

# Barnardos Australia Response to Royal Commission on Institutional Responses to Child Sexual Abuse

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## **Issues Paper 4: Preventing sexual abuse in out of home care**

Barnardos welcomes this opportunity to examine ways to prevent sexual abuse in out of home care. This submission is based on Barnardos' learning over the past century - failure and successes - and our assessment of the impact of management strategies to stop abuse and provide better outcomes for children in care. Ultimately, we believe that the opportunistic nature of sexual assault means that a proactive approach to risk will always be required. This submission to some degree may duplicate our response to Issues Paper 3.

Barnardos Australia provides out of home care including adoption, foster care, residential care, statutory kin care and youth homelessness programs in NSW and the Australian Capital Territory. Every year we care for approximately 700 children and young people in out of home care. Barnardos has a history of child migration from 1921 and in the past has run farm training schools and group homes. We have learnt from all of these experiences and appeared before Senate enquiries into Child Migration and Children in Institutions and we maintain close relationships with many of the now adult child migrants, one of whom is a Barnardos Board member.

From the mid -1950s Barnardos mainly utilised group homes but, for the past 20 years, have predominantly run short-term and permanent foster care programs. We do not generally take Aboriginal children into our services, preferring instead to partner with Aboriginal out of home care agencies. Most of the children in permanent care have parental responsibility to the Chief Executive via a Deed of Agreement with the Minister in NSW. We hold Class or Kind status with the NSW Ombudsman. Barnardos utilises the Looking After Children (LACES) case management system for all children in out of home care. This system encourages active engagement with children and is a well researched means of tracking children's wellbeing (Wise 1999; Cheers and Morwitzer 2006; Tregear 2010; Cheers, Fernandez et al. 2011).

## Responses to Required Information

### 1. **An essential element of OOHC is for children to be safe and secure. Are there core strategies to keeping children in OOHC safe from sexual abuse and what is the evidence to support them?**

Barnardos believes that the **culture** of an organisation needs to be developed, which encourages positive and trusting relationships with children, listens to them and gives clear messages that offending will be unearthed and punishment will follow. This culture is only achieved through detailed attention to quality in service delivery and a number of management strategies which Barnardos have found helpful are detailed below. Nevertheless, examination of evidence of our own agency's performance shows that, historically and today, this is not enough to prevent all abuse. We believe that a proactive risk policy around risks to children and compliant with Australian Standards is also required to focus the agency on constant vigilance.

- a. **A child's right to safety is a central value.** Expectations of high standards of care in all aspects are needed. Our experience is that agencies that do not stress ongoing quality of standards are in danger of allowing pragmatic compromises for children's care, such as overloading carers with too many children in their homes. In such cases, this creates stresses when children's care is compromised and access to potential abusers occurs. The standards we refer to are those detailed in the Standards of Out of Home Care set out by the NSW Children's Guardian.
  
- b. **Children are given permission and encouragement to talk about issues of concern to them.** Assisting children to understand their right to safety of their bodies is fundamental and strategies for children to talk alone to a safe adult require training of staff and carers to develop and maintain their skills in relating to children. For example, foster care agencies should ensure that children have the opportunity to talk alone to a worker at predictable intervals. This can be done effectively if workers take children to spaces outside the home and talk to them alone every few months (when a placement is ongoing). Fundamental to a child disclosing is that the child has a trusting, long-term relationship with that adult. Children also need the words to use to describe parts of their body and to understand what inappropriate behaviour is, and to be encouraged to talk about feeling 'not safe'. Carers also need assistance to encourage conversations as our experience has shown that carers are most often the first disclosure point of a child of abuse in the past, either when at home or with previous carers.

- c. **Allegations and complaints are encouraged.** Workers, carers and volunteers need to be clear that their organisation supports them valuing the children rather than ‘the organisation’ or their staff group or carer group, and that allegations/complaints are encouraged and rapidly investigated and pursued. There needs to be a strong whistleblower policy.

*Management techniques to achieve this culture include:*

- **‘Risk Policy’ compliant with Australian standards and specifically addresses risk to children (Standards Australia AS/NZ ISO 31000:2009).**

This standard means that the agency continually identifies the nature, likelihood, timeframe, tolerance levels and combinations of risks, and then acts to reduce risk. Risks to children are regularly discussed and reviewed by the organisation (at all levels) and are reflected in all agency processes, with the child as the central focus of responsibility – rather than the focus being predominantly on finance or reputation.

Risk policy focused on children means we try to be constantly vigilant about child sexual abuse. Despite the organisational procedures described below, Barnardos still has occasional instances of allegations related to sexual misconduct and therefore we endorse the principle that every welfare agency needs to be proactive and learning. In our view, the nature of adults who perpetrate inappropriate sexual behaviour towards children means that it will always be hard ever to be one hundred percent certain about children’s safety, so that constant vigilance and review is essential. The private nature of family homes provides access and opportunity for offending behaviour.

- **A clear comprehensive case management system, valued by workers and managers, which assists them in their day to day work with children.**

Barnardos has developed and provided to other out of home care agencies in NSW the international best practice system, Looking after Children (LAC) and its electronic system, LACES, which is soon to be developed into MyStory. Effective systems ensure that children and carers are seen at regular intervals and that issues of safety are routinely discussed. This system records that children are seen alone and their opinions recorded.

A standardised case management system allows the accumulation of data and enhances the communication essential to keeping children safe. For example, review of data from the case management system can check compliance with policies and provide the management information which can enhance the development of policy initiatives. Currently, some bureaucracies cannot even locate the children in their care to ensure appropriate individual visiting by a caseworker. Most are unable to easily assess the number of placement moves a child may have, or the number of moves for cohorts of children. Yet the number of moves in care can enhance behavioural disturbance and expose children to increasing numbers of adults (who may be abusive).

- **Accreditation**

Accreditation of Out of Home Care agencies in NSW ensures that an agency is at the standard of service expected to keep children safe. This is audited by an external body – in NSW, this is the Office of the Children’s Guardian (OCG) - to ensure compliance. The standards outlined are all important for building a child safe environment. All agency policies and procedures need to be updated every five years to comply with the most recent research and legislative developments. The OCG has access to all policies and the audits described above. However, we are concerned that funding in NSW may mean that the agency auditing visits of the Children’s Guardian are likely to be discontinued.

- **Supervision of all welfare staff.**

Supervision of those people who have face to face contact with children should be held at least each month, at a set time, for at least one hour, and conducted by an experienced child welfare worker. Supervision must be used for on-going review of children on a caseload, including identifying any safety concerns, and to ensure that conversations about child safety occur. Supervisors must also routinely explore the appropriateness of the relationship between child and worker and carer. Supervision should use the case management system described above - which can provide the information to inform supervisors. A case management system can help monitor that all caseworkers and placements are supervised and to draw on standardised data which can be easily referenced. It collates data about the child’s life and highlights possible anomalies which need follow-up.

- **Well-developed recruitment policy/employment procedures for staff.**

These must include thorough checking of qualifications, intensive interviews of potential workers, exhaustive reference checks and review of applicants by experienced managers. Every new person with face to face contact with children must have approval of the NSW Working with Children Check (WWCC) or the ACT Working with Vulnerable People (WWVP) checks or equivalent, as well as being assessed as suitable for the task.

- **Carer assessment should include multiple interviews by a number of caseworkers, with decisions made by experienced managers or teams.**

Assessment of adoption, foster and kin carers should examine the background of all members of the household and include a very personal history of each individual. There must be full reference checks.

- **Quality staff training.**

All workers and carers need to receive initial and ongoing training to ensure quality standards, with a particular focus on the vulnerability of children and the importance of their safety. This training should be informed by data drawn from research and from case management systems. Training should be conducted both inside the agency and by external bodies. The importance of periodically seeing the child alone needs to be stressed and the development of a trusting relationship critical to any work. Training on the handling of disclosure needs to be thorough (see recent articles Flam and Haugstvedt 2013; McElvaney 2013). In NSW, Accreditation Standards check that this training occurs.

- **Rapid investigation of allegations and immediate action to move children to safety.**

Barnardos has found the timeframes and investigative processes instigated by the NSW Ombudsman to be very useful in ensuring timely and fair investigations of allegations. We have extended this process in our Canberra programs, because they were not previously as thorough. The NSW investigative framework means that a decision must be made formally and quickly as to the immediate safety of the child, by people who know the child's situation. The engagement of the Chief Executive in all decisions is an important principle for us in ensuring that allegations are treated with the utmost respect.

We believe that recent changes to the *Working with Children Check* in NSW will increase safety further.

- **Regular ongoing review of allegations and their implications for agency management.**

Data on allegations should be routinely collated by the agency and considered at the highest levels to ensure that children's rights are observed and that the agency as a whole is treating each situation with gravity. Barnardos does this through CEO involvement and regular reports to the Board. The insurance we carry also requires that we inform of any matter which needs to be reported to a government agency.

- **Analysis of standard issues.**

Organisations need to review their adherence to 'standards of care', for example, the level of stability of placements and ongoing research on the risk to children's wellbeing in organisations. For example, Barnardos has undertaken, with the University of NSW, a ten-year longitudinal review of children in our permanent foster program. Review of the academic literature can assist in the identification of risk to children, for example, Barnardos finds it useful to regularly analyse articles on child protection systems in the United Kingdom, where there are extensive inquiries as to children's safety. We fund staff visits to other states and countries, as well as funding quality overseas experts to visit NSW.

- **Well articulated policies directed to workers, carers and volunteers.**

All accredited agencies in NSW are required to have appropriate 'protective' policies in place and available to carers, workers and volunteers (in our case, through program specific practice handbooks). We have found it important to have clear procedures, for example, on complaints, contact with children outside the workplace, use of the Internet and information exchange.

- **Biennial audits of programs and centres.**

Barnardos' policies are checked in supervision, as described above, however, we have found that we need stronger mechanisms to monitor compliance with key policies. We have found that we require regular audits to make sure that policies are implemented fully in each program. For example, we check that each program provides updated information to carers, which is important to reinforce understandings about what will happen if an allegation or

complaint is made. Compliance with completing the case management system also needs to be reviewed. Our audit information is checked by the Centre Senior Manager and is sent to the Board every two years.

- **A special visitor program for each Centre.**

Members of the Board are allocated to familiarise themselves with particular programs and so they are able to observe the morale of staff.

- **Liaison with industry bodies.**

Membership of PEAK bodies, such as the NSW Association of Children's Welfare Agencies (ACWA), is helpful in identifying risk and ways of reducing it and for organisations to learn from one another about situations of concern.

*Our internal evidence shows that our strategies, alone, do not stop all allegations or incidents of sexual abuse.*

- **Allegations of Sexual Abuse and Rate**

In the 1960s and 70s, Barnardos had two known incidents of paedophile activity and, in both situations, there were written policy guidelines to protect children, and workers monitoring the program. At that time, little was known about the frequency of child sexual abuse. In the 1960's case, a child disclosed to a manager sexual abuse by staff members. The police were informed and perpetrators convicted. The second case, in the 1970s, involved disclosure years after the incident and initial unwillingness to report to police by the victims. Victims recreated their story on two hour-long TV programs and the later imprisonment of the abuser raised awareness for the general public and was critically important for Barnardos. The incidents have been influential in shaping management's integration of child protection concerns throughout the whole organisation.

Recent practice has evidenced that Barnardos still experiences allegations of sexual assault despite all the processes described above being in place. We have maintained data over the past five years in which we have had 1,705 children in foster, residential and community placement care. We have had 17 allegations of sexually inappropriate behaviour which we have sent to the NSW Ombudsman or ACT department. Of these: 3 have been sustained, 4 are awaiting determination (over some time), 6 were deemed non reportable (because they did not involve an employee or carer), 4 were not sustained or were uncertain in outcome. These figures show that, whilst the vast majority of children are safe, less than one percent were subject to allegations and of these in our estimation **0.3%, are 'likely' to be sustainable**. Two (0.1%) involved allegations of penetration. Police and the state or territory welfare departments were immediately involved in all relevant instances (10), and in all cases meetings to assess risk to the child or other children were held within 24 hours of the allegation coming to light. The Chief Executive was informed within two weeks and the Ombudsman within a month.

Note - the bulk of allegations of sexual assault have been made in relation to either family day carers or foster carers. Only one involved staff members. This pattern reflects the access which becomes possible in a family home.

**2. Is there evidence for having different strategies to keep children in OOHC safe from sexual assault, depending on whether a child is in relative or kin care, foster care or one of the forms of residential care?**

There is evidence for the broad conclusion that children's wellbeing and functioning is improved with stable placement - a secure, ongoing placement in the same household with adults who have a positive relationship with the child. While we know of no research directed at the question of what setting produces the least sexual assault, long-term, stable placement seems to provide the least allegations and clearly exposes the child to the fewest potential abusers. Barnardos' experience strongly supports the role of secure, positive placements. Barnardos believes that it is important that each child has a separate bedroom and that, in residential settings, bedrooms are located in areas which can be easily monitored. In our experience, sexual abuse can occur when older children are co-located with younger children and sometimes with members of the same family, cared for in the same setting. Out of home care agencies need to be knowledgeable of the likelihood of this and institute proper arrangements to protect children.

Our current concern, as Barnardos accepts transition of kin carers previously serviced by the Dept of Community Services, and from our previous work with kin care, centres around the poor standard of assessment of kin carers for their task. We accept that there are differences in placement of children with kin which need to be retained but, prior to placement, Government departments or social workers should not 'rubber stamp' the claims of kin. Rather, a full assessment should be undertaken, particularly around the capacity of kin to keep the children safe. We are currently engaged in a trial of an Aboriginal Assessment Tool with Winangay Resources Inc, who are supported by FaHCSIA. Frequently, Aboriginal kin have high numbers of children placed, which create supervision problems that can lead to children being abused.

We are interested in further research on the physical environment which may create opportunities for abuse, as foster care and kin care are now the major places for care and are highly private environments. Barnardos would be interested to see research about offenders who had not previously offended until a new child entered the household, as well as research on the ages of greatest vulnerability in these settings. We would be interested in a review of prevention and self-protection programs in Australia (Thakkar-Kolar, Ryan et al. 2008).

Barnardos now works with numbers of families who care for children known to them (kincarers) and believes that those families should be subject to ordinary community standards (even if under statutory care). Agency monitoring should not be intrusive after

good initial assessment and must move to normalise the child's circumstances as much as possible, with support offered in useful ways to the kin carer and the child.

Educating children about their right to safety has been noted above as an important element in allowing children to disclose, however evidence of how this may occur will be different in different care settings. As previously noted, carers are more usually approached by children to disclose past abuse.

**3. What are the strengths and weaknesses of models that check OOHC practices by an audit approach, a regular supervisory visit, or an irregular visit by someone like a community visitor?**

We are unsure of the exact meaning of practices in this question, so will make some general comments.

Firstly, an audit should be on quality of practice in the broadest sense not just reporting on processes or investigative behaviours. As we have stressed, an agency where there are strong relationships between child and worker, and where there is strong and assertive management, is most likely to prevent abuse and neglect. Barnardos fully supports the development of standards and the process of auditing undertaken by the NSW Office of the Children's Guardian. The development of this process over the last few years has resulted in a flexible but rigorous audit system, with both a formal and informal process working in tandem through audit visits. Barnardos believes that all agencies in Australia should be subject to the same level of accreditation and auditing. We are very concerned that budgetary considerations may threaten this audit process in NSW. We support an audit which selects files from the whole agency, investigates staff and talks to carers/children.

We do not support the notion of 'community visitors', which we have experienced. The visitors were of variable quality, with variable frequency. They had very little relationship credibility with young people. While this may be very useful in prisons/juvenile justice with clear breaches of human rights and could provide some insights into some residential care settings, it does not provide assistance to change in the same way the Children's Guardian process has allowed. We believe that the NSW Accreditation system, which requires policies to be in place and participation of children and young people, is the most robust way to protect children. Children need a relationship with a person before 'opening up communication' and an occasional visitor is unlikely to develop such a relationship.

**4. What are the strengths and weaknesses of having OOHC providers regulated by the child protection department, or regulated by a body separate from the child protection department?**

Barnardos supports the model of a separate body from the child welfare department. The Children's Guardian and the NSW Ombudsman have led the way in developing such strategies. It is important to note that the NSW Department was not able to achieve accreditation in NSW in 13 years and therefore it would seem ridiculous to have them monitoring other agencies.

**5. What are the core components of training needs of those working with children who might be sexually abused including carers, caseworkers and staff or regulatory bodies? What priority should be given to training in relation to sexual abuse compared to other training needs?**

Carers and workers need initial training and supervision in developing an appropriate relationship with children and an awareness of the vulnerability of children in out of home care. Very many children in Out of Home Care have been sexually abused, therefore all staff need a good foundation of understanding the trauma for children associated with sexual abuse. Many of the natural parents are also victims of inter-generational abuse, including sexual abuse. The close association between serial abuse and removal of children by the children's courts is well known and therefore all workers, carers and managers need to be highly trained to understand both the short term and long term effects, for example the emergence of acute distress at the time of puberty in children who have suffered sexual abuse at an early age.

Sexual activity of children in care also needs to be understood.

Workers need to understand how to manage initial disclosures by children of all abuse and be trained to assist carers when children disclose abuse to them.

**6. Is there adequate and effective training and information available to carers who are caring for children who have been sexually abused?**

Barnardos long-term and short-term foster carers are all trained in the likely behaviour of children who have been sexually abused. They are all informed and have paper copies of the allegation policies and protocols and provisions that need to be made to make the child safe whilst an investigation is underway.

**7. How should the rate of sexual assault of children in out of home care be determined, noting that the National Standards in Out of Home care require reporting on substantiated claims of all types of abuse. Would a form of exit interview assist in capturing information? What should be introduced to ascertain whether information on child sexual abuse in OOHC resulting in changed OOHC practice?**

We believe that research into NSW individual reports to the Ombudsman and Children's Commissioner would be a useful indication of abuse levels for monitoring and differentiating between unfounded, uncertain outcomes and whether these have been sustained. We point out that this may be a measure of systems issues and not a measure of actual abuse, nevertheless it would be useful for other states and territories to maintain such a register.

Many allegations are highly ambiguous and there frequently are no clear answers to whether abuse has taken place. Although we always err on the side of the child, that is, we give children the 'benefit of the doubt', this lack of clear outcomes of investigations is

problematic. We would point out that non-government agencies such as our own often find it difficult to learn the outcome of reported allegations, despite the involvement of *Joint Investigative Review Teams* (JIRT) ie, police and welfare departments working together.

**8. What is the usefulness and validity of different ways to address allegations of sexual abuse brought against carers? In particular which approaches enhance participation by the child particularly approaches best suited to seeking possible disclosures of abuse from children? Are the current processes fair? What appeal processes should be available for carers?**

We are unsure what ‘different ways’ of handling allegations involving carers the Commission is referring to. In Barnardos all allegations against carers are treated in the same way as an allegation against a staff member and are reported to the Ombudsman. We involve the Department of Families & Community Services and their Joint Investigative Team, which includes police.

As stated above, it is only in a trusted relationship with an adult that disclosures are likely to be made. Agency workers try to secure this relationship and, even if the child does not make a disclosure, it is important that carers know that children are seen alone by agency workers. Sometimes this disclosure comes during a child’s contact visit with a birth parent and it is important to make sure good contact arrangements are in place.

Barnardos always puts the child’s safety as the primary consideration and carers are forewarned in training that we must act as if an allegation is true.

Although we always give children’s allegations the highest credibility, in a small minority of cases we have experienced situations in which previous experience of inappropriate behaviour and understanding of how allegations can discredit adults have been used by teenagers. We believe that this is the case in two of the allegations we have received in the past five years. More knowledge is needed in this area of our work.

Because it is impossible for us to be sure that abuse has not occurred, it is important that the agency’s beliefs about the circumstances are respected. No agency should be expected to work with carers that they do not trust, even though the level of proof required may leave the position uncertain.

**9. What measures could be used to assess whether the safety of children from sexual abuse in OOHC is enhanced by independent oversight of the handling of allegations?**

It has been our experience that external oversight is important in that it prevents investigations from taking an inappropriate length of time, allowing proper investigation and fair process.

## **10. What are the strengths and weaknesses of different oversight mechanisms in keeping children safe from sexual abuse in OOHC?**

As noted above, we believe that a close relationship with trusted adults is the key to disclosure and knowledge of that can help prevent other adults from abusing. Oversight of the general quality of out of home care by the NSW Children's Guardian has proved an effective way of ensuring policies are in place to protect and visit children.

## **11. What implications exist for record keeping and access to records, from delayed reporting of child abuse?**

No record keeping system seems to be foolproof in this area.

Research should be undertaken about the effectiveness of current reporting and investigative regimes. We are aware of errors that have occurred in the past and believe that there should be some external scrutiny. Organisations like *Child Death Review* teams may be able to do such work.

As pointed out in our response to Issues Paper 1, we believe that an agency should be able to report any concerns to a centralised register, such as that maintained by the NSW Children's Commissioner. Currently we are restricted to reports on employees or carers and we have unsuccessfully tried to put the names of relatives of carers onto registers. There have been 7 allegations of this nature (out of the 17 in the past 5 years), most of which we believe should have been recorded by the NSW Children's Commissioner but which were deemed to be non-reportable.

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