



# Child Protection Systems Royal Commission Report

Volume 1: Summary and Report

August 2016

The life they  
deserve

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# The life they deserve

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## **CHILD PROTECTION SYSTEMS ROYAL COMMISSION REPORT VOLUME 1: SUMMARY AND REPORT**

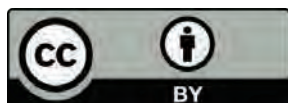
**The Hon Margaret Nyland AM  
Commissioner**

August 2016

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ISBN 978-0-9942693-0-0 (hardback)  
978-0-9942693-1-7 (paperback)  
978-0-9942693-2-4 (online resource)

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**Suggested attribution:**

Child Protection Systems Royal Commission, *The life they deserve: Child Protection Systems Royal Commission Report, Volume 1: Summary and Report*, Government of South Australia, 2016.

**Suggested attribution for set (Volumes 1 and 2):**

Child Protection Systems Royal Commission, *The life they deserve: Child Protection Systems Royal Commission Report*, Government of South Australia, 2016.

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## Child Protection Systems Royal Commission

5 August 2016

His Excellency the Honourable Hieu Van Le AO  
Governor of South Australia  
Government House  
ADELAIDE SA 5000

Your Excellency

On 15 August 2014 I was invested with the powers of a Royal Commissioner in respect of an inquiry into the adequacy of existing laws and policies relevant to South Australia's child protection system for children at risk of harm, and improvements that could be made to existing laws, policies and allocation of resources, as well as the practices and procedures of Families SA and other agencies. I now have the honour to present the report of my inquiry into these matters, which consists of two volumes:

- Volume 1: This volume contains details of the work undertaken by the Commission in the course of this inquiry, an analysis of system deficits and recommendations for improvements to the child protection system in this state.
- Volume 2: This volume comprises a summary of five case studies undertaken by the Commission to examine system operation and practice quality in specific areas. Evidence given in these studies informed the recommendations in Volume 1.

I feel privileged to have been entrusted with this task and I hope that the report will lead to a better future for the vulnerable children and young people of South Australia.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Margaret Nyland'.

**The Hon Margaret Nyland AM**  
Commissioner



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## PREFACE

The activities of Shannon McCoolle were the catalyst for establishing this Commission. However, this inquiry was not just about McCoolle. Substantial community disquiet and adverse publicity had surrounded Families SA, and the child protection system generally, for some time before McCoolle's arrest. The Terms of Reference for this Commission thus required me to conduct a thorough examination of the child protection system in this state, with provision for a supplementary report on McCoolle, should his legal proceedings be protracted.

The problems besetting Families SA and the child protection system proved to be far greater than anyone had initially envisaged. McCoolle's ongoing criminal investigation and prosecution indicated that his activities were likely to be relevant to other issues being examined by the Commission. I therefore considered it undesirable and unrealistic to treat his case as a discrete matter, and the subject of a separate report. The Government of South Australia granted an extension for the Commission to prepare a comprehensive and integrated report on all matters, including McCoolle, and present it by 5 August 2016.

The investigation of McCoolle occupied several months, including taking evidence from 76 witnesses and examining more than 4000 pages of written documentation. As anticipated, the evidence proved highly relevant to many issues raised by the Terms of Reference and supported my decision to defer the report until that matter was concluded.

We were faced with many challenges in producing this report. Of concern was the continuation of a number of issues that had been the subject of recommendations from the Layton Review of Child Protection in South Australia and the Mullighan Children in State Care Commission of Inquiry. However, the greatest challenge was trying to find a way to fix a system in disarray. From the outset of this Commission it was obvious that workers undertaking the difficult business of child protection felt undervalued, under-resourced and overwhelmed by a system which lacked the capacity to respond appropriately to children in need of care and protection. At the same time, I was impressed by the enormous goodwill and enthusiasm for change demonstrated by the many workers and other people who came forward and shared with me their concerns, thoughts and suggestions about creating a better system for the vulnerable children and young people of our community.

Regrettably, there is no quick fix to the many problems of the child protection system in this state. Some matters require urgent attention, such as the issues surrounding children in residential care, some matters need to be the subject of ongoing discussion and debate, and some matters require long-term planning.

In conducting this Commission, I have done the best I can to ensure that the report's recommendations are fully informed by relevant sources of information, knowledge and expertise, and that they have a sound evidentiary base.

The substantial reform needed for the child protection system was considered unattainable if Families SA continued to be part of the larger Department for Education and Child Development. The Agency needed to make a fresh start, which would best be accomplished by establishing Families SA as a department in its own right. I made that recommendation in advance of this report, which the government accepted, to enable planning to begin for the organisational changes necessary for this major reform.



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I hope that this new child protection department with a refreshed leadership will establish a much improved system to keep children safe from harm, and restore public confidence. I trust it will include early support and assistance for families struggling to care for their children, to keep those children out of the child protection system.

When things go wrong, it is tempting to lay all the blame on the statutory agency. However, child protection is everyone's business. The new agency cannot operate in isolation. It should coordinate and collaborate with all other relevant departments and organisations, both government and non-government, to give children better outcomes. It must also be proactive and engage the community to play its part in developing programs and systems that ensure all children have the best chance possible to be safe and develop to their full potential.

**The Hon Margaret Nyland AM**

Commissioner

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## ACKNOWLEDGEMENTS

The extensive work undertaken by this inquiry was only made possible by the efforts of all those who worked for the Commission throughout the inquiry. Emily Telfer, as Counsel Assisting, together with her dedicated and hard-working legal team, worked long hours often into the night and on many weekends to bring this report to fruition. Angel Williams, the Director of the Commission office, capably managed and attended to all administrative matters and I thank her for that. I am particularly grateful to my Personal Assistant, Jackie O'Brien, who coped with my constant tweaking of the many drafts that preceded the production of this report and provided me with ongoing personal support throughout this Commission. I thank all employees of the Commission for their hard work and the support they provided to me in undertaking this task.

Although most of the metropolitan hearings were conducted in the hearing room at the Commission's premises, that room was inadequate for some of the more formal hearings. I acknowledge and thank Chief Justice Kourakis and Chief Judge Muecke and Judges of the Supreme and District Courts for permitting the Commission to use the courtrooms and facilities in the Supreme Court and Sir Samuel Way buildings for those hearings. The Commission also recognises the assistance provided by Judge Roder and Phil Hocking, Executive Director and Principal Registrar, Higher Courts, Courts Administration Authority of South Australia, for making the necessary arrangements with respect to those courtrooms.

I also acknowledge and thank the registrars of the Mount Gambier and Port Augusta courts for facilitating the Commission's use of rooms in their respective court complexes for hearings. I also express my gratitude to the sheriff's officers and reporters of the Courts Administration Authority for their assistance in court during the McCoole hearing.

I would also like to acknowledge the support provided by the Chief Executive and staff of the Attorney-General's Department.

As will be evident from the description of the evidence-gathering processes described in this report, the Commission issued a large number of summons requiring the production of documents and data from various government and non-government organisations. I acknowledge the cooperation of the various organisations who provided information sought in that way.

Staff at the Crown Solicitor's Office, acting on behalf of various government agencies, worked tirelessly to ensure documents were provided to the Commission promptly.

I would also like to acknowledge and thank all those people, including past and present employees of Families SA, who came forward to share their thoughts and suggestions with us as to improvements that could be made to the child protection system in this state.

**The Hon Margaret Nyland AM**

Commissioner



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## TERMS OF REFERENCE

By Letters Patent dated 15 August 2014, His Excellency Rear Admiral The Honourable Kevin John Scarce AC, DSC and Governor in and over the State of South Australia, invested Margaret Jean Nyland with the powers of a Royal Commissioner.

The Terms of Reference require the Commissioner to inquire and provide a report on the following matters:

- 1 The adequacy of existing laws and policies relevant to the State's child protection system for children at risk of harm.
- 2 Improvements that may be made to existing laws, policies, structures and allocation of resources relevant to the State's child protection system for children at risk of harm.
- 3 The adequacy of existing practices and procedures adopted by Families SA and other relevant agencies, including entities licenced by the Minister, in implementing the State's child protection system for children at risk of harm.
- 4 Improvements that may be made to the practices and procedures of Families SA and other relevant agencies, including entities licenced by the Minister, to provide for the best practical and financially achievable implementation of the State's child protection system for children at risk of harm.
- 5 The inquiry into the above matters should include consideration of, but is not limited to, the following matters:
  - a The means by which a child who may be at risk of harm is brought to the attention of relevant authorities.
  - b The assessment, by relevant authorities, as to whether a child is at risk of harm.
  - c The assessment, by relevant authorities, about whether to remove, or not to remove, a child from the custody and care of their guardians and to place the child in the custody and/or under the guardianship of the Minister.
  - d Whether the environment into which a child is placed, either on a short-term or long-term basis, is safe.
  - e The assessment, by relevant authorities, of persons who work and volunteer with children in the custody and/or under the guardianship of the Minister.
  - f Management, training, supervision and ongoing oversight of persons who work and volunteer with children in the custody and/or under the guardianship of the Minister.
  - g The reporting of, investigation of and handling of complaints about care concerns, abuse or neglect of children cared for in the custody and/or under the guardianship of the Minister.
  - h The staffing of the State's child protection system to ensure the safety of children at risk of harm.

On 16 July 2015 and 11 February 2016 respectively, additional instruments were issued amending the requirement for the Commission to report on a specific date. The final instrument required the Commission to present its report to the Governor on 5 August 2016.



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## SUMMARY

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### OVERVIEW

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**Many children in the care of the state have been abused and neglected, not only by their families but by the system that was supposed to protect them. It is time for that to change. It is time for all of us to work together to give all our children the life they deserve.**

The child protection system in South Australia involves numerous government and non-government agencies who should work together to improve the state's capacity to protect children. At the heart of the system is the statutory agency, Families SA, which has recently been the subject of a great deal of complaint and dissatisfaction. The heavy focus of this report on reforms to the statutory agency should not be taken as implying that the Agency alone is responsible for the safety of children. For sustainable improvements to the quality of life for children at risk of harm, changes are required well beyond statutory functions at both a government and community level.

The Commission adopted a liberal approach to interpreting its Terms of Reference and conducted a wide-ranging inquiry into the child protection system. Determination of what amounted to a risk of harm was not limited to questions of physical or sexual safety, but was taken to include such matters as emotional, social and educational development. In addition, the Commission examined ways to keep children safe in their environments, such as rotational care and home-based care, and considered the circumstances of children with diverse needs, such as children with disabilities and those in regional or remote locations. The Commission also had regard to preventative and early intervention strategies to keep children and their families out of the child protection system.

This Inquiry reveals a system overwhelmed by the volume and complexity of work, with notifications received every day relating to children living in dire circumstances who desperately need someone to take action on their behalf. In many cases the response comes so late that there is little choice to do anything other than to remove the child from their family.

When this happens it is not always possible to find an alternative care placement that meets their needs. Too many children languish in unsatisfactory rotational care situations (including emergency care) for long periods. As reliance on rotational forms of care has grown in this state, the costs of alternative care have grown to soak up more than 70 per cent of the overall child protection budget. This leaves little to invest in prevention and early intervention strategies to stop children entering the child protection system in the first place.

The reforms recommended in this report will not completely fix the system. Child protection is not a problem with an easily identifiable 'fix' or an end point at which the problem can be assessed as solved. The best that can be hoped for is that the proposed reforms *improve* the system and mark the start of a process of continuous evaluation and improvement.

The Commission's investigations reveal deficiencies across many parts of the child protection system. Under-investment over many years has hindered much service provision. Efforts to grapple with increasingly complex problems with increasingly limited resources have not worked.

The system itself is based on an outdated model constructed many years ago to respond to specific incidents of child maltreatment that were thought to be isolated and rare. The understanding of child abuse and neglect is now more sophisticated, and simply investigating and responding to specific incidents is no longer adequate.

The child protection system in this state (and in other jurisdictions) has developed with little reliance on understanding and developing the evidence base for interventions and strategies. Other professional disciplines, such as medicine, intervene only after an evidence base is established and the interventions are consistently evaluated. In child protection practice, this approach is less common. It is difficult to know whether the interventions offered are good value for the investment, in the sense that they are making a real difference to outcomes for children and their families.

Similarly lacking is investment in growing the knowledge base of the workforce tasked with managing this complex work. The gap between the complexity of the task, and the resources and skills of the Agency required to manage it, has been filled with innumerable policies and processes in an attempt to bring structure and certainty to the work. However, this array of 'guidance' has made little impact on the quality of the work. One of the most striking observations made by the Commission is the yawning gap between policy requirements and day-to-day practice in many areas.

## Recurring themes

The recurring themes identified in the course of the Inquiry have informed the Commission's consideration of recommendations for reform across each aspect of the system:

- investing in growing skills and expertise across the child protection workforce, in the Agency, other government departments and the not-for-profit sector;
- relying on professional skills and judgement in decision making more than compliance with processes;
- reforming the Agency's leadership and structures to build an environment where professional knowledge and skill are valued, nurtured and retained;
- investing more in prevention and early intervention for vulnerable families outside the statutory agency, including greater reliance on the not-for-profit sector to deliver and coordinate services;
- growing the evidence base about the services families need, where they need them, and which services are most likely to work, and using this data systematically to plan services statewide;
- emphasising stability and certainty for children who come into the statutory system;
- investing in the out-of-home care sector to ensure that children who can no longer live at home are given stable, nurturing placements appropriately matched to their needs, including therapeutic care to heal past trauma;
- respecting and valuing foster parents and kinship carers;
- improving scrutiny of adults who care for children in out-of-home care placements, whether as foster parents, kinship carers or employees caring for children in rotational care;
- using data to track the quality of care that the state is delivering to children in out-of-home care;
- improving communication between the Agency and other organisations that provide services to children, and within the Agency;
- increasing the influence of independent voices in critical decision making in the Agency, to improve transparency of decision making;
- understanding and prioritising the experiences of children who are at risk of abuse and neglect, who come into the statutory system; and
- increasing the profile of children's opinions, experiences, wellbeing and development across the child protection system and the state more broadly.

The temptation to impose additional layers of policy and process to achieve sustainable change should be resisted. System change does not come from imposing more regulation on *how* the work is to be done; it comes from a greater investment in growing the knowledge base of workers, both at a planning and service delivery level.

If improvements are to be effected to the child protection system, relevant government and non-government departments and agencies also need to play their part in supporting families outside the statutory system. This report emphasises the importance of cooperation and collaboration between all parties and suggests some strategies to achieve that result.

A fundamental shift is required for the system to hear and understand the experiences of children. Too often the Commission heard stories of children whose needs were left unmet because attention focused on what the adults needed and wanted, at the expense of the experiences of the child. Keeping children safe relies on adults listening to them, understanding what they have to say and prioritising their experiences.

The large number of reports, inquests and inquiries on the topic of child protection over the years is testament to the persistence of the problem, in this

state and elsewhere. The Report of the Review of Child Protection in South Australia (Layton Review) in 2003 made a comprehensive series of recommendations for a complete overhaul of the system to keep children safe. Five years later the Children in State Care Commission of Inquiry (CISC Inquiry) focused attention on the experiences of children who had been sexually abused or who died as a result of criminal conduct in state care. The Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry which followed focused on issues relating to Aboriginal children on the Lands.

Each of these reports made important recommendations designed to improve the safety of children in this state. Notwithstanding those recommendations, the child protection system remains ill-equipped to respond to the needs of many children who are at risk in the community, and in out-of-home care.



## SUMMARY

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### CHALLENGES FOR THE AGENCY AND THE WORKFORCE

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The Commission received the strong message that morale within the Agency was at the lowest it had been for many years. There was a sense that professionalism and knowledge were not valued in the organisation. Efficient and effective case management was being thwarted by the tight holding of operational decision making within a small group of managers and executives who were distanced from the workers in the field and from the children about whom the decisions were being made. The capacity of front-line workers did not appear to be trusted and a culture of micromanagement was undermining the development of professional skill. The operational orientation of senior staff, including executives, was inhibiting the Agency's capacity to engage in strategic thinking and planning in the medium and long term.

Workers were burdened with a multitude of policies, processes and administrative requirements which had accumulated over time without being rationalised. These policies had come to replace professional practice with process compliance and had diverted the focus from making good decisions for the benefit of children to making decisions that minimised the risk for the Agency.

### A NEW DEPARTMENT

It is clear that the Agency needs to make a fresh start. The Commission considered whether the reforms recommended in this report could be achieved if the Agency continued to be part of the Department for Education and Child Development. It concluded that a new independent department should be established with child protection as its primary focus. As this was a major reform, an interim recommendation was made, and accepted by the government, to establish the new department to enable the government to start planning the necessary organisational change in advance of the other reforms set out in this report.

The new Agency requires a refreshed leadership, including a chief executive with established professional credibility in the area, capable of leading by example. The Agency should invest in a high profile professional development and learning unit that can build the capacity of the workforce. It should also have a dedicated data collection and research division to collect, extract and analyse data to monitor the quality of its own services, and the services it commissions. The Agency's case management system (commonly called C3MS) was the subject of critical comment throughout the Inquiry. That system is in need of improvement and should be reviewed to ensure that it can support data collection in the new department, and if, indeed, it is viable in the long term.

### INVESTING IN THE WORKFORCE

The workforce that carries the child protection system has been neglected for far too long. The Agency's human resource capacity is crying out for significant investment, as is the capacity to track and plan for its workforce. No overarching workforce plan addresses the challenges of recruitment and retention in either the medium or long term. Recruitment strategies are crisis driven.

Specific attention is needed on developing robust processes to track vacancies, planning the workforce (including recruitment and retention strategies), and creating and retaining complete sets of employee records. Specific measures are needed to counteract the high turnover of staff, and the consequent loss of knowledge, skill and relationships.

Workforce planning should be guided by the overarching principle that child protection is complex work requiring appropriately qualified staff. The professional base of the child protection workforce could be expanded by employing professionally qualified staff from disciplines other than social work, but case management in child protection should be reserved for staff who have relevant tertiary qualifications and appropriate experience.

The Agency has a role to play in leading cross-sector education and training. There are many advantages to closer relationships between the Agency and the not-for-profit sector, as well as tertiary training institutions. Joint training promotes economies of scale as well as important collaborative relationships. The Agency should lead workforce planning and development across the sector. The Commission recommends improvements to support the professional development of staff, which include a professional development reimbursement program modelled on that operating in SA Health.

### CHILDREN AT RISK IN THE COMMUNITY

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The current system for notification of children at risk relies on the Agency's call centre as the single entry point to receive, assess and funnel notifications for a response. The Agency is currently overwhelmed by the number and complexity of notifications, and only the most serious and critical cases receive a response. In 2014/15 a staggering 61 per cent of notifications assessed as requiring a response were closed with no action, because of more urgent priorities. Notifiers who have contact with children become frustrated because they see no evidence of action and notify again.

Evidence to the Commission indicated the existence of a large cohort of children who are the subject of notifications and need assistance, but do not receive a response until their situation is critical.

A strong and consistent theme in submissions and in evidence was the need to place more emphasis on services that *prevent* children from being harmed, or that respond early, when there is a greater possibility for issues to be successfully resolved.

### **EARLY INTERVENTION RESEARCH DIRECTORATE**

Preventative and early intervention services need to substantially grow to respond to families before their circumstances become untenable. Services that help families to safely care for children should be delivered by a variety of government departments and non-government organisations funded by the government. Services in this category would not be delivered by the Agency, which must focus its work on meeting its statutory mandate. Cases in which the Agency currently delivers some prevention and early intervention services should be devolved to the not-for-profit sector.

Any service that the government provides or invests in should be good value for money. The Commission therefore proposes the establishment of a cross-departmental Early Intervention Research Directorate (EIRD). That directorate would be responsible for creating and coordinating a five-yearly whole of government prevention and early intervention strategy. This strategy would guide funding priorities and enable greater coordination of services in each local area. Only services identified in the strategy should be pursued. The first step for EIRD would be a comprehensive mapping of all services currently available across the state.

Immediate funding priorities should include services to families in the prenatal period, services for young and first-time parents, and targeted services for care leavers who become parents.

EIRD should also be tasked with evaluating innovative service models in operation in other jurisdictions to ascertain their suitability for South Australia. EIRD should require evidence-based evaluations, or clear program principles with a framework for future evaluation, as a condition of program funding.

### **A DUAL PATHWAY SYSTEM**

Additional services will make no difference to children's lives unless they appropriately match family needs and are delivered in accessible ways.

A number of models in Australia provide 'dual pathway' mechanisms which allow families to be referred to services as opposed to being the subject of a report to the relevant statutory agency. Such a dual pathway program should be developed in South Australia to divert appropriate families from the statutory system.

### **CHILD AND FAMILY ASSESSMENT NETWORKS**

Child and family assessment and referral networks should be established in each metropolitan region, and in the largest country centres (Mount Gambier and Port Augusta or Whyalla). These networks would rely on a lead not-for-profit organisation in partnership with the Agency receiving reports from notifiers and coordinating service responses. Legislative amendments would be required to enable notifiers to satisfy their mandatory reporting obligations by referring families, where appropriate, to such networks rather than making a report to the call centre. These networks should also be tasked with preparing an annual local area needs assessment which would report to EIRD to inform funding decisions for services in that area.

### **CHILD WELLBEING PRACTITIONERS AND CHILD WELLBEING ASSISTANTS**

Two other strategies would encourage government staff to consider making a referral to a network rather than a report to the Families SA Call Centre. Child wellbeing practitioners are now employed in Education sites to help educators understand and clarify child protection issues and in particular whether an identified problem should be the subject of a mandatory report. This important initiative is strongly supported. It should also be permissible for educators to satisfy their mandatory reporting obligations by making a report to a child wellbeing practitioner at the school.

In addition, government agencies should train some of their existing staff to act as child wellbeing assistants, equipped to guide their colleagues on options that might be available to support vulnerable families. A report to a child wellbeing assistant would not be a substitute for making a mandatory report but should help prospective notifiers better understand how to deal with the problem and determine the appropriate pathway.

### **CHILD ABUSE REPORT LINE**

The Child Abuse Report Line (CARL) is the subject of constant complaint, primarily due to the unreasonably long waiting times imposed on people who are trying to make a report about a child protection matter.

Implementation of a referral pathway should reduce the demand on the statutory agency and early intervention services should, over time, limit the cycle of notification and re-notification.

There is a perception that some of the overload of work at CARL is due to unnecessary reports. This in part is attributed to notifiers reporting any sort of concern to avoid the possibility of a breach of their mandatory obligations without proper regard to the nature of the problem and whether the matter should be the subject of a mandatory report.

## SUMMARY

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That does happen on occasion, but the examination of files by the Commission did not disclose this to be a significant issue. To the contrary, many notifications screened out as not warranting a response revealed children left in unacceptable circumstances in which they needed help.

The Commission is also not persuaded that legislative change would necessarily modify notifier behaviour. Therefore, no change is proposed in mandatory notification duty. However, some categories of mandatory notifiers should be obliged by law to attend regular training to ensure that key messages about notifiers' responsibilities are heard and understood. A mandatory notifiers' guide should be prepared to complement this additional training.

Notifiers should also be advised of the Agency's intended response. Knowing whether the Agency will or will not respond to a notification helps a notifier to decide what, if any, action they may need to take.

The long waiting times suffered by notifiers calling CARL are unacceptable. The Commission understands there is a call-back feature currently available at CARL, which should be activated. Callers then have a choice to wait on hold, or to receive a call back when their position in the queue is reached. Workloads and staffing levels should be reviewed to achieve the following service benchmarks:

1. maximum wait time of 30 minutes for a call to be answered;
2. maximum 24 hours for an eCARL notification to be assessed; and
3. maximum delay of two hours wait for a call back.

The ballooning rate of notifications that do not receive a response should be acted on. It will take time to resolve. The alternative referral model should eventually reduce the number of notifications, but the rate needs to be closely monitored and publicly reported. The government should provide sufficient staff in the Agency so that it takes no more than five years to phase out the closure of files without any action.

### BETTER INFORMATION AND ASSESSMENT EXPERTISE

Where children are identified as living in circumstances that cannot be ameliorated by preventative or early intervention strategies, an effective and decisive response is required from the Agency.

The Commission's investigations revealed consistently poor quality assessments undermined by excessive optimism, lack of focus on the child's experience, too little reliance on the expertise of other practitioners and unrealistic reliance on informal agreements in which

parents promise to reduce their dangerous behaviour. Greater training and skill development is required to improve the quality of this work.

Legislative reform is required to give the Agency greater powers to obtain information to inform quality assessments at an early stage. The Agency should be empowered to obtain a range of information about children at risk, and about their parents, from both government and non-government sources without a court order.

The *Children's Protection Act 1993* (SA) has a provision for the Chief Executive to apply to the Youth Court for an order requiring parents to undergo a drug or alcohol assessment in certain circumstances. These powers should be amended to permit the Agency in appropriate cases to issue a written direction to the parents to undergo such an assessment without having to make an application to court.

There is a need for greater reliance on independent expert assessment with respect to matters that proceed to court. A model of independent expert assessment should be developed which gives the court power to order expert assessments independent of either party to the court action. The current Child Protection Services at the Women's and Children's Hospital and Flinders Medical Centre should be developed to provide this service.

The north has a high level of need for hospital-based child protection services, and a child protection service modelled on that in operation at Flinders Medical Centre should be established at Lyell McEwin Hospital.

### CERTAINTY FOR CHILDREN ON SHORT-TERM ORDERS

By the time children's circumstances are dire enough to attract a response, issues in the family often require the child's removal to attend to entrenched safety concerns. Once removed, the child's need for stability and certainty is given insufficient weight. Attempts to reunify children with their parents drag on for far too long, causing instability as well as denying young children the certainty of the attachment relationships crucial for their development. It is also of concern that many children taken into care are subsequently reunified with their parents when the issues that undermined their safety in the first place have not been sustainably addressed. Of the children who entered care in 2014/15, 36 per cent had spent previous time in care. In the same period, 20 per cent of children reunified with their parents returned to care within six months. These are children whose development is undermined by lengthy uncertainty about their relationships and care arrangements.

When children are removed into the care of the state, it is essential that decisions are made in accordance with a developmentally appropriate time line. When an application is made to the court for a short-term order for care and protection, a permanency plan should be prepared and filed in court by the Agency. That plan should detail the contemplated timeframe for reunification of the child with their family, the changes expected of the family to enable that to occur, and the services given to the family to help them make those changes. The timeframe in the vast majority of cases should not exceed six months for a child under two years, or 12 months for older children. If at any time it appears that reunification is not realistic, the Agency should immediately apply for a long-term order and file a permanency plan which sets out the proposals for the long-term care of the child.

The Commission recommends improvements to some procedures in the Youth Court. All matters should be heard expeditiously. Greater use should be made of Family Care Meetings, which could be held at any time and not simply as a precursor to court proceedings. Contact arrangements should not be included as part of a court order but should be the subject of negotiations with the Agency or determined by a case review panel with independent membership in the event of a dispute.

### CHILDREN IN OUT-OF-HOME CARE

When a child is removed, the state assumes a heavy burden to provide safe and nurturing care. Evidence to the Commission highlighted that this burden is not always met and service barriers continue to exist.

The specific recommendation from the CISC Inquiry in 2008 that all children in care be allocated a case manager and have face-to-face contact at least monthly remains unmet. Many children do not have an allocated case manager, or are subject to what is called a 'differential response'. That means they are visited rarely, if at all. This is particularly concerning—the CISC Inquiry recommendation noted that many children who had experienced abuse in care lacked a caseworker to whom they could complain.

It also appears that the South Australian Standards of Alternative Care, in place since 2008, are routinely breached. Of particular concern are:

- standards that require allocation of a caseworker, frequency of caseworker contact, and regular case planning;
- health standards that require comprehensive health assessments for children entering care; and
- the legislative requirement to conduct an annual review of the circumstances of all children in care.

Only 83 per cent of children entitled by legislation to an annual review in 2014/15 had received a review, although this was an improvement on 53 per cent in the preceding year.

### TRACKING THE QUALITY OF CARE BEING DELIVERED

In order to track the quality of care the Agency gives children in care, the Agency should be required to report quarterly both to the Minister and the Guardian for Children and Young People (GCYP) against the following measures:

- all children in care have an allocated caseworker;
- the allocated caseworker has face-to-face contact with the child at least monthly;
- every child in care has a case plan that is actively monitored and reviewed every six months;
- every child who enters care has preliminary and comprehensive health checks, in accordance with the Health Standards for Children and Young People under the Guardianship of the Minister; and
- every child has their circumstances reviewed at an annual review in compliance with section 52 of the Children's Protection Act.

### IMPROVING SERVICE DELIVERY

South Australia has an extraordinarily high rate of placement instability compared to other Australian jurisdictions. Of the children who left care in 2014/15, 13 per cent had had more than 11 different placements during their period in care. Placements that appear to be in danger of breaking down should be promptly identified. Early therapeutic support would help carers who may be having difficulty in coping with the challenges of caring for children with high or complex needs.

It also appears that gains made in service accessibility for children in care through the government's Rapid Response plan have not been sustained. The plan should be renewed and reinvigorated. An interdepartmental committee to review and refocus Rapid Response should also be reinstated, and the document should be updated every two years.

A panel led by the Child and Adolescent Mental Health Service could bring greater focus on linking children to relevant therapy by considering the therapy needs of children in care and advocating for access to appropriate services where necessary.

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### IMPROVING CHILDREN'S PARTICIPATION IN DECISION MAKING

The files examined by the Commission and the detailed case studies showed little evidence of children being given appropriate opportunities to participate in decisions about their care. Legislative amendments are recommended to require children to be included in decision making about their care to the extent that they are capable and willing to do so, and that their views be given weight in accordance with their age and maturity.

### HOME-BASED CARE

Foster parents play an important role in the care and protection of children who can no longer safely live with their families. Developing the number of home-based care placements is a key aim for a reformed child protection system. When children are removed from abusive or neglectful families they need quality, nurturing, consistent environments to help them heal. Unfortunately, the gap is ever widening between the demand for home-based carers and the number of people available to perform that role. Not only does this mean that children are sometimes removed to unsuitable environments, it can also affect a decision about removal. When a child protection worker fears that the removal of a child from an unsatisfactory family environment will place that child in an unsuitable care environment, they are faced with an invidious choice as to which is the lesser of two evils.

While greater effort needs to be made to recruit new carers, existing carers must also be valued, and ensuring that the experience of caring is a positive one is essential.

More than 80 per cent of children in care live in home-based placements. These placements are described broadly as foster care (carers previously unknown to the child) and kinship care (relatives of the child who deliver care on behalf of the Minister as the guardian). Kinship care has contributed most of the substantial growth in home-based care in South Australia, but regulation and assessment processes have not kept pace with that growth.

### REFORMING KINSHIP CARE

When children are placed with kinship carers in urgent circumstances, provisional registration is facilitated with a short-form assessment. It does not include child-related employment screening, which is a mandatory part of a full assessment. This provisional assessment is considered to be acceptable for no longer than three months. However, the Commission discovered that as at 9 October 2015, 34 per cent of children in kinship care placements (a total of 334 children) had been there longer than three months without the necessary comprehensive assessment of the suitability of their carers. Almost 150 of those children had been in the placement for more than 12 months.

The processes by which full assessments are completed for kinship carers are not subject to the same rigour applied to assessing foster parents. An appropriate tool for the assessment of kinship carers should be identified, and endorsed for use.

The current regulatory regime that applies to kinship carers should be comprehensively reformed. This includes amending the *Family and Community Services Act 1972* (SA) to ensure that the registration and monitoring requirements apply to both foster parents and kinship carers for a child who is under the guardianship, or in the custody of, the Minister.

The assessment and support of kinship carers should be outsourced to the not-for-profit sector, on the same terms as currently apply to the sector's work as registered foster care agencies.

### RELATIONSHIP OF CARERS WITH THE AGENCY

A number of foster parents told the Commission that they loved their foster children, but they would not recommend the experience to others. There were some examples of good cooperative relationships but, in many other examples, carers were treated poorly and the value of their contribution was minimised. They were often met with the comment, 'You're just the carer'.

The Layton Review emphasised that the state cannot parent, but it must facilitate and support the parenting done by others. Thirteen years later, a lack of clarity remains about the reach of the Agency into day-to-day decision making for children in home-based placements.

Foster parents consistently complained about receiving insufficient information to help them manage the needs of the children. Support was inadequate to meet many of those needs and when they sought help, the Agency attributed the children's problems to them. Legislative amendment is required, giving:

- carers the right to access information they may need to make an informed decision about whether or not to accept a placement;
- carers the right to information they will need to properly care for a child;
- children a right to information about a carer before the placement; and
- carers the right to participate in decision making about matters which go beyond the day-to-day care and control of the child.

Carers do not have an independent advocacy service to help them deal with the Agency, or to exercise rights they may have to make submissions in proceedings in the Youth Court according to section 47A of the Children's Protection Act. An advocacy service should be funded that includes specific funding to raise awareness among carers of their legislative rights to contribute to decision making about children in their care.

#### TRANSPARENCY OF DECISION MAKING

Carers provide day-to-day care for children while living in fear that the Agency will remove the child from them at any time. Recent high profile cases reported in the media have further fuelled this fear. Sometimes removal is unavoidable, but greater transparency should accompany such a decision.

Decisions to remove a child from long-term foster parents should not be arbitrary. They should be made by a panel located in the Agency, but chaired by an expert independent of the Agency. The focus should always be on the best interests of the child.

The panel should consider the need for such removal, whether the proposed alternative placement meets the child's needs, and the adequacy of any transition plan. The carer should also be able to make representations to that panel.

#### SUPPORT PROVIDED TO CARERS

The current level of reimbursement to foster parents should be reviewed to ensure equity across general and specialist models of care. Carers should have access to a package of training to equip them to care for children with complex needs. Suitable carers should be identified to undertake this training. Carers who do so should be entitled to a care payment that acknowledges that quality care to a child helps *prevent* the development of complex behaviours. Helping carers to deliver this quality of care is economically responsible in the long term.

#### CHILDREN IN OTHER ENVIRONMENTS

Rotational care describes any care arrangement in which children are cared for by adults who are employees and who work on a shift basis. Rotational care of two types is delivered in South Australia: emergency care (also referred to as commercial care) and residential care.

South Australia relies on rotational care more than any other jurisdiction in Australia. It has the dubious distinction of caring for a higher proportion of infants and young children in this form of care than anywhere else. Rotational care is developmentally inappropriate for most children and is a poor substitute for the care provided in a loving family home. Despite universal acceptance that rotational care is developmentally

unsafe for children in their active attachment phase, 48 children under the age of three years were cared for in this way in South Australia in 2014/15.

The proposed reforms of early intervention in families should reduce the number of children coming into care, and reforms to home-based care should build the numbers of kinship carers and foster parents. Nevertheless, rotational care will still be needed in specific circumstances. Recommendations for reforming emergency and residential care are made against that background.

If the state can reduce its reliance on rotational care, it will significantly improve the quality of care for children. It will also free up funds for investment in more productive child protection services.

#### EMERGENCY CARE

Children placed in emergency care are looked after by staff who have minimal training and are employed through commercial agencies. These staff are deployed in shifts to care for children in locations such as motels, caravan parks, bed and breakfast cottages, and short term rentals. These 'emergency' arrangements are intended to be short-term and stop gap until a more suitable placement can be identified. However, children remain in these circumstances for much longer than the term 'emergency' implies.

Reliance on emergency care by commercial carers should cease in all but genuine emergency circumstances. This will take some time, and require considerable investment in building other care options, including the capacity of the residential care workforce in the Agency.

In the interim, greater scrutiny and supervision must be applied to emergency care environments, including the workers who staff them. Service agreements with agencies that provide staff should be reviewed to ensure consistent standards for the selection and appointment of workers. The establishment and supervision of placements should be consolidated in the residential care directorate of the Agency. Workers engaged by commercial agencies should be restricted from working for the Agency through more than one employer at a time. They should also be required to register with the Agency and be pre-approved before being rostered to work.

The risks of sexual abuse in rotational care have been well known by the Agency for many years. However, Shannon McCool's offending occurred in that environment and his actions demonstrate that the risk has not diminished, and action is long overdue.

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The risk of children being cared for by commercial care workers on single shifts (that is, working alone) is substantial. Single shifts should cease immediately. Carers employed through a commercial agency should be restricted to shifts with two workers at any one time.

### RESIDENTIAL CARE

The experiences of children in residential care were examined in detail in the case studies. Residential care provided by the Agency has grown without adequate planning to ensure that enough well trained staff are available to work in those facilities. It has also grown with inadequate attention to the changing population of children who live there. Residential care traditionally housed adolescents for whom home-based care was no longer appropriate or available. Now more children and infants, who are especially vulnerable in rotational care environments, are housed there.

This does not mean that there is no continuing role for residential care. Some children are not suited to being cared for in a home-based setting, and good residential care can meet their needs. The home-based care sector is also unlikely to experience sufficient growth in the immediate future to enable residential care to shrink quickly.

However, wholesale reform of residential care is needed. A streamed model of residential care should replace all other forms of residential care being delivered. The streamed model should:

- apply a therapeutic framework applicable across all care environments, which gives a theoretical background for care decisions;
- endorse consistent standards and approaches to care as a solid basis for supervision and performance management of staff who work outside this endorsed approach;
- have facilities for short-term assessment of children over a period of no more than eight weeks to assess the needs of the child;
- include facilities for children on long-term orders who do not have high or complex needs;
- include facilities for children with high or complex needs, whether psychological, physical or behavioural;
- house no child under 10 in residential care, except where necessary to keep a sibling group together; and
- house no child in a facility with more than four children, except where necessary to keep a sibling group together.

Adoption of an appropriate therapeutic model should be accompanied by an obligation to make a substantial investment in the training of workers in residential care.

Too many children continue to reside in large residential care units (sometimes called congregate or community care units) which cater for up to 12 children. Large units do not provide the homely environment that children need, and the warehousing of a large number of children with complex behaviours under one roof inevitably leads to residents learning new behaviours from each other. It creates an unsafe living environment.

A focus on keeping residents safe in such a volatile environment has increased their institutional atmosphere. Children as young as nine live in facilities where they have to ask staff to unlock their bedroom door if they need time to themselves, or ask for the kitchen to be unlocked if they want something to eat. The risks of peer-to-peer sexual abuse, assaults and other critical incidents are aggravated by poor matching of residents within the units. The evidence against this form of care continuing is overwhelming and recommendations for their closure have been made repeatedly. The Commission recommends that these units be closed.

### PROTECTING CHILDREN FROM SEXUAL ABUSE

Children in institutional care are especially vulnerable to sexual abuse, and if they are to stay safe, this risk must be addressed. Children and infants who are too young to understand what is happening to them, or for whatever reason are unable to complain, rely on the presence of consistent and attentive caregivers who understand when they feel secure and well, and when they do not. There are difficulties in providing this security in a rotational care environment.

Single-handed shifts by residential care workers should be abandoned. This too will take time and depends on building the number and capacity of the workforce significantly.

The McCoole case study showed up gaps in the knowledge of workers about the behaviour of child sex offenders and responses of children to sexual abuse. It highlighted a dangerous naivety about the risks to children in rotational care. Expectations of workers were confused and senior staff did not follow up disciplinary matters. Information from various sources was never compiled to give a complete picture of McCoole's behaviour.

Carers employed in rotational care (both emergency and residential care) should be subject to much greater scrutiny in the workplace. Measures that should be implemented to improve the Agency's ability to identify risk are:

- a unit specifically dedicated to tracking information on the conduct of carers, including from care concerns, critical incident reports, supervision records and information from other staff;
- compulsory training for all residential care workers in the dynamics of sexual abuse in institutional environments, grooming behaviour, children's responses to sexual abuse, and how to respond to children whose behaviour or statements raise the possibility of sexual abuse; and
- specific obligations imposed on all workers to report issues which concern them, even those which fall short of activating mandatory reporting obligations.

The process by which McCoole was able to gain employment with the Agency was investigated in detail. A reformed recruitment process has since been established and that model should continue to be used.

However, a fundamental change in the organisational culture in the residential care directorate is required. That change will only be effective if it is sustained and helps develop a culture of openness, where concerns are routinely discussed and addressed, and the issue of the ongoing risk to children is kept high on the agenda.

Prioritising the experiences of children, and creating an environment in which children can speak and be heard, can prevent sexual abuse. When the experiences of children are ignored or dismissed, those who are minded to commit abuse will flourish. To date, the voices and perspectives of children living in residential care have not been heard and there are no clear pathways to enable those children to complain.

Regulations that require staff using physical force against a child to ensure the child records their own version of events have been systematically ignored. When some children complained about their treatment, their version of events was disregarded.

Reforms are required to improve the profile of the perspectives of children:

- Amendments to section 56 of the Family and Community Services Act should be made to require the Chief Executive to hear complaints from all children who live in residential care or emergency care, not just those who live in licensed facilities.
- An accessible process should be developed for children to exercise their rights according to section 56.

- Amendments to the Family and Community Services Regulations are required to improve the accuracy of records of physical force being used against children in care.

GCYP should develop an education program for children in residential and emergency care to advise them about their rights. A community visitors scheme should also be developed to focus on children and young people in residential and emergency care.

#### SECURE THERAPEUTIC CARE

Establishment of a secure therapeutic care facility for children has been debated for many years. It was the subject of recommendations in both the Layton Review and CISC Inquiry.

The obvious concern about such a facility is that it could be regarded as a form of incarceration, or simply used as a dumping ground for difficult children. However, some children have high needs that can be dealt with only if they are kept securely in place for therapy. This Commission considers that there is a need for such a facility but that any such model should have the safeguard of oversight by the Supreme Court. It should also have appropriate step-up and step-down services for children so detained and a scheduled evaluation of outcomes for the children subject to this intervention.

#### ADOPTION AND OTHER PERSON GUARDIANSHIP

Stability of care relationships for children is an important precondition to their development. Adoption is one way of securing that stability. Some members of the community hold the view that adoption of children from care solves the problem of the shortage of suitable home-based placements. However, the Commission is not persuaded that an increased emphasis on making children in care available for adoption is necessarily appropriate, when fundamental considerations of the child's best interests are brought into account. That is not to exclude the possibility of adoption of children in care when it is genuinely in their best interests.

However, children can gain additional feelings of security within a loving family through Other Person Guardianship where guardianship responsibilities and powers are shifted in certain circumstances from the Minister to the carer of the child under the Children's Protection Act. It can bring a greater sense of stability, certainty and normalcy to a child's life, including placing important decision making in the hands of the adults who know the child best.

Other Person Guardianship has been under-used in South Australia. The Agency has retained decision-making powers over many children in situations in which, for all intents and purposes, they are a settled part of a new



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family. In 2014/15 South Australia had the lowest rate of Other Person Guardianship carers of any state in Australia.

The focus on Other Person Guardianship should be renewed. The Commission recommends a new procedure to facilitate such applications being made by foster parents—an independent expert panel established to enable foster parents and relative carers to apply for an official assessment of their suitability and timely consideration of such applications.

The Children's Protection Act should be amended to limit the ability of a child's birth parents to oppose the making of an Other Person Guardianship order if the court is satisfied that such an order is in the best interests of the child.

### LEAVING CARE

Children in care leave the system on the automatic expiry of their care order, when they reach the age of 18. However, this is a time when many adolescents experience challenges in education, health, life skills, housing and relationships. Care leavers embark on these challenges of adulthood without the safety net offered by a traditional family structure. The way in which the state supports children and young people to transition out of care is a measure of the success of those charged with raising them. Young people approaching care-leaving age are entitled to be part of specific planning addressing their goals and plans on leaving care. However, since 2011/12 no more than one-third of these young people had transition plans. Very few young people received any support from the Agency after they turned 18.

Amendments to the Children's Protection Act are required to enable the state, in appropriate cases, to help care leavers up to the age of 25. This should include expanding the eligibility of some Rapid Response initiatives to them.

Some children are fortunate enough to be able to remain with their long-term foster parents or kinship carers after they reach the age of 18 and have the benefit of their support while they pursue training and educational opportunities. In such situations, changes to carer support payments should be made to help young people to study or undertake a course of training while they remain at home. For young people living independently, the Commission endorses Housing SA initiatives to develop flexible models of housing which support care leavers.

### INVESTIGATING ABUSE AND NEGLECT

When children in care do not receive quality care, or when abuse or neglect in out-of-home care is suspected, the Agency must be able to provide a timely and focused investigation which is procedurally fair, but keeps the safety and interests of the child firmly at its centre.

Since its establishment, the Department's Care Concern Investigations Unit (CCIU) has struggled to define its role or establish clear processes and standards for its work. Evidence to the Commission disclosed a high level of frustration and concern about delays in the care concern investigation process, and the way in which investigations were conducted.

The Commission's investigation of CCIU during the McCoolle case study highlighted a number of deficiencies and underlined the need for substantial reform to investigative processes in order to keep children safe.

The Commission recommends that care concerns be managed between two units:

1. an investigative unit staffed by a multidisciplinary team of child protection specialists and people with law enforcement expertise; and
2. a response unit in the Agency's quality and practice section that liaises with staff in the field, monitors care concern data and identifies system-wide issues.

A maximum timeframe of six weeks should apply for most investigations. Some delay is inevitable when the conduct is the subject of a criminal investigation but in such cases liaison between the response unit and South Australia Police would identify aspects of the care concern that may be investigated by the Agency while criminal proceedings are pending.

In appropriate cases, some less serious care concerns could be managed by staff in the field. A structured screening tool is recommended for implementation at CARL which would enable staff to direct a concern to the field or for an investigative response, as appropriate. For matters that require an investigative response, a panel of three senior staff would determine whether it should be undertaken by the investigations unit or by staff in the field. Any allegation of sexual misconduct would always be addressed by the investigation unit.

Consistent with other recommendations, quarterly reports should be made to the Minister and GCYP on key performance indicators for CCIU:

1. the number of care concerns received and response provided;
2. the number of care concerns completed;

3. the proportion of investigations completed within set timeframes, and for those not completed, the reason for delay; and
4. details of system issues identified and how they are being addressed.

### **CHILDREN WITH DIVERSE NEEDS**

Some children in South Australia's population have needs that will not be met by a one-size-fits-all approach, and for whom particular approaches should be designed. The Commission considered the needs of four particular groups:

1. Aboriginal and Torres Strait Islander children;
2. children who live in regional areas;
3. children with disabilities; and
4. children from culturally and linguistically diverse backgrounds.

### **ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN**

Aboriginal and Torres Strait Islander children are still vastly over-represented in the children reported to the child protection system and brought into care. Greater effort is needed on specific issues for Aboriginal families, both in helping them to care safely for children, and helping Aboriginal children in care retain connections to their community and culture.

All the reforms in this report are recommended against the fundamental principle that all children, regardless of their race or culture, are entitled to a full life, including care and protection, and an adequate standard of living. In assessing whether Aboriginal children who come to the attention of the child protection system are having these needs met, it is necessary for workers to understand their observations in a cultural context, specifically the strengths of some Aboriginal parenting practices.

The recommendations made by the Commission for a strategic approach to early intervention programs (EIRD) should take account of the specific needs of Aboriginal communities (including remote communities). It is also important that new services take advantage of referral pathways from existing credible services, especially those that are led by the health sector and those that have contact with Aboriginal parents in the prenatal period.

### **THE ABORIGINAL AND TORRES STRAIT ISLANDER CHILD PLACEMENT PRINCIPLE**

The Agency continues to be challenged by its ability to comply with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP). In some cases suitable Aboriginal carers are not located for children

until well after their entry into care. The creation in the Agency of a family scoping unit for Aboriginal children is recommended. This unit should have access to other organisations with relevant records and build a database of information about families to help locate safe and appropriate carers in a timely way.

Compliance with ATSICPP requires more than simply following a hierarchy of care options. It requires genuine partnership with Aboriginal-led organisations when making decisions about the welfare of Aboriginal children. The Agency has not always embraced this obligation. It needs renewed focus on consulting with prescribed agencies as required by the Children's Protection Act.

The gap between available Aboriginal carers and the number of children needing care will not close quickly. Better support for non-Aboriginal carers should include help in attending to the cultural needs of Aboriginal children in their care.

### **APPROPRIATE CARER ASSESSMENT TOOLS**

With more than 50 per cent of Aboriginal children in care being looked after by relatives, the problems that beset the assessment and monitoring of kinship carers require specific attention. Current assessment tools do not adequately capture the strengths and needs of many Aboriginal families, and the Agency should invest in a culturally appropriate tool that engages potential carers to deliver better quality care.

### **ALTERNATIVE CARE OPTIONS IN REMOTE AREAS**

Some Aboriginal children in remote communities such as the APY Lands continue to live in unsafe conditions, despite improvements since the APY Lands Inquiry.

Because there are no foster parents or residential care facilities on the APY Lands, children taken into care are either looked after by relatives or are removed from their community to a regional town or even to the metropolitan area. Greater effort needs to be made to identify alternative care providers in Alice Springs and Coober Pedy, where children who are removed from their communities are more likely to have family or cultural connections.

A working group should be established to promote collaborative practice between the South Australian, Western Australian and Northern Territory child protection agencies in the tri-border region, including working towards an across-border legislative scheme for child protection in the three jurisdictions.

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Many children in remote areas are placed in relative care (the care of relatives) through Family Care Meetings without formal court orders. Where these arrangements are made, monitoring by the Agency should continue to ensure that they are safe and sustainable.

### COORDINATION OF SERVICES IN REMOTE COMMUNITIES

The Commission has emphasised the advantages generally of collocated services through Children's Centres in metropolitan and regional areas. In remote communities, service delivery could be similarly coordinated. The facilities available in each community should be audited and, through EIRD, services coordinated and collocated where possible.

### CHILDREN IN REGIONAL AREAS

Suitable placements can be hard to find for children in the metropolitan area, but the situation in a regional area can be much worse. Children removed from the care of their families are sometimes placed many kilometres away, interrupting their education, their stability and their ability to maintain contact with their family and friends.

Children in regional areas who need specific therapeutic or health services find it difficult to access them locally. The Agency's in-house psychological services should place greater focus on service provision in regional areas to ensure equity of access.

Judicial officers rarely travel to regional areas for hearings on children in need of care, and some of the arrangements for hearings in regional areas are unsatisfactory. The government should collaborate with the Courts Administration Authority to improve access to justice for children in regional areas, for example by using appropriate technology.

### CHILDREN WITH DISABILITIES

The services available for children with disabilities, both those at risk of coming into the child protection system and those living in out-of-home care, can be improved.

The rollout of the National Disability Insurance Scheme (NDIS) could give families struggling to safely care for children with disabilities additional support to meet the necessary standard. Because NDIS does not assertively engage with families who might benefit from involvement, staff in the child protection system should be mindful of potential eligibility and help eligible families to obtain access.

Children in out-of-home care rely on attentive case managers to recognise their potential eligibility and negotiate on their behalf. Many children who enter care with developmental delays, or psychological conditions originating in abuse and neglect, might benefit from

NDIS services. To ensure this group of children is proactively supported to access NDIS, and to help with forward planning, the Agency should track children who are potentially eligible to participate in the scheme. Employment of disability specialists and additional training are also recommended to develop expertise in the Agency.

### CHILDREN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Children from culturally and linguistically diverse backgrounds received little attention in submissions and evidence before the Commission. It may be that the challenges of responding to child abuse and neglect in those communities are not yet well known. However, these communities experience many of the disadvantages which are risk factors for child abuse and neglect, including social isolation and socioeconomic disadvantage. Some families' pre-migration experiences may have left a lasting traumatic legacy.

The challenges of responding in a culturally appropriate way in Aboriginal communities are similar in culturally and linguistically diverse communities. The Agency should improve its cultural understanding of those families who come to the attention of the child protection system as well as for those children who are already in care.

It appears that the Agency currently knows very little about the population of culturally and linguistically diverse families who might need a child protection response. Data about the origin of children reported to the system has been inconsistently recorded and retained, and is not likely to be reliable.

Without a reliable picture of the cultural origins of the children and families coming into contact with the system, planning is difficult. Data recording and collection about the diverse backgrounds of children at risk should be improved, and that data should be used to plan services which respond to the strengths and challenges of this particular population.

### SYSTEM-WIDE CHANGES TO IMPROVE SAFETY

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The Commission's enquiries focused substantially on the reforms needed within the statutory agency, but other government structures and services could work more effectively and efficiently. In particular, the Commission considered:

- Department for Community and Social Inclusion's (DCSI's) Screening Unit;
- Ombudsman SA, and Health and Community Services Complaints Commissioner;
- Guardian for Children and Young People;

- Child Death and Serious Injury Review Committee;
- Council for the Care of Children; and
- proposed Children’s Commissioner.

### SCREENING FOR RISK

Screening adults who come into contact with children through paid or voluntary employment is a strategy by which children’s environments can be kept safe. However, it is not the only strategy required. Caution must always be exercised to ensure that people are not lulled into a false sense of security by the fact that a person holds a screening clearance.

The current system for screening in South Australia is in need of reform. Delays in responding to applications for screening clearances are an ongoing vexed issue and the subject of considerable media attention. Unreasonable delays undermine the capacity of people to engage or volunteer in their community. It can interfere with their employment and might cause prospective foster parents to lose interest. Nevertheless, the current rigour of the process must not be diluted simply for the sake of greater efficiency.

An Australia-wide screening system has been under consideration since 2005. A 2015 report by the federal Royal Commission into Institutional Responses to Child Sexual Abuse focused attention on a proposed national model. Any reforms to the South Australian system must take the proposed national scheme, and the changes that might be required to join such a scheme, into account.

At present, South Australia has two pathways for obtaining a screening clearance: a check completed by a proposed employer or the more rigorous check completed by the DCSI Screening Unit. The DCSI check has regard to a much greater breadth of information than is available to an employer. An applicant could obtain a clearance from an employer when they would not get a clearance from the Screening Unit. This is clearly inconsistent and unsatisfactory—and confusing for people working or volunteering in more than one role who may have to apply for multiple clearances.

A single screening pathway should be implemented for all applicants through the DCSI Screening Unit. Organisations should no longer be permitted to complete their own assessments. Individuals who want to undertake a child-related employment role should be required to obtain a clearance directly through the Screening Unit, rather than an organisation making the application on their behalf. This would overcome confusion surrounding intrastate portability. In addition, exemptions for teachers should no longer apply.

The current fragmentation of information across the Children’s Protection Act, the Regulations and the standards issued by the Chief Executive is difficult to

negotiate. A single piece of legislation should consolidate the relevant screening requirements and standards with greater clarity.

This legislation should provide for:

- one authorised screening unit for the state;
- one clearly defined pathway to obtaining a clearance through the screening unit;
- an employee or volunteer driven system, where clearance cards or unique electronic identification numbers are issued;
- clarity on who must hold a clearance for employees, volunteers and organisations;
- portable clearances across roles within the state;
- a register of all clearances issued;
- a requirement for employers to register the use of a clearance with the Screening Unit, to ensure they can be notified if a clearance is cancelled; and
- offences for both individuals and organisations for failing to comply with the legislation, in particular undertaking child-related employment in the absence of a clearance.

Legislation should also provide for a right of appeal against a refusal to grant a clearance, which could be heard by the South Australian Civil and Administrative Tribunal.

The Commission has considered the recommendations in the report of the federal Royal Commission and supports continued negotiation towards a national standard to achieve national consistency. However, there is a need for caution to avoid the adoption of any recommendations which diminish the rigour of the current DCSI screening process.

The timeliness of assessments by the Screening Unit has improved since January 2015, when its staffing complement grew significantly. The changes proposed by the Commission inevitably mean a greater workload for the unit. Staff levels should therefore be re-assessed to ensure that excessive delays do not result. Assessments should be performed against a service benchmark of seven days for those applications which can be considered administratively (that is, no adverse information located), and 28 days for those which require assessment (some adverse information; needs closer assessment).

In light of these service benchmarks the Commission does not recommend that applicants be permitted to begin work while their application is pending.

## SUMMARY

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### STRUCTURES TO PROMOTE COLLABORATION

A consistent theme in this Commission (and other inquiries across Australia) is the need to improve collaboration and cooperation between agencies involved in service delivery to children.

Caution about information sharing between government departments and other non-government services has created administrative barriers to meeting the needs of children. The current balance assumes that information is confidential except in certain circumstances.

This balance should shift to give greater emphasis to information sharing as a responsibility of those working in the child protection system. This would require legislative change to establish a scheme for information sharing between prescribed agencies. The arrangement should be modelled on the New South Wales scheme, which provides for prescribed bodies to share information on the safety, welfare or wellbeing of a child, to help with providing services to, or managing risk to, a child. Strict controls will be needed to ensure shared information is used only for its permitted purpose.

Improved information-sharing powers will enable more efficient action, and smooth the way for better collaboration and coordination in service provision. To emphasise the importance of such cooperation, an amendment to the Children's Protection Act could impose a duty on the prescribed bodies to coordinate decision making and delivery of services for children.

At a strategic level, the executive leadership of government and non-government agencies involved in the child protection system should meet at least quarterly to address issues of common concern and promote inter-agency work.

To help busy executives prioritise this work, the Commission recommends that chief executives from government agencies with responsibility for the health, safety and welfare of children should have included in their performance agreements provisions that oblige them to promote inter-agency collaboration in child protection matters, and key performance indicators against which performance can be measured.

Barriers to information sharing between states also inhibit service delivery. The Family Law Council's recent interim report on the intersection of child protection and family court systems recommended a database to facilitate the sharing of information on court orders made by each state jurisdiction and the Family Court. The Commission recommends that the South Australian Government support and promote this recommendation for action.

### PROMOTING SYSTEM TRANSPARENCY

It is clear that the child protection system, in particular Families SA as the statutory agency, has been the source of a great deal of dissatisfaction and complaint in the community. However, child protection is difficult and demanding work and the Agency has been operating for a considerable period of time without adequate resources to meet demand. Greater transparency is needed to promote the rights of service users and others who are affected by the operation of the system.

To facilitate this transparency, the Commission recommends establishment of a number of panels with independent membership within the Agency to consider major decisions such as removal of children from long-term carers and applications for Other Person Guardianship assessment.

Greater oversight is also needed at a system level.

### A CHILDREN'S COMMISSIONER

The Layton Review's recommendation for appointment of a Children's Commissioner was not implemented. It has continued to be the subject of discussion and there is now strong bipartisan support for such an appointment. However, the precise model and powers of that office have not yet been agreed. Many people expressed a hope that a Children's Commissioner would be capable of 'fixing' the system by providing a comprehensive independent complaints function. The functions of a Commissioner should be clearly identified at the outset. The Commissioner would be required to have oversight of all children, not just those who are in care or in need of protection. If the Commissioner is tasked with investigating individual complaints, the danger is that important systemic oversight and promotion of the rights and wellbeing of *all* children, not just those in care, will be sidelined.

The Commission is not persuaded that investigation of individual complaints that do not have the capacity to identify system issues is a function that should be performed by the Children's Commissioner.

The Commission recommends the appointment of a Children's Commissioner with the following functions:

1. Promote and advocate for the rights and interests of children and young people in South Australia.
2. Promote participation by children and young people in making decisions that affect their lives.
3. Advise, and make recommendations to, Ministers, state authorities and other bodies (including non-government bodies) on matters related to the rights, development and wellbeing of children and young people at a systemic level.
4. Help ensure that the state, as part of the Commonwealth, satisfies its international obligations to children and young people.

5. Inquire into and investigate topics concerning the rights, development or wellbeing of children at a systemic level, including investigating individual cases which, in the opinion of the Children's Commissioner, could identify systemic issues of sufficient importance to warrant inquiry.
6. Prepare and publish reports on matters related to the rights, development and wellbeing of children and young people at a systemic level.
7. Engage with children in the performance of other functions and develop a strategy for doing so.
8. Undertake or commission research into topics that relate to children and young people.

The Children's Commissioner should hold powers equivalent to those currently held by the Ombudsman. The Commissioner should also have an unfettered power to publish information and reports relevant to their legislative mandate.

A key part of the Children's Commissioner's work would be promoting the experiences and views of children and young people. Consultation with this group should be the primary focus, although the Commissioner should consult with other groups as appropriate.

The Children's Commissioner should be empowered to make recommendations for system reform, including the power to report to the Minister responsible for the aspect of government services under consideration.

The Children's Commissioner should also be empowered to require a report from state authorities on whom recommendations have been made. If the Commissioner remains dissatisfied with the response, he or she should be able to escalate the matter by reporting the case to the relevant Minister, who should report to Parliament on the matter. The Children's Commissioner should also retain an absolute right to publicly report on any matter escalated in this way.

#### OTHER OVERSIGHT BODIES

It is not proposed that the Children's Commissioner replace or incorporate either the Child Death and Serious Injury Review Committee (CDSIRC) or the Guardian for Children and Young People (GCYP). Each of these bodies has specialist functions and they should retain their current legislative independence. However, there are opportunities for the functions of those important oversight bodies to be collocated and coordinated.

Recommendations made by bodies such as CDSIRC and GCYP have not always been actioned, or achieved the required improvements for children. There should be greater capacity to require agencies to report their response to recommendations. Rather than develop separate reporting lines, CDSIRC and GCYP should be empowered to refer matters to the Children's

Commissioner where actions they regard as necessary are delayed, or barriers to action appear to exist. The Children's Commissioner may then action those matters in any way deemed appropriate, including in accordance with the powers held to monitor and escalate his or her own recommendations.

The functions of the current Council for the Care of Children should be absorbed into the functions of the Children's Commissioner, and a newly appointed Child Development Council.

#### REVIEW ARRANGEMENTS

A separate child protection complaints agency is not necessary. The powers of the Health and Community Services Complaints Commissioner (HCSCC) and the Ombudsman are adequate for the review of decisions and services in the child protection system.

However, HCSCC, which is currently empowered to investigate most matters relating to child protection, is not necessarily best placed to perform that function.

The matters which appear to form the bulk of complaints about the child protection system frequently concern administrative decisions, rather than the quality of service. Accordingly, complaints about the child protection system should, in the main, be considered by the Ombudsman. Legislative change to this effect would be needed.

To allow flexibility in the response to complaints there should be a legislative amendment to permit the Ombudsman to exercise the jurisdiction of the HCSCC where the nature of the complaint makes that appropriate. An administrative agreement between the Ombudsman and the HCSCC would identify the appropriate categories of matters.

A number of contributors to the Commission (in particular from foster parents and kinship carers) advocated for a right to appeal on some major decisions made by the statutory agency about the care of children (for example, decisions to remove a child from long-term foster parents). The South Australian Civil and Administrative Tribunal could be the avenue for such appeals.

However, the consequences of such a right would not necessarily promote the best interests of the children at the centre of the decision. In particular, the right of appeal would exclude the jurisdiction of the Ombudsman in most cases, which is better placed to use its substantial powers to investigate. Appeals in an adversarial forum could exclude a child from participating, as a child would not necessarily be a party to the appeal and would need to obtain representation to have their perspective heard. In these circumstances, the Commission does not recommend such change.

## SUMMARY

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### IMPLEMENTATION AND MONITORING

The government will need committed, strategic and transparent implementation processes in place to make the reforms recommended in this report. The Commission hopes that this report is the start of a new approach to child protection in this state, where blame is replaced with constructive participation in a well overdue reform process.

The Commission recommends a reporting regime on recommendations from this report to maintain the necessary momentum:

- a report on or before 30 December 2016;
- a further report on or before 30 June 2017; and
- an annual report for a period of not less than five years after the 30 June 2017 report.

Regular, accessible reports should be published online to keep the community informed of progress.

The reform to the system to protect children in this state is not the responsibility of government alone. The entire community can play a greater role to ensure that South Australia's children are safe and well.

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## RECOMMENDATIONS



## RECOMMENDATIONS

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The Commission recommends that the South Australian Government:

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| 1 | Establish a protocol to govern eligibility for a grant of legal aid to carers, where the child's best interests would be better or more appropriately secured by obtaining Family Court orders, rather than by proceedings in the Youth Court. Further, that funding be provided to the Legal Services Commission and quarantined for this specific purpose. | 9  | Review the delegation of powers to enable decision making to occur at the closest possible level to the child, subject to questions of fiscal responsibility and sensitivity or complexity of the issues.  |
| 2 | Fund, subject to a protocol, any required filing costs where there is a need for Youth Court orders to be registered in the Family Court to improve the safety of the children to whom they relate.  | 10 | Adopt a policy that gives a child's caseworker the primary responsibility for case management and, except in special circumstances, ensures that the caseworker is made aware of all discussions and decisions that affect the child.                        |
| 3 | Support and promote for action, recommendation 5(a) of the Family Law Council interim report (June 2015), which advocates for the development of a national database of child protection and Family Court orders.  | 11 | Conduct a formal review of Solution Based Casework™ (SBC) to critically examine whether the model is being used with fidelity to the original model in practice.   |
| 4 | Reinstitute the court liaison role as a strategic link between the Agency, the Family Court and the Youth Court, to improve system interface and to develop service responses in accordance with the requirements of each jurisdiction.  | 12 | Provide an ongoing SBC consultation and training service to be delivered by principal social work staff and appropriately accredited trainers in SBC who remain within the Agency.   |
| 5 | Move the office of child protection and the functions of Families SA out of the Department for Education and Child Development to establish a separate department that has the business of child protection as its primary focus, and which has elements and functions as set out in this report.  | 13 | Audit the range of process and policy documents to identify and discard those that are out of date. Develop a single database that is accessible to all staff via the Agency's intranet, to electronically file all current documents.                       |
| 6 | Appoint a Chief Executive of the new department who has strong leadership skills and recognised credibility in child protection work, and who has a direct line of ministerial responsibility.   | 14 | Employ administrative assistants at adequate levels of expertise to support casework teams to manage the administrative requirements of C3MS.  |
| 7 | Implement a structure in the new department that reduces the hierarchies between leadership and front-line workers.  | 15 | Develop clear guidelines for recording information on C3MS, which identify those responsible for data entry and the categories under which data is entered. Rationalise available categories to limit inappropriate categorisation of important information. |
| 8 | Establish a refreshed leadership in the new department with emphasis on the attraction and retention of leaders who have recognised credibility in child protection work, and who have the capacity to lead a major reform of organisational culture.  | 16 | Develop training in the use of C3MS to ensure that practitioners understand their obligations in uploading data, and the limitations of the incident-based nature of recording.  |
|   |  | 17 | Provide practitioners with mobile devices to allow access to C3MS from remote locations.   |
|   |  | 18 | Permit stakeholders such as other government agencies and not-for-profit organisations limited access to C3MS to facilitate cooperation, collaboration and transparency.   |

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| 19 | Set constructive and practical benchmarks for the development of critical enhancements to C3MS.  | 25 | Provide a psychological service to work with the executive to address the high levels of workplace stress in the Agency.   |
| 20 | Conduct a review of the long-term viability of C3MS, and monitor research and developments in the area of electronic information management systems with a view to determining whether C3MS should be replaced with a more suitable and effective electronic information system.   | 26 | Appoint clinical managers to each metropolitan hub and regional office of the Agency and review professional line-management structures accordingly.   |
| 21 | Establish a human resources unit in the Agency that has sufficient specialist expertise and resources to develop and implement strategic workforce plans and to manage operational demands to ensure high quality child protection practice.   | 27 | Invest in clinical management, supervision and practice improvement, including the development of a supervision framework.   |
| 22 | Establish a learning and professional development unit in the Agency to lead training and professional development, for both professional and operational staff.   | 28 | Establish formal and regularly evaluated relationships between the Agency and the tertiary education sector that are designed to: <ul style="list-style-type: none"> <li>a enhance student and academic knowledge and experience of child protection practice;</li> <li>b attract desirable graduates;</li> <li>c expand and focus child protection practice research; and</li> <li>d ensure that the Agency and its staff are kept abreast of contemporary professional research and literature.</li> </ul> |
| 23 | Require professional staff in the Agency to complete a minimum number of hours of professional development each year as a condition of their employment.   | 29 | Establish a postdoctoral fellowship program in conjunction with the tertiary education sector to advance areas of research relevant to the Agency.   |
| 24 | Charge the executive of the Agency, through the human resources unit, with a review of current practices and the development of evidence-based strategies relevant to: <ul style="list-style-type: none"> <li>a workforce records and data management;</li> <li>b workforce qualification profiles, including requiring any staff holding a case load to be degree qualified in a discipline relevant to child protection;</li> <li>c the recruitment, selection, induction and retention of staff, including managing all recruitment and selection centrally;</li> <li>d career, including management, pathways;</li> <li>e workload management;</li> <li>f performance planning, support and monitoring for enhanced staff performance; and</li> <li>g professional development requirements, opportunities and resourcing, including adopting a professional development reimbursement program modelled on that operating in SA Health.</li> </ul> | 30 | Require the Agency to take a lead role with other stakeholders to develop and implement a workforce strategy designed to improve staffing practices and performance across the broader child protection system.  |
|    |  | 31 | Maintain the current mandatory reporting threshold set out on section 11 of the <i>Children's Protection Act 1993</i> .  |
|    |  | 32 | Review the screening and response priority tools to ensure they give due weight to cumulative harm, chronic neglect, social isolation, underlying causes of dysfunction, the need to conduct timely forensic medical assessments, and the expertise and experience of professional notifiers.  |
|    |  | 33 | Review screened-out notifications periodically to ensure the threshold is being correctly applied.   |

## RECOMMENDATIONS

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| <p>34 Invest in the professional development of the Agency's Call Centre practitioners, including, but not limited, to:</p> <ul style="list-style-type: none"> <li>a the implementation of case reading;</li> <li>b regular clinical supervision;</li> <li>c the introduction of a tailored induction program; and</li> <li>d ongoing training in the specific skills required of Call Centre practitioners.</li> </ul> | <p>41 Record notifications directly into an electronic log sheet that pre-populates the C3MS intake record.</p>  |
| <p>35 Implement the automated call-back feature at the Call Centre for a trial period, followed by an assessment to determine whether its ongoing use is justified.</p>   | <p>42 Review and improve the efficiency of recording practices of Notifier Only Concerns (NOCs).</p>   |
| <p>36 Staff the Call Centre at a level that would permit the achievement of the following service benchmarks:</p> <ul style="list-style-type: none"> <li>a a maximum waiting time of 30 minutes for a telephone call to be answered;</li> <li>b a maximum of 24 hours to assess an eCARL notification; and</li> <li>c a maximum delay of two hours for a call back.</li> </ul>  | <p>43 Ensure the Agency regains control of, and strictly oversees, mandatory notification training, including creating and updating an appropriate training package and a mandatory notifiers' guide, and regularly auditing training to ensure fidelity.</p>  |
| <p>37 Ensure that the Call Centre is never left unattended. Crisis Care staffing levels should be immediately increased to no fewer than three staff at each shift.</p>   | <p>44 Make mandatory notification training compulsory for:</p> <ul style="list-style-type: none"> <li>a registered teachers;</li> <li>b general medical practitioners;</li> <li>c police officers; and</li> <li>d other mandated notifiers who are employees of, or volunteer in, a government or non-government organisation that provides health, welfare, education, sporting or recreational, childcare or residential services wholly or partly for children, where the notifier either (a) is engaged in the actual delivery of those services to children or (b) holds a management position in the relevant organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.</li> </ul> |
| <p>38 Abandon the proposal to engage unqualified call agents to receive telephone notifications. Telephone calls from notifiers must only be taken by degree-level, tertiary qualified and experienced practitioners.</p>   | <p>45 Restrict access to eCARL to notifiers who have completed mandated notifier training.</p>   |
| <p>39 Update, as a matter of urgency, public information concerning the services offered by the Crisis Care service.</p>  | <p>46 Include an interactive mandatory notifier guide at the start of eCARL.</p>   |
| <p>40 Provide automated electronic feedback to all notifiers, confirming receipt of their notification (in the case of eCARL) and, post-assessment, what screening and response priority assessments were made in relation to their notifications.</p>  | <p>47 Amend Part 4, Division 1, of the <i>Children's Protection Act 1993</i> to include a new provision permitting, but not requiring, a notifier to report concerns about an unborn child, regardless of the stage of pregnancy.</p>  |
|   | <p>48 Abandon the policy restricting the recording of Report on Unborn (ROU) children to 34 weeks' gestation or later.</p>   |
|   | <p>49 Institute longer term funding arrangements for prevention and early intervention services, subject to evaluation and performance criteria.</p>   |

- 50 Establish an Early Intervention Research Directorate (EIRD) to:
- a prepare a Prevention and Early Intervention Strategy that is updated at least every five years:
    - i to identify service models that have proved effective or show promise in promoting the health, safety and wellbeing of children in South Australia;
    - ii to serve as the basis of decisions by South Australian Government agencies to fund prevention and early intervention services;
    - iii to form the basis of negotiations with the federal and local governments, with a view to coordinating funding priorities;
  - b establish research partnerships and fund evaluations of innovative service models to determine their effectiveness and value for money; and
  - c focus on the prevention and early intervention investment priorities identified in this report.
- 51 Establish child and family assessment and referral networks in each region of Greater Adelaide and regional South Australia that include:
- a a lead not-for-profit agency to manage, in partnership with the Agency, a local entry point to services provided by partner agencies in the region, focusing on collaborative practice and coordinated, multi-service responses, when required;
  - b an annual Local Assessment of Needs (LAN) prepared by the lead not-for-profit agency after mapping the needs of vulnerable families and children in each region. The LAN would inform funding decisions for services; and
  - c child protection practitioners in each child and family assessment and referral network to support decision making in relation to child safety including when to refer higher risk families for a statutory response by the Agency.
- 52 Employ qualified child wellbeing practitioners (CWPs) accessible to all staff in the Department, but focusing on locations of greatest need, to consult with staff and to work directly with vulnerable families. CWPs should have on-site access to the Agency's electronic database.
- 53 Equip relevant government agencies to support vulnerable families by appointing existing employees as child wellbeing assistants (CWA), in addition to their usual role, to provide staff guidance about options to support vulnerable families.
- 54 Implement a simple, common assessment framework, such as Common Approach, for use by government and not-for-profit services who work with vulnerable children and families.
- 55 Convene regular cross-agency training and networking sessions for all CWPs and CWAs in each local metropolitan and country region to increase their knowledge and support local inter-agency collaboration.
- 56 Amend the *Children's Protection Act 1993* to permit mandated notifiers to discharge their obligations by: reporting to the Agency's Call Centre (Child Abuse Report Line); or to designated child wellbeing practitioners, or by referral to a child and family assessment and referral network where the notifier believes a child's circumstances would be adequately attended to by a prevention or early intervention program.
- 57 Review procedures for strategy discussions to ensure they are convened promptly upon the receipt of notifications requiring investigation (and without delay when children present with physical injury). Discussions should include all relevant government and non-government participants and be re-convened as necessary.
- 58 Provide the Agency's practitioners with training, support and supervision to equip them to make realistic assessments of risks, particularly in areas of chronic maltreatment, cumulative harm, social isolation, drug and alcohol abuse, mental health, family violence, and attachment and care needs of young children, to consider the views of children and to develop appropriate safety plans.
- 59 Reconcile and integrate the Agency's assessment tools and documentation (including Solution Based Casework™, the assessment framework and decision-making tools).

## RECOMMENDATIONS

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- 60 Amend section 20 of the *Children's Protection Act 1993* to delete section 20(2) and (3), and include a provision which empowers the Agency to issue a written direction to parents, guardians or other persons requiring them to submit to a drug and alcohol assessment, with the results to be provided to Families SA.
- 61 Ensure the Agency responds to all screened-in notifications, either directly, or by appropriate referral, including responding promptly (including after hours) to notifications in which physical injuries are notified and the Agency's assistance is required to facilitate a forensic medical assessment.
- 62 Phase out the closure of intakes and files due to a lack of resources. This should occur over a period of no more than five years from the date of this report. In the interim, practitioners should be provided with clear guidelines as to the circumstances in which such closures are appropriate. There should be quarterly reports to the public on the rate of closures that are due to a lack of resources.
- 63 Amend section 19(1) of the *Children's Protection Act 1993* by deleting section 19(1)(b) thereof to provide that:
- a if the Chief Executive suspects on reasonable grounds that a child is at risk, the Chief Executive must cause an assessment of, or investigation into, the circumstances of the child to be carried out or must effect an alternative response which more appropriately addresses the potential or actual risk to the child.
- 64 Ensure that the Agency focuses on case management of protective intervention cases and that not-for-profit agencies provide direct service delivery to families. All protective intervention programs should be evaluated on a regular basis to ensure that all such programs have an established evidence base.
- 65 Establish a Child Protection Service (CPS) unit at the Lyell McEwin Hospital.
- 66 Amend the *Children's Protection Act 1993* to provide an independent model of expert assessment in similar terms to the Children's Court Clinic in New South Wales.
- 67 Amend the *Children's Protection Act 1993* with respect to the procedures relating to Family Care Meetings (FCMs) as follows:
- a amend section 27(1) to provide that the Agency should consider causing an FCM to be convened whenever it is of the opinion that a child is at risk but the risk appears capable of being addressed at an FCM;
  - b repeal section 27(2);
  - c amends 36(6) to provide that an FCM decision would not be valid without the agreement of the relevant members of the family and the Agency;
  - d require the Agency to give effect to FCM decisions, unless they are impracticable or inconsistent with the principles of the legislation, in which case the FCM should be reconvened or proceedings commenced in Court; and
  - e require FCM decisions to be reviewed after three months, but provide that any party to the decision may request an earlier and/or subsequent review, if required.
- 68 Review procedures and funding arrangements for the Youth Court Conferencing Unit:
- a to enable the Unit to recruit and train a panel of child advocates for Family Care Meetings (FCMs)—advocates should hold a valid child-related employment screening clearance; and
  - b to consider whether in an appropriate case a child's foster parent should be invited to an FCM.

**69 Amend the *Children's Protection Act 1993*:**

- a to require the child's lawyer to:**
- i act in accordance with the child's instructions to the extent the child is able and willing to give such instructions**
  - ii supplement those instructions with his or her own view of the child's best interests to the extent the child is not able and willing to give instructions (provided the lawyer's views do not contradict any instructions the child is able and willing to give)**
  - iii indicate the nature of the role to the child, in accordance with the child's developmental capacity**
  - iv indicate to the court on which basis submissions are made; and**
- b permit the court to appoint a child's representative or, in emergencies, to dispense with the need for a representative. In the latter situation, the court should only make interim orders and then adjourn the proceedings to enable a duly instructed lawyer to represent the child.**

**70 Amend the *Children's Protection Act 1993* as follows:**

- a repeal section 38(1)(a) which concerns the making of orders for supervision and undertakings and section 38(2)(a);**
- b include as an object in the Act the importance of timely decision making to promote stability and maintenance for a child;**
- c at the time of the commencement of care and protection proceedings the Agency should assess whether there is a realistic possibility of reunification:**
  - i within six months for a child under two years, or**
  - ii within 12 months for a child over two years; and**

- d if there is a realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should seek an order placing the child under the guardianship of the Minister for a period of either six or 12 months (depending on the age of the child), and file a permanency plan setting out the proposals for reunification;**
- e if at the commencement of care and protection proceedings, or at any time thereafter, there does not appear to be any realistic possibility of reunification within the timeframe specified in Recommendation 70(c), the Agency should immediately apply for an order placing the child under the guardianship of the Minister until the age of 18 years and file a permanency plan setting out the proposals for the long-term placement of the child;**
- f if at any time special circumstances arise (particularly with respect to an older child) which make it necessary to extend the timeframes set out in Recommendation 70(c) hereof the Court shall have the discretion to extend the timeframe for a period no longer than six months. In any such case the onus will be on the parties to demonstrate the need for such extension having regard to the child's best interests and the potential risk to the child's need for stability and permanence;**
- g amend section 39(a) to delete the requirement to commence a hearing within 10 weeks, but provide that all proceedings be heard and determined expeditiously and that once the hearing commences, without special reasons, it should continue until the conclusion of evidence with the judgement delivered as soon as practicable thereafter.**

**71 Encourage lawyers employed by the Legal Services Commission and the Crown Solicitor's Office to undertake child protection training and require lawyers engaged through the Legal Services Commission to represent children in state child protection proceedings to hold a valid child-related employment screening clearance.**

**72 Ensure that contact arrangements meet the changing needs of children with respect to such matters as venue, transport arrangements and supervision and that contact never occurs when the parent is or is suspected of being affected by drugs and/or alcohol.**

## RECOMMENDATIONS

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- 73 Amend the *Children's Protection Act 1993* to exclude contact arrangements from orders of the court and require all contact arrangements be referred to the Agency for determination in accordance with the best interests of the child. The permanency plan filed at court should include a provision as to the resolution of contact disputes, including mediation procedures wherever possible.
- 74 Establish an independent standing expert Case Review Panel to review the issue of contact when mediation is unsuccessful and it is necessary to resolve any dispute as to contact arrangements.
- 75 Review and republish Rapid Response with updated guidance as to the extent of priority access for children in care.
- 76 Reinstate the inter-departmental committee overseeing Rapid Response to review its operation, at least biannually.
- 77 Ensure that every child or young person in care has an allocated caseworker who has face-to-face contact with them once a month at a minimum.
- 78 Assess all children who are currently receiving a differential response for eligibility for Other Person Guardianship.
- 79 Assess whether allocation of a primary and secondary worker to deliver guardianship case management would improve the continuity of relationships with children.
- 80 Review the policy guidance and all other documents used for annual reviews to ensure compliance with section 52 of the *Children's Protection Act 1993*, including requiring greater sharing of the information discussed at annual reviews.
- 81 Require that all annual reviews be chaired by a suitably qualified person who is independent of the case.
- 82 Give concurrent planning greater emphasis in case planning, especially for children during their active attachment period.
- 83 Review all placement breakdowns to determine and correct identified system deficits.
- 84 Provide therapeutic support to placements that are identified as being at risk or under stress.
- 85 Fund initial health assessment clinics at the Women's and Children's Hospital, Flinders Medical Centre (FMC) and Lyell McEwin Hospital to operate in accordance with the service model employed at FMC. This includes funding clinics at a level that enables a psychosocial component to be offered at every initial health assessment.
- 86 Invest in the ongoing development of a therapeutic needs assessment panel led by Child and Adolescent Mental Health Services for children in care whose therapeutic needs are identified in their initial health assessment.
- 87 Develop an inter-agency panel modelled on the Exceptional Needs Unit's management assessment panel to support case management of those children in care with complex needs who are not appropriately managed by existing services.
- 88 Develop a mobile outreach service modelled on Yarrow Place's mobile youth team for children and young people who frequently abscond from placement, and who are at risk because of factors other than sexual exploitation.
- 89 Improve the profile of Strategies for Managing Abuse Related Trauma (SMART) training for educational staff, requiring that to be part of professional development where appropriate.
- 90 Review and promote Education's policies regarding school suspension, exclusion and expulsion to ensure that they are used as strategies of last resort for children in care.
- 91 Regularly conduct an audit of children in care who are on reduced hours of attendance at school and ensure they have plans to re-engage them in mainstream education.
- 92 Require Education to fund any in-school support needed by children in care.
- 93 Recruit and train a panel of school services officers to support children with trauma-related behavioural challenges.
- 94 Amend the practice guidelines regarding written directives to comply with the provisions of the *Children's Protection Act 1993* and provide training to child protection workers to ensure that they understand them.

- 95 Amend section 51 of the *Children's Protection Act 1993* to include a requirement that in all decisions affecting the child that are made in accordance with an order for guardianship, the child must be included in the decision making to the extent that they are capable and willing, and that the views of the child are given due weight in accordance with the age and maturity of the child.
- 96 Require the Agency to report quarterly to the Minister and to the Guardian for Children and Young People, and make public a report as to the following matters:
- a compliance with the Standards of Alternative Care in South Australia 2.1, 2.2 and 2.6;
  - b the proportion of children entering care whose health needs are assessed in accordance with the requirements of the relevant health standards; and
  - c the number and proportion of children and young people who have been reviewed in accordance with section 52 of the *Children's Protection Act 1993* at the time the review falls due.
- 97 Amend the *Family and Community Services Act 1972* to include relative carers within the regulatory provisions of Part 4, Subdivision 3 and section 80. The definition of relative carers should include the categories of relatives who are currently excluded from the definition of foster parent in section 4 (step-parent, brother, sister, uncle, aunt, grandfather or grandmother), who care for children in the custody of, or under the guardianship of, the Minister.
- 98 Amend the *Family and Community Services Act 1972* to provide approved carers with a right to information for the purposes of caring for children in the same terms as in sections 143–145 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- 99 Amend the *Family and Community Services Act 1972* to provide for approved carers to be involved in decision making concerning a child in their care, in the same terms as in section 146 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- 100 Amend the *Family and Community Services Act 1972* to provide a specific right to approved carers to contribute to a child's annual review pursuant to section 52 of the *Children's Protection Act 1993*.
- 101 Amend section 80 of the *Family and Community Services Act 1972* to repeal the current requirement that foster parents care for a child for three years or more before delegations of powers can be made, and instead prescribe a minimum period of 12 months.
- 102 Outsource assessment and support of kinship carers to appropriately qualified non-government organisations in accordance with the service models which currently apply to foster care.
- 103 Develop or purchase a comprehensive kinship assessment tool for assessing the safety and appropriateness of kinship placements.
- 104 Invest resources in the Department's Carer Assessment and Registration Unit to expand services to include consideration of applications for registration by kinship carers. These registrations would be in accordance with an appropriate assessment tool, and would authorise the carer to provide care to a specific child or children only.
- 105 Establish a Families SA Carer Assessment and Registration Unit service benchmark for assessment and registration decisions of 14 days where the assessment is complete and further information is not required from the assessing agency.
- 106 Develop a process for carers seeking approval (foster parents and kinship carers) to provide preliminary information about themselves and other adults who frequent their home to enable comprehensive C3MS checks to be done before a full Step by Step or other appropriate assessment is completed.
- 107 Include in the service agreement with all registered agencies the requirement that Families SA Carer Assessment and Registration Unit be notified of any person who begins an assessment process for carer registration (by Step by Step or another appropriate process) who is screened out, or, for whatever reason, subsequently withdraws from the assessment.



## RECOMMENDATIONS

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| <p>108 Develop an approved panel of practitioners authorised to provide priority assessments of specific child only carers on behalf of registered agencies.</p>  | <p>118 Create an expert panel within the Agency to consider the removal of children from long-term home-based placements.</p>   |
| <p>109 Create a project team to address the backlog in assessments of kinship carers and comprehensively review carers whose assessment is limited to an iREG assessment where the child has been living in the placement for more than three months.</p>   | <p>119 Review reimbursement rates to bring general foster rates with loadings for children with complex needs closer to rates payable to therapeutic carers.</p>  |
| <p>110 Cease reliance on medical self-assessment forms and response priority assessments for kinship carers.</p>  | <p>120 Develop a specific package of training for general foster parents which can lead to payment of additional skills based loadings.</p>   |
| <p>111 Enter an administrative arrangement with the Department for Communities and Social Inclusion to provide priority screening clearances for carers where a child has been placed pursuant to an iREG process.</p>                                      | <p>121 Support carers who are registered to general agencies to transfer to therapeutic agencies where the needs of children in their care require it.</p>  |
| <p>112 Review initial orientation training for carers seeking approval to include training on recognising and managing trauma related behaviours, together with information as to availability of, and access to, therapeutic assistance if required.</p>   | <p>122 Conduct a review of contractual conditions and payments to registered agencies to promote greater consistency of payments to agencies which support foster parents.</p>  |
| <p>113 Include Agency staff, children in care and existing foster parents and kinship carers in the delivery of preliminary information and training for new and prospective approved carers.</p>   | <p>123 Update the Alternative Care Support Payments: Manual of Practice and make it available to all approved foster parents and kinship or relative carers.</p>  |
| <p>114 Develop a practice guide identifying the circumstances in which delegations pursuant to the amended section 80 of the <i>Family and Community Services Act 1972</i> should be made.</p>  | <p>124 Monitor developments in professional models of foster care in other states with a view to adopting or adapting a proven model.</p>   |
| <p>115 Develop a written document which sets out the role and duties of the supporter of carers (SOC), including their role if care concerns arise, and to whom various duties are owed. This document should be freely available to home-based carers.</p> | <p>125 Engage and support the Child and Family Welfare Association to develop more coordinated provision of training to carers.</p>   |
| <p>116 Fund Connecting Foster Carers, or an appropriate alternative agency, to deliver an advocacy service with paid staff to support carers to access and exercise their rights.</p>   | <p>126 Engage and support CAFWA to improve the coordination of respite provision to carers.</p>   |
| <p>117 Fund the advocacy service to develop education material which clearly describes foster parents rights to contribute to decision making, and their rights of review regarding decisions which affect them.</p>  | <p>127 Develop a centralised system for receiving and resolving complaints from carers, including informal mediation or escalation to executive staff where appropriate. Timely written responses should be made to complaints.</p> |
|   | <p>128 Phase out the use of commercial carers in any rotational care arrangements except in genuine short-term emergencies.</p>   |

- 129 Review service agreements with commercial agencies who supply emergency care staff to:
- a require the commercial agency to develop job and person specification and selection criteria which must be approved by Families SA;
  - b prohibit workers from undertaking shifts through more than one commercial care agency at a time when engaged by Families SA to look after children in care. This includes a prohibition on undertaking shifts for a commercial care agency at the same time as undertaking shifts for Families SA;
  - c require commercial care workers to be registered and approved by Families SA before their employment begins; and
  - d require commercial agencies to report any information that reflects on the suitability of a care worker, to initiate tracking via the system outlined at Recommendation 142.
- 130 Provide Families SA staff who work with commercial carers with access to relevant portions of service agreements to clarify work expectations and specific conditions of engagement.
- 131 Provide the residential care directorate with sole responsibility for engaging, supervising and supporting emergency care placements.
- 132 Forthwith abandon single-handed shifts by commercial carers engaged through commercial agencies.
- 133 Reform the manner in which the use of force against children in residential care facilities is recorded and tracked by:
- a amending regulation 14 of the Family and Community Services Regulations to require any worker who participates in or witnesses an incident involving or leading to the use of force against a child to verify the accuracy of the written report of the incident or, in the alternative, where the accuracy of the written report is not verified, provide an independent written account with respect to the incident;
  - b amending the pro forma of the report to clarify the requirements of regulation 14(3);
  - c requiring supervisors to reject any report that does not comply with regulation 14(3) in the absence of any adequate explanation for non-compliance. If a non-compliant report is accepted, the supervisor should specify the reason for acceptance in the absence of compliance; and
  - d regularly audit reports to ensure compliance with the regulations.
- 134 Amend section 56 of the *Family and Community Services Act 1972* to extend the operation of the section to children in all facilities (including emergency care) established by the Minister, and develop a specific and identifiable pathway to enable a child to make a complaint to the Chief Executive pursuant to that section.
- 135 Require the Chief Executive to provide a quarterly report to the Guardian for Children and Young People (GCYP) and the Minister with respect to the number of complaints received, and any recurring themes which emerge from those reports.
- 136 Request GCYP to develop an education program for children in facilities run by the Agency or non-government organisations (emergency and residential) to explain and promote their rights pursuant to regulation 14(3) of the Family and Community Services Regulations 2009 and section 56 of the *Family and Community Services Act 1972*.
- 137 Legislate for the development of a community visitors' scheme for children in all residential and emergency care facilities.
- 138 Recruit child and youth support workers in accordance with the 2016 recruitment model, including a requirement that all applicants for those positions undergo individual psychological assessment.
- 139 Require all new child and youth support workers to complete a minimum six-month probationary period, to be followed by a rigorous performance review before approval for further employment.

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- 140** Require all child and youth support workers to complete ongoing professional development and training, particularly in the following areas:
- a the dynamics of abuse in institutional environments;
  - b understanding children who are at risk from institutional environments;
  - c the way in which children react and respond to abuse;
  - d how to respond to children whose behaviour or statements may indicate the possibility of abuse; and
  - e the early years child development, and caring for infants and young children (for selected workers).
- 141** Review and clarify policies that guide the behaviour of workers, particularly in relation to:
- a physical contact with children (to provide clear and unambiguous guidance);
  - b recording observations in observation logs; and
  - c reporting lines for information about the wellbeing of children.
- 142** Develop a clear process for workers in the residential care directorate which:
- a obliges workers to report any concerning behaviours from other workers, including those behaviours that do not necessarily meet the requirements for a mandatory report;
  - b obliges workers to report concerning behaviours from children in the absence of action by case management staff; and
  - c clarifies the availability of reporting pathways external to workers' immediate line of supervision.
- 143** Create a specific unit and database to receive and track information about the conduct of staff from:
- a care concerns;
  - b critical incident reports;
  - c information from other staff; and
  - d complaints made by children.
- This process should apply to staff employed by the directorate and those engaged through commercial agencies. Staff should be permitted to provide information directly to that unit.
- 144** Review the conduct of the specific staff identified in Volume 2, Case Study 5: Shannon McCoolle and consider their ongoing suitability for employment in their role.
- 145** Develop a streamed model of residential care with the following elements:
- a short-term assessment;
  - b long-term care for children who are not suitable for home-based care;
  - c care for children with high therapeutic needs; and
  - d built-in measures of outcomes that can be used to evaluate performance of the model on a regular basis.
- 146** Identify and adopt a model of therapeutic care which is sufficiently flexible to be applied across all categories of residential care, and which promotes a consistency of approach and standard of care for all children.
- 147** Replace operational services (OPS) 5 supervisors in residential care with allied health professional (AHP) or professional officer (PO) degree qualified staff, and recast the job and person specification to focus on the provision of staff with high level expert knowledge.
- 148** Ensure that all youth workers in residential care have regular supervision as a means to promote their professional development and, where necessary, manage deficits in their performance.

- 149 Apply the following standards across residential care:
- a no child under 10 years to be housed in a residential care facility except where necessary to keep a sibling group together; and
  - b no child to be housed in a facility with more than four children, except where necessary to keep a sibling group together.
- 150 Recruit a sufficient complement of staff to:
- a cease using commercial carers in residential care facilities;
  - b develop a casual list to provide staff who are available on a flexible basis; and
  - c abandon single-handed shifts.
- 151 Abandon any plan to outsource any residential or emergency care service that is currently delivered by the Agency.
- 152 Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.
- 153 Amend the *Children's Protection Act 1993* to enable carers to apply to be appointed an Other Person guardian where children who are subject to long term orders have been in their care for a minimum period of two years, or such lesser period as the court in its absolute discretion determines is appropriate in the circumstances.
- 154 Amend the *Children's Protection Act 1993* to provide that biological parents who oppose an application for the appointment of an Other Person Guardian bear the onus of proving to the court on the balance of probabilities why the order should not be made.
- 155 Establish an independent assessment panel to consider applications for Other Person Guardianship, in accordance with the following procedures:
- a the application to be made by a foster parent in person or by a caseworker or foster care support worker on behalf of the carer;
  - b an initial review be carried out by the Assessment Panel to determine the utility of referring the application for a full assessment;
  - c the application to be referred to the caseworker or such other appropriate person as is available to carry out the assessment and prepare the case plan in a timely manner;
  - d when the assessment has been completed and case plan prepared, the application to be referred back to the Assessment Panel for final determination;
  - e all decisions of the Assessment Panel are to be final.
- 156 Promote the use of section 80 of the *Family and Community Services Act 1972* for the delegation of decision making to support potential applications for Other Person Guardianship.
- 157 Consider the question of adoption where that is in the best interests of the child and an Other Person Guardianship order would not be appropriate.
- 158 Amend the *Children's Protection Act 1993* to require the Minister to provide or arrange assistance to care leavers aged between 18 and 25 years. Assistance should specifically include the provision of information about services and resources; financial and other support to obtain housing, education, training and employment; and access to legal advice and health care.
- 159 Expand financial counselling services to manage access to post-care financial support from the Agency provided in accordance with Recommendation 158.
- 160 Amend the *Children's Protection Act 1993* to permit care leavers to access, free of charge, original and copy documents that relate to them from the Agency, approved carers, and any non-government agencies contracted to provide care to them.

## RECOMMENDATIONS

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| <p>161 Continue to make modified payments to foster and kinship carers where the care leaver is engaged in tertiary education, apprenticeship, or any post-high school training, and where their best interests would be served by remaining in foster or kinship care until the qualification is completed.</p> | <p>172 Provide specialist training and documented guidance to staff within the Agency, as well as home-based carers and carers engaged through commercial agencies, as to their roles and responsibilities with respect to identifying and reporting conduct that may amount to a care concern, and the processes that follow such a report.</p>  |
| <p>162 Review the Rapid Response policy to identify opportunities to expand priority services to care leavers up to the age of 25.</p>   | <p>173 Consider developing technology to provide children in care with a user-friendly mechanism to engage with caseworkers in the care team and other responsible adults about their experiences and concerns.</p>   |
| <p>163 Prepare a new service model and work instruction for leaving care that incorporates the relevant elements of the National Approach, including specific reference to supporting care leavers who want to access further education and training.</p>  | <p>174 Review and implement the Structured Decision Making<sup>7</sup> care concern screening criteria tool for use by Call Centre practitioners.</p>   |
| <p>164 Redeploy transition-from-care caseworkers to provide an add-on service for young people planning their move to independence.</p>  | <p>175 Establish a panel in the Agency to determine the appropriate response pathway with respect to a care concern that is not diverted by the Call Centre to the field, but noting that all allegations that raise a suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) must be investigated by the investigations unit.</p>                    |
| <p>165 Reach an administrative arrangement with the CREATE Foundation to provide it with the names and contact details of children entering care and/or their carers (as appropriate).</p>   | <p>176 Establish in the Agency an investigations unit independent of the operations of the Agency to investigate matters referred to it by the panel, and staff that unit with a multidisciplinary team of investigators with expertise in child protection and law enforcement, and provide training and guidelines as to the scope of their roles.</p>  |
| <p>166 Fund the development of a smartphone application that provides young people with up-to-date information about services and entitlements when leaving care.</p>  | <p>177 Ensure that all care concern notifications are investigated in a timely manner:</p> <ul style="list-style-type: none"> <li>a investigations should commence within 48 hours of the receipt of a notification; and</li> <li>b in the absence of ongoing criminal proceedings or special reasons, investigations should be completed within six weeks from receipt of the notification.</li> </ul> |
| <p>167 Review contractual conditions governing service specifications for non-government independent living programs to develop greater flexibility in the age of admission and the age of discharge from programs.</p>  | <p>178 Require a strategy meeting to be held at the start of all investigations undertaken by the investigations unit.</p>  |
| <p>168 Fund Housing SA to develop innovative housing models, particularly those that use supported share housing where appropriate for care leavers.</p>   | <p>179 Define the standards against which deficiencies in the care provided to a child in care should be assessed.</p>  |
| <p>169 Fund a pilot program of intensive case management assistance for vulnerable care leavers, to be delivered by an agency with established relationships with vulnerable children in care.</p>   |   |
| <p>170 Conduct a review of the needs of the population currently accessing Relationships Australia's services to identify the specific needs of service users.</p>   |   |
| <p>171 Make a significant injection of funds into post-care services currently provided by Relationships Australia, to enable these to be delivered more flexibly and more assertively.</p>  |   |

- 180 Clarify the powers available to investigators, including putting in place appropriate delegations and authorities pursuant to sections 45 and 47 of the *Family and Community Services Act 1972* and section 19 of the *Children's Protection Act 1993*.
- 181 Ensure that staff are available in the investigations unit who are trained in forensic interviewing of children when this service is required.
- 182 Amend section 104 of the *Summary Procedure Act 1921* to permit the filing in committal proceedings of a transcript of a recorded interview with a child under the age of 14 years that has been verified by a person in attendance at the interview, other than an investigating officer as defined in the Act.
- 183 Require investigators to record an outcome as 'undetermined' in any case in which there is insufficient evidence to make a definitive finding.
- 184 Establish a response unit within the directorate responsible for quality and practice to:
- a provide advice to front-line staff about care concerns;
  - b provide a report to the Chief Executive of the Agency outlining responses and intended actions to issues identified in an investigation report. This should be provided within four weeks of the response unit receiving the investigation report;
  - c undertake a monitoring role in respect of all care concern notifications;
  - d analyse trends in care concern data to proactively address systems issues and inform the management of staff and carers; and
  - e make recommendations to the Chief Executive of the Agency as to proposed improvements in response to identified systems issues.
- 185 Establish a liaison function between the response unit and SAPOL, particularly with respect to identification of aspects of a care concern investigation that may be commenced by the Agency while criminal proceedings are pending.
- 186 Require the Agency to provide quarterly data to the Minister and the Guardian for Children and Young People about care concerns, including:
- a the number of care concern notifications received and their response pathway;
  - b how many care concern investigations have been completed;
  - c whether investigation timeframes have been met and the reasons for timeframes not being met;
  - d the outcomes of investigations; and
  - e how identified systems issues are being addressed.
- 187 Develop an Aboriginal recruitment and retention strategy in the Agency as part of a broader workforce strategy.
- 188 Review procedures to streamline the sources of internal cultural advice to the Agency.
- 189 Review practice guidance, funding arrangements and the range of declared agencies to ensure that a recognised Aboriginal agency is consulted on all placement decisions involving Aboriginal and Torres Strait Islander children, in accordance with the provisions of section 5 of the *Children's Protection Act 1993*.
- 190 Establish a dedicated family scoping unit.
- 191 Provide all practitioners in the child protection system with training, support and clinical supervision to give them the knowledge, skills and techniques to work effectively with Aboriginal children and families, including, where appropriate, the specific skills required to work effectively in remote Aboriginal communities.
- 192 Use the proposed Early Intervention Research Directorate to identify evidence-based service models for early intervention that meet the needs of Aboriginal children and families.
- 193 Outsource the services currently provided by Kanggarendi to an appropriately qualified and experienced non-government organisation.
- 194 Commission not-for-profit agencies to develop service models that can respond to higher risk Aboriginal families with multiple, complex needs.

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| <p>195 Ensure that Local Assessments of Needs (LANs) specifically consider the needs of Aboriginal children and families and consult with local Aboriginal people and service providers.</p>  | <p>204 Ensure that the Agency's practitioners monitor children cared for in accordance with Family Care Meeting agreements to ensure the safety of the child.</p>  |
| <p>196 Place local Aboriginal support services within child and family assessment and referral networks to promote service coordination and act as a visible point of entry.</p>  | <p>205 Commission not-for-profit agencies to provide alternative care in areas close to the APY Lands, such as Alice Springs and Coober Pedy. Alternative care could include a mixture of foster care and residential care.</p>  |
| <p>197 Adopt a culturally appropriate assessment tool, such as Winangay, for the assessment of foster parents and kinship carers in the Aboriginal community, initially in remote communities, and more widely if the tool proves promising.</p>  | <p>206 Require that full carer assessments be completed in a timely manner in remote communities.</p>  |
| <p>198 Require the Agency to report to the Minister and the Guardian for Children and Young People quarterly on service criteria 3.1.4.1, 3.1.4.4 and 3.1.4.6, which form part of standard 3.1.4 of the Standards of Alternative Care in South Australia.</p>                           | <p>207 Ensure that approved carers in remote communities receive the same level of support as carers elsewhere in the state, recognising the particular challenges faced by carers in these remote areas.</p>                    |
| <p>199 Consult with each remote Aboriginal community about the implementation of the recommendations following this report, as part of ongoing engagement with communities about the strategic direction of services to improve the health, safety and wellbeing of their children.</p> | <p>208 Ensure that the unit tasked with investigating care concerns offers a service in remote communities equivalent to that provided elsewhere in the state.</p>   |
| <p>200 Offer stable employment arrangements with competitive, ongoing retention allowances to attract and recruit six permanent Lands-based workers to support the Agency's fly-in fly-out teams.</p>   | <p>209 Provide secure, long-term funding for playgroups in remote Aboriginal communities, administered by a single agency.</p>   |
| <p>201 Actively pursue joint training opportunities for agencies in remote communities and require operational managers from agencies to meet regularly to identify areas for collaboration and to resolve issues of concern.</p>   | <p>210 Establish an integrated administration information communication technology (ICT) system to allow access to a complete range of student data to children who move schools in remote Aboriginal communities.</p>           |
| <p>202 Ensure that at least one principal Aboriginal consultant has experience and expertise in remote Aboriginal communities, including in the APY Lands.</p>  | <p>211 Provide additional funding to meet demand for the Walytjapiti program, and ensure that the Agency keeps case files open for participants until satisfied about the child's ongoing wellbeing over a sustained period.</p> |
| <p>203 Identify opportunities to develop strength in the interpreter service available in remote communities, and ensure that the Agency's practitioners use interpreters where possible. Consider the viability of interpreters accompanying the Agency's fly-in fly-out teams.</p>    | <p>212 Commission an early intervention service for families in remote communities for whom the Agency has lower level concerns and who could benefit from support to prevent escalation of issues.</p>                          |
|   | <p>213 Conduct an audit of services in remote Aboriginal communities to ensure access to adequate facilities to serve as a service hub for playgroups, preschools and other services that visit the community.</p>               |

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| 214 | Reform funding and structural arrangements to enable a single agency to oversee the service hub facilities across all communities. This agency should regularly map, in collaboration with the local community, the needs of children and families through an annual Local Assessment of Needs.  | 223 | Ensure that every child in care, or who enters care, and who is potentially eligible, applies to participate in the National Disability Insurance Scheme (NDIS). For children already in care, this must occur by 31 March 2017.                     |
| 215 | Establish a working group to promote collaborative practice between South Australian, Western Australian and Northern Territory agencies involved in the child protection system in the tri-border region, including working towards a cross-border legislative scheme for child protection across the three jurisdictions.  | 224 | Develop the function in C3MS to require caseworkers to input information when a child enters care, and for those children already in care, as to their potential eligibility for NDIS. This data should be extractable for analysis.                 |
| 216 | Review child protection service provision in Ceduna, Yalata and Oak Valley, including the viability of introducing a fly-in fly-out service.   | 225 | Determine and fund demand for specialist disability foster care placements in accordance with the available data about children in care who are eligible for NDIS.   |
| 217 | Develop strategies to improve out-of-home care options in regional areas including: <ul style="list-style-type: none"> <li style="margin-bottom: 10px;">a focusing attention on the recruitment of foster parents, particularly in areas of need; and</li> <li>b identifying areas where there is a demand for residential care placements and develop facilities in those areas.</li> </ul> | 226 | Employ specialist disability workers to consult across the Agency in matters involving children with disabilities.   |
| 218 | Require the Agency to develop a dedicated psychological service to deliver therapeutic services to children in care in regional areas.   | 227 | Train Agency caseworkers to recognise and respond to the needs of children with disabilities, particularly in accessing and maximising support services offered by NDIS.   |
| 219 | Collaborate with the Courts Administration Authority to improve access to justice for children in need of care in regional areas, including providing appropriate technology with respect to hearings in remote locations.   | 228 | Ensure Agency caseworkers, when participating in NDIS planning, prioritise the use of the Alternative Care Therapeutic Team program when appropriate to meet the therapeutic needs of a child in care.   |
| 220 | Prepare an annual Local Assessment of Needs for each regional area.  | 229 | Develop clear guidelines on the role of home-based carers in planning and decision making in NDIS for children in their care.  |
| 221 | Ensure that the Agency's practitioners in regional areas have access to ongoing professional development, through locally delivered training and videoconferencing.  | 230 | Require child and family assessment and referral network members to provide support for families who are caring for children with disabilities, to enable them to engage with NDIS.  |
| 222 | Require the Agency to develop attraction and retention strategies specific to building workforce sustainability in regional areas, including the use of financial incentives for staff.  | 231 | Require that the cultural background of children coming into contact with the child protection system be recorded on C3MS, including in the Life Domains area, for all children in care who have a culturally and linguistically diverse background. |
|     |  | 232 | Analyse data collected regarding the cultural background of children coming into contact with the child protection system to determine how to best respond to children at risk in culturally and linguistically diverse communities.                 |
|     |  | 233 | Undertake a qualitative review of the capacity of the Agency's Multicultural Community Engagement Team (MCET).   |



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- 234** Evaluate the effectiveness of specialist MCET staff working together with front-line practitioners on child protection cases and assess the value of collocating MCET staff in the Agency's offices.
- 235** Assist staff and carers who work with children in care who have a culturally and linguistically diverse background to achieve culturally informed best practice through the development of practice guides.
- 236** Ensure that every child in care with a culturally and linguistically diverse background has a comprehensive cultural maintenance plan that is regularly reviewed, having regard to the child's age and placement circumstances.
- 237** Identify key performance indicators on the cultural competency of the Agency's workforce, and regularly review the effect of these recommendations on that competency.
- 238** Enact a stand-alone legislative instrument to regulate the screening of individuals engaged in child-related work which:
- a** declares that the paramount consideration in screening assessment must be the best interests of children, having regard to their safety and protection;
  - b** invests powers in only one authorised government screening unit which is charged with maintaining a public register of all clearances and their expiration dates;
  - c** empowers the screening authority to take into account in its assessments criminal offence and child protection history, professional misconduct or disciplinary proceedings, and deregistration as a foster parent or other type of carer under the *Family and Community Services Act 1972*;
  - d** provides a clear definition of child-related work, including the meaning of incidental or usual contact;
  - e** declares that the outcome of a screening assessment will be limited to either a clearance or a refusal and that all applications, even if withdrawn, will be assessed;
- f** requires individuals to seek and maintain a personal clearance, valid for a period of up to five years, through a card or unique electronic identifier system, which has portability across roles and organisations in the state; and to notify the screening authority of relevant changes in their offence, conduct or child protection circumstances;
  - g** requires employers to ensure that all relevant personnel in their organisations, at all times, hold current clearances;
  - h** precludes exemptions from screening requirements for—
    - i** registered teachers
    - ii** applicants waiting on screening outcome decisions
    - iii** those working or volunteering with children who are in care
    - iv** those who have been refused a WWCC;
  - i** details offences for individuals and organisations who fail to comply with the provisions of the legislation, including engagement in or for child-related work without a clearance, and dishonesty in the application process; and
  - j** permits appeals from decisions of the screening authority to the South Australian Civil and Administrative Tribunal or other independent body.
- 239** Establish a real-time monitoring system which ensures that changes in screened individuals' circumstances are communicated to the screening authority, that clearances are reviewed, and that changes are reflected in the register, and communicated to employers.

- 240 Charge the screening authority with:
- a ensuring that it has access to forensic expertise in child protection and behavioural indicators of risk;
  - b developing a consolidated set of standards, matrices, and weighting guidelines for use in screening assessments, that include substantiated and unsubstantiated criminal, child protection and disciplinary matters, and ensuring that assessors are appropriately trained in their application;
  - c developing guidelines for ensuring that applicants are afforded appropriate procedural fairness, including circumstances in which information may be withheld from applicants;
  - d developing and promulgating timeline benchmarks for screening outcomes, and procedures for informing applicants whose clearances may fall outside benchmarked times;
  - e developing information sharing protocols with interstate screening units.
- 241 Develop an independent mechanism and evaluation process for reviewing the performance of the screening authority.
- 242 Amend the *Children's Protection Act 1993*:
- a to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies that have responsibilities for the health, safety or wellbeing of children where it would promote those issues; and
  - b to require prescribed government and non-government agencies to take reasonable steps to coordinate decision making and the delivery of services for children.
- 243 Require senior leaders from government and non-government agencies that have responsibilities for the health, safety and wellbeing of children to meet at least quarterly to identify strategic measures to promote inter-agency collaboration and information sharing.
- 244 Review procedures and employment arrangements so that chief executives of government agencies with responsibilities for the health, safety and wellbeing of children have a provision included in their performance agreements that obliges them to ensure inter-agency collaboration in child protection matters, and measure that performance.
- 245 Establish the statutory office of the Commissioner for Children and Young People and provide the Commissioner with the functions and powers referred to in this report.
- 246 Consolidate the legislation for the Children's Commissioner, the Guardian for Children and Young People (GCYP), the Child Death and Serious Injury Review Committee (CDSIRC) and the Child Development Council in a single Act of Parliament.
- 247 Empower GCYP and CDSIRC to refer matters to the Children's Commissioner, where they are of the view that escalation through processes available to the Children's Commissioner is appropriate.
- 248 Empower the Children's Commissioner to exercise its statutory powers and functions in relation to such matters, including employing the regime to monitor government responses to recommendations, and escalate the matter to the Minister and Parliament where necessary, at his or her sole discretion.
- 249 Collocate the Children's Commissioner, GCYP, CDSIRC and the Child Development Committee, and make arrangements for the sharing of some administrative functions.
- 250 Amend legislation to permit, but not require, GCYP, CDSIRC and the Children's Commissioner to share de-identified data.
- 251 Amend legislation to empower the Children's Commissioner or GCYP to make complaints to the Ombudsman and HCSCC on behalf of a child.
- 252 Amend the *Ombudsman Act 1972 (SA)* to ensure that complaints about the actions of government agencies, and other agencies acting under contract to the government, concerning child protection services, find principal jurisdiction with the Ombudsman, and not the Health and Community Services Complaints Commissioner, where the complaint is about an administrative act.

## RECOMMENDATIONS

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- 253 Amend the *Ombudsman Act 1972* to permit the Ombudsman to exercise the jurisdiction of Health Care and Community Services Complaints Commissioner (HCSCC) in appropriate cases.
- 254 Develop an administrative arrangement between the Ombudsman and HCSCC to determine matters in which the Ombudsman would exercise dual jurisdictions, including, but not limited to, child protection complaints.
- 255 Develop the capacity of the Ombudsman's Office to respond specifically to child protection complaints.
- 256 Develop a package of information regarding making complaints about child protection matters, including information and complaint forms which are suitable for children and young people.
- 257 Establish an across-government steering committee to monitor and oversee the implementation of recommendations. Membership of the committee should include representation by senior executives from relevant government agencies and include at least one independent member external to the South Australian Government. The Committee should report directly to the Minister for Child Protection Reform as Chair of the Child Protection Reform Cabinet Committee.
- 258 Establish a response and implementation team consisting of staff with expertise in child protection, policy, data analysis, stakeholder engagement and legislative development.
- 259 Ensure the implementation of recommendations within the newly formed child protection department is adequately managed with high-level change agents and appropriately qualified and skilled child protection staff.
- 260 Respond to the recommendations in this report as follows:
- a on or before 31 December 2016, provide a report setting out—
    - i the recommendations of the Commission that have been implemented either partly or in full
    - ii the recommendations of the Commission that have been accepted, but have not yet been fully implemented, the manner in which they will be fully implemented and the intended timeframe for that implementation
    - iii the recommendations of the Commission that will not be implemented and the reason for not implementing them;
  - b on or before 30 June 2017, provide a further report as to—
    - i the recommendations that have been wholly or partly implemented and the manner in which they have been implemented
    - ii if a decision has been made not to implement a recommendation that was to be implemented, the reason for not implementing that recommendation
    - iii if a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for that decision and the manner in which the recommendation will be implemented;
  - c for a period of not less than five years after the provision of the report referred to in paragraph 4(b) hereof, provide an annual report setting out—
    - i the recommendations that have been wholly or partly implemented in the relevant year and the manner in which they have been implemented
    - ii if, during the relevant year, a decision has been made not to implement a recommendation that previously was to be implemented, the reason for not implementing that recommendation
    - iii if, during the relevant year, a decision has been made to implement a recommendation that previously was not to be implemented, the reasons for the decision and the manner in which the recommendation will be implemented;
  - d make reports publicly accessible, including being published online.