home owned or rented by an agency, who are reimbursed for expenses. The range of placement types available for children and young people include: emergency or crisis placements, short term (temporary) placements, bridging (medium) placements, permanent care placements, respite care placements, and adolescent community placements.

Guardian ad litem A person appointed by the court to instruct a legal representative on behalf of a child/young person or a parent in court where the child/young person or parent is not capable of giving proper legal instructions.

High Needs Kids A term used by DoCS to refer to children and young people in OOHC with high and complex needs.

In need of care and protection A term used by DoCS in two different circumstances, and according to two different standards of proof:

- a. when, following a Secondary Assessment, DoCS forms an opinion on reasonable grounds that the level of future risk to a child or young person is sufficient to warrant protective action by DoCS (under s.34 of the Care Act) to safeguard the child's or young person's safety, welfare and well-being. Action by DoCS includes the provision of support services, protective intervention or court action; or
- b. when a matter is placed before the Children's Court for a care order, and the court is satisfied on the balance of probabilities that the child is in need of care and protection (s.72 of the Care Act).

Initial Assessment Initial Assessment refers to the first gathering and analysis of information contained in a report about possible risk of harm to a child or young person. It is usually undertaken by the DoCS Helpline. The purpose of the assessment is to assist caseworkers to determine whether or not a child or young person is at risk of harm, and whether that child or young person may be in need of care and protection.

Joint Investigation Response Team (JIRT) Joint investigations of child abuse have been conducted by NSW Police and DoCS since 1997. NSW Health provides support to joint investigations. Joint investigation occurs where there are allegations that a child or young person has been the victim of sexual assault, serious physical abuse or neglect that may involve a criminal offence.

Key Information and Directory System (KiDS) DoCS' electronic system for keeping records and plans of its clients.

Kinship care Care with a person who is not a relative of the child, but who shares cultural, tribal and community connection that is recognised by that child's community.

Mandatory reporter A person who as part of their professional or paid work or as the supervisor/manager of a person who as part of their professional or paid work, delivers health care, welfare, education, children's services, residential services or law enforcement to children or young persons. Mandatory reporters are required under s.27 of the Care Act to make a report to DoCS if they have reasonable grounds to suspect that a child is at risk of harm, and those grounds arise during the course of or from the person's work.

Out-of-home care (OOHC) The care of the child or young person who is in the parental responsibility of the Minister, or a non-related person, residing at a place other than their usual home, and by a person other than their parent, as a result of a Children's Court order that lasts for more than 14 days, or because they are a protected person.

PANOC This is an acronym for Physical Abuse and Neglect Of Children, a counselling and therapy service provided by NSW Health for children or young persons referred to them by DoCS.

Parental responsibility to the Minister An order of the Children's Court that places the child or young person under the parental responsibility of the Minister (s.79(1)(b) of the Care Act).

Permanency planning Permanency planning is a requirement of the Care Act (ss.78A and 83). It involves giving early consideration to the long-term needs of a child in care based on an assessment of family strengths, to work out whether or not there is a realistic possibility of restoration. Permanency planning can include restoration to the birth family, long-term care (including sole parental responsibility orders) and relative/kinship care or adoption.

Protected person Under s.135 of the Care Act a protected person is a child or young person who is a:

- a. ward of the Supreme Court or subject to an order by the Court in its *Parens Patriae* jurisdiction who is in the custody or care of the Minister or Director-General, or
- b. non-relative child or young person awaiting adoption, or
- c. child or young person under the guardianship or custody of the Minister or Director-General by order of the Family Court or the Supreme Court.

Relative Care Care provided to a child or young person by a relative.

Reporter Any person who conveys information to DoCS concerning their suspicion that a child, young person or unborn child (once born) is at risk of harm as defined under s.23 of the Care Act.

Restoration Following the removal of a child or young person from the care of a parent or parents the child or young person is placed back in the care of a parent or parents where that environment is assessed as safe, nurturing and secure.

Secondary assessment Procedurally, Secondary Assessment follows an Initial Assessment where the outcome is that a child or young person is believed to be at risk of harm and may be in need of care and protection. The secondary assessment employs the Secondary Assessment Framework. Secondary assessment is usually conducted by the CSC or JIRT.

Service provider Includes government and non-government agencies, designated agencies and other contracted providers.

Short term re-report A report received, with the same reported issue type, within seven days of another report for the child. For re-reports a report is considered to have the same issue type if any of the three reported issues match those from a previous report. Issues are grouped into physical, sexual, psychological, neglect and carer for matching.

Young person Under the Care Act, a young person is defined as a person aged 16 years or above, but under the age of 18 years. Under the *Crimes Act 1900*, the *Commission for Children and Young People Act 1998*, the *Child Protection (Prohibited Employment) Act 1998*, and the *Ombudsman Act 1974*, any person under the age of 18 years is defined as a child.

Appendix 2 List of legislation (and abbreviations where applicable)

NSW Acts:

Aboriginal Land Rights Act 1983

Aborigines Act 1969 (repealed)

Aborigines Protection Act 1909 (repealed)

Administrative Decisions Tribunal Act 1997

Adoption Act 2000

Child Protection (Offenders Prohibition Orders) Act 2004

Child Protection (Offenders Registration) Act 2000

Children (Care and Protection) Act 1987 (1987 Act)

Children (Criminal Proceedings) Act 1987

Children (Detention Centres) Act 1987

Children (Protection and Parental Responsibility) Act 1997

Children and Young Persons (Care and Protection) Act 1998 (the Care Act)

Children's Court Act 1987

Commission for Children and Young People Act 1998 (CCYP Act)

Community Relations Commission and Principles of Multiculturalism Act 2000

Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)

Community Welfare Act 1987 (Community Welfare Act)

Coroners Act 1980

Crimes (Administration of Sentences) Act 1999

Crimes (Domestic and Personal Violence) Act 2007

Crimes (Serious Sex Offenders) Act 2006

Crimes Act 1900

Criminal Procedure Act 1986

Disability Services Act 1993

Education Act 1990

Evidence Act 1995

Evidence Amendment Act 2007

Health Administration Act 1982

Health Records and Information Privacy Act 2002 (HRIP Act)

Housing Act 2001

Independent Commission Against Corruption Act 1988

Liquor Act 2007

Local Court Act 2007

Local Government Act 1993

Ombudsman Act 1974 (Ombudsman Act)

Pre-Trial Diversion of Offenders Act 1985

Privacy and Personal Information Protection Act 1998 (PPIP Act)

Public Sector Employment and Management Act 2002

Public Sector Management Act 1988 (repealed)

Rural Assistance Act 1989

NSW Acts:*Special Commission of Inquiry Act 1983**State Emergency and Rescue Management Act 1989 (SERM Act)**State Emergency Service Act 1989**Status of Children Act 1996**Supreme Court Act 1970**Young Offenders Act 1997 (Young Offenders Act)***NSW Regulations***Adoption Regulation 2003**Children and Young Persons (Care and Protection) Regulation 2000 (the Regulations)**Children and Young Persons (Savings and Transitional) Regulation 2000**Children's Court Rule 2000 (the Rules)**Children's Services Regulation 2004**Community Services (Complaints, Reviews and Monitoring) Regulation 2004**Police Regulation 2000 (repealed)**Uniform Civil Procedures Rules 2005***Other Acts and Regulations***Adoption Act 1984 (Vic)**Adoption Act 1988 (SA)**Adoption Act 1988 (Tas)**Adoption Act 1993 (ACT)**Adoption Act 1994 (WA)**Adoption of Children Act 1964 (Qld)**Adoption of Children Act 1994 (NT)**Care and Protection of Children Act 2007 (NT)**Child Protection Act 1999 (Qld)**Children Act (1989) (UK)**Children Act (2004) (UK)**Children and Community Services Act 2004 (WA)**Children and Young People Act 1999 (ACT)**Children, Young Persons and their Families Act 1997 (Tas)**Children, Youth and Families Act 2005 (Vic)**Children's Protection Act 1993 (SA)**Family Law Act 1975 (Cth) (Family Law Act)**Family Law Rules 2004 (Cth)**Privacy Act 1988 (Cth)*

Appendix 3 Terms of Reference

14 November 2007

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

TO

The Honourable James Roland Tomson Wood AO QC

GREETING:

By these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise and commission you to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

- i. The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters;
 - ii. Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;
 - iii. Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;
 - iv. Recording of essential information and capacity to collate and utilise data about the child protection system to target resources efficiently;
 - v. Professional capacity and professional supervision of the casework and allied staff;
 - vi. The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies;
 - vii. The adequacy of arrangements for inter-agency cooperation in child protection cases;
 - viii. The adequacy of arrangements for children in out of home care;
 - ix. The adequacy of resources in the child protection system,
- and establish a Special Commission of Inquiry for that purpose.

ENTERED on Record by me, in REGISTER OF PATENTS, No, 89 Page 359,
this 14th day of November, 2007


DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS His Excellency
The Honourable James Jacob Spigelman,
Companion of the Order of Australia,
Lieutenant Governor of the State of New South
Wales in the Commonwealth of Australia.

Dated this 14 November 2007.

A handwritten signature in black ink, appearing to be 'James Spigelman', written in a cursive style.

Lieutenant Governor

By His Excellency's Command,

A handwritten signature in black ink, appearing to be 'Peter Beattie', written in a cursive style.

Premier

7 December 2007

*ELIZABETH THE SECOND, by the Grace of God, Queen
of Australia and Her other Realms and Territories,
Head of the Commonwealth.*

TO

The Honourable James Roland Tomson Wood AO QC

GREETING:

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, We appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed,

AND WHEREAS it is desirable that those Letters Patent be revoked and new Letters Patent be issued on the same terms of reference,

NOW THEREFORE, by these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise and commission you to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed and specifically to examine, report on and make recommendations in relation to:

- i. The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters;
- ii. Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making;
- iii. Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families;
- iv. Recording of essential information and capacity to collate and utilise data about the child protection system to target resources efficiently;
- v. Professional capacity and professional supervision of the casework and allied staff;

ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 361,
this 7th day of December, 2007


DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

- vi. The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies;
- vii. The adequacy of arrangements for inter-agency cooperation in child protection cases;
- viii. The adequacy of arrangements for children in out of home care;
- ix. The adequacy of resources in the child protection system,

and establish a Special Commission of Inquiry for that purpose.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS Her Excellency
Professor Marie Bashir,
Companion of the Order of Australia,
Commander of the Royal Victorian Order,
Governor of the State of New South Wales
in the Commonwealth of Australia.

Dated this 7th December 2007.

Governor

By Her Excellency's Command,

Premier

4 June 2008

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To the Honourable James Roland Tomson Wood AO QC

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, WE appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.

AND WHEREAS those Letters Patent were revoked and new Letters Patent issued in Our Name by Our Governor of Our said State on 7 December 2007 on the same terms of reference, and it is desirable that those Letters Patent be varied to provide additional time for the preparation and delivery of your report.

NOW THEREFORE WE do, by these Our Letters Patent issued in Our Name by Our Governor of Our said State, with the advice of the Executive Council, and pursuant to section 6 of the *Special Commissions of Inquiry Act 1983*, DECLARE that the Letters Patent constituting your Commission shall have effect as if the paragraph "AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 June 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney," were deleted and replaced with the following paragraph:

"AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 September 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney."

ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 402, this 4th day of June, 2008

DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

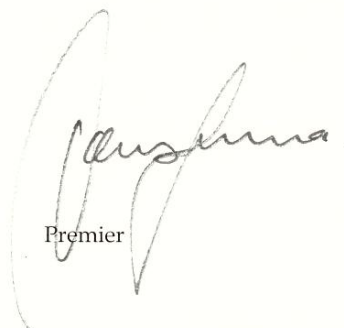


WITNESS Her Excellency
Professor Marie Bashir,
Companion of the Order of
Australia, Commander of the
Royal Victorian Order, Governor
of the State of New South Wales
in the Commonwealth of
Australia.

Dated this 4th day of June 2008.


Governor

By Her Excellency's Command,


Premier

10 September 2008

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To the Honourable James Roland Tomson Wood AO QC

WHEREAS BY Letters Patent issued in Our Name by Our Lieutenant Governor of Our State of New South Wales on 14 November 2007, WE appointed you as sole Commissioner to conduct an inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.

AND WHEREAS those Letters Patent were revoked and new Letters Patent issued in Our Name by Our Governor of Our said State on 7 December 2007 on the same terms of reference and varied on 4 June 2008, and it is desirable that those Letters Patent be further varied to provide additional time for the preparation and delivery of your report.

NOW THEREFORE WE do, by these Our Letters Patent issued in Our Name by Our Governor of Our said State, with the advice of the Executive Council, and pursuant to section 6 of the *Special Commissions of Inquiry Act 1983*, DECLARE that the Letters Patent constituting your Commission shall have effect as if the paragraph "AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 September 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney," were deleted and replaced with the following paragraph:

"AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 31 December 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney."

ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 53, this 10th day of September 2008


DIRECTOR GENERAL
DEPARTMENT OF PREMIER AND CABINET

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

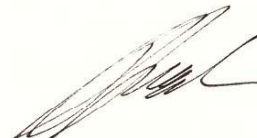


WITNESS His Excellency
THE Hon. J.J. SPIGELMAN
~~Professor Martin Bassin~~

Companion of the Order of
Australia, ~~Commander of the~~
LIEUTENANT
~~Royal Victorian Order~~, Governor
of the State of New South Wales
in the Commonwealth of
Australia.

J.S.

Dated this 10th day of September 2008.


LIEUTENANT Governor

J.S. By His Excellency's Command,



Premier

Appendix 4 The Inquiry's Approach

Commencement of the Inquiry

As can be seen, the Terms of Reference are wide, and required a systemic inquiry not an inquiry into specific catastrophic incidents, or an inquiry seeking to attribute individual blame for specific cases – those roles belong to other agencies.

The letters patent were amended on three occasions, although the terms of reference did not change. The report to the Governor of NSW was ultimately required by 31 December 2008.

On 17 December 2007 the Inquiry conducted a public sitting to announce the terms of reference and to outline the processes to be followed by the Inquiry, including the means by which it intended to inform itself.

Staff

Gail Furness was appointed as Counsel Assisting the Inquiry on 14 November 2007.

During the information gathering phase of the Inquiry (discussed below), the Inquiry was served by 10 full time staff members with relevant experience, who were seconded from various NSW government agencies.

The staff included two senior officers seconded from DoCS, Anne Campbell (Executive Director, Operations Development) and Helen Rogers (Director, Strategic Policy). Each was quarantined from DoCS for the duration of the Inquiry. Neither accessed any confidential submission from a DoCS employee. Without the assistance of these officers, each with significant experience in and knowledge of the child protection system, the Inquiry would not have been able to understand the complexities of that system as quickly or as thoroughly as it did.

The Inquiry was assisted during its term by the following members of its staff who were seconded from other government agencies.

- a. Barbara Alvos (Police Integrity Commission)
- b. Ben Haylock (Roads and Traffic Authority)
- c. Carl Hook (Office of the Protective Commissioner)
- d. April Hyde (Department of Health)
- e. Marlene Krasovitsky (Department of Premier and Cabinet)
- f. Fiona Russell (Police Integrity Commission)
- g. Prudence Sawyer (Crown Solicitor's Office)

h. Julie Wynn (Police Integrity Commission)

Clerical staff were engaged on a temporary basis as required.

During the report writing phase, the Inquiry required fewer full time staff, and accordingly, two staff members returned to their substantive positions.

Assistance

Retired Family Court Judge, the Honourable Richard Chisholm, was engaged by the Inquiry as a consultant in relation to the interface between the child protection system in NSW and the family law courts.

Two barristers, Kate Morgan and Caroline Spruce were engaged to provide assistance from time to time.

The Inquiry also received valuable assistance from Judge Ken Taylor AM, (NSW Privacy Commissioner), Professor Patrick Parkinson, (University of Sydney, Sydney Law School) and Associate Professor Dr Judy Cashmore, (University of Sydney, Sydney Law School).

Accommodation

The Inquiry was accommodated at Level 8, John Maddison Tower, 88 Goulburn Street Sydney until 25th July 2008, when the premises were required for other purposes. The Inquiry then moved to accommodation at Darlinghurst Supreme Court, Taylor Square, Darlinghurst.

Public Forums (discussed below) held in Sydney were conducted in Courtroom 8A in John Maddison Tower. Public Forums held in regional areas were conducted in local venues. Meetings (discussed below) were generally conducted either at the Inquiry's premises, or, in the case of meetings with regional government agency staff, at either the local DoCS office, or at another local venue.

Advertising the Inquiry

Between 8 December 2007 and 15 December 2007 advertisements were placed in *The Sydney Morning Herald*, *The Daily Telegraph* and *The Australian*, announcing the Terms of Reference for the Inquiry and inviting interested parties to make submissions by 11 February 2008.

Public Forums held in Sydney were advertised in *The Sydney Morning Herald* and *The Daily Telegraph*. Public Forums held in regional areas were advertised in local newspapers and Indigenous publications. These advertisements also invited interested parties to make submissions to the Inquiry.

The Commissioner also publicised the Inquiry during various radio interviews, including one with Gadigal Koori Radio, and one with ABC Radio Statewide Drive.

The Inquiry's website

On 17 December 2007, the Inquiry established a website at www.lawlink.nsw.gov.au/cpsinquiry which was hosted by the Attorney General's Department. All significant information concerning the progress of the Inquiry, including how to make submissions, was placed on the website.

Various documents were also published on the website. These included agendas and fact sheets in relation to each Public Forum held in Sydney, transcripts of each Public Forum held in Sydney and in regional areas, and public submissions from government and non-government agencies. Before transcripts were placed on the website, information (usually names) which could identify individual children or reporters, or comments which could be defamatory, were 'blacked out.'

As at November 2008, Inquiry staff are continuing to review all submissions made to the Inquiry, with a view to placing any further 'publishable' submissions on the website. A publishable submission is one that has not been marked by the contributor as confidential, does not breach relevant legislative provisions in relation to the publication of information identifying children, and does not contain offensive or defamatory comments, that is material which on investigation was found to be manifestly without foundation such that its further publication would not serve any legitimate purpose.

Processes through which the Inquiry acquired information

Shortly after the commencement of the Inquiry, letters were sent to 147 key government and non-government agencies, inviting the agency to provide information to, and to liaise with, the Inquiry. Some agencies were also specifically asked to provide information in relation to their programs (current or recently completed), as well as in relation to their policies and any agreements to which they were a party, relevant to the provision of services to families and to the protection of children.

Documents produced on summons and documents provided on request

Whilst most of the material obtained by the Inquiry was provided voluntarily, some information was obtained under summons. The Commissioner's power to summons material was derived from the *Special Commission of Inquiry Act 1983*. In providing material pursuant to a summons, individuals were able to provide information and assistance to the Inquiry without breaching confidentiality or secrecy requirements that otherwise would have prevented them from providing material to the Inquiry.

The Inquiry issued 85 summons to produce documents. Thirty two of which were directed to the Director-General of DoCS, 18 to the Director-General of Health, and eight to the Commissioner for Police, and the remainder to various other individuals and agencies.

The Inquiry also made many less formal requests for information from agencies and individuals. Most of these requests were directed to DoCS, which responded to over 250 requests for information.

Submissions

The Inquiry publicly invited submissions from interested parties. The Inquiry made it clear that submissions could be received on either a confidential or non-confidential basis, and were intended to inform it in relation to potential systemic problems.

The Inquiry received 669 submissions from government agencies, non-government agencies, other organisations and members of the public. Some people and organisations made more than one submission. A number of submissions were provided on a confidential basis, some were anonymous, and some were received from people who specified that they did not wish to be identified as having made a submission.

The Inquiry continued to receive submissions until mid-November.

A list of the names of the agencies, other organisations, individuals and academics who provided submissions other than those whose submissions were received on a confidential basis or not to be identified basis is contained in Appendix 5.

Regional visits

Between March and May 2008 the Inquiry travelled to regional centres to conduct Public Forums, interagency meetings, and meetings with DoCS staff. The areas visited by the Inquiry during this time were Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Shellharbour, Toomelah, Wagga Wagga, and Wollongong.

The Inquiry made a second visit to Boggabilla to meet with people from the Boggabilla and Toomelah communities and to further investigate the particular issues faced by these communities, as discussed in Chapter 19 of this Report. On this occasion, the Inquiry invited, by individual letter, 46 members of those communities to a meeting.

In July, the Inquiry travelled to Melbourne to obtain information about its child protection system, including the success of recent reforms, and the models of service available in that State.

Forums and meetings conducted during these regional and interstate trips are discussed below.

Visits to non-government organisations

In February 2008, the Inquiry visited the UnitingCare Burnside Family Services Centre in Minto, near Campbelltown, and met with staff from the Centre, as well as with senior officers from that agency, to discuss the operation of the Centre, and the programs offered in that area.

In May 2008, the Inquiry visited the Barnardos South Coast Children's Family Centre in Warrawong, near Wollongong, and met with staff from the Centre to discuss the programs offered by the Centre, as well as with foster carers to hear about their experiences.

Public Forums

Between February and May 2008 the Inquiry conducted nine Public Forums in Sydney. Each forum concentrated on one of the following specific issues of relevance to the Terms of Reference: mandatory reporting, the role of courts in the child protection system, out-of-home care, the role of oversight agencies in the child protection system, interagency cooperation, health and disability, assessment models and processes, Aboriginal communities, and early intervention.

Representatives of relevant agencies and individuals with relevant experience were invited to participate in panel discussions at these forums. A full list of panel members who participated in each of the Public Forums is contained in Appendix 7 to this report. The Inquiry prepared an agenda and a fact sheet in advance of each of these forums, and published these on its website. Members of the public were invited to attend, and there was some opportunity for members of the public to comment or ask questions at the end of the forums.

Public Forums were also held in Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Wagga Wagga, and Wollongong. These forums did not involve panel discussions, rather, members of the public were invited to attend and share their concerns about the child protection system with the Inquiry. There was some opportunity for those who did not want to share their concerns publicly to talk to Inquiry staff in private.

All Public Forums were transcribed and the transcripts made available on the Inquiry's website.

Meetings with DoCS and the Court

During the initial stages of the Inquiry, the Commissioner and Inquiry staff met on a number of occasions with senior executives from DoCS.

The Inquiry also met with staff and managers from 19 CSCs to hear their views about the child protection system and any problems they may experience in carrying out their work. These CSCs included Ballina, Bourke, Broken Hill, Campbelltown, Central Sydney, Coonamble, Dubbo, Eastern Sydney, Gosford, Griffith, Inverell, Lismore, Moree, Newcastle, Nowra, Parramatta, Shellharbour, Wagga Wagga, Wollongong. Staff from near-by CSCs also attended some of these meetings. The Inquiry also spoke with DoCS Project Team about the Toomelah/Boggabilla Child Protection Project.

The Inquiry also visited the Helpline, a Caseworker Assessment Centre, and a JIRT to witness operations and talk to staff. It attended the Children's Court at Parramatta, held meetings with the Senior Children's Magistrate and two former Children's Court Magistrates, and met the Director of the Children's Court Clinic to inform itself as to the way in which the clinic operated. It also had a meeting with members of the Family Court of Australia, and with the Judge of the District Court of NSW managing that Court's appeal jurisdiction in relation to care cases.

Meetings with representatives from key agencies

The Inquiry held individual meetings with senior representatives from each of the government and non-government agencies concerned in the care and protection system, or in the delivery of service to children and young persons.

A list of these agencies with which the Inquiry met in private meetings is contained in Appendix 6 to this report.

Interagency meetings in regional locations

During its visits to Ballina, Boggabilla, Bourke, Broken Hill, Coonamble, Dubbo, Griffith, Moree, Newcastle, Nowra, and Wagga Wagga, the Inquiry conducted interagency meetings with senior staff from regional offices of government departments involved in the child protection system (generally, these meetings were attended by representatives from DoCS, Police, Health, Education, DADHC, and Housing. Relevant meetings were also attended by representatives from Aboriginal Affairs and from Premier and Cabinet).

Prior to these meetings, the Inquiry outlined the issues that it wished to discuss, which included the types of services needed in the relevant region, the types of service models that might improve interagency cooperation in the delivery of service, and any barriers to effective interagency relationships.

Meetings with academics

The Inquiry was briefed by a number of academics from NSW, interstate and overseas, with relevant backgrounds in fields related to the care and protection of children. A list of those within this group is included in Appendix 6 to this report.

Other meetings

The Inquiry also met with various other individuals and groups, including young people from the CREATE Foundation, members of the Guardian ad Litem panel, a group of midwives, and lawyers specialising in care and protection law in the Children's Court.

In Melbourne, the Inquiry met with the Victorian Department of Human Services, relevant non-government agencies, the Centre for Excellence in Child and Family Welfare and the Victorian Aboriginal Child Care Agency Cooperative Limited to discuss the Lakidjeka program.

A list of these meetings is included in Appendix 6 to this report.

Case file audit

The Inquiry undertook a review of DoCS case files in relation to 75 children and young persons, in order to examine casework practice compliance against DoCS policies and procedures. All DoCS regions, all program areas (Child Protection, OOHC and Brighter Futures), and all age groups were represented in the audit. The files of the 75 children and young persons included those of 37 females, 38 males, 30 Aboriginal children and young persons and nine children and young persons from CALD backgrounds.

Expression of appreciation

The Inquiry wishes to thank all those who provided submissions, who participated in public forums and meetings, and who otherwise provided assistance. In particular, the Inquiry wishes to thank those who gave their time in providing specific assistance, or in providing feedback in relation to preliminary views formed by the Inquiry which were then taken into account in the finalisation of this Report.

The Inquiry also wishes to acknowledge the cooperation it received from DoCS, and from all other key government and non-government agencies, in the provision of information and advice concerning the operation of the child protection system in NSW and in other jurisdictions.

Appendix 5 Submissions

Submissions from anonymous sources, and submissions from people who stated that their submission was confidential or that they did not wish to be identified as having made a submission, are not included in these lists.

Government Agencies

1. Australian Institute of Family Studies (Commonwealth)
2. Children's Court Clinic
3. Children's Court of NSW
4. Commission for Children and Young People
5. Community Relations Commission for a multicultural NSW
6. Legal Aid NSW
7. Local Court of NSW
8. NSW Commission for Children and Young People
9. NSW Department of Aboriginal Affairs
10. NSW Department of Ageing, Disability and Home Care
11. NSW Department of Education and Training
12. NSW Department of Health
13. NSW Department of Juvenile Justice
14. NSW Department of Premier and Cabinet
15. NSW Office for Children - The Children's Guardian
16. NSW Ombudsman
17. NSW Police Force
18. Office of the Protective Commissioner
19. Redfern Waterloo Authority
20. Sydney Children's Hospital
21. The Children's Hospital at Westmead

Non-government agencies and other organisations

1. Aboriginal Child, Family and Community Care State Secretariat
2. Aboriginal Legal Service (NSW/ACT) Limited
3. Anglican Church of Australia
4. Anglicare Canberra and Goulburn
5. Association of Children's Welfare Agencies
6. Association of Independent Schools of NSW
7. Australian Association of Social Workers
8. Australian Dental Association (NSW Branch) Limited
9. Australian Lawyers Alliance
10. Australian Medical Association (NSW) Limited
11. Baptist Community Services NSW and ACT
12. Barnardos Australia
13. Berkeley Neighbourhood Centre
14. Binaal Billa - Family Violence Legal Service
15. Bravehearts
16. Care Leavers Australia Network
17. CareSouth
18. Caring and Parenting ACT Inc.

19. Carries Place Inc. - Women's and Children's Crisis Service
20. Casino Neighbourhood Centre - Brighter Futures Early Intervention Program
21. Catholic Commission for Employment Relations
22. Catholic Social Services NSW/ACT
23. Centacare Broken Bay
24. Centacare Catholic Community Services Sydney
25. Child Abuse Prevention Service
26. Child and Family Health Nurses Association (NSW) Inc
27. Clarence Valley Foster Carers Support Group
28. Combined Community Legal Centres' Group (NSW) Inc
29. Council of Social Service of NSW
30. Council of Social Service of NSW – joint submission with:
 - a. Local Community Services Association
 - b. NSW Family Services Inc
 - c. Youth Action and Policy Association NSW
 - d. Western Sydney Community Forum
 - e. Local Government and Shires Association Illawarra Forum
31. Country Women's Association of NSW
32. CREATE Foundation
33. Disability and Aged Information Services Inc
34. Disability Enterprises
35. Families Australia
36. Family Inclusion Network- Australian Catholic University
37. Family Inclusion Network NSW Inc
38. Family Services Illawarra Inc
39. Federation of Parents and Citizens' Associations of NSW
40. Foster Care Association NSW Inc
41. Foster Parent Support Network
42. Foster Parent Support Network Hunter Region
43. Good Beginnings / National Association for Prevention of Child Abuse and Neglect
44. Gosford Family Support Services
45. Goulburn Family Support Service Inc
46. Homeless Persons Information Centre Sydney
47. Homelessness NSW/ACT
48. Hunter Community Legal Centre and Children's Court Assistance Scheme
49. Illawarra Multicultural Services Inc
50. Illawarra Neighbourhood Centre Forum
51. Intellectual Disability Rights Service
52. Jannawi Family Centre
53. Katungal Aboriginal Corporation Community and Medical Services
54. Kids Off the Streets
55. Kinship Care Regional Project
56. Law Society of NSW
57. Learning Links
58. Life Without Barriers
59. Lower Hunter Temporary Care Inc
60. MacKillop Rural Community Services
61. Mallee Family Care
62. Marist Youth Care
63. Mission Australia
64. Moree Plains Shire Council

65. Multicultural Disability Advocacy Association of NSW
66. National Abuse Free Contact Campaign
67. National Association for Prevention of Child Abuse and Neglect
68. National Children's and Youth Law Centre
69. National Drug and Alcohol Research Centre
70. National Research Centre for the Prevention of Child Abuse
71. Newcastle Family Support Services Inc
72. Non-Custodial Parents Party (Equal Parenting)
73. Northern Region Young Women's Accommodation Project auspiced by Casino Neighbourhood Centre Inc.
74. NSW Family Services Inc
75. NSW Liberal/National Parliamentary Parties Coalition
76. NSW Primary Principals' Association
77. NSW Schools for Specific Purposes Principals Network
78. NSW Women's Refuge Movement Working Party Inc
79. Official Community Visitors
80. People with Disability Australia
81. Phoenix Rising for Children
82. Public Interest Advocacy Centre
83. Public Schools Principals Forum
84. Public Service Association of NSW
85. Pymble Ladies College
86. Redfern Legal Centre
87. Regional Youth Development Officers Network Inc
88. Regulatory Institutions Network
89. Rekindling the Spirit
90. Royal Australasian College of Physicians
91. Royal Australian and New Zealand College of Psychiatrists
92. Samaritans Foundation - Diocese of Newcastle
93. SDN Children's Services Inc
94. Secretariat of National Aboriginal and Islander Child Care
95. Shoalcoast Community Legal Centre Inc.
96. South West Child Adolescent and Family Services
97. Southern Youth and Family Services
98. Stepping Stone House
99. Stolen Generations Link Up (NSW)
100. The Australian Family Association (NSW)
101. The Benevolent Society
102. The Cottage Family Care Centre
103. The Gunedoo Centre
104. The Joseph Varga School
105. The NSW Secondary Principals' Council
106. Tongan Community Support Services
107. UnitingCare Burnside
108. Victims of Crime Assistance League Inc. NSW
109. Wesley Dalmar Child and Family Services, Wesley Mission
110. West Street Centre
111. William Campbell College
112. Women's Electoral Lobby NSW
113. Women's Lawyers' Association of NSW

114. Women's Legal Services NSW
115. Yawarra Meamei Women's Group Inc
116. Youth Accommodation Association
117. Youth Justice Coalition
118. Youth Off the Streets

Individuals and academics

1. Adams, James and Thompson, Jason
2. Agate, Adelaide and Brian
3. Ainslie-Wallace, the Hon Judge Ann
4. Ainsworth, Dr Frank and Hansen, Dr Patricia
5. Ainsworth, Dr Frank and Pollock, Dr Reg
6. Alderton, Helen
7. Alexander, Susan
8. Allinson, Ross
9. Altman, Darius
10. Anderson, Jordan Thomas
11. Anscombe, Aw (Bill)
12. Austin, Richard And Geraldine
13. Azzopardi, Victor
14. Bailey, Bronwynne and Samuel, Janene
15. Bao-Er, Dr
16. Bartlett, Jane (provided by Harris MP, David)
17. Bartlett, Martin
18. Baxter, Christina
19. Baxter, Terri (provided by Humphries MP, Kevin)
20. Bayona, Aldo
21. Blackburn, Ben
22. Bond, Tamara
23. Bootes, Byron and Phyllis
24. Bor, William
25. Borg, Robyn
26. Bowes, Jennifer Professor
27. Brennan, Regan, Tom and Brett
28. Brown, Micheal John
29. Brown, Michelle Lee
30. Brown, Neil
31. Brown, Yvonne
32. Bull, Karen
33. Burden, Mike
34. Byrnes, Sue
35. Cairns, Andrea
36. Caldersmith, Susie and Warwick
37. Calvert, Gillian; Cashmore, Dr Judy; Scott, Professor Dorothy
38. Campbell, Cheryl
39. Campbell, Linda
40. Campbell, Michael
41. Capsis, Reverend George
42. Carpenter, John

43. Carpenter, Maria (provided by Fardell MP, Dawn)
44. Carter, Mary Lou
45. Catt, Robyn
46. Clancy, Therese
47. Clark, Kathleen
48. Clarke, Christopher
49. Clarke, Jeremy
50. Cleere, Marjory
51. Collinson, Mary and Edward (provided by McFarland, Paulette)
52. Colwell, Deirdre (provided by Fardell MP, Dawn)
53. Conway, Josephine
54. Costello, John
55. Cotter, Carol
56. Cowgill, David
57. Cowie, David
58. Cox, Judith (provided by Allen, Judith)
59. Crawford, the Hon John
60. Crewdson, Gerard
61. Crisp, Denise
62. Crofts, Stuart and Natasha
63. Crowley, Luke
64. Cubbon, Kim and Geoffrey
65. Cunningham, Christine
66. Cuzen, Naomi
67. Davies, Mark
68. De Bussey, Rozlyn
69. De Guio, Anne-Lyse and Fowler, Professor Cathy
70. Dee, Elizabeth
71. Doggett, Charles
72. Donaldson, Tony
73. Doolan, Lynda
74. Eastwood, Joyce
75. Edgar, Jeanette
76. Edmonds, William
77. Edwards, Amanda
78. Eid, Amera
79. Fardell MP, Dawn
80. Farrell, May
81. Fenwick, Kerri
82. Fernandez, Elizabeth
83. Field, Norman
84. Fieldsend, Neil and Yvonne
85. Fisher, Suzanne
86. Foley, Sue
87. Ford, David
88. Ford, Judith and John
89. Fowler, Samantha
90. Francis, Leanne
91. Franklin, Chris and Lyn

92. Fry, Leanne
93. Fuller, Colleen
94. Gam, Maureen (provided by Hodgkinson MP, Katrina)
95. Glen, Sharon
96. Glynn, Christine
97. Goddard, John
98. Grayson, David (provided by Rickuss MP, Ian)
99. Guggisberg, Nick
100. Hamilton, Margaret
101. Hansen, John, Tawa Sandy, Cowan, Angela, Slade, Pettina, Sinclair Jeanette
102. Hapgood, Brett
103. Harwood, Alwin
104. Hayward-Brown, Dr Helen and Nott, Michael
105. Hazell, Kerrie
106. Healy, Associate Professor Karen and Meagher, Professor Gabrielle
107. Helderman, Irene
108. Hellyer, John
109. Heuston, Stan
110. Hiller, Nicholas
111. Hodge, Brian
112. Holborow, Barbara
113. Honey, Kim
114. Hope, Andrew
115. Hughes, Jane
116. Humphries MP, Kevin
117. Humphries, Theresa
118. Hundy, Peter
119. Hutton, Garry
120. Iggleden, Tarlai
121. Ilievski, Lidia
122. Irwin, Michelle
123. James, Dr John and Garvan, Marg
124. Johan, Harley and Smith, Rhonda
125. Johnson, Dee
126. Johnson, Patricia
127. Jones, Jahlia (provided by Fardell MP, Dawn)
128. Joyce, Roger and Karen
129. Jubb, Gavin
130. Kendall, Rod and Robyn
131. Kennedy, Jocelyn
132. Khan, Akmal and O'Donohue, Terry
133. Kiernan, Teresa
134. Kippax, Rod
135. Kirbyshire, Chris
136. Kitching, Lindsay
137. Kozera, Stan
138. La Greca, Gwen
139. Laird, Albert Leo
140. LaMond, Eunice

141. Lee, Kate
142. Lees-Smith, Elizabeth
143. Lewis, John
144. Lloyd, Neridah
145. Lobegeier, Mark and Gillian
146. Lord, Janine
147. Macaulay, Catherine
148. Macpherson, Hilary
149. Madden, Tony
150. Mandeno, Melody
151. Manning, Margaret
152. Marr, Busfield and Lynette
153. Marshall, Gordon
154. Mason, Jan
155. Mathews, Dr Ben
156. Mazlin-Law, Jenni
157. McCarthy, Bernadette and Ray
158. McDonald, Cheryl
159. McDonald, Fiona
160. McFarland Paulette, Beach, Mary Jane and Chilcott, Sandra
161. McFarlane, Abbie
162. McFarlane, Robyn
163. McGuire, Nicole
164. McLennan, Jane
165. McMahan, Jodie
166. McMahan, Julie
167. Millington, John
168. Moore MP, Clover
169. Morgan, Jennifer
170. Morgan, Joy
171. Morgan, Paul
172. Mosley, Raymond and Mechelien
173. Murray, John
174. Muscat, Danielle
175. Musgrave, Carol
176. Nicholson, John
177. Norman, Andrew and Eileen
178. Norman, J
179. Norman, Shauna
180. Nott, Michael
181. O'Donnell, Carol
182. O'Donnell, Tom (provided by O'Farrell MP, Barry)
183. Olive, Leanne
184. Parker, Scott
185. Parker, Wendy
186. Parker-Gallagher, Cynthia
187. Parkinson, Patrick Professor
188. Parry, Sarah
189. Patterson, Andrew

190. Peet, Denise and Cesco, Ray
191. Pemberton, Jan
192. Peters, Vivienne
193. Pettet, Kayleen
194. Phillips, Angelee
195. Philpott, Kenneth Ian
196. Picton, Natasha
197. Pidgeon, Terry
198. Pitney, Ngaia and Paul
199. Podgorczyk, Peter and Lynnette
200. Pollock, Joanna
201. Pottie, James and Jenny
202. Raftery, Garry
203. Rankin, Claire
204. Ratcliffe, Dr Terrence
205. Rayner, Lesley
206. Reicheldt, Lola
207. Reid, Donna
208. Rennie, Maree, Neal, Stuart and Guest Sharon (provided by Rennie, Andrew)
209. Richards, Earl
210. Roberts, Margret
211. Robinson, Alan
212. Robinson, Louise
213. Robinson, Vera
214. Rogan, June
215. Roser, Leonard G
216. Ross, Nicola
217. Rowles, Mark
218. Rowling, David
219. Russell, Suzanne
220. Ryan, Olivia-Mai
221. Sargeson, Bill and Julie
222. Scanlan, Ken
223. Scarborough, Grant and Christina
224. Schultz, Sandy
225. Scott, Greg
226. Scott-Irving, Stewart
227. Seddon, Sarah
228. Seneviratne, Surangani
229. Sentence, Jodi
230. Shaunak, Dr Sunita
231. Sheridan, John and Margaret
232. Sherwood, Yatra
233. Shrayner, Izabella
234. Shumack, Patrick
235. Siddiqui, Jane
236. Singleton, Peter
237. Slatyer, Cheryl
238. Smith, Fred (provided by Stoner MP, Andrew)

239. Smith, Jane
240. Smith, Peter
241. Snell, Leonie
242. Souther, Kim
243. Spielman, Dr Ron
244. Springthorpe, Dr Barry
245. Steen, Jeanette
246. Stevens, Alan
247. Stewart, Keryn and Bourke, Ben
248. Stien, Rhonda
249. Stokoe, Wendy
250. Stone, Marcia
251. Stubbs, Professor Julie and Graycar, Professor Reg
252. Stubbs, Taryn
253. Sullivan, Gloria
254. Sweeney, Paul
255. Sweeting, Emma
256. Szpak, Michele
257. Szymanski, Steffan
258. Szyndler, Dr Janina
259. Tasker, Chris
260. Taylor, Wanda (provided by Hodgkinson MP, Katrina)
261. Tedd, Catherine
262. Tester, Sherree
263. The Bloggerator
264. Tilly, Julie
265. Todd, Ray
266. Travers, Wendy
267. Trevaskis, Mark
268. Tucker, Heather
269. Turner, Judy
270. van der Veer, Elisabeth
271. Van Gorp, Sean
272. Vimpani, Professor Graham
273. Waddington, John and Dianne
274. Wagstaff, Patricia
275. Walker OAM, Patricia
276. Watts, Jon Richard
277. Wilder, Christine
278. Willetts, Jeffrey
279. Williams, John Stewart
280. Wilton, Jim
281. Witten, Bryan
282. Wooden, Alison
283. Worley, Tracy
284. Youngs, Robin

Appendix 6 Meetings

The Inquiry met with senior representatives from the following Government agencies:

Australian Crime Commission, National Indigenous Violence and Child Abuse Intelligence Task Force (Commonwealth)

Australian Institute of Family Studies (Commonwealth)

Children's Court Clinic

Children's Court NSW

Children's Guardian

Department of Families, Housing, Community Services and Indigenous Affairs (Commonwealth)

Family Court of Australia (including the Honourable Justice Robert Benjamin)

Legal Aid NSW

Ministerial Advisory Committee, Aboriginal child sexual assault task force

NSW Commission for Children and Young People

NSW Department of Aboriginal Affairs

NSW Department of Ageing, Disability and Home Care

NSW Department of Education and Training

NSW Department of Health

NSW Department of Housing

NSW Department of Juvenile Justice

NSW Ministry for Police

NSW Ombudsman

NSW Police Force

NSW Privacy Commissioner

South Eastern Sydney and Illawarra Area Health Service

Sydney Children's Hospital

The Children's Hospital at Westmead

The Inquiry met with senior representatives from the following non-government agencies and other organisations:

Aboriginal Child, Family and Community Care Secretariat

Aboriginal Legal Service (NSW/ACT)

Anglicare Diocese of Sydney

Association of Children's Welfare Agencies

Australian Medical Association (NSW)
Barnardos
Catholic Social Services (NSW/ACT)
Centre for Excellence in Child and Family Welfare (Vic)
Council of Social Services of NSW
Foster Care Association (NSW)
Foster Parents Support Network
Law Society of NSW
Life Without Barriers
NSW Family Services Inc
NSW Primary Schools Principals' Association
Public Schools Principals' Forum
Public Service Association of NSW
Royal Australian and New Zealand College of Psychiatrists (NSW Branch)
Tharawal Aboriginal Corporation
The Benevolent Society
The NSW Secondary Principals' Council
UnitingCare Burnside
Youth Off The Streets

The Inquiry met with the following academics, individuals and groups

Ainslie-Wallace, Her Honour Judge Ann (District Court)
Ainsworth, Dr Frank; Ramjan, Barbara; Foley, Sue (Guardians ad litem)
Brodie, Professor Pat; Homer, Professor Caroline; Everitt, Louise; Smith, Rachel; Minnis, Jeannie (Midwives)
Cashmore, Associate Professor Dr Judy
Crawford, John (former Children's Court Magistrate)
Daniel, Professor Brigid
Dewdney, Micheline
Faulks, John (Deputy Chief Justice, Family Court of Australia)
Freitag, Dr Raelene
Graycar, Professor Reg and Stubbs, Professor Julie
Holborow, Barbara (former Children's Court Magistrate)
Katz, Professor Ilan and Sullivan, Carol

Limbury, Alan (lawyer specialising in Alternative Dispute Resolution)

McLachlan, Robert; Nasti, Sam; Robertson, Laurie; Braine, Peter; Clarke, Ross;
Renshall Kathryn (Lawyers specialising in Children's Law)

Morgan, Paul

Munro, Dr Eileen

Parkinson, Professor Patrick

Scott, Professor Dorothy

Spielman, Dr Ron

Symonds, The Honourable Ann

Young consultants from the CREATE Foundation

Appendix 7 Public Forums in Sydney - panel representatives

Mandatory reporting - 15 February 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Helen Freeland	Executive Director, Helpline
NSW Police Force	Det Sup Helen Begg	Detective Superintendent, Child Protection and Sex Crime Squad
Department of Health	Professor Debora Picone AM	Director-General
Department of Education and Training	Mr Michael Coutts-Trotter	Director-General
Department of Housing	Ms Melissa Gibson	Director, Housing Policy and Partnerships
Department of Ageing, Disability and Home Care	Ms Carol Mills	Deputy Director-General, Development, Grants and Ageing
Association of Independent Schools of NSW	Mr Graham Wilson	Director, Compliance
Public Schools Principals' Forum	Mr Brian Chudleigh	Deputy Chairperson
Sydney Children's Hospital	Dr Dimitra Tzioumi	Director, Child Protection
Children's Hospital at Westmead	Mr Mark Palmer	Senior Clinician, Team Leader, Child Protection Unit
Australian Medical Association (NSW) Ltd	Dr Michael Gliksman	Chairman, NSW Council
University of Sydney	Dr Judy Cashmore	Research Academic

Role of courts – 22 February 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Mr Roderick Best	Director, Legal Services
NSW Police Force	Sup Anthony Tritcher	Superintendent, Court and Legal Services
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
Legal Aid NSW	Ms Deborah de Fina	Solicitor in Charge, Care and Protection Legal Service
Aboriginal Legal Service (NSW/ACT)	Ms Angela Jones	Consultant, Children's Care and Protection Law
Attorney General's Department	Mr Michael Talbot	Assistant Director-General, Court and Tribunal Services
NSW Ombudsman	Mr Steve Kinmond	Deputy Ombudsman, Community Services Division
Children's Court NSW	Her Honour Helen Syme	Deputy Chief Magistrate
Administrative Decisions Tribunal	Ms Anne Britton	Deputy President, Head of Community Services Division

Out-of-home care – 29 February 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Annette Gallard Dr Gül Izmir	Deputy Director-General, Operations Deputy Director-General, Service System Development
Department of Ageing, Disability and Home Care	Mr Brendan O'Reilly Ms Carol Mills	Director-General Deputy Director-General, Development, Grants and Ageing
Department of Health	Ms Cathrine Lynch	Acting Director, Primary Health and Community Partnerships
Children's Guardian	Ms Kerryn Boland	Children's Guardian
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
UnitingCare Burnside	Mr Paul Drielsma	Director, Development
Aboriginal Child, Family and Community Care State Secretariat	Mr Bill Pritchard	Executive Officer
Wesley Community Services	Ms Theresa Burgheim	Manager, Out-of-Home-Care Systems
Centacare Catholic Community Services	Ms Maureen Eagles	Director, Children and Youth Services
Life Without Barriers	Mr Ray Dunn	Chief Executive Officer
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer
CREATE Foundation	Ms Daryn Elston-Smith	Regional Coordinator
Foster Care Association NSW Inc	Ms Mary Jane Beach	President
Foster Parents Support Network	Ms Sue O'Connor	President
University of Sydney	Dr Judy Cashmore	Research Academic

Oversight agencies – 28 March 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Jennifer Mason Ms Donna Rygate	Director-General Deputy Director-General, Strategy, Communication and Governance
Children's Guardian	Ms Kerryn Boland	Children's Guardian
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
NSW Ombudsman	Mr Steve Kinmond Ms Anne Barwick	Deputy Ombudsman, Community Services Division Assistant Ombudsman, Children and Young People
State Coroner's Court	Mr John Merrick	Manager, Coronial Information and Support Program
Department of Premier and Cabinet	Mr Philip Berry Mr Anthony Lean	Policy Manager, Human Services and Justice Branch Policy Manager, Legal Branch
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer

Interagency cooperation - 4 April 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Jennifer Mason Ms Annette Gallard	Director-General Deputy Director-General, Operations
NSW Police Force	Det Sup Helen Begg	Detective Superintendent, Child Protection and Sex Crime Squad
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Education and Training	Ms Robyn McKerihan	General Manager, Access and Equity
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
Department of Juvenile Justice	Mr Peter Muir	Deputy Director-General, Operations
Department of Ageing, Disability and Home Care	Mr Brendan O'Reilly	Director-General
Attorney General's Department	Ms Natasha Mann	Policy Manager, Legislation Policy and Criminal Law Review Division
Association of Children's Welfare Agencies	Mr Andrew McCallum	Chief Executive Officer
Department of Premier and Cabinet	Ms Vicki D'Adam	Assistant Director-General, Policy

Health and disability – 11 April 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Annette Gallard	Deputy Director-General, Operations
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Ageing, Disability and Home Care	Ms Carolyn Burlew Ms Lauren Murray	Deputy Director-General, Service Development Executive Director, Community Access
Westmead Children's Hospital	Ms Martine Simmons	Senior Social Worker, Brain Injury Service, Department of Rehabilitation
Sydney Children's Hospital	Dr Vivian Bayl	Developmental Paediatrician, Tumbatin Clinic
Department of Education and Training	Mr Brian Smyth King	Director, Disability Programs
Royal Australian and New Zealand College of Psychiatrists	Dr Michael Bowden Dr Josey Anderson	Chair, Faculty of Child and Adolescent Psychiatry Executive, Faculty of Child and Adolescent Psychiatry
Life Without Barriers	Mr Ray Dunn	Chief Executive Officer
Hunter Children's Health Network	Professor Graham Vimpani AM	Clinical Chair
Royal Australasian College of Physicians	Dr Jacqueline Small	Fellow, Paediatrics and Child's Health Division
People with Disability Australia Inc	Ms Therese Sands	Co-Chief Executive Officer
Royal Far West Children's Health Scheme	Dr Shola Faniran	Clinical Director, Children's Services

Assessment model and process – 18 April 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Annette Gallard Ms Helen Freeland	Deputy Director-General, Operations Executive Director, Helpline
Department of Health	Ms Cathrine Lynch	Director, Primary Health and Community Partnerships Branch
NSW Police Force	Assistant Commissioner Dave Hudson	State Crime Commander
Barnardos Australia	Ms Rosemary Hamill	Senior Manager, Barnardos Auburn Centre
The Benevolent Society	Ms Jenni Hutchins	Senior Manager
Commission for Children and Young People	Ms Gillian Calvert	Commissioner for Children and Young People
University of Sydney	Professor Julie Stubbs	Deputy Director, Institute of Criminology
Department of Premier and Cabinet	Ms Vicki D'Adam	Assistant Director-General, Policy
Australian Institute of Family Studies	Dr Leah Bromfield	Manager, National Child Protection Clearinghouse

Aboriginal communities – 24 April 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Linda Mallett Ms Anne-Maree Sabellico	Acting Deputy Director-General, Service System Development Acting Executive Director, Operations Development
Department of Aboriginal Affairs	Ms Jody Broun	Director-General
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
NSW Police Force	Assistant Commissioner Dave Hudson	State Crime Commander
Aboriginal Child, Family and Community Care State Secretariat	Ms Amanda Bridge	Chairperson
Aboriginal Legal Services	Mr John McKenzie Ms Angela Jones	Chief Legal Officer Consultant, Children's Care and Protection Law
Secretariat of National Aboriginal and Islander Child Care	Mr Julian Pocock	Executive Officer
NSW Aboriginal Justice Advisory Council	Mr Terry Chenery	Executive Officer
Attorney General's Department	Mr Brendan Thomas	Assistant Director-General, Crime Prevention and Community Programs
UnitingCare Burnside	Ms Servena McIntyre Mr Reg Humphreys	Coordinator, Children's Services, Orana Far West Manager, Orana Far West

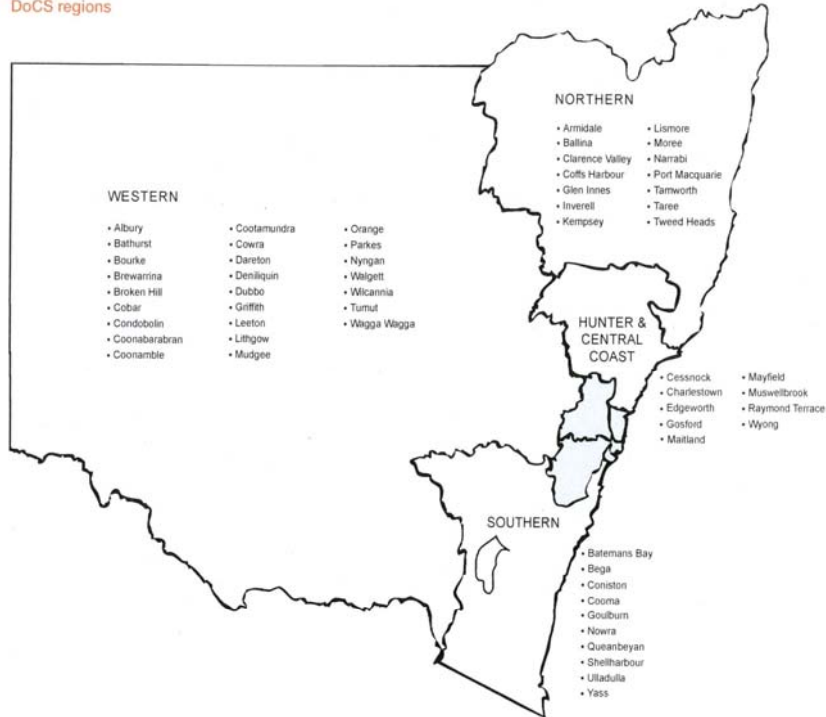
Early intervention – 16 May 2008

<i>Agency</i>	<i>Representative</i>	<i>Title</i>
Department of Community Services	Ms Linda Mallet	Acting Deputy Director-General, Service System Development
Department of Ageing, Disability and Home Care	Ms Carolyn Burlew	Deputy Director-General, Service Development
	Ms Lauren Murray	Executive Director, Community Access
Department of Health	Dr Richard Matthews	Deputy Director-General, Strategic Development
Department of Education	Mr David McKie	Director Student Welfare
Barnardos Australia	Ms Louise Voigt	Chief Executive Officer and Director of Welfare
UnitingCare Burnside	Ms Jane Woodruff	Chief Executive Officer
	Ms Linda Mondy	Director Operations, Western Sydney
NSW Family Services Inc	Ms Sue Richards	Chief Executive Officer
Wesley Dalmar	Mr Peter O'Brien	Operations Manager, Family Services
Mission Australia	Ms Helen Lunn	Operations Manager, Child, Family and Migrant Services
The Benevolent Society	Ms Maree Walk	General Manager, Operations
Uniting Church in Australia	Ms Meg Herbert	Associate Secretary
Hunter Children's Health Network	Professor Graham Vimpani AM	Clinical Chair
University of NSW	Professor Ilan Katz	Director, Social Policy Research Centre
Macquarie University	Professor Jennifer Bowes	Director, Children and Families Research Centre, Institute of Early Childhood
SDN Children's Services Inc	Ms Julie Druce	Director, Early Intervention, Family Support

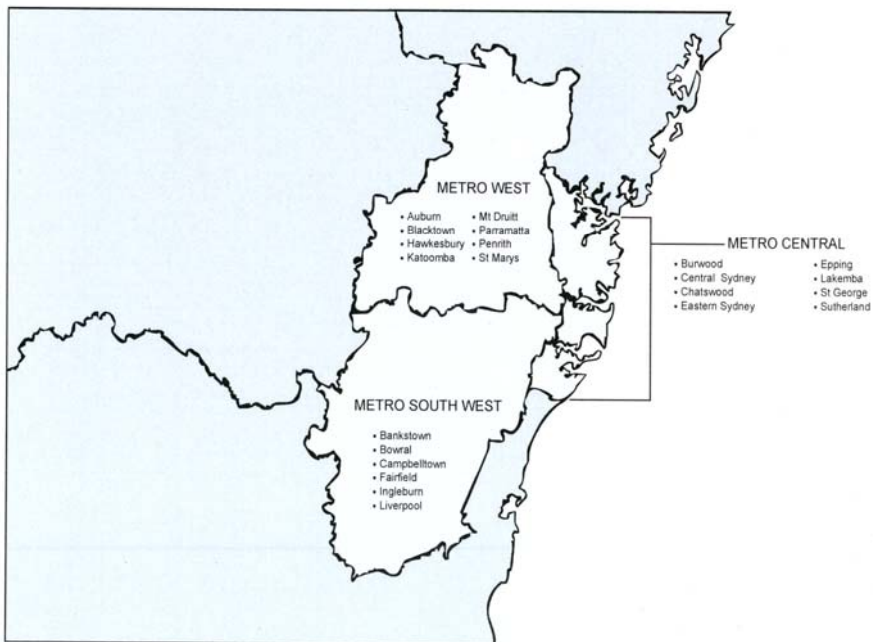
Appendix 8 DoCS CSCs

Directory of DoCS Offices

DoCS regions



DoCS metropolitan regions



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Australian Institute of Family Studies: www.aifs.gov.au

Australian Institute of Health and Welfare: www.aihw.gov.au

Australian Research Alliance for Children and Youth: www.aracy.org.au

Children's Guardian: www.kidsguardian.nsw.gov.au

Commission for Children and Young people: www.kids.nsw.gov.au

CREATE Foundation: www.create.org.au

Department of Families, Housing, Community Services and Indigenous Affairs: www.facs.gov.au

DoCS: www.community.nsw.gov.au

National Child Protection Clearinghouse: www.aifs.gov.au

National Drug and Alcohol Research Centre: ndarc.med.unsw.edu.au

NSW Ombudsman: www.ombo.nsw.gov.au

Secretariat of National Aboriginal and Islander Child Care: www.snaicc.asn.au

